

**Historical Trauma Theory:
Implications for Nursing in Aotearoa New Zealand**

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Abstract

Historical Trauma Theory conceptualises Indigenous distress in response to colonisation, and is unique in that it focuses on the collective and multigenerational trauma of colonisation from an Indigenous worldview. Historical Trauma Theory links contemporary Indigenous health disparities to the process of colonisation through biological, psychological, and socio-political pathways. Nurses should consider Historical Trauma Theory to understand the implications of colonisation on the wide array of health disparities experienced by Indigenous people. Furthermore, using Historical Trauma Theory as the basis of Indigenous distress provides many possibilities for culturally appropriate healing from historical injustices and the improvement of health outcomes for Indigenous people. The research question for this literature review is: *What are the implications of Historical Trauma Theory for nursing practice in Aotearoa New Zealand?*

This research paper presents the findings of an integrative literature review, which explored the possibility of applying Historical Trauma Theory to nursing practice in Aotearoa. Kaupapa Māori Theory and a decolonising research methodology informed a conceptual and empirical review of the Historical Trauma Theory within comparative Indigenous communities, health care practice, and nursing literature. An integrative literature review method enabled a variety of literature to be included, and it is argued to be an appropriate method for research within the nursing field. This research focussed on the application of Historical Trauma Theory to health care practice, specifically the implications for generic nursing practice (both indigenous and non-indigenous nurses) in a Māori context in Aotearoa.

Few articles conceptualise Historical Trauma Theory within the context of Aotearoa and this dissertation is the first attempt to do so from a nursing perspective. The literature available within an Aotearoa context does, however, resonate with international concepts and debates, such as the need for culturally grounded interpretations of historical trauma. Five main themes emerged from the literature: 1) the *interpretation of Historical Trauma Theory*, 2) the *multigenerational transmission of historical trauma*, 3) *linking 'historical' events to contemporary Indigenous health*, 3) *healing from historical trauma*, and 5) *Historical Trauma Theory and health care practice*.

The findings have been used to construct a discussion chapter on the implications for nursing within Aotearoa. Given the lack of Historical Trauma Theory conceptualisation within Aotearoa and the profession of nursing, the discussion chapter focuses on how Historical Trauma Theory can support an existing nursing model, Wilson and Barton's (2008) Te Kapunga Putohe, to guide all nurses when practising within a Māori context. The discussion also highlights new avenues for how Historical Trauma Theory could contribute to generic nursing practice and

theory in Aotearoa. The implications for nursing theory and practice when caring for Māori include understanding the ongoing effects of colonisation on various social and health outcomes, the importance of culturally grounded health care practice including nursing practice, whānaungatanga, cultural connectedness, and tino rangatiratanga. To summarise, nursing praxis needs to incorporate Historical Trauma Theory as a framework for understanding the underlying cause of the major health disparities still endured by Māori nearly two centuries since the colonisation of Aotearoa began.

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed: _____

Date: 25.09.20_____

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Chapter 1: Introduction

Te whenua, te whenua

The land, the land

Hei oranga o te iwi

is the wellbeing of the people

No ngā tupuna

It is from the ancestors

I tuku iho, I tuku iho

passed down through time

My Whakapapa

Ko Wharepuhunga te maunga

Ko Waikato te awa

Ko Tainui te waka

Ko Ngāti Raukawa te iwi

Ko Ngāti Huia te hapū

Ko Aotearoa te marae

My people are from Ngāti Raukawa in the south of the Waikato region and down the Kapiti Coast in the lower North Island. My father is Māori and my mother is pākehā – of Irish descent. I have seen and experienced, both personally and in a professional capacity, unlawful and unethical Māori land confiscation, material deprivation, health inequities and racism as a wahine Māori. All my experiences are heart felt and painful and there are no words to describe the sadness that accompanies witnessing whānau members, including myself, being treated, in what I would regard, as second class citizens because we are Māori.

As a registered nurse, I often felt isolated and vulnerable to colleagues attitudes and health institutions policies and practices regarding Māori health. My Māori colleagues and I, which were few as it was, would talk privately about the racism we encountered as Māori and the mamae ran deep. The experience of being Māori in Aotearoa is unique to Māori, including the intergenerational mamae of colonisation. As a young registered nurse working on a medical ward, I began to gain a voice for my people, staff and patients. I questioned non-Māori colleagues about their perceived discriminative attitudes towards Māori and even complained to a Charge Nurse Manager about staffs attitudes and how they may effect whānau experiences of health care, including health outcomes. The excuses for racist nursing practice were weak and it was

becoming clear that the unacceptable attitudes and beliefs about Māori were normalised within the health care environment that I was practising. However, I would like to acknowledge the staff who were professional and respectful of Māori whānau and staff too. Nevertheless, my personal and professional experiences as a wahine Māori and as a Māori registered nurse motivated me to deepen my own understanding of colonisation and Māori health, and my journey led me to indigenous peoples' health and Historical Trauma Theory. The Historical Trauma Theory literature provided a structured framework which has enhanced my understanding of the ongoing impact of colonisation on Indigenous people's health outcomes. Therefore, given that registered nurses in Aotearoa are expected to provide culturally safe nursing care to Māori, which includes understanding the impact of colonisation on Māori health, I chose to examine how Historical Trauma Theory could inform nursing practice, for all nurses, when working with Māori in Aotearoa New Zealand.

This dissertation examines the potential use of Historical Trauma Theory in nursing practice in Aotearoa New Zealand. Historical Trauma Theory, developed by Native American scholar Maria Yellow horse Braveheart, is a framework for conceptualising the trauma of colonisation over multi-generations of Indigenous communities through an Indigenous lens. Historical Trauma Theory was selected as the focus of this dissertation because the ongoing health disparities that Māori experience are evidence of the need for closer examination into the ongoing effects of colonialism on Māori health. Historical Trauma Theory could be an appropriate framework to support and guide nursing practice with Māori.

This chapter discusses the whakapapa (genealogy) of Māori health in a contemporary context, focussing on the drastic changes that colonisation created for Māori society. Next, the development of Historical Trauma Theory and its core concepts are discussed. The chapter concludes with a discussion of nursing practice in Aotearoa, specifically focussing on nurses' ethical obligation to provide culturally competent and culturally safe care to Māori, which includes understanding the impact of colonisation on Māori health.

Māori Health

In te ao Māori, everything has a genealogy or whakapapa. Whakapapa is the foundation of mātauranga Māori (Māori knowledge) and Māori society in that it organises all living things and the spiritual realm within the context of the creation story (Salmond, 2017). The connection between past and present is fundamental to a Māori reality, so it is essential that Māori health is examined within te ao Māori (Durie, 2001). Therefore, historical contexts are equally as important as contemporary issues when understanding Māori wellbeing (Bryers-Brown, 2015; Durie, 2001).

Given the importance of whakapapa in te ao Māori, the examination of the colonisation of Aotearoa is fundamental to Māori wellbeing. The colonisation of Aotearoa has many

similarities to Australia and North America (Wirihana & Smith, 2014). The significant events of the colonisation of Aotearoa include the land wars, death by infectious diseases, land confiscation and dispossession, and cultural oppression and assimilation—ethnocide (Durie, 2001).

Colonisation affected every aspect of Māori society and is the unique factor in contemporary Indigenous health, especially when comparing Indigenous health to the non-Indigenous settler nation (Lowe, 2007). Alike the American Indian colonisation experience, the exposure to infectious diseases had a devastating impact on the non-immune Māori population. The population was declining at such an alarming rate that the extinction of Māori seemed inevitable and was predicted by the British colonists (Durie, 2001). During colonisation, mātauranga Māori was invalidated by western knowledge and belief systems. Fundamental concepts to Māori societal function such as tapu (restricted) and noa (unrestricted) that had previously protected Māori wellbeing were being substituted for western concepts of health (Gillies, 2011). Unsurprisingly, although the mortality rate declined, Māori health continued to suffer. It soon became evident that Māori wellbeing required more, or something different, than what western medicine had to offer. Māori leaders advocated for Tino Rangatiratanga (including Māori health aspirations) and mātauranga Māori to be integrated into health care practice to ensure that the services were meaningful and effective for the Māori people. Interestingly, Māori are still challenging mainstream health services to integrate these concepts in contemporary health services (Durie, 2010; Gillies, 2011; Waitangi Tribunal, 2019).

Māori assimilation to a patriarchal Christian societal structure was a goal of colonial forces, which had a detrimental impact on the roles and relationships of men and women (Wirihana & Smith, 2014). Social structures and relationships were disrupted by colonisation, including the breakdown of fundamental relationships such as that between men and women and the position of children within Māori society. Traditionally, Māori men and women held important roles that sustained the functioning of Māori society and were interdependent on the harmony between the spiritual and physical realms (Barlow, 1991, cited by Wirihana & Smith, 2014). The roles were based on Māori philosophies, values, and belief systems. For example, women carried the whare tangata (womb) so were protectors of whakapapa of the iwi. Moreover, tamariki Māori (Māori children) are taonga (treasure) in Māori society. Every member of Māori society held an important role in fostering the growth, safety, and nourishment of tamariki (Wirihana & Smith, 2014).

In a contemporary context, Māori are over-represented in virtually every social and health problem such as low education attainment, incarceration, children in state care, and disease morbidity and mortality (Ministry of Health, 2015). Within the health sector, Māori often present to health care services later, have shorter hospital stays, experience inequities in referrals for medical interventions and rehabilitation, and report negative experiences in their interactions

with staff and the medical services in general (Anderson et al., 2017; Wepa, 2016; Wilson & Barton, 2012).

In summary, colonisation and colonialism are powerful processes which had a profound impact on Māori wellbeing, and which sustain the inequities that perpetuate the distress associated with colonialism. Therefore, the socio-political processes that produce the right environment for diseases to proliferate within the Māori population are ongoing (Came, 2013; Durie; 2001). Moreover, Māori health disparities persist despite being a long-term priority of the government (Ministry of Health, 2015).

Historical Trauma Theory

Historical Trauma Theory is a framework for conceptualising the collective response of Indigenous communities' experiences of colonisation over multiple generations. Historical Trauma Theory, developed by Maria Yellow Horse Braveheart (2000), was informed by literature that examined the trauma experiences of Jewish Holocaust survivors. Braveheart conceptualised parallels between the Jewish holocaust and the American Indian genocide. Based on her research, and many years of working in the role of social worker with the Lakota people, Braveheart (2000, 2003) developed Historical Trauma Theory to:

1. Validate the devastation of historical events of colonisation for Indigenous people;
2. Identify a historical trauma response that is experienced by the collective;
3. Situate concepts of the theory within an Indigenous reality; and
4. Conceptualise the various modes of historical trauma transmission.

Since its development 20 years ago, Historical Trauma Theory has become a popular framework for understanding contemporary Indigenous social and health disparities, particularly within the behavioural sciences; including the development of interventions for addressing unresolved grief in Indigenous communities (Braveheart, 2003; Gone, 2013).

Historical Trauma Theory literature has a broad array of foci that includes its application to issues within Indigenous communities, contentions with conceptual issues, and practice-based interventions from the behavioural sciences (Braveheart, 2000; Charbonneau-Dahlen et al., 2016; Gone, 2013; Lawson-Te Aho, 2014). The conceptual literature on Historical Trauma Theory provides a foundation for interpreting contemporary social and health distress, including the meaningfulness of historical trauma from an Indigenous perspective (Gone, 2013; Hartmann & Gone, 2016). Clinical interventions from the behavioural sciences provide a comprehensive exploration of the relevance of merging cultural concepts and practices with western theories from different health disciplines (Gone, 2013; Lawson-Te Aho, 2014). However, the interventions, mainly from the psychology discipline, are beyond the scope of this literature review and outside

the scope of nursing. That said, general concepts of merging Indigenous concepts with western based health disciplines are of relevance.

Nursing in Aotearoa

Nurses in Aotearoa make up a large proportion of front-line health workers, working in primary, secondary, and tertiary level health care; and are more than likely to work with Māori whānau throughout their career (Nursing Council, 2015; MOH, 2016). Unique to nursing philosophy in Aotearoa New Zealand, Kawa Whakaruruhau (cultural safety in a Māori context) is the philosophy guiding the standards for nursing practice with Māori. Fundamentally, Kawa Whakaruruhau was developed by Māori nurse Dr Irihapeti Ramsden (1991) to incorporate cultural safety within the constructs of Māori health, including Te Titiri o Waitangi (Māori language version) and The Treaty of Waitangi (English language version). The treaty between Māori and the British Crown, signed on the 6th February 1840, outlined the terms for British settlement in Aotearoa and set the historical context of Māori health—namely, colonisation (Nursing Council, 2011). To date, the implementation of Kawa Whakaruruhau into nursing practice has not been formally evaluated by the consumers of health care services. Unfortunately, there is evidence that nursing care is, at times, culturally unsafe for Māori (Anderson et al., 2017; Wepa, 2016; Wilson & Barton, 2012). Essentially, nurses have an ethical and legislative obligation to provide safe, non-discriminative, equitable health care to Māori which incorporates an understanding of the impact of colonisation on Māori health (Nursing Council, 2011).

Nurses, the largest body of front-line health care workers, are in a prime position to provide effective care for Māori and contribute to the rectification of Māori health inequities. The colonisation of Aotearoa has affected Māori health in a unique way and is a powerful determinant of Māori health and wellbeing (Durie, 2001). Colonisation is the defining difference between Māori and non-Māori health outcomes, so it is a fundamental aspect of conceptualising contemporary Māori health (Pihama et al., 2014). Therefore, nurses need to understand historical and cultural contexts of Māori health that are unique to Māori and fundamental to understanding Māori health and providing effective health care. Historical Trauma Theory provides a framework for understanding how colonisation has led to Indigenous health disparities, such as substance abuse, cardiovascular and endocrine dysfunction, and mental illness (Sotero, 2006). Historical Trauma Theory also supports the need for nurses to provide culturally appropriate health care for Māori if Māori health outcomes are to improve. Furthermore, the focus on trauma-informed care in Aotearoa mental health services requires health care workers centralise trauma histories in the clinical presentation of the patient so that effective trauma care can be provided (Pihama et al., 2017).

To summarise, this literature review aims to explore the foundations of Historical Trauma Theory, primarily its concepts and contentions, and the application of Historical Trauma Theory within clinical practice. Furthermore, in examining Historical Trauma Theory, the implications for nursing philosophy and practice in Aotearoa New Zealand have been examined, particularly focussing on how Historical Trauma Theory can complement and/or inform practice for all nurses when nursing Māori whānau. To demonstrate the potential implications for nursing in Aotearoa, Māori models of nursing practice and Kawa Whakaruruhau have been drawn upon to understand the key Māori values which should guide nursing practice when nurses care for Māori whānau. Pihama et al.'s (2014) article has been used as a framework for understanding the usefulness and limitations of Historical Trauma Theory as a framework underpinning praxis in Aotearoa to date. Nevertheless, Historical Trauma Theory has been used to provide a cultural and historical framework for deepening all Aotearoa/New Zealand nurses' understanding of the effects of colonisation on Māori wellbeing, including the multiple health avenues in which the historical trauma response is evident.

The conceptualisation of Historical Trauma Theory within Aotearoa is needed to ensure that it is applied appropriately to the Māori experience of colonisation and to avoid the premature application of the theory when guiding policy and practice (Pihama et al., 2014). Therefore, the application of Historical Trauma Theory to nursing philosophy and practice in Aotearoa New Zealand supports fundamental aspects of Kaupapa Māori theory, including Māori models of nursing (Pihama et al., 2014). Key concepts of Historical Trauma Theory can be interlinked with key concepts of Kaupapa Māori Theory such as whānaungatanga, whakapapa, and core Māori values and beliefs which can provide a pathway for understanding the complexity of colonisation and Māori health for nurses in Aotearoa. However, kaupapa Māori research is required to explore Historical Trauma Theory within a Māori context (Lawson-Te Aho, 2014, 2017).

Chapter 2: Background

Indigenous people are some of the most marginalised and socially excluded communities in the world (The United Nations, 2009). Social marginalisation and exclusion result in struggles for Indigenous self-determination and development in all social arenas, including health; whereas socio-political exclusion and inequity are manifested in disproportionate morbidity and mortality, and socio-economic and political struggles for Indigenous communities (Came, 2013; The United Nations, 2009). The colonisation of Indigenous people's land is considered a major determinant of health and is the prime difference when comparing Indigenous and non-Indigenous health contexts (Lowe, 2007; Sotero, 2006). This background chapter will start with a brief description of colonisation, followed by a background of Historical Trauma Theory, followed by a brief description of the colonisation of Aotearoa and the contemporary struggles of Māori. Finally, this chapter will describe nursing practice in Aotearoa and the obligations of the nursing profession to Māori health and wellbeing.

Colonisation and Decolonisation

Colonisation is not a series of events with a finite timeline (Hartmann & Gone, 2014). Instead, the ongoing effects of colonisation, such as racial discrimination, profound poverty, and health inequities, are perpetuated by intrapersonal, interpersonal, and institutional constructs (Jones, 2000; Smith, 2012). The power imbalances established by colonisation between non-Indigenous and Indigenous communities sustain socio-political inequities endured by Indigenous populations, including health inequities (Came, 2013).

Decolonisation is a powerful process that validates Indigenous peoples' struggles and removes the barriers to Indigenous self-determination within various domains, such as research methodologies (Smith, 2012). Decolonisation challenges the power imbalances that perpetuate the psycho-social, socio-economic, and political inequities experienced by Indigenous people (Smith, 2012). Decolonisation is key to freeing Indigenous communities to re-establish Indigenous identities within colonial societies (Smith, 2012).

Historical Trauma Theory

Colonisation is recognised as a powerful determinant of health for Indigenous people. The atrocities of the colonisation of North America have been so devastating for the American Indian population that the United Nations definition of genocide has been met (Braveheart, 2000; Charbonneau-Dahlen, Lowe & Morris, 2016). Like the colonial history of Aotearoa, the

colonisation of the existing people and land of North America was completed using warfare, violence, deception, introduction (intentional and unintentional) of infectious disease, and broken treaties. The colonisation process was validated by the dehumanisation and depiction of Indigenous peoples as a savage population who needed to be civilised by the colonisers (Charboneau-Dahlen et al., 2016; Smith, 2012). Consequently, the American Indian population have higher disease morbidity and mortality, violence, incarceration, lower socio-economic status, substance abuse, accidental deaths, and childhood exposure to trauma than their non-Indigenous counterparts (Braveheart, 2000; Brown-Rice, 2013). Contemporary social and health profiles of the American Indian population appear to be alike that of other Indigenous populations internationally, including the Māori of Aotearoa New Zealand.

Historical Trauma Theory was developed by Maria Yellow Horse Braveheart, an American Indian scholar, to validate the enormity of the devastation caused by the processes of colonisation endured by the American Indian population. During Braveheart's career as a clinician, based in her native Lakota community, she observed widespread patterns of distress and dysfunction amongst her people that she hypothesised to be a direct result of colonisation and/or an accumulation of traumatic historical events (Braveheart, 2000). Moreover, as Braveheart (2003) wrote from within the context of the Lakota American Indian people, she acknowledged that Lakota history is unique to her people and that the associated historical trauma response is constructed within a socio-cultural context. Fundamentally, Historical Trauma Theory is a conceptual framework that links colonisation to contemporary distress in Indigenous communities through various modes of intergenerational transmission of the historical trauma (Braveheart, 2000). Historical Trauma Theory encapsulates the manifestation of historical trauma over multi-generations in various psycho-social domains of Indigenous societies (Braveheart, 2000, 2003).

Since its emergence 20 years ago, Historical Trauma Theory has become a widely accepted theoretical framework underpinning the constructs of Indigenous emotional, social, and psychological distress amongst various health science disciplines (Gone, 2013; Hartmann & Gone, 2014). In its early development, Historical Trauma Theory and the historical trauma response was supported by and constructed on theory and empirical evidence on Post Traumatic Stress Disorder (PTSD), trauma work, and the Jewish Holocaust (Braveheart, 2003; Reid et al., 2014).

Although bearing some similarities in clinical presentation, the diagnosis of PTSD and other trauma theory was insufficient in describing the manifestation of trauma within the American Indian population (Braveheart, 2000). Within the context of colonisation, PTSD is limited in that it focuses on the individual expression of trauma; whereas Historical Trauma Theory examines and captures the intergenerational expression of trauma within the collective (Reid et al., 2014). Moreover, a PTSD diagnosis has the potential to pathologise historical trauma

as an Indigenous problem; attributing the trauma responses to the individual as opposed to examining the socio-economic, political, and environmental conditions that sustain inequity (Reid et al., 2014). Therefore, historical trauma has clinical features similar to PTSD but which are built upon three unique features; collective-felt trauma, intergenerational transmission of trauma, and unresolved grief and loss (Braveheart, 2000). Although, each “illustration of Historical Trauma” (Braveheart, 2000. p. 8) is unique to the affected population, there is a collection of features that can be generalised across Indigenous people internationally (Braveheart, 2003).

Definition of Historical Trauma

The recurring definition of historical trauma within the literature is “cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences” (Braveheart, 2003, p. 7). Trauma can be experienced directly or can be secondary trauma (experienced vicariously) (Wirihana & Smith, 2014). Braveheart (2003) defined the historical trauma response as the “the constellation of features in reaction to this trauma” (p. 7) manifested in psychological and social symptoms and behaviours. The three general domains in which the historical trauma response is evident within communities are biological, psychological, and sociological (Sotero, 2006).

The literature highlights a consensus about what constitutes historical trauma. Mohatt et al. (2014) specified historical trauma has three defining features:

1. There has been an event or events which are experienced as traumatic;
2. The trauma is experienced by numerous people from a specific population group; and
3. The trauma is experienced over multi generations.

Five assumptions that underpin Historical Trauma Theory are:

1. The trauma is inflicted intentionally by the dominant group;
2. The trauma was inflicted for individual and collective gain;
3. Traumatic processes are sustained over a long period of time and often condoned on a socio-political level;
4. The trauma is experienced as a collective over multi-generations and is exhibited as a collective response; and
5. The trauma has significantly impacted the projected “life course” of the affected population which is manifested in various domains in society (Braveheart, 2003; Sotero, 2006).

As identified by Braveheart (2000, 2003; 2015), the features of the historical trauma response include:

- Survivor guilt

- Depression
- Sometimes PTSD symptoms
- Psychic numbing
- Fixation to trauma
- Somatic (physical) symptoms
- Low self-esteem
- Victim identity
- Anger
- Self-destructive behaviour including substance abuse
- Suicidal ideation
- Hypervigilance
- Intense fear
- Dissociation
- Compensatory fantasies
- Poor affect (emotion) tolerance

The historical trauma response is manifested within a collective of people over multi-generations. There are three categories for understanding the impact of the effects of historical trauma; the immediate impact (within 6 months following the event), the long-lasting impact, and the severity of the impact of the trauma (Palacios & Portillo, 2009). Braveheart (2003) demonstrated that historical trauma narratives exist within Indigenous communities, and connect historical losses with contemporary suffering. Braveheart's article showed that the unique historical experiences of the Lakota people were evident in contemporary manifestations of the historical trauma, such as the wearing of short hair as a sign of grief for a chief who was killed 100 years prior.

Historical Trauma Theory and an Indigenous Worldview

Historical Trauma Theory is embedded in an Indigenous worldview. Indigenous realities are centred on the connection between past and present and the spiritual realm, all of which exist simultaneously (Braveheart, 2000; Salmond, 2017). There is an innate connection between American Indian people, and other Indigenous people, with their ancestors; thus, a connection to the distress of their ancestors is a natural part of an Indigenous reality (Braveheart, 2000). Moreover, the contemporary expression of historical trauma within Indigenous populations makes sense given the interconnection of the past and the present (Braveheart, 2000). The concept of past-present connection has been captured in research with Indigenous people (Braveheart, 2000; Swanson Nicolai & Saus, 2013). The deep connection to ancestors is manifested in the Lakota historical trauma response as the *Waikuksuyapi* (The memorial people). The key features were developed by Braveheart (2000) based on the research participants' responses:

1. Living between the present and the past, and life becomes situated around ancestral distress;
2. “Identification with the dead” (p. 247) – feeling the suffering of ancestors, feeling numb;
3. An overwhelming loyalty to the distress of ancestors, guilt in enjoying life; and
4. “Survivor guilt” (p. 247) – fixation on injustices, reparatory fantasies.

Unresolved Grief

Unresolved grief is a unique feature of historical trauma and is manifested in Indigenous populations in various ways. For example, substance abuse is an attempt to numb pain and feelings of loss and hopelessness (Braveheart, 2003). The concept of unresolved grief is based on the overwhelming speed and force of the traumas of colonisation (e.g., mass mortality due to warfare and infectious diseases); hence, Indigenous people were unable to process the grief associated with the losses that were being experienced (Braveheart, 2003;). The losses included life, family, culture, spirituality, land, language, dignity, autonomy, and self-determination (Braveheart, 2000). It is important to note that although there are general commonalities of the losses experienced by Indigenous populations resulting from colonisation, there will be losses that are not listed here that will be unique to specific Indigenous communities.

During colonisation, ethnocide was enforced by politically forced assimilation and acculturation, resulting in many Indigenous people being unable to process their grief using their traditional cultural practices of mourning (Braveheart, 2003; Zambas & Wright, 2016). More specifically, spirituality and healing practices were often outlawed, lost, or forcibly removed from Indigenous societies leaving populations in a state of overwhelming grief (Braveheart, 2000). Furthermore, Braveheart (2000) concluded that the stages of grief could be specific to the Lakota and vary from euro-centric Grief Theory. For example, Braveheart argued that the mourning practices of the Lakota demonstrate their own distinct attachment or bond between relatives

Terminology

There are a variety of terms used across the Historical Trauma Theory literature to describe the manifestation of historical trauma within Indigenous communities, such as suffering, soul wound, the historical trauma response, and distress (Braveheart, 2003; Gone, 2013). Decolonisation literature caution against using terms that victimise and perpetuate long-dwelling stereotypes of Indigenous people. In this dissertation, I acknowledge that distress and suffering experienced by Indigenous peoples is culturally and socially constructed and is unique to the specific population.

As an example, Mohatt et al. (2014) highlighted the concept of 'soul wound' as a culturally specific phenomenon experienced as a response to historical trauma.

Aligning with Indigenous methodologies, specifically Kaupapa Māori Theory, this dissertation applies the concept of health as a holistic balance of the multi-dimensions of human wellbeing. Therefore, health is a culturally constructed concept (McGibbons et al., 2014; Salmond, 2017). Within the discussion chapter, a Māori model of health, Te Whare Tapa Whā, is implemented as the definition of health. The model is a generalised framework of Māori wellbeing based on the ontological constructs of te ao Māori. However, it is probable that there could be iwi, hapū, and whānau variations in the understanding and interpretation of health and wellbeing (Durie, 2001).

The term *Indigenous* refers to the pre-existing populations, which preceded the dominant population and establishment of colonial societies that became the dominant society/culture of the country (Smith, 2012). As identified by the United Nations (2009),

Indigenous peoples are inheritors and practitioners of unique cultures and ways of relating to people and the environment. They have retained social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live. Despite their cultural differences, Indigenous peoples from around the world share common problems related to the protection of their rights as distinct peoples.

Historical Trauma Theory and Aotearoa

Historical Trauma Theory literature is limited within the Aotearoa context. However, when conceptualised in an Aotearoa context, Historical Trauma Theory is applicable to Māori experiences of colonisation and supports core concepts of Kaupapa Māori Theory (Pihama et al., 2014; Wirihana & Smith, 2014). Historical Trauma Theory concepts resonate with the colonisation of Aotearoa such as grief for loss of life, land, language and culture, and ongoing systemic oppression which sustains historical loss for the Māori people (Durie, 2001; Pihama et al., 2014; Smith, 2012). Pihama et al. (2014) argued that western psychiatry and psychology are unable to fully articulate the experience of colonisation for Indigenous people, but Historical Trauma Theory could. Moreover, Pihama et al. argued that Historical Trauma Theory aligns well with Kaupapa Māori Theory as both theories focus on the collective experience of colonisation and analyse historical trauma transmission over multiple generations.

Māori Concepts of Health

Indigenous concepts of health and wellbeing were marginalised and colonised by the settler population (McGibbon et al., 2014). Despite colonisation, Indigenous concepts of health still exist

based on Indigenous worldviews. Māori wellbeing is based on a balance of the dimensions of health—Te Taha Tinana (the physical), Te Taha Wairua (the spiritual), Te Taha Hinengaro (the psychological), Te Taha Whānau (family/extended kinship networks)—as outlined in Te Whare Tapa Whā, developed by Durie (1982, cited in Te Ara The Encyclopaedia of New Zealand, 2011). Te Whare Tapa Whā is embedded within te ao Māori, in which all non-living, living and spiritual entities exist interdependently (Salmond, 2017). Within Te Whare Tapa Whā, Māori wellbeing is represented as a wharenui (traditional meeting house), whose structural strength is dependent on all the foundations being robust (Maloney-Moni, 2006). Furthermore, Māori health is built upon the socio-political foundations as outlined by Durie (2001):

- Te ao hurihuri – socio-economic factors, such as economic security, household income, educational attainment
- Te ao hou – lifestyles of the individual and whānau, such as recreational activities, alcohol and drug use, diet and exercise
- Hikoi tangata – collective experiences, such as colonisation
- Te ao Māori – access to all things Māori, participation in society as Māori, such as access to whānau and turangawaewae
- Mana ake – individuality, such as genetics

Health Care Practice and Indigenous People

Health care practice theory underpins clinical research, evidence-based practice, assessment, and policies. Health care practice requires empirical evidence to develop policies, implement population-specific care, and support the use of clinical interventions (Gone, 2013). However, there is great difficulty in measuring human experience, especially given the diversity of emotions, cognition, behaviour, and spirituality within humanity (Durie, 2001; Gone, 2013). Various health disciplines' theory underpinning practice, including psychologists, counsellors, nursing, and the medical profession, have been criticised for its mono-cultural foundation and the lack of evidence-based practice for people of culturally diverse groups, including for Indigenous people (Gone, 2013).

Globally, Indigenous people have difficulty in accessing quality health care (The United Nations, 2009). Health care access is complex and comprised of interpersonal, institutional, and systemic constructs such as poverty and transportation issues, and racism and culturally inappropriate care (Zambas & Wright, 2016). The complexity of Indigenous health must be contextualised within history and examine the ongoing processes which perpetuate inequity if there is to be any improvement to the effectiveness of health care practice for Indigenous people (Palacios & Portillo, 2009).

Nursing within a Māori Context – Kawa Whakaruruhau

Registered nurses are the largest professional body of frontline health workers in Aotearoa; therefore, nursing care of Māori is of relevance. To date, the impact of culture on health is documented and nurses are educated on the importance of cultural competence for patient health outcomes. Cultural competency and cultural safety are required to achieve competency to practice as a Registered Nurse in Aotearoa (Nursing Council, 2012). Nursing competence is legislated in the Health Practitioners Competence Assurance Act (HPCAA) 2003 that guarantees the public a competent regulated healthcare workforce in Aotearoa. Moreover, the 2019 amendment to the HPCAA includes, in section 118, the “clinical and cultural competency (and respectful and effective interaction with Māori”. The Nursing Council regulates nursing practice within Aotearoa, ensuring the practice safety of nurses for the public of Aotearoa. As outlined in the Nursing Council (2011) *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice*, the Nursing Council ensures nurses practice cultural competency and culturally safety within the context of Māori health. The Nursing Council (2011) requires “the nurse to practise nursing in a manner that the health consumer determines as being culturally safe, and to demonstrate ability to apply the principles of the Treaty of Waitangi/Te Titiri O Waitangi to nursing practice” (p. 8). Furthermore, the Nursing Council’s (2012) *Code of Conduct* “treat health consumers as individuals and in a way they deem to be culturally safe” (p. 9). Cultural safety requires nurses engage in ongoing self-reflection of one’s own culture to gain understanding of how culture impacts nursing practice, as well as the wider culture of health care in Aotearoa (Nursing Council, 2011).

Within a Māori context, Kawa Whakaruruhau is the philosophy underpinning culturally safe nursing practice. Cultural safety was developed by Māori nurse Irihapeti Ramsden in 1991 and implemented into the Aotearoa New Zealand nursing curriculum in 1990. Following nursing backlash over the relevance of cultural safety to nursing care, there have been various revisions and amendments, with the last amendment of Kawa Whakaruruhau being in 2011 (Nursing Council, 2011, 2013; Ramsden & Spoonley, 1994). Kawa Whakaruruhau was developed by Ramsden (1991) as a branch of cultural safety to incorporate the unique features of Māori health including Māori as tangata whenua—holding a unique place in Aotearoa, Te Titiri o Waitangi, and the impact of colonisation on contemporary Māori health (Nursing Council, 2012). Kawa Whakaruruhau philosophy ensures the nurse’s care would demonstrate an understanding, competency, and safety towards te Titiri o Waitangi and the colonisation of Aotearoa (Ramsden & Spoonley, 1994). The Nursing Council’s (2012) commitment to Kawa Whakaruruhau ensures that nurses are protective of tino rangatiratanga, determining that whānau health aspirations are kept central to the nursing process. Furthermore, Kawa Whakaruruhau in practice includes striving for social justice by uncovering and challenging power imbalances and advocating for

health equity for Māori (Barton, 2018). To date, implementation of Te Titiri o Waitangi into nursing practice is audited by a self-assessment completed by the nurse and verified through a peer review process, not by the recipients of health care services. Moreover, despite being developed nearly 30 years ago, there has been no research evaluating cultural safety, including Kawa Whakaruruhau, in nursing practice in Aotearoa.

To summarise, colonisation has had profound effects on Indigenous people internationally, including health outcomes (The United Nations, 2009). The decolonisation process uncovers the socio-political processes embedded in society that directly cause the power imbalance evident between Indigenous and non-Indigenous population, which is manifested in various social domains, including health outcomes. Moreover, decolonisation is fundamental to the assertion of Indigenous identities, aspirations, and self-determination within the settler society. Historical Trauma Theory was developed to validate the magnitude of devastation experienced by Indigenous people in response to the processes of colonisation (Braveheart, 2000, 2003). Furthermore, Historical Trauma Theory is centred within Indigenous realities to conceptualise the intergenerational and collective nature of the trauma associated with colonisation, which is unique and different to western concepts of trauma. Historical Trauma Theory provides a pathway for understanding physical, social, and psychological/emotional manifestations of historical trauma experienced by subsequent generations of Indigenous people (Pihama et al., 2014; Sotero, 2006).

The colonisation of health and health care practice has had an impact on the quality and effectiveness of health care services received by Indigenous people, including Māori (McGibbon et al., 2014; Theunissen, 2011). Indigenous realities, including concepts of wellbeing, still exist and are independent of western concepts of health, which is the foundation of western health care practice. Moreover, institutional processes established during colonisation, such as political disempowerment and racism, have produced major health inequities for Indigenous people, including Māori (Came, 2013). Nursing philosophy is underpinned by social justice and health equity, so the impact of colonisation on Indigenous health is essential to providing meaningful and effective nursing care to Indigenous people (Nursing Council, 2011; Theunissen, 2011). Historical Trauma Theory has the potential to provide a framework for conceptualising the impact of colonisation on contemporary Māori health, as well as the possibility of guiding effective nursing practice for Māori based on the concept of historical trauma as the core of health disparities.

Chapter 3: Methodology

The overarching argument underpinning research within Indigenous people is that the research needs to be beneficial and contribute to the aspirations of the Indigenous community of interest (Braun et al., 2013; Chambers et al., 2018; Smith 2012). This argument is based on Western research devaluing, decimating, and silencing Indigenous ways of living (Smith, 2012). This integrative literature review embeds te ao Māori as the worldview underpinning the ontological and epistemological constructs for interpreting the Historical Trauma Theory literature. To critically examine the Historical Trauma Theory literature from an Indigenous standpoint, this review uses a decolonising research methodology. Whittemore and Knalf's (2005) guidelines for conducting an integrative literature review for nursing practice has been implemented as the framework for the research methods used. This chapter starts with descriptions of Kaupapa Māori Theory and decolonising research methodologies, including how both frameworks informed the research process. Next, the methods section describes how the review was completed, including managing rigour issues such as researcher bias. Whittemore and Knalf claimed that if the integrative literature review is completed using sound methodological rigour, it can provide a comprehensive review of the relevant literature which can be used to guide nursing practice and policy.

Kaupapa Māori Theory

Kaupapa Māori Theory is a "body of knowledge, accumulated by the experiences through history, of the Māori people" (Nepe, 1991, p. 4, as cited by Pihama, 2010). Kaupapa Māori Theory is a philosophical view that embeds te ao Māori as the 'normative' reality and challenges the power constructs that continue to oppress te ao Māori (Eketone, 2008). Kaupapa Māori Theory is not new and is based upon mātauranga Māori (Māori knowledge systems) and tino rangatiratanga (Māori self-determination). As asserted by Pihama (2010) "Kaupapa Māori theory is presented as an Indigenous theoretical framework that challenges the oppressive social order within which Māori people are currently located and does so from a distinctive Māori cultural base" (p. 6). Kaupapa Māori Theory is transmitted through te reo and tikanga Māori. The assumptions underpinning Kaupapa Māori research are:

1. Te Ao Māori is a valid knowledge system that co-exists with western epistemologies; and
2. Tino rangatiratanga and Mana Motuhake are fundamental to Māori advancement, including health outcomes.

The foundation of Kaupapa Māori Theory, mātauranga Māori provides the conceptual framework to understand Māori realities (Salmond, 2017). Concepts, such as time, space, male-female and parent-child relationships, the creation story, farming and cultivation, and navigation, have always existed for Māori and are independent of a western worldview (Durie, 2001; Smith, 2012). The foundation of mātauranga Māori, the layers of whakapapa (genealogy), date back to the creation of the world and essentially organise te ao Māori (Pihama, 2010). Mātauranga Māori is a complex system reflecting Māori ontology and epistemology. Wiri (2011 as cited by Pihama, 2010) defined the many levels of mātauranga Māori as follows:

Māori epistemology; the Māori way; the Māori worldview; the Māori style of thought; Māori ideology; Māori knowledge base; Māori perspective; to understand or to be acquainted with the Māori world; to be knowledgeable in things Māori; to be a graduate of the Māori schools of learning; Māori tradition and history; Māori experience of history; Māori enlightenment; Māori scholarship; Māori intellectual tradition. (p. 25)

Māori have always been theorists, so Māori knowledge systems can generate new knowledge that is of benefit and purpose to Māori (Pihama, 2010). The underlying principles of Kaupapa Māori Theory include:

- Tino rangatiratanga and mana motuhake to assert Māori identity as tangata whenua in Aotearoa and make space for Māori ontology and epistemology;
- Te reo me ōna tikanga Māori, which is the fundamental mode of transmission of mātauranga Māori; and
- Kaupapa Māori Theory as a framework “to think and act” Māori within the dominant colonial society is a form of resistance to colonialism (Pihama, 2010, p. 6).

Decolonising Research Methodologies

Essentially, decolonising research methodologies involves the critical examination of the impact of the socio-political constructs of colonisation on Indigenous people. The researcher examines how western research methodologies influence research with Indigenous people, including the impact that research has had on Indigenous peoples’ knowledge systems. Moreover, decolonisation challenges the space that western knowledge occupies and makes space for Indigenous epistemologies as legitimate knowledge systems. By challenging the dominance of western research methodologies and privileging Indigenous epistemologies, decolonising research methodologies ensures that Indigenous aspirations and interests are the focus and foundation of research (Lee, 2009; Smith, 2012). Therefore, decolonising research methodologies align well with Kaupapa Māori Theory and are appropriate for examining Historical Trauma

Theory. The key concepts that have informed this literature review are: *colonialism, the misrepresentation of Indigenous peoples by western research, uncovering dominant methodologies, and re-writing Indigenous histories*. These concepts were used to reduce researcher bias by challenging western dominance in Indigenous research. Further detail of how these concepts informed the research and were used to reduce researcher bias is described in the rigour section.

Colonialism

Although the literature identifies colonialism as a concept that is difficult to define, Walker et al. (2013) defined colonialism as “.... generally characterised by the need to dominate and to profit from that domination” (p. 155). Processes of colonialism include social exclusion, marginalisation, political disempowerment, and multiple levels of racism (Zambas & Wright, 2016).

The researcher needs to engage with colonialism to understand the complexity of the constructs that support the continuation of colonialism in contemporary society (Smith, 2012). In this dissertation, I have applied an appropriate methodology to align with decolonisation and to interpret the research findings within the context of nursing. For example, decolonising research methodologies uses a critical stance to examine the constructs of race and racism in praxis (Werunga et al., 2016). In moving away from biomedical models of health, Indigenous health needs to be examined within the wider socio-cultural and political climate, including racism and colonisation—two powerful determinants of health (Came, 2013; Jones, 2000).

Misrepresentation of Indigenous Peoples by Western Research

By applying a decolonising research methodology, the researcher acknowledges the legacy of mistrust felt by Indigenous communities regarding research with Indigenous people (Smith, 2012). Research with western methodologies has constructed a grossly inaccurate and biased portrayal of Indigenous people, often based on minimal experience and interaction with Indigenous people (Smith, 2012; Walker et al., 2013).

The negative portrayal of Indigenous people by the colonial state justified political disempowerment, social exclusion, and legislative processes used to displace Indigenous people from their land, culture, settler society (Lawson-Te Aho, 2014; Smith, 2012). The term ‘native’ (also termed aboriginal, tribal, ethnics) was developed to position the Indigenous population within the context of the colonial society (Smith, 2008). Western research and science largely contributed to the development of the ideology of the ‘native’ as living backward, uncivilised, and savage existences. The *other* are then measured against the ‘norm’ dominant population whose cultural value systems and knowledge are the taken-for-granted systems of the colonial society. Moreover, Indigenous realities are on display, open to scrutiny and misinterpretation by society,

while the dominant culture is not required to demonstrate any transparency of their values systems (Elkington, 2014).

Indigenous people were grouped into one category in which cultural assumptions and generalisations about 'Indigenous' are applied by the dominant population (Chambers et al., 2018). Moreover, the examination of Indigenous populations through a western lens developed many binary views of the Indigenous population in relation to their position in the settler society. Binary views of the settler-native dynamics are still evident in western discourse; for example, the west has knowledge and Indigenous populations have culture. Binaries created by western ontology maintain the limited 'space' for Indigenous methodologies within institutions (Pihama et al., 2002).

By applying a decolonising methodology to this literature review, the dominant discourse on Indigenous peoples is uncovered and removed from the interpretations of the findings (e.g., by the removal of racially discriminative terminology within Indigenous health literature). It is argued that terms such as 'vulnerable', 'high-risk', and 'hard-to-reach' reinforce negative stereotypes of Indigenous people, who are often blamed for their health disparities through lifestyle choices instead of examining the inequity of access to the social determinants of health (Barton, 2018; Chambers et al., 2018). Furthermore, Lowe (2007) cautioned against descriptions of Indigenous societies as societies of 'loss', loss of language, loss of land, loss of culture, as he argued that survival and resistance of Indigenous peoples is often overlooked.

Moreover, this dissertation acknowledges the vast uniqueness of Indigenous populations internationally (Smith, 2012); although, I targeted literature pertaining to the experiences of the Indigenous peoples of North America, Australia, and New Zealand due to the commonalities in their colonial histories (Wirihihana & Smith, 2012). The implications of Historical Trauma Theory for nursing practice in Aotearoa is based on te ao Māori, and incorporates the uniqueness of each iwi, hapū, and whānau system (Durie, 2001). The notion of one cultural group is contradictory to pre-colonisation Indigenous societies (Smith, 2012). For example, Māori did not exist as a single population but instead were defined by whānau, hapū, and iwi identities.

Uncovering Dominant Methodologies

The dominance of western philosophy has created the assumption that there are universal processes of human emotion, psychology, and development. Indigenous ontology and epistemology were viewed by the settler state as invalid and sometimes made illegal. For example, in Aotearoa, Māori tohunga, labelled as 'witch doctors', were holders of expert mātauranga (knowledge) but the Tohunga Suppression Act passed in 1907 outlawed practice of Māori medicine (Smith, 2012; Te Ara The Encyclopaedia of New Zealand, 2011). The colonisation

of Indigenous ontology and epistemology, and subsequent decimation of Indigenous 'ways of knowing' by the colonial state, is to dehumanise Indigenous people (Smith, 2012).

The generation of 'knowledge' through western research methodologies created the normalisation of Western ideology and the decimation of Indigenous epistemology (Mlcek, 2017; Smith, 2012). The normalisation of western research methodologies created a benchmark for measuring Indigenous methodologies against; that is, Indigenous methodologies exist within the western paradigm instead of co-existing as a legitimate knowledge system (Walker et al., 2013).

Smith (2012) argued that decolonising research methodologies is based on the principle that western and Indigenous epistemologies can co-exist to support Indigenous development in contemporary society. Therefore, when decolonising research methodologies, Indigenous ways of knowing are 'privileged' to draw on the expertise of Indigenous people as the appropriate authority in their own lives while western epistemology is not rejected (Mlcek, 2017). This dissertation privileges Indigenous methodologies for examining Historical Trauma Theory and then for interpreting and applying it to nursing within a Māori context.

Re-Writing Histories

Central to the colonisation of Indigenous knowing is the colonisation of Indigenous histories, which is a very important concept when examining Historical Trauma Theory. Colonisation included the re-writing of Indigenous history, implementing a universal history, and further dehumanisation of the Indigenous people in that the West had history and Indigenous societies have myths and legends. In the process, the accessibility to Indigenous history has been restricted by the dominant population through the loss of Indigenous languages, practices, and the introduction of Western education systems (Smith, 2012; Werunga et al., 2016).

Decolonising and Indigenous methodologies seek out meaningful findings that can be useful for the intended community. Although there is a generalised Indigenous worldview, Indigenous societies are unique with their own histories (Smith, 2012; Werunga et al., 2016). In applying a decolonising methodology to this literature review, the power of history and the colonisation of Indigenous histories are incorporated into the interpretations of the research findings (Werunga et al., 2016). This literature review privileges Indigenous ontology and epistemology, both of which are embedded within Indigenous histories. The concept of colonisation of Indigenous knowing and histories, and the importance of decolonisation of both, is central to Historical Trauma Theory. Firstly, Indigenous colonial histories have been silenced so Historical Trauma Theory gives validation and voice to the destruction of colonisation through an Indigenous lens. Secondly, through healing and reclamation of Indigenous cultural identities, Indigenous histories (pre and post colonisation) can become available to Indigenous people again, which is fundamental to Indigenous health and wellbeing (Durie, 2001; Smith, 2012).

To summarise, Indigenous methodologies have been developed to privilege Indigenous epistemologies, ontological positions, and cosmologies whilst embedding Indigenous self-determination and aspirations as the key focus of the research and resisting western dominance in research with Indigenous communities (Kurtz, 2013; Smith, 2012; Walker et al., 2006). Key to Indigenous methodology principles is that the knowledge that it is generated from research is of importance to and will be beneficial to the intended community. The processes of colonisation disempowered Indigenous peoples' authority over their own lives, decimating traditional roles and relationships in which Indigenous societies were structured and functioned (Wirihana & Smith, 2012). Therefore, an important step in the Indigenous research process is having the community actively involved, or steering, the agenda, methods, and knowledge dissemination so that Indigenous self-determination is upheld (Smith, 2012).

Methods

Problem identification and review purpose

A clear purpose and objective of the integrative literature review ensures the appropriate literature is extracted and that the data analysis is focussed to meet the objective of the research (Whittemore & Knalf, 2005). The issue of importance to nursing practice, which underpins this dissertation, is the ongoing health disparities endured by Māori over multi-generations. Viewing Māori health within an appropriate cultural and historical context is an important aspect of providing culturally safe care (NZNC, 2012). Therefore, the impact of colonisation is an essential construct of Māori health. This integrative literature review reviewed empirical and theoretical literature on Historical Trauma Theory from within an Indigenous peoples' context and pertaining to Indigenous health outcomes or health care practice only. The objective of this dissertation was to formulate a discussion on how Historical Trauma Theory can inform nursing care within a Māori health context, here in Aotearoa. Therefore, the question guiding this integrative literature review is: *how can Historical Trauma Theory inform nursing practice within Aotearoa New Zealand?*

Literature search strategy

I searched the following electronic databases; CINAHL, MEDLINE, Australia and New Zealand reference centre, SocINDEX, and Google Scholar. Key words used were: Historical Trauma Theory, Indigenous, Māori, health, health care practice and nursing. Behavioural and social science databases were included because most Historical Trauma Theory literature sits within the behavioural sciences. Inclusion criteria and exclusion criteria are outlined below (see Table 1). A total of 432 articles were returned. Initial relevancy to the inclusion and exclusion criteria was decided by reading the abstract. After excluding articles that did not fit the inclusion or exclusion criteria and removing duplicates, 29 articles were included in the review. Due to the

limited amount of Historical Trauma Theory literature within Aotearoa New Zealand that pertains to health care and/or health care practice and within a nursing context, I also included publications pertaining to Historical Trauma Theory and Indigenous health outcomes and/or health care practice.

Table 1. Summary of inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Literature published from the year 2000-2019	Literature published pre-2000 and post 2019
Historical Trauma Theory within an Indigenous context	Historical Trauma Theory within a non-Indigenous context for example, African American context
Historical Trauma Theory literature from within a health discipline and/or a health perspective	Historical Trauma Theory literature not pertaining to health or health care practice for example, education focus
Literature focussed on Historical Trauma theory as a core concept for understanding Indigenous health outcomes and underpinning health care practice	Literature that uses Historical Trauma Theory as background only and has a different focus as the main topic, such as education, and/or no health focus

Data evaluation

The data extracted included theoretical frameworks outlining Historical Trauma Theory as a pathway to adverse health outcomes for Indigenous people, discussion papers arguing for Historical Trauma Theory to be integrated into clinical practice with Indigenous people, quantitative research and qualitative research investigating a variety of Historical Trauma Theory concepts from an Indigenous perspective. Data were evaluated based on conceptual relevancy (health care outcomes) and applicability (clinical practice implications and/or health care interventions) to the purpose of this dissertation. All data were assigned a code using a 2-point coding system (Whittemore & Knalf, 2005). The coding system was used to grade the pertinence of the data to the implications for Historical Trauma Theory and nursing within a Māori context. For example, research that focussed on the application of Historical Trauma Theory as a framework underpinning health care practice was given a 2 (high relevancy). As identified by Whittemore and Knalf (2005), data of high relevancy were prioritised and contributed more to the overall analysis.

Data analysis

The data were analysed using Whittemore and Knalf's (2005) method of reduction, display, comparison, and conclusion. During data reduction, the data were grouped into theoretical and

empirical evidence, and then grouped into subcategories. The categories are outlined in Table 2.

Table 2. Data categories

<i>Theoretical Data</i>	<i>Conceptual/model</i>	<p>Outlining how Historical Trauma influences Indigenous health outcomes in contemporary society</p> <ul style="list-style-type: none"> • Biological, sociological, political pathways <p>How to make the connection between historical events and contemporary health</p> <ul style="list-style-type: none"> • Historical trauma narratives • Historical loss and symptom scales
	<i>Discussion</i>	<p>Arguments about Historical Trauma Theory being integrated into health care praxis</p> <ul style="list-style-type: none"> • Appropriate historical and social context for Indigenous health • Historical Trauma Theory and building practitioner-client relationships • Indigenous interpretations of Historical trauma constructs <p>Implications for health research</p> <ul style="list-style-type: none"> • Empirical evidence needed to support application of historical trauma research to evidence based practice
<i>Empirical Data</i>	<i>Qualitative</i>	<ul style="list-style-type: none"> • Indigenous peoples' interpretations of Historical Trauma Theory's relevance and function within contemporary society • Trauma transmission • Healing
	<i>Quantitative</i>	<ul style="list-style-type: none"> • Pre and post interventions for unresolved grief • Prevalence of historical loss thoughts and feelings

Display

All data were compiled into a table that described the setting, the purpose, participants, methodology, findings, limitations, and relevance to this research (by coding system). By reading and re-reading the display table, recurring and related themes became evident. The

patterns in the findings were highlighted using a colour coding system. Next, data displays were compiled by colour coding for further examination to identify “important and accurate patterns and themes” (Whittemore & Knalf, 2005, p. 55).

Comparison

Data displays were read and compared, looking for patterns and themes. The pertinence of data to the research objective was assessed frequently to ensure that it was relevant and applicable to nursing practice. Four major themes became evident.

Presentation

A synthesis of the theoretical and empirical data pertinent to the purpose of this research has been presented in a discussion chapter, outlining the implications of the research findings to nursing in a Māori context. A Māori-centred nursing model, Te Kapunga Putohe, by Wilson and Barton (2008) has been utilised as the foundation for understanding the Māori values that need to be incorporated into nursing practice when caring for Māori whānau.

Rigour

The integrative literature review can provide a comprehensive synthesis of a wide range of data, both theoretical and empirical, on a topic of importance to nursing. If completed with rigorous methodology, the synthesis of the available literature can be used to inform nursing practice and knowledge development (Whittemore & Knalf, 2005). However, the wide range of data sources can also be problematic to the rigour of the research and produce a biased, incomplete review without a robust methodology (Whittemore & Knalf, 2005). Whittemore and Knalf’s (2005) article was selected and used as a framework for this review as it is specific to integrative literature reviews within the field of nursing, particularly identifying integrative reviews as having the potential to inform nursing practice when completed robustly. Firstly, the methods used in this integrative literature review are based on Whittemore and Knalf’s article, which provides methodological strategies to enhance the rigour of the integrative review. A logical approach to data extraction and evaluation was utilised to ensure that data of relevance and applicability to the research question were selected, and the data’s overall contribution to the analysis was dependent on these two factors.

Researcher bias

Researcher bias and subjectivity is identified as a challenge to the integrative literature review (Whittemore & Knalf, 2005). Wadams and Park's (2018) article was used as the framework for addressing potential researcher bias in this literature review. Their article focusses on rigour in qualitative research in correctional facilities. The main challenges to avoiding the "authentic (mis) representation of the participant's story" (Wadams & Park, 2018, p. 72) are the influence of researcher bias and western ideology on research outcomes. In terms of researcher bias, conceptual bias and anticipation bias are of relevance to this integrative review. Conceptual bias is when the researcher assumes that the findings are applicable to a similar situation or concept. Anticipation bias refers to the researcher's unconscious bias towards an argument based on their own "beliefs, values and assumptions about the world" (Wadams & Parks, 2018, p. 73). Both types of researcher bias are applicable to this literature review because of my personal experiences with colonisation and discrimination as a Māori woman (as identified in my whakapapa in the Introduction). To manage researcher bias, I applied the following strategies:

- I used a methodologically sound method of data extraction and evaluation (see methods) to include all relevant data for the purpose of this literature review (Whittemore & Knalf, 2005). Moreover, there is greater benefit for Māori health in reviewing all relevant data on Historical Trauma Theory to avoid an incomplete and biased synthesis on the available literature on Historical Trauma Theory and health care practice.
- Establishing rigour when using a decolonising research methodology approach requires reflexive practice from the researcher (Chambers et al., 2018; Wadams & Park, 2018). A key challenge to the decolonisation of research methodologies is the removal of a western lens when evaluating and analysing the data. Throughout the research process, I engaged in critical reflection and reflexivity of the research methods to ensure the methods aligned with the core principles of decolonisation, such as critiquing data based on the overall relevance to Indigenous agendas (Chambers et al., 2018; Werunga et al., 2016). This process was completed numerous times by reading and re-reading my arguments as recommended by Chambers et al. (2018). As a form of reflexive practice, bracketing (in the form of a mind map) was used to bring my own beliefs, emotions, and assumptions about the process of colonisation on Māori health into my own awareness so that I could attempt to complete an unbiased review and analysis of the Historical Trauma Theory data. I also included my whakapapa which includes my experience of being Māori. My whakapapa was included for transparency of my position as a Māori women and my bias when completing this research.

- By using a decolonisation approach, western ideology and power imbalances inherent in colonial-Indigenous research is challenged. Moreover, a Māori worldview is privileged when formulating the discussion of Historical Trauma Theory and nursing within a Māori context.

Summary

To summarise, Kaupapa Māori Theory and a decolonising approach are the philosophical standpoint for this literature review. Kaupapa Māori Theory is embedded within te ao Māori so is the appropriate methodology for interpreting Historical Trauma Theory's relevance and applicability to nursing within a Māori context. Using a decolonising approach can focus research on Indigenous people. Moreover, a decolonising approach is relevant to various concepts central to Kaupapa Māori Theory and Historical Trauma Theory. Whittemore and Knalf's (2005) integrative literature review methods have been used as a framework to guide a robust review of the Historical Trauma Theory data of relevance to the purpose of this research.

Chapter 4: Findings

The overarching argument within the Historical Trauma Theory literature is that Indigenous health disparities are caused by the historical losses of colonisation, as well as ongoing structural violence and oppression, such as racism and socio-economic disadvantage (Braveheart, 2000; Bryers-Brown, 2015; Evans-Campbell, 2008; Gone; 2013). Historical Trauma Theory centralises an Indigenous worldview for understanding the experience of colonisation. Therefore, Historical Trauma Theory is relevant to nursing practice in Aotearoa as the theory provides a framework for understanding the intergenerational impact of colonisation on Māori health in a contemporary context, through an Indigenous lens. Understanding the impact of colonisation on health is important given the longstanding overrepresentation of Māori in health disparities, including chronic health conditions. Moreover, understanding Māori health disparities as a manifestation of major historical trauma could potentially inform and improve nursing practice when working with Māori whānau. This chapter presents the five themes from the integrative literature review: The interpretation of Historical Trauma Theory, the modes of historical trauma transmission, establishing a link between historical events and contemporary health, healing from historical trauma, and historical trauma and health care practice. Please see table 3 for a list of summary of the literature used in this integrative literature review.

Theme One: The Interpretation of Historical Trauma Theory

Due to the popularity of Historical Trauma Theory, the growing body of Historical Trauma Theory literature is mainly theoretical (Walters et al., 2011). Empirical evidence is limited to the intergenerational transmission of trauma and the trauma responses unique to specific ethno-cultural populations. Moreover, Swanson Nicolai and Saus (2013) argued that scientific models of research could contribute to the undermining of Indigenous theories such as Historical Trauma Theory. Furthermore, the popularity of Historical Trauma Theory has potentially led to a lack of conceptual clarity, which is problematic for cementing the theory as a core framework underpinning Indigenous social and health issues (Mohatt et al., 2014; Walters et al., 2011). Therefore, it is essential to understand Historical Trauma Theory from the perspective of Indigenous communities so that the application of the theory to health care practice is meaningful and supportive of improving health outcomes for Indigenous people (Hartmann & Gone, 2016).

Table 3. Summary of articles included in the integrative literature review

REFERENCE	CONTEXT & PARTICIPANTS Focus/objective of study of article. Setting. Who are the participants? How many participants? Who are they not?	RESEARCH DESIGN & METHODS Methodology and methods – data collection and analysis, ethics, research rigour; review of literature, discussion or opinion piece.	KEY FINDINGS	LIMITATIONS Weaknesses or restrictions related to the context of the study, research design, and/or the findings.	RELEVANCE TO WHAT I AM DOING
Braveheart, M. Y. (2000). <i>Wakiksuyapi: Carrying the historical trauma of the Lakota. Tulane Studies in Social Welfare.</i>	The experience of HT ¹ among the Lakota, in North America. Quantitative and qualitative data. Braveheart is the founder of HT theory and a native Lakota woman who has worked as a social worker.	Quantitative study (1992) on unresolved grief: pre & post psychoeducational intervention 45 Lakota human service providers. Orientational qualitative research: focus on Wakiksuyapi – high functioning participants of Lakota descent would describe affect in response to HT. Culturally significant location and ceremonies conducted to provide safe space for participants. Videotaping, field notes, audiotaping, personal journals.	<ul style="list-style-type: none"> • Wakiksuyapi – the memorial people. Carrying a collective survivor identity, including a desire for reconnection to traditional life. • Psychoeducation about HT can increase awareness of associated affects. • Exploring affects in a culturally safe environment contributed to healing. • Trauma testimony: Wounded knee massacre, Residential boarding schools (RBS)²system and day school trauma. • The trauma response features: concern with anger impulses, impaired bonding related neglect, identification with the dead, survivor guilt. • Transcending the trauma: coping strategies, healing and transforming trauma. • Reconnection to tradition facilitates healing. Possible trauma is culturally 	Setting within researcher's own cultural group only ? generalisation of results No limitations identified	Relevant to understanding HT from a cultural perspective. Important aspects regarding reconnection to traditional ways of life as essential to healing. Code: 2

¹ HT = Historical Trauma

² RBS =

			grounded – including grief resolution.		
REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Braveheart, M. Y. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. <i>Journal of Psychoactive Drugs</i> .	The focus of the article is the HT response, and how to incorporate HT into clinical practice. Examples from prior work highlighted to demonstrate the HT response.	A discussion paper on the HT response, with specific focus on substance abuse amongst the Lakota people.	<ul style="list-style-type: none"> • Substance abuse, suicide and violence are common psycho-social problems in the Lakota population, outweighing national statistics. • Superimposed trauma - HT compounded by racism, socio-economic hardship, including major unemployment. • Unresolved intergenerational grief – unique attachments to family – distinct from a western lens. Outlawing spiritual practices – impeding resolution of grief and major losses being experienced. • Alcohol use a major concern in American Indian communities. Compounded by parental struggles due to RBS legacies and other assimilation practices. • Reattachment to traditional ways of life protective against substance abuse – possible in clinical interventions. • Promoting native values such as parent-child relationships through an indigenous lens. • Culturally safe environments for healing practices/interventions. 	Lakota tribal context only.	<p>Highly relevant. Discusses HT and health concerns, particularly the importance of culturally grounded understandings of HT and interventions. Cultural reconnection protective.</p> <p>Code: 2</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Begay, T. K. (2012). <i>Toxic stress: Linking historical trauma to the contemporary health of American Indians and Alaska Natives</i> . [Unpublished dissertation]. The University of Arizona.	To investigate the biological impacts of HT. To develop a conceptual framework for understanding the biological changes caused by HT which are manifested in health and cognitive development. Set in North America.	A theoretical dissertation to conceptualise the neuro-biological impacts of HT children and adult indigenous people in North America.	<ul style="list-style-type: none"> • Chronic toxic stress impacts brain development, cortisol levels. • Behaviour in children is affected including the ability to cope with future stressors. • Behavioural responses to HT are controlled by the autonomic nervous system. Coping behaviours can become intergenerational and integrated into society and normalised. • Psychological symptoms and behavioural responses to HT impact relationships including mother/child and parenting, perpetuating biological changes. • Neurophysiological response to environment inevitable and environment can be a buffer for biological changes and vice versa. • HPA axis dysfunction leads to hyper or hypo cortisol levels which are associated with learning difficulties, anxiety/depression, physical illness and immune problems. 	None identified.	Highly relevant to understanding the multifaceted compounding impact of trauma exposures and HT effects on wellbeing. Highly relevant to nursing. Code: 2

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING ...
Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian residential schools: Implications for the concept of historical trauma. <i>Transcultural Psychiatry</i> .	Investigates the intergenerational social and health consequences of familial attendance at the RBS in Canada.	Literature review.	<ul style="list-style-type: none"> • Descendants of individuals who attended a RBS is associated with various forms of psychological distress. • Stress proliferation from RBS makes descendants vulnerable to stress exposure and heightened stress response. • Families with multiple generations attending the RBS associated with greater distress – supporting a cumulation theory. • HT outcomes vary between tribes based on past experiences (e.g., self governance in some tribes without RBS attendance). 	Focuses on the RBS survivors only.	<p>Relevant to understanding stress associated health conditions in descendants of indigenous people who experience HT. The cumulation of HT and stress is interesting as a factor in ongoing health disparities. Demonstrates trauma trajectories associated with specific trauma events.</p> <p>Code: 2</p>
Brown-Rice, K. (2013). Examining the theory of historical trauma among Native Americans. <i>The Professional Counsellor</i> .	Explores the theoretical framework of HT and how it can guide counsellors in understanding how HT experienced by indigenous peoples' ancestors are manifested today. Set in North America.	A discussion paper – written from the perspective of professional counselling.	<ul style="list-style-type: none"> • A summary of psychosocial, psychological, socio-environmental concerns, physiological functioning in response to HT. • Amygdala and HPA axis responses of significant importance. Research demonstrates trauma elicits responses in both. • PTSD is a strong predictor of medical conditions in later life. • Understanding HT is essential to integrating it appropriately into clinical practice. • Counselling frameworks need to integrate indigenous worldviews & • Counsellors need to validate historical loss and contemporary struggles of indigenous people 		<p>Relevant – discusses clinical practice and HT integration.</p> <p>Code: 2</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Bryers-Brown, T. (2015). <i>“He reached across the river and healed the generations of hara”: Structural violence, historical trauma, and healing among contemporary Whanganui Māori.</i> [Unpublished master’s thesis]. Victoria University of Wellington.	Investigated Māori experiences of the health care system, perceptions of wellness and healing. Participant observation and interviews of Māori from Whanganui – 11 interviews in total.	Kaupapa Māori Theory as the philosophy underpinning the research and structural violence and HT Theory as the theoretical frameworks underpinning the analysis.	<ul style="list-style-type: none"> • Institutions represent HT and can be re-traumatising. • Socio-cultural experiences of HT. • Internal displacement of Māori with their own iwi boundaries. • Contemporary reminders of HT exist. • Media portrayals of Māori as unwell, physically less robust – concepts of wellness. • Discriminatory behaviour puts a barrier up to accessing primary health care. • Spatial containers of HT a mode of transmission. • Healing can also flow through generations through cultural practices such as karakia and waiata. • Healing grounded in whānaungatanga, whakapapa and wairuatanga. 		<p>Very relevant – Māori experiences of structural violence and HT. Discussion on health and healing.</p> <p>Code 2</p>
Charbonneau-Dahlen, B. K., Lowe, J., & Morris, S. L. (2016). Giving voice to historical trauma through storytelling: The impact of boarding school experience on American Indians. <i>Journal of Aggression, Maltreatment and Trauma.</i>	Events of survivors who experienced HT in relation to the American Indian mission boarding school. The dream-catcher medicine wheel used as a tool for story telling. 9 female indigenous participants from 2	Snowballing sampling. A descriptive exploratory qualitative method. Thematic analysis of written and taped storytelling.	<ul style="list-style-type: none"> • Participants reported suffering from depression, substance abuse – alcohol, and poor life style choices and relationship difficulties. • Some experiences in the boarding school resulted in long term physical injury and emotional pain. • Highlighted grief in response to being unable to speak native language, and mourning of traditional parenting skills. • Nurses need to be upskilled on using culturally safe methods of data 	The transferability of this research to be reproduced in another sample of people.	<p>Participants highlighted health issues related to HT.</p> <p>Code 2: provides a link between individuals perceptions of HT and current health outcomes.</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
	different reservations.		collection in research, such as story telling. <ul style="list-style-type: none"> • Story telling between nurse and client can be healing and promote health. 		
Conching, A. K. S., & Thayer, K. (2019). Biological pathways for historical trauma to affect health: A conceptual model focussing on epigenetic modifications. <i>Social Science & Medicine</i> .	A conceptual model for biological pathways of HT transmission.	A discussion paper outlining a model on epigenetic changes and transmission of HT. Using relevant trauma and stress research to support model.	<ul style="list-style-type: none"> • Biological modes of HT transmission – epigenetic changes happening 1. To the individual 2. Mother-unborn child transmission. • Prolonged stress and trauma can change chemical/cellular mechanisms in a human mainly resulting in HPA axis, immune and mental health dysfunction. • Is possible to reverse or alter epigenetics (gene expression). Important to understanding HT transmission. 	None identified.	Highly relevant for addressing the biological responses and transmission of HT in indigenous communities. Provides a model for making the pathway between historical events and contemporary indigenous health. Relevant for nurses to know as a framework for understanding the overrepresentation of indigneous people in chronic disease (e.g., diabetes and mental health) Code 2
Gone, J. P. (2013). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. <i>Spirituality in Clinical Practice</i> .	Investigating the healing lodge (substance abuse facility) as a therapeutic approach to healing from HT for Canadian Indian people – including the exploration of the meaning of healing from HT. 19 staff and clients involved in a AI healing lodge.	Discovery-orientated methodology. Western and indigenous practices incorporated in study. Semi-structured, open ended questions. Thematic content analysis.	<ul style="list-style-type: none"> • Four themes emerged in relation to being able to heal from HT: • Emotional burdens: childhood abuse and adult chaos very challenging for clients. • Cathartic disclosure: acknowledging and talking about past experiences valuable. • Self-as-project reflexivity. • The impact of colonisation on healing: identifying ones self within colonial society – most prominent 	Study sample included participants who had graduated from the program only. Sample may not be generalisable.	Relevant to understanding HT in a clinical context. Code 2

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
	Majority of people in attendance at the residential facility were effected by the RBS programme.		colonial institution the RBS. Spiritual oppression discussed by clients; not knowing ones culture but knowing the culture of the dominant population. <ul style="list-style-type: none"> • A revitalisation of indigenous culture regarded as essential to healing. EBP and Native American healing are different. 		
Baker, N. (2018). <i>The effect of embodied historical trauma on musculo-skeletal pain in a group of urban Māori adults</i> . [Unpublished thesis]. Unitech.	To investigate the embodiment of HT on musculoskeletal pain in 6 urban Māori adults.	Kaupapa Māori philosophical viewpoint Korero (semi-structured and open) about musculoskeletal pain. Location of participants' choice. Verbatim transcription and recordings listened to multiple times. Rourou method of data analysis.	<ul style="list-style-type: none"> • Concepts of healing identified by participants; whānau affair, spiritual, physical pain as a representation of an emotional/spiritual pain such as grief, whenua a source of healing; reconnecting to whakapapa. • Pain recognised by participants as; mothers struggle to hold onto whenua; land confiscation; struggling with Māori culture and whakapapa, loss of te reo and tikang, incorrect pronunciation of names. • Emotions, suppressed emotions maybe related to long term pain. • Tapu essential for healing. 	6 urban Māori only – small study sample.	Highly relevant. Discusses embodied HT manifested in musculoskeletal pain in Māori . Supports concepts of integrating HT Theory into practice. Code: 2
Hale, J. (2012). <i>The importance of historical trauma & stress as a factor in diabetes and obesity prevention among American Indian adolescents</i> . Unpublished master's thesis]. University of Kansas.	Examines the diabetes epidemic in North American Indian population. Argues that programmes aimed at reducing diabetes fail to address the underlying cause-HT.	Integrative literature review.	<ul style="list-style-type: none"> • The diabetes epidemic is multifaceted. • Colonisation has had a multifaceted impact on the diabetes epidemic in indigenous communities – disruption to traditional diets and physical activity and chronic stress, compounded by life course stressors and intergenerational stress. 		Relevant – provides a sound example of a common illness in which indigneous people are overrepresented and gives a comprehensive review of how HT has directly led to the diabetes epidemic.

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
			Indigenous concepts of wellbeing and healing need to be included in adolescent diabetes and obesity prevention programmes.		
Hartmann, W. E., & Gone, J. P. (2014). American Indian historical trauma: Community perspectives from two Great Plains medicine men. <i>American Journal of Community Psychology</i> .	To understand how HT was functioning on a reservation, from the perspectives of two prominent medicine men from the Great Plains reservation. Medicalisation vs. socio-cultural understandings. Set in American Indian context. Two participants only but prominent healers and educators in the community.	Part of an ethnographic informed project on a Great plains reservation in America. Undertook 3 months of community participation to learn about important issues first. Used semi-structured interviews and avoided top-down imposition. Engaged in cultural protocols prior to starting the interview.	<ul style="list-style-type: none"> • One participant defined HT aligned with HT literature. • One participant focussed on socio-cultural change as the cause of social disruption – viewed colonial past as put to rest. • Cultural spiritual interpretations of transmissions described; biological/gene alteration theory also highlighted. • One participant focussed on healing – using sacred sweat lodge. Another focussed on healing from the past and returning to traditional ways of life. • Both identified long standing problems such as lack of employment opportunities etc.; sustaining HT • Findings to support a therapeutic vs. Nation building discourse – individual vs. community focus for the amelioration of HT. 	Translation of native language done by participants. Lack of language in reserachers identified as a barrier to communication. Neither medicine man was aware of the other's comments.	Relevant – understanding HT from an indigenous perspective. Understanding how indigenous perspectives of HT could guide clinical intervention for HT. Code 2

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Hartmann, W. E., & Gone, J. P. (2016). Psychological-mindedness and American Indian historical trauma: Interviews with service providers from a Great Plains Reservation. <i>American Journal of Community Psychology</i> .	Set in North America. Investigation of the concept of HT theory amongst Great Plains Reservation human service providers. 23 participants – all indigenous and all working as human service providers.	Part of an ethnographic informed project on a Great plains reservation in America. Undertook 3 months of community participation to learn about important issues first. Used semi-structured interviews and avoided top-down imposition. Engaged in cultural protocols prior to starting the interview.	<ul style="list-style-type: none"> • Participants favoured a socio-cultural understanding of HT and used it to explain the ongoing social problems in the community, as opposed to the traditional psychological-minded framework. • Indigenous suffering attributed to ongoing oppression and lack of economic opportunity. • Traditional frameworks for HT theory can pathologise indigenous social distress, which takes spotlight off ongoing oppression. • Cultural lens evident in explanation of ongoing social distress in the community. 	From 1 reservation.	<p>Relevance to understanding HT from an indigenous perspective, including those working in human services.</p> <p>Code 1</p>
Kirmayer, L. J., Gone, J., & Moses, J. (2013). Rethinking historical trauma. <i>Transcultural Psychiatry</i> .	North American setting.	Discussion paper arguing against universal trauma definition/intervention.	<ul style="list-style-type: none"> • Problems in comparing the holocaust to indigenous HT argued; pre-trauma context, violence types, loss types, post-trauma context and larger social context comparisons. • Difficult to establish a link between colonial processes and contemporary social and health problems of experienced by indigenous people. • Ongoing psycho-social problems such as violence and substance abuse related to ongoing structural violence and inequities, and negative portrayals of indigenous people. 		<p>From a health field – psychiatry. Relevant arguments for applying HT Theory to nursing in a Māori context.</p> <p>Code 1</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Lawson-Te Aho, K. (2014). The healing is in the pain: Revisiting and re-narrating trauma histories as a starting point for healing. <i>Psychology and Developing Societies</i> .	Set in Aotearoa. 5 Māori women from the same hapu (related). All were active members of the hapu.	Kaupapa Māori methodology. Interviews in participants' homes using traditional hui format. Research approved by female elders – including questions. Participants reviewed interviewer notes and themes. Themes developed using HT literature and participant narration.	<ul style="list-style-type: none"> • Trauma narratives can provide a platform for healing from HT when done in a culturally safe facilitated way. • Recent allegations of sexual abuse within the hapu discussed by 3 participants; identified as intergenerational sexual abuse. Participants discussed culturally appropriate means of restoration. • Connections between colonisation and dysfunction recognised having had time to process history through story telling. • Colonisation identified as leading to substance abuse, moral and value system breakdown. 	Only five participants from one hapu.	<p>Relevant – discusses cultural interpretations of HT, including aspects of healing from HT that could be applied to clinical practice.</p> <p>Code 2</p>
Lawson-Te Aho, K. (2017). The case for re-framing Māori suicide prevention research in Aotearoa New Zealand. <i>Journal of Indigenous Research</i> .	Set in Aotearoa, focussing on Māori suicide prevention and suicide prevention research.	Discussion paper.	<ul style="list-style-type: none"> • Suicide research needs to utilise HT theory for research in suicide prevention in Māori. • HT theory could provide a more accurate framework for understanding Māori suicide. • Ongoing structural violence and suicide in Māori validated by research. • Māori issues, such as suicide, need to be contextualised within appropriate Māori social and cultural contexts. • HT theory is underdeveloped in Aotearoa – particularly as a framework for trauma trajectories. 		<p>Supports HT Theory as a framework for understanding specific health issues in response to HT events within Aotearoa. health context.</p> <p>Code 2</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Lowe, J. (2007). Research brief: The need for historically grounded HIV/AIDS prevention research among Native Americans. <i>Journal of the Association of Nurses in AIDS Care</i> .	Considers the need for culturally and historically grounded HIV research in American Indian populations. Set in North America. Author is an indigenous American registered nurse.	Brief discussion paper	<ul style="list-style-type: none"> When viewed through an inappropriate lens, research with indigenous people often portrays indigenous communities as communities of loss and disparities. Historical and cultural contexts are essential to researching health topics in indigenous communities. 	Brief article.	<p>Written from an indigenous nursing perspective – adds to implications for nursing practice.</p> <p>Code 1 – narrow focus</p>
McQuaid, R. J., Bombay, A., McInnis, O. A., Humeny, C., Matheson, K., & Anisman, H. (2017). Suicide ideation and attempts among First Nations people living on-reserve in Canada: The intergenerational and cumulative effects of Indian residential schools. <i>The Canadian Journal of Psychiatry</i> .	Investigate the connection between RBS legacy and suicide/suicide risk over multigenerations living on-reserve. Set in Canada. No participants had attended RBS directly.	Data from a national survey conducted from 2008-2010 were analysed. 30,000 participants representative of First Nations population over 18 years old and living on-reserve. 4 groups analysed – no RBS, 1 parent attended, grandparent attended, grandparent and parent attended.	<ul style="list-style-type: none"> 1 generation of RBS attendance was associated with suicidal ideation compared with those who had no familial attendance. 2 generations of RBS attendance history were more likely to report suicide attempts compared to having 1 generation attend RBS. 	First Nations in Canada living on-reserve setting only.	<p>Supports the pathway between HT events and health outcomes.</p> <p>Code 1</p>
Maxwell, K. (2014). Historicizing historical trauma theory: Troubling the transgenerational transmission paradigm. <i>Transcultural Psychiatry</i> .	Discusses HT Theory having the potential to pathologise indigenous suffering and remove attention off the ongoing colonialism in Canada.	Discussion paper.	<ul style="list-style-type: none"> Drawing on trauma theory could perpetuate colonial perceptions of indigenous parents failing to assimilate children. Pathologising indigenous parents can continue power imbalances and divert attention from structural violence that sustains inequities. Colonial professions pathologising indigenous families & imposing interventions on children. 		<p>Has relevance to HT Theory and health care practice. Has arguments cautioning against pathologisation of indigenous social struggles.</p> <p>Code 1</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. <i>Social Sciences & Medicine</i> .	Examining how HT influences health of indigenous people today. Set in North America.	Critical literature review.	<ul style="list-style-type: none"> • HT narratives provide an opportunity to understanding HT and ease psychological distress. • The salience of community HT narratives determines whether there will be health impacts. • Short and long term health impacts associated with HT narratives. • Narratives can also be hope and resilience. 		<p>Relevant to understanding the importance of indigenous peoples' perceptions of HT and how it impacts health outcomes.</p> <p>Code: 1</p>
Nutton, J., & Fast, E. (2015). Historical trauma, substance use, and Indigenous peoples: Seven generations of harm from a "Big Event". <i>Substance Use & Misuse</i> .	Theoretical framework for understanding how a "big event" (colonialism) led to HT and substance misuse in indigenous communities.	Conceptualisation of colonialism, HT, and substance misuse in indigenous communities in North America.	<ul style="list-style-type: none"> • Loss of self autonomy over life can lead to internalised anger which is a risk factor for substance abuse. • Culturally appropriate solutions to ameliorate HT essential; decolonisation – communities with autonomy associated with lower rates of socio-economic and social distress, cultural reconnection and identity, and culturally adapted interventions – reflected of an indigenous worldview – identified values, beliefs and healing practices as most successful for interventions for substance abuse. 	<p>No inclusion of resilience literature.</p> <p>Possibility of re-inforcing negative stereotypes about indigenous people by focussing on 'problems' such as substance use.</p> <p>Did not focus on structural violence which reinforces the effects of HT.</p> <p>Difficulty in linking HT to substance abuse.</p>	<p>Relevant to research, particularly guiding culturally appropriate health care practice.</p> <p>Code 2</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Palacios, J. F., & Portillo, C. J. (2009). Understanding Native women's health: Historical legacies. <i>Journal of Transcultural Nursing</i> .	A framework for better understanding native women's health outcomes – one theory HT Theory. Set in North America. Published in nursing journal – both authors registered nurses.	Discussion paper – theoretical frameworks discussed and applied to core constructs of native womens health.	<ul style="list-style-type: none"> • HT theory contextualises native women's health appropriately. • Unresolved grief – inability to properly mourn ancestors due to impact of trauma. • Transmission; secondary trauma, intergenerational and parenting skills. • HT is compounded by ongoing marginalisation. • The accumulation of stressors puts pressure to use unhealthy behaviours (i.e., smoking and drinking alcohol). • HT theory lack of empirical evidence makes cementing it as a core theory in indigenous health challenging. 	North American setting.	<p>A relevant article from within the nursing discipline – provides an example of how HT (in conjunction with another theory) provides clarity on indigenous health problems in contemporary society.</p> <p>Code 1 -pathway to understanding HT and health outcomes in indigenous women</p>
Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. <i>Journal of Disparities Research and Practice</i> .	To conceptualise HT theory in relation to contemporary health disparities endured by ethnic/culturally diverse populations. Set in North America. Written within the public health domain.	A broad literature reivew and conceptual model outlining HT Theory and minority populations long standing health disparities.	<ul style="list-style-type: none"> • Type of trauma effects outcome of trauma response – HT results from a minority population being subjugated by a majority population; subjugation is legitimised on socio-political levels and achieved by various modes of warfare and oppression. • Subsequent generations are effected by parenting challenges, maladaptive coping behaviours, biological changes in gene expression. • Argument that HT theory is invaluable to public health and population health but requires empirical evidence. • Many aspects of an indigenous reality are in HT Theory which 		<p>Highly relevant to the application of HT Theory and nursing – particularly understanding the impact of HT on physcial outcome.</p> <p>Code 2 – pathways to understanding indigenous health outcomes – from various public health frameworks</p>

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
			gives an appropriate context for understanding the long standing impact of colonisation.		
Struthers, R., & Lowe, J. (2003). Nursing in the Native American culture and historical trauma. <i>Issues in Mental Health Nursing</i> .	Original research. A conceptual model for nursing in the Native American context. Set in North America. Participants are registered Native American nurses – first focus group 203 & second 193. Data collected from two separate summits for Native American nurses via facilitated focus groups. Data analysis performed by Native American nurses with advanced degrees in nursing.	A conceptual model incorporating a nursing model for nursing in a Native American context and HT.	<ul style="list-style-type: none"> • Caring • Traditions • Respect • Connection • Holism • Trust • Spirituality • Asked about tribal histories and if they are impacting on the client in the present. • Nurse-client relationship building essential in HT care – creates a healing space. • Culturally appropriate nursing care, such as an indigenous model of nursing, essential to healing from HT. 	Native American context.	Highly relevant Discusses practical application of HT Theory to a native American nursing model which can be utilised by all nurses. Code: 2
Swanson Nicolai, S., & Saus, M. (2013). Acknowledging the past while looking to the future: Conceptualising Indigenous child trauma. <i>Child Welfare</i> .	Investigation of service providers' conceptualisation of indigenous children's trauma. Based in western Montana and Northern Norway. 17 participants service providers working with indigenous children.	Exploratory qualitative study. Semi-structured interviews. Participants had a wide age range, professions and educational background.	<ul style="list-style-type: none"> • Mistrust in the system – trauma experienced in the institutions. • Resilience. • Grief and trauma – high amounts experienced by indigenous children (i.e., premature death is common) Indigenous values – spirituality, relationships, materialism and humour identified by participants. Participants highlighted differences in indigenous childcare and communication styles compared to mainstream.		Adds to clinical implications and ideas how HT can guide clinical practice. Code 1 – not health practice specifically but counselling

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
			<ul style="list-style-type: none"> • Lack of understanding of indigenous clients' values hinders practice. • Most likely a difference in indigenous child trauma and child trauma; HT is the difference. • Participants actively engaged with HT theory to understand indigenous child trauma better. • Culturally appropriate treatment is required – based on indigenous value systems. • Recommend that service providers treating indigenous clients are educated about HT Theory. 		
Walters, K. L., Mohammed, S. A., Evans-Campbell, T., Beltran, R. E., Chae, D. H., & Duran, B. (2011). Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives. <i>Du Bois Review</i> . DOI 10.1017/S1742058X1100018X.	Using ecosocial theory and the indigenist stress-coping model, the authors argue that indigenous physical health, including risky health behaviour, is partly the embodiment of HT. Set in North America.	Discussion paper – a framework for on the embodiment of HT in indigenous health disparities.	The concept of embodiment aligns with an indigenous worldview of the interdependence of the land, person and spiritual realm. The embodiment of the stress – epigenetic changes – HPA axis dysfunction. Maternal transmission of stress hormones to unborn child. Cultural identity can buffer HT effects. Multifaceted pathways contribute to the HT biological expression which cumulate over generations. Research needed to support theory of embodiment of HT.	None identified. Future research recommended on topic of embodiment of HT as physical ill health in indigenous populations.	Relevant – discusses a pathway for how HT is manifested in indigenous populations, such as health disparities. Code 2

REFERENCE	CONTEXT & PARTICIPANTS	RESEARCH DESIGN & METHODS	KEY FINDINGS	LIMITATIONS	RELEVANCE TO WHAT I AM DOING
Whitbeck, L. B., Adams, G. W., Hoyf, D. R., & Chen, X. (2004). Conceptualising and measuring historical trauma among American Indian people. <i>American Journal of Psychology</i> .	To develop and use a quantitative measure of historical loss and the associated symptoms in American Indian people. Specifically to gauge the prevalence, frequency and intensity of the thoughts of loss and associated symptoms. Set in North America. 143 participants were a parent generation of AI people who had not directly experienced HT.	Scales were developed in conjunction with elders from the community. Focus groups were run to determine the types of historical losses experienced by the particular tribe and the associated feelings experienced when thinking/discussing the losses (including loss of language, land, culture, family breakdown and dysfunctional behaviour such as substance abuse). The scales were reviewed by the appropriate tribal members.	<ul style="list-style-type: none"> • The participants think about losses very frequently. • Nearly one fifth of participants thought about historical losses every day and one third thought daily about loss of language. • One third thought about loss of spirituality daily. • Half of respondents thought about alcoholism daily. • The most common feelings associated with thoughts of historical losses were anger, distrust in white people, depression, anger and intrusive thoughts. • Thoughts of historical loss are associated with emotional reactions. • The more frequent the thought of historical loss, the more intense the emotional reaction. 	Unable to determine how the emotional reactions affect day to day living.	<p>Relevant quantitative research demonstrating how historical loss is experienced emotionally (leading to health impacts) by adult AI people.</p> <p>Code: 1</p>
Wirihana, R., & Smith, C. (2014). Historical trauma, healing and wellbeing in Māori communities. <i>MAI Review</i> .	Set in Aotearoa. Explores traditional views of Māori health and wellbeing – including healing practices.	Discussion on Māori healing and trauma using HT as a theoretical framework.	<ul style="list-style-type: none"> • Traditional social structures in Māori society disrupted by colonisation. • Māori wellbeing and healing disrupted by colonisation processes. • Māori wellbeing connected to whenua and ancestors. • Māori emotions expressed in a uniquely Māori way – Waiata and Whaikorero and haka. • Healing based on a Māori view of wellbeing. 		<p>Relevance to literature review – discusses trauma of colonisation and disruption to Māori health and wellbeing. Provides arguments for the importance of culturally grounded healing for Māori .</p> <p>Code: 2</p>

Although some scholars argued that Historical Trauma Theory is westernised in its approach to conceptualising Indigenous suffering from colonisation, Braveheart (2000) stated that many core concepts are grounded within an Indigenous reality, which is also identified by various other authors (Reid et al., 2014; Struthers & Lowe, 2003; Walters et al., 2011). The concept of historical trauma is based on the past, present, and spiritual interdependence of an Indigenous reality as demonstrated by Indigenous peoples' innate connection to the collective's ancestors—all of which is true for te ao Māori (Braveheart, 2000; Durie, 2001; Salmond, 2017). Moreover, research demonstrates that Indigenous people have a strong connection to ancestral pain which is experienced as loyalty to their ancestors' pain, associated guilt when experiencing good emotions, living with pain and history today, and feelings of being already dead (Braveheart, 2000; Swanson Nicolai & Saus, 2013; Whitbeck et al., 2004).

Historical Trauma Theory validates the devastation of colonisation for Indigenous people (Braveheart, 2000). The dominant discourse on colonisation marginalises Indigenous histories, including the impact of colonisation (Braveheart, 2000; Smith, 2012). However, despite the marginalisation of Indigenous people and their history, collective narratives about colonisation exist within Indigenous populations (Mohatt et al., 2014; Palacios & Portillo, 2009; Smith, 2012).

Collective narratives are formulated on socially endorsed memories of the event, which are retold over multi-generations and interpreted within the cultural context of the population (Gone, 2013; Kirmayer et al., 2013). Supported by research, narratives provide opportunities for Indigenous communities to process historical losses and link historical trauma to contemporary problems within their community (Lawson-Te Aho, 2014). The narratives identify the event(s) as traumatic including how the trauma is experienced, manifested, and represented amongst the population in contemporary society (Mohatt et al., 2014). Therefore, history is socially and culturally constructed, including the dominant discourse surrounding adverse events, which often discredits the significance of colonisation that includes blaming Māori for long-standing health disparities (Smith, 2012). Hence, Indigenous narratives are essential to the application of Historical Trauma Theory to health care practice to ensure practice is therapeutic for Indigenous people and historical trauma (Struthers & Lowe, 2003).

Historical Trauma Theory is known among Indigenous communities, but the interpretations of historical trauma vary greatly (Hartmann & Gone, 2013, 2016; Swanson Nicolai & Saus, 2015). Research demonstrates that Indigenous people, both human service workers and non human-service workers, are familiar with Historical Trauma Theory (Bryers-Brown, 2015; Hartmann & Gone, 2016; Swanson Nicolai & Saus, 2015). However, personal interpretations of how historical trauma effects and is manifested in Indigenous populations is unique and grounded in socio-cultural factors; such as historical events specific to Indigenous communities and cultural understandings of death and loss (Braveheart, 2000; Hartmann & Gone; 2013, 2016; Kirmayer et

al., 2014). Moreover, grief and mourning are most likely grounded in Indigenous ontology and varies significantly from the euro-centric definition (Braveheart, 2000). Research demonstrates that ancestral trauma and historical loss is described by descendants of Indigenous people who experienced colonisation as 'pain', 'soul wound', and 'intergenerational mamae (pain, injury, wound, hurt)', and is connected to Indigenous spirituality (Braveheart, 2000; Hartmann & Gone, 2013; Bryers-Brown, 2015).

Hartmann and Gone (2016) argued that historical trauma is often contextualised by Indigenous people within a socio-cultural framework, which differs from the psychological focus of the original Historical Trauma Theory framework proposed by Braveheart. Research shows that the historical trauma of the colonisation process was viewed by Indigenous research participants as the genesis of the contemporary problems evident in their community, and the socio-political structures as what maintains the distress, such as poverty, racism, and distrust in the government (Hartmann & Gone, 2013, 2016; Lawson-Te Aho, 2014). In a similar vein, Lawson-Te Aho's (2014) research participants identified colonisation as the root cause of unemployment, alcohol abuse, and violence within their hapū that allowed sexual abuse to happen over multiple generations due to a breakdown in value systems caused by the various psycho-social problems. The processes of cultural assimilation and acculturation oppressed Indigenous spirituality, including cultural practices surrounding death, which resulted in intergenerational unresolved grief and mourning for the mass losses caused by colonisation; for example, mass mortality due to infectious diseases and land wars (Braveheart, 2003; Baker, 2018). The pain surrounding ancestral pain was identified by Indigenous research participants as being linked to substance abuse, cigarette use, anxiety, and depression.

The intergenerational transmission of historical trauma, including unresolved grief, is an accepted construct of Historical Trauma Theory by Indigenous people (Braveheart, 2003). However, the modes of trauma transmission are grounded within an Indigenous worldview and associated with Indigenous spirituality (Braveheart, 2000; Hartmann & Gone, 2014). For example, research participants identified the intergenerational trauma transmission caused by the absence of the appropriate cultural practices; loss of spiritual foundations and practices for mourning; the re-incarnation of ancestors in offspring; maternal transmission of historical trauma to her offspring before conception; the collective memories of violence against one's ancestors; the attachment of 'bad' energy to whakapapa; and the disruption to whakapapa caused by cultural suppression (Baker, 2018; Braveheart, 2003; Bryers-Brown, 2015; Hartmann & Gone, 2014). Moreover, the intergenerational experience of historical trauma was believed to be associated with profound grief and mourning, poor health decisions such as alcohol and drug use, violence, chronic pain and the breakdown of familial structures by Indigenous people (Baker, 2018;

Braveheart, 2003; Hartmann & Gone, 2014; Gone, 2013; Lawson-Te Aho, 2014; Whitbeck et al., 2004).

Theme Two: The Multigenerational Transmission of Historical Trauma

The modes of trauma transmission are an essential component of Historical Trauma Theory (Braveheart, 2000). The modes of trauma transmission are an important aspect of Historical Trauma Theory when considering the implications for clinical practice as there is the potential to interrupt the transmission of historical trauma to future generations (Braveheart, 2000). Therefore, it is essential that historical trauma transmission is fully understood. The modes of trauma transmission are multifactorial, vast and have biological, sociological, political, institutional, and psychological pathways of transmission through multi-generations of communities (Sotero, 2006; Walters et al., 2011).

Historical trauma transmission is affected by an array of factors (Sotero, 2006). Trauma is influenced by numerous variables such as gender; the nature of the traumatic event (intentional and imposed by subjugating population opposed to a natural disaster) where one or both parents were affected; the type of trauma experienced; and the duration of the traumatic event (e.g., long periods of land confiscation vs. massacre [Evans-Campbell, 2008]). For example, the removal of children from families under the residential boarding school policy in North America was associated with depressive symptoms, whereas events with direct physical harm, such as massacre, are associated with anxiety symptoms (Braveheart, 2003; Walters et al., 2011).

Biological transmission

Since the development of Historical Trauma Theory, there is a growing body of empirical evidence supporting the biological transmission and expression of historical trauma (Conching & Thayer, 2019; Walters et al., 2011). The biological transmission of historical trauma is the intergenerational transmission of the biological changes, which occurred due to repeated exposure to traumatic events caused by colonisation such as loss of life by massacre and infectious diseases (Braveheart, 2000; Walters et al., 2011). Of importance to the biological transmission of trauma is the cellular changes that happen because of prolonged periods of toxic stress (Begay, 2012; Coching & Thayer, 2018).

Walters et al. (2011) argued that there was robust empirical evidence to conclude that profound “environmental conditions can leave an imprint or ‘mark’ on the epigenome (cellular genetic material) that can be carried into future generations with devastating consequences” (Walters et al., 2011 p. 11). Conching and Thayer (2019) proposed two pathways for biological changes that led to poor health outcomes in populations who have experienced historical trauma. Firstly, Coching and Thayer argued that the epigenome, which controls chemical factors in gene expression, can be altered by environmental factors such as prolonged toxic stress and trauma

which are directly experienced by the individual. Secondly, the intergenerational effects of historical trauma are transmitted antenatally when the unborn child is exposed to maternal stress hormones, which also alter the child's epigenome. The biological transmission of historical trauma is an essential component of Historical Trauma Theory, including when applying the theory to clinical health practice because there is the potential to halt transmission, especially in the field of epigenetics (Coching & Thayler, 2019). The biological responses to historical trauma include immune and HPA axis dysfunction that manifests in diseases in which Indigenous people are overrepresented, such as diabetes mellitus, hypertension, and mental health issues (Begay, 2012; Coching & Thayler, 2019; Walters et al., 2011).

One significant area of research is in the maternal transmission of trauma to her unborn child (Coching & Thayer, 2019). Most significant is poor maternal nutrition, specifically during fundamental developmental periods of the unborn child, which can lead to the development of adulthood cardiovascular disease such as hypertension and changes to the metabolic system, such as diabetes mellitus, with an increased associated mortality. Moreover, maternal stress has a significant impact on the neurobiological and neurodevelopment of her unborn child due to the exposure to maternal stress hormones. Stress hormone exposure can alter the epigenome in the foetus potentially leading to hypothalamic-pituitary-adrenal (HPA) axis regulation, metabolic system dysfunction, cardiovascular disease, immune system dysfunction, and anxiety and/or depression (Begay, 2012; Coching & Thayer, 2019). HPA axis dysregulation is associated with abnormal cortisol levels which cause an array of physical and mental health issues, such as immune system dysfunction, anxiety, and depression (Begay, 2012).

Transmission through parenting

Parent-child relationships are a pathway of historical trauma transmission (Braveheart, 2003). Colonisation processes, such as the residential boarding school policy in North America, resulted in major disruptions to traditional American Indian parenting (Bombay et al., 2014; Braveheart, 2000; Brown-Rice, 2013). Parental stress can expose their offspring to stressful environments either by indirect means such as lower socio-economic status or directly such as through parental substance abuse. Moreover, the psychological impacts of historical trauma such as maternal depression and anxiety can directly affect the vital maternal-infant relationship which perpetuates stress on the mother and the infant. Stress exposure in infancy and early childhood can lead to biological changes and neuro-developmental delay associated with behavioural and learning difficulties (Begay, 2012). Moreover, neurodevelopmental delays are associated with the development of poor coping strategies due to the areas of the brain that are affected by chronic stress. Interestingly, high levels of stress exposure as a child are associated with high levels of stressors as an adult (Bombay et al., 2014).

Residential boarding schools in North America

Specific mass trauma events are associated with specific trauma responses, such as the trauma response of those who experienced the residential boarding school policy in North America (Braveheart, 2000). The residential boarding schools are a major mass trauma event(s) frequently discussed within the American Indian and Indigenous Canadian literature (Bombay et al., 2014; Braveheart, 2000; Charbonneau-Dahlen et al., 2016;; Sotero, 2006). The residential boarding school policy enforced mandatory attendance by North American Indian children, over six generations. It is well known that many residential boarding school survivors were not provided safety, care or education, and many were subjected to multiple traumas including widespread sexual, physical, emotional abuse, corporal punishment and removal from parents, community, and culture (Bombay et al., 2014; Charbonneau-Dahlen, 2016). Some children were subjected to appalling abuse such as “the repeated insertion of a hat pin into a child’s rectum” (Assembly of First Nations, 1994, cited by Gone, 2013, p. 51). Consequently, parenting was not learnt within a ‘culturally normative’ environment, which was identified by Indigenous research participants as being a major source of grief (Braveheart, 2003; Charbonneau-Dahlen et al., 2016). As well as major disruption to traditional parenting, research demonstrates an increased risk for psychological distress, low educational attainment or difficulties at school, suicidal ideation and attempts/behaviours, and alcohol and drug abuse in the survivors and children and grandchildren of residential boarding school survivors (Bombay et al., 2014; Braveheart, 2003; Charbonneau-Dahlen et al., 2016; McQuaid et al., 2017).

Historical trauma can be transmitted through “contemporary reminders of historical trauma” (Mohatt et al., 2014, p. 131), such as physical landmarks that have historical significance to the Indigenous community, such as government institutions (Bryers-Brown, 2015). Individual and societal reminders of historical trauma, such as ongoing racism and personal trauma, trigger the affected Indigenous population to remember and re-experience the historical traumatic event(s) (Bryers-Brown, 2015; Evans-Campbell, 2008; Mohatt et al., 2014). For example, the Whanganui awa, Te Awa Tupua, is a living entity, an ancestor of the local iwi of the region. In a settlement with the crown, Te Awa Tupua was given recognition of its spiritual significance, including the interconnection and interdependence between the iwi and the awa. Of importance is the profound socio-economic disadvantages endured by Indigenous populations internationally. Socio-economic deprivation perpetuates historical trauma by sustaining the intergenerational historical losses experienced by Indigenous people, such as loss of traditional nutrition and internal displacement (Bryers-Brown, 2015). For example, in Aotearoa, profound socio-economic disadvantage is a reminder of colonisation and perpetuates negative stereotypes of Māori (Bryers-Brown, 2015).

The embodiment of historical trauma

The theory of the embodiment of historical trauma is based on the individual being intrinsically connected with all the systems of society (Sotero, 2006; Walters et al., 2011). Walters et al. (2011) argued that the concept of embodiment aligned well with the American Indian worldview in that it acknowledged the intrinsic connection between the individual, the family, society, the environment, the past and present and spiritual dimensions—all of which is also true for te ao Māori (Durie, 2001; Salmond, 2017). Therefore, Walters et al. argued that the “gene-environment interaction” (p. 184) theory explained how an individual’s genetic predisposition to disease interacts with an individual’s immediate and wider socio-economic and political environment in disease development (Sotero, 2006). Due to the multitude of historical and lifetime stressors that American Indian and other Indigenous populations are exposed to, historical trauma and stressors are embodied and expressed as disease patterns evident over multi-generations, such as diabetes mellitus and possibly chronic pain (Baker, 2018; Walters et al., 2011). For example, Hale (2012) argued that colonisation directly disrupted traditional ways of life for the American Indian people that disrupted nutrition and dietary habits, stress levels, and physical activity (e.g., hunting and fishing excursions for food sources). In a contemporary setting, healthy eating and exercise and physical activity are limited by multiple socio-economic factors, such as lack of employment opportunities and socio-economic deprivation in American Indian populations. Consequently, the North American Indigenous population are experiencing a diabetes mellitus epidemic (Hale, 2012),

Superimposed trauma

Historical trauma complicates and compounds the effects of life course trauma (Braveheart, 2000). A sensitive and exaggerated stress response is inherited through historical trauma, such as through biological changes to the HPA axis (Braveheart, 2000). In superimposed trauma, the background of historical trauma exaggerates the trauma response to life course trauma. As evidenced in studies with descendants of the Jewish holocaust, the sensitisation of the stress response is mainly due to HPA axis dysfunction and disruption within the limbic system and frontal cortex. Sensitivity of an individual’s stress response may also be due to learnt poor coping strategies and individual appraisal of the stressor (Bombay et al., 2014).

Theme Two: Linking Historical Events to Contemporary Health

The presentation of trauma associated symptoms in Indigenous populations is a topic of ongoing debate within the literature, particularly whether the presentation of trauma symptoms is a manifestation of proximal or distal stressors (Walters et al., 2011). Research demonstrates that Indigenous peoples are more likely than the non-Indigenous populations to report a higher incidence of traumatic or adverse even(s) and circumstances throughout their lifetime (Brown-

Rice, 2013; Gone, 2013). Considering Indigenous people are often living in areas of high socio-economic deprivation, exposed to and disadvantaged by institutional, interpersonal, and internalised racism, it is understandable that there would be higher prevalence of social and health distress (Bryers-Brown, 2015). Therefore, there is a need to determine whether contemporary distress evident in Indigenous communities is linked to historical or life course trauma (Whitbeck et al., 2004). Moreover, there is a need to establish how historical trauma interacts with the daily functioning of those who experience it and how it interacts with life-course trauma. It has been argued that there is a need for research to establish how historical trauma is functioning within Indigenous communities, particularly before Historical Trauma Theory is used as a framework for clinical practice with Indigenous people experiencing historical trauma (Gone, 2013; Hartmann & Gone, 2014; Lawson-Te Aho, 2014).

Existing Historical Trauma Theory research reveals that historical losses are associated with perceived emotional symptoms, such as sadness and guilt, and risky health behaviours like alcohol use and cigarette smoking in Indigenous communities (Braveheart, 2003; Whitbeck et al., 2004). Quantitative measures of perceived historical loss and perceived associated symptoms, developed by Whitbeck et al. (2004), demonstrated participants who did not directly experience the processes of colonisation, such as the residential boarding schools or forced sterilisation, are still very connected to the historical losses endured by their ancestors, which is a concept that has been shown by various other studies (Braveheart, 2000; Bryers-Brown, 2015; Swanson Nicolai & Saus, 2013). Furthermore, thoughts of historical losses are associated with feelings of depression, anxiety, guilt, numbness, anger and avoidance, and behaviours such as alcohol use and cigarette use (Braveheart, 2003). Moreover, McQuaid et al. (2017) found that First Nation participants who did not directly attend a residential boarding school but had a parent or grandparent attend were significantly more likely to attempt suicide over the course of their life time compared to those who did not have a relative attend one. Furthermore, Whitbeck et al. (2004) found an increase in the intensity of feelings were reported when the frequency of the thoughts of historical losses were increased.

Although there is research that links historical loss and the associated distress by a quantitative measure, qualitative research, specifically historical trauma narratives, can support Historical Trauma Theory (Lawson-Te Aho, 2014; Mohatt et al., 2014). Narratives are recounts of experiences and collective memories of a community told through a relevant cultural and social lens (Lawson-Te Aho, 2014). Historical trauma narratives validate, reinforce, or modify individual understandings of collective experiences, and can provide insights into the manifestation of historical trauma in contemporary Indigenous communities, such as intergenerational breakdowns in familial interactions (Lawson-Te Aho, 2014; Mohatt et al., 2014). Historical trauma narratives could support Historical Trauma Theory because narratives are what trauma studies

have been constructed upon; for example, individual testimonies of traumatic experiences have been used to build trauma theory.

Theme Four: Healing from Historical Trauma

Historical Trauma Theory can be interpreted differently depending on the cultural context of the person engaging with the content (Evans-Campbell, 2008). Healing from historical trauma and what is required for healing may also be culturally grounded (Baker, 2018; Gone, 2013; Wirihana & Smith, 2014). For example, Wirihana and Smith (2014) stated Māori healing is based on a Māori view of wellbeing, which is linked to the whenua and connection to Tupuna. Gone (2013) asserted that western evidence-based treatment and interventions need to be culturally appropriate, such as in healing from the historical trauma associated with the residential boarding school experience, which was manifested in survivors as substance abuse. Moreover, Gone's (2013) and Baker's (2018) research highlighted the need to re-learn and reclaim Indigenous culture as essential to healing from historical trauma, such as reconnection to whenua and te reo Māori. Research demonstrated that facilitating an attachment to traditional cultural values and beliefs, such as in parenting and spirituality, was a protective factor against substance abuse now and in subsequent generations (Braveheart, 2003; Hartmann & Gone, 2014). For example, an American Indian medicine man talked about how participation in a traditional Sun Dance ceremony helped participants heal from historical trauma so that the participants gave up alcohol and drug use. Subsequently, the next generation did not use alcohol or drugs (Hartmann & Gone, 2014).

Having the opportunity to revisit trauma histories in a culturally safe space could support healing from historical trauma (Braveheart, 2003; Charbonneau-Dahlen et al., 2016; Lawson-Te Aho, 2014). Research has shown that individuals may describe feelings of both loss and resilience and survival in response to the profound adversity associated with historical losses experienced trauma narratives can be reframed to be narratives of hope and survivance to support healing from historical trauma by communities (Lawson-Te Aho, 2014; Mohatt et al., 2014). Healing potential from pain is demonstrated in the following response given by one of the participants ".....I am older, wiser and can see mamae for what it is... it is an opportunity for recover, to rebuild, reclaim and heal ourselves" (Lawson-Te Aho, 2014, p. 200). Importantly, Indigenous people need to be able to re-define their experiences and themselves as an Indigenous person within the settler state to heal from historical trauma (Gone, 2013; Lawson-Te Aho, 2014).

Theme Five: Historical Trauma and Health Care Practice

The application of Historical Trauma Theory to clinical health practice remains a contentious issue (Maxwell, 2014). Since its development 20 years ago, Historical Trauma Theory has become an accepted theoretical framework for examining the effects of colonisation within Indigenous

populations (Maxwell, 2014). Some authors argued that the psycho-analytical foundation of Historical Trauma Theory focusses on individual trauma expression from a psychological perspective that is at odds with an Indigenous worldview (Reid et al., 2014; Struthers & Lowe, 2003). Focussing on the psychological impact on individuals poses a risk that another *syndrome* has been developed to describe the societal distress evident in Indigenous populations internationally (Struthers & Lowe, 2003). Maxwell (2014) argued that Historical Trauma Theory not only pathologises Indigenous social practices such as parenting, but also assumes universal experiences of colonisation. Therefore, pathologising individual distress has the potential to perpetuate dominant health discourse in which Indigenous people are inferior and Indigenous distress is attributed to individuals' and communities' social and biological-based weaknesses, taking the spotlight off the role of the dominant society (Maxwell, 2014; Reid et al., 2014; Struthers & Lowe, 2003). Moreover, Maxwell (2014) argued pathologising Indigenous social issues by a western based trauma theory permits further intrusion on Indigenous communities by colonial ideological health practice. Therefore, centralising an Indigenous worldview when applying Historical Trauma Theory is essential to keep Indigenous aspirations the priority of clinical practice. Moreover, Nutton and Fast (2015) identify cultural reconnection and identity by applying culturally adapted interventions as essential for Indigenous people. As identified in the previous sections, Historical Trauma Theory centralises many aspects of an Indigenous worldview, including affinity with one's ancestors and past and present connections.

The application of Historical Trauma Theory to clinical practice depends on the objective of amelioration from historical trauma (Hartmann & Gone, 2014; Struthers & Lowe, 2003). Hartman and Gone (2014) identified the use of Historical Trauma Theory as a therapeutic discourse that encompasses a clinical diagnosis of trauma, but argued that the healing needs to come from within the cultural context of the person with Historical Trauma. When utilising Historical Trauma Theory, from this angle, the authors concluded that historical trauma discourse could support cultural revitalisation as a mode of healing. However, the individual diagnosis of historical trauma could potentially lead to it becoming the 'problem' of the individual as opposed to examining the ongoing environmental (political, social, historical) issues that allow historical trauma to flourish (Hartmann & Gone, 2014; Maxwell, 2014). Hartmann and Gone added that a diagnosis of historical trauma could lead to colonisation being viewed as a set of events within a certain time frame rather than an ongoing process still evident in contemporary society (Maxwell, 2014). Therefore, Hartmann and Gone identified a 'Nation Building' discourse which supports a community-led re-building of Indigenous communities, whilst challenging political disempowerment and oppression. However, these authors argued that the trauma discourse places the individual as a "patient" whereas the nation-building discourse places the individual as an "agent" of social and political change.

The incorporation of Historical Trauma Theory into clinical health practice could be essential for the improvement of Indigenous health inequities because western based health practice does not understand historical trauma response experienced by Indigenous people (Anderson et al., 2017; Durie, 2001; Struthers & Lowe, 2003). However, there is a lack of literature surrounding the application of Historical Trauma Theory to clinical practice. Swanson Nicolai and Saus' (2013) research demonstrated that practitioners who are already engaging with Historical Trauma Theory in their clinical practice state that they implement it as a framework for understanding the unique constructs of Indigenous child trauma, including the connection between the past and the present and future. Also, the Historical Trauma Theory framework was accessed for treatment, specifically identifying positive and supportive aspects of family and community values that fostered resilience through profound adversity, including historical trauma (Swanson Nicolai & Saus, 2013).

The importance of establishing an authentic relationship between the practitioner and client is highlighted as an essential component when working with Indigenous clients with historical trauma. Building the practitioner-client relationship, within the context of historical trauma, requires the practitioner demonstrate respect and empathy for the history of Indigenous people and the contemporary adversity that Indigenous people endure (Brown-Rice, 2013; Palacios & Portillo, 2009; Struthers & Lowe, 2003). From within a counsellor-client context, Brown-Rice (2013) added the acknowledgement of historical trauma and current adversity is essential if the counsellor is from the dominant population. Secondly, Indigenous mental health practitioners advocate for the integration of tribal histories into practice, such as during clinical assessments, to provide effective care to Indigenous populations (Struthers & Lowe, 2003). Struthers and Lowe (2003) suggested that nurses can assess their clients for historical trauma by enquiring about clients' tribal histories and past events that affect them in the present. Struthers and Lowe further identified the utilisation of a culturally appropriate and meaningful nursing model, such as their Nursing in the Native American Culture (NINAC) model, when assessing for historical trauma when working with American Indian clients. Using an appropriate model of care will ensure that clients are assessed from a culturally appropriate position. For example, Nutton and Fast (2015) highlighted that interventions for substance abuse in Native American communities were most successful when they incorporated Native American values and beliefs. Similarly, Brown-Rice argued that Indigenous clients need to be assessed within a collective context, validating the importance of tribal trauma histories.

In summary, Indigenous understandings of Historical Trauma Theory concepts, including how historical trauma is functioning within Indigenous communities, is essential if historical trauma theory is going to be applied to clinical practice. Although some interpretations lean toward aspects of the psychological focus of Historical Trauma Theory, most interpretations from

Indigenous people encapsulate ongoing socio-cultural oppression as the detrimental factor influencing Indigenous wellbeing. This chapter provides insights into the importance of understanding Indigenous interpretations of historical trauma so that the theory can be applied appropriately to clinical practice. Furthermore, the findings suggest that Historical Trauma Theory can provide sound insights into understanding the pathways of intergenerational trauma transmission, which has potential benefits for Indigenous health outcomes. However, further research that demonstrates how historical trauma contributes to poor health outcomes in Māori is suggested.

Chapter 5: Implications for Nursing in Aotearoa

This discussion chapter is divided into sections that demonstrate how Historical Trauma Theory could support nursing knowledge and practice when nursing Māori whānau. The main implications for nurses who are working with Māori whānau are understanding the ongoing effects of colonisation on various social and health outcomes, the importance of culturally grounded health care practice including nursing practice, whanaungatanga, cultural connectedness, and Tino Rangatiratanga

There is limited literature about Historical Trauma Theory and nursing practice. Literature about nursing and Historical Trauma Theory is from the North American context (Struthers & Lowe, 2003, Lowe, 2007). Indeed, Historical Trauma Theory and nursing practice in Aotearoa New Zealand has not been discussed in any literature. Therefore, this discussion chapter demonstrates how Historical Trauma Theory aligns with and supports an existing Māori-centred model of nursing, Wilson and Barton's (2008) *Te Kapunga Putohe*, which all nurses can implement when working with Māori whānau. The chapter provides arguments in support of Historical Trauma Theory as a framework for deepening nurses' understandings of how colonisation impacts Māori health today. The research findings of the literature review have been interwoven with Wilson and Barton's (2008) *Te Kapunga Putohe* to formulate a discussion on how Historical Trauma Theory can situate contemporary Māori health within an appropriate historical and cultural context and support all nurses to provide sound care to Māori whānau.

The Ongoing Effects of Colonisation on Māori Health and Wellbeing

The overarching argument underpinning this discussion chapter is that Māori wellbeing, including current health disparities, needs to be appropriately socially and historically contextualised; namely, in the experience of colonisation. Currently, dominant health discourse portrays a negatively biased perception of Māori health, particularly the normalisation of Māori health disparities; the attribution of poor health to Māori deficits, such as low education attainment and genetic endowment; and the examination of Māori health within the contemporary context only—all through a western lens (Barton, 2018). However, the colonisation of Aotearoa, and subsequent ongoing colonialism, including racism and profound socio-economic disadvantage, is the defining difference between Māori and Pākehā health outcomes. Historical Trauma Theory could provide a framework for nurses to understand how historical events are manifested in contemporary Māori health outcomes (Baker, 2018; Bryers-Brown, 2015; Harris et al., 2012; Lawson-Te Aho, 2014; Pihama et al., 2017). The historical trauma theory literature also examines

and challenges the inherent social injustices which plague Indigenous communities, sustaining health and social disparities in Indigenous communities. However, as identified by Pihama et al. (2014), further research that contextualises Historical Trauma Theory in Aotearoa is required to provide insights into how Historical Trauma Theory could underpin nursing clinical practice with Māori whānau.

Historical Trauma Theory could deepen nurses' understanding of the impact of colonisation on Māori health and wellbeing, which is manifested in Māori health disparities. Historical Trauma Theory identifies historical trauma as the root of Indigenous social and health disparities (Braveheart, 2000; Struthers & Lowe, 2003), and counteracts the dominant discourse surrounding Indigenous health, including the misconception of colonisation being 'all in the past' which contributes to Indigenous people being blamed for health disparities (Braveheart, 2000; Sotero, 2006). Historical Trauma Theory centres an Indigenous worldview where the connection between the past and the present is paramount, including one's innate connection to ancestors. Importantly, research shows that Indigenous people are connected to the historical trauma of colonisation experienced by their ancestors and that the trauma is alive and felt intergenerationally—it is not in the past. As identified by research with Indigenous people, historical trauma is manifested in a variety of social issues and dis-ease, such as violence, substance abuse, depression and/or anxiety and chronic illnesses such as diabetes (Baker, 2018; Braveheart, 2003; Hale, 2012; Whitbeck et al., 2004).

The intergenerational transmission of historical trauma has pathways in virtually every aspect of society, including socio-cultural pathways related to Indigenous spirituality, such as the attachment of historical trauma to whakapapa (Baker, 2018; Bryers-Brown, 2015; Gone, 2013). Socio-political constructs in society keep the pathways of historical trauma transmission open, such as internal displacement of Māori within their own iwi boundaries, institutional racism, and reminders of historical losses such as profound poverty (Bryers-Brown, 2015). Historical Trauma Theory conceptualises the intergenerational transmission of historical trauma through multi-generations that manifests in various social and health disparities for Indigenous people. Therefore, the array of pathways of intergenerational historical trauma transmission is important for nurses to know as historical trauma manifests in various social and health outcomes in which Māori are overrepresented, such as diabetes, cardiovascular disease, and mental illness. Moreover, Braveheart (2000) argued that understanding the pathways of historical trauma transmission provides an opportunity to disrupt its transmission to subsequent generations, supporting the incorporation of Historical Trauma Theory into nursing knowledge and practice when working within a Māori context.

Historical Trauma Theory literature also highlights the importance of understanding the historical trauma of colonisation through an Indigenous lens (Gone, 2013). Understanding

historical trauma through an Indigenous lens is essential for the development as a therapeutic discourse; including in the application to health care practice, such as nursing (Gone, 2013; Struthers & Lowe, 2003). Indigenous experiences of historical trauma may not fit into western frameworks of trauma, which is a pertinent concept when providing trauma-informed nursing care (Braveheart, 2000; Durie, 2001; Pihama et al., 2017). Interpretations and experiences of history are likely to vary between different Indigenous communities, so a one-size-fits-all framework for applying Historical Trauma Theory to practice may be problematic (Bryers-Brown, 2015; Gone, 2013; Hartmann & Gone, 2014; Swanson Nicolai & Saus, 2013). Although there is a generalised array of historical trauma symptoms proposed by Braveheart (2000), the historical trauma response is likely unique to the specific community affected. Literature argues that historical trauma is experienced within a socio-cultural context, including emotions and cognitive processes, and may have a spiritual context for Indigenous people, such as being described as a 'Soul Wound' and 'Soul Pain' by Indigenous research participants (Baker, 2018; Bryers-Brown, 2015; Gone, 2013). Therefore, nursing practice that is fundamentally embedded within a western worldview is most likely inappropriate in caring for clients with historical trauma. Effective nursing care of Māori whānau needs to incorporate a Māori worldview and culturally grounded interpretations of the historical trauma of colonisation so that nursing practice is relevant for Māori.

Culturally Grounded Health Care Practice

Historical Trauma Theory highlights the importance of incorporating culturally grounded health care practice when working with Indigenous people, which could also be true for nursing Māori whānau (Braveheart, 2000; Gone, 2013; Struthers & Lowe, 2003). Health care practice is embedded within the worldview of the health discipline, institution, and the health care professional (Brown-Rice, 2013; Gone, 2013). Although that is not a new concept, the depth to which Indigenous and western worldviews collide is vast, including understanding the health and social consequences of colonisation for Indigenous people (Braveheart, 2003; Salmond, 2017). Historical Trauma Theory acknowledges that Indigenous worldviews still exist and are independent of the dominant western worldview (Braveheart, 2000; Smith, 2012). Historical Trauma Theory literature identified the application of an Indigenous worldview to health care practice as essential when working with Indigenous clients (Brown-Rice, 2013; Struthers & Lowe, 2003; Wilson & Barton, 2008). Therefore, the application of Māori models of nursing by all nurses to practice when working within a Māori context is supported by the Historical Trauma Theory literature.

In the context of Aotearoa, te ao Māori survived colonisation and still exists as a legitimate reality for Māori (Wilson & Barton, 2008). Māori realities, including understandings of

health and the whakapapa of disease are essential to the redress of health disparities (Lawson-Te Aho, 2014). In te ao Māori, illness cannot be viewed in isolation from the other dimensions of wellbeing (Lyford & Cook, 2005). Therefore, Historical Trauma Theory not only contextualises Māori health appropriately, but also supports the implementation of culturally appropriate nursing interventions for Māori whānau to support the amelioration of historical trauma for the improvement of Māori health outcomes (Braveheart, 2003; Gone, 2013).

Using an appropriate model of care when working with Indigenous clients, such as Māori whānau, ensures that the application of Historical Trauma Theory as a framework underpinning nursing practice is done so from a culturally appropriate position (Brown-Rice, 2013; Struthers & Lowe, 2003). Struthers and Lowe (2003) argued that the incorporation of Historical Trauma Theory into nursing practice is essential for the improvement of American Indian health inequities; as western based psychology and psychiatry cannot fully understand the historical trauma response in response to colonisation, a concept that resonates with Indigenous literature from Aotearoa (Anderson et al., 2017; Barton, 2018; Durie, 2001; Wepa, 2016; Wilson & Barton, 2008). Therefore, Kaupapa Māori nursing models should be the foundation of nursing practice for all nurses working with Māori whānau. Aligning with Struthers and Lowe's argument, once an appropriate model of care is embedded in nursing practice with Māori, Historical Trauma Theory could also be incorporated into care.

Māori nursing models exist but do not include Historical Trauma Theory as a framework for conceptualising colonisation and Māori health in a contemporary context. Māori models of nursing provide a culturally grounded and culturally safe framework for all nurses clinical practice in a Māori context. A nursing model that centralises whānau, acknowledging the individual as an integral part of the collective, is essential to providing effective nursing care to whānau (Mahoney-Moni, 2006; Wilson & Barton, 2008). Wilson and Barton's (2008) Te Kapunga Putohe, Māori-centred nursing model, for both Māori and non-Māori nurses, has been utilized as the foundation for understanding the key Māori values that should underpin nursing practice when caring for Māori whānau. In doing so, the themes discussed in chapter 4 have been discussed in relation to Wilson and Barton's (2008) Te Kapunga Putohe to highlight and discuss how Historical Trauma Theory can inform nursing practice when caring for Māori whānau. Furthermore, professional standards for nursing practice in Aotearoa have been outlined as per the Nursing Council's (2009) Code of Conduct.

Wilson and Barton's (2008) kaupapa Māori nursing model outlined the following core Māori values that are essential to nursing within a Māori context:

- Nursing tikanga – legislative and practice standards for nursing in Aotearoa New Zealand, including Ramsden's (1991) Kawa Whakaruruhau (Cultural Safety in a Māori context)

- Pono – trustworthiness, genuine, authenticity, loyalty
- Aroha – compassion, empathy, kindness
- Manaakitanga – accommodating, hospitable, supportive and flexibility
- Tiakitanga – advocacy, overseeing, navigating the whānau through the health care system
- oranga – a state of wellbeing, balance, holism
- Whānaungatanga – establishing relationships through whakapapa and kaupapa, building partnerships
- Tikanga Māori – the ‘right way’, cultural practices foundational to te ao Māori
- Mana tangata – protecting and upholding mana of an individual and whānau
- Wairuatanga – ones’ spiritual connection between the collective, spiritual realm and environment

Whānaungatanga

As highlighted in the research findings, the Historical Trauma Theory literature identified building an authentic practitioner-client relationship in health care is essential to providing therapeutic care to Indigenous clients with historical trauma (Brown-Rice, 2013; Struthers & Lowe, 2003). The concept of building authentic nurse-client relationships to support healing from historical trauma aligns with core Māori concepts that are identified by Māori nurses as crucial to nursing Māori whānau (Lyford & Cook, 2005; Maloney-Moni, 2006; Wilson & Barton, 2008).

Whānaungatanga is fundamental to Māori wellbeing, including accessing and utilising health care services (Anderson et al., 2017; Mahoney-Moni, 2006; Slater et al., 2013). Whānaungatanga is also essential to the nursing process within a Māori context and it is imperative that the nurse dedicate time to the process. Whānaungatanga is the process of building relationships between parties based on whakapapa (genealogy) and kaupapa (agenda) (Lyford & Cook, 2005). Historical Trauma Theory literature suggests the health practitioner acknowledge the historical trauma of colonisation and contemporary adversities that Indigenous people live with, including the impact on Indigenous health (whakapapa). As well as centralising concepts of health, including the collective or whānau health aspirations, from an Indigenous viewpoint as the objective in health care practice (kaupapa) (Brown-Rice, 2013; Struthers & Lowe, 2003). In a Māori context, the importance of the nurse-whānau relationship is based on that premise that when sharing in the whānau experience of health and illness, nurses essentially become whānaunga (Lyford & Cook, 2005).

As identified in Wilson and Barton’s (2008) *Te Kapunga Putohe*, in te ao Māori relationships are built for the long term and flourish on reciprocal aroha (care, love, affection), pono (peace) and manaakitanga (hospitality, flexibility), and the demonstration of respect for te ao Māori as a legitimate reality (Durie, 2001; Salmond, 2017). Furthermore, aligning with the Nursing Council’s (2011) guidelines, it is essential that the diversity of Māori is recognised by the

nurse and practice should be tailored to the needs of the whānau, hapū, and iwi. However, understanding and working effectively with the diversity of contemporary Māori can only be achieved with an authentic commitment to building the nurse-whānau relationship through whānaungatanga (Lyford & Cook, 2005). Whānaungatanga relies on kanohi kitea (the seen face) and kanohi-ki-te-kanohi (face to face) interactions when possible (Maloney-Moni, 2006). Therefore, the research findings could be interpreted to suggest that nurses caring for Māori whānau need to understand ~~the process of~~ whānaungatanga and incorporate this process into nursing practice to create a supportive nurse-client relationship for healing from Historical Trauma.

Cultural Connectedness

The Historical Trauma Theory literature supports the need for health care practice to incorporate cultural and spiritual dimensions of health and wellbeing when working with Indigenous people, which is also true for nursing practice (Braveheart, 2000). Specifically, assimilation and the suppression of Indigenous spirituality and cultural practices by the colonial state are at the core of intergenerational unresolved grief (Braveheart, 2000). Therefore, cultural connectedness is identified as being supportive of healing from historical trauma, and is also identified as protective of health (Baker, 2018; Braveheart, 2003; Hartmann & Gone, 2014). Facilitating cultural connectedness through embedding native cultural values in health care interventions may prevent the transmission of historical trauma to subsequent generations (Braveheart, 2000; Gone, 2013). For example, Braveheart (2003) identified the prevention of the transmission of historical trauma in the Lakota people was built upon cultural reconnection to traditional values and practices, such as parental roles and views of children as sacred. In a Māori context, the implementation of tikanga Māori into practice and care is highlighted by Wilson and Barton (2008) as essential to culturally safe nursing care and has also been identified by Māori research participants as being essential to healing from health complications (Baker, 2018; Lyford & Cook, 2014). Tikanga Māori are the values and customs of te ao Māori and translate into ‘the right way’. Regarding the importance of tikanga Māori and Kawa Whakaruruhau in Māori health care, Edwards (2017 as cited in Protecting Kawa Whakaruruhau, 2017), former Māori advisor to the NZNC, asked “How can we be any safer than in our own tikanga?” (Protecting Kawa Whakaruruhau, 2017).

As identified by Wilson and Barton (2008) and throughout the Historical Trauma literature, culturally safe nursing practice that is protective of wairuatanga is essential to Māori wellbeing and healing from historical trauma (Baker, 2018; Braveheart, 2003; Gone, 2013; Mahoney-Moni, 2006). Historical Trauma Theory literature identifies trauma interpretations, including the transmission of trauma, through an Indigenous worldview as interlinked with

spirituality (Gone, 2013). The concept of wairuatanga denotes one's mauri (life force) and wairua (spirit, soul) including ones' connection to the past, the present and all living things (including the environment). One's wairua is intrinsically linked with mana and whakapapa and can be described as human dignity and sacredness. Maloney-Moni (2006) identified wairua as the key dimension in healing from dis-ease. She added that when nurses protect and support wairua, whānau can manage their physical dis-ease and without the nourishment of wairua the disease can be overwhelming (Maloney-Moni, 2006). For example, a research participant from Bryers-Brown (2015) stated "my elders always taught me, spiritual things first and foremost; physical things will naturally follow..." (p. 62). To conclude, the research findings suggest that indigenous cultural values and customs need to be incorporated into clinical health practice to support indigenous health and wellbeing and possibly support healing from historical trauma. Therefore, to be protective of Māori health, nurses caring for Māori whānau need to understand historical trauma, Māori values and a Māori worldview, as well as practising in a culturally safe manner that is protective of Wairuatanga.

Tino Rangatiratanga

Indigenous self-determination appears to be the overarching desire of Indigenous peoples struggles (Wirihana & Smith, 2014). Within a Māori context, Tino rangatiratanga can be loosely translated to sovereignty and self-determination. As guaranteed in Te Titiri o Waitangi, Māori sovereignty and self-determination would remain over whenua, pā, and taonga. Māori wellbeing is taonga which can be passed on to future generations of Māori. Furthermore, tino rangatiratanga is foundational to the concept of mauriora which sustains the mauri (life force) of the collective, which is essential to building healthy futures for mokopuna (Durie, 2001).

As identified in the findings of this literature review, indigenous people have culturally grounded interpretations of their experiences of colonisation and healing from historical trauma needs to also be culturally grounded (Gone, 2013). Therefore, Indigenous self-determination over the experience of colonisation, healing from historical trauma and health aspirations is critical to improving indigenous health outcomes. Within a Māori health context, the Historical Trauma Theory literature supports the importance of tino rangatiratanga in health care practice. For nurses to practice in a way that promotes tino rangatiratanga, nurses need to centralise whānau and their wellbeing aspirations. The implementation of a culturally grounded and a safe model of care is identified in the findings as important for indigenous health outcomes and healing from historical trauma (Brown-Rice, 2013, Braveheart, 2000; Gone, 2013). Supporting the importance of tino rangatiratanga, Historical Trauma Theory conceptualises colonisation as a process of subjugation of one population by a dominating population for power and personal gain (Braveheart, 2000). As a result, Indigenous distress associated with colonisation includes feelings

of hopelessness, loss of control, resentment, and fear (Braveheart, 2000). Tino rangatiratanga re-establishes Māori as the drivers of their own destinies, including health, acknowledging that te ao Māori exists and needs space to thrive. Although new to literature in Aotearoa, Historical Trauma Theory provides a framework conceptualising the profound effects of colonisation on Indigenous people, including the embodiment of historical trauma as manifested in health disparities. As agents of social justice, nurses can uncover the power imbalances cemented in Aotearoa, advocating for Māori as experts of their health, wellbeing, and healing from the colonial histories of whānau/hapū/iwi (Nursing Council, 2011).

Chapter 6: Conclusion and Recommendations

This integrative literature review sought out literature relevant and applicable to Historical Trauma Theory and nursing in Aotearoa to answer the research question: *How can Historical Trauma Theory inform nursing practice in Aotearoa?* Due to the lack of literature from the field of nursing, literature pertaining to health care outcomes and health care practice was included in the search. Moreover, comparable Indigenous histories, such as North America, were included to widen the search. Kaupapa Māori Theory was the philosophical foundation applied to interpreting the research findings, especially when formulating a discussion for the implications of Historical Trauma Theory for all nurses when caring for Māori whānau. A Māori-centred nursing model, Wilson and Barton's (2008) Te Kapunga Putohe, was drawn upon to provide the foundation for understanding what Māori values are required by nurses to provide effective care when caring for Māori whānau. Additionally, a decolonising approach was used as a methodological approach as it aligns with Kaupapa Māori Theory and Historical Trauma Theory, both of which centralise Indigenous worldviews, wellbeing, and challenge dominant discourse surrounding Indigenous experiences of colonisation. The methods used in this review were based on Whitemore and Knalf's (2005) framework for undertaking an Integrative literature review. Their framework was developed for nursing research with the objective of providing robust methods for producing a rigorous synthesis of a comprehensive range of literature available on the topic of interest.

To summarise, the research findings highlight Historical Trauma Theory as a framework that encapsulates the collective experience (pain, soul wound, soul pain) of colonisation over multi-generations of Indigenous communities. Although there is scholarly debate regarding Historical Trauma Theory's contribution to the pathologisation of Indigenous communities' social struggles, the intention of Historical Trauma Theory was to validate the devastation of colonisation for Indigenous communities, through an Indigenous worldview (Braveheart, 2000). The historical trauma response has features of psychological trauma, and encompasses features that are unique to Indigenous people, such as the interconnection between past and present and one's ancestors. Furthermore, the western definition of trauma may not encapsulate the Indigenous experience of historical trauma, and the experience of historical trauma is most likely reflective of an Indigenous worldview. The manifestation of historical trauma, including the transmission over multi-generations of Indigenous people, has various biological, psychological, emotional, spiritual, and social avenues (e.g., violence, substance abuse, social difficulties, such as parenting, and suicide/suicidal ideation). Colonisation is the most significant variable when examining the gaps between Indigenous and non-Indigenous health disparities (Lowe, 2007).

Furthermore, historical trauma is sustained by the socio-political conditions that allow it to proliferate in Indigenous communities, such as social marginalisation, profound poverty, systemic racism, and cultural disconnection.

As the largest body of frontline health workers in Aotearoa, nursing as a professional body is in a unique position to make a difference to Māori health. Moreover, the Nursing Council's (2012) professional code of conduct and professional competencies for practice standards stipulate that culturally competent and culturally safe care for Māori is expected from registered nurses. Colonisation is a unique experience to Māori, and Māori health needs to be understood in the appropriate social and historical contexts. Therefore, Historical Trauma Theory has the potential to contribute to nursing knowledge and practice when nursing Māori whānau.

Firstly, the profession of nursing in Aotearoa could explore Māori wellbeing and health within the context of colonisation using Historical Trauma Theory as the conceptual framework for understanding how historical events can affect contemporary health (Lawson-Te Aho, 2014; Pihama et al., 2014). Specifically, Historical Trauma Theory could contribute to nursing knowledge in Aotearoa by providing a framework with the various social and physical pathways that link historical losses to major diseases in which Māori are overrepresented, such as diabetes and cardiovascular disease. However, due to the lack of Historical Trauma Theory literature from within Aotearoa, further research that contextualises Historical Trauma Theory in Aotearoa is suggested (Lawson-Te Aho, 2014; Pihama et al., 2014).

From a practice point of view, the application of Historical Trauma Theory to nursing practice supports the application of a culturally appropriate model of care, including culturally grounded interventions, when working with Indigenous people. As argued by Struthers and Lowe (2003), the effective application of Historical Trauma Theory to nursing practice, including assessing for Historical Trauma in clients, is only feasible if the nurse is using an appropriate nursing model to care for indigenous clients. Therefore, it is recommended that the implementation of a Māori model of nursing, such as Wilson and Barton's (2008) Te Kapunga Putohe, should be the foundation of all nursing practice when caring for Māori whānau. Te Kapunga Putohe incorporates the core Māori values which are foundational to te ao Māori, including the New Zealand professional standards for Registered Nurses such as Ramsden's (1991) Kawa Whakaruruhau. Thus, Historical Trauma Theory can be drawn upon as a framework for contextualising Māori health in an appropriate historical context and, potentially, to underpin clinical interventions with Māori whānau once Māori nursing models, such as Te Kapunga Putohe, are authentically implemented into nursing clinical practice with Māori.

It is recommended that nurses in Aotearoa New Zealand have a solid understanding of, including the ability to demonstrate in clinical practice, whānaungatanga, cultural connectedness and tino rangatiratanga when nursing Māori whānau. Firstly, nursing practice underpinned by

Historical Trauma Theory would prioritise whānaungatanga (the authentic relationship between practitioner and whānau). As highlighted in the discussion chapter, within the context of historical trauma, it is recommended that the health practitioner acknowledge and demonstrate understanding of the historical and contemporary injustices endured by Indigenous people (including the major impact on health) in order to build the practitioner-client relationship. Secondly, the concept of cultural connectedness is highlighted as protective of health, as well as foundational to healing from historical trauma. By implementing a Māori model of nursing the nurse acknowledges that an Indigenous reality exists and is the most appropriate worldview for the client or whānau and, also adheres to core values in te ao Māori such as tikanga Māori and whānaungatanga that is protective of wairuatanga. Thus, hopefully, providing a culturally safe and culturally connected space for Māori whānau. Lastly, it is recommended that nurses demonstrate an understanding and commitment to the concept of tino rangatiratanga when nursing Māori whānau. Historical trauma is associated with feelings of profound grief and hopelessness which supports the need for nursing practice that is whānau centred, focussed on whānau health aspirations, and is protective of wairua (the key to Māori healing and wellbeing from disease) when working with Māori whānau.

Limitations

The limitations of this integrative literature review include the lack of literature from the field of nursing and Aotearoa New Zealand and the lack of conceptual clarity of Historical Trauma Theory, namely the argument that Historical Trauma Theory is westernised in its concepts so may be inappropriate as a framework for indigenous health and social contexts (Maxwell, 2017). The lack of Historical Trauma Theory literature in a Nursing and Aotearoa New Zealand context limited arguments for the practical application of Historical Trauma Theory to clinical nursing practice in Aotearoa New Zealand currently. Given the lack of contextualisation of Historical Trauma Theory within Aotearoa New Zealand, there are definite limits to utilising the theory exclusively for nursing theory and practice in Aotearoa New Zealand. Therefore, without further research contextualising Historical Trauma Theory within a Māori context, the application to nursing knowledge and practice is limited to the possibilities of using Historical Trauma Theory in a supportive capacity to existing Kaupapa Māori model of nursing frameworks. This led to the conclusion that Historical Trauma Theory can be utilised mainly in a theoretical capacity as a framework for understanding the profound effects of colonisation on indigenous health and social outcomes, generations after colonisation began. Nevertheless, in conjunction with Te Kapunga Putohe, which includes legislative and ethical practice standards for registered nurses in Aotearoa New Zealand, the findings of this research demonstrate that Historical Trauma Theory

could be a core theory for understanding colonisation and Māori health and underpinning clinical nursing practice however, further research on the topic is required.

To summarise, despite the long-term prioritisation of Māori health by the Aotearoa New Zealand Government and the array of research showing that Māori experience substandard health care, Māori health disparities persist which evidences a need for practice evaluation and change (Anderson et al., 2017; Wepa, 2016; Wilson & Barton, 2008). Aligning with a Māori reality which connects one's wellbeing to the wellbeing of the surrounding environment, health disparities endured by Indigenous people are manifestations of the embodiment of centuries of displacement, oppression, marginalisation and social exclusion. Historical Trauma Theory can provide the theoretical framework for nurses to understand colonisation fully, including long term health disparities. Moreover, Historical Trauma Theory supports the critical need for culturally safe nursing practice when caring for Māori whānau.

The Historical Trauma Theory literature acknowledges that historical trauma is not just in the past, but the genesis of the ongoing socio-political challenges which sustain Māori health disparities, such as poverty and racism. However, there is a need for culturally appropriate research that contextualises Historical Trauma Theory within Aotearoa, including the diversity of Indigenous communities such as within iwi and hapū. As identified by Lawson-Te Aho (2014), iwi histories are unique, including specific events of colonisation; therefore, Historical Trauma Theory could be applied as a framework for understanding trauma trajectories. Further, Historical Trauma Theory aligns well with Kaupapa Māori Theory so has the potential to contribute and support Māori health research and practice models/frameworks (Pihama et al., 2014). To conclude, the historical trauma response has permeated into every level of Indigenous society so health care research and practice must challenge and rectify the various societal constructs that provide an environment for sustained Indigenous health disparities to flourish (Lowe, 2007).

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