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Investigating Māori approaches to trauma informed care

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Abstract

This article gives an overview of a three-year Health Research Council funded research project "He Oranga Ngākau: Māori approaches to trauma-informed care". The study is informed by Kaupapa Māori which provides both the theoretical and methodological foundation for understanding the world, exploring and conceptualising issues. The need for contextualised and culturally safe health and social services is well recognised within Aotearoa and particularly within Mental Health and Addiction Services. While trauma is an experience that can impact on all people, Māori experience trauma in distinct ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health. Given that Māori are impacted by trauma in specific ways, it is important to explore and identify practice principles that contribute to the development of a framework that supports Māori Providers, counsellors, clinicians and healers in working with Māori.

Te Rangahau: Research Overview and Design

"He Oranga Ngākau: Māori approaches to trauma-informed care" is a three-year research

project established to support Māori Providers, counsellors, clinicians and healers explore the notion of Trauma Informed Care, and developing with them a framework that will provide practice principles when working with whānau Māori. It has been noted by Māori Providers that there is an increased use of Trauma Informed Care in Aotearoa with little or no recognition of the need for cultural approaches within such constructs. Presentations by Indigenous researchers, scholars and Indigenous behavioural health experts have for some time drawn attention to the fact that such approaches fail, on the whole, to provide for Indigenous experiences of collective trauma, such as historical and intergenerational trauma (Duran, 2012; Duran & Duran, 1995; Walters, Mohammed, et al., 2011; Walters, Simoni, Evans-Campbell, 2002). This project offers the timely opportunity to collaborate with those working most intimately with Māori survivors of trauma to build capacity and capability in the area of trauma-informed care, and to design and develop a framework of culturally specific interventions that utilise Indigenous approaches to collective trauma experiences, such as historical and intergenerational trauma.

It is essential that those working in the field of mental health and wellbeing understand and work well with people who have suffered both personal and collective trauma. The aim of the proposed research is to inform the development of a framework that supports practitioners working with whānau experiencing trauma. The identification of Māori Trauma Informed Care principles contributes to the development of this framework and also complements the wider Trauma Informed Care approach that is growing within Aotearoa. The need to develop a Māori specific approach stems from the distinctive Māori and Indigenous experiences of trauma that are explained below. The existing dominant models in Aotearoa fail to adequately engage with trauma from a Māori and Indigenous perspective and as such they have limited applicability to our communities. The development of a Māori approach to Trauma Informed Care also aligns with the understanding within mental health that there is a need for therapies firmly rooted within cultural contexts (Duran & Duran, 1995; Gergen, Gulerce, Lock, & Misra, 1996).

Kaupapa Māori research methodology provides the basis for all aspects of this project. There is a focus on ensuring Māori working in the area of counselling and healing are actively involved both in contributing to the information gathered and the analysis. Collective knowledge sharing is key to ensuring that broad provider and practitioner views are engaged within the project. This form of collaboration is critical to the development of cultural practice concepts that will inform Māori approaches to Trauma Informed Care. Key principles of rangatiratanga, taonga tuku iho, ako, whānau, whakapapa, te reo, tikanga and wānanga will inform and underpin both the approach and the associated methods undertaken within the project (Pihama, Tiakiwai, & Southey 2015; Smith, 1999).

The project includes a range of methods that will be employed to investigate Māori approaches to Trauma Informed Care. The collaborative research team will undertake an extensive literature review and policy analysis. Kanohi Kitea refers to 'the seen face' and brings to the fore our understanding, as Māori, that to be connected and committed to whānau, hapū, iwi and Māori community wellbeing is critical in undertaking research of this type (Smith, 1999) and is embodied within the notion that to be seen in your own community is an indication of your connection. Methods to be employed also include 30 interviews and eight regional hui with Māori Social Service Providers and Indigenous peoples a symposium and 'Thought Space' wānanga. for dissemination and translation. The 'Thought Space' wānanga is a method designed by Professor Linda Smith and has been developed across a range of Te Kotahi Research Institute projects. The wānanga focuses on a deep engagement with the research findings and a facilitated process in collaboration with Māori providers and invited policy developers and analysts. It enables the research team to work alongside those in policy and practice within the sector to strategise way to influence and inform policy makers and as such to create spaces for intervention at a systemic and structural level. The key research output for "He Oranga Ngākau" is the development of a Māori approach to Trauma Informed Care that can be utilised by Māori Social Service Providers, counsellors, clinician and healers who are working with

whānau who have experienced both collective and personal trauma. Discussions with Maori providers have indicated it is important that this project also make significant contribution to all working in this area to ensure appropriate cultural and historical considerations are undertaken with our whanau. The methods support an exploration of Kaupapa Māori Trauma Informed Care practice principles through conducting research co-produced with Māori and Indigenous practitioners and will culminate in a symposium that will provide a platform for sharing information, developing principles and strategically positioning findings to inform practice. As such, the data analysis process will be undertaken through a series of research wānanga where the research team will identity and discuss the key themes and principles that have emerged from both the interviews and regional hui. Within such a process Kaupapa Maori co-production of knowledge approach is considered to be methodology, method and provide the outcome pathways for the research.

Pākehā Trauma Informed Care Developments in Aotearoa

Trauma is described as something that develops from an individual's experience of or exposure to an overwhelming event that is threatening to the individual's physical, emotional, and/or psychological safety. The experiences may be sudden or they can be gradual, they can include one-time events characterised as being dramatic in nature, or they can be continuous violations perpetrated and experienced over longer time periods (Emerson & Hopper, 2011).

The America Psychological Association (n.d.) defines trauma as:

> an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions. (para. 1)

One of the criticisms of current trauma approaches is that psychiatric definitions and associated therapeutic structures hold a dominant position within the care environment. Wirihana and Smith (2014) highlight the limitations in regards to western definitions of trauma to engage more deeply with Indigenous experiences,

> Trauma research in the field of psychology developed in the 1980s when Vietnam War veterans were first diagnosed with post-traumatic stress disorder (Briere & Scott, 2006). Since this period, research in this field has prioritised psychological theory and practice which focuses specifically on individual experiences of single trauma incidents. For example, the recently revised Diagnostic and Statistical Manual for Mental Disorders, 5th Edition defined trauma as "exposure to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p. 271). This includes being witness to such an event, having a close family member or friend who has suffered from a traumatic event, or experiencing repeated aversive exposure to the event. These definitions emphasise individual and actual events allowing for clear and succinct diagnostic utility, yet they fail to account for long-term chronic and complex individual and collective trauma. In addition, they do not allow for experiences of historical trauma due to assimilative colonial practices, which have occurred for indigenous populations worldwide. (p.198)

Diverse experiences of trauma are often said to be silenced within this context and there are calls for trauma services to fully integrate the political conditions and wider context in which people live (Burstow, 2003). Reeves (2015) notes that there is a growing body of literature in regards to Trauma Informed Care in diverse settings and contends that there is a need for an "understanding of the experiences and needs of survivors of different types of trauma, as well as those of health care providers, is missing from current literature on trauma-informed physical health care" (p.704). Reeves provides little discussion in terms of diversity in relation to either race or ethnicity, however she advocates for a need for more research to be undertaken that is inclusive of more diverse participants, stating

> Because trauma-informed care is patient-centered care, it is important to understand how trauma occurs within the context of culture, and how

culture affects the ways in which meaning is attributed to trauma. Culture affects trauma symptoms, health care experiences and, subsequently, the provision of trauma-informed care. Future research also should explore relationships between other demographic factors, such as race, socioeconomic status, and education level and the health care experiences of trauma survivors. (p. 706)

Trauma Informed Care is not a new concept within New Zealand Mental Health and Addiction Services settings. Some form of Trauma Informed Care has always been present in various treatment modalities within both the Mental Health and Addition Services sectors given that clinical practice includes diagnosing and treating labelled behaviours such as Post Traumatic Stress Disorder (Street, 2007). A range of trauma types are readily recognised within clinical practice that range from acute trauma - usually characterised by recent traumatic events (Bryant, Sackville, Dang, Moulds & Guthrie, 1999), to complex or chronic trauma caused by prolonged or repeated traumatic events over a lifetime (Street, 2007).

Te Pou o te Whakaaro Nui, (national mental health, addiction and disability workforce agency [Te Pou]) has provided Trauma Informed Care training in Aotearoa since 2011 defining Trauma Informed Care as;

> the experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss domestic violence and/or the witnessing of violence, terrorism or disasters
>
> a person's response that involves intense fear, horror and helplessness, extreme stress that overwhelms the person's capacity to cope. (https://www.tepou.co.nz/resources)

Within the information provided Te Pou (n.d.) notes the importance of contextualising the 'behaviour' of the individual. This context includes understandings of various types of trauma including repeated vs single events, and prolonged life-span experiences; the high prevalence of trauma among those who receive mental health services, along with the profound neurological, biological, psychological and social effects and the relationship of traumatic

experiences in childhood to poor adult health including increased rates of disease and drug abuse (Felitti et al., 1998; Steele & Malchiodi, 2012). Key practice principles outlined by Te Pou that further reinforce the importance of contextualisation with emphasis on seeing trauma as a central issue rather than being viewed as a side or peripheral issue associated to 'behaviour'. The re-orientation of clinical practice shifts the analysis away from asking what is wrong with the individual to asking what has happened to the individual. An important message put forward within the training material is the need to move away from 'patient-blaming' and focus instead on addressing the training needs of staff to improve knowledge and sensitivity (Te Pou, n.d.).

Trauma Informed Care is growing as a philosophical understanding of mental health issues within Aotearoa. While Te Pou made a major contribution to the implementation of Trauma Informed Care, and initial training of health care providers, through hosting dedicated training in 2011[1], few government strategic mental health and addiction services (MH&AS) documents are explicitly support a dedicated investment in this approach, and there is no discussion of the need for specific Kaupapa Māori based provision or the need for education that focuses upon Kaupapa Māori of those health care providers delivering Trauma Informed Care. The Blueprint strategies (Mental Health Commission, 1998, 2012) that outline what is needed in MH&AS, while not directly focussing on Trauma Informed Care, do make mention of recovery principles that strongly align with a Trauma Informed Care methodology. For example, the first Blueprint document released by the Mental Health Commission in 1998 discussed mental illness and recovery in terms of events impacting on the person rather than focussing on the person as the cause. In addition, Blueprint II (2012) further enforces these principles by advocating a 'new wave' of support that is driven by service user's perspectives and experiences and contextualises these experiences, including the historical context;

> understanding of the interaction between mental health and addiction, physical health and a

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[1] http://www.tepou.co.nz/improving-services/trauma-informed-care

person's social context. It (the 'new wave' of development) provides insight into how a person's context and history can shape their mental health. (Mental Health Commission, 2012, p. 10)

The Blueprints reference to the role of context and history shaping mental health is particularly relevant to this research. Both versions of the Blueprint also point to the importance of providing effective care that carries the ability to see the person in context. However, there is no engagement with colonisation, historical or colonial trauma, the impact of those experiences or a pathway for collective healing. Culture is discussed solely in relation to the MH&AS 'culture' and in a context of re-traumatisation that can occur as a result of controlling behaviour that is seen in practices such as seclusion. A 'cultural shift' is advocated to achieve an organisational commitment to Trauma Informed Care and to minimise power and control. Other aspects of MH&AS 'culture' that are addressed include the tendency for clinicians to view behaviour as a deficit under paternalistic power models of treatment.

Trauma Informed Care work carried out within Indigenous communities provides an important steer in developing an Aotearoa based, culturally congruent Māori approach to Trauma Informed Care as a growing aspect of practice. Key aspects of Indigenous trauma theory are presented below as an introduction to a cultural perspective that will provide an important framework for Māori specific Trauma Informed Care. Such a development must be cognisant of the work undertaken in regards to the impact of Historical and Colonial trauma that echoes across generations within kinship and cultural groups (Duran, 2012; Linklater, 2014; Waldram, 2012) and trauma associated to racism, stereotyping and internalised oppression are considered to link to historical trauma within the context of cumulative stressors (Carter, 2007; Walters, Mohammed, et al., 2011).

Indigenous Approaches to Trauma

Trauma research specific to Indigenous peoples is being actively engaged in Aotearoa (Lawson-Te Aho, 2013; Cameron, Pihama, Kopu, Millard, &

Cameron, 2017; Pihama, Reynolds, et al., 2014; Waretini-Karena, 2014). As such Māori Providers have highlighted the need for research that specifically seeks to define and create Kaupapa Māori approaches to the growing focus on Trauma Informed Care within Aotearoa in order to ensure culturally grounded approaches and practices are underpinned by a strong evidence base. The most compelling drive to better understand trauma, its impact and the importance of Trauma Informed Care is the disparities in health and high levels of trauma amongst Indigenous Peoples (Million, 2013; Walters, Evans-Campbell, Simoni, Ronquillo & Bhuyan, 2008). Within *Tatau Kahukura* (Ministry of Health, 2015) the latest statistics highlight that Māori have "higher rates than non-Māori for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma. Māori also experience higher disability rates" (p.1). It is also noted that Māori adults were one and half times more likely to report high or very high probability of anxiety or depression compare to non-Māori and have higher rates of hospitalisation from interpersonal violence, self-harm and suicide, all of which can be linked to trauma. Traumatic life experiences are noted as being far more common than has been previously estimated (Bowie, 2013; Huckshorn & Lebel, 2013) and particularly pronounced in mental health care, where it is estimated that nearly all consumers have experienced trauma (NASMHPD, 2010, as cited in Huckshorn & Lebel, 2013; Jennings, 2004). In fact, it is estimated that the majority of clients in human service systems are trauma survivors (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

Moran and Fitzpatrick (2008, p.153) state that, "trauma is a sudden harmful disruption impacting on all of the spirit, body, mind and heart that requires healing". In his article, "Trauma and its wake: The study and treatment of post-traumatic stress disorder" Figley (1985, p. xviii) affirms that psychological trauma has been defined as, "an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm." On the other hand, Phillips (2008) talks about three areas of trauma experienced by Indigenous peoples:

> Situational trauma - trauma that occurs as a result of a specific or discrete event, for example from a car accident, murder or being taken away. Cumulative trauma - it is subtle and the feelings build over time, for example racism. Intergenerational trauma – if trauma is not dealt with adequately in one generation, it often gets passed down unwittingly in our behaviours and in our thought systems. For example, if you want to heal children and youth, you have to heal yourself as well to break the cycle. (p.1)

Importantly Phillips (2008) notes that, "for Indigenous peoples who have experienced trauma as a result of colonisation, dispossession and dislocation, as well as the trauma of on-going racism, family violence and other events, often all three forms of trauma are applicable" (pp. 2-3). Trauma in this context can be defined as an event, or series of events, that are psychologically overwhelming for an individiual, family or community (Atkinson, 2013; Walters, Evans-Campbell, et al., 2008). In the context of Indigenous peoples, trauma can be viewed as a contemporary manifestation of the succession of systematic assaults perpetrated through colonisation and oppression, including genocide; ethnocide (systematic destruction of life ways); forced removal and relocation; health-related experimentation; and forced removal and placement of Indigenous children. Indigenous understandings of trauma include an historical and intergenerational awareness of systemic assaults perpetrated through colonisation and oppression, including genocide; ethnocide (systemic destruction of life ways); forced removal and relocation; health-related experimentation; and the forced removal and placement of indigenous children (Duran & Duran, 1995; Million, 2013; Pihama, Reynolds, et al., 2014; Walters, Simoni, et al., 2002). These events leading to historical trauma also manifest in intergenerational violence within our communities which are intensified through the imposition of heteropatriarchal ideologies and systems and which culminate in increased violence against Indigenous women, Two Spirit/ Takatāpui and children (Bear, 2016; Hunt, 2016; Million, 2013). Understandings of the impacts that historical events can have over generations within populations can also be found within studies that focus on the collective experiences of peoples including Holocaust survivors

(Braveheart, 2000; Evans-Campbell, 2008; Kellermann, 2001). These traumatic assaults are referred to as historical trauma and can lead to wounding of the spirit or the soul (Waldram, 2012; Walters, Evans-Campbell, et. al., 2008). Indigenous studies on the interface between culture, trauma and wellness identify that Native/Indigenous peoples experience higher rates of personal trauma than non-Native/Indigenous (Balsam, Huang, Fieland, Simoni & Walters, 2004; Waldram, 2012), and also that the concept of a "damaged communal self" presents a challenge to Western scientific constructs that reify the individual (Couture, 1994, p. 15).

Massive group trauma experiences impact on collectives of people and manifest in conditions and behaviour that are often reconstructed within dominant pathologising view as common traits belonging to Indigenous Peoples (Atkinson, 2013; Million 2013; Walters, Mohammed, et al., 2011). The fallout from massive group trauma experiences has been described as "the central role of colonisation and its aftermath" (Day, Jones, Nakata, & McDermott, 2012, p.106), and is linked as a factor in the prevalence of violence within indigenous communities (Million, 2013). This view acknowledges the ripple effect that colonisation has across generations including inherited grief and trauma, dispossession of land and loss of traditional language and cultural practices, loss of traditional roles within culturally defined social structures, economic exclusion linked to the high prevalence of poverty, and difficulties confronting issues (Victorian Indigenous Family Violence Task Force, 2003). Historical trauma is also linked to racism and discrimination and the way in which historical events and policies have created current myths and misconceptions about people of colour (Carter, 2007). The intergenerational transmittance of trauma has been discussed in both an indigenous and science context (Waretini-Karena, 2014; Linklater, 2014). Blood memory is described as an ancestral experience that is embedded in a peoples physical and psychological being (Younging, 2009), and memories that we are born with (Shilling, 2003). Soul wounds are described as trauma that stems from historical events that continue to impact over time and across generations (Duran, 2006)

along with oppression (including all forms of racism) that, left unrecognised, is internalised by populations (Braveheart, 1999). There is a growing body of work on epigenetics and historical trauma and therefore the impact of trauma and how it imbeds itself in our genetic material (Kellermann, 2001).

Research conducted in the context of Indigenous Australian children found that service providers working with all population groups who are affected by trauma need to adapt their programmes to account for the specific needs of their clients (Harris et al., 2006; Robson & Harris 2007). There is no single way to provide trauma-specific care; instead, practitioners and service providers need to identify the strategies and practices best suited to the needs and circumstances (including geographic location) of the individuals, families and communities they seek to support (Atkinson, 2013). In the Australian Aboriginal context, the documented practice experience of trauma and research experts on their delivery of trauma-informed services and trauma-specific care suggests that approaches informed by Indigenous culture show promise for supporting the healing and recovery of victims/survivors of trauma. Some examples of these practices are art therapy, yarning therapy – where the client tells their story as part of the therapeutic process, enabling them to validate their experiences. Success factors of these initiatives include: empowering clients to take control and do things for themselves; providing workshops that incorporate Indigenous cultural practices and therapeutic skills; as well as workshops that also provide appropriate training for people delivering the healing (Atkinson, 2013).

Conclusion

Māori experiences of both historical and colonial trauma and current collective trauma (multiple forms of racism) have been ongoing for close to 170 years. Million (2013) emphasises the violence of the impact of trauma on Indigenous Peoples, stating;

> Trauma supposes a violence that overwhelms, wounding individual (and collective) psyche sometimes suspending access to memory. The victims of traumatic events suffer recurrent

wounding if their memory/pain is not discharged. (p.2)

The severity and the ongoing impact of some violence calls us to act with urgency to explore, identify and develop practice principles that address how these experiences impact on Māori. Doing so transcends mono-cultural approaches to working with trauma and contributes to providing recognition of specific cultural trauma experiences which is a significant step in healing for Indigenous peoples and other groups affected by collective trauma (Braveheart, 1999; Duran & Duran, 1995). Conversely, lack of recognition is said to be linked to unresolved grief that can lead to internalised oppression, acted out in ways that include violent behaviour, and drug and alcohol abuse (Balsam et al., 2004; Braveheart, 1999).

For Māori, historical colonisation is marked by land alienation, a breakdown of social structures (Mead, 1994), disruption of gender relationships (Mead, 1994; Pihama, 2001) violence at the hands of colonial forces (Stanley, 2002), and extreme depopulation (Pool, 2015). Contemporary colonisation is seen in systemic, institutional and interpersonal racism including the ongoing negative stereotyping of Māori (Paradise, Harris, & Anderson, 2008). Evidence of racism against Māori in Aotearoa show that Māori are ten times more likely to experience multiple forms of racism than Europeans/Other and that experiences of racism are associated with higher incidences of physical disease (Harris et al., 2006). Internalised racism, defined as the in –group acceptance of negative attitudes, beliefs or ideologies about members of stigmatised ethnic groups (Paradies et al., 2008), have also been discussed by Māori researchers in relation to the negative self-perception of being Māori reported by primary school aged Māori children (Ramsden, 2002) and by Māori men (Stanley, 2002). Further, Te Hiwi (2007) in a study that focussed on the impacts of racism, found that participants experienced negative self-identities, stating that they knew it was not considered good to be Māori. Te Hiwi also discusses findings in the context of intergenerational transference where participants reported the inferiority of things Māori being reinforced in the home through the exclusion of te reo Māori (language) and tikanga (protocols).

It is our contention that in order to grow an understanding of Indigenous approaches to Trauma Informed Care that can positively impact on the healing experiences of Māori there must be (i) the development of Kaupapa Māori and Indigenous approaches to healing the collective impacts of Historical and Colonial Trauma and (ii) a clear critique and understandings of the limitations of imported individualistic western approaches that currently dominate the construct of *Trauma Informed Care* in Aotearoa. Kaupapa Māori approaches are grounded within principles that require such developments to be undertaken through a meaningful co-production of knowledge approach with Māori whānau, hapū, iwi and communities and that is located within the spaces that Māori live, can support Māori and non-Māori providers to be cognisant of the distinct issues that contextualise Māori trauma. Ultimately, the development of a Kaupapa Māori framework will guide practice in regards to Māori approaches to trauma and Trauma Informed Care and add to a drive for cultural safety and relevancy in service provision within Aotearoa that has been a cornerstone of Māori aspirations for service provision principles for decades.

Cultural Safety

For Māori, effective and contextualised provision of care has been articulated by Irihapeti Ramsden in her work on Cultural Safety. Ramsden (2002) conceptualised cultural safety as the ability for the health workforce to make the correlation between historical events, political agendas, economics and ill health. It includes an awareness of how social conditioning has shaped the health professionals attitudes, beliefs and practice, including attitudes and beliefs towards indigenous peoples. Cultural safety is ultimately about social justice, and the use of power and prejudice by the practitioner as opposed to focussing on the differences of Māori patients. Over time, the concept of cultural safety has been re-invented, through a dominant lens, as cultural competency and has tended to focus on the attributes of Māori as the *patient* receiving care. Cultural competency has been critiqued as a concept that allows the dominant culture, expressed through social institutions like health care systems, to regulate what sorts of problems are recognised and what kinds of social or cultural

differences are viewed as worthy of attention (Kirmayer, 2012). "He Oranga Ngākau" aligns with the concept of Cultural Safety as articulated by Ramsden (2002), and discussions on providing effective care to Māori should be viewed in this frame. Cultural Safety is important not only because of enduring inequalities in the incidence and prevalence of physical and mental illness (Robson & Harris, 2007) but also because of the principle of indigeneity and the recognition of Māori world views as a distinctive and legitimate frame for working with Māori who access health services (Durie, 2003; Nikora, 2007).

Indigeneity as a key principle of quality service provision to Māori (Durie, 2003) expands beyond the principles of person centered, and person directed therapy that are advocated for through the Blueprint (I and II). The expression of indigeneity within health care, including MH&AS, links to an understanding of mono-culturalism and what we now know about the negative impacts of a 'one size fits all approach'. For example, we now know that there is a clear connection between inequalities and culturally incongruent health service provision (Bacal, Jansen, & Smith, 2006; Kirmayer, 2012). Within MH&AS services cultural incongruence has been linked to lower access rates (Durie, 1994; Murchie, 1984) and worsening attitudes towards MH&AS after contact (Diala et al., 2000). In this sense, "He Oranga Ngākau" aims to contribute to reducing inequalities and enhancing outcomes for Māori through the development of culturally safe Trauma Informed Care approaches that are cognisant of Māori experiences, as Māori. Models of care shaped by Māori world views such as Whare Tapa Wha (Durie, 1994; Murchie, 1984) represent valid perspectives that can be seen as equal yet distinct models of practice (Farrell, 2013). A Māori specific Trauma Informed Care approach follows from models like Whare Tapa Wha, providing detail in the form of principles of practice that can guide Māori and non-Māori practitioners in working effectively and competently with tangata Māori. Further Māori specific trauma research has already been engaged in Aotearoa and the proposed research would add to this growing body of knowledge. (Lawson-Te Aho, 2013; Pihama, Reynolds, et al., 2014).

For Māori, the application of the principles of Cultural Safety carries an impetus set within a context related to Aotearoa specific experiences (racism, discrimination, patriarchy, homophobia, negative stereotypes and ethnicity based self-image) that are prevalent to the point of becoming phenomenological situations (Borell, Gregory, McCreanor, Jensen, & Moewaka-Barnes, 2009), albeit observed within health provision settings at the individual level within the clinical interface. It is important to note here that a common experience of racism within a group brings forward the notion of collective experiences which is a primary component of how indigenous peoples have conceptualised Trauma Informed Care (Waldram, 2012). The notion of collectivism within te ao Māori (the Māori world) is a traditional and contemporary cultural reality that is actively expressed through whanaungatanga and whakapapa relationships and contrasts with fundamental western valuing of individualism (Hutchings, 2009). Where some health services are steadily developing to reorient towards valuing the collective, expressed through explicit provisions for whanau centred approaches (Durie, 2003; Mental Health Commission, 1998, 2012; Ministry of Health, 2012) this has been slow in coming and the impetus has been from Māori communities ourselves.

Most therapeutic approaches utilised within Aotearoa healing professions stem from offshore knowledge basis and do not come equipped to adequately address diverse cultural contexts (Marsden, 2003). Therapeutic and diagnostic disciplines within MH&AS, such as psychology and psychiatry, are built upon and applied within mono-cultural frames (Duran & Duran, 1995), largely considering non-dominant cultures as simply being a point of difference in the expression of a universal general theory of behaviour (Gergen et al., 1996). In order to locate principles of practice in the lived realities of Māori, the proposed research aims to work with Māori Providers and the wider Māori community to gain an understanding of a Māori approach to Trauma Informed Care.

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