

RESILIENCE: A HEALTH PROMOTING STRATEGY FOR ABORIGINAL WOMEN FOLLOWING FAMILY SUICIDE

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ABSTRACT

The purpose of this research was to explore resilience in Aboriginal women following family suicide. A participatory action research design, using in-depth interviews was used for the study. Ten Aboriginal women who had lost loved ones to suicide were interviewed twice to explore factors which contributed to their resilience. An inductive process was used to analyze the data, iteratively coding to identify themes and relationships among themes. After a very difficult adjustment period, the women developed strategies to reestablish balance in their lives. Spiritual beliefs, prayer, a connection to the deceased, and the support of family and friends were key supportive factors. Other health promoting strategies included: keeping busy and having a routine; the pursuit of physical health; the importance of laughter; and comfort in nature. The themes that emerged were consistent with the holistic perceptions of health represented in the teachings of the traditional medicine wheel. The lessons learned from the suicide helped the women cope with other adversities and motivated them to give back to their community. In spite of experiencing the profound loss of a loved one to suicide, these Aboriginal women demonstrated their resilience by developing health promoting strategies that enabled them to move forward in their healing journey. A better understanding of how resilient women develop health promoting strategies will guide the development of effective services and programs in communities to assist women in adverse situations regain balance in their lives.

Key words: resilience, Aboriginal women, suicide, grief, medicine wheel, healing journey

In Aboriginal¹ culture, individual health and healing is integral to a balanced family and community life (Aboriginal Healing Foundation, 2006; Bartlett, 2005; Government of Canada, 2006). Colonization and cultural oppression experienced by Aboriginal peoples of Canada profoundly disrupted the cultural continuity of communities and interrupted the passing on of traditional teaching and practices (Aboriginal Healing Foundation, 2003; Bobet, 2006; Mignone and O'Neil, 2005; Government of Canada, 2006; Gracey and King, 2009). As a result there are disproportionately high rates of suicides, injuries, drug and alcohol abuse, and sexual violence in the Aboriginal population in Canada (Adelson, 2005; Chandler and LaLonde, 2004). In 2000, suicide in First Nations² communities was twice the national average (First Nations and Inuit Health Branch, 2001). In addition, the report *Health Determinants for First Nations in Alberta 2010* describes much higher rates of substance use and abuse including smoking and heavy drinking for First Nations compared to other Canadians (Lachance et al., 2009).

Women are considered the "backbone" of the Aboriginal family (personal communication, Otter 2007) and it is evident that many demonstrate strength in coping and in assisting family members to deal with adversity, particularly the suicide of a family member. Studies have been done with other populations of women who exhibit exceptional strength in the face of adversity (Humphreys, 2003; Todd and Worell, 2000; Valentine and Feinauer, 1993). To date, however, no study has been con-

Acknowledgments. Research funding was received from: the Aboriginal Capacity and Development Research Environment (ACADRE), University of Alberta; First Nations and Inuit Health Branch, Health Canada; the Alberta Registered Nurses Education Trust Fund; and the Faculty of Nursing, University of Alberta. We thank our advisory committee for providing ongoing guidance and wisdom for the study. Lastly, we would like to acknowledge the Aboriginal women in our study for their willingness to share very personal aspects of their lives.

1 The term Aboriginal in this study includes individuals who identify themselves as Métis, First Nation, or Inuit (Government of Canada, 2006).

2 The term First Nations "came into common usage in the 1970s to replace the word 'Indian'. Although the term is widely used, no legal definition exists." (Lachance et al., 2009, p. 3).

ducted that explicitly focuses on how Canadian Aboriginal women cope following the loss of a loved one to suicide. In this paper, we present findings from a recent study that explored the experience of Aboriginal women in Alberta following the suicide of a family member.

LITERATURE REVIEW

HEALTH DISPARITIES

Health disparities, including high rates of depression and suicide, are indicators of distress in Aboriginal communities (Adelson, 2005; Kirmayer et al., 2000). First Nations communities reported suicide rates that were twice the national average in 2000 (First Nations and Inuit Health Branch, 2000). In 1999 the suicide rate for Aboriginal youth was 2.1 times the Canadian rate (Adelson) and in Alberta between 1989–1993 the rate was 5–7 times higher than among non-Aboriginal youth (Capital Health Authority, 2003). Aboriginal women are 3 times more likely to commit suicide than their non-Aboriginal counterparts (Capital Health Authority). The Royal Commission on Aboriginal People (1996) described an epidemic of substance abuse and hopelessness that resulted in the highest suicide rates among Aboriginal youth in Canada. Research on the problems that Aboriginal populations face has important implications for health service and health promotion (Kirmayer et al., 2000).

RESILIENCE

Resilience is one attribute that may enhance emotional health following suicide of a loved one. It is the process of interaction between an individual and his or her environment to face adversity and to develop moral strength and a sense of optimism (Tousignant and Sioui, 2009). Resilience has been described as the capacity for successful adaptation, positive functioning, and competence despite adversity (Luther, 2006; Wright, 1998). In a study of resilience in poor women, one participant described resilience as “the ability to keep going in the face of hardship or to face difficult times in life and still do o.k.” (Todd and Worell, 2000, p. 120). Characteristics such as optimism, intelligence, creativity, and humour have been found to assist individuals to thrive

from and in adversity (Tusaie and Dyer, 2004). A resilient individual has an inner strength that helps her to bounce back from the problems that would seem to lead to certain failure (Brodkin and Coleman, 1996). Resilient women are characterized by: an active approach to solving life’s problems; an ability to perceive experiences constructively even if these experiences have caused pain and suffering; an ability to gain other people’s positive attention and support; a network of supportive adults within or outside the family; and a strong reliance on faith to maintain a positive view of a meaningful life (Wright, 1998). From an Aboriginal perspective resilience combines the interplay between spirituality, family strength, Elders, ceremonial rituals, oral traditions, tribal identity, support networks (HeavyRunner and Marshall, 2003), and their relationship to the land (Andersson, 2008; Government of Canada, 2006). According to James Clairmont, a Lakota Elder, resilience may be used to overcome adversity in Aboriginal communities:

The translation of resilience is a sacred word meaning resistance, to resist bad thoughts and bad behaviors. We accept what life has to offer us, good or bad, as gifts from the Creator. We try to overcome stressful and difficult periods with a good heart. The gift of adversity is the lesson we learn when we pass through it. (Graham, 2001, p. 1)

Studies have documented a positive relationship between resilience and health, indicating that healthy women are more resilient (Felten, 2000; Humphreys, 2003; Wagnild and Young, 1993). Participants in one study believed that self-care activities such as exercise, nutrition, and not smoking or drinking were useful in helping them achieve resilience (Felten, 2000). In several studies women have mentioned that relationships to family or family-like support and having someone who believed in them assisted them to believe in themselves (Bachay and Cingel, 1999; Todd and Worell, 2000; Valentine and Feinauer, 1993). Support included helping with childcare and caring during an illness. Resilient older women have said that it was important to offer support to other women to help give life a purpose (Felten). These women believed that doing for others enhanced their own well being.

Spirituality and religious values have also been found to be very important sources of strength for women in adverse situations (Bachay and Cingel, 1999; Felten, 2000; Todd and Worell, 2000; Valentine and Feinauer, 1993). Spiritual beliefs are viewed as important for providing personal comfort, meaning, and balance. Spiritual beliefs connect Aboriginal women with their culture and with people who understand and support them (Leipert and Reutter, 2005; HeavyRunner and Marshall, 2003).

Resilient women report that critical life events involving losses, or experience with hardship, have made them stronger and acted as catalysts for change and growth (Bachay and Cingel, 1999; Felten, 2000). Women have commented on the strength that their cultural beliefs and spiritual and religious values give them. Discrimination promoted the development of ethnic identity in minority women while environmental or social factors such as language barriers and poverty deepened their strength of beliefs (Bachay and Cingel). Northern Canadian women of various cultures reported that developing new behavioural and psychological strategies and enhancing existing ones helped them to develop resilience (Leipert and Reutter, 2005). The exploration of factors that promote recovery and personal growth following stressful events may provide greater insight into processes critical to resilience (Wright, 1998).

ABORIGINAL VIEWS OF HEALTH

An Aboriginal view of health considers the body, emotions, and spirit to be interconnected and inseparable (Aboriginal Healing Foundation, 2006; Alberta Health and Wellness, 2004; Cardinal et al., 2004; Government of Canada, 2006; Smylie et al., 2003). This world view is portrayed by the traditional medicine wheel, which is a circle divided into four quadrants. The medicine wheel symbol has various meanings and expressions for different First Nations people. Some of the concepts represented by the medicine wheel are: everything is related to everything else; things cannot be understood outside of their context and interactions; and there are four aspects to the human condition, the physical, emotional, mental, and spiritual (Graham and Leeseberg Stamler, 2010; Severson and Lafontaine,

2003). An awareness of a First Nations world view and knowledge of local cultural resources enhances well-being in First Nations people (Wyrostok and Paulson, 2000). Several Canadian reports (National Aboriginal Health Organization, 2002; Stout et al., 2001; Stout and Jodoin, 2005) have highlighted the need for research to explore Aboriginal mental health including cultural and spiritual influences and effective approaches to promote health and resilience. The purpose of this study was to explore the experience of Alberta Aboriginal women following the death by suicide of a loved one and to understand how they coped during the grief recovery process.

RESEARCH DESIGN AND METHODS

A participatory action research design (PAR) using a qualitative approach was used for the study. PAR is an appropriate design for research with Aboriginal communities (Fletcher, 2003; Kaufer et al., 1999; McLeod, 1997; Patterson et al., 2006; Smylie et al., 2003), consistent with the principles for research with Aboriginal communities (Alberta Mental Health, 2006; Castellano, 2004; Canadian Institutes of Health Research [CIHR], 2007; Macaulay et al., 1998; Smith, 2005). The research was guided by a community advisory committee (CAC) composed of community women and an Elder (Figure 1). The committee were consulted prior to and throughout the research process, from the development of the research question to the dissemination of results.

In-depth interviews, congruent with the storytelling approach to sharing Indigenous knowledge (Smylie et al., 2003), were used to collect the data. A purposive sampling technique (Polit and Beck, 2004) was used to recruit participants. Professionals in the community who were knowledgeable about the culture and who had an ongoing relationship with the researcher provided an information letter to potential study participants. A preliminary list of guiding questions was developed by the researcher in consultation with the CAC. The questions were open-ended to allow the participants freedom to share their stories and were refined as the interviews progressed. The interviews were audio-taped with permission from the participants, and then



**Figure 1. Community Advisory Committee
Comprising Community Women and an Elder.**

Left to right (standing): Mary Moonias, community member; Cecilia Moonias, Elder; Lyla Goin, first author.

Left to right (sitting): Teresa Bull, community member; Rachel Brown, community member.

transcribed verbatim. The researcher compared the written transcripts with the taped interviews to ensure accuracy. This ensured that the perspectives of the participants were reported as clearly as possible (Morse and Field, 1995). Recurring themes were identified from the interviews and developed into broad categories. The categories were revised as themes emerged that were not included initially. The software program QSR N6 was used to help organize the data. The emerging findings were shared with the participants during the second interview for feedback and validation (Carmen and Profetto-McGrath, 2004). The participants were also asked to share their experience of participating in the interview process.

INCLUSION CRITERIA

The target population for this study was Aboriginal women living on a First Nations reserve in Central Alberta, Canada. The inclusion criteria were women who: agreed to participate; were Aboriginal; were over the age of 18 years; had experienced a suicide in their family during the previous ten years; and demonstrated resilience in grief recovery. The criterion for resilience was defined by the CAC as women who

“had learned a lesson.” This study was conducted with the ethical approval of the Health Research and Ethics Review Board (Panel B) of the University of Alberta, Edmonton, Alberta. Letters of support were obtained from the First Nations Reserve Band, CAC, and the local Mental Health Program. Arrangements were made for referral to a counselor in the Hobbema Mental Health clinic in the event that this was required. Lyla Goin had worked in the community for an extended time and had established a relationship of trust with the community. Rigour was maintained by adhering to a framework that utilizes eight criteria as described by Meleis (1996). Participants signed an informed consent and pseudonyms were assigned to the participants.

FINDINGS

Ten women, ranging from 19–64 years (mean 46 years), participated in two interviews in 2007. Nine of the women identified as Cree and one woman identified as Stoney. Collectively the women had suffered the loss of 22 loved ones; nine women had lost more than one family member to suicide. One woman lost her husband, one her daughter, one her female cousin, three lost sons, two lost boyfriends, and two lost brothers. Many of the participants had to cope with the death of family members at an early age. Amy said “it all started when I was 11,” then added, “I guess I grew up fast.” She had lost multiple family members to suicide including her mother, four brothers, and her best friend.

The participants told the story of their experience and the lessons that they had learned through their healing journey. Although reliving the story was difficult for the participants, the interviews appeared to have a cathartic effect. Some women said that the interviews helped them to discuss details of the suicide that they had never talked about before. One young woman who had lost multiple family members said that it “felt good to let it out, like a weight was lifted.” Another woman shared that she used the interview as a “yardstick” to measure how far she was along in her healing.

Over time, the participants realized that they were not responsible for the choice that was made by their loved one; they began to accept the loss

and to forgive themselves. Participants repeatedly expressed their thankfulness for what they had left, including their children and grandchildren. Sharing the lessons they had learned with other women who had suffered losses, including the strategies that had helped them, was perceived as an opportunity to “give back” to the community. Lillian said that she would like to start a “support group for parents, siblings, and children-survivors ... because it’s so important to stop the cycle [of suicide].”

The women demonstrated the characteristics of optimism, hope, humour, and creativity during the healing process. They expressed belief in themselves, their own strength, and their ability to reach out to others to receive the help they needed. The participants expressed a strong desire to change and the belief that life was going to get better. Each followed her own path to healing, but several common phases were identified: experiencing the loss; living in the pain; learning to cope; and gaining strength. Although the phases overlapped, the duration of each phase varied for the women; some felt that they were just beginning the healing phase many years after their loss.

EXPERIENCING THE LOSS

The participants described the experience of losing a loved one to suicide as “horrifying, brutal, and devastating.” Martha said “my soul mate, my best friend, my pillar, my strength is forever gone and I’m never going to see him, but of course I will never forget.” The women referred to being in a state of shock, walking around but not really aware of what was happening. Lucy said that she did not remember what happened after she was told that her son had been found. Many of the women mentioned that they withdrew either physically or emotionally to try to find the strength to withstand the loss. Mary left her home for 2 months recalling, “I didn’t have the strength — I’d go there, but I just couldn’t handle it. It helped a little bit to be away but the pain was still there.” A very consuming question for all of the participants was “why did he take his own life?” The women were consumed with guilt and the fear of losing another loved one. This resulted in them not wanting to let their remaining children out of their sight.

LIVING IN THE PAIN

Participants described the profound pain and emptiness that they felt after the suicide. One participant described herself as being “just broken,” while another woman said that she felt that “part of me was gone.” Betty said that there was so much pain in the family following the suicide that everyone went their separate ways instead of supporting each other. She created a barrier around herself and the other family members did the same. Several participants said that they had tried to hold the pain inside. Angie, who had lost ten family members, including four in one year, said “we used to learn to hold our emotions inside; you’d just learn to stop feeling stuff, you’d see so much you just block them out.” Lillian initially thought that people were keeping their distance because they blamed her for the death, however later she understood that they just didn’t know how to help with the grief. Some women tried to cope by using drugs and alcohol. The only time Kathy could “let it out” after losing her baby’s father was when she drank. Patricia said that she drank “for a good year straight,” and had her “booze and a whole bag of pills” to help her cope. Subsequently the participants had to find a “different way to cope.” Lillian described how she made her decision:

Nobody’s going to — nobody’s going to slap something on me to fix me. This isn’t going to go away on its own. I’ve got to work on it.... So from that point on, it was a long, hard, difficult journey.

The memory of the suicide was still so vivid for some women that they relived the pain during the interview. In addition to the pain, the women described not caring about eating and having difficulty sleeping following the suicide. All of the women talked about crying incessantly. Mary said that she had “cried a river of tears.” Later she realized that crying was healing and it was better than “holding it in.”

COPING WITH THE LOSS

After surviving a period of not caring about what happened to them, the women began to search for strategies to help them to heal and get on with their lives. Talking about the loss and their loved one was a very important strategy and, although it was very

difficult initially, all of the women said that it was very beneficial. It was especially helpful if the listener had experienced a similar loss since then they “really understood.” Lillian said:

I think, to me, that was my way of dealing with my problems ... talking about it ... and I think that's what made me stronger ... you just go on and be strong.... I'm able to talk about it and not feel bad about it or guilty, I wasn't able to talk about it at all. Today I can talk about it, and I can say, 'My son committed suicide, and this is what I did.'

Keeping busy and having a routine helped some of the participants to cope. Lillian didn't want to give herself time to think and feel. Cara found that writing, painting, dancing, or singing was helpful for her. Martha found that spending time with nature was healing while for Lucy humour and the cultural value in laughter was comforting. She shared that:

Sometimes one of them [family] will end up with something that brings laughter. And that's why, a long time ago, I guess different people would have different gifts, and when there was a death in the community, there was this one guy who had a gift of telling stories all night and making people laugh. They laughed through the night, 'cause they believed that laughter healed.

All of the participants said that they “hung onto” the early teachings that they had received from parents and grandparents. The teachings included: spiritual teaching; instruction in living a healthy lifestyle; learning respect; parenting instruction; and cultural teachings such as “things happen for a purpose” and “destiny cannot be changed.” Although they often didn't understand the teaching at the time, the women found that they understood the meaning of the lesson and could “fall back” on it when they needed to. Usually cultural beliefs were comforting and helped to release the women from feeling blame and guilt because of the suicide. Occasionally the cultural beliefs caused conflict for the women. For example, the belief that crying for the deceased should be avoided sometimes caused the women to try to “hold the pain inside.” Eventually it became a priority for the women to take care of themselves physically again. To be healthy the participants said that they had to make

an effort to eat healthy diets, exercise, and avoid alcohol and drugs. This included prescription drugs which had frequently been prescribed by their physicians to help them through the ordeal.

One of the women believed that her experience in boarding school had helped her to learn to be strong because “boarding school was a tough place to survive.” Some of the women had to cope with the loss of more than one family member, often at an early age, which added to the pain of the experience. For many of the women, although their loss was many years prior to the interview, certain times or occasions still brought the pain back. The participants spoke of being comforted by being connected spiritually to the deceased, and knowing at certain times that their presence was with them. They kept the connection to the deceased through belongings such as a hockey bag, a three wheeler, or a daughter's hair. Although celebrations like Christmas remained difficult, the women also felt close to the deceased during the special occasions of birthdays and memorial feasts. Participants planned for these special occasions by preparing birthday cakes and favorite foods to share with the deceased:

His birthday's coming up, and I'm having a hard time dealing with it. You know, one thing I do know about, and that's I give a party, a birthday party for him. It makes it a lot easier for me. I go get a cake, and we cook, and the things he used to like to eat, we put on the table, and the old man prays, and we all eat together. That's how I deal with that. It's hard — Christmas, any of the holidays. Like, part of me aches.... I guess it'll always be there....

Comfort was also found in dreams which provided the opportunity to receive advice from the deceased loved one and the grandfathers (ancestors) and to say goodbye to the deceased.

STARTING TO HEAL

For some women, their healing journey began with a dramatic “hope” or a “spark” when they realized that they would get better. Amy called this a “turning point to healing” while Mary called it “turning my life around.” After losing her husband, Martha recalled:

I had that desire to be better. I *wanted* to get better ... one day, one morning; I'm lying there, thinking, 'This pain is still here. What can I do with this pain; I want to get rid of this pain. Lord, help me!' So I forced myself, something sparked, and I said, 'Get up! Get up! Go to that bathroom, take a shower, and face the day.' And I did. That's what I did. That was the day I decided, 'Okay, I've got to do something.' ... But already, by that time, I had this hope, this desire, 'I'm going to get well.' I knew that.

For others healing was more gradual, not beginning for many years. Mary decided that she was “not going to cry all her life” after losing her son. Lillian described her journey as “getting my strength back and rebuilding myself.” The women worked on developing their self esteem and celebrating their accomplishments. One participant described her healing:

I would call it work, because you have to work on yourself and work on the people that are close to you.... I just pushed myself, just kept going and going and going. But that was the only way that I thought I could do it, just to forget, just keeping myself working and working and working.

A big part of healing was learning to let the loved one go, even though “he took a big chunk of my heart.” One of the things that helped was the realization that their loved one would have wanted them to be happy and to go on with their life.

Many of the women said that their belief in the Creator was what “pulled them through.” Some of the participants had both Western and Traditional spiritual beliefs. Martha talked about the importance of spirituality for her:

We're very spiritual people, eh, us Indians — Cree. I'm thankful for my parents instilling that in me, in us. To me, it's a survival technique. I don't know what I would do had I not ... if I wasn't a believer in that sort of thing. I honestly can't imagine how I would have handled it if I didn't have that, that connection to the Guy upstairs.

Spiritual help, including prayer and smudging (ceremonial use of sweet grass), was essential. Most of the women found that going to Elders was very helpful for prayer, guidance, support, and spiritual uplifting. Women participated in cultural ceremonies such as sweat lodges, feasts, and sun dances:

I felt stronger after that [sweat], because I gave a lot of it back to the Creator, and I asked for forgiveness. I believe in our ways, strongly ... that was what really changed me. Well, it didn't change me, it just found me. I couldn't even find myself. I wanted help so bad, and just asking, not a person, but asking the Creator was probably the strongest thing that you can do when you seek.

A few of the women, however, said that they did not know Elders that they could go to for help and some said that they had not been raised in the traditional way. These women sought spiritual support in Western traditions. Some of the women said that initially they were so broken that they could not pray themselves, and felt that they could not have made it through without friends, family, and Elders praying for them until they were able to pray for themselves.

The participants were able to reach out to receive the support that was essential to help them heal and move on with their life. Family, including immediate, extended, and adopted, was usually identified as the main source of support. In one case it was an adopted sister who was “just there.” Martha said her sister:

... would be the one to carry me through. She allowed me to cry, she listened to me, she just was there, and I'm forever indebted to her.

Family support included taking care of the survivor physically, making sure the family member ate, cleaning the house, or accompanying the survivor to spiritual activities. Usually the support included listening, talking, and praying for and with the participants and just being there for them. Often the family stayed together for extended periods either at the participant's home or the extended family's home. The women said that when they were feeling lonely they would go to visit family for support. Children and grandchildren were a valuable source of support and understanding and often they were the motivation to continue. Lucy described her family support:

It [support] would have been just my family. They gave me a lot of support; like, they were there when I needed them, and even after that happened to my son, when he took his life, they stayed. Even

after the funeral, they stayed. My sister stayed for a whole week, and then after she left, my brother was there. He stayed for about a month, just helping around with the horses and talking to me.

For some of the participants friends provided the strongest support. The friends were there to listen, to pray, and to support. One woman spoke about the importance of having close friends:

I believe that it's important to have a connection with someone, even just one or two people.... I have about five persons that I'm really close to. We tell each other stuff that we would take to our graves, that sort of thing. So I always say find someone that you trust. You never know when they might carry you, carry you through sometime.

The participants said that even though the experience was "almost worse than dying" they felt that they had learned from it. These "lessons" had made them stronger so that they felt that they could cope with anything. Martha shared:

Even though I won't ever forget the event, it has strengthened me in terms of being able to withstand difficult situations.... I just gained the extra strength that's needed.... But of course, I never forget, I will never forget that time. It strengthened me emotionally, mentally, because surviving an ordeal like that ... nothing else affected me.

Angie very eloquently described the lessons she had learned following her loss:

It's almost as bad as dying, having to live with all that hurt and that anger. It's really hard. It's heartbreaking, and it's really emotionally hard on a woman. But that's what makes us strong. But those hard times, they're like lessons in life; either you can go with them or go against them, but you've got to move forward, don't move back. You've always got to move forward. Whatever's happened, it's happened; you can't change what's happened. Just don't blame yourself. Things happen for a reason. God put us here for a reason. We're all gifts from God. Just like our children, they're gifts; they're not ours, they're His, so He can take any of us at any time, and we have no say in it. I can die tomorrow, but at least I know if I was to die knowing that I was sober and I was there for my kids, and I gave them stuff that I couldn't give them before when I was drinking.

A few of the women accessed professional counseling although it was helpful if the women had a prior relationship of trust with the therapist. Lillian said that she had tried four therapists but that there was only one that she was comfortable talking with. Amy said that she had found the counselors very judgmental and so she didn't want to "access those resources." Martha described the importance of a trusting relationship with her counsellor:

I saw a psychologist. In fact, I had to see a psychiatrist, but I can't say I got a heck of a lot out of the psychiatrist. He was merely there to sign my disability. But the psychologist helped me some, yeah; I believe that worked.... I seemed to know who really cared.

Patricia had not found professional counselling to be helpful:

I did go for help — I was there, I was going for my appointments and stuff, but it wasn't helping me ... it gave me some support, but it wasn't enough. Because what I found was I felt I was being studied. I felt *that* I was being studied, and I felt that my community was being studied — it was not about me and what I was going through and how I was going to get the help. I needed help — and I felt nothing would help me. I was talking to people off and on, and no one — like, the doctors gave me pills for this and that, and nothing was working.... I don't think they were ready for me, and I wasn't ready for them; it was a bad time for both of us ... because I don't think the psychologist had the information to say, 'Yeah, you will be experiencing this,' or 'You will be experiencing that.' or say something like that.

Many of the women did not access any professional help.

DISCUSSION

In spite of experiencing severe adversity following the loss of a loved one to suicide these Aboriginal women demonstrated their resilience by developing health promoting strategies which enabled them to move on in the healing process. The participants struggled to restore balance in their lives. The traditional medicine wheel stresses interconnectedness and balance in all four areas of life: physical, mental, emotional, and spiritual. (France et al., 2004; Peters

and Demerais, 1997) A model (Figure 2) has been developed to illustrate key components of resilience demonstrated in the current study, using the medicine wheel as the framework. The survivor is represented at the centre of the circle, with the strategies utilized by the participants have been listed in the surrounding quadrants. Women used physical, emotional, spiritual, and mental strategies to restore balance in their lives. The women stressed the hard work that was required to regain a balanced life.



Figure 2: Resilience Following Suicide.

Although some participants suffered from depression and guilt and used drugs or alcohol to ease the pain, the women eventually developed the strength to cope and to assist their remaining family members to deal with the suicide.

Aboriginal women have an important and central role as sacred life givers and have been at the forefront of the healing movement (Chansonneuve, 2005; Walters and Simoni, 2002; Aboriginal Healing Foundation, 2006). Although literature on resilience in Aboriginal people is limited, Aboriginal peoples have traditionally placed great emphasis on fostering resilience (Stout and Kipling, 2003). Despite their loss, the women in the current study had the ability to withstand adversity and demonstrate commitment to their family and community. Most of the participants had experienced the loss of loved ones

at an early age. Some of the women identified this as a factor in helping them to be strong. One woman also identified hardships in residential school as being a factor that promoted healing. Previous experience with hardship and personal loss has been reported as a catalyst for growth (Bachay and Cingel, 1999; Felten, 2000).

Historically, Aboriginal people have shown remarkable ability to survive and thrive in the face of adversity. This characteristic has been described not only in reference to individuals, but also in relation to the achievements of families and communities (White and Jodoin, 2003; Durie, 2006). Wellness and strength for Aboriginal peoples emphasizes the collective values of connection, interdependence, and community (White and Jodoin, 2003; Durie, 2006). In the current study the participants turned to their family and friends for support during their healing journey. The support included practical help as well as emotional support. The ability to reach out has been identified as a characteristic of resilient women (Wright, 1998). Turning to family and community members for social support is characteristic of Aboriginal people and is often the approach used in traditional healing (Ladd-Yelk, 2001; France et al., 2004; Trimble and Hayes, 1984). Women in a northern Canadian community identified having at least one close friend as contributing to their resilience (Leipert and Reutter, 2005); having close friends was also an important support for the women in the current study.

The participants identified a "turning point" which prompted their decision to move on and to work toward healing. Family members in a study on healing following youth suicide made a clear and deliberate decision to move on to healing, life, and living (Kalischuk and Davis, 2001). Aboriginal women living with HIV also described reaching a "turning point" in adapting to their illness and shifting their life path in a more positive direction (Mill et al., 2007). Talking about the loss to family and friends, keeping busy and having a routine, finding comfort in nature, laughing, powwow dancing, writing, painting, and walking, were found to be very helpful to the healing of the participants. Similar strategies were used by family members in a study of teenage

suicide survivors (Kalischuk and Davis, 2001). Self-care activities such as good nutrition, exercise, and not drinking or using drugs were frequently mentioned as important healing factors in the current study. Self-care and good health have been previously identified by women as being helpful in developing resilience (Felton, 2000; Humphreys, 2003).

Aboriginal cultural beliefs provided comfort for many of the women. A teaching that was frequently mentioned was the belief that the past was gone and you had to go on living for today: each person's destiny is set from birth and the outcome cannot be changed. Ladd-Yelk (2001) has described a similar Aboriginal belief that each child has a prophetic destiny. This cultural teaching helped to free the participants from feeling responsible for the suicide and to deal with feelings of guilt for not having prevented the death. Focusing on today may reflect a cultural time orientation towards the present while incorporating the past may reflect the Western tendency to focus on the future (France et al., 2004). The participants in the current study were also able to look beyond their circumstances and believe that the future would be better for them. The ability to perceive their experience constructively has also been identified by women who survived sexual abuse (Valentine and Feinauer, 1993).

The participants expressed a strong belief in themselves and a desire to move on with their lives and accept their loss. The ability to accept loss and come out stronger has been identified in other studies of resilient women (Felton, 2000; Humphreys, 2003; Valentine and Feinauer, 1993; Wagnild and Young, 1990). Some of the participants believed that their experience was a gift because they had learned lessons, achieved greater spiritual awareness, and initiated changes in their lives. A belief in being thankful for what you have been given is recognized as a cultural trait in Native American Indian cultures (Ladd-Yelk, 2001). The focus is placed on the positives in one's life rather than the negatives. Mill and colleagues (2007) also found that many Aboriginal participants living with HIV viewed their illness as a gift that had triggered positive changes in their life. Survivors in other studies have also described their difficult experiences as providing a key for un-

locking the doors of self-discovery and self-growth (Kalischuk and Davis, 2001).

The participants in this study described lessons which they had learned through their experience. In Aboriginal cultures learning is viewed as a lifelong activity and individuals constantly strive to create balance and harmony (Aboriginal Healing Foundation, 2006; Bartlett, 2005; HeavyRunner and Marshall, 2003). Learning a lesson was also described by the CAC as the essence of resilience. The women stated that following the suicide they had learned the importance of expressing love to their family members. They had a compelling desire to "give back" to the community and to assist others who had experienced the loss of a loved one to suicide. Helping others became an important factor in their healing process. The desire to reach out to others in a more meaningful way following a suicide was reported among survivors of youth suicide (Kalischuk and Davis, 2001) and a study of resilient older women (Felton, 2000).

Spirituality was consistently described by the participants as essential for their healing. Many of the women in this study stated that without their faith they could not have survived. A strong reliance on faith or spirituality was also described by Wright (1998) as a key characteristic among resilient women. This is consistent with the traditional Aboriginal view that mental health is much more spiritual and holistic than Western views and balance is an integral part of healing (Locust, 1988; White and Jodoin, 2003). Balance also is emphasized from birth to death, between animals, nature, humanity, and spirits regardless of time, space, or physical existence (France et al., 2004; Ladd-Yelk, 2001). The participants in the current study shared the significance of spiritual ceremonies such as healing and sharing circles, sweat lodges, and fasting. Through prayer they were able to forgive themselves, release anger, and find the strength to move forward. Patricia described "finding herself again" by fasting and going into the sweat lodge to ask the creator for help. As France and colleagues (2004, p. 275) describe:

The sweat lodge symbolizes the womb. As the participants leave the womb they are symbolically re-

born. The new beginning creates a new state of mind and a change in attitudes. Those who have cleared their minds during the ceremony can now see the power of the animal spirits and all of the hurt, anger and negative feelings are released.

Several Canadian studies (Caine, 2002; Mill, 2000) have reported a strong desire by Aboriginal women to participate in ceremonies, as well as visits to Elders and medicine men. In the current study women found that spiritual ceremonies were an important factor in maintaining and restoring their emotional, spiritual, mental, and physical well-being. Spiritual beliefs, traditions, and culture have been described in several other studies as being a very important factor for support (Bachay and Cingel, 1999; Bobet, 2006; Felton, 2000; Leipert and Reutter 2005; Wright 1998). Some Aboriginal people, however, experience contradictions between the traditional Aboriginal and Western views of spirituality (Bobet, 2006). Although most of the woman in this study did not separate Western religion from Aboriginal forms of spirituality, one woman felt that she had to choose between the two.

Dreams were a vital link to the deceased, acting as a source of information and comfort to the grieving survivors. France and colleagues (2004) reported that dream sharing is a vital part of the lives of Aboriginal people because it links them to the world beyond themselves and provides a pathway to other spiritual dimensions. Through dreams, people find ways to deal with unexpected death and accept it as a natural consequence of living (France et al., 2004). In a study of suicide survivors (Kalischuk and Davis, 2001), family members mentioned dreams as a powerful source of information. Comfort was also received from nature and from the bear, who was perceived to be an animal kin. This reflects the Aboriginal belief in the kinship between humans and animals. For Aboriginal people, a good relationship with animals helps to facilitate health and healing through the animal's spiritual power (Bobet, 2006; Government of Canada, 2006).

The principle of connectedness was apparent in the comfort which the women received from continued communication with the deceased. Most of the woman spoke about their loved ones as being

present and watching over them. This continuing bond of love between the survivor and the deceased was described by Kalischuk and Davis (2001) as a healthy expression of love which was represented as a "love knot." The women also spoke about receiving help from their ancestors, the grandfathers, during dreams. The connection to others extends to those who have come before, the ancestors, who are sometimes referred to as "grandmother or grandfather" (Bobet, 2006). France and colleagues (2004, p. 276) comment that "it is believed by First Nations people that those who have gone on before are watching over all from the spirit world."

The findings from this study will assist nurses and others working with survivors of suicide to better understand the dimensions of the healing journey. Some of the women accessed professional counseling and said it was helpful if they had a prior relationship of trust with the therapist. One of the participants, on the other hand, said that she found the counselors to be very judgmental. Practitioners need to be familiar with the strategies which women use to maintain their health (Leipert and Reutter, 2005). Women in Leipert and Reutter's study said that "they wanted health care providers who would listen to them and not dismiss or denigrate their perspectives and experiences" (p. 55). The women valued nurses who were "approachable and took a holistic approach to health" (p. 58). Professionals must acknowledge the importance of understanding the cultural identity of their clients; affirmation of the value of traditional medicines by health care workers validates the caring practices of community women (Brown and Fiske, 2001). The development of a positive relationship of trust requires a long term commitment and therefore every effort should be made to provide continuity of staff in a community. Brown and Fiske (2001) reported that affirming encounters frequently arose out of long-term positive relationships grounded in respect and trust. By understanding their client's contexts practitioners are better able to advocate for their clients to develop effective resources (Leipert and Reutter). Support programs should be designed with an Aboriginal perspective and a focus on wellness in keeping with Aboriginal beliefs. Both traditional and Western spiritual sup-

port should be included in program design to provide the clients the opportunity to choose. Some of the participants were unable to find the cultural help they felt they needed. Although few had the opportunity to access these, the participants felt that support groups and healing circles would be beneficial because people who have been through the experience understand. Sibling support groups and suicide prevention programs were identified as critical to teach people to listen when a loved one threatens to commit suicide. Support is needed on a long term basis to ensure that it is available throughout the long healing process. Aboriginal people living with HIV also found that it had taken many years before they felt that they could “get on with their lives” (Mill et al., 2007).

The findings from the current study have important implications for practice, programming, and policy. Participants highlighted the need for support programs and services in the community and community ownership of these services. To be effective programs must be congruent with community beliefs and the identified needs of the community. The importance of a trusting relationship with counselors was highlighted by several participants. Since this trust develops over time, programs need to be long term with stable funding. Services also need to be accessible in terms of location, cost, and wait times to meet the needs of clients. The findings provide critical insights to inform policy makers in both Aboriginal and non-Aboriginal communities to ensure that support services for individuals following the suicide of a loved one are accessible, effective, and culturally relevant.

CONCLUSION

The stories of Aboriginal women's experiences following the loss of a loved one to suicide provide a better understanding of their healing journey. The healing journey was described as being “a long, hard, difficult journey.” The hard work included trying to get back some sense of normalcy. The participants said that even though they would never forget their loved one they perceived the lessons which they had learned as a gift. These women were motivated to share their experiences in order to bene-

fit others who also suffered the loss of loved ones to suicide. The results of this study can be used to empower communities and encourage policy makers to develop programs and policies that can help women to develop resilience following the loss of a loved one to suicide.

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