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The Healing the Past by Nurturing the Future: Cultural and emotional safety framework

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Abstract

The Healing the Past by Nurturing the Future (HPNF) research project aims to co-design perinatal awareness, recognition, assessment, and support strategies for Aboriginal and Torres Strait Islander parents who have experienced childhood complex trauma.

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Safety is essential for working in and collaborating with others in the context of complex trauma. Therefore, the purpose of this framework is to

- provide a guiding document for emotional and cultural safety protocols;
- identify, document, and synthesise the existing safety aspects within the HPNF project; and
- foster opportunities for cultural exchange.

Utilising a community-based participatory action research (CBPAR) approach, elements of this framework are drawn from the literature; HPNF protocols; investigator expertise, consultation, and feedback from workshops. Various themes emerged about safety that include connectivity, therapeutic support, communication, reciprocity, flexibility, recognising expertise, and governance. The application of these safety themes is discussed in relation to four main groups of people impacted by the HPNF project: parents; service providers; project staff, investigators, and stakeholders; and the broader Aboriginal and Torres Strait Islander community. This framework is dynamic, requiring discussion, reflection, and review to continue to forge a framework to foster safety to address the legacy of complex trauma.

Keywords: Aboriginal, intergenerational trauma, complex trauma, emotional safety, cultural safety, lateral violence, oppression.

Partners and collaborators
There have been many partners and collaborators for the HPNF project; these include La Trobe University; the Victorian Aboriginal Health Service; Murdoch Children's Research Institute; University of Melbourne; We-Ali Pty Ltd; Orygen-The National Centre of Excellence in Youth Mental Health; South Australian Health and Medical Research Institute; University of Adelaide; Flinders University; James Cook University; Monash University; Aboriginal Health Council of South Australia; Aboriginal Medical Service Alliance Northern Territory; Nunkuwarrin Yunti Inc (South Australia); Women's and Children's Health Network (South Australia); Central Australian Aboriginal Congress (Northern Territory); and Bouverie Centre (Victoria).

Background and Context

Background to Healing the Past by Nurturing the Future project

Overview. The Healing the Past by Nurturing the Future (HPNF) research project aims to co-design perinatal (pregnancy to two years after birth) awareness, recognition, assessment, and support strategies for Aboriginal and Torres Strait Islander[3] parents who have experienced complex trauma in their own childhoods. The four-year project involves four community-based participatory action research (CBPAR) cycles. Reflection and planning for mixed-method research activities (evidence synthesis, qualitative research, psychometric evaluation) are being conducted in four key stakeholder co-design workshops with HPNF study investigators, service providers, and Aboriginal community members (including parents) that are aligned with the first four intervention mapping steps. The HPNF project activities and phases are outlined in the HPNF project and conceptual framework document (see Chamberlain, Gee, et al., 2019).

The Core Values of the HPNF Project. Safety (cultural and emotional) is at the forefront of a set of core values that underpin the conceptual framework for the HPNF research project. These core values will guide the development of

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[3] Throughout this paper, the term "Aboriginal" will respectfully be used to refer to the diversity of both Aboriginal and Torres Strait Islander nations and peoples.
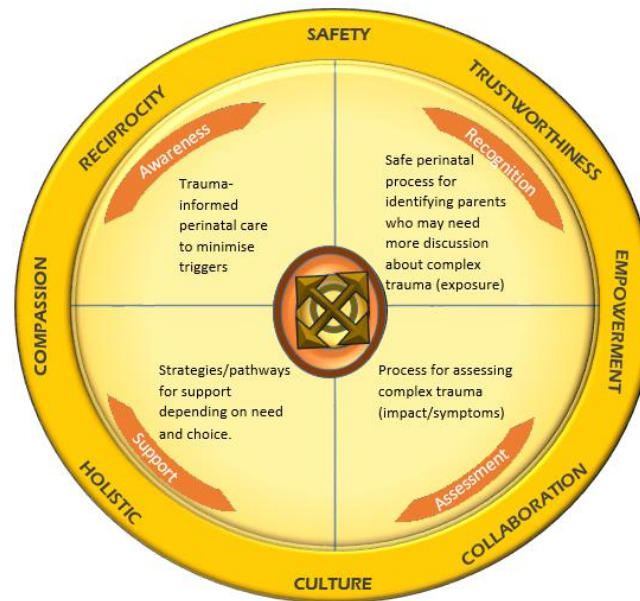
Figure 1. A conceptual framework for co-designing perinatal awareness, recognition, assessment, and support strategies for Aboriginal parents experiencing complex trauma.

strategies within the four HPNF domains of *Awareness, Recognition, Assessment,* and *Support.* The project values are outlined in Figure 1. These are consistent with the National Health and Medical Research Council (NHMRC, 2018) guidelines to ensure that research is safe, respectful, responsible, ensures ongoing connections to each other and culture, is of high quality, and of benefit to Aboriginal peoples and communities

Trauma and Safety Concepts

Complex Trauma. Within Indigenous communities, understandings of complex trauma have been variously referred to as *intergenerational trauma* (J. Atkinson, 2002) and *collective trauma* (Krieg, 2009; Ratnavale, 2007) in Aboriginal Australian contexts, and *historical trauma* in Native American contexts (Evans-Campbell, 2008), Aboriginal Canadian contexts (Wesley-Esquimaux & Smolewski, 2004), and New Zealand Maori contexts (Wirihana & Smith, 2014). The origins of Intergenerational trauma among Indigenous people stems from colonisation. A common experience of trauma for Indigenous people is that it involves the occurrence of collective, prolonged, cumulative, and compounded intergenerational processes of personal, lateral, and structural violence and oppression. In Australia, traumatic effects of colonisation initially progressed via government

sanctioned policies in which Aboriginal peoples were subject to frontier wars, dispossession of land, and the systemic practice of forced removal of Aboriginal peoples to government institutions-reserves and children from their families and culture. The legacies of these and subsequent policies continue and contribute to current loss, grief, marginalisation, poverty, and other health inequalities (J. Atkinson, 2002; Dudgeon, Wright, Paradies, Garvey, & Walker, 2014; Glover, Dudgeon, & Huygens, 2005; Ralph, 2010; Ralph, Hamaguchi, & Cox, 2006). Whilst Aboriginal peoples have been greatly affected by colonisation, Aboriginal nations are resilient and continue to draw strength from the revival of language, culture, and access to land. Despite this there remains a consistent theme in the related literature and national reports that these intergenerational effects mean that many Aboriginal peoples are vulnerable or at heightened risk of experiencing further trauma on an everyday basis (Krieg, 2009; Ratnavale, 2007) and prone to distress, trauma triggers, and re-traumatisation (J. Atkinson, 2002; C. Atkinson, Atkinson, Wrigley, & Collard, 2017).

The lack of recognition of complex trauma in mental health documents such as the current *Diagnostic and Statistical Manual of Mental Disorder* (DSM-5; American Psychiatric Association, 2003) has had unintended consequences such as

compromising the ability to determine the nature and prevalence of complex trauma experienced by Aboriginal peoples. However, recent advances such as the introduction of Complex Post-Traumatic Stress Disorder (CPTSD) in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11; World Health Organization, 2010) appears to be more consistent with Aboriginal experiences of trauma at the individual level. CPTSD is defined and operationalised as including three of the four core symptom clusters of Post-traumatic stress disorder (PTSD) that have been met at some point during the progression of the disorder. These include re-experiencing the trauma in the present, avoidance of traumatic reminders, and a persistent sense of current threat (exaggerated startle and hypervigilance; Karatzias et al., 2017). In addition to this, the ICD-11 definition of CPTSD encompasses three core symptoms that relate to "disturbances in self-organisation", which include (1) severe and pervasive problems in affect regulation; (2) persistent beliefs about oneself as diminished or worthless accompanied by deep feelings of shame or failure related to the traumatic event; and (3) persistent difficulties in sustaining relationships and closeness to others (Karatzias et al., 2017). These disturbances need to be associated with significant impairment in personal, family, social, educational, occupational or other important areas of functioning, and results in accumulative stress, distress and suffering from difficulties with emotions, relationships, and self-worth.

While the introduction of the CPTSD construct is timely and well-needed, as a construct it still lacks important areas of trauma-related distress that have been documented in Aboriginal trauma focussed research in Australia. For example, several studies (C. L. Atkinson, 2008; Gee, 2016; Holmes & McRae-Williams, 2008) have now highlighted other culturally salient areas of trauma-related distress, such as experiencing community disconnection (feeling isolated and disconnected from ones community); identity loss/fragmentation; profound grief and loss (unresolved or unintegrated grief); and other cultural idioms of distress that include harm against self and others, drug and alcohol abuse, other addictions, and suicidality.

For many Aboriginal families, one pathway in which the intergenerational nature of complex trauma is believed to be manifested is in childhood through unresolved parental trauma (C. Atkinson et al., 2017). Parents' capacity to care for their children can be compromised, contributing to inconsistent attempts to protect their children. This is often associated with impaired bonding and attachment between parents and children. Research indicates that maladaptive or unhealthy parent and child attachment responses can be carried through to adulthood and impede the capacity of parents to nurture and care for their children (Alexander, 2016; Amos, Furber & Segal, 2011).

Some parents are particularly vulnerable to "triggering" of trauma responses in the perinatal period due to the intimate and potentially intrusive nature of some perinatal care experiences and the attachment needs of their infant. Due to a variety of reasons such as perinatal anxiety and depression (Alexander, 2016), parents may also be isolated from family and community supports potentially increasing vulnerability.

Understanding parental needs and providing support during the perinatal period is opportunistic for promoting healing and emotional development (Fava et al., 2016), with the potential to prevent the intergenerational transmission of trauma (Choi & Sikkema, 2016; Sperlich et al., 2017; Kezelman & Stavropoulos, 2012). A gap in the literature is that we do not currently know what proportion of parents who have experienced complex trauma have adapted positive and enabling ways to provide nurturing environments for their children. Yet the literature does indicate that many parents who have experienced maltreatment themselves can and do provide nurturing care for their children (McCrory, DeBrito, & Vidins, 2010), especially in a supportive and nurturing strengths-based environment. A history of childhood maltreatment in and of itself is not predictive of postpartum parenting quality (Sexton, Davis, Menke, Raggio, & Muzic, 2017). Yet there are some issues with the over and under detection of parents considered "at risk" (Wisdom, Czaja, & Dumont, 2015).

Cultural Safety. Cultural safety processes espouse an empowering and positive practice (Bin-Sallik, 2003) that creates resilient, safe and secure environments, and builds relationships and cohesiveness that fosters productive working environments (Frankland, Lewis, & Trotter, 2010). Cultural safety is an overarching systemic structure or final element in a continuum of care that can include other concepts such as cultural awareness and cultural competency mainly targeted to non-Aboriginal peoples. Cultural safety is multidimensional and dynamic, enabling individuals to nurture their identities, cultural background, and skills (Australian Human Rights Commission, 2011). It is a process inclusive of many cultures and identities, yet it is particularly relevant for Aboriginal peoples in Australia to directly address the effects of colonisation and disempowerment within dominant systems. Cultural safety focuses on power imbalances in systemic processes where power imbalances are also recognised for consumers; between the professional/service deliverer and the receiver. Culturally unsafe environments can be detrimental to a person's health and wellbeing in the community and require improvement and redress (Downing, Kowal, & Paradies, 2011; National Aboriginal and Torres Strait Islander Health Workers Association, 2016).

Emotional Safety. The ability to manage emotions and respond to emotions is an important skill for people working in health and wellbeing fields, whether that is clinically or within a research role. Understanding the conditions that can elevate people's emotions is an important consideration for the HPNF project. Managing emotional and psychological risks for people within projects is not only ethical but also critical, and these risks can be unexpected and multidimensional (Huggard & Nichols, 2011). Emotionally unsafe environments can contribute to negative self-esteem, a breakdown of interpersonal relationships (Kiseleva, 2016), psychological distress (Pyper & Paterson, 2016), stress and burnout (Huggard & Nichols, 2011), work absences due to mental health (Kivimäki et al., 2010), and influence development over a lifespan (Marsh, Coholic, Cote-Meek, & Najavits, 2015). Furthermore, personnel involved in service delivery or research topics such as trauma are at risk due to distress related to trauma triggers (people can be triggered by all sorts of stimuli), re-traumatisation (a relapse into trauma), susceptibility to vicarious trauma (where someone incorporates the trauma or a traumatic reaction of the interviewee's distress or trauma), and transference-counter transference (emotional and behavioural reactions to participants based on one's own trauma experiences (Marriage & Marriage, 2005).

Consequently, many organisations and environments adopt policies and strategies to counterbalance such risks. These strategies range from productive communication strategies, the nurturing of interpersonal relationships, to the creation of positive and inclusive environments (Kiseleva, 2016). These types of strategies can also be used to create a culture of caring and valuing; promote self-care and awareness practices and setting boundaries, particularly around life-work balance (Huggard & Nichols, 2011). Other strategies include individual or collective support via supervision, debriefing, regular feedback sessions, healthy rostering practices, regular forums for communication and social time to assist colleagues (Slater, Edwards, & Badat, 2018). Workplaces can provide access to pre-incident preparedness training that may help staff cope with trauma experienced in their work (Phoenix Australia - Centre for Posttraumatic Mental Health, 2013). This also includes programs such as psychological first aid, trauma-informed care training, or complex needs training.

Counselling support is usually provided to workers and researchers though Employer Assistance Programs (EAP) in Australia (Bowtel, Sawyer, Aroni, Green, & Duncan, 2013). In some areas of Australia Aboriginal people (i.e., staff) may have access to traditional healers such as Ngangkari (i.e., South and Central Australia; Panzironi, 2013), Marban (i.e., North Western Australia; Roe, 2010), and Aboriginal Elders. For example, at various universities students and academics can seek out the services and support of Aboriginal Elders on their campus (i.e., the University of Adelaide). Practices specifically relevant for qualitative researchers include reflexivity (awareness and influence of the "self" in the research) and ethical mindfulness (for noticing, processing, and actioning ethical

dilemmas in qualitative health research). Counselling support and advocacy for Aboriginal community members (including parents) are via services in the private, public as well as churches depending on the location, funding, and community needs. Many community members have access to primary health care in the Aboriginal community-controlled sector that provides access to doctors and allied health which includes support for mental health, and social and emotional wellbeing (Australian Institute of Health and Welfare, 2018)

A culturally informed trauma integrated healing approach (C. Atkinson et al., 2017) recognises the need for trauma champions who mentor and support an organisation through change and ensure the topic of trauma remains in the spotlight. This empowers services to integrate trauma informed and cultural care for staff and clients. This active approach identifies five key assumptions within this framework which are to realise the widespread impact of trauma; recognise trauma related symptoms and patterns of distress; respond to the trauma; resist re-traumatisation; and rebuild connection to community, family, kin, country, culture, body-mind, and spirit-spirituality. This active approach also identifies seven core values which are respect, rights, responsibility, reciprocity, relatedness, resilience, and resonance; and eight core principles and strategies for services to adopt that provide an understanding of trauma and its impact on individuals which include promoting safety, ensuring cultural competency, supporting client control, sharing power and governance, integrating care, supporting relationship building, and enabling recovery.

In an Aboriginal context, health and healing encompass aspects of physical, emotional, social, spiritual, and cultural health (South Australia Health, 2017). The impact of compromised health is also associated with trauma (C. Atkinson et al., 2017), social and emotional wellbeing (SEWB; Gee, Dudgeon, Schultz, Hart, & Kelly, 2014), coping (Clark, Augoustinos, & Main, 2017), racism (Awofeso, 2011; Paradies, 2006), and identity (Clark et al., 2016). Gee et al. (2014) identified several common domains and broader determinants that Aboriginal peoples in Australia attribute to healthy wellbeing. These included SEWB being shaped by the strengths of one's

connections to the body, mind, emotions, family, kinship, community, culture, country, spirituality, and ancestry. Importantly, these areas of SEWB were recognised to be influenced by social, historical, and political determinants. Thus, strengthening and nurturing such connections, at an individual, collective, or systems level and in work and research contexts, facilitates cultural and emotional safety.

Lateral Violence and Oppression. Lateral violence (LV) is defined as the way oppressed and powerless people overtly and covertly direct their dissatisfaction toward each other, toward themselves, and toward those less powerful than themselves (Native Counselling Services of Alberta, 2008, as cited in Clark & Augoustinos, 2015). This inward deflection has been found in many environments where oppression exists, such as within Indigenous communities, including Canada (Bombay, Matheson, & Anisman, 2014) and Australia (Clark & Augoustinos, 2015; Gorringe, Ross, & Fforde, 2011). In Australia, LV is an overarching term that incorporates any form of violence within an Aboriginal cultural environment, yet it is often portrayed in its covert form, which is subtle and insidious; practised as bullying, gossiping, undermining each other's Aboriginal identities, sabotage of projects and jobs, to name a few. Hence, LV in combination with oppression (i.e., racism and discrimination) is an everyday occurrence (Reconciliation Australia, 2015) and a disabling process that can divide team members and disrupt stakeholder relationships. Lateral violence is both a cause and consequence of trauma arising from colonialism and continuing oppressive policies, laws, and practices.

Lateral violence can coincide with negative discourses which may also compromise safety and collaboration in Aboriginal environments (Clark et al., 2016). Negative and deficit discourses are tied to notions of deficiency (Fforde, Bamblett, Lovett, Gorringe, & Fogarty, 2013) and problematising, where blame is then attributed in a "blame the victim" construct. It can also overlap with external and internal racism that shades out solutions that recognise strengths, capabilities, and rights of Aboriginal peoples, which in turn are needed to counterbalance the negative discourses (Fogarty, Bulloch, McDonnell, & Davis, 2018).

Furthermore, deficit discourses are linked to the "authenticity" debate (Fforde et al., 2013), where Aboriginal identity is constructed as typical, traditionally oriented, internally homogenous, linked to the past, and where membership is in solidarity. This idealised view of Aboriginality ignores and fails to recognise contemporary Aboriginal peoples who are not assimilated and have strong Aboriginal identities. This view of the ideal or authentic Aboriginal person is not only constructed by non-Aboriginal people but also by Aboriginal peoples and is at the heart of debates around LV within Aboriginal communities (Gorringe et al., 2011). The use of language to recognise and convey personal and collective Aboriginal identities needs careful consideration, as there is potential to cause distress and trauma when language is used in ways that result in negation or undermining of Aboriginal identities (Clark et al., 2016).

The former Social Justice Commissioner, Mick Gooda indicated cultural safety can "bullet proof our communities so that they are protected from the weaponry of lateral violence" within our communities (Australian Human Rights Commission, 2011, p. 123). Thus, providing information, awareness, and an increased understanding of trauma, oppression, LV, and deficit discourses for cultural and emotional safety initiatives will potentially assist in building safe and collaborative communities and working environments (Clark et al., 2017).

Background to the Safety Framework for the HPNF project
The safety framework has been developed via information from existing HPNF protocols as well as consultation and co-design within the project.

Current Protocols and Frameworks. The protocol documents have unique purposes yet are relational to the safety framework and align with Indigenous methodologies that have also been used to guide Indigenous research around the world, as they embrace cultural safety and respect for Indigenous world views (Rigney, 1999; Smith, 2012; *see* Figure 1, Appendix A, and La Trobe University, n.d.).

HPNF workshop one: consultation and themes for creating safe spaces
The aims for the first HPNF workshop conducted in Adelaide, South Australia (27/3/2018) were to create a safe environment and establish protocols for emotional and cultural safety; share knowledge of current research about complex trauma; clarify goals, hopes, and aspirations for the project; understand community needs and how the influence of complex trauma is being addressed in and by communities/health services. There were 40 participants who attended the workshop, most of whom were Aboriginal. According to the workshop evaluation, 100 per cent of responding participants (selecting *"Agree/Highly Agree")* felt safe in the workshop. Safety elements were discussed throughout the workshop as well as a dedicated session where participants brainstormed ideas about how to work together safely. The discussions were recorded and analysed via a thematic analysis process (Braun and Clarke, 2013). The safety themes are presented below (*see* Table 1). Further information on safety themes can be found in the Workshop One Report (Ralph et al., 2018).

Implementing Safe Spaces for HPNF Project

Overview
The safety elements described above, for those who are and will be involved in the HPNF project, provides the basis for action-oriented safety strategies. Although cultural safety and emotional safety are considered separate concepts, they are interchangeable within the HPNF research project and are reported together.

Certain safety components will be central to everyone, whilst other elements will take prominence for specific groups of people. Even though there is diversity of people and involvement, four broad groups of people are recognised as being potentially impacted by the HPNF project. These are (1) Aboriginal and/or Torres Strait Islander community; (2) service providers; (3) Aboriginal and/or Torres Strait Islander parents and families; and (4) the project

Table 1. Themes from safety discussion and examples of how these are embedded in practices

Connectivity, relatedness, and belonging	Connecting and building relationships with each other, culture, and country. A sense of belonging may have been immersive as there were opportunities for participants to get to know each other; and share information in discussions on culture, inspirations, aspirations, strengths, and services/organisational roles.
Cultural support – Ensuring Aboriginal spaces	Accountability, connection, and obligation to culture and country by including local Aboriginal peoples, Elders, services, culture, and Aboriginal facilitators.
Emotional and psychological support and access to therapeutic resources	Self-care information sheets by We Al-Li (2018) and information on emergency, counselling, and psychological services were provided. Therapeutic self-care and healing via voluntary activities such as "mindfulness colouring sheets" (developed by the Victorian Aboriginal Community Health Service) and rocks with paint pens were provided.
Reflection	Reflective processes were in-built and included the "circling up" of participants to assist with a sense of belonging and connection to each other, and to facilitate continued caring during the day.
Appropriate communication, valuing, and engagement	Appropriate, genuine, and open communication and valuing aspects included deep listening; considering other people's views; being heard and valued; using various formats to ensure communication exchange (i.e., reference groups, interpreters, individual and group work); and enabling the visibility and transparency of documents (i.e., strategy and vision statement). Some participant examples included "visual communication" and "feeling heard and acknowledged".
Reciprocity, collaboration, and unity	Reciprocal and collaborative initiatives for fostering knowledge exchange, learning (two-way), relationships and respect among people involved in the project can cultivate greater collegiality, which potentially unites and strengthens a group rather than competition. Participant examples include "two-way learning", and "relational participation".
Flexibility and open to change	Flexibility and openness by seeking involvement rather than imposing expectations. This means to challenge one's rigidity and working to ensure flexibility and overcome barriers. For example, "challenging ourselves to work differently" and "being aware and open to knowledge".
Participating, learning, and recognising community expertise and needs	Genuine learning from Aboriginal communities about their needs, the crucial matters affecting them, and advice on improvements. Community members own their own local knowledge and their expertise must be recognised to be as important as other forms of expertise or evidence. Participant examples included "community ownership of information" and "reflecting local cultural needs".
Guidance, leadership, and commitment to achieve	Guidance and leadership with the investigator team and staff accountable to take the lead, progress, and keep the project on track to guide and ensure that outcomes will be achieved yet at the same time ensure inclusivity and shared power. Examples include "commitment to follow through" and "tangible outcomes".
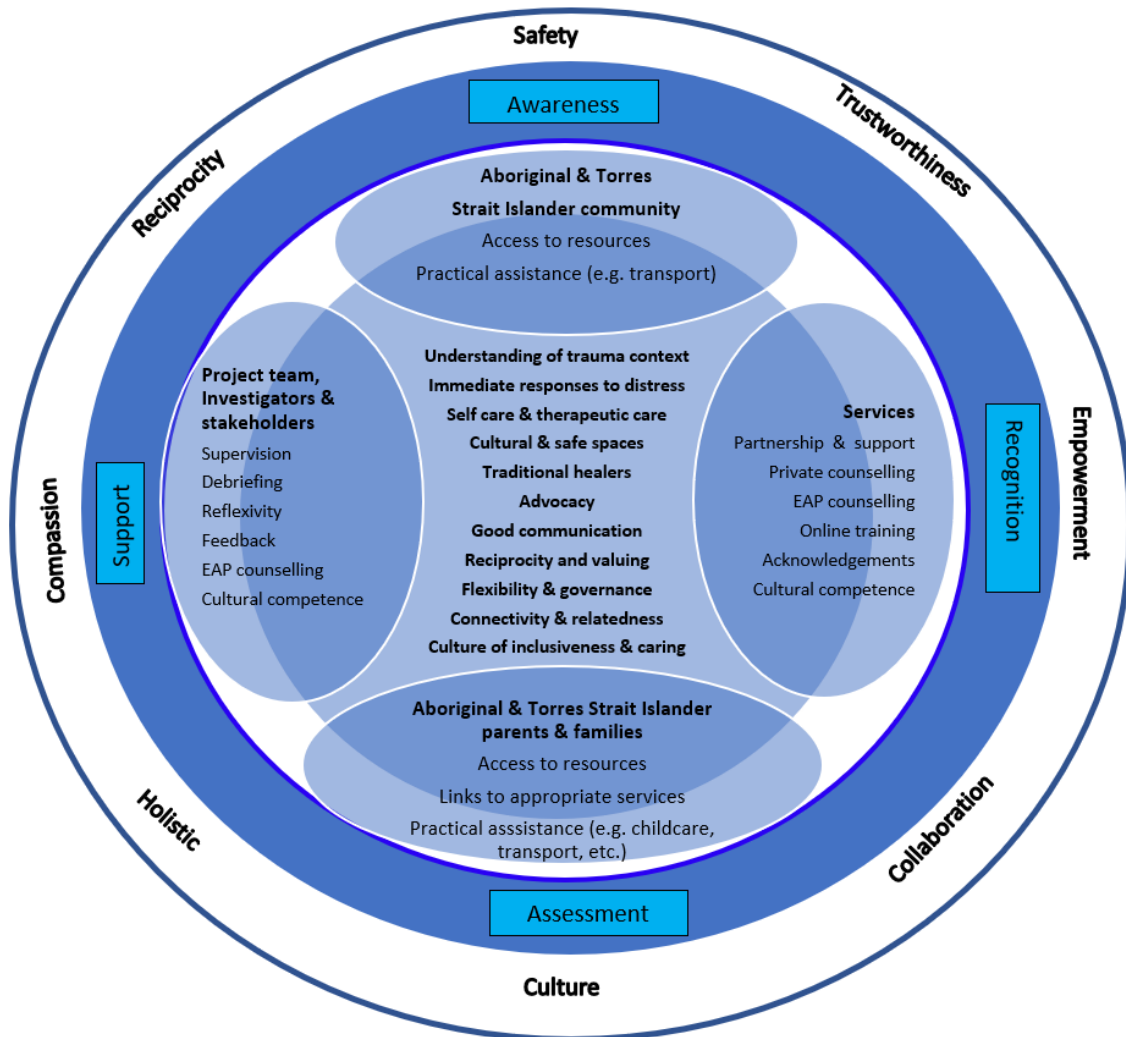
Figure 3. HPNF safety framework: Specific and central safety elements for the different groups involved in the HPNF project

team, investigators and stakeholders. Figure 3 outlines the central and group specific safety elements for the HPNF project.

Central Safety Framework

The central safety framework are features common to all the groups recognised as involved in the HPNF project.

Understanding and Awareness of the Context of Complex Trauma. Emotional and cultural safety may include an increased understanding of the context of trauma for Aboriginal people. This understanding may involve learning about trauma informed care, Aboriginal history, racism, violence, LV, and disadvantage, the language of oppression, and deficit discourses about Aboriginality. Many of these realities contribute to health and wellbeing issues within Aboriginal

communities and can render an environment unsafe. Violence and LV as a corollary of oppression and racism are both causes and consequences of trauma within Aboriginal communities and can be mechanisms for division. Education practices along with training have the potential to enhance recognition and understanding of these processes.

Training. Training on complex trauma needs to be offered to all groups involved in the project in a range of formats. According to practice guidelines for the treatment of complex trauma, it is an organisational requirement for all those involved in trauma care to receive at least basic training (Kezelman & Stavropoulos, 2012).

Lateral violence, racism distress, and trauma responses may also occur in workplaces between

project team members, investigators, stakeholders, Aboriginal community and parents, and affect others in those environments (Clark & Augoustinos, 2015). Oppression and institutional racism can coincide with deficit discourses about Aboriginality and/or Indigeneity, which can affect health and wellbeing (Fogarty et al.,2018). Thus, negative stereotypes or messages about Aboriginal parenting, childhood trauma or maltreatment have the potential to be misinterpreted by various forums such as mainstream media, attributing to further discrimination. To help minimise this the HPNF publication guidelines require consensus from the investigators (the majority are of Aboriginal background) who apply a strength-based lens to publications. Furthermore, managers and supervisors of research staff, as well as EAP counsellors need to be aware of the context of complex or intergenerational trauma; the effects of lateral violence, racism, and oppression; and how these can be unwittingly instigated through various mediums such as behaviour and language, in a work and research environment. This is especially important for the learning by non-Aboriginal people.

A session on oppression, LV, and trauma in relation to safely working together was incorporated into workshop one to assist with cultural understandings for safety. This was viewed as helpful in the evaluation feedback. Thus, options for training in cultural safety, racism, and LV may further assist Aboriginal and non-Aboriginal researchers and investigators in understanding and strategising to deal with and cope if environments become acrimonious.

Different groups and individuals involved in the HPNF project have varying levels of expertise and therefore, different training needs. Further, the co-design nature of the project means that learning and training can occur across groups involved in workshop forums. Some training resources and links will be available on the HPNF website[4].

Trauma Informed Care. Many people (particularly Aboriginal peoples) have been subject to intergenerational and accumulative traumas and can be vulnerable to distress,

ongoing trauma triggers, re-traumatisation, and vicarious trauma or countertransference. This is inclusive of all people involved in the HPNF project as staff, investigators, within partner organisations, parents, and Elders; all of whom need to be supported with safety.

Aboriginal community, in particular, *parents*, *Elders*, and *grandmothers* involved in the project may be susceptible to trauma, as often they carry their own, their children's, and grandchildren's experiences of trauma. Thus far, consultation has occurred with an Aboriginal grandmothers' group in South Australia to hear their wisdom on trauma and safety advice for working with Aboriginal parents. This collective of grandmothers work toward connecting grandchildren to culture and language through music and engagement.

As the primary aim of the HPNF project is to develop assessment and support tools for Aboriginal parents, parents will feature predominately in future focus groups, interviews, and workshops. The perinatal period is a highly vulnerable time for parents who are prone to trauma triggers. Thus, concerted efforts will be needed for trauma and distress to be prevented, minimised and/or managed. It will be imperative that facilitators and interviewers are highly trained in trauma informed care and able to respond appropriately to triggers and refer to appropriate local cultural or culturally informed services and counsellors. A protocol for engaging with focus groups (see Appendix A and Chamberlain, Gee, et al., 2019) included negotiating a safe space, providing a counsellor and information on self-care and trauma, and extending invitations to co-design in the project.

Furthermore, members of the Aboriginal community may have or request their own adaptive or healing strategies, and these will be discussed and respected. For example, access to a traditional healer, a religious pastor, or seek a support person (e.g., family member) to assist their involvement with the research. Thus, safety is paramount to counter trauma response patterns being activated and assist steps toward healing.

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[4] https://www.latrobe.edu.au/jlc/research/healing-the-past

In relation to the safety of the project team, investigators, and stakeholders; these members will have a variety of roles that include facilitation, data analysis, review, and writing. Many are attached to existing organisations, research institutes, and universities and will have access to workplace policies and procedures that cater for risk, protection, and support of staff. It may be particularly difficult for this group who are potentially affected by trauma stories, as there may be an expectation that they maintain their strength to perform their role, despite the effects of distress. For example, when conducting workshops or focus groups, it will be a requirement that two or more facilitators are assigned for the additional purposes of providing back-up, support, and promoting healing.

Service providers are at the forefront of working with Aboriginal populations. Such work can be challenging. For example, the systemic and chronic under-resourcing of services can place families at risk and families can feel unsupported or underserviced and react in various ways. There may be a constant balancing of the rewards of helping clients versus client distress and dissatisfaction. Furthermore, issues of child protection and safety are a significant concern in the community. Many service providers are mandatory reporters, which can place staff in a quandary between reporting potential abuse and potentially compromising client and worker relationships, which in turn can be distressing for staff. Furthermore, service providers who work with the Aboriginal community and complex trauma are vulnerable and at risk of distress from their own trauma, similarly to other Aboriginal peoples. This can occur daily. Services will have their own risk and protective policies for staff to be culturally and emotionally safe which often include EAP counselling. Staff may also have access to specialised cultural and clinical supervision as well as training. However, this can be an added expense that the service may not be able to afford.

Appropriate and Inclusive Methods of Communication. The co-design aspect of the HPNF project contributes to the inclusivity of involvement. The communicative aspects include an active and ongoing process of material distribution via email, newsletters, the HPNF website, face-to-face visits, and workshops. These modes are easily accessible and potentially available to everyone.

Reciprocity and Being Valued. The values and principles of reciprocity and valuing are recommended in many articles and documents relating to Aboriginal peoples (NHMRC, 2018; South Australian Health and Medical Research Institute, 2014). In the HPNF context, a reciprocal and mutual exchange of ideas, sharing, caring, knowledge, information, hearing and being heard, was instilled from the first workshop, and will continue in future workshops, peer mentoring, and project initiatives. Valuing includes acknowledgement of participation, valuing diverse experiences and views, invitations to attend and present at workshops and to co-publish material.

Connectivity and Relatedness. Opportunities for connection and relatedness to each other, culture, and country are necessary and facilitated by nurturing a culture of inclusiveness and belonging in the HPNF project. This is an important process to safeguard against LV and racism. Connectivity practices included in workshops one and two will continue and may include providing opportunities for sharing information and working on tasks together.

Flexibility and Governance. Both flexibility and governance need to be aligned together to cater for the diversity of personnel involved in the project. Flexibility in relation to governance includes incorporating both mainstream and Aboriginal cultural governance practices and finding the best fit for the local environment, time, and space. Flexible governance also relates to the investigators in the HPNF project to share their expertise via mentoring and providing feedback to other investigators for the benefit of all involved in the project. Flexible investigator leadership, as well as the co-design elements of the project, empowers a collaborative process for decision making which supports the achievement of desired outcomes. Some examples include writing documents, comments, feedback, and potential authorship benefits.

Immediate Responses to Trauma. There has been a concerted effort to minimise distress to individuals and groups involved in this research. These efforts include conversations about

trauma; the inclusion of a suicide risk assessment; and step-by-step procedures to assist with the management of individual distress, referral, and harm minimisation. This entails awareness and acknowledgement of an individual's distress, review, support, and follow up initially by the research facilitator (*see* Appendix B). Furthermore, the potential for group distress and triggering also needs careful strategising, discussion, and action. Therefore, it will be part of the pre-planning process and protocols before any group activity.

Therapeutic Care and Referral. During workshops and focus groups (particularly for Aboriginal parents and Elders) the presence of a negotiated and designated therapeutic person(s); i.e., psychologist, counsellor, traditional healer; is necessary to assist with emotional safety of participants. Psychological support has already been provided for participants in past workshops and discussion groups and will be provided in the future. Furthermore, safety warrants prior negotiations and established links with services providing therapeutic care to enable immediate or easy access for participants to their local service.

Self-Care. Information and advice on self-care has been provided by We Al-li via an information handout on trauma and self-care for people involved in workshops and discussion groups. The We-Al-li handout has useful tips on the GROWTH technique which encourages becoming grounded, breathing, noticing body changes, debriefing, and healing (We Al-li, 2018).

Safe Spaces. At events such as workshops and discussion groups, a culturally safe and separate physical space will be provided for participants. Such a safe space could have flexible and multipurpose functions, including taking a break to access a counsellor/psychologist, resting, or feeding room. Additionally, natural or green spaces such as gardens and spaces for sitting and/or walking will be considered when securing a venue for research, for healing and for regathering purposes.

Aboriginal Cultural Spaces. An Aboriginal space is not a physical space but a safeguard process for cultural immersion. Thus far there has been much effort to ensure that there are local Aboriginal cultural elements, values, and input to the HPNF project. This can facilitate new and reciprocal learnings and knowledge and an opportunity for cultural pride, sustainability, and renewal for many Aboriginal personnel involved in the project. Further, cultural elements will provide non-Aboriginal people with a cultural context to ensure that the power imbalance is tackled as a feature of cultural competence and cultural safety. Each workshop is planned in a different location to optimise cultural diversity. Furthermore, tools and symbols to aid facilitation of research activities will include initiatives created and supported by Aboriginal people (i.e., strength cards, tarnuk, coolamon, mindfulness colouring in sheets etc.) as well as nourishment (i.e., food and drinks).

Additional Safety Framework Features

In addition to the core features of the safety framework, there are additional areas specific to each group involved in the HPNF project, and these are detailed here.

Aboriginal Community, Parents and Families

Support and Practical Resources

Parents may lack practical resources to support their involvement in the research, where possible parents will be linked to services involved in the project. However, difficulties may include caring responsibilities, with limited funding to pay for babysitting. Therefore, assistance to childcare (at centres, in-house, or venue babysitting) and or providing children's activities may be necessary. Parents and community members may have limited access to transport to get to a session which may be lengthy. Therefore, support could include assistance with transport (via cab or petrol vouchers) and nourishment.

Acknowledgements

As the research is a co-design process, acknowledgement of services and individuals may form part of project journal publications (*see* Chamberlain, Gee, et al., 2019). Furthermore, opportunities for discussion and the sharing of service ideas and wisdom can be incorporated into future HPNF workshops.

Project Team, Investigators, and Stakeholders

Access to Counsellors

Many of the staff, researchers, and stakeholders will have access to EAP; where they can utilise counselling and support. Aboriginal personnel, under this scheme, may need the option of both Aboriginal and culturally competent non-Aboriginal counsellors as well as other forms of healing (i.e., traditional healers)

Self-Care

Information on self-care has been discussed as central to all groups. In circumstances where team, investigators, or stakeholders congregate, such as face-to-face planning days or combined investigator/staff/stakeholder research meetings and gatherings, other self-care options may be useful. For example, on an HPNF staff planning day, a local spiritual walk was incorporated into the day. This provided potential health and wellbeing benefits such as increased physical exercise; connection to spirituality, nature, country, and each other (team bonding); mindfulness; and reflection. This self-care activity was highlighted in the July 2018 HPNF newsletter (HPNF, 2018).

Supervision, Debriefing, and Reflexivity

Supervision, debriefing, and reflection are often part of the culture of organisations, but what is less recognised by supervisors, particularly non-Aboriginal supervisors, is the high vulnerability of trauma triggers and re-traumatisation of Aboriginal employees, investigators, and stakeholders. Thus, regular supervision is important to monitor trauma issues. Debriefing immediately after a workshop, focus group, or interview is essential to enable information processing, to settle, and re-dress if necessary. Furthermore, it is important for researchers to reflect on their place and influence in the research and outcomes. Such reflective practices can also be integrated into supervision and debriefing sessions.

Awareness and training

HPNF researchers who conduct focus groups or interviews with Aboriginal participants may need training in interpersonal skills, managing group dynamics, self-care processes, identifying distress and trauma triggers, and knowledge of appropriate referral processes and resources.

Service Providers

Partnerships and Training

Some services have become partners to the project, which involves a reciprocal relationship and co-design in the research. Some partnerships can potentially assist with recruitment and referral of Aboriginal families and parents to the research activities; and upon negotiation, assist with the provision of ongoing counselling and support for research participants (i.e., parents and Elders). The HPNF obligation could include providing resources for training once the assessment tools have been developed. On the HPNF website there will be links to further training and as the project progresses, webinars and other resources on trauma will also be made available to services to enable them to remain up-to-date or to seek additional information or assistance.

Cultural competence

Cultural competence is within a broader framework of cultural safety and is usually an in-house and often obligatory process for Aboriginal Services to ensure staff are equipped with knowledge, awareness, and competency to work with Aboriginal populations. The HPNF project can assist with ensuring that a cultural space, cultural information, and engagement are present at workshops for participants, therefore prospering cultural safety.

Summary

The HPNF research aims to support families and interrupt the intergenerational transmission of trauma to future generations of Aboriginal peoples. It has been well understood that complex trauma or intergenerational trauma is an everyday reality for many personnel involved in the project, and there is a vulnerability to distress due to trauma. This safety framework was developed to guide safety over the course of the project for HPNF investigators, researchers, and other stakeholders in how we work with each other, with research participants (parents and other community members), and services in a project focusing on healing and recovery from complex trauma. The framework outlines the many steps and processes involved in generating and maintaining cultural and emotional safety for different stakeholders. Many safety features have already been incorporated into the project. Key issues highlighted in the framework include the

importance of everyone involved feeling valued, having a sense of belonging in the project, and feeling confident of reaching the project outcomes.

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Karen Glover (BEd, MBA) is a Mein:tnk and Wotjobaluk woman currently employed as a Senior Research Fellow; Women and Kids Theme; South Australian Health and Medical Research Institute. She has over 30 years' experience working in the Aboriginal health and community services sectors, including in policy, planning, service development, management, and advocacy.

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Appendix A: Summary of HPNF Protocols

1.	*HPNF: protocol for a community-based participatory action research study*	This document provides the broad structure for the HPNF research and outlines the main research activities, values, principles, behaviours, risks, and strategies for project management (see Chamberlain, Gee, et al., 2019).
2.	*HPNF: Suicide Risk Protocol*	This guides the process of reactions to distress and for a suicide assessment initially (via a brief questionnaire) before referring to appropriate services. Step by step procedures for participants distress to review, support, and follow up is in Appendix B.
3.	*HPNF: Pilot research with community groups (phase 1 qualitative research)*	This document highlights the importance of fostering safety with consultative groups. This includes direct safety features such as acknowledging the sensitivity of the content, access to counsellors and quiet/safe places, as well as administrative functions, to name a few (Chamberlain, Gee, et al., 2019).
4.	*HPNF: Critical friends' protocol*	This internal document is indirectly relevant to safety because it fosters a transparent and value-adding process for identifying additional expertise and inviting critical friends to the research process.
5.	*HPNF: Authorship guidelines*	This internal document is potentially relevant to safety as it systematically guides contributions for authorship. Meaning participation, valuing, and recognition appear to be important aspects of the project.
6.	*HPNF: Protocol for systematic review of qualitative studies*	This protocol is relevant to safety in that it will inform the development of perinatal awareness, recognition, assessment, and support strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma (Chamberlain, Ralph, et al., 2019).

Appendix B: Specific Protocols/Procedures

HPNF Managing Distress Protocol with Focus Group Participants

Participant Distress	A participant tells you or exhibits behaviours which suggest that the focus group is distressing to them; such as crying, shaking, being angry or aggressive, withdrawing, or walking away.
Facilitators Response	The facilitator will • acknowledge the participants distress; • ask the participant if they would like to take a break, and if so, guide them to a designated safe area; • ask the participant if they would like to speak with a counsellor (clinical psychologist/psychologist; co-facilitating the focus group), and if so, organise for them to sit with the distressed participant while facilitator continues with focus group; • acknowledge that the participants distress may be upsetting for those continuing in the focus group, and encourage others to take a break if needed, and to use the designated safe areas.
Co-facilitator/ Counsellor Response	The co-facilitator/counsellor will • remind the participant that they can stop participating at any time; • use a conversational approach to assess the participant's mental status ("Can you tell me what you are feeling?", "Do you feel able to go on about your day?", "Do you feel safe?", "Can you tell me what thoughts you are having?"); • if suicidal thoughts or plans are disclosed, then the counsellor is to follow the suicidal risk procedures overleaf; • talk about what sort of support the participant feels they need at present, and what referral options are available in their area.
Review	The co-facilitator/counsellor will establish • if the participant feels able to carry on, then assist them to return to the focus group; • if the participant is unable to carry on, assist with further support as outlined below.
Co-facilitator/ Counsellor Further support	The co-facilitator/counsellor will • organise for the participant to stay in the safe area, and to resume the group if sharing a cup of tea or meal afterwards, or if travelling home together; • assure participant that their contribution to the project, even in part, is valuable, and discuss how their information will be used, confidentiality etc.; • ask if there are any family members the participant would like you to contact, and if so, make contact with that person; • discuss facilitating access to immediate support as needed; • discuss referral to ongoing local support services, and seek consent to contact a member of their health care team to initiate this as needed; • discuss and provide details for other online and phone based support services.
Follow up	The co-facilitator/counsellor will • seek consent to contact the participant 2-3 days following the focus group to check in on their wellbeing (will need to ask for their phone number); • give the participant their phone number and encourage them to call, or to use the 24 hour phone based contact services, if they become distressed again in the hours/days following the focus group; • at the earliest opportunity, take detailed notes of exactly what happened and what support was offered/taken up; • contact one of the Chief Investigators within 24 hours to discuss your concerns and options for any further action.