

Résumé

Renverser les effets intergénérationnels des pensionnats sur les populations autochtones : implications pour les orientations et les pratiques en matière de santé

Dawn Smith, Colleen Varcoe et Nancy Edwards

Cet article recense la première vague de résultats issus d'une enquête sur les opinions et les expériences de certains acteurs communautaires travaillant à l'amélioration des soins offerts aux femmes enceintes et aux parents chez les populations autochtones du Canada. La question du manque d'accès aux soins prénatals est traitée ici à la lumière d'une analyse postcolonialiste définissant le contexte historique et social. L'étude de cas proposée est fondée sur des principes de recherche participative. Les données ont été recueillies au moyen d'entrevues exploratoires et de discussions en petits groupes. L'échantillon comprend des dirigeants communautaires, des fournisseurs de soins et des membres de la communauté affiliés à deux services de santé autochtones dans une région surtout rurale, tous choisis à dessein. Les participants des trois groupes considèrent que la prestation des soins aux femmes enceintes, aux mères et aux familles autochtones devrait tenir compte des priorités et des expériences de ces dernières. Voilà pourquoi les auteures ont ajouté la question « Quelle importance la grossesse et le parentage revêtent-ils aux yeux des parents autochtones » au questionnaire d'entrevue. Selon les répondants, la prestation des soins doit absolument tenir compte de la nécessité de « renverser » les effets intergénérationnels des pensionnats. Les résultats suggèrent que la grossesse et le parentage doivent être envisagés comme une expérience propre aux personnes et aux familles appartenant aux communautés autochtones. Par ailleurs, il faut traiter les effets intergénérationnels des pensionnats comme un instrument de violence collective et comme un facteur clé pouvant expliquer le traitement inégal que subissent les Autochtones du Canada en matière de santé et d'accès aux services.

Mots clés : populations autochtones, pensionnats, grossesse et parentage

Turning Around the Intergenerational Impact of Residential Schools on Aboriginal People: Implications for Health Policy and Practice

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This paper reports on the first wave of results from a study exploring the views and experiences of community-based stakeholders on improving care for pregnant and parenting Aboriginal people in Canada. The issue of poor access to prenatal care by Aboriginal women and families is viewed through a post-colonial lens within a historical and social location. This case study was guided by participatory research principles. Data were collected through exploratory interviews and small-group discussions. The sample comprised purposively selected community leaders, providers, and community members affiliated with 2 Aboriginal health-care organizations in a mainly rural region. Participants from all 3 stakeholder groups expressed the view that care should be based on an understanding of the priorities and experiences of the pregnant and parenting Aboriginal women and families themselves. Therefore the research question *What are Aboriginal parents' views of the importance of pregnancy and parenting?* was added to highlight the views and life experiences of Aboriginal parents. "Turning around" the intergenerational impact of residential schools was identified as pivotal to care. The results suggest that pregnancy and parenting must be understood as reflecting both the unique individual and family experiences of Aboriginal people and the intergenerational impact of residential schools as an instrument of collective violence and as a key factor in Aboriginal Canadians' inequitable health status and access to health services.

Keywords: Aboriginal people, residential schools, health impact, pregnancy and parenting, population health

Introduction

Two thirds of that last generation to attend residential schools has not survived. It is no coincidence that so many fell victim to violence, accidents, addictions and suicide. Today the children and grandchildren of those who went to residential schools also live with the same legacy of broken families, broken culture and broken spirit. (Chief Councillor Charlie Cootes, cited in Royal Commission on Aboriginal Peoples [RCAP], 1996, p. 22)

From the mid-1800s until as late as 1996 an estimated 100,000 Aboriginal¹ children aged 4 to 18 were removed from their families and placed in residential schools as part of the Canadian government's assimilation plan to "deal with the Indian problem" (Indian and Northern Affairs Canada, [INAC], 1998; RCAP, 1996). Along with the enforced separation of young children from their families and communities, residential schooling entailed the deliberate suppression of language and culture, substandard living conditions and second-rate education, and widespread physical, sexual, emotional, and spiritual abuse (Aboriginal Healing Foundation [AHF], 2002; INAC, 1998; Nuu-chah-nulth Tribal Council [NTC], 1996; RCAP, 1996; United Church of Canada, 1998). "Disclosures of abuse, criminal convictions of perpetrators, and findings from various studies tell of a tragic legacy...that leave former students, their families and communities to deal with issues such as physical and sexual abuse, family violence, and drug and alcohol abuse" (INAC, 1998, p. 1). As a result of the residential school system,

Aboriginal children learned to despise the traditions and accomplishments of their people, to reject the values and spirituality that had always given meaning to their lives, to distrust the knowledge and life ways of their families and kin. By the time they were free to return to their villages, many had learned to despise themselves. (RCAP, 1996, p. 57)

The residential school system and its enduring impacts is a complex and historically situated phenomenon.

While it is not uncommon to hear some former students speak about their positive experiences in these institutions, their stories are overshadowed by disclosures of abuse, criminal convictions of perpetrators and the findings of various studies such as the Royal Commission on Aboriginal Peoples, which tell of the tragic legacy that the residential school system has left with many former students. They, and their communities, continue to deal with issues such as physical and sexual abuse, family violence, and drug and alcohol abuse. (INAC, 2004, p. 1)

Aboriginal people have sought an approach to healing that addresses individual, family, and community needs arising from the legacy of physical and sexual abuse at residential schools. In response, the federal government has committed \$350 million in support of a 5-year

¹ The term Aboriginal "refers to organic political and cultural entities that stem historically from the original Peoples in North America, rather than collections of individuals united by so-called 'racial' characteristics" (RCAP, 1996). These include the First Nations, Inuit, and Métis peoples of Canada.

community-based healing strategy and has acknowledged that it is in the interests of Aboriginal and non-Aboriginal people to support individuals, families, and communities in their efforts to begin the healing process (INAC, 2004).

Though there has been legal and political recognition, and the commencement of a process of retribution for the enduring and intergenerational impacts of residential schools (Government of Canada, 1998; United Church of Canada, 1998), the implications of residential schools for health policies and programs have received limited attention. Qualitative and quantitative research has begun to describe the long-term health impacts of residential schools (Dion Stout & Kipling, 2003; NTC, 1996; Tait, 2003). For example, a qualitative study exploring the experiences of close to a hundred survivors in one region of British Columbia found that 93% of former residents reported extreme loneliness and feelings of abandonment, 91% reported loss/suppression of language and culture, 92% had witnessed abuse of other residents, 90% reported having been abused in one or more ways (e.g., sexually, physically, emotionally), 76% reported having lost their self-respect or feeling inferior, and 84% reported problems with relationships, family, parenting, and communication (NTC, 1996).

During a study focusing on learning from successful care for pregnant and parenting Aboriginal women, the critical importance of the Aboriginal participants' vision for "turning around" the intergenerational impact of residential schools (IGIRS) became central. Participants viewed pregnancy and childrearing as an opportunity to turn around the IGIRS on Aboriginal individuals, families, and communities. Orienting care for pregnant and parenting Aboriginal people within this understanding will require a significant shift in the roles, relationships, and intended outcomes of care. Understanding IGIRS as one of the root causes of the inequitable health and social conditions experienced by Aboriginal people has implications for the underlying purpose and rationale of health policy, health programs, and the practices of health-care providers more generally.

This paper focuses on this central finding from the study and describes participants' vision for "turning it around." The participants' experience of pregnancy and parenting, and therefore their care needs and priorities, could be understood only in the context of their experiences of and efforts to change the IGIRS and related colonizing influences and structures. Participants felt that understanding and acknowledging the IGIRS as a root cause of poor health and social conditions such as poverty, addictions, and violence was imperative for healing and building strength.

Background

The federal government has had jurisdiction over health services for First Nations and Inuit people living on reserves since 1876 and passage of the *Indian Act* (Government of Canada, 1985). Since that time, services have been provided through the First Nations and Inuit Health Branch, formerly known as the Medical Services Branch of Health Canada. At present, a growing majority of First Nation communities have transferred, or are in a multi-year process of transferring, administration and delivery of on-reserve health services from the federal government to First Nation control (First Nations and Inuit Health Branch, 2005). Health services for Aboriginal people living off-reserve are the responsibility of provincial governments, and in most provinces are regionally administered.

On-reserve maternal-child health care comprises pre- and postnatal care and evacuation from rural, but not necessarily remote, settings to provincial tertiary care facilities for birth (Smith, 2002). Pre- and postnatal programs are delivered primarily by registered nurses in partnership with community health representatives, and are delivered alongside several related programs such as the Canada Prenatal Nutrition Program, the Fetal Alcohol Syndrome/Fetal Alcohol Effects Prevention Program, and the Aboriginal Head Start On-Reserve Program. Services vary considerably across the regions and among communities in terms of presence, size, and scope (Health Canada, 2000). The result of this variety of services is a collection of programs with independent administrative, governance, and implementation systems, rather than a coherent, integrated system of care. Further, continuity and depth of care over the childbearing continuum are disrupted by evacuation for birth, high turnover among nursing staff, and difficulty integrating the various programs offered on-reserve (Smith).

Anecdotal and research evidence suggest that this model of maternal-child health care has contributed to the health and social inequities experienced by Aboriginal women, children, families, and communities (Adelson, 2004; Dion Stout & Kipling, 1999a, 1999b). Aboriginal people have pointed out that new health and healing systems must embody equitable access to services as well as health status outcomes, holistic approaches to interventions, Aboriginal authority over health systems, responsiveness to differences in cultures and community realities, and, where feasible, community control over services (RCAP, 1996). The need for change has been publicly acknowledged. For example, Romanow (2002) asserts that “action must be taken to create new models to coordinate and deliver health services,” address health needs further

upstream, adapt health services and programs to each community's unique cultural, social, economic, and political circumstances, and "give Aboriginal people a direct voice in how health care services are designed and delivered" (p. 212).

While the need for change is being recognized, studies describing the problems related to maternal-child health care far outweigh those describing appropriate alternatives for indigenous² populations globally. For example, the problem of late access or lack of access to care, poor use of care, and poor pregnancy outcomes in Aboriginal women is well documented (Baldwin et al., 2002; Bridge, 1999; De Costa & Child, 1996; Goldman & Gleib, 2003; Heaman, Gupton, & Moffat, 2005; Hoyert, Freedman, Strobino, & Guyer, 2001; Humphrey & Holzheimer, 2000; Luo, Kierans, et al., 2004; Luo, Wilkins, Platt, & Kramer, 2004; Public Health Agency of Canada, 2005). Evidence suggests that Aboriginal women and families require care that is more culturally appropriate and more relevant to their needs and strengths (Battiste, 2000; Browne & Smye, 2002; Long & Curry, 1998; Powell & Dugdale, 1999; Sokolowski, 1995; Westenberg, van der Klis, Chan, Dekker, & Keane, 2002). Evidence shows that culturally appropriate prenatal services have resulted in improved client satisfaction with care, earlier initiation of care, and higher rates of breastfeeding initiation and duration among indigenous women, although definitions of "culturally appropriate" interventions vary (Affonso, Mayberry, Inaba, Matsuno, & Robinson, 1996; Affonso, Mayberry, Inaba, Robinson, & Matsuno, 1995; Buchareski, Brockman, & Lambert, 1999; Nel & Pashen, 2003). Research and evaluation studies (Affonso et al., 1995; Buchareski et al.; Fisher & Ball, 2002; Martens, 2002; Nel & Pashen) have found that community involvement in program design, implementation, and evaluation results in improved participant satisfaction, early access to and participation in care, improved health behaviours such as with regard to nutrition, lower tobacco and alcohol consumption, and feelings of mastery concerning infant care.

However, programs of research thus far have been conducted in single settings, close to urban centres, and/or with particular populations. Given the gap in knowledge to inform a responsive and sustainable approach to care for pregnant and parenting Aboriginal people, research exploring the views and experiences of Aboriginal and community-based stakeholders is needed.

² The term Aboriginal is used widely in some contexts (e.g., in Canada and Australia), while the term indigenous is more globally inclusive.

Method

The purpose of this study was to describe the perspectives of community-based stakeholders on their experience in designing, implementing, and evaluating care for pregnant and parenting Aboriginal women and families. As the study progressed it became clear that participants felt that care should be based on the priorities and experiences of the women and families themselves. Therefore, the focus of the study brought into the foreground the views and life experiences of the Aboriginal parents in the sample, to answer the research question *What are the views of Aboriginal parents regarding the importance of pregnancy and parenting?*

The study takes a critical postcolonial stance (Battiste, 2000; Reimer-Kirkham & Anderson, 2002) and uses participatory research principles (Cargo, Levesque, Macaulay, & McComber, 2003; Fletcher, 2002; Macaulay et al., 1998). Participatory research principles include explicating power imbalances, subject-subject relations in the focus and process of research, and application of the knowledge generated in the inquiry to influence change in the research problem (Anderson, 2002; Mill, Allen, & Morrow, 2001). Methods used to uphold these principles in the study included critical reflexivity (Anderson et al., 2003; Browne, 2003), maintaining the integrity of participants' voices in context (Dion Stout, Kipling, & Stout, 2001; Kirby & McKenna, 1989), and taking direct action on the research problem (Cargo et al.; Fletcher, 2002).

Participants' experiences were viewed through a critical postcolonial lens to explicate their efforts to understand, deconstruct, resist, and transform the impact of colonialism and its institutions (Battiste, 2000; Reimer Kirkham & Anderson, 2002). Postcolonial and participatory research perspectives include diverse value systems, are sensitive to differences (Battiste), value all forms of knowledge, and seek to generate knowledge that is relevant to stakeholders and is useful for solving problems (Mill et al., 2001). A case study design (Yin, 2003) was used to collect in-depth contextual data regarding the experience of individual and organizational participants in improving care for pregnant and parenting Aboriginal people in each setting (Abelson, 2001; Cowley, Bergen, Young, & Kavanaugh, 2000; Dopson, 2003; Langley, Denis, & Lamothe, 2003). Ethical approval for the study was granted by the Health and Social Sciences ethical review board of the University of Ottawa, the ethical review committee of the participating Tribal Council, and the Chiefs and Councils of the participating communities.

In phase 1 of the study, 16 participants from provincial, regional, and community-based organizations responsible for services for pregnant and parenting Aboriginal people were selected using snowball sampling tech-

niques. They were interviewed by phone or in person. Participants were asked to share their perspectives with regard to influences on the pregnancy experiences of Aboriginal women and families. They were also asked to identify health-care organizations with a reputation for having developed prenatal services with high rates of early access and participation by Aboriginal women.

In phase 2, one urban and one rural Aboriginal health-care organization located within a single region in a Canadian province agreed to participate in the community-based case study. Research partnerships were formed and research agreements developed with the two partner organizations in order to identify ownership, control, access, and possession of the research process and products. Formalization of the agreements followed the protocols and requirements of the partner organizations and communities. For example, a description of the study, including cost/benefits to the community, was presented to local Chiefs and Councils and necessary adjustments were made in order to secure their support for the study. Once ethical approval was obtained, participants in each setting were purposively selected with a view to obtaining a variety of perspectives. Clients, family members, providers, managers and administrators, policy decision-makers, and community leaders were interviewed. Table 1 shows the composition of the sample for phase 1 and for each of the community settings in phase 2.

Over 60% of the total sample self-identified as Aboriginal and 90.4% were women. Many of the Aboriginal participants chose to share their personal experiences as children and as parents, grandparents, aunts, and uncles. For many participants, it was imperative that their perspectives be understood and acknowledged within personal, historical, and social

Phase and Setting	Total	Aboriginal Identity		Female	
		#	%	#	%
Phase 1	16	8	50	15	93.75
Phase 2 – rural community	29	21	72.4	25	86.2
Phase 2 – urban community	28	15	53.6	26	92.9
Phase 2 totals	57	36	63	51	89.5
Study totals	73	44	60.3	66	90.4

contexts. As the purpose of this paper is to describe those experiences and their significance, the paper draws extensively on the interviews with Aboriginal community members, providers, and leaders.

Data were collected by the first author using one-to-one exploratory interviews and small-group discussions during field work for a period of 3 months in the two settings. In response to the opening question, “Tell me a bit about yourself and your experiences related to pregnancy and parenting,” many participants chose to share their personal experiences growing up and becoming parents, grandparents, aunts, and uncles. Although it was not a planned area of exploration, residential schools emerged as central to participants’ experiences and their efforts to make a difference for the children of the future. Supplementary documents and field notes were included in the data set. Interviews were audiotaped and then transcribed by a third party.

During a long period of immersion in the data, the first author used NVivo software and an interpretive descriptive method to analyze the data (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004). “The intellectual task of the analyst [is] to engage in a dialectic between theory and the data, avoiding theoretical imposition on one hand and atheoretical description on the other, in the quest for a coherent rich interpretation that allows apriori theory to be changed by the logic of the data” (Thorne et al., p. 4). During the course of carrying out this analytic task it became clear that turning around the IGIRS pervaded the participants’ experience of becoming and being parents. “Turning it around” was therefore brought into the foreground in the purpose and ontological landscape of the study.

Findings

“Turning it around,” a central and overriding theme of the project, reflected a sense of hope based on understanding and confronting the IGIRS:

We are turning it around... We are going to be better parents for our children because we are healing. And our children won't experience the legacy. I mean, that is my hope, that my children won't experience the pain and things like that, that they will have an understanding, and what they will acquire is the gift of...resiliency and the gift of survival, but not the pain of the abuse and everything else. (parent/provider/leader)

“Turning it around” had three sub-themes: understanding the IGIRS, healing, and building strength and capacity. A fourth, cross-cutting, sub-theme of turning it around, “rebuilding our cultures in contemporary

contexts,” was interwoven within participants’ journey through successive cycles of understanding the IGIRS, healing, and building strength and capacity.

***Understanding and Acknowledging
the Intergenerational Impact of Residential Schools***

“Turning it around” starts with and depends on “understanding and acknowledging the IGIRS.” Participants described many levels of disconnection and alienation resulting from the IGIRS. Because children were removed from their families over multiple generations, cultural teachings, parenting skills, and community identities were disrupted:

It’s so intergenerational. You have generations of people who have been affected by the trauma.... I have talked to people who have got five generations of trauma coming down. So you have four or five generations of people who haven’t been able to connect, who haven’t had a sense of spirituality, who haven’t been able to make firm attachments with their caregivers. It is a direct result of residential school violence. (provider)

Participants described how residential schools shamed and belittled Aboriginal values, beliefs, practices, and people. For those attending residential schools, this resulted in disconnection or dissociation from painful feelings, low self-esteem, negative identity as an Aboriginal person, and lack of respect for traditional beliefs and practices. Because these experiences occurred during a formative period of emotional and moral development, they became encoded into identity, beliefs, and behaviour patterns:

They all went to residential schools except the youngest. And, again, that’s when we are starting to work on the child’s confidence and esteem too. ...the older kids in residential school are told: “You are good for nothing. You are just an Indian. You will never amount to anything.” (parent/provider)

Participants conveyed the powerful influence of this encoding process in their stories about the role of “teachings” in human social, emotional, and moral development. They described “teachings” as how children learn to interpret the world and their place in it. Teachings are the values, beliefs, knowledge, and practices that make up a person’s culture. In children, they shape identity and ways of being in relationships. Participants described how residential school survivors pass on to their children the residential school teachings with which they grew up. The cycle continues as their children take up residential school teachings and then subconsciously pass them on to their own children:

To be really perfectly honest, for years we weren't even considered citizens — or people, for that matter. There were certain things that...stereotyping — we were this and we were that. So that attitude, I went through that, and I think in a sense I passed that on to my kids, you know, without me really saying it so much, and anyway I think that is where it comes from. It's hard to see. Sometimes I don't notice it until I start talking about it. Sometimes we have to forgive ourselves for what we did to our kids, for what we passed on to them. (elder/parent)

Participants described the IGIRS as the root of a *downward spiral of addiction, violence, and poverty* in individuals, families, and communities:

The IGIRS is seen as underlying a lot of the substance abuse issues, the sexual abuse and the physical abuse. So to get [to] the root of the problem, there was more attention put on the experience of residential school. (provider)

As emotional, spiritual, and social well-being were compromised by IGIRS and people became caught in the *downward spiral of addiction, violence, and poverty*, their strength and ability to successfully manage life's challenges diminished. For example, many participants described leaving home as a preteen or teenager to escape the chaos and interpersonal violence in their family, home, and community. This often meant dropping out of school to look for work, finding only unskilled or seasonal jobs and inadequate housing. These difficulties further alienated them from family, community, and culture, perpetuating the downward spiral.

Healing

Healing from the trauma brought on by the IGIRS is the second sub-theme of “turning it around.” Participants explained that if things are to be different for their children and grandchildren, if the cycle is to be broken, then they have to face their own trauma resulting from the IGIRS and the intergenerational transmission of residential school teachings in order to stop the downward spiral of behaviours, cope with life's challenges, and find ways of healing. They described healing as a self-determined process, for individuals, families, and communities. Participants described their healing journey as a gradual back-and-forth process of facing up to and forgiving oneself and others for the hurts, changing beliefs about oneself and others, and accepting responsibility for oneself and one's choices. Healing requires courage, determination, persistence, and support:

People need to do their own work...their own healing work: develop the skills, the life skills, the decision-making skills, the comfort with themselves.

And that's one part. But then another part is the relationships thing...the relationship with self, the relationship with family, relationship with community. And I think number one is that you really have to get your relationship with yourself sorted out. (grandmother)

Participants identified forgiving self and others for past hurts and acknowledging strengths as important aspects of healing. One parent said, "I'm afraid to admit when I'm wrong; I'm afraid, but I have the ability to forgive." Participants expressed the view that part of healing is changing personal core beliefs, particularly regaining *respect* for self and all living things:

We don't need to be powerful; we just need to be equal, to respect each other. Letting it all go to hate, that is not good for your inside. You got to think about your own body, deal with it, heal it and not fill it with hate. Turn things around. Let's do it with love and respect for each other as women and in turn feed it to our children. (parent/community member)

Building Strength and Capacity

Building strength and capacity was described as a significant priority for individuals, families, and communities, in order to address the deficits resulting from decades of the IGIRS. Healing was seen as a process of going back to make sense of, to accept, and to heal the losses and hurts resulting from the IGIRS. Building strength and capacity was about acquiring the skills and resources to move forward towards one's vision for a better future. Participants described their efforts to develop the knowledge, skills, confidence, and networks of support required to work towards their vision for strong and healthy people, families, and communities. Developing goals according to their own priorities, beliefs, and vision for the future was described as a necessary and significant part of capacity building.

Participants' experiences and efforts in building strength and capacity were focused at individual, family, and community levels. At the individual level the efforts included returning to school, reaching out, developing healthy support networks, and renewing spiritual practices. Community capacity building was reflected in many of the interviews. One participant described a community's coming together, talking, and building the capacity to set and achieve goals:

[Treaty negotiations] brought the community together to talk about the problems, to talk about the issues, to talk about what we wanted. And really, what they did in the development of treaty negotiations is they said, "This is what we want in economic development, this is what we want in

education, this is what we want in social development.” They went through everything, and what they did without realizing it is that they just did their long-term goals. And then once they realized what they wanted, then of course they started doing things about it. (leader)

Parents and community leaders described collective efforts to rebuild a strong infrastructure and a positive social environment in order to support parents in making better choices. One community leader described years of commitment and tenacity on this issue:

I will always stand for making this community safe for women and children. And I need the support of everyone here. I can't do it myself. I can't be everywhere. When you see something, you have to speak up about it. I'm always telling people that we all have responsibility for making this a safe, healthy community. Like, if you see someone molesting a child over there, it is your responsibility to speak up. (community leader/parent)

The emphasis on rebuilding positive parenting capacity and skills cut across many programs and sectors. Initiatives that were successful fit into all three sub-themes — *understanding the IGIRS, healing, and building strength and capacity* — to create a supportive environment for individuals and families as they moved through their own process of “turning it around”:

There's more linkage there now. They [have] a lot of parenting initiatives that they did at a school level, which would get the kids before they were pregnant actually, and then... a lot of parenting support for young parents, or teen parents themselves, and... a lot of professional workers who had been given training in developing parenting programs and parenting support programs... So I think that the issues that relate to residential schools that affect a person's ability to parent in a healthy way were probably addressed in those programs. In addition, there was... the [Residential Schools] Survivor Program. (provider)

Role models, mentors, and support people were described as important to capacity building. Many participants described the importance of having even one person who believed in them and showed them that it was possible to achieve their goals and dreams. For many participants, having a single person — a sister, an aunt, a grandparent — believe in them and witness their struggles and achievements played a significant part in turning childhood adversity and trauma into resilience, coping, and acquiring life skills.

There's a lot that happens in our communities, and I think one of the big challenges for me was getting past that whole idea that there was no way I could be successful and be a mother. And I think that one of the things

that greatly helped me was the fact that my mom was a teen mom. She was 16 when I was born, 15 when she got pregnant. And everyone said that she should either have an abortion or give me up for adoption...when I was born her doctor said to her, "There's no way that you are going to provide her with a good life, and you are going to be condemning this little girl to a horrible life and she will never amount to anything." And my mom did not stop working her butt off to make sure that I had a really good life, and I did. And so I guess from seeing her I knew that all hope was not lost. I knew that if I just worked really, really hard...I could get there. Unfortunately I think that not everybody grows up being able to see that. (parent)

Rebuilding Our Cultures in Contemporary Contexts

The sub-theme rebuilding our cultures in contemporary contexts cut across all aspects of "turning it around," because it is a healing, reconnecting activity in itself and because it was viewed as at the root of strong people, families, and communities. Rebuilding our cultures in contemporary contexts reconnects people with their culture and is rooted in a strong positive identity:

How do you change society? But that's where the cultural pride comes in — to have strong cultural teachings and strong pride in who you are, [and] to really give children a sense of pride in who they are. (parent/provider)

Reconnecting with their culture and nurturing a strong positive cultural identity was viewed by the participants as an opportunity to reconnect with themselves. For the participants, the process of rebuilding their culture also reconnected families and provided them with opportunities to heal broken relationships. Family members reached out to learn, discuss, and make decisions about how to adopt traditional ways and teachings. For the participants, reclaiming their culture was an affirmative process that engaged them in the upward spiral of "turning it around": understanding how the IGIRS influences parenting behaviours, forgiving, accepting and recovering from past hurts, and coming together to build a different future for themselves and their children.

However, participants acknowledged that reconnecting with their culture meant that they had to work through multiple impacts of the IGIRS simultaneously. They had to mend relationships, learn how to engage with each other in a healthy way, identify lost cultural teachings and work out how they will be practised today, and help the person and family reframe their cultural identities and beliefs:

There's a lot of disjoining in our communities. We talk about how we have these strong family bonds...these strong cultural bonds, but quite honestly I don't believe they are there, all together. For instance, if we were to sit down and talk about a practice such as a coming-of-age ceremony, truly people would, like, say, "You're doing it wrong..." There's no appreciation for the real differences between people. We are really, really focused on making sure that everybody does it right — our way. There's a huge cultural loss and a huge problem of identity, both culturally and as a family. (parent/leader)

Rebuilding our cultures in contemporary contexts was often described as challenging, as people debate how to manage, grow with, and live traditional cultural teachings given today's social, geographical, and occupational realities. It is not a matter of simply reclaiming traditions; rather, it entails the creation of a new culture that honours tradition and identity. For example:

It depends. If you're in more of an urban area maybe you'll draw on, say, the Cree cultures and a mix of cultures, Métis cultures. Whereas...say [large First Nation], who are really strong and they're feeling comfortable, they draw maybe more from one culture. But if you go outside of the [large First Nation] tribe group, to, say, a Friendship Centre, it's quite different how they might approach it. So I think that diversity exists — how they do their teachings and how they involve the family and the mother. (leader)

Discussion

According to international law, “forcibly transferring children of the group to another group” is a form of genocide, or state-perpetrated collective violence intentionally targeting a population group with the aim of destroying it (*Convention on the Prevention and Punishment of the Crime of Genocide, 1951*, cited in Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 216). The long-term individual and population health effects of genocide are well documented. They include increased rates of depression and anxiety, psychosomatic ailments, suicidal behaviour, intra-familial conflict, substance abuse, and antisocial behaviour (Krug et al., p. 216). “Intergenerational transmission of mental health sequellae (of collective violence) has also been documented, with offspring of holocaust survivors reporting higher rates of current and lifetime post-traumatic stress disorder symptoms than control subjects, despite similar self-reported rates of traumatic experiences in both groups” (Yehuda et al., cited in Krug et al.). Thus an extended burden of disease may be conferred on communities already coping with a multiplicity of genocide-related health consequences (Adler, Smith, Fishman, & Larson,

2004). In the case of Canada's Aboriginal peoples, the residential school system was just one in a collection of human rights abuses: being required to stay on reserve (written permission to leave was required until the mid-1960s), loss of work because of traditional activities such as fishing or hunting, denial of rights of citizenship such the right to vote or to own land (Furniss, 1995, 1999; NTC, 1996; RCAP, 1996), and a host of others.

Aboriginal participants' experiences of and explanations for intergenerational transmission of the traumas inflicted by the residential school system are congruent with evidence on the impact of childhood trauma on neurobiological (National Clearinghouse on Child Abuse and Neglect, 2001), moral, and emotional development (Tangney & Dearing, 2002). Trauma during childhood often results in withdrawal and dissociation, with the person being cut off from his or her feelings (Dion Stout & Kipling, 2003; Tangney & Dearing). The unhealthy relationship behaviours modelled in residential schools, such as coercion, abuse, and neglect, as well as dissociation from feelings, constrains opportunities for affected children to develop the skills necessary to form healthy relationships (Dion Stout & Kipling, 2003). These problems are complicated by the dysfunctional coping behaviours, such as alcohol and drug use, that they pick up from residential school staff in order to escape from the spiritual and emotional pain, loneliness, and isolation (AHF, 2005; Dion Stout & Kipling, 2003; NTC, 1996; RCAP, 1996). Survivors then pass on the resulting identities, beliefs, and patterns of social behaviour.

Participants' experiences with turning around the IGIRS extend the evidence on resilience, recovery from trauma, and cultural continuity into the domain of care during pregnancy and parenting. For example, participants stated that having at least one person witness either their painful experiences or their successes was critical to their progress in "turning it around." This finding echoes the conclusion of many studies that being connected to at least one other person is a significant factor in the health of survivors of trauma such as severe violence or child sexual abuse (Brown, Henggeler, Brondino, & Pickrel, 1999; Gilgun, 1990; Hall, 1996; Rew, 2002; Testa & Miller, 1992; Wilcox, Richards, & O'Keeffe, 2004). Dion Stout and Kipling (2003) synthesize evidence on resilience to identify its potential contribution to facilitating resilience among residential school survivors and their family members. The results from the present study suggest that understanding the IGIRS may tap into sources of resilience that serve to transform parenting and family relationships and to avert the intergenerational transmission of patterns set by residential schools.

Participants' experiences of *rebuilding our cultures in contemporary contexts* resonates with evidence on the positive impact of community-

based efforts to rebuild First Nations cultural continuities devastated by decades of colonization (Chandler & Lalonde, 1998). The results of this study extend the significance of this work on cultural continuity into the domain of pregnancy and parenting.

The present study contributes to the emerging body of evidence on cultural safety (Browne, 2001; Browne & Smye, 2002) by raising the issue of safety in the context of care during pregnancy and parenting. Culturally safe care entails an understanding of the history of colonization and its impact on Aboriginal people, attention to power relations in health-care relationships, and the fostering of safe, supportive relationships (Polashek, 1998; Wood & Schwass, 1993). The present findings add to the literature on cultural safety by demonstrating the importance of bringing these issues to the fore in the design and delivery of safe and supportive policies and programs.

Implications

Understanding and acknowledging the IGIRS emerged as central to participants' vision for a better future for their children, and thus as salient to safe and supportive health-care relationships. *Understanding and acknowledging the IGIRS* requires an understanding of the pathway of devastation that results from multiple levels of disconnection and alienation when people undergo decades of genocidal policy and social relationships. The resulting *downward spiral of addiction, violence, and poverty* is often racialized as being an Aboriginal "characteristic" instead of recognized as the consequence of collective violence (Browne, 2001; Reimer Kirkham & Anderson, 2002).

Colonialist health policies and practices and colonialist relations in general are reinforced by silence on the subject of residential schools, both within and outside of Aboriginal communities, and racialized explanations for the inequitable health and social conditions endured by Aboriginal people (AHF, 2005; Adelson, 2004). Health policy and programs may inadvertently reinforce stereotypes if addictions and violence, rather than IGIRS, are conceptualized as the root cause of health and social inequalities. The underlying assumption is that characteristics of Aboriginal people actually explain increased rates of addiction and violence. When policies and practices are based on racialized explanations of health and social conditions, the result is unresponsive and unsafe services. Such racialized explanations may also be responsible for the pattern, among Aboriginal people, of poor access to and use of mainstream pregnancy and parenting programs. The health and social conditions resulting from the IGIRS cannot be reversed unless the views and experiences of Aboriginal people are recognized and unless their vision

for change is brought into the foreground of maternal-child health policy and practice.

The present results suggest that the understanding of community-based stakeholders with regard to both the root causes of and acceptable approaches to safe and supportive care in Aboriginal communities must be part of the discourses that shape health policy and programs as well as training programs for health professionals. Health status and experiences like pregnancy and parenting must be seen within a broad understanding of the impact of colonization on Aboriginal people. The unique life experiences and life meanings of individuals, families, and communities must also be acknowledged. Practitioners must develop a critical understanding of colonization as a process of collective violence perpetrated to “deal with the Indian problem.” However, safe practice also requires respect for individual responses to the IGIRS shaped by the interplay of diverse personal, family, and community contexts. Further, system differences related to geographical location, population size, and governance arrangements also contribute to variations in experiences and meanings with regard to both individuals and communities.

Conclusion

The foregrounding of Aboriginal parents’ explanations for the root causes of poor health and social conditions in their communities represents a paradigm shift for maternal-child health policy and programs and professional practices, which have positioned Aboriginal people themselves as “the problem” and focused efforts on the downstream effects of residential schools. The sub-themes in the participants’ stories serve as a prescription for action, on the part of both Aboriginal and non-Aboriginal people, with regard to relationships, programs, and policies to bring the culture back by acknowledging the profound effects of IGIRS, emphasizing healing, and focusing on strength and capacity. Such a perspective will enable health policy, organizations, and providers to work in closer harmony with Aboriginal people to achieve their vision, instead of reinforcing the colonizing relations that are a legacy of the past and a feature of everyday practice.

Such a shift will require nurses to develop the individual competencies necessary for culturally safe nursing practice. Further research is needed to explicate competency development processes that will build partnerships between Aboriginal organizations and communities and to identify implications and actions for the nursing education and practice organizations that oversee our professional responsibilities to the public.

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