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Historical Trauma and the Support of Wabanaki Elders Caring for Indigenous Children

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I would like to take this time to acknowledge the sovereignty of the Wabanaki people in Maine. This includes sovereignty over their data, the design of research performed on their population, and how results of the research are used. This is an important lesson for me. I should have asked permission to perform a systematic review from the Wabanaki tribal leaders ahead of time.

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Abstract

The Indigenous Wabanaki population in Maine have experienced centuries of trauma. In the United States removal of children from their parents and tribal communities in an effort of planned cultural genocide has continued for decades. In 2016, Maine and federal ICWA laws sought to protect Indigenous children from being separated from their families and communities. When Indigenous children require removal from their biological parents, the priority is placement within their Indigenous community, and care often falls onto elders. However, many Indigenous elders experience significant challenges when children are placed in their care as a result of the consequences of historical trauma they have endured.

To support Indigenous elders in the care of Indigenous children, family nurse practitioners (FNPs) must understand these challenges, implement interventions, and advocate for resources and policies. A systematic review of the literature on evidence-based clinical guidelines to support Indigenous elders and children in their care can inform practice, policy, and research for FNPs and other primary care providers.

*Keywords:*Indigenous elders, Wabanaki, healthcare disparities, historical trauma

Historical Trauma and the Support of Wabanaki Elders Caring for Indigenous Children

Indigenous people in the United States (U.S.) have been subject to oppression since 1607 when European explorers settled on U.S. soil. Children and adolescents were specifically targeted in these acts of oppression. The history of US oppression of Indigenous people can be described as "colonial injury" which resulted in historical trauma. Historical trauma is emotional wounding that occurred across generations because of conquest, dispossession, and subjugation experienced by Indigenous people mostly at the hands of white, Euro-American settlers (Brave Heart et al., 2011; Hartmann & Gone, 2014).

Indigenous children were assumed to be raised in a savage and superstitious culture; hence, forcible removal was considered to be an act of mercy and a way to better their "station". Indigenous children were forcibly removed from the home in attempts to force assimilation to the dominant European white culture. The U.S. Government assimilation initiatives toward Indigenous people formally began in 1819 with the passage of the Civilization Fund Act by U.S. Congress. This act funded white missionaries and religious organizations in the forced schooling and indoctrination of Indigenous tribes (McMurtrey, 2019).

For decades at the end of the 19th century into the middle of the 20th century, the U.S. Bureau of Indian Affairs funded the creation of boarding schools for erasure of Indigenous cultures. The first established boarding school for Indigenous children in the United States was the Carlisle Indian School, opened in Carlisle, Pennsylvania on November 1, 1879. The founder of the Carlisle Indian School, Captain Richard Pratt described the educational philosophy of the Carlisle school as the following:

> "All the Indian there is in the race should be dead. Kill the Indian in him, and save the man" (Pratt, 1892, p 46).

In the following decades, the US federal government used the Carlisle school as a model for other boarding schools that would attempt to force assimilation of Indigenous children into dominant white Euro-American culture. Parents who refused the forcible taking of their children were forced to hide, relocate, or face imprisonment. Some Indigenous parents sent their children willingly because Indigenous children were not permitted to attend local public schools, making boarding schools their only opportunities for formal education (Bell, 2009).

The federal government supported these schools for decades. Indigenous children were given English names, forced to cut their hair, and forbidden to speak their native languages. The residential boarding schools were notorious for poor living conditions, malnourishment, medical experimentation, and physical and sexual abuse. Over a century later, the last boarding school for Indigenous children in the US closed in 1986, as the federal government supported cessation of unwarranted taking of Indigenous children (Bell, 2009).

Boarding schools were not the only method of separating Indigenous children from their families. In 1958, the Bureau of Indian Affairs with the cooperation of the Child Welfare League of America created a contract termed the Indian Adoption Project (IAP) which was binding between 1959 and 1967. Indigenous children residing on reservations and enrolled in residential schools were matched with adoptive parents. The IAP eliminated legal adoptions requirements however, parental rights were never terminated. Indigenous children from infancy to 11 years old were simply adopted into white, euro-centric middle-class families justified by social superiority. This resulted in 395 adoptions which paved the way for other adoption agencies to implement the same practices hence, leading to more adoptions (Palmiste, 2023).

As late as 1978, 25%-35% of Indigenous children in the U.S. were living outside of their homes and communities in foster care, adoption, or residential school. Most were forcibly

removed from their homes, and over 85% were placed into non-Indigenous homes, despite the options of available fit and willing Indigenous families and extended families. The unlawful removal of Indigenous children from their homes by Child Welfare Services and adoption agencies and placing them with white, Euro-American families or in federally backed residential school lead to protests by Indigenous Tribes. Subsequently, a major press conference in 1968 by the Association of American Indian Affairs (AIAA) ensued and was the impetus for federal Senate and House hearings in which Indigenous parents and tribes recounted the forcible removal of their children from 1974-1978 (Palmiste, 2023).

The widespread issue of unequal and unwarranted removal of Indigenous children, and the resounding testimony to legislators led to the proposal and passage of the Indian Child Welfare Act (ICWA) by Congress in 1978. The ICWA's stated purpose is

> "...to protect the best interest of Indian Children and to promote the stability and security of Indian tribes and families by the establishment of minimum Federal standards for the removal of Indian children and placement of such children in homes which will reflect the unique values of Indian culture" (Indian Child Welfare Act, 1978).

Following the passage of the ICWA and funding provided by the federal government, states began implementing the tenets of the ICWA. However, changes in states such as Maine could be considered slow at best, due to lack of guidance on implementation along with lack of training by Maine Child Protective Services (CPS) (Attean et al., 2012). Although some children from Maine tribes were sent to boarding school or orphanages, most Indigenous children removed from their Indigenous home were adopted or placed with white Euro-American families. In the late 1990's, Maine CPS was removing Indigenous children from their homes at a rate higher than over 40 other states in the U.S. (Attean et al., 2012).

The dominant narrative in Maine to justify separation of Indigenous children from their families was that the Indigenous population (i.e., Wabanaki people) were unable to properly care for their children. This narrative was not based on evidence. Maine CPS justified the practice of separating Indigenous children from their families based on their premise that the state of Maine and its Indigenous tribes were incapable of working together or being considered equal entities. This narrative was accepted by a majority of the Maine population, hence many Wabanaki people began to internalize it (Bjorum, 2014). Systems of inequality are maintained and replicated partially through internalization by those who are oppressed (Pyke, 2010). Wabanaki people internalized the stereotypes that they were unfit as parents which served to increase the power of the dominant white culture in Maine. Internalization of being inferior or undesirable can lead to acting out of negative stereotypes and perpetuating power structures that benefit colonizers (Holohan, 2022).

In 1999, an investigative report by the federal Child and Family Services Review (CFSR) found many states out of compliance with the ICWA and CPS regulations, removing Indigenous children from their homes at the same rate before passage of the ICWA. In Maine, tribes were not notified by CPS when Wabanaki children were removed from their homes as CPS workers lacked training about the ICWA or Wabanaki culture. Additionally, the Maine judicial system was not upholding the ICWA process in court (The Maine Wabanaki Truth & Reconciliation Commission, 2015).

The findings of the CFSR review led to creation of a work group composed of Wabanaki Tribal Case Workers and Maine CPS workers. This state-tribal work group created mandatory training on the ICWA and Indigenous culture for all Maine CPS workers (Wabanaki- REACH, 2021). Yet in 2011, a state review of open ICWA cases revealed tribes were still not being

consulted regarding Maine's Indigenous child abuse and neglect cases. The state-tribal work group recognized state CPS practices needed to be changed in a meaningful way and voices of Wabanaki people regarding their experiences in the CPS system must be heard. The decades of oppression of the Indigenous population created a legacy of historical trauma that was perpetuated by CPS practices (Bjorum, 2014).

Historical trauma (HT) is a concept introduced in the late 20th century. Previous generations of Indigenous people subjected to trauma from the abuses of colonization internalized these experiences. These shared experience of Indigenous people of perceived monumental loss of their culture resulted in a historical trauma response (HTR) leading to emotional distress and unresolved grief. The collective experience of HT over generations can lead to permanent changes in the brain's neurochemistry because chemicals released during trauma experiences physically alter the brain. The chronicity of the trauma experienced by Indigenous people and their ancestors lead to genetic passage of traits including predisposition toward depression, suicide, obesity, diabetes, substance use disorder, cardiovascular disease, and domestic violence. HT impacts entire generations of Indigenous people and contributes to current social and health disparities (Brave Heart, 2000; Gone, 2014; Ho et al., 2021; Tally, 2018; Whitbeck et al., 2004). The continued presence of racism and oppression in American society perpetuate these disparities which are "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations' ' (CDC, 2023, para. 1). Social and health disparities from HT contribute to a higher morbidity and mortality rate. While the U.S.'s average age of death was 79 in 2010, the average age of death for the Wabanaki is 54 years of age (UPSTANDER Project, 2016).

In 2011, a Maine initiative to end one of the contributors of historical trauma, namely the removal of Indigenous children from their homes and communities, was launched during the administration of Governor Paul LePage. Four Wabanaki chiefs from federally recognized tribes in Maine and Governor Paul LePage mandated creation of the Maine Wabanaki-State Child Welfare Truth and Reconciliation Commission (TRC). The TRC was tasked with finding the truth of Indigenous people's experiences with CPS and to generate a report with policy recommendations. The TRC was allotted three years to complete this task. The Maine TRC was the first of its kind to address the unauthorized taking of Indigenous children in the United States (Collins & Watson, 2023).

Based on the recommendations of the TRC, the Maine Indian Child Welfare Policy was created in 2016. The tribal affiliation of Indigenous children in Maine referred to CPS must be identified during intake and assessment and the tribe's ICWA welfare office had to be notified immediately. From that moment on, the child's case must be handled by state CPS workers in conjunction with tribal CPS workers. Funding is provided for these services by the Department of Health and Human Services (DHHS) and the ICWA. If removal from the Indigenous child's home is required, a priority placement occurs with close relatives first, tribal extended families or community members second, and a foster home outside the tribe with an Indigenous family being third. Both state and tribal methods are utilized to promote child wellness and reunification efforts (An Act to Enact the Maine Indian Child Welfare Act, 2023).

While Indigenous children are still removed from their homes at an incidence of five times that of white children in Maine, much progress has been made in both keeping any needed placements within the tribal community and community families who value the importance of tribal community identification to upbringing (Satz, 2020). Traditionally, Indigenous elders are

valued members of the Wabanaki Tribes and participate in teaching and upbringing of children consistent with cultural values and beliefs. Elders are considered a group to consult in decision-making by tribal leadership and are afforded special status in the tribe along with being holders of the history, tellers of stories, and performers of ceremonies (Pelkey et al., 2019). Indigenous children involved with CPS are remaining in tribal extended care which holds promise to preserve Indigenous cultures and foster healthy Indigenous children, families, and communities. However, the extended role of primary caretakers for children in CPS can be more stressful to Indigenous elders than other aging populations in Maine who care for foster children. Wabanaki elders face disproportionate social and health disparities when compared to other populations of aging people in Maine as a result of HT which impacts their ability to care for Indigenous children placed in their care.

Research Question

What evidence-based practices implemented by Advanced Practice Nurses (APNs) support Indigenous elders in the parenting of Indigenous children placed in their care by CPS?

Methods

The study was conducted from November 2023 to March 2024 by accessing articles in Google Scholar, CINAHL, and Medline databases. Keywords used in the search were Indigenous, Native American, Indian, Health Care, Harm, Primary Care, Elder, Wabanaki, Historical Trauma, Indigenous Health Research, Clinical Recommendations, Clinical Guidelines, and Trauma informed Care, kinship care, tribal child welfare, and Indigenous grandparent care.

All research types were considered. There is limited quantitative research available regarding the culture, health care and evidence-based practices among Wabanaki elders. Indigenous research differs from colonizer research as it is predominantly qualitative studies

often based on case studies, interviews, and story-telling, where all voices are heard. Indigenous populations are often hesitant to participate in quantitative research because historical medical harm of Indigenous people has led to mistrust of non-Indigenous researchers and agencies. Without participation of Indigenous elders, or a relationship being built, researchers may be seen as those trying to advance their own career by extracting, and not providing a benefit to the communities being studied, or the elders within it. This makes Indigenous elders less likely to participate or provide accurate information (Braun et al., 2014).

The scope of this project is among the Wabanaki, a borderless Indigenous group, hence, the search is limited to North America. Tribe specific research and statistics should be taken within that area's context and unique experiences of historical trauma. Studies on urban Indigenous populations were excluded as Maine is the most rural state in the U.S.

Excluded search terms were Australia and New Zealand, because health care models and Indigenous populations may have different policies and procedures and Indigenous populations may utilize different health care practices on a different continent.

After becoming more familiar with the data set and their meaning and significance, additional studies that did not follow the precepts of Community-Based Participatory Research (CBPR) methods were eliminated from the data set. In respect for the sovereignty of Indigenous populations over their people, governance, data, research design, and implication use, research that does not ask permission to study, nor give tribes ownership over results is not considered. Such research that does not involve the community studied is likely performed through a westernized, colonizer lens, and likely lacking in validity (Braun et al., 2014; Crouch et al., 2023).

Results

A total of 51 research studies were initially gathered for the systematic review, based on search results of the databases searched. After exclusions were applied, 31 studies remained. An additional 16 studies were excluded that were of interest to the topic, but did not specifically address any part of the research question and 15 studies remained

Two additional mixed method research studies that met criteria were added, one compared the experience of Indigenous and non-Indigenous grandparent caregivers and the other elicited the experiences of Indigenous Alaskan grandparents. The latter was not yet published at the time of the initial search so it was included when discovered. Two more studies were added regarding the effectiveness of traditional interventions for indigenous youth struggling with their experiences with CPS and being removed from their homes and the utilization of talking circles to improve quality of life for Indigenous elders in primary care (Latimer et al., 2018; Mehl-Madrona & Mainguy, 2014)

The final data set of 19 studies includes 13 qualitative and five mixed-method studies, and one quantitative study. The majority of the data set was qualitative; hence data extraction is organized in thematic synthesis supported by quantitative data.

The Braun and Clarke (2008) method of thematic analysis was utilized to code and synthesize the data set to answer the research question. The data was coded, and pertinent themes, phenomenon, challenges, needs, and protective factors were identified as important to identifying evidence-based practices that support Indigenous elders in the parenting of Indigenous children.

Data Analysis

The results of this systematic review of the literature is organized into the categories of themes, phenomenon, challenges, needs, and protective factors. Two overarching themes "respect" and "family" are foundational to interventions by APNs or other HCPs to support the needs of custodial Indigenous elders. The extracted phenomena are Indigenous healthcare and research practices, and the need for APNs and other HCPs to understand these phenomena to collaborate and integrate care. Challenges and barriers to effectively support custodial Indigenous elders are their justifiably low healthcare utilization and the impacts of historical trauma on health. The data set identifies the needs of custodial Indigenous elders and children in their care. Finally, protective factors for elders are identified by the data.

Themes

17 of the 19 articles identified dominant themes of respect and/or family that support Indigenous elders in their parenting of children placed in their care.

Respect

Respect is an important element that has been missing in treatment of the Wabanaki people by HCPs trained in the Western medical model. Disrespect had its roots in a lack of cultural humility and began during colonization when forced medical experimentation and sterilization of Indigenous people was common practice. These practices no longer exist but lack of cultural humility by non-Indigenous providers is manifested in other ways such as providers' failure to consider elders Indigenous world views and unique needs when creating care plans. To practice cultural humility, HCPs must recognize the need to examine their own privileges and biases informed by the culture and medical model in which they are trained. Collaborative practice, respect of Indigenous values and beliefs and gaining informed consent to treat is

consistent with respect and serves as the foundation of the therapeutic relationship (Centers for Disease Control and Prevention, 2022; Logan et al., 2020).

A study by Brown et al. (2014) reported that Indigenous elders often prefer services offered by the tribes or providers who embody cultural humility. Elders felt they were not only misunderstood by the Western system of medicine but also that no attempt was made to understand Indigenous beliefs and values. In Indigenous cultures, time to answer provider questions and an attempt by the provider to understand Indigenous culture is viewed as a sign of respect. In this study, Indigenous Hawaiian people reported they were often asked questions, and not given time to answer. Further, they perceived providers did not make an effort to know them, their families, or their customs. Elders reported they were not given time to have interventions explained, time to answer questions, or explanations about important screenings or procedures (Browne et al., 2014).

A demonstration of respect of Indigenous elders is a provider's effort to understand historical atrocities Indigenous communities have endured at the hands of white colonization and recognition of the impact of historical trauma on patterns of disease. Lack of a provider's acknowledgement of historical trauma sustained by Indigenous communities can lead to increased cortisol levels that contribute to chronic inflammatory diseases (e.g., cardiovascular disease) and genetic changes that perpetuate these conditions in future generations (John-Henderson, 2023; Brave Heart, 2011; Brockie et al., 2021; Crouch et al., 2023).

Although research focused on provider interactions and interventions that support the health of Indigenous elders may improve health outcomes for this population, research methods must be respectful of Indigenous communities. Flannagin et al. (2021) reported that historically health care research among Indigenous people involved research design, data collection, and

publication and dissemination of results without permission or respect of Indigenous communities. Respect in this context extends beyond the provider/patient relationship to include conducting research that is collaborative and respectful of Indigenous communities.

Respect for cultural healing traditions is an important component of healthcare and well-being for the Wabanaki people. Traditional Wabanaki healing practices and ceremonies to promote well-being should be integrated into the care provided to Wabanaki community members. Custodial Wabanaki elders in Maine need to be able to exercise the right to practice cultural healing traditions together, whether celebrating nature, their community, milestones, or when there is a perceived need (Bjorum, 2014: Day et al., 2018; Flanagan et al., 2021; Logan et al., 2020).

Wabanaki and other Indigenous communities' health and well-being is closely tied to the land and nature that surrounds them. Part of respect for the wellbeing of Wabanaki and other Indigenous people is the acknowledgement that connectedness with the earth is significant (Flanagin et al., 2021; Bjorum, 2014). Healthcare providers should acknowledge this importance and advocate for healthy preservation and sustainability of the world around them.

For APNs to be able to support custodial Indigenous elders, it is imperative that they understand the role Indigenous elders play within the Indigenous community (Browne et al., 2014; Crouch et al., 2023). Elders provide vision and direction to the community and responsibility to guide toward a better future (Flanagan et al., 2021). They are considered caregivers for the younger generations of the whole community and are respected for their perspective and roles as knowledge keepers, healers, protectors, and ceremony providers (Dennis et al., 2017; Bjorum, 2014; Lewis et al., 2018). HCPs should recognize and respect custodial

Indigenous elder's roles in their communities and allow them to exercise these roles in their culturally appropriate care of Indigenous children.

Family

For Indigenous people the concept of family is not nuclear, it is more inclusive and expansive (Bjorum, 2014; Gerlach & Gignac, 2019; Lewis et al., 2017). Family members may include individuals related biologically as well as non-biologically. HCPs working with custodial Indigenous children and elders must understand that a family is who they say they are and may include parents, grandparents, extended family, friends, and/or tribal members (Gerlach & Gignac, 2019; Lewis, 2017). Wabanaki child welfare case workers interviewed children affiliated with the tribe and referred to them as "our children" and a member of the tribe's family, testimony to the inclusive and expansive nature of family for the Wabanaki people. Indigenous elder caregivers interviewed in Alaska believe any young person in the community in need, is the responsibility of the entire Indigenous community (Bjorum et al., 2014).

It is important for APNs to recognize the most effective and accepted health care interventions for Indigenous elders are family-centered (Browne et al., 2014; Dennis et al., 2017; Gerlach & Gignac, 2019). Indigenous grandparents are four times as likely to care for their grandchildren than non-Indigenous grandparents, and although for some it is an unanticipated situation, intergenerational living can provide joy for Indigenous elders, and clear familial roles and responsibilities for the children in their care. Intergenerational transmission of knowledge is important to many custodial Indigenous elders along with the companionship and help with tasks that grandchildren and other younger relatives can provide for grandparents (Morgan & Lewis, 2017; Henderson et al., 2017).

Instead of focusing on a deficit framework with emphasis on disparities and challenges, strengths of custodial Wabanaki elders should be identified and fostered. APNs should amplify "resilience factors" as opposed to "risk factors" so often focused on with interventions in Indigenous families (John-Henderson et al., 2023). Each Wabanaki family unit has a diverse composition with unique strengths. Those strengths should be identified, celebrated, and fostered in both health care and health research to support custodial Indigenous elders.

The theme of family has a subtheme of protection. Historically, the Wabanaki have experienced trauma of family separation and powerlessness against outside entities forcibly separating the family. Families need to be empowered by protections and the opportunity to understand their legal rights as family members. When state CPS are involved, they must notify tribes immediately, and the Indigenous child must be assigned a tribal caseworker as well, who ensures priority placement is within the tribe or with a family who will ensure tribal connection is maintained (Day et al., 2018; Lewis et al., 2018).

Phenomenon

Phenomena to support Indigenous elders in parenting Indigenous children placed in their care include (1) a holistic approach to evidence-based practice informed by research that honors the Wabanaki people, (2) incorporating Indigenous healthcare practices, and (3) practicing cultural humility. When APRNs and other HCPs use research to guide their approach to care of Indigenous elders it is important to consider various research methodologies to inform practice. The dominant Western medical perspective views quantitative research and double blinded clinical trials as the gold standard of health research to inform practice often marginalizing qualitative research (Logan et al., 2020). However, clinical practice that fails to consider values and beliefs of the population, inherent in qualitative research may undermine best practices.

Qualitative research is considered decolonizing and restorative such that it supports “Walking in two worlds”, talking circles, interviews, and storytelling which are highly valued by the Wabanaki people. When these qualities are intertwined with Western medical best practices, health outcomes for custodial Indigenous elders may be achieved (Browne et al., 2023; Flanagan et al., 2021; Ivanich et al., 2020)

Incorporating Indigenous healthcare practices is another phenomenon that can support Indigenous elders in the care of custodial children. Creating space in practice for Indigenous healing practice when treating Indigenous elders can be considered an act of reconciliation for past harms and may also increase healthcare utilization (Logan et al., 2020).

Low healthcare utilization by Indigenous people stems from mistrust and historical mistreatment (Day et al., 2018). When HCPs create space for Indigenous healthcare practices cultural humility is implied and may serve to build trust. Honoring the use of Indigenous language by elders and respecting values and beliefs are demonstrations of cultural humility (Ivanich et al., 2020). Building trust is essential to address barriers and challenges.

Barriers and Challenges

Barriers and challenges to optimal health for Indigenous elders and the children in their care include the cost of healthcare, transportation needs, preference for tribal services, and historical trauma. Cost of healthcare can be prohibitive for Indigenous elders as many are underinsured and often have not planned to be financially supporting children in their older age. The cost of some health care services for children in Indigenous elders care such as orthodonture, vision, dental and mental health are either not covered, or they involve large, costly copays. This may add an extra financial burden because in addition to their own healthcare cost they must now assume these additional costs for children in their care. Furthermore, custodial arrangements

are oftentimes not formal and do not involve any financial assistance from Maine CPS or Indian Health Services (Bailey et al., 2019; Day et al., 2024).

Transportation is an additional barrier to healthcare and support for Indigenous elders. Custodial elders should be provided with either transportation, or offered home visits. (Ivanich et al., 2020; Dennis et al., 2017). Another possible solution may be identifying convenient places or events within the custodial elder's community that allow for provision of care (Browne et al., 2014; Dennis & Momper, 2016).

A barrier for many Indigenous elders who are providing care for Indigenous children is the mistrust of non-indigenous HCPs along with preference for health services offered by tribes (Gerlach & Gignac, 2019; Browne et al., 2014; Ivanich, 2020; Huber-Ito, 2021). Fear of judgment from non-Indigenous HCPs is an additional reason that Indigenous elders are hesitant to seek care from non-Indigenous providers (Huber-Ito, 2021; Mehl-Madrona & Mainguy, 2014; Robertson et al., 2022). Mistrust and fear of judgment often have their roots in the consequences of historical trauma hence, trauma informed care may serve to eliminate or mitigate these emotions. HCP who practice trauma informed care recognize the impact of trauma on health and well-being. Interventions should avoid re-traumatizing the individual. Non-traumatizing interventions include a non-judgmental approach, honoring the culture, and avoid stereotyping (Cullen et al., 2022).

Historical trauma can lead to dysfunctional parenting practices by Indigenous elders and increased incidence of chronic health conditions that impact their ability to care for children placed in their custody. These dysfunctional parenting practices subsequently create trauma for the children in their care thus creating a cycle of adverse childhood experiences for Indigenous children. Additionally, elders, who have experienced their own trauma, may have difficulty

stepping in to provide emotional and financial help. Interacting with school personnel, often an expected role of parents/caregivers (e.g., parent/teacher conferences) may trigger recall of their own school traumatic experiences in boarding or day schools.

Expressive suppression, a consequence of historical trauma, can make it difficult for many Indigenous elders to cope with emotional pain (Latimer et al., 2018; Mehl-Madrona & Mainguy, 2014; John-Henderson, 2023). Expressive suppression is the inhibition of emotional reactions to situations that would be considered emotion-eliciting. Expressive suppression stems from trauma responses and modeling (John-Henderson et al., 2023). Expressive suppression can interfere with the custodial elder understanding of how to navigate CPS to advocate for mental and behavioral health services to provide therapy and trauma informed care for Indigenous children removed from their parents (Dennis et al., 2017; Bailey et al., 2019; Day et al., 2024; Gerlach & Gignac, 2019).

The physical manifestations of historical trauma include chronic stress and resulting chronic illnesses such as diabetes, hypertension, pain, cancers, and autoimmune disorders. Other manifestations of historical trauma include mental illness and substance use disorders that lead to more physical illnesses, lower quality of life, and higher likelihood of early death (Crouch et al., 2023; Mehl-Madrona & Mainguy, 2014). Best practices to ameliorate the impacts of historical trauma include respect, talk therapy, and family and/or community centered approaches to address chronic illness (Day et al., 2024; Mehl-Madrona & Mainguy, 2017; Dennis & Brewer, 2017; Logan et al., 2014).

Needs of Custodial Elders and Children in Their Care

APRNs need to be aware of the unique needs of Indigenous children who have been removed from their parents and placed in custodial care with Indigenous elders. Likewise,

Indigenous elders also have unique needs that need to be addressed to support them in the care of Indigenous children in their custody.

Needs for custodial elders include support groups, cultural centering, and traditional healing practices. Additionally, Indigenous elders may need assistance navigating the complexities of schools, technology use, and the Maine CPS system (Crouch et al., 2023; Mehl-Madrona & Mainguy, 2014; Day et al., 2024; Robertson et al., 2022; Henderson et al., 2017). APRN or other HCP may be able to address some of these needs in practice and should be knowledgeable of existing resources however, when these resources are lacking advocacy for resources will be needed.

Identified needs for Indigenous children under the care of custodial elders are similar to those of Indigenous elders, however children are unique as they have fewer life experiences and cognitive, emotional, and social skills that are still developing. Children who are not able to be cared for by their parents need permanency and a sense of belonging along with cultural identity (Bjorum, 2014; Day et al., 2014; Latimer et al., 2018). Many Indigenous children in the care of elders have experienced multiple traumatic experiences such abuse, neglect, and exposure to substance misuse. Emotional support, accessible therapy, healthcare, and providers acceptance of self-expression are interventions that may provide healing. Cultural and traditional practices and support for Indigenous elders and children hold promise to improve quality of life (Latimer et al., 2018).

Protective Factors

Recognition of protective factors against the consequences of historical trauma for custodial Indigenous elders is central to strengths-based approach to care. These protective

factors include qualities and practices that can support the health and well-being of custodial elders and children in their care (John-Henderson, 2023).

Effective protective factors for Indigenous elders may include reflection on life experiences that influenced past parenting practices. Through lived experience Indigenous elders may have gained new knowledge and perspectives of parenting that can positively impact their relationship with children in their custody (Bailey et al., 2019). This may be a welcome opportunity as a second chance to parent Indigenous children in their care. Modeling and learning positive parenting skills has been demonstrated to be protective factor for many custodial Indigenous elders, as community-based skill building supports all parents and caregivers. Collaboration in the organization and implementation of community-based parenting education supports the Indigenous values of community and family and often is well received (Day et al., 2018; Bjorum, 2014). Elders can support this initiative through activities such as recollecting positive childhood experiences and family building skills that can be shared with the group (Bailey et al., 2019)

Cognitive reappraisal is a protective factor by which an individual can reframe their thoughts about an adverse emotional experience to reduce its negative impacts (Gross & John, 2023). Cognitive reappraisal has been demonstrated to protect the cardiovascular system and reduce chronic stress- that can lead to negative physical and mental health outcomes (John-Henderson, 2023). Culturally grounded community involvement that fosters social relationships can also serve as a protective factor for chronic stress experienced by Indigenous elders. (Bailey et al., 2019; Mehl-Madrona & Mainguy, 2014).

Mastery of an art or skill is a protective factor against depression and depressed mood for both Indigenous elders and the children in their care APRNs can help custodial Indigenous elders

identify a skill or art they would like to master and identify resources to help them achieve this goal. Sharing an art or skill with children in their care may also serve as a protective factor for the child (John-Henderson, 2023).

Resilience is a protective factor that has been demonstrated to improve health outcomes and support coping skills. Indigenous elders who share experiences of trauma, survival, stories of perseverance and overcoming adversity can empower cultural pride and resilience (Crouch et al., 2023). Engagement in traditional Indigenous cultural and spiritual practices is an important moderator between poor health outcomes and resilience (John-Henderson, 2023; Robertson et al., 2022).

Conclusion

Although there is still work to be done, changes in policy in child protective services for Indigenous children in Maine has had a positive impact on Indigenous communities. As a result of these changes, Indigenous children are more likely to be placed with Indigenous elders who can nurture their children in ways consistent with their culture. This serves not only to strengthen Indigenous families and communities but also holds promise to heal the wounds of historical trauma. These initiatives however, have revealed challenges that still need to be addressed to support Indigenous elders in the care of children placed in their custody. The extended role of primary caretakers for children in CPS can be more stressful to Indigenous elders than other aging populations in Maine who care for foster children. Wabanaki elders face disproportionate social and health disparities when compared to other populations of aging people in Maine because of HT which impacts their ability to care for Indigenous children placed in their care. Strategies that APRNs and other HCPs can implement to support Indigenous elders and foster healing from historical trauma have been identified in this systematic review of the

literature. Future implications for practice, policy, and research can extend the work needed to support Indigenous elders in the care of their children and pave the way to a healthy future for Indigenous communities in Maine.

Implications for Practice, Policy, and Research

The results from this systematic review of the literature can inform practice, policy, and research by APNs and other primary HCPs posited to support custodial Indigenous Wabanaki elders. Cultural understanding, collaboration, trauma-informed care, and community-based interventions are promising strategies when working with Indigenous elders caring for Indigenous children that transcend practice, policy, and research.

Implications for Practice

APNs have the opportunity to better understand the Wabanaki population's experiences, strengths, and unique challenges to promote health and support custodial elder caregivers. This goes beyond generic diversity and inclusion education requirements (Ivanovich et al., 2017). Wabanaki Reconciliation, Engagement, Advocacy, Change, and Healing (REACH) offers organizational training on decolonization and the impact of historical trauma, especially experiences of those involved with Maine CPS (Wabanaki REACH, 2021). It confers respect for HCPs to become educated in the historical experiences and worldview of Indigenous elders in their community (Browne et al., 2016). Trauma-informed healthcare that recognizes Wabanaki elders have experienced multiple forms of systemic, and individual trauma can serve to prevent re-traumatization in elders by avoiding practices that trigger and perpetuate trauma responses (Cullen et al., 2022; Browne et al., 2016; Dennis et al., 2017). Trauma-informed interventions are based on trust and include avoiding individual shaming and judgment which serves to empower individuals and remedies community health disparities (Cullen et al., 2022). Recognizing power

differentials and historical harms also fosters understanding and serves as a foundation to integrate traditional Indigenous healing practices (Cullen et al., 2021; Browne et al., 2014; Browne et al., 2016; Huber-Ito, 2017; Gerlach & Gignac, 2019).

Collaboration with Indigenous communities is essential for successful health care initiatives and to amplify Indigenous voices and choices in the healthcare they receive (Flanagan et al., 2021; Robertson et al., 2022; Browne et al., 2016). Honoring the voices of Indigenous elders requires inclusion on healthcare organization boards of directors and advisory committees. HCPs can initiate outreach programs in conjunction with local tribal health entities to provide health screening and information in tribal community centers. Non-Indigenous centers of care should be welcoming, safe, and convenient for Indigenous elders (Browne et al., 2016; Cullen et al., 2021). These interventions minimize cost and barriers to custodial Indigenous elders obtaining support (Beavis et al, 2015; Lorig, 2022; Robertson et al., 2022).

Implications for Policy

Community tribal-based healthcare centers can improve healthcare access. There are five tribal based healthcare centers in Maine as well as the Wabanaki Public Health and Wellness (WPHW) organization that serves all four tribes. These organizations address factors associated with placement of Wabanaki children with Indigenous elders such as addiction, violence, abuse, incarceration, chronic health issues, and accidental death. Substance use disorder (SUD) treatment incorporates Indigenous healing practices such as sweat lodges, sober houses, ceremonies and talking circles (Patani & Rodriguez, 2024; Robertson et al., 2022; Mi'kmaq Nation Health Department, 2024). The Houlton Band of Maliseet provides a monthly caregiver support group and children's activity at their community center that directly addresses some of the parenting challenges experienced by elders. Positive parenting practices disseminated to

whole communities is protective for those who have both experienced and learned impaired parenting skills as a result of historical trauma (Dennis et al., 2017; Huber-Ito, 2021).

These state tribal health centers however, are not adequate to provide access to custodial elders who are spread geographically and lack access to health care. Additional funds should be allocated to the Wabanaki health centers and other rural tribal health centers to increase offerings of health initiatives across the state. APNs can advocate for more resources and culturally appropriate health care initiatives to serve custodial Indigenous elders (Day et al., 2024; Dennis & Momper, 2016; Browne et al., 2014).

APNs should be advocating for more involvement of tribal caseworkers, leadership, and culturally appropriate policies regarding the removal of children from their tribal community by CPS. Informal custodial arrangements should be recognized and supported financially and with other resources. Maine CPS policies should defer to tribal sovereignty and courts regarding recommended re-unification methods, policies, restorative justice, and timelines (Bjorum, 2014, Lorig, 2022).

Implications for Research

Many healthcare interventions, from preventative to problem-based care, have been based on reductionist models such that disparities and risk factors guide research. Promising new research focuses on impact of healthcare based on strength-based models such as Indigenous elder “resilience factors” and strengths of Indigenous communities and families (Crouch et al., 2023; Cullen et al., 2021; John-Henderson et al., 2023).

Maine CPS often cites research on permanency as a reason for swift termination of the parental rights of children in the state, to afford them the opportunity of a safe and stable home environment to decrease incidence of adverse childhood experiences (Bjorum, 2014; Lorig et al,

2022). Although there is evidence to support that remaining connected to Indigenous cultures improves mood and mental health outcomes, research equating remaining in the tribal community with Indigenous elders and other Indigenous families is lacking (Day et al., 2017; Bjorum, 2014). More research exploring the impacts of remaining culturally connected by formal or informal guardianship is important to guide policy procedure, and resource allocations in support of custodial Wabanaki elders (Cullen, 2021; Bjorun, 2014).

Limitations

Lack of research on topics that promote health by honoring Wabanaki healing and healthcare practices were limited for this systematic review of the literature. Inferences were made based on other Indigenous tribes in North America and their support of their custodial elders, but each individual and tribal culture is different. Additional knowledge of Wabanaki culture and health care practices would be very valuable for Maine HCPs.

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