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Cultural Continuity as a Determinant of Indigenous Peoples' Health: A Metasynthesis of Qualitative Research in Canada and the United States

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Abstract

As a strengths-based alternative to Western notions of enculturation and acculturation theory, cultural continuity describes the integration of people within their culture and the methods through which traditional knowledge is maintained and transmitted. Through reviewing relevant, original research with Indigenous Peoples in Canada and the United States, the purpose of this metasynthesis is to describe and interpret qualitative research relating to cultural continuity for Indigenous Peoples in North America. This metasynthesis was conducted through the selection, appraisal, and synthesis of 11 qualitative studies. Across the selected studies, five key themes arose: the connection between cultural continuity and health and well-being, conceptualizations of cultural continuity and connectedness, the role of knowledge transmission, journeys of cultural (dis)continuity, and barriers to cultural continuity.

Cultural Continuity as a Determinant of Indigenous Peoples' Health: A Metasynthesis of Qualitative Research in Canada and the United States

Numerous research studies have identified culturally specific risk and protective factors for health through quantitatively examining the effects of culture, historic trauma, and various health outcomes within Indigenous communities in North America (Currie et al., 2011; Walters & Simoni, 2002; Whitbeck, Chen, Hoyt, & Adams, 2004). While these studies, which rely on validated quantitative scales built around enculturation and acculturation theory,[1] have been instrumental in building an understanding of Indigenous resiliency as a protective factor that offsets the impacts of historical trauma, oppression, and discrimination (Tousignant & Sioui, 2009; Whitbeck et al., 2004), few studies have sought to contextualize the meaning of these social constructs from community-based perspectives. Alternatively, cultural continuity and cultural connectedness are emerging areas within Indigenous health research. In their research, Snowshoe, Crooks, Tremblay, Craig, and Hinson (2014) defined *cultural connectedness* as "the extent to which a FN [First Nations] youth is integrated within his or her FN culture" (p. 249). This construct is measured by survey items within three dimensions: identity, traditional and cultural activities, and spirituality. *Cultural continuity*, which has also been increasingly conceptualized within Indigenous health research (Greenwood & de Leeuw, 2012; Kirmayer, Tait, & Simpson, 2009; Loppie Reading & Wien, 2009), builds on cultural connectedness to emphasize the importance of "intergenerational cultural connectedness, which is maintained through intact families and the engagement of elders, who pass traditions to subsequent generations" (Loppie Reading & Wien, 2009, p. 18). Cultural continuity also situates culture as being dynamic through the maintenance of collective memory, which may change over time (LaRocque, 2011).

Within the larger body of Indigenous health research, there is a lack of shared understanding or common conceptualization of cultural continuity. The recent shift from acculturation to enculturation within research has been an important step in recognizing both Indigenous resilience and the systemic impacts of colonialism (Weinreich, 2009; Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1996). However, there is also a need to find common ground between enculturation theory and alternative constructs, such as cultural connectedness and continuity, which have been supported by Indigenous communities (Snowshoe et al., 2014). Further, there are well-cited examples that provide alternative understandings to cultural continuity as a determinant of health. For example, Chandler and Lalonde (1998) have produced a body of research under the umbrella of "cultural continuity" and their work is highly revered. Their research examines the correlation between six "markers of cultural rehabilitation" and youth suicide rates in BC First Nations communities. The independent variables examined in this research included community involvement in land claims processes (i.e., securing Aboriginal title), involvement in self-government, control of police and fire services, establishment of local cultural facilities, youth attendance in band-administered schools, and control over health services (Chandler & Lalonde, 1998). Chandler and Lalonde found that the presence of each variable in communities was associated with lower rates of suicide. While Chandler and Lalonde's research is undoubtedly important, and provides insight into the importance of self-determination in community health and well-being, it does not actually measure cultural continuity; rather, they examine the impact of community control and local administration on First Nations youth suicide rates. Among the critiques of this work,

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[1] Enculturation refers to the degree to which an individual is connected or integrated within his or her culture. Conversely, acculturation is the extent to which a person has assimilated into a "dominant" culture (Fleming & Ledogar, 2008).

Kirmayer and colleagues (2009) noted, "the involvement of Aboriginal people in contemporary institutions like municipal government or formal school systems can hardly be viewed as cultural traditionalism" (p. 19). They also highlighted protective factors that have been overlooked in past research, specifically citing the role that self-esteem, community organization, and youth leadership can play in improving mental health for First Nations youth. More recently, Snowshoe and colleagues (2014) demonstrated that cultural connectedness is associated with pro-social behaviours, increased engagement in school and community, and lower rates of substance abuse among First Nations high school students in Saskatchewan and Southern Ontario.

Cultural continuity has also been identified as a social determinant of health[2] for Indigenous Peoples in Canada, with the development of explanatory models for proximal, intermediate, and distal determinants (Greenwood & de Leeuw, 2012; Loppie Reading & Wien, 2009). However, few research studies have sought to build on this understanding through working with Indigenous communities. The aim of this metasynthesis is to describe and interpret qualitative research relating to cultural continuity for Indigenous Peoples in North America. This review of relevant, original research concerning Indigenous Peoples in Canada and the United States will (a) position cultural continuity within a framework that considers social determinants of health, and (b) aim to understand the gaps in conceptualizing cultural continuity, while respecting diversity across Indigenous Nations.

Methods

Rationale for Conducting a Qualitative Metasynthesis

Qualitative research requires that the researcher become deeply immersed in the research field, usually a naturalistic setting, to ensure that the research question is explored in depth (Crouch & McKenzie, 2006). This research design often allows researchers to form close relationships with the research participants, or the larger community. These relationships are often of great benefit to both the participants and the researcher, as they can facilitate bilateral knowledge translation. Moreover, within the area of Indigenous health research, it is widely accepted that these designs are "more conducive to a holistic worldview and oral tradition . . . add[ing] fluidity and flexibility to the research process and utilizes the art of traditional storytelling" (Struthers, 2001, pp. 129-130). In this same sense, open-ended questions encourage the development of rich data and allows for the researcher to be responsive to participant cues, which can broaden the scope of the data (Crouch & McKenzie, 2006). In this way, qualitative research plays an integral role in understanding cultural continuity as a determinant of Indigenous Peoples' health.

In building on the value of qualitative research, a metasynthesis was chosen as the most appropriate way of summarizing the body of work that has been produced with respect to cultural continuity for Indigenous Peoples. Starting in 1985, when qualitative metasyntheses were first utilized, they have aimed to develop and understand complex theories through interpreting and synthesizing a body of findings from qualitative studies (Walsh & Downe, 2004). In this way, the goal of metasynthesis is to create a product that both combines and interprets a number of works into a whole.

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[2] Broadly, the social determinants of health are defined as the environments and circumstances that shape the health and wellness of individuals, families, and communities. This includes social and economic conditions, which are "shaped by the distribution of money, power and resources at the global, national and local levels" (Greenwood & de Leeuw, 2012, p. 381).

Two-Eyed Seeing as a Critical Lens

As a Métis woman, I have a clear and vested interest in Indigenous conceptualizations of cultural continuity and I carry this passion throughout the research process. Two-eyed seeing, which is an ontology and way of life that aims to bring together Western and Indigenous knowledge (Iwama, Marshall, Marshall, & Bartlett, 2009), was used throughout this research. This approach is used to honour both Indigenous and Western ontologies and methodologies, as well as to draw attention to the relational aspects of diverse understandings of complicated issues. In this way, this article aims to honour the teachings of Elders Albert and Murdena Marshall by weaving back and forth between multiple forms of knowledge, with the goal of replacing a hierarchy of knowledge systems with a process of walking forward together (Bartlett, Marshall, & Marshall, 2012).

Search Strategy

With the goal of understanding the meaning of cultural continuity for Indigenous populations in Canada and the United States, combinations of terms for the phenomenon and population were used (Table 1). A cross-discipline approach was taken to review articles published from 1990 to 2016, through searching MEDLINE, PsychInfo, Social Sciences Full Text, and Open Access Theses and Dissertations. A manual search was also conducted, using reference lists from included studies and their forward citations, in addition to hand-searching relevant research journal titles, online conference materials, and government report documents.

Study Selection and Appraisal

The inclusion criteria included qualitative research studies, or a significant qualitative component within mixed methods; studies that address cultural continuity for Indigenous Peoples in Canada and/or the United States; and articles that were published between January 1990 and January 2016. Articles were excluded if they had a quantitative study design, did not include primary data collection (e.g., literature reviews, editorials, opinion articles), were non-English articles, or used a priori analytic categories (e.g., pre-developed indicators used in mixed method questionnaires).

Initially, each record title that arose in the search was reviewed for relevance by applying the inclusion and exclusion criteria. Following this, abstracts were reviewed, and any records that were deemed relevant were read in full. Articles that met the inclusion criteria were then critiqued for methodological rigour, using the Critical Appraisal Skills Programme (CASP). The CASP appraisal tool assesses the research aims, methodological approach, qualitative methods, ethical concerns, and findings (Figure 1; CASP, 2013). Each of the 11 studies that were assessed for methodological rigour met at least nine of the ten CASP criteria (Table 2). For those that only met nine criteria ($n = 7$), this was due to a lack of discussion around the ethical issues in the research ($n = 5$) or the relationship between the researchers and participants ($n = 2$). While both of these components are important within qualitative studies, the overall quality of these seven studies was still deemed to be adequate for inclusion within this metasynthesis. In addition to assessing the overall rigour of the research articles, of considerable importance in this assessment was evidence of relationship building with community, in light of past mistakes that have been made by utilizing authoritative and non-collaborative research methodologies with Indigenous communities (Brant-Castellano, 2004).

Table 1. Key Search Terms

Phenomenon	Population
Cultural continuity	Indigenous People
Cultural connectedness	Aboriginal People
Acculturation	First Nations
Enculturation	Métis
	Inuit
	Native American
	American Indian
	Alaska Native

1. Clear, relevant, and important research purpose
2. Appropriate methodology to address the purpose
3. Appropriate research design
4. Appropriate recruitment methods
5. Justified and explicitly stated data collection methods
6. Critically examined relationships between research and participants
7. Ethical issues are considered
8. Rigour in data analysis
9. Clear presentation of results
10. Overall value of the research

Figure 1. **Components of the CASP Tool (2013).**

Table 2. Appraisal of Qualitative Research Studies Based on CASP Criteria (CASP, 2013)

Article	Research Purpose	Methodology	Research design	Recruitment	Data collection	Relationships	Ethical issues	Data analysis	Results	Overall value
Brunanski, 2009	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Drywater-Whitekiller, 2006	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Flynn, Olson, & Yellig, 2014	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Hunter, Logan, Goulet, & Barton, 2006	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES
Iwasaki, Bartlett, & O'Neil, 2005	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES
Long & Curry, 1998	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Lucero, 2010	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Lucero, 2014	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Oster, Grier, Lightning, Mayan, & Toth, 2014	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Smith, Varcoe, & Edwards, 2005	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Wexler, 2014	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES

Data Analysis and Synthesis Approach

The analysis was conducted through multiple reads of the selected research studies with attention to the context and themes that arose across the studies. Each study was thematically analyzed using a content-driven codebook. Studies were re-read multiple times and re-coded when necessary, using the constant comparative method (Sapsford & Jupp, 2006), involving the continual clarifications of the data, the assigned codes, and the overarching themes. Despite this process of compartmentalization, attention was paid to the context in which each of the findings is presented (e.g., the populations involved, settings and methods used), through the creation of multiple tables to provide context for each of the studies included. Methodological information was added to Table 3, while rough notes on themes and concepts, as well as quotes, were added to a second table. In a review of common themes across all of the selected studies, Table 4 was created. Further, an audit trail of explanatory notes was recorded with respect to decision-making for screened studies that were not included.

Results

Search Results

Figure 2 depicts the process of article identification, screening, and inclusion, with the number of articles that were maintained throughout each of these steps. The initial database search revealed a total of 771 records across four databases. After screening the articles by title and abstract, 26 were identified that met the inclusion criteria. A deeper read excluded half of these records, as they did not fully meet the relevancy criteria with respect to addressing cultural continuity. Of these articles, two were excluded based on the critical methodological assessment. Although a second search was manually conducted and initially revealed 32 records, none of these articles passed the screening stage. This process led to a total 11 articles for inclusion in this metasynthesis.

Study Characteristics

A matrix summarizing the study characteristics for each of the 11 articles (Table 3) includes each citation, country, participant characteristics, inclusion criteria, research design, methods, and discipline. The studies were conducted between 1998 and 2015, within different disciplines, including health sciences ($n = 3$), social work ($n = 3$), nursing ($n = 3$), and psychology ($n = 2$). Nearly equal, six of the studies were conducted in the United States and five were conducted in Canada. While many of the articles specified the specific nations or tribal affiliations with which participants identified, all of the articles worked with a diverse sample where multiple groups are represented. Sample sizes ranged from 4 to 57 participants, with a range of subgroups, including youth, adults, and Elders.

As a key inclusion criterion, nearly all of the studies were solely qualitative, while one study included a formative qualitative step as part of a mixed methods design. When further specified, qualitative study designs included phenomenology ($n = 2$), ethnography ($n = 2$), participatory action research ($n = 2$), grounded theory ($n = 1$), narrative inquiry ($n = 1$), qualitative description ($n = 1$). All of the studies used types of purposive sampling approaches. Data collection methods included interviews (e.g., exploratory, open-ended, semi-structured, or structured) and focus groups. Typically, data was analyzed thematically using software (e.g., NVIVO, Atlas.ti, Ethnograph) or understood through narrative analysis, and studies commonly used a number of rigour checks, including member checking, journaling, and critical reflexivity.

Table 3. Matrix of Included Research Records

Article	Country	Participants	Inclusion Criteria	Study Design	Methods	Discipline
(1) Brunanski, 2009	**Canada**	4 participants; youth (aged 18-24); First Nations women; previously street involved	1. Qualitative study 2. Aboriginal people in Canada 3. Cultural connectedness	Narrative inquiry	Purposive sampling through agency partnerships; in-depth, conversational interviews; narrative analysis (story-telling)	Psychology
(2) Drywater-Whitekiller, 2006	**USA**	19 participants (11 females, 8 males); Native American 4th year undergraduate students	1. Qualitative study 2. Native American 3. Enculturation	Ethnography	Criterion-based and snowball sampling; one-on-one structured interviews; person-centred, narrative analysis	Social Work
(3) Flynn, Olson, & Yellig, 2014	**USA**	42 participants (18 men, 24 women), including American Indian university students ($n = 25$) and their family members ($n = 12$), and administrators ($n = 5$)	1. Qualitative study 2. American Indian 3. Acculturation	Grounded theory	Criterion-based and snowball sampling; interviews and focus groups, with presentation of digital photos (i.e., artifacts); grounded theory analysis; "trustworthiness procedures" (e.g., reflexivity, journaling, member checking)	Psychology
(4) Hunter, Logan, Goulet, & Barton, 2006	**Canada**	8 participants (3 men and 5 women); First Nations people in an urban area who access the health centre	1. Qualitative study 2. Aboriginal people in Canada 3. Assimilation	Ethnography	Convenience sampling; individual, semi-structured interviews; thematic analysis concurrent with data collection, conducted until saturation; various credibility checks	Nursing
(5) Iwasaki, Bartlett, & O'Neil, 2005	**Canada**	26 participants living with diabetes: First Nations men ($n = 9$) and women ($n = 8$), and Métis women ($n = 9$)	1. Qualitative study 2. Aboriginal people in Canada 3. Enculturation	Qualitative study with a phenomenological analysis framework	Voluntary sampling; 3 focus groups; team approach to thematic analysis using a phenomenological analytics framework, participants validated data interpretations	Health Sciences
(6) Long & Curry, 1998	**USA**	57 participants; Native American Elders ($n = 22$) and young women ($n = 35$)	1. Qualitative study 2. Native American 3. Acculturation	Qualitative; exploratory	Snowball sampling; focus groups, field notes, and journals; all data coded using Ethnograph software; member checking	Nursing
(7) Lucero, 2010	**USA**	7 participants (2 men and 5 women); American Indian adults who have lived in an urban area since childhood	1. Qualitative study 2. American Indians 3. Cultural connectedness	Descriptive phenomenology	Purposive sampling for maximum variation; open-ended interviews to elicit personal narratives; phenomenological data analysis	Social Work

(continued)

Table 3. Matrix of Included Research Records (continued)

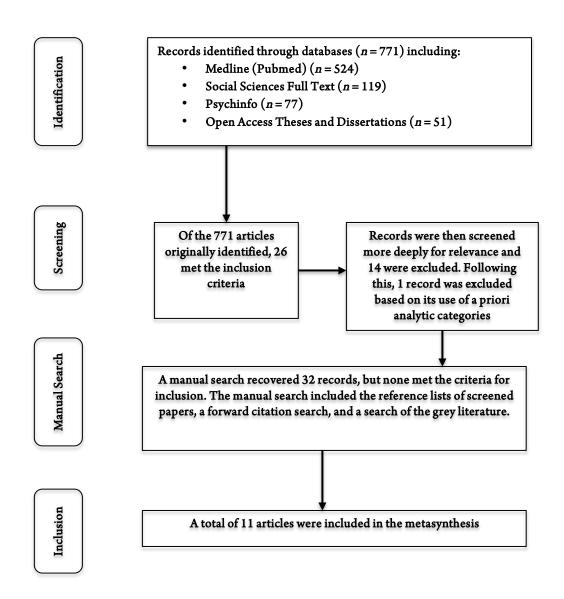|						
(8) Lucero, 2014	**USA**	14 participants, members of 5 families; American Indian adult women living in an urban area	1. Qualitative study 2. American Indians 3. Cultural connectedness	Descriptive phenomenology	Purposive sampling; conversational interviews; phenomenological data analysis; narrative synthesis	Social Work
(9) Oster, Grier, Lightning, Mayan, & Toth, 2014	**Canada**	10 participants; First Nations Band Council leadership (past and present)	1. Mixed methods study (qualitative component) 2. First Nations peoples 3. Cultural continuity	Mixed methods – with formative "qualitative description"	Purposive sampling; semi-structured interviews; thematic analysis using Atlas.ti; reflexivity and rigour checks	Health Sciences
(10) Smith, Varcoe, & Edwards, 2005	**Canada**	16 participants; community-based stakeholders for Aboriginal prenatal and parenting services	1. Qualitative study 2. Aboriginal people in Canada 3. Cultural continuity	Participatory research; case study design; critical post-colonial lens	Snowball sampling; exploratory interviews and small group discussions; thematic analysis using NVIVO; critical reflexivity	Nursing
(11) Wexler, 2014	**USA**	25 participants; Inupiaq Elders ($n = 7$), adults ($n = 7$), and youth ($n = 11$)	1. Qualitative study 2. Alaska Natives 3. Enculturation	Community-based participatory research; Intergenerational Dialogue Exchange and Action	Purposive sampling, youth co-researchers helped to recruit adults and Elders; both interviews and focus groups; thematic analysis using NVIVO	Health Sciences

Identification

Records identified through databases ($n = 771$) including:
- Medline (Pubmed) ($n = 524$)
- Social Sciences Full Text ($n = 119$)
- Psychinfo ($n = 77$)
- Open Access Theses and Dissertations ($n = 51$)

Screening

Of the 771 articles originally identified, 26 met the inclusion criteria

Records were then screened more deeply for relevance and 14 were excluded. Following this, 1 record was excluded based on its use of a priori analytic categories

Manual Search

A manual search recovered 32 records, but none met the criteria for inclusion. The manual search included the reference lists of screened papers, a forward citation search, and a search of the grey literature.

Inclusion

A total of 11 articles were included in the metasynthesis

Figure 2. **Study selection and appraisal process.**

Participant groups were primarily made up of American Indian or Native American ($n = 5$), or First Nations people ($n = 4$). One study was conducted in Alaska with Inupiaq participants and another study included a sub-group of Métis participants (in addition to First Nations participants). Finally, one study took a pan-Aboriginal approach and did not further identify participants by nation.

Themes that Arose from the Analysis

The analysis to distil key themes and subthemes from each of the 11 original articles led to five overarching themes (Table 4). The first theme suggests that cultural continuity is interconnected to health and wellness for Indigenous populations, as a number of health and wellness outcomes arose across nine of the reviewed papers. The second theme involves conceptualizations of cultural connectedness and continuity, which nine of the papers addressed. The topic of knowledge transmission also arose many times across eight of the papers as an integral component of cultural continuity, and is discussed as the third theme. Participants' narratives also commonly spoke to experiences with both cultural continuity and disconnection—this theme arose across seven of the papers reviewed. The final theme that arose was barriers to cultural continuity, which were discussed in six of the reviewed papers. These themes are described in more detail in the sections to follow.

Health and wellness outcomes. Nearly all of the reviewed papers found that there were health and wellness outcomes connected to cultural continuity for Indigenous Peoples. Most commonly, wellness outcomes were associated with a sense of cultural identity (i.e., being proud of who you are), a positive identity, and strong self-esteem (Brunanski, 2009; Drywater-Whitekiller, 2006; Lucero, 2010; Oster et al., 2014; Smith et al., 2005; Wexler, 2014). Wexler (2014) positioned this concept through a life course[3] perspective:

> Cultural understandings, including those related to historical trauma and current strengths, can provide platforms for mutual affinity and shared meaning-making. These perspectives inform ideas of selfhood, and can define youth pathways into adulthood. This orientation can provide a sense of self-worth, social belonging, and purpose to help youth overcome challenges. (p. 86)

The research reviewed also discussed increased senses of community, belonging, and social purpose as outcomes of being connected to culture (Drywater-Whitekiller, 2006; Iwasaki et al., 2005; Lucero, 2010; Wexler, 2014). Specifically, Wexler (2014) discussed youth outcomes in this way: "Having a strong sense of identity was seen as essential for youth well-being . . . [it] gives a sense of pride and belonging, but also provides a vantage point to take action and move into the future" (p. 83). Cultural continuity was also described as an integral component in participants' healing journeys from their past experiences and from trauma (Brunanski, 2009; Iwasaki et al., 2005; Lucero, 2010; Smith et al., 2005). Additionally, empowerment arose as a wellness outcome across papers. Related to this, increased resistance to colonialism was also discussed (Lucero, 2014; Wexler, 2014). As Lucero (2014) noted, practicing "spirituality [was] a way of resisting assimilation and cultural dislocation" (p. 15).

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[3] A life course perspective contextualizes an individual's experiences within the structural, historical, and cultural contexts that impact that person across the different stages of their development (i.e., gestation through death) (Loppie Reading & Wien, 2009).

Table 4. Themes and Subthemes that Arose from the Metasynthesis

Derived Analytic Themes and Subthemes	Paper Representation (# as listed in Table 1)
Health and wellness outcomes ($n = 27$)	
Cultural pride, esteem, and strong sense of identity	1, 2, 7, 9, 10, 11
Healing from past experiences or trauma	1, 5, 7, 10
A sense of community, belonging, social purpose	2, 5, 7, 11
Empowerment	4, 5, 11
Healthy and strong communities and families	9, 10, 11
Helps to cope with stress, grief, and loss	4, 5
Holistic health and balance	4, 9
Increased resistance to colonialism	8, 11
Linked to diabetes, cancer, heart disease, oral health, STDs, addictions and alcoholism, and mental health	9
Components of cultural connectedness and continuity ($n = 16$)	
Practicing spirituality and ceremonies	1, 3, 4, 7, 8
Respect (e.g., culture, Elders)	2, 9
Connection can be seen as relationships between other members of community (in an urban sense as well)	3, 8
Relational (social, behavioural elements)	3, 8
Holism (e.g., connection to earth, interconnectedness with language)	3, 9
Attending cultural events, participating in activities	5, 8
Importance of traditional healing practices (Western practices not effective)	3
Connection to home	11

(continued)

Table 4. Themes and Subthemes that Arose from the Metasynthesis (continued)

Derived Analytic Themes and Subthemes	Paper Representation (# as listed in Table 1)
Knowledge transmission ($n = 16$)	
Importance of passing on knowledge inter-generationally (e.g., teaching youth)	4, 5, 6, 9, 11
Influence of Elders, grandparents, and teachers in sharing knowledge	1, 2, 4, 6
Sharing knowledge of history and traditions with others in general	1, 8
Death of Elders as a challenge in knowledge transmission	2, 6
A sense of being part of intergenerational cycles, self-positioning as "cultural bearers"	2, 11
Responsibility for passing on culture and knowledge to future generations	2
Shared by modeling behaviours	4
Journeys of cultural (dis)continuity ($n = 10$)	
Making a conscious choice to re-connect with community and identity	1, 4, 7
Forgiveness	10, 11
Childhood experiences of "othering" and cultural disconnection	1, 7
Walking in two worlds —balance in navigating Indigenous and Western society	2, 3
Making conscious efforts to incorporate traditional teachings into everyday life	2, 3
Continual process, personal journey	4
Barriers to cultural continuity ($n = 8$)	
Historical trauma (e.g., assimilative policies, residential schools, etc.)	4, 6, 9
Pressures or institutions that impose acculturation (e.g., postsecondary)	3, 9
Discrimination, ignorance, micro-aggressions	3, 9
Lack of funding for cultural programming and services	9
Youth apathy (as described by youth)	11
Toxicity in home community damages connections	3

Direct connection to specific health outcomes were discussed less commonly, but were prominent topics in three papers. In these cases, health outcomes included holistic health and balance (Hunter et al. 2006; Oster et al., 2014), and increased coping skills for managing stress and grief (Hunter et al., 2006; Iwasaki et al., 2005). Oster and colleagues (2014) also illustrated the positive impact that cultural continuity has with respect to specific health issues (e.g., diabetes, cancer, heart disease, sexual health, mental health, and addictions).

Components of cultural connectedness and continuity. Findings from the reviewed papers commonly included a discussion of cultural connectedness and continuity. In conceptualizing these phenomena, the findings often emphasized the importance of practicing spirituality and ceremonies (Brunanski, 2009; Flynn et al., 2014; Hunter et al., 2006; Lucero, 2010; Lucero, 2014). For instance, Brunanski (2009) spoke about the importance of healing ceremonies, such as Yuwipi ceremonies, sweat lodge ceremonies, and smudging, which resonated for the First Nations women with which she spoke. Ceremony is one aspect of traditional healing, which promotes holistic health and balance. Similarly, some studies also cited that attending cultural events and participating in activities were important aspects of cultural continuity (Iwasaki et al., 2005; Lucero, 2014). In one study, Métis women spoke about the important role that activities, such as group projects in Métis history and genealogy, and participation in craftwork, have in their coping and healing (Iwasaki et al., 2005). These examples demonstrate the importance of traditional healing practices as a significant aspect of cultural continuity, particularly as Western healthcare methods may be ineffective in some cases (Flynn et al., 2014).

More broadly, the concept of holism (Flynn et al., 2014; Oster et al., 2014) was described with respect to an innate connection with the earth and the interconnectedness of language and culture. In a more detailed description, First Nations leaders defined culture as being inclusive of "traditions, values, knowledge, hunting and trapping, living off the land, traditional food, medicines, games, sweats, spirituality, ceremonies, celebration, praying and language" (Oster et al., 2014, "Conceptualizing Cultural Continuity", para. 1). The value of respect, including respect for Elders and respect for culture, was also discussed in the literature (Drywater-Whitekiller, 2006; Oster et al., 2014). Connection was also described in terms of the relationships between members of the community, a component in both urban and reserve communities (Flynn et al., 2014; Lucero, 2014). In this sense, Lucero noted, "it was common for participants to refer to their relationships to, and social interactions with, other American Indians as their 'connection'" (p. 16), while a study of acculturation for Native American students more broadly spoke to the importance of family support and community connection for students living away from home (Flynn et al., 2014). Cultural continuity was also described as a relational phenomenon, with social, intellectual, and behavioural elements (Flynn et al., 2014; Lucero, 2014).

Knowledge transmission. In the reviewed papers, the transmission of knowledge was commonly described as an integral component of cultural continuity; more specifically, the topic of intergenerational knowledge transmission arose (Hunter et al., 2006; Iwasaki et al., 2005; Long & Curry, 1998; Oster et al., 2014; Wexler, 2014). For example, teaching youth was described as an important part of "cultural rehabilitation" (Oster et al., 2014) and, more broadly, "the intergenerational transmission or 'passing down' of cultural wisdom about beliefs and practices among Native American women was recognized as an important strength among Native American women" (Long & Curry, 1998, p. 213).

The influence of Elders, Grandparents, and teachers in sharing traditional knowledge was also a frequent subtheme (Brunanski, 2009; Drywater-Whitekiller, 2006; Hunter et al., 2006; Long & Curry, 1998). For example, Hunter et al. (2006) found that "relating, sharing, and learning in the circle of life were accomplished with the help of counselors and elders . . . guides to the knowledge" (p. 18). Participants spoke about growing up and hearing about traditional ways and forming their cultural identities through sharing knowledge of the language, traditional songs, and traditional foods (Drywater-Whitekiller, 2006). Related to the importance of Elders and Grandparents, the death of Elders was discussed as a challenge in knowledge transmission (Drywater-Whitekiller, 2006; Long & Curry, 1998) and participants spoke about a sense of responsibility for passing on culture and knowledge to future generations and keeping traditions "alive" (Drywater-Whitekiller, 2006). In addition to passing on knowledge to future generations, several articles also discussed lateral knowledge transmission (Brunanski, 2009; Lucero, 2014), which occurs through the sharing of traditions with other members of one's community. Participants also spoke about being part of intergenerational cycles and understanding their role in passing on knowledge, as "adult narratives described coming to terms with the cultural oppression experienced by Elders, and repositioning themselves as strong culture bearers" (Wexler, 2014, p. 86).

Journeys of cultural (dis)continuity. Findings across the reviewed studies also provided narratives around journeys of cultural continuity and discontinuity. This included experiences of "othering" and cultural disconnection during childhood and adolescence (Brunanski, 2009; Lucero, 2010), which were coupled with emotional struggles of feeling lost, detached, and isolated, as well as attempts to reject Indigenous culture and question cultural identity (Lucero, 2010). Participants also spoke about making a conscious choice to re-connect with their communities and identities (Brunanski, 2009; Hunter et al., 2006; Lucero, 2010), where they made references to going home or "returning to the people" (Lucero, 2010, p. 332). In a more general sense, cultural re-connection involved a process of "learning about traditional ceremonies and then by using ceremonies to understand and become a part of Aboriginal culture" (Hunter et al., 2006, p. 17). Similar stories also included the role that forgiveness plays in connecting with culture, with respect to healing past trauma and as an aspect of cultural resilience (Smith et al., 2005; Wexler, 2014). The concept of "walking in two worlds" also arose as a metaphor for Indigenous peoples' journeys in balancing and navigating both Western and traditional ontologies as well as making conscious efforts to incorporate traditional teachings into everyday life (Drywater-Whitekiller, 2006; Flynn et al., 2014; Oster et al., 2014). Further, these journeys were also noted to be continual, self-directed, and specific to each individual (Hunter et al., 2006).

Barriers to cultural continuity. To a smaller extent, when compared to other common themes that arose across the literature, barriers to cultural continuity were also discussed. Historical trauma was most commonly discussed as a challenge, which includes, but is not limited to, the negative impacts that assimilative policies and residential schools have had on Indigenous communities (Hunter et al., 2006; Long & Curry, 1998; Oster et al., 2014). Pressures and institutions that impose acculturation were also discussed (Flynn et al., 2014; Oster et al., 2014); this included a prominent study that described the predominantly White, non-inclusive post-secondary setting as an "acculturation gateway" (Flynn et al., 2014, p. 286). Challenges were also described as motivations to acculturate, which were rooted in toxicity in communities (e.g., alcoholism, gossip), as well as challenges with racism, ignorance, and microaggressions (Flynn et al., 2014; Oster et al., 2014). For example, this included negative stereotypes in society and the media, feelings of being invisible, and tokenism of Indigenous students (Flynn et al.,

2014). Additional barriers include a lack of funding for cultural programming and services (Oster et al., 2014), and youth apathy toward cultural continuity (Wexler, 2014).

Discussion

As a whole, the literature demonstrates that cultural continuity is associated with a number of health and wellness outcomes in Indigenous communities, both in Canada and the United States. In their proposed models of social determinants and Indigenous Peoples' health, Loppie Reading and Wien (2009), and Greenwood and de Leeuw (2012) position cultural continuity as an intermediate determinant of health, in that it provides a connection between the distal and proximal determinants of health. The reviewed studies align with this conceptualization in that cultural continuity was described as a phenomenon that shapes a number of proximal, or psychosocial, determinants, including self-esteem, cultural identity and pride (Brunanski, 2009; Drywater-Whitekiller, 2006; Lucero, 2010; Oster et al., 2014; Smith et al., 2005; Wexler, 2014), and coping skills (Hunter et al., 2006; Iwasaki et al., 2005). This aligns with a larger body of research that speaks to the importance of enculturation as a psychological asset or protective factor (McIvor, Napoleon, & Dickie, 2009; Whitbeck et al., 2004).

Distal determinants, or colonial forces, including assimilative policies and historical trauma from residential schools (Hunter et al., 2006; Long & Curry, 1998; Oster et al., 2014), as well as racism, discrimination, and microaggressions, also shape cultural continuity (Flynn et al., 2014; Oster et al., 2014). There is also a considerable amount of research that explores these pathways through the development of anthropological and sociological theory within the area of acculturation (Keen, 2001). Despite the common tendency to compartmentalize determinants of health and explore specific pathways to health, the findings from this metasynthesis demonstrate the interconnectedness of all social determinants of health (Greenwood & de Leeuw, 2012). This is consistent with related research in the field of Indigenous health, including studies addressing Canada's colonial legacy (Czyzewski, 2011; Peters & Self, 2005), and research that addresses the negative health impacts from racism and discrimination, ranging from microaggressions and historic trauma to systemic racism (Paradies, 2016; Senese & Wilson, 2013; Walters et al., 2011). Colonization is often understood as a distal determinant of Indigenous Peoples' health, which has had significant and pervasive impacts on Indigenous Peoples across Canada (Czyzewski, 2011; Loppie Reading & Wien, 2009). While many aspects of colonization are framed in a historical context, it is important to note that colonization continues to place Indigenous peoples within a bureaucratic framework that politically controls communities and devalues traditional forms of knowledge (Alfred, 2009). Alfred (2009) noted that the degradation of traditional knowledge and ongoing oppression of cultural identity has led to the creation of "colonial mentalities," a term for the "mental state that blocks recognition of the existence or viability of traditional perspectives . . . prevent[ing] people from seeing beyond the conditions created by the white society to serve its own interests" (p. 94). Further, Paradies (2016) noted that colonial mentalities involve tolerance of historical trauma and ongoing oppression, and therefore have been connected to a number of mental health concerns (e.g., anxiety, low self-esteem, emotional distress). Colonization has had profound effects on individual notions of identity, collective memory, and community cohesion (Kirmayer et al., 2009), thus impacting cultural continuity for Indigenous communities. Despite these challenges, Indigenous Peoples have continually proven to be both resilient and resourceful (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011), and while resilience was only directly cited in two of the reviewed papers, there is a strong body of literature that demonstrates the critical role that cultural continuity plays in

Indigenous narratives of resilience (Fleming & Ledogar, 2008; Tousignant & Sioui, 2009). Additionally, Pearce and colleagues (2015) have moved beyond individualist, Western measures of resilience, and demonstrate the integral role that traditional culture, spirituality, and language play as buffers to adversity, as "cultural resiliency."

Cultural continuity was described as a dynamic concept, through participant narratives that contextualize cultural disconnection and reconnection as an ongoing journey (Brunanski, 2009; Flynn et al., 2014; Hunter et al., 2006; Lucero, 2010) that is highly personal to each individual (Hunter et al., 2006). Despite these characteristics, cultural continuity is also holistic: it encompasses individuals, families, and whole communities (Flynn et al., 2014; Lucero, 2014), as well as a connection to earth and language (Flynn et al., 2014; Oster et al., 2014). The selected literature defined community in different ways. For some, community was referred to when speaking of a defined space, such as participants' reserve communities (Wexler, 2014), and for others, particularly from an urban Indigenous perspective, community meant a network of connections to family, friends, and other Indigenous Peoples in the city (Flynn et al., 2014; Lucero 2014). Related to this, cultural continuity was often associated with a sense of community and belonging (Drywater-Whitekiller, 2006; Iwasaki et al., 2005; Lucero. 2010; Wexler, 2014), which is interconnected with the health and wellness of both Indigenous individuals and communities (Goudreau, Weber-Pillwax, Cote-Meek, Madill, & Wilson, 2008; Senese & Wilson, 2013).

The qualitative findings from this study also demonstrated that cultural continuity plays a role in maintaining healthy and strong communities and families (Oster et al., 2014; Smith et al., 2005; Wexler, 2014), as well as being part of larger, intergenerational cycles (Drywater-Whitekiller, 2006; Wexler, 2014). These outcomes move beyond the dominant body of quantitative research on enculturation as a buffer for adverse health outcomes, which has largely focused on individual-level indicators, such as stress (Walters & Simoni, 2002; Wolsko, Lardon, Mohatt, & Orr, 2007); alcohol and substance abuse (Currie et al., 2011; Fleming & Ledogar, 2008; Walters & Simoni, 2002; Whitbeck et al., 2004; Wolsko et al., 2007; Zimmerman et al., 1996); depressive symptoms (Bals, Turi, Skre, & Kvernmo, 2011; Fleming & Ledogar, 2008; Walters & Simoni, 2002; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002); suicidal ideation (Yoder, Whitbeck, Hoyt, & LaFromboise, 2006); externalizing behaviours (Bals et al., 2011; Fleming & Ledogar, 2008); and impacts of discrimination (Whitbeck et al., 2002; Whitbeck et al., 2004). In their research with the Maori, Houkamua, and Sibley (2011) found that while increased enculturation was associated with both increased individual well-being and decreased community well-being; however, their study illustrates the complexity of community health and wellness within a context of ongoing oppression and colonialism. While the authors were unable to understand both individual and community wellness beyond the measures of life satisfaction and well-being (Houkamua & Sibley, 2011), their work represents an important step in moving beyond strict psychosocial models of cultural continuity.

The findings from this metasynthesis suggest that conceptualizations of Indigenous cultural continuity are much more nuanced and complex than what is offered by the mainstream definitions of enculturation. Deductive approaches to operationalizing enculturation are often limited to these definitions, which look at the level to which an individual is connected to their cultural identity, traditional activities, and traditional spirituality (e.g., Bals et al., 2011; Fleming & Ledogar, 2008; Snowshoe et al., 2015). Indigenous conceptualizations build on these components, both relationally and holistically, providing insight to both individual and community components and outcomes of cultural

continuity. Further, knowledge transmission is a central component of maintaining and strengthening the inter-generational components of cultural continuity.

Traditional knowledge, which is made up of cultural values, lessons, and worldviews, has been transmitted inter-generationally as a way of connecting past and future generations, as well as strengthening connections between people and the land (Smith, 1999). The transmission of traditional knowledge was a common theme across the reviewed papers, emphasizing the importance of sharing cultural practices, Indigenous epistemologies, and oral traditions with future generations to maintain cultural continuity (Hunter et al., 2006; Iwasaki et al., 2005; Long & Curry, 1998; Oster et al., 2014; Wexler, 2014). Similarly, LaRocque (2011) speaks about the importance of oral and written forms of communication in Indigenous communities in the renewal and maintenance of cultural continuity and fluidity. The reviewed studies also highlight challenges that Indigenous peoples have faced with respect to the maintenance, transmission, and practice of their culture. These challenges were often specific to single studies, which suggest the heterogeneity of barriers to cultural continuity. These diverse barriers and challenges include issues of youth apathy (Wexler, 2014), toxicity in communities with respect to addiction and gossip (Flynn et al., 2014), a lack of funding for cultural programming (Oster et al., 2014), and acculturative pressures within Western institutions (Flynn et al., 2014; Oster et al., 2014). While it is important to understand these barriers in an effort to improve policies and programs that recognize and enhance cultural continuity, it is promising that they arose as one of the less common crosscutting themes in this metasynthesis. The stronger focus on strengths-based interpretations of cultural continuity represents a shift away from deficit-based models of Indigenous health and toward promoting community empowerment. Additionally, despite the method of knowledge compartmentalization, through thematic analysis, these components of cultural continuity and connectedness cannot be interpreted individually. Rather, they are understood to be relational and interconnected (McGuire, 2010). For example, while divided by subthemes, relationships with the land and language are inseparable from community cohesiveness, as McCormick (2000) stated, "connection to traditional Aboriginal culture and values means that a person must become connected to extended family, community, the natural world, the spirit world, in essence, all of creation" (p. 28). As well, knowledge translation is not separate from other components of cultural connectedness and continuity. In this sense, while the division of themes by subthemes (Table 3) puts forward an understanding of some of the individual components of cultural continuity and connectedness, it also creates an overly neat representation of these concepts.

Despite the limitations of the thematic analysis, this synthesis summarizes a small body of literature that represents the voices of Indigenous Peoples in Canada and the United States. Far too often, quantitative scales for enculturation and acculturation are put forth without a qualitative component that seeks to understand the meaning of these constructs from perspectives that are rooted in lived experience. For example, in working with Maori peoples, Te Huia and Liu (2012) came to a similar conclusion around the lack of Indigenous voices in acculturation theory. When this research is put forward it masks the voices of Indigenous Peoples and can actually cause further harm; a key example of this is when acculturation theory is used to disprove Indigenous title (Ankler, 2004; Keen, 2001). Cultural continuity as a research program was co-opted by Chandler and Lalonde (1998), whose measures of community control (lacking any solid connection to culture) were based solely on archival research. Despite new

and emerging research on cultural continuity, given that this research was the first of its kind, it has been a primary source with widespread application.[4]

Over the past few decades, numerous documents have encouraged the participation of Indigenous communities in health research projects; however, "until very recently, Aboriginal people were seldom invited to participate in health research beyond their role as data sources" (Loppie, 2007, p. 278). Helicopter research, as it is termed by Vine Deloria (1991), illustrates a common approach to research with Indigenous communities, where researchers would swoop in as experts in health, history, and culture; they would promise benefits from their research to the communities that they were researching—yet, they would often leave the community and never return. This symbol for unethical research has been fulfilled throughout much of the work on acculturation theory, which has involved quantitative research *on* (rather than *with*) Indigenous Peoples. As a result, this research has produced deficiency-based models, programs, and policies, which are often rooted in the notion that Indigenous Peoples have poor health and lack the capacity to address health issues. Despite a shift toward a strengths-based paradigm through the use of enculturation measures, much of this research still lacks Indigenous involvement. To move forward, there is a need for increased community-based participatory action research; Indigenous Peoples understand the issues in their communities and should play an active role in designing the research projects, and translating them into program implementation, policy development, and social change. It is critical to produce culturally responsive research and policy, as Greenwood (2006) noted, "non-Aboriginal research, policy, and practice are too often applied—ineffectively—to Aboriginal contexts. Evidence-based public health in Aboriginal communities should not be sought through a 'one size fits all' application of non-Aboriginal research" (p. 67).

The research reviewed in this metasynthesis represents a range of levels of engagement with Indigenous Peoples, where two of the studies explicitly used participatory methods (Smith et al., 2005; Wexler, 2014). While the use of participatory methods, compared to other qualitative approaches, did not appear to impact the quality or scope of the qualitative findings on cultural continuity, the benefits of meaningfully including Indigenous Peoples throughout research design, delivery, and implementation has been widely stated (Loppie, 2007; Smith, 1999). Snowshoe and colleagues (2015) also demonstrated that community-based methods can be applied to quantitative research, given the integral role that Indigenous voices played in shaping the development and appraisal of a culturally responsive, strengths-based scale to measure cultural connectedness. In using two-eyed seeing and mixed methods approaches, there are opportunities to strengthen community conceptualization of cultural continuity, which can inform and create empirical measurement of cultural continuity as a determinant of Indigenous health.

While this metasynthesis presents a broad overview of common themes in qualitative research on cultural continuity, it is integral to understand the diversity between Indigenous nations throughout Canada and the United States, where nations are culturally heterogeneous, with vast differences in language and cultural practices, as well as unique political, social, and economic structures (Voyageur & Calliou, 2000). However, many Indigenous Peoples do have shared worldviews and experiences with colonialism, which are interconnected with conceptualizations of cultural continuity. In this sense, it is

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[4] Chandler and Lalonde's (1998) research around "cultural continuity" is often the sole reference used within mainstream documents that address the social determinants of health (e.g., CSDH, 2008).

interesting to note that there were no noticeable differences in comparing the findings from research conducted with American Indian populations and those conducted with First Nations peoples in Canada. Overall, the research articles included in this synthesis presented an understanding of diversity across Indigenous nations, through working with specific communities, identifying participants' nations (to an extent where their identity was still protected), and avoiding creating pan-Indigenous generalizations for cultural continuity. However, given the small body of qualitative research on the subject, it was not surprising that considerable gaps in the body of cultural continuity literature arose. The majority of research has focused on the perspectives of American Indian people in the United States (Drywater-Whitekiller, 2006; Flynn et al., 2014; Long & Curry, 1998; Lucero, 2010; Lucero, 2014) and First Nations people in Canada (Brunanski, 2009; Hunter et al., 2006; Iwasaki et al., 2005; Oster et al., 2014), demonstrating a clear need for increased community-based research with Métis, Inuit, and Alaska Native communities.

Limitations

This metasynthesis was limited by the author's inability to review studies in languages other than English. Studies that were selected on the basis of their relevance and quality were given equal weight in the analysis of crosscutting themes; this is a potential limitation, given that the studies ranged in qualitative design and sample sizes, suggesting different levels of generalizability. Further, there were a number of subthemes that arose in isolation, meaning that they are rooted in single research studies. However, noting that there were a total of only 11 research studies that met the inclusion criteria for this metasynthesis, the findings do not represent saturated themes.

Conclusion

There is a small body of qualitative research that has sought to conceptualize cultural continuity for Indigenous peoples in Canada and the United States, yet this synthesis provides a formative understanding of its role a determinant of Indigenous health. The findings across the synthesized research articles speak to the importance of cultural continuity in shaping positive health and wellness outcomes for Indigenous Peoples. It is also clear that intergenerational knowledge transmission is a central component of renewing and maintaining cultural continuity for Indigenous Peoples. Increased research that explores community driven conceptualizations for cultural continuity can help to inform the development of culturally responsive quantitative scales and practical assessment tools, as well as effective health services and programming for Indigenous communities.

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