Perceptions and experiences of traditional healing in two North Queensland Aboriginal communities

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Statement of Original Authorship

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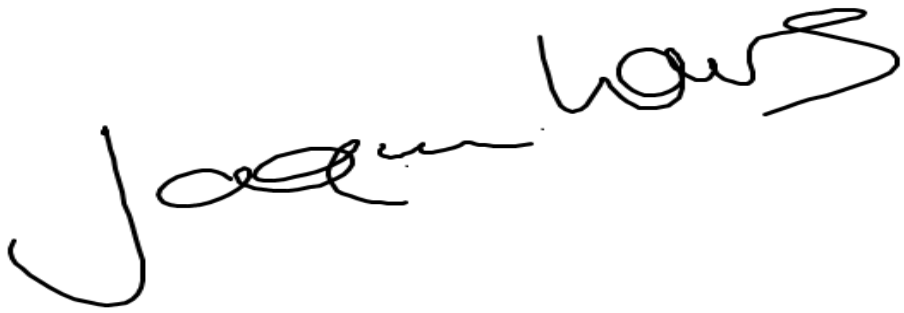

Jacqui Lavis

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Abstract

My research examines the perceptions and experiences of traditional healing among Aboriginal Australians in Far North Queensland within community settings. This question was informed by the following: firstly, the World Health Organisation has acknowledged the value and contribution of traditional healing to health, wellness, and people-centred care. Secondly, Australia's Productivity Commission found, in an Inquiry into mental health, that traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. The Inquiry recommended that the Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services to improve health outcomes. Most scholarly research in Australia on this topic has tended to address questions of cultural appropriateness of mainstream healthcare for Aboriginal people, rather than look to Indigenous viewpoints to inform potential integration between traditional and mainstream healthcare. This is in contrast to the literature from Asia and Africa where traditional healing is frequently considered the most immediate treatment option particularly where distance or resource limitations limit the delivery of mainstream healthcare.

In North Queensland, there is no structured or systematic recognition of healers by mainstream health services and little substantial published research on either the role of traditional healing, or the experiences of community members as to its practice. Significant interest was shown in this subject by the Apunipima Cape York Health Council with the Chairman acting as cultural broker to ensure the cultural safety of the research. An ethnographic study was conducted in two phases in two distinct North Queensland Indigenous communities, Aurukun and Yarrabah. Data collection involved observation, in depth interviewing, and participant observation, with thematic analysis (Fereda & Muir-Cochrane, 2006) used to critically examine field notes.

Members of the two study communities offered contrasting insights into how healing is constructed and the role traditional healing played and continues to play in their communities. Aurukun residents who participated in the study sustain Wik customary lore and belief and utilise totemic symbolism in everyday life. The relocation of Stolen Generation children to the Yarrabah mission, and the consequential family disruption, created competing interests between language groups, and resulted in cultural fragmentation.

In some Aboriginal communities, traditional healers continue to practice, but rarely in health services. Individual health service practitioners recognise that their patients might choose to access traditional healing during a treatment regime. Despite this emerging understanding however, there are no systems, policies or processes for formal recognition of traditional healers in mainstream health systems in Australia.

International research regarding medically pluralistic behaviour shows that initial choice of a therapeutic mode is driven by patient beliefs about illness causation. For example, symptoms attributed to disturbance of spirits are often believed to be incurable by biomedicine. Such beliefs are common in Aurukun. Therapeutic healing places within Yarrabah have been recognised historically and accounts within the community level attest to the significance of continuing connection. Such beliefs influence how people in both communities view approach the biomedical work of their health services.

Indigenous leaders and healers use a cultural lens to view an intercultural domain of social recovery and health practice. The intercultural domain is an "in-between" space, characterised by hybridity where identity can be expressed, and innovative sites of collaboration created. Conclusions drawn from analysis of the data suggest that such an intercultural domain of health practice could respond to personal and family-based expectations of healing and community cohesion. This could occur through integration of Indigenous expectations of biomedicine, social recovery, cultural belief, and traditional healing practices within unique social ecologies of healing.

Acknowledgment of Country

I acknowledge the traditional owners from the Wik and Gunggandji nations, together with the historical residents of Aurukun and Yarrabah, who also have enduring connection with these places. I am humbly grateful for their generosity, friendship, and support of my learning journey. I acknowledge the Elders past, the Elders present, and emerging together with those Elders yet to come. I respectfully interpret the term “Indigenous” to include Australian Aboriginal and Torres Strait Islander peoples.

Acknowledgements

I am grateful in a myriad of ways for the support of Bernie Singleton, as cultural broker, research collaborator, and friend. As a traditional owner on his father's side, he speaks for Yirriganydji (Salt Water Djabugay). Bernie is an Elder of the Umpila tribal group on Cape York, and was born and raised in Yarrabah as a Stolen Generation descendant. His knowledge of Cape York and its people is unparalleled. He is trusted and welcomed as a mediator and advocate across Cape York communities, and under his cultural protection I was privileged to hear the voices of a number of Cape York healers, knowledge keepers, and community members.

Cleveland Fagan, as Chief Executive Officer of Apunipima Cape York Health Council, provided the opportunity to seek the endorsement of the research by the Board. Over the years, he also acted as a sounding board for research reporting and conceptual thinking. In a subsequent role as Executive Officer of the Yarrabah Leadership Forum, he facilitated access to the Leadership Forum strategic planning process, so I could observe Indigenous governance of healing in action.

The participants from Aurukun and Yarrabah trusted me with their stories, perceptions, fears and hopes as to how experiences within their life-worlds impact on their view of healing.

My supervisors, Professor Christine Phillips, ANU Medical School and Dr Rosalie Aroni as primary supervisor have helped bring the research to fruition, through patient attention to detail, acting as a sounding board as I interpreted my results, and ensuring I was able to maintain focus. The Learning Advisers Dr Jillian Schedneck and Dr Thuy Do were also a valued resource.

Dr Graham Fordham, my first supervisor, instilled a love of ethnography through his suggested readings. Samia Goudie, Associate Professor of Indigenous Studies at the University of Canberra, ensured I could hear the Indigenous voice.

Family members and professional supporters were numerous and I realised the reach of my work when seven people personally close to me participated in my Oral Presentation by Zoom; an extraordinary and moving event in the pandemic affected year of 2020.

My husband Russell Watkinson has been magnificent, alternating between helping to challenge my thinking and nurturing as required.

This research is supported by an Australian Government Research Training Program (RTP) Scholarship. This support enabled me to travel remotely to undertake the fieldwork. It

also enabled me to attend conferences and seminars to support my learning and to hear contemporary analysis of Indigenous issues across a number of disciplines.

I was also privileged to receive a Vice Chancellors Travel Award which enabled me to explore a European perspective on Indigenous research at the University of Warsaw.

Declaration concerning terminology when referring to Aboriginal and/or Torres Strait Islander Peoples

This thesis uses the term Aboriginal Australians when referring to the peoples of Cape York and North Queensland, where community identity is considered Aboriginal. and in recognition of the land upon which the research is conducted. The term Murri is also broadly used in these regions. Within these communities some people will identify as Torres Strait Islanders but no participants have so identified.

This thesis uses the term Aboriginal and Torres Strait Islander peoples as terminology when referring to situations or information relevant to settings that are not community specific.

This thesis uses the term Indigenous when referring to literature that does not specify affiliation or uses that term and/or when overseas material is being referred to.

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Glossary

Aak-ngeeyan, komp kath, kon puchalam	Wik spirit beings manifesting as dwarves or little men (Martin, 1993).
Aboriginal Community Controlled Health Services	A primary health care service that is initiated and operated by the local community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).
Afghan camel trader	Afghan camel traders in Australia, also known as "cameleers" were camel drivers who worked in Outback Australia from the 1860s to the 1930s transporting supplies from cities to regional towns, inland mines, and stations.
Alternative therapies	Used instead of standard treatments, these can include acupuncture, massage, naturopathy, homeopathy and osteopathy.
Apunipima Cape York Health Council	Community Controlled Aboriginal Medical Service representing health interests of Cape York Aboriginal communities including provision of primary health care.
Ayurveda	Ayurveda, is a form of Traditional Indian Medicine literally translating from Sanskrit to mean "systematic knowledge of the lifespan." A person's health is based on their osha, the balance of the five elements of the world known as air, earth, space, water, and fire. (Monier-Williams M. 2002)
Auwa	Centres of totemic power (Wik) where pulwaia or totems are found.
Complementary medicines	Complementary medicines used in addition to standard treatments, include vitamin, mineral, herbal, aromatherapy and homoeopathic products.
Community governance	Processes of decision making and the scope of control, power, and authority that Indigenous governing bodies have to make and exercise laws, resolve disputes, carry on public administration and community development, and assert and exercise choice. These are the product of localised cultural values, institutions, behaviours, and motivations (Hunt & Smith, 2005).
Cultural fragmentation	The concept of cultural fragmentation implies the disintegration of "singular" cultures and the formation of numerous diverse cultures, be they associated with particular ethnicities, religions, concepts of nationhood or people groups, or those associated with particular forms of lifestyle, values, or commodification (Mansvelt, 2011).
Cultural gatekeeper	A person who has power and influence in a community setting, generally by virtue of their kinship affiliation but sometimes attributed to their native title holder status or governance roles. They "can add value and credibility to

	a research project. Alternatively, they can prevent access, erect barriers, and effectively hold up or shut down a project" (Sullivan, 2020, p. 350).
Culture men and women	Term used by cultural broker to describe those people actively engaged in cultural practice and recognised for skills and/or knowledge.
Deed of Grant in Trust land	Land granted in trust under the Queensland Land Act 1962 for the benefit of Aboriginal inhabitants or for the purpose of an Aboriginal reserve.
Gunggandji	Aboriginal peoples and traditional owners of Yarrabah and surrounding land.
Historical Owner	A term used within the Yarrabah community to denote those who have long standing community connection based on family members who were forcibly removed to the Yarrabah mission.
Centrelink "activity" (To qualify for certain social security payments, a person must satisfy an activity test.)	Paid work, approved course of education or study, training to improve work skills and/or employment prospects, unpaid voluntary work, unpaid work experience, unpaid internship, unpaid work for a family business owned by immediate family member; actively looking for work or actively setting up a business that has not yet started to operate.
Free lunch program	A program delivered at school in response to the nutritional and social needs of children
Integrative medicine	The practice of integrative medicine refers to the blending of conventional and evidence-based natural and complementary medicines and/or therapies with lifestyle interventions to deliver holistic, patient-centred care (RACGP, 2016).
Intercultural mediators	Intercultural mediation is a relational and interpretative activity. Intercultural mediators seek to explain, comment, interpret and negotiate alternate cultural understandings of situations and circumstances (Irishkanova et al., 2004).
Knucklebones	Metatarsus or metacarpus bones from a small animal, cleaned and shaped and used in a throwing game for divination or magic.
Little man	Dwarf spirit beings from Wik cultural beliefs. Wik language terms for these beings include aak-ngeeyan, komp kath, kon puchalam (Wik lexicon), sometimes manifesting in pairs "like brothers" (Kilham, 1986; Martin, 1993).
Mandingalbay Yidinji	Aboriginal peoples and traditional owners of Yarrabah and surrounding land.
Manual medicine	Manual medicine is a variety of hands-on therapies ranging from gentle, passive joint stretching to forceful mobilisation to improve biomechanical range of motion. These techniques are most commonly utilized to treat musculoskeletal disorders, particularly neck and low

	back pain. Includes osteopathy, chiropractic medicine, and therapeutic massage.
Mudshell	Wik term for geiorna expansa - mangrove clam –edible shellfish
Murri	North Queensland term for Aboriginal person.
Murri Court	Murri Courts are courts for sentencing Indigenous offenders who have pleaded guilty to an offence that can be dealt with in a Magistrates Court. A Murri Court is more informal, Indigenous Elders assist the Magistrate with cultural issues, and an attempt is made to work out why the offender committed the offence (Queensland Parliamentary Library, 2006).
Native Title connection report	A connection report is required by the Queensland government for management and mediation in the native title process. The report defines the potential native title claimant group, the identification and location of claim areas, and presents evidence about the nature of the connection between the claimant group and the area of claim under traditional law and custom. It is not a statutory requirement of the Commonwealth Native Title Act 1993.
Natural helper	Community based volunteers, with strong relational connections, who can be first point of contact in social or medical situations of risk. They provide emotional support and practical assistance while waiting for emergency services.
Ngangkari	Traditional healer for the Annangu nation, the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara people of the desert country which crosses Northern Territory, South Australia, and Western Australia borders.
Nganwi or ngeen-wiy (Wik)	Sickness and the practice of spiritual healing.
Party houses	Term used commonly in Aboriginal communities to refer to a dwelling where disturbance from loud music after hours and general noise is experienced. May also refer to houses where drug usage and alcohol consumption is thought to be common.
Pig dog	Dog bred specifically for hunting feral pigs for pest management and recreation.
Pulwaia	Totem (Wik language) or ancestor figure.
Purriy Purriy	Sorcery practices – term used specifically in Aurukun and on Mornington Island and intermittently across northern Cape York Peninsula.
Remote Schools attendance program	The Remote School Attendance Strategy (RSAS) is a community-focused strategy, funded by the Australian Government to improve school attendance of children in remote settings. RSAS works with local providers to employ teams of school attendance supervisors and school attendance officers to help kids get to school.

Songline	Songlines trace the journeys of ancestral spirits as they created the land, animals, and lore. Integral to Aboriginal spirituality, songlines are deeply tied to the Australian landscape and are represented by customary songs, dances, painting, and stories. (Chatwin, 1987; Lilienthal & Ahmad, 2017).
Shaman	Shamanic phenomenology involves the control of dimensions of the environment and spirit worlds through arousal, affect, and mental imagery. Shamans frequently interact with the spirits and sometimes "incorporate" them, but remain in control of the process, only suspending volition temporarily.
Stolen Generation	The Stolen Generations (also known as Stolen Children) were the children of Australian Aboriginal and Torres Strait Islanders who were removed from their families by the Australian federal and state government agencies and church missions, under acts of their respective parliaments. The removals of those referred to as "half-caste" children were conducted in the period between approximately 1905 and 1967, although in some places mixed-race children were still being taken into the 1970s (Human Rights and Equal Opportunity Commission, 1997).
Talisman	A talisman is any object to which are ascribed religious or magical powers intended to protect, heal, or harm individuals for whom they are made. They were called “tricks” by one Wik participant.
Thaypan	Ritual name for snake invoked in Wik initiation ceremonies. May also be used colloquially to refer to a Wik “doctor” or healer.
Traditional Chinese medicine	Seeks to restore the body’s balance and harmony between the natural opposing forces of yin and yang, which can block qi (life force) and cause disease. Traditional Chinese medicine includes acupuncture, diet, herbal therapy, meditation, physical exercise, and massage.
Traditional Owner	An Aboriginal person who has, in accordance with Aboriginal tradition, social, economic and spiritual affiliations; socially validated genealogical connections and responsibilities for particular lands or country.
Whitefellas	Aboriginal term for non-Aboriginal people
Wik	Native title owners of Aurukun and surrounding country.
Wirral	Edible mollusc (Yarrabah name) – similar to mudshell.

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List of Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CHHHS	Cairns and Hinterland Hospital and Health Service
HREC	Human Research Ethics Committee
NGO	Non-government organisation
RACGP	Royal Australian College of General Practitioners
WHO	World Health Organisation

Preface

When I reflect on how this research came to be undertaken, I realise the privileged access to Indigenous knowledge, culture and friendship that has been extended to me. A series of formative events and experiences include the many simple encounters and the mostly unspoken offers of assistance, guidance and tolerance that I have encountered in remote community settings.

An early experience of the significance of learning by observation and applying community focused solutions occurred while I was working as a community consultation adviser to an engineering company. Within the Aboriginal community of Wujal Wujal in Kuku Yalanji country, I encountered for the first time, a world of ancient language, ancestral belief, and tradition. A technical presentation about the disposal of effluent from a sewage system was conducted through translation into Kuku Yalanji by a community leader. I was conscious of a group of women at the back of the room growing vocal and impatient. After the presentation finished, I was led outside, a short distance from the effluent disposals site, and shown a basket of potato-like roots, which I eventually realised were native yams. The English communication from these women was limited but their concerns were soon clear. Would a food source be polluted by effluent irrigation? The yam samples were taken back to the office, where a plant ecologist checked genus and skin permeability and found one susceptible species. We revisited the site and adjusted the effluent disposals area. The community then cleared and replanted an extended yam garden.

I spent the next year working across a further six communities. I facilitated workshops; explained the operation of water supply and sewerage systems and how to read gauges and dials; walked and talked with Elders; discussed housing needs, dugong hunting, and outdoor kitchens; said prayers and went to church; heard about the tensions of spirits influencing community business, talked about fishing, bush tucker, and raising children; and absorbed the ground rules of ethnography as described by Hammersley and Atkinson (2007, p. 3):

> "…participating in people's daily lives…watching what happens, listening to what is said, and/or asking questions…collecting documents and artefacts - in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry."

An open heart and mind coupled with cultural curiosity concerning these transitioning lives led me to seek employment with Apunipima Cape York Health Council developing "Whole of Health" plans for Cape York communities. There, Bernie as Chairman and cultural broker created opportunities for me to meet with Elders and holders of cultural power and knowledge and to experience their daily lives. This included developing understanding and then acknowledging their frustrations as to the operation of unresponsive government services including overt racism and judgmental positioning. I learnt also that ancestral guidance remains fundamental to directing behaviours, but that cultural authority can be disregarded in some Indigenous settings and that many Indigenous Elders attribute addiction and violence to lack of continuity of such authority.

As my understanding grew, I decided to undertake this research to attempt to give voice to experiences of and aspirations for recognition of healing practices that are embedded in Indigenous belief systems. Listening to the voices of the many men and women who have told me their stories and constructed complex cultural narratives for me over the years, I have found my own voice.

As a white Australian woman (who has discovered the complexity of her own Asian/European background during this research), I have learnt ways to hear and communicate how the complexities of Indigenous belief, power, kinship and association with place need to influence mainstream governance. Working with Bernie Singleton, we have been able to assist in aligning Indigenous and mainstream health governance and operations in some settings through identifying how collaborative power structures might work and how funding and investment can underpin such collaboration.

Above all however, nurturing practices of listening and hearing the voices, their context and their needs and finding ways to respond has been the pivotal research practice.

Chapter 1: Introduction

1.1 Why examine traditional healing?

There are significant health disparities between Indigenous and non-Indigenous people in Australia, fully documented within the public record (AIHW, 2020a; ABS, 2019a; ABS, 2019b). There have been some improvements in Indigenous health outcomes in the last ten years, as demonstrated through Close the Gap reports (Australian Human Rights Commission, 2018). However, Indigenous health outcomes are still not optimal. Infant and child mortality occurs at twice the rate that it does for non-Indigenous children (Department of Prime Minister & Cabinet: Closing the Gap Report, 2020). Overall, mortality rates are 1.7 times higher for Aboriginal and Torres Strait Islander Australians than the non-Indigenous population (ABS, 2019b). This leads to ongoing differences in life expectancy, where Aboriginal and Torres Strait Islander Australians will live approximately 10 years less than non-Indigenous people in similar age groups (AIHW, 2016; ABS, 2019a).

Propositions that have been identified as having potential to improve Indigenous health outcomes include cultural competency training for non-Indigenous clinicians (Hearn et al., 2011; McRae et al., 2008; Mooney et al., 2005); investment in Aboriginal community controlled health services (Chong et al., 2011; O'Brien et al., 2004; Reibel & Walker, 2010); addressing the stressors affecting Aboriginal health workers (Deroy & Schütze, 2019); investing in health promotion to encourage alternate health behaviours in Aboriginal communities (Parker & Fleming, 2020); and developing pathways for Aboriginal people to train in health professions (Jongen et al., 2019).

Another option that has not been comprehensively explored is consideration of how traditional healing practices have been viewed and accessed within Aboriginal communities. It has been argued that differences in cultural beliefs between Indigenous and mainstream communities create distinctive experiences of healing (McKendrick et al., 2013). In other international settings, traditional healers have been recognised and merged into biomedical practice at a local level (Allen et al., 2020; Bodeker & Kariippanon, 2020; McKendrick et al., 2013).

It is not known how the merging of traditional healers into biomedical practice might work in North Queensland and there are no reports of any attempts to locate, support or understand traditional healing and healers in these places. To my knowledge, neither is there available research or information available about the attitudes of Indigenous communities in

North Queensland to traditional healing. Such information might apprise practitioners, policy makers and the communities of opportunities for health systems to incorporate traditional healing practices.

This gap in knowledge warranted asking the following research question which privileges personal narratives about Indigenous health perspectives:

> *What are the perceptions and experiences of Indigenous people in North Queensland regarding traditional healing?*

This thesis is an attempt to answer that question by exploring and examining the Aurukun and Yarrabah community members' perceptions and experiences of traditional healing. To improve local health outcomes, it is important to seek personal opinions in attempting to respond to Indigenous health needs. Yarning is the appropriate style of inquiry in such cases and has been used extensively in this research. Yarning is a conversational process that creates knowledge through the sharing of stories. It is an Indigenous way of communicating, in that it is culturally aligned and collaborative (Walker et al., 2014). The awareness of the significance of seeking the Indigenous voice through yarning, in designing health systems has been established. (Bessarab D, Ng'andu B. 2010; Durey, A., McEvoy, S., Swift-Otero, V. et al. 2016)

1.2 Indigenous voice and experience of healing in Aurukun and Yarrabah

This is a study of community-based perceptions of traditional Indigenous healing within Aurukun and Yarrabah, two distinct Aboriginal communities in North Queensland. In seeking to hear the Indigenous voice from the perspective of a white female researcher, I was honoured to have the assistance of Bernie Singleton who, as cultural broker, nurtured interpersonal situations of trust and rapport.

In Aurukun, I was permitted to explore narratives on how the locus of the Spirit World, together with the activity of benign or evil spirits, healers and sorcerers, impact on wellbeing. Healers manage these interactions with community members, adapting their expectations of biomedicine to accommodate their beliefs and preferences. The Indigenous cultural landscapes of Aurukun have been recorded and categorised for nearly ninety years.

There is limited ethnography however related to health beliefs and practices and no investigation of such beliefs in the context of improving health services.

In Yarrabah, I was privileged to observe Indigenous leadership in action, and to observe the progress of a social recovery agenda. Crucial to this process was the need to recognise the nuances of lateral transfers of power in community settings, and being aware of how "not talking black" can advance a change agenda.

The focus of this research was on the meaning that participants attributed to their perceptions and experiences of traditional healing. There is substantive literature, nationally and internationally, suggesting that traditional healing provides advantages in treating Indigenous people (Dudgeon & Bray, 2018; Bodeker & Kariippanon, 2020; Allen et al., 2020). In Australia, the value of traditional healing practices has been recognised in the field of mental health (Dudgeon, 2017; Westerman, 2010) and cancer care. (Ristevski E, et al., 2020). Community control has been effective in improving access to health services that are culturally aligned with community needs in local settings (Panaretto et al., 2014) but the use of traditional healers is inconsistent (McKendrick et al., 2013). One explanation for such inconsistency might include the loss of cultural knowledge, including healing as Elders pass away, with limited options for cultural transmission of skills and reduced recognition of the value of those skills by younger people (Viscogliosi et al., 2020). Another explanation might be that health services, clinics and biomedical practitioners have failed to invest the time or resources to recognise the benefits of traditional healing regimes (Gonzalez & Davis, 2016). There may also be the possibility that communities have been reluctant to expose healing practices to mainstream scrutiny (Oliver, 2013).

1.3 International and national perspectives of healing

Traditional healing within Indigenous Australia encompasses a holistic worldview which is reflected in the World Health Organization's definition of health as "physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 2013). This Indigenous worldview recognises good health as a complex system involving interconnectedness with the land, recognition of spirit and ancestry, and social, mental, physical, and emotional wellbeing both of the individual and the community (Oliver, 2013; Wilson & Richmond, 2009).

Indigenous Australians view ill health as the result of one of three causes – a natural physical cause, a spirit causing harm, or sickness due to sorcery (Wilson & Richmond, 2009;

Maher, 1999). The impact of colonisation and the subsequent displacement and disconnection of people both from their traditional lands and later from their traditional families has been significant in its effect on cultural practices including healing (Campbell & Burgess, 2012).

The World Health Organisation defines traditional medicine as "the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses" (WHO, 2019). As the antithesis to this definition of traditional medicine, biomedicine is defined as clinical medicine based on the principles of the natural sciences; that is, the practice of healing is based on scientific, biological, and physiological principles rather than traditional knowledge. Biomedicine is based on the view that illness is a quantifiable episode (Ahlberg, 2017) and can be diagnosed and treated through recourse to Western scientific evidence.

In traditional healing in Australian Indigenous communities, illness tends to be viewed as a breakdown of balance between natural and spiritual forces (Pesek et al., 2006). This can be due to omissions, such as breaking codes of conduct now or in the past, as well as interaction with ancestral spirits, sometimes benign and sometimes evil (Clarke, 2007; Martin, 1993; Poroch et al., 2009). This understanding of illness causation is congruent with beliefs in other regions where traditional healing is commonly used. Ifeanyi (1992, p. 30) notes that in African traditional healing belief systems, "health involves not only physical exuberance but also harmonious integration of an individual with the entire universe, both spiritual and material." Traditional healers across cultures seek to restore spiritual and physical balance, requiring intimate, personalised interactions (Labhardt et al., 2010).

It has been acknowledged that Indigenous healing practices are uniquely situated in place and cultural practice (McKendrick et al., 2013, p. 2). This finding is consistent with Amery's (2017) view that Indigenous language, with unique and often localised morphology, idiom, expression, and syntax, can never be congruent with biomedical or clinical terminologies. The "lost in translation" effect is nowhere more critically problematic than in the Indigenous experience of health care: the terms "therapeutic noncompliance," "lost to follow up," "did not wait for treatment," and other commonly used expressions on discharge summaries or clinical file notes suggest a story of significant failure of communication in clinical practice (Aboriginal Health Policy Directorate, WA, 2018).

Such deficiency in communication practices is underpinned by a fundamental failure to provide culturally safe health care settings for Aboriginal and Torres Strait Islander peoples. [1]

The concept of human health where an individual is dynamically situated in community and place is central to Indigenous beliefs (Hunter et al., 2006). In practice, this perspective includes following a cultural path (losing and regaining culture), regaining balance (physically, spiritually, emotionally, and mentally), and respectful interactions with others. The interconnectedness of the mental, physical, emotional, and spiritual realms of well-being is fundamental to health (Mark & Lyons, 2010). Globally, indigenous cultures create collective values and identity, where health and wellness are functions of relationships with land and spirits (MacDonald et al., 2015; Poroch et al., 2009; Shepherd et al., 2017). Research in international settings, including Africa, Latin America, Thailand, and amongst the First People of Canada and Native Americans, demonstrate a range of understandings of traditional healing across cultures (Adams, 2013; Birn, 2009; Hollenberg et al., 2008; Kane, 2010; Singh & Madhavan, 2015;). Culturally adapted assessment and treatment strategies have shown a positive impact on well-being, substance dependence, and self-management among Indigenous people (Hinton et al., 2015, pp. 18–22).

1.4 Overview of the study area

The study sites of Aurukun and Yarrabah are discrete examples of Aboriginal communities, which evolved from Christian missions established from the late 19th century by a variety of European Church groups. Aurukun and Yarrabah are over 1000 km apart,

[1] Definitions of Cultural Safety vary across the policy documents of Indigenous and non – Indigenous organisations, but broadly the concept seeks to create an environment that is safe for Aboriginal and Torres Strait Islander people. (Bnads et al. 2021) This means there are no racist attitudes exposed or challenge or denial of their identity and experience.
Cultural safety is about:

- Shared respect, shared meaning and shared knowledge.
- The experience of listening and learning together with dignity.
- Strategic and institutional reform to remove barriers to the optimal health, wellbeing and safety of Aboriginal people. This includes addressing unconscious bias, racism and discrimination, and supporting Aboriginal self-determination.
- Individuals, organisations and systems ensuring their cultural values do not negatively impact on Aboriginal peoples, including addressing the potential for unconscious bias, racism and discrimination.
- Individuals, organisations and systems ensuring self-determination for Aboriginal people. This includes sharing power (decision-making and governance) and resources with Aboriginal communities (see also 2.3.3).

Aurukun being on the north-western side of Cape York and Yarrabah being south of the Murray Prior Range, south of Cairns (Figure x p 90). Both communities experienced oppressive cultural impacts imposed by longstanding mission personnel. Government responses to the strategic significance of the resources of the respective locations (bauxite, timber, marine resources, agricultural land potential) resulted in wholesale dislocation of community access to traditional lands. A cadre of white administrators related to both resource exploitation and to government service delivery has existed in both communities for many decades, although this is slowly changing. In Yarrabah, education and training opportunities for local people to obtain professional qualifications are easily available within Cairns and this is reflected in current and emerging local Indigenous leadership of health services and local government administration. Aurukun is much more remote and until recently local public schooling was only available to Year 6, with only a few children and families able to access the benefits of boarding school to Year 12. This coupled with the fact that Aurukun is a smaller community than Yarrabah reduces the potential pool of those who might aspire to attain professional qualifications and work within their home community setting. Indigenous community control is therefore taking a slower path in Aurukun.

1.4.1 Aurukun – a constellation of individuals, families, clans, ceremonial and language groups

Pre-contact dispersed semi-nomadic groups, occupied a broad area of land, between the Embley and Edward Rivers. Patrilineal clans owned the land, each with certain hunting rights but with tenure also defined by totemic association action with place and linguistic affiliations. There could have been some 2,000 Wik. At least 2000 Wik people could have occupied the rich coastal zone with similar numbers in the less ecologically diverse but extensive inland forest and sand ridge zone (Martin, D. F., 1997).

The Aurukun Mission (known initially as the Archer River Mission Station) was established on 4 August 1904 for the Presbyterian Church of Australia to the north of this locality. This Mission, was not registered under the *Industrial Schools and Reformatories Act 1865*, which meant that the government did not remove any Aboriginal children from other regions to the community under these legislative provisions. [2]Aurukun has retained its

[2] https://www.qld.gov.au/firstnations/cultural-awareness-heritage-arts/community-histories/community-histories-a-b/community-histories/aurukun

cultural tradition, as recognised in its Wik native title claim which established that native titles can co-exist with pastoral tenures, (Brennan 1997.)

In other words, colonially derived tenure systems and their associated dispossession have not restricted the ongoing Aboriginal connection with the land. The Wik traditional healers of Aurukun, Cape York, are active and create political agency; by retracing acquired cultural memories and nurturing new generations of healers to travel paths of resistance, reciprocity, and responsibility with their ngangk thanth (spiritual life force), these individuals influence contemporary beliefs and practices.

1.4.2 Yarrabah – a culture of shared identity but divergent viewpoints

Yarrabah is a discrete Aboriginal community, south east of Cairns. The traditional custodians of the area are the Gunggandji people. The community was founded as an Anglican Mission in 1892. The Industrial and Reformatory Schools Act 1865 allowed Indigenous children to be sent to industrial schools or reformatories on the grounds of `neglect'. Simply being Aboriginal was proof of neglect and for the purposes of the Act, some missions were declared to be industrial schools or reformatories to which Indigenous children could be sent. Under these provisions State governments forcibly relocated Aboriginal and some South Sea Islander peoples to Yarrabah. The first Aboriginal Council was established in the mid-1960s, principally as an advisory body. The community received a Deed of Grant in Trust (DOGIT) land tenure status in 1986 and is now self-governing. As a result of its history, the community currently has residents representing more than 30 Aboriginal nations. There is a cultural and political divide between the traditional owner groups (defined as part of a major native title claim determined in 2011 and subsequent land transfers of Deed of Grant in Trust land) and historical owners (the descendants of the Stolen Generations brought to Yarrabah, often as young children). Representatives of both groups have historically provided significant leadership as community activists for change, in Christian ordained or lay leadership and as local government elected members.

1.5 Organisation of the thesis

The first chapter of this thesis established the rationale and context for the study of healing practices in Far North Queensland Aboriginal communities. It presents the statement of the problem, the research question, and develops a rationale for seeking personal contextual experiences of healing.

Chapter 2 contextualises the study by examining the extant literature to determine the current state of knowledge about Indigenous health and traditional healing amongst Indigenous populations internationally, nationally, and within select localities of North Queensland. This identifies a gap in knowledge related to localised understandings of the perceptions and experiences of Indigenous people in relation to traditional Indigenous healing. This literature review also explores some concepts of Aboriginal spirituality and belief related to healing and constructs of wellbeing. It additionally presents selected literature that contributes to concepts of social ecologies of healing and other social theories that provide the theoretical basis for the study. The rationale for the study is established in Chapter 2, noting that in an environment of continuing ill health for Australian Aboriginal people, understanding both historical and contemporary cultural interpretation of healing knowledge is of value to healing practice.

Chapter 3 provides an outline of the research design and explains the rationale behind it. This chapter discusses developing trust amongst community members (where the role of the cultural broker was significant); some logistics of the study; identifying potential study participants and recruiting them to the study; together with data collection, thematic analysis, and discussion of the ethical parameters and dilemmas of the research. Themes were derived from "a recurring idea that threads its way through the data (albeit using different, nuanced words," (McGregor, 2018. p 13). Themes were identified through coding of data from pertinent field notes with verbatim quotes presented as evidence for the theme. The themes and supporting data were then analysed according to interpretations of literature in the field about a similar phenomenon (Ramello et al., 2015).

In Chapters 4 and 5, the results from Aurukun and Yarrabah are presented respectively as narratives in which the data are presented as verbatim quotes, descriptions of context, and the actions of participants from which interpretations of data are made.

The final chapter outlines the conclusions drawn from the results of this study and sets out the key ways in which it contributes to existing knowledge of Indigenous healing and how such knowledge might be accessed in an intercultural domain of healing. Discussion points are suggested as an option to use within further research to progress the understanding of Indigenous viewpoints of healing.

Chapter 2: Literature Review

2.1 Indigenous health – contemporary challenges

2.1.1 Disparities in health within Australia

Health disparities between Indigenous and non-Indigenous people in Australia are fully documented within the public record (AIHW, 2020a; ABS, 2019a; ABS, 2019b).

The Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report (AIHW, 2020e) states that the burden of disease among Aboriginal and Torres Strait Islander people is 2.3 times that of non-Indigenous Australians, with over - representation of mental health conditions and chronic diseases such as cancer, cardiovascular disease, respiratory diseases, diabetes and kidney disease amongst Indigenous peoples. This health inequity has figured prominently in Close the Gap reporting for the last ten years and includes higher rates of chronic and communicable diseases, injury, and avoidable hospitalisations for Aboriginal and Torres Strait Islander Australians than for non-Indigenous Australians (Dawson et al. (2020) The Closing the Gap initiative was developed in 2008 in response to a social justice campaign (Australian Human Rights Commission. 2018). Australian Governments sought to close the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians (Lowitja Institute, 2020). Targets were set for child mortality, childhood education, life expectancy, and health with the goal to close the gap by 2030. In 2018, a ten-year review (Australian Human Rights Commission, 2018) found that governments had failed to implement the Closing the Gap Strategy, fund policy commitments, or undertake required systemic reform. The Prime Minister's Closing the Gap Report (2020) found that only two of the seven targets are on track, related to early childhood education and attainment of the last year of secondary education. The target to close the gap in life expectancy by 2031 is not on track, nor are those related to child mortality, employment, or foundation educational skills.

The rate of infant and child mortality in Australian and Torres Strait Islander children is twice that of non-Indigenous children (Closing the Gap Report, 2020). Mortality rates are 1.7 times higher for Aboriginal and Torres Strait Islander Australians than the non-Indigenous population (ABS, 2019b). This leads to ongoing differences in life expectancy, where Aboriginal and Torres Strait Islander Australians will live approximately 10 years less than non-Indigenous people in similar age groups (AIHW, 2016; ABS, 2019a).

Indigenous people are reported to have a higher frequency of risky health behaviours than is seen within the general population (Waterworth et al., 2015). The influence of marginalisation in social networks, including intergenerational trauma, racism, social and economic disadvantage, together with psychological distress, exacerbate risk taking behaviours (Matheson et al., 2019). Kinship and family connections and associated cultural obligations can both reinforce or disrupt positive health behaviour, depending on highly localised circumstance (Arabena, 2020). Communication between Indigenous and non-Indigenous people may be characterised by distress. This can reduce the effectiveness of health interventions (Waterworth et al., 2015). Kelaher et al. (2014) found that those experiencing racism in healthcare settings were almost twice as likely to have high or very high levels of psychological distress compared to indigenous people who experienced racism in other settings.

Paradies et al., (2013) find that racism can result in negative health impacts for Indigenous peoples in several ways:

- Poor self-assessed health status (Paradies & Cunningham, 2012a),
- Cognitive, emotional, and physical strain, stress, or damage impacting upon mental, physical, spiritual, or social well-being;
- Reduced engagement in adaptive behaviors (e.g., physical activity);
- Maladaptive behaviors (e.g., alcohol and drug use);
- Compromised access to key health-promoting settings (e.g., education);
- Attenuated benefit from everyday routine activities (e.g., sleep); and
- Heightened contact with health-damaging exposures (e.g., toxic substances).

Harrell et al (2011) find that psychophysiological pathways link facets of racist environments with physiological reactions that contribute to disease. Such pathways include prenatal experiences, subcortical emotional neural circuits, conscious and preconscious emotion regulation and negative affective states arising from the impacts of experiences of racism.

The conscious perception of threatening events is one pathway leading to the disruption of physiological regulation. Stress responses can activate distinct neural circuits in the brain (LeDoux 1996). When the body is initially challenged by a stressor it responds with physiological activation (also known as arousal) of a defense system to deal with the immediate stressor. (LeDoux 1996). Unconscious or conscious awareness of elements of racism may cause physiological activation to take place. Repeated encounters with individual

or institutional racism and its context can elicit physiological reactions of which the individual is unaware. (Harrell et al., 2011).

Emotion regulation refers to the ability to increase, maintain, or inhibit the expression and experience of an emotional response. Successful suppression of an emotion may enhance physiological responses to stress. Those who deny or suppress the existence of racism can experience higher systolic blood pressure than individuals who confront and actively cope with racially motivated threats (Krieger and Sidney, 1996). Friedman and Thayer (1998) argued that chronic threats from racism can impact the calming impact of the vagus nerve on cardiac functions by creating anxiety. Kuzawa and Sweet (2009) proposed that the prenatal effects of racism are potentially transgenerational. The effects of stressful environments on the fetus can cause metabolic alterations during adulthood, and chronic psychosocial stressors experienced by the mother during gestation can threaten the well-being of the fetus. Racism can therefore be encountered before the brain of its victim is developed sufficiently to acknowledge the experience. Low birth weight may result (Giscombe and Lobel, 2005); but altered neural development, may not become evident until later in life.

Cave at al (2020) find that allostatic load is an indicator of multisystem physiological dysregulation resulting from over- or under-activation of systems designed to adapt to stress (i.e. metabolic, cardiovascular, immune, and neuroendocrine systems) (McEwen, 1998) Long periods of repeated exposure to psychosocial stressors such as racial discrimination are considered to increase allostatic load (Berger and Sarnyai, 2015) promoting pathophysiology and ultimately increasing morbidity and mortality (Juster et al, 2010) .

Vos et al. (2009) found that non-communicable chronic diseases account for 70% of the health gap between Indigenous and non-Indigenous Australians. Cardiovascular disease is most significant (23%), then diabetes (12%), and chronic respiratory disease (9%). Smoking, misuse of alcohol and drugs and poor-quality nutrition also contribute to these rates of disease (Vos et al., 2009; Petrie et al., 2008; Mathers et al., 2000). In 2017, suicide was the second leading cause of death for Indigenous Australian men and seventh for Indigenous Australian women (ABS Causes of Death, Australia, 2017). Within the non-Indigenous population, suicide is the tenth leading cause of death for men and twenty-first for women (ABS, 2019b).

2.1.2 Burden of disease

Indigenous Australians experience a burden of disease 2.3 times the rate of non-Indigenous Australians (AIHW, 2020d) and are far more likely to live with ill health and die

prematurely. In 2011, it was estimated that 284 years of healthy life were lost due to premature death or living with disease or injury for every 1,000 Indigenous people in Australia. Chronic diseases represent 64% of the total disease burden among Indigenous Australians (AIHW, 2016). The leading causes of total disease burden experienced by Indigenous Australians included mental and substance use disorders (19%); injuries (including suicide) (15%); cardiovascular diseases (12%); cancer (9.4%), and respiratory diseases (7.9%). Indigenous Australians are at greater risk of disability due to their higher prevalence of low birthweight, chronic disease, infectious diseases, injury, and substance use (AIHW, 2018b). In 2018–19, an estimated 38% (306,100) of the Indigenous Australian population had a disability that restricted their everyday activities. Limitations to schooling and employment due to disability were reported by 27% with a further 11% (85,700) reporting an impairment with no specific limitation or restriction (AIHW, 2018b). Indigenous Australians therefore reported a disability or restrictive long-term health condition in 2018–19 at 1.8 times the rate for non-Indigenous Australians (ABS, 2019b). Long-term health conditions and the social and economic consequences of these conditions may affect people's quality of life and could contribute to premature mortality and morbidity (ABS, 2019b). In 2018–19 (ABS, 2019a), among Indigenous Australians it was estimated that 67% (545,200) reported at least one current long-term health condition, while 38% (307,300) reported eye or sight problems and a further 24% (187,500) reported a mental health or behavioural condition.

2.1.3 Social determinants of health

Early life experiences, housing conditions, transportation and access to health services are broadly accepted social determinants of health (Wilkinson & Marmot, 2003). The Aboriginal and Torres Strait Islander Health Performance Framework (Australian Health Ministers' Advisory Council, 2012) presents a more comprehensive list of social determinants of health. These include community factors, such as connection to family, community, country, language, and culture, while others relate to wealth, e.g., employment, income, housing, environment, infrastructure, and food security. This framework confirms that engagement with the wider community impacts upon health, including interaction with government systems and services; health choices; experience of law and justice; and experience of racism. All of these factors have implications for early childhood development, education, and youth, which are themselves determinants of health (Moore et al., 2015). These findings are reinforced in a 2015 report compiled by the Sydney Metropolitan Local Aboriginal Health Partnership (2015), an alliance of mainstream and community controlled

Aboriginal Health Services, together with the hospital networks. Their report stresses the importance of proper access to work, education, government services and housing, and inclusivity within the wider community as factors that contribute to health and wellbeing.

The AIHW (2018b) quantified the role of social determinants behind the average health gap between Indigenous and non-Indigenous Australians using a composite measure of health. The analysis related to data on people aged 15–64 years from the ABS 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (Indigenous data), and comparable data from the ABS 2011–12 Australian Health Survey (non-Indigenous component).

In these Health Survey data, 28% of Indigenous adults were assessed to be in good health, based on the composite health measure, compared with 54% of non-Indigenous adults. The results of the statistical analyses showed that more than half (53%) of this health gap between Indigenous and non-Indigenous working-age adults can be accounted for by social determinants (34% of the gap) and "health risk factors" (19% of the gap). The former includes employment and hours worked, highest non-school qualification, level of schooling completed, housing adequacy, and household income, while the latter include binge drinking, high blood pressure, overweight and obesity status, inadequate fruit and vegetable consumption, insufficient physical exercise, and smoking.

Household income differences alone contributed almost 14% of the overall health gap, followed by differences in employment and hours worked (12%), and level of schooling completed (8.7%). Among the health risk factors, the key component was the difference in smoking status between Indigenous and non-Indigenous Australians (which contributed to 10% of the health gap).

2.2 Other factors affecting Indigenous health

2.2.1 Abuse of human rights

Poor health among Aboriginal peoples is a reflection of historic societal inequities (Carson et al., 2007). Dispossession and exclusion from access to traditional lands and breakdown in sustaining kinship, language, and culture are fundamental to this position (Human Rights and Equal Opportunity Commission, (HREOC), 1997; King et al., 2009). Racism underpins situations of exclusion from Australian social, political, and economic life. Such exclusion can have adverse consequences for health (Paradies, 2006; Marwick et al., 2019). Contraventions of Indigenous human rights have been ongoing throughout the postcolonial

experiences of Aboriginal Australians. This is demonstrated through the ongoing tragedy of Indigenous deaths in custody. The National Deaths in Custody Program has monitored the extent and nature of deaths occurring in prison, police custody and youth detention in Australia since 1980. The Australian Institute of Criminology has coordinated the program since its establishment in 1992, the result of a recommendation made in 1991 by the Royal Commission into Aboriginal Deaths in Custody, Recent figures show there were 489 Indigenous deaths in custody between 1991 to June 30, 2021, (Doherty, 2021).

Contextual research on health equity confirms that health cannot be secured amongst the vulnerabilities of human rights abuse within minority populations (Braveman & Gruskin, 2003; Gray, 2009).

Human rights abuses, the systematic inequalities of poverty and opportunity, alongside situations of dispossession, exclusion, discrimination, and marginalisation, are all implicated in Indigenous health inequity (Kairuz et al., 2020). The scoping review of Kairuz et al., (2020). will add evidence as to how racism and discrimination are associated with risky health behaviours and the consequent impact on the physical and mental health of Aboriginal and Torres Strait Islander peoples.

2.2.2 Resistance, social exclusion and cultural survival.

Merry (1998) suggests that an oppressed group (such as might be seen in Indigenous people in postcolonial societies) might "utilise existing structures to create a "way of understanding social transformation that is attentive to agency, to competing cultural logics, and to the complexity of the social fields within which change takes place" (Merry, 1998, p. 602). This form of resistance may appear as "accommodation and adaption" to other societal situations (Merry, 1998, p. 602). Similarly, Bhabha (1994) describes a renewed identity, created when groups seek recognition of alternative viewpoints, while using operational practices that are actively recognisable to government. Clifford (1994) suggests that such practices of accommodation, adaption, and positioning support group cultural survival. Within this survival realm, cultural focus on family and kinship obligation and responsibility alters the priority of personal needs and motivation derived from identity, self-esteem and empowerment in favour of group solidarity.

Waterworth et al. (2015) contend that culture, social networks, history, racism, socioeconomic disadvantage, and associated psychological distress interact to affect health behaviour. The multiplicity of influences on health behaviours both in individuals and group settings can be analysed using social models of health (Lynch, 2000). Such models categorise

factors into a series of social groupings that include broader societal influences (i.e., culture, politics, and discrimination), neighbourhood or community social interactions (i.e., social interactions and connections through groups and organisations), close social connections (i.e., friends and family), and individual characteristics (i.e., behavioural and psychological); (Waterworth et al., 2015).

2.2.3 Influence of historical events on psychological distress

Indigenous Australians have endured significant periods of genocide. There were at least 270 frontier massacres over 140 years of Australian history, as part of a government sanctioned intent to eradicate Aboriginal populations (Peters-Little et al., 2010). Genocide, the introduction of European diseases, dispossession, subjugation, and segregation reduced the Indigenous population by 90% between 1788 and 1900 (Harris, 2003). Aboriginal protection policies involved removing children from their families and forcing them onto state-controlled reserves often run as missions (Atkinson, 2005). These children are commonly referred to as the "Stolen Generations" (HREOC, 1997). The destruction of Indigenous languages, culture, religion, and social institutions was also widespread (Jalata, 2013). A synthesis of relevant research by the Australian Institute of Health and Welfare has confirmed that, due to such policies, many members of the Stolen Generations, including their families and descendants, suffer from trauma, which has been shown to increase the risk of substance misuse, adversely affect mental and physical health, and cause serious bodily or mental harm (AIHW, 2018).

Radford et al. (2021) find that adverse childhood experiences may be an explanatory variable for heightened rates of mental and physical health difficulties for Indigenous populations. These communities have experienced a lack of adequate health care due to remoteness, historical traumas, cultural insensitivity, racism, and the perpetuation of systemic discrimination. Those who have suffered such experiences demonstrate increased rates of suicidality and psychological distress. Protective factors to reduce the impact are recognising cultural identity and connectedness, education, social support, and psychological resilience.

Discrimination and racism towards Indigenous Australians continue to affect their lives, merging inherited trauma with current mistreatment (Atkinson, 2002; Kelaher et al., 2014). Synthesising a range of documented surveys, reports, and census reporting, Kelly et al. (2009) created a discussion paper for the Australian Indigenous Psychologists Association (AIPA) to instigate debate around the determinants of Indigenous social and emotional wellbeing. They identified a range of risk factors for psychological distress, including:

distressing life events; trauma, grief, and loss; child removals; cultural dislocation; unresolved grief and loss; uncertainties concerning cultural identity; economic and social disadvantage; poor physical health; incarceration; child removal by care and protection orders and juvenile justice supervision; violence; substance use and abuse; and systemic discrimination. Some of the negative outcomes from serious psychological distress include suicide and intentional self-harm; anger and aggression; problem gambling, and smoking.

Kelly et al. (2009) showed that serious psychological distress is an independent predictor of, and part of, the causal pathway towards physical illness and mortality risk. Causal associations include reduced life expectancy, premature mortality, greater incidence and prevalence of disease, increased behavioural risk factors for ill health, and lower overall health status. They argue that measuring and monitoring levels of psychological distress could reposition Indigenous social and emotional wellbeing from a descriptive construct to an explanatory framework.

2.3 Indigenous health and human rights – the advocacy response

2.3.1 Historical change in an Indigenous health organisation

The capacity of health organisations to improve in substantial and sustained ways is demonstrated by the example of Apunipima Cape York Health Council. Since its inception, Apunipima has evolved from a small advocacy organisation to the largest ACCHO in Queensland. It emerged as part of the outcomes of an Indigenous Australian health conference in 1994, attended by representatives of 17 Cape York communities and associated homelands concerned about the poor health status of Cape York Aboriginal and Torres Strait Islanders (Tilton et al., 2015). Apunipima was officially established later that year as a health advocacy body mandated to inform the Cape York Land Council and the ATSIC Regional Council about local health issues. While maintaining its advocacy role, it now delivers comprehensive primary health care in unique facilities to 11 local communities, through community based and fly-in–fly-out services from Cairns. There are in excess of 6000 people registered with Apunipima health services and in a typical recent year, there are more than 53,000 client contacts.

Although one third of staff have clinical roles, the Apunipima model of care incorporates health promotion. A study by Mcfarlane et al. (2016) characterises health promotion activities as providing health information, but also delivering health education, counselling, and skill development in health behaviours. Apunipima adheres to a family-

centred model of comprehensive primary health care which sees clients as people embedded in families and communities. Their significant advocacy position continues to pursue Queensland government commitment to transition health services in Cape York to community control. Page (2015) argues that Indigenous community-run organisations are distinct because they are manifestations of continued attempts to negotiate and transform the power relations between the settler-colonial state and Indigenous peoples. According to Merlan (2005, p. 168) such organisations are political and cultural structures, existing as "inter-cultural mediators" between Indigenous population expectations, wants, and needs on the one hand, and the "legitimising through recognition by the state" on the other (Page, 2015).

Harfield et al. (2018) found that the broad range of Indigenous health disparities can be effectively addressed by Indigenous primary health care service delivery with local cultural values, customs, and beliefs at the centre of such care. Durey and Thompson, (2012, p. 28) suggest that health systems should develop a "critical consciousness." where health care providers suspend disbelief and subjugate their own worldviews; becoming "attentive to the client's understanding of health and illness."

2.3.2 Translational health systems for Indigenous Australians

The concept of a translational health system refers to evidence-based practice bridging the divide between research knowledge and its application to treatment options, policy, and practice (Curtis et al., 2017). An example of this approach can be seen in responses to chronic disease in Indigenous Australians. Indigenous Australians with complex chronic conditions are expected to access health and support services at increasing rates in the future. A current key focus of the Australian health system is therefore the prevention and improved management of chronic disease in the Aboriginal and Torres Strait Islander population (AIHW, 2014). Chronic disease management is both challenging and complex for individuals and the healthcare system at large, requiring a wide range of health literacy skills and support from social networks (Hosking et al., 2018; Lloyd et al., 2014). Recognising that Aboriginal and Torres Strait Islander people experience high rates of chronic disease has been the first step; the current challenge is to anticipate chronic disease comorbidity and to invest in promoting self-management and disease specific education. A literature review by McMullen et al. (2015) reviews interventions in chronic disease for Indigenous people. Examples include interventions in CVD (Mathur et al., 2006; Wilson, 2010), diabetes (Azzopardi et al., 2012), and kidney disease (Burnette & Kickett, 2009; Stamp et al., 2006). These studies describe measures taken to identify and reduce systemic barriers such as poor

access, which might be caused by anything from transport issues, lack of affordability, appropriateness and availability, to poor communication, racism, lack of cultural awareness in non-Indigenous staff, lack of health education, poor continuity of care, lack of support, and fear and mistrust (Artuso, 2013).

The NSW Health Clinical Services Redesign Program Chronic Care for Aboriginal People (2010) created a model of care for working with chronic disease in Aboriginal communities after extensive consultation with Aboriginal Health Workers, clinicians, hospital executives, and community members. The eight fundamental elements that were identified as being essential to the model of care included screening and assessment, clinical indicators, treatment, education (responding to biomedical perspectives of health and healing), referral, identification, trust, and follow up (responding to Aboriginal expectations of acknowledgement of personal identity in relationships in healing). This approach reinforces the understanding that Aboriginal people do not expect to be defined as disease sufferers, valuing functionality in daily life above biomedical concepts of good health (Aspin et al., 2012).

Despite such emerging focus on evidence-based practice however, there is still inadequate response to addressing social determinants of health (see 2.2.3). For example, the following are significant predictors of some chronic illnesses: income level and its impact on diabetes incidence; (Dinca-Panaitescu et al., 2012); poor housing condition and impacts on hospitalisation and multiple chronic conditions, (Takahashi et al., 2016); adverse childhood experiences and incidence of poor mental health (Radford et al.; 2021) Social determinants of health, similarly influence prevention and management of specific conditions such as cardiovascular and renal disease (Tobe et al., 2015).

2.3.3 Cultural Safety and Cultural Competency

Within Queensland, the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033 provides policy direction seeking to acknowledge and respect the diversity in Aboriginal and Torres Strait Islander peoples and cultures and their right to equitable, accessible and quality health care. The concept of cultural capability, just like clinical capability, is considered to be an ongoing journey of continuous individual learning and organisational improvement, in order to ensure best practice in health service delivery. The core principles of cultural safety are embedded within a Cultural Respect and Recognition principle referring to the knowledge, skills, behaviours and systems that must be demonstrated. Examples of culturally respectful and safe practice include

- Recognition and responsiveness to the fundamental link between the health of an individual and the health of their family, recognising the complexities and significance of kinship.
- Treatment of all Aboriginal and Torres Strait Islander people with dignity, fairness and respect, regardless of their background and position
- Respect for persons that is consumer-oriented, including respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support network, and choice of provider
- Respect for the consumer's chosen family members or others in advocacy roles.
- Respect for the rights of individuals regarding decisions about their own health care, based on the provision of adequate, clear information, free of cultural bias, upon which to base those decisions.
- Respect for holistic and cultural traditions in health, healing, birthing, death and dying.
- Recognition by clinicians of the importance of addressing the specific needs of Aboriginal and Torres Strait Islander consumers in assessment and treatment decisions, with understanding of epidemiology including risk factors that impact on the health status of Aboriginal and Torres Strait Islander people.

The Framework has supporting principles relating to culturally sensitive communication, establishment of relationships and build effective long-term partnerships with other agencies and with Aboriginal and Torres Strait Islander organisations and communities and capacity building in leadership and human resources.

2.3.4 Patient Engagement

Policies and practices that support nuanced approaches to patient engagement are emerging within health care systems. Tobiano et al., (2021) have undertaken a scoping review on patient engagement approaches in health care. Their findings are that an engaged patient has a strong motivation to become more knowledgeable and hold more power in healing relationships. Medical practitioners need understanding of patients' clinical condition, personal situation, decision making capabilities and aspirations together with personal or family-based preferences for engagement to achieve participation and involvement in healing journeys. They propose an Interactive Care Model that consists of the following phases: assess the person's capacity for engagement; exchange information and communicate choices; planning between people and clinicians/healers; appropriate interventions determined; and

regular review. Unfortunately, their research suggests that encouragement of patient engagement is sporadic and interventions by medical practitioners to promote patient engagement are not always appropriately individualised.

Looking at Indigenous Australian perspectives for patient engagement, Conway et al. (2017) find that access to Aboriginal Medical Services and Indigenous Australian health workers is vital for effective communication and engagement. Poor cultural safety in mainstream health services limits and discourages patients' understanding of physiology and disease in a linguistically and culturally suitable form and fails to reflect different world-views. Conway et al. (2017) argue for the need to value Indigenous knowledge and cultural beliefs in order to build trust and empowerment and to promote awareness of the social context of racial discrimination, loss and grief associated with colonisation. Appropriate language, a de-medicalised approach and honest disclosure have been identified also as facilitating trust and communication with Indigenous Australians. (Conway, 2017). Miscommunication and poor health education leads to a cycle of suspicion, blame and distrust of medications. (Lowell at al, 2012) Sharing knowledge between patients, Indigenous Australian health workers and families is a culturally appropriate approach to building community knowledge, (Jennings et al, 2014).

Roche et al (2020) in their *Valuing All Voices Framework* outline four essential components of patient engagement, (trust, self-awareness, empathy, and relationship building). *Trust* addresses the 'bearing witness' aspect of trauma-informed practice and listening to others' experiences. *Self-awareness* embodies critical reflexive practice and the need for self-care in a trauma-informed approach. *Empathy* requires acknowledgement of how systems of power and oppression attempt to divide and 'other' people by masking unearned privilege and oppression. Empathy also addresses how trauma-informed practice connects us through the universality of traumatic experiences. *Relationship building* values lived experience and all forms of knowledge.

Pomey at al. (2015) argue that patients must be recognised as proactive partners in care. Learning practices allow them to acquire experiential and scientific knowledge about their health, assessment practices evaluate the partner relationship, as to how a health professional's actions adapt to sharing of the care relationship. patients' experiential knowledge and unique position as experts on living with their chronic illnesses allow them to have a greater role in ensuring optimal care. Pomey at al. (2015) suggest that in the future, exploring the notion of patient partnership should focus equally on the perspectives of healthcare professionals. How do they view patient partners, and what are the key

components that enable them to establish constructive and trusting relationships with their patients? Only then will it be possible to gain a broader understanding of how productive interactions between healthcare professionals and patients might include the recognition of alternate healing beliefs and practices alongside clinical response.

2.4 Terminologies of healing

2.4.1 Why are definitions of healing important?

In a qualitative assessment of healing practitioner beliefs, Egnew (2005) found that themes of wholeness, narrative, and spirituality are congruent with the derivation of the term "healing." However, biomedicine promotes no operational definition of healing, and its explanation of its mechanisms describe physiological processes associated with curing disease (Dorland, 2007; Dossey, 1995; Weil, 1983). More concerns of biomedicine arise from the emerging clinical value of analysis of large biomedical data sets and the use of personalised genetic information (Mittelstadt, 2019).

The dissonance between understandings of biomedical practice and traditional healing (with its focus on wholeness and spirituality) is obvious in the narratives presented in this research. The analysis of this dissonance is important in understanding future options for traditional healing practices.

In an examination of the biomedical approach, Krieger (2011) summarises the following features: that biomedicine is the domain of disease with causes restricted to biological, chemical, and physical phenomena; that within biomedicine there is an emphasis on laboratory research and technology and translational health research; and that the patient's body is considered a system of physical parts, which can be fixed or exchanged with new parts when broken (Marcum, 2004). In biomedicine, the language of knowledge and data is based on texts in scientific literature, such as in clinical, technical, and administrative guidelines in health care settings, and in a myriad of databases such as pathology and diagnostic reports (Casteneda et al., 2015). In health care facilities, patient information mainly occurs in narrative notes and reports, which is then uploaded to electronic health records to facilitate health information exchange (Evans, 2016).

2.4.2 The world view of traditional healing

2.4.2.1 Global Perspectives

The World Health Organisation (WHO, 2019) defines traditional medicine as "the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses." The WHO (2019), acknowledges the contribution of traditional medicine to health, wellness, people-centred health care, and universal health coverage and has sought and continues to seek to integrate traditional medicine with mainstream health care. Traditional healing within Aboriginal Australia encompasses a holistic worldview which reflects that of the World Health Organization's (WHO 2008) definition of health, that is "physical, mental and social wellbeing and not merely the absence of disease or infirmity." This worldview recognises good health as a complex system involving interconnectedness with the land, recognition of spirit and ancestry, and social, mental, physical, and emotional wellbeing both of the individual and the community (Oliver, 2013). Indigenous Australians view ill health as the result of one of three causes – a natural physical cause, a spirit causing harm, or sickness due to sorcery (Wilson & Richmond, 2009; Maher, 1999). The impact of colonisation and the subsequent displacement and disconnection of people both from their traditional lands and later from their traditional families has been significant in its subsequent effect on cultural practices including healing (Campbell & Burgess, 2010).

2.4.2.2 Different viewpoints of human health

Mehta (2011) states that in the biomedical model of health, human beings are viewed as biological organisms (materialism), to be understood by examining their constituent parts (reductionism) using the principles of anatomy, physiology, biochemistry, and physics. Disease is seen as a disturbance from the biological norms. Consequently, health is defined as an absence of disease and associated with activities of doctors to the extent that, to most people, medicine became synonymous with health (Hart, 1985). In the scholarly literature, our understanding of human beings has changed significantly, as reflected in Merleau-Ponty's (1962, cited in Gold, 1985) notion of the "lived-body" and Sprenger's (2005) summary of characteristics of living organisms. The "lived-body notion maintains that our bodies are not objects, but are multiphasic, experiential beings of finite freedom" (Gold, 1985, p. 664). From this perspective, the body is a nucleus of one's consciousness and intentionality. Moreover,

living systems have come to be seen as systems (of which mind and body are a unit) that are integral parts of larger systems, in permanent interaction with their environment and capable of constructing their own subjective realities. These concepts are embedded in Indigenous views of a healthy mind and body (Sutherland & Adams, 2019).

Traditional Indigenous beliefs explain why sickness occurs. McCoy (2006) indicates that the traditional health model, which guides and influences people's beliefs and behaviour, contrasts with a very different emphasis on the physical body offered by Western medicine in the local clinic or hospital. He indicates that the traditional desert healers of South Australia (*maparn)* would say that "new" diseases such as kidney disease, diabetes, and cancer lie outside their powers. These sicknesses have become identified with incursion of non-Aboriginal people to their world, and require non-Aboriginal solutions.

International research on traditional healing has included identification of parallel diagnostic systems, although these seem to rely on continuity of practice and belief and limited contact by outsiders. For example, a longitudinal study reported by Herndon et al. (2009) shows a strong degree of convergence in shared perception between the ethnomedical system of the Trio tribes of the Guiana rainforest, and Western biomedical systems. Many Trio disease conditions were shown to correspond to disease constructs within a biomedical system. The investigation demonstrated, for example, that within respiratory condition diagnosis, Trio shamans identified three distinct conditions corresponding closely to Western biomedical concepts of upper respiratory tract infection (*toon*), pneumonia (*irori*), and tuberculosis (*otonoimë).* The research of Hendon and his colleagues indicates that the perceived gap between traditional healing and modern Western medicine is not as clear cut as previously assumed, and is perhaps more a matter of cultural perception and bias than of sound theoretical principles.

2.4.3 Diagnosis within traditional medicine practices – a contemporary view

A chapter on diagnosis of disorders by traditional medicine practices is included in the International Classification of Diseases 11th Revision (World Health Organization, 2018). Disorders are identified by their symptomatology (based on traditional medicine diagnostic skills) and unique aetiology, that is, as explained by cultural relationships to environment, emotional states, and human pathology. This recognition of traditional medicine is based on healing practices from China, Japan, and Korea (World Health Organization, 2018). There is no specific reference to practices within Australia or closely parallel cultures within Oceania or the Americas. The Australian Institute of Health and Welfare has responded to those

recommendations of this updated 11th Revision (AIHW, 2020). However, its response relates primarily to data management and workforce, while largely ignoring traditional medicine diagnostic practices in its considerations. This is consistent with government approaches at both Commonwealth and State level, which have undertaken little action to progress an understanding of cultural knowledge in healing, with more attention paid to questions of cultural positioning of mainstream health services (Bainbridge et al., 2015).

2.4.4 Categorisation of knowledge

Agrawal (2005) suggests that research that categorises Indigenous knowledge can be regarded as a redemption, that is that the knowledge is regained or saved and its loss is prevented by the act of description. Clifford (1986, p. 115) has referred to such works or recording and retrieval of knowledge as "allegories of salvage." An example of this is when continuation of cultural practices is secured in oral or video history recording in Aboriginal communities (Gwatkin-Higson, 2019). Such knowledge must always be maintained and held subject to Indigenous protocols regarding the obtaining of the knowledge and its future use (Janke & Sentina, 2018). The knowledge may then potentially be viewed in relation to scientific or social utility, including being made available those who are not Indigenous (Agrawal, 2005).

For these scholars, the notion of salvage is central to research on Indigenous knowledge work because of its concern with loss and value. As Agrawal (2005, p. 72) puts it, "scholars of the Indigenous see the subject of their interest as always-already disappearing." Questions related to loss, value, and salvage are intimately concerned with power: "what threatens Indigenous knowledge is also precisely what many advocates of Indigenous knowledge seek to advance by identifying, documenting, collecting, and systematising Indigenous knowledge" (Agrawal, 2005, p. 72). Agrawal suggests that such knowledge may be at risk of becoming obsolete in the face of economic, social, and scientific "advances", demonstrating the need for intervention that both incorporates and respects Indigenous needs and expectations.

This opinion of Agrawal is not shared or demonstrated in the research, the subject of this study. The knowledge concerned is far from obsolete but is fragmented and not properly acknowledged or understood within mainstream health services.

Nakata (2007a), a leading researcher in Indigenous education, has argued that Indigenous Australians seek to reshape, understand, and analyse how Western science and thought has surrounded Indigenous knowledge systems. According to his research, the

growing "confidence" of Indigenous critique of Western knowledge in Australia informs Indigenous political resistance and principles of self-determination, and creates solidarity with other Indigenous peoples internationally. However, Nakata (2007a) also contends that a critique of Western knowledge is not sufficient for the defence of Indigenous systems of thought or the re-building of Indigenous lives and communities. He argues that new forms of "decolonial knowledge-making" and Indigenous knowledge create mechanisms through which political resistance, as the path to Indigenous "liberation" and re-affirmation of traditional identities, is exercised. To adapt cultural practices and re-instate conceptual thought from Indigenous knowledge systems or traditions, Smith (1999) suggests a "decolonising priority to re-claim, re-name, re-write, and re-right to attain Indigenous autonomy and distinctiveness" (p 45).

Nakata (2002) explains that "the invocation of the 'traditional' or 'community' realm brings a regime of knowledge authorisation tied to the assertion of ancestral, spiritual, authentic, and distinct Indigenous identities." Nakata (2007b) also introduces the concept of the "cultural interface" as a framework for exploring the exchange between Indigenous and non-Indigenous systems, as well as situating Indigenous life-worlds in the dynamic space between ancestral and Western realities. Nakata (2007b) asserts that an Indigenous standpoint theory must be more than a personal narrative that counters the accounts of others; but must be reflexive and provide a distinction between experience and standpoint, generating change from the possibilities in the spaces between Indigenous and non-Indigenous positions.

2.4.5 Traditional healing practice in the context of primary health care

In her review of the literature concerning the role of traditional medicine practice in primary health care within Aboriginal Australia, Oliver (2013) observes that its existence depends on association with culture and beliefs about disease causation, type of illness presenting, success of biomedical treatment, and accessibility to traditional healers and bush medicines (Devanesen & Henshall, 1982). What is missing, however, is the acknowledgement that recovery may be enhanced with recognition of the cultural context. Whilst the benefits of palliative care for terminal illnesses are not proven scientifically, anecdotally there is much to suggest that significant comfort can be given. Oliver (2013) finds that traditional medicine practices are used both sequentially and concurrently with biomedical healthcare. She suggests we need to understand the role of traditional medicine practices, and improve and support integrative and governance models for such practices.

Stanifer et al. (2015) identify five major determinants for the use of traditional medicine in their research conducted in Tanzania: biomedical healthcare delivery, credibility of traditional practices, strong cultural identities, individual health status, and disease understanding. These findings are based on extensive survey and qualitative fieldwork with local patients, healers, and medical professionals. They identified significant divergence on the topic of healthcare-seeking behaviour, allocating the cause of this divergence to a possible combination of reporting bias on the part of the structured survey, and researcher bias on the part of biomedical practitioners. Their interview results show that participants, including healers, confirmed that most people attend hospital clinics for diagnostic testing only but preferred to seek treatment from traditional healers. However, according to the analysis of their questionnaire survey, nearly all participants confirmed they attended hospital clinics for diagnostic testing and treatment. The perceived credibility of traditional practices was closely related to participants' strong cultural identities. Stanifer and his co-researchers observe from other studies that concurrent biomedicine and traditional medicine use exists even for conditions with strong links to traditional medicine, such as epilepsy. Such practices also exist in chronic disease management commonly regarded as "white man's diseases." When an individual's health status declined and biomedicine is perceived as ineffective, traditional healing may be sought (Albert et al., 2017; Saethre,2017).

Stanifer's model is inclusive of complementary and alternative medicine as well as traditional medicine. Other research in this field includes work by Nambiar et al. (2014), which examines traditional and complementary medicine providers across three Indian states. This study focused on local health practitioners, homoeopaths, Ayurvedic and/or Unani practitioners, with the purpose of understanding the operational and ethical challenges posed by the integration of these providers when delivering essential health services. The processes of integration of practitioners were studied using qualitative interview methods to help identify systemic and ethical challenges. Their findings revealed that, despite the high-level of political will required to support these types of innovative approaches to medicine, a number of practices are within scope of many local health services. These include case documentation and sharing across systems, including in the academic literature; providing routine opportunities for interaction and collaboration across systems (e.g., health camps, health promotion drives) and within co-located facilities (e.g., staff meetings); rewards for the integrative initiative of individuals (e.g., challenge grants or institutional recognition) and at the systems or facility level (e.g., joint targets such as the number of monthly referrals, number of cases resolved jointly); and the development of clear guidelines for collaboration

(criteria and conditions for cross-referral, jointly developed by practitioners, non-clinical aspects of work together, including health promotion and managerial duties).

Nambiar et al. (2014) conclude that integration occurs when individuals exercise personal initiative "in the form of collegiality, recognition of stature, when dealing with fellow practitioners" (p. 5). Their research identified barriers to integration at a systems level, including fragmentation of jurisdiction and facilities, intersystem isolation, lack of trust in and awareness of traditional, complementary, and alternative systems and inadequate infrastructure and resources. Their view is "that it is a system where 'little somethings' of individuals that catalyse integration are met with 'nothing as such' at the systems level" (p5) in other words, it is left to empowered and passionate individuals to make traditional healing work.

The concept of traditional healing integration seems to fare better when given a biomedical-type title such as "integrative medicine." Hunter et al. (2016) makes a case for establishing a research network into Australasian integrative medicine practice. A debate about the relationship of traditional Indigenous healing with the Australian concept of integrative medicine is beyond the scope of this research. However, some synergies are obvious. The Royal Australian College of General Practitioners (RACGP) defines integrative medicine as:

> "The blending of conventional and evidence-based natural and complementary medicines and/or therapies with lifestyle interventions to deliver holistic, patient-centred care. The overarching aim of integrative medicine is to use the most appropriate, safe, ethical and evidence-based modality(ies) available, with a particular focus on prevention and lifestyle interventions." [3]

Examples of integrative medicine modalities in the RACGP's Curriculum for Australian general practice (2016) include mind–body medicine interventions (e.g., mindfulness meditation, biofeedback, cognitive behavioural therapy and hypnotherapy) with a natural association with the mind-body philosophy of traditional healing. Yet there is a dissonance implicit in the RACGP Curriculum for Australian General Practice (2016) which also states that the following therapies are not in the scope of the curriculum:

[3] https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/processes/im16-integrative-medicine

> "Traditional healing systems – (which) are built upon complete systems of theory and practice such as naturopathic medicine and traditional Chinese medicine, including acupuncture and Ayurvedic medicine."[4]

The RACGP supports GPs undertaking cultural assessments to understand belief systems of patients. However, without the curriculum providing guidance as to how knowledge might be sought regarding traditional healing, there is little opportunity to progress this approach a structured way.

The debate concerning integrative medicine within Australia is ongoing but currently inconclusive as to whether research concerning Indigenous traditional healing will be actively sought as part of integrative medicine philosophy and practice (Hunter et al., 2016).

The work on development of integrative medicine curricula introduced into USA residency programs for graduate medical education was documented by Jani et al. (2015). This work identified integrative medicine guiding principles, such as that patient and practitioner are partners in the healing process. Furthermore, all factors that influence health, wellness, and disease are taken into consideration in medical treatment, including mind, spirit, and community considerations. Integrative medicine competencies for a preventive medicine residency curriculum have been approved by the Accreditation Council of Graduate Medical Education. Within graduate medical education, candidates are expected to show knowledge of a range of medical systems, common complementary and integrative health approaches, and manual medicine disciplines, including osteopathy, chiropractic medicine, and therapeutic massage.

Panzironi (2013) queries a World Health Organization view that Australia is considered to be at an advanced stage of policy development in "traditional, complementary and alternative medicine." Her report disputes this positioning and argues that Australia sits at the end of that spectrum occupied by countries in which the policy process on traditional medicine from the Indigenous perspective has not yet started. She contends that traditional knowledge has been colonised and that, in the minds of the biomedical profession, a temporal linear progression exists from "primitive" Aboriginal traditional medicine through to the modern science-based biomedical model. The possibility that Aboriginal traditional medicine can, in these circumstances, coexist or be integrated with biomedicine would be viewed by

[4] https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/processes/im16-integrative-medicine

Panzironi as remote, particularly as major national policy agendas make limited mention of the issue. Nevertheless, Panzironi suggests that within South Australia, where the desert traditional healers (the ngangkari) still practice in a range of ad hoc situations, evidence demonstrates that the provision of ngangkari healing services has a range of benefits. These benefits include positive health outcomes for patients, produced by enhanced feelings of calmness and familiarity, which in turn increases the patients' likelihood of complying with their treatment. Within her research. Panzironi suggested that the development of a holistic two-way health care model has also been shown to increase the cost effectiveness of health care, reduce cases of misdiagnosis, and build wider community trust in Western medicine. Panzironi (2013) recommends a new state-wide policy framework of a two-way health care model based on six constitutive components:

- The Anangu Ngangkari Tjutaku Aboriginal Corporation as the central body for the coordination, administration, and delivery of ngangkari services.
- A ngangkari accreditation process with qualification, accreditation, and registration standards for the recognition of ngangkari as legitimate health practitioners.
- A Register of accredited ngangkari.
- A ngangkari employment scheme grounded on a state-based model.
- A systematic database on ngangkari interventions.
- Introduction of health professional training and development modules on the role of ngangkari in health care.

However, nominating a specific Aboriginal Corporation to take a state-wide role is contested. For example, Angela Lynch (Kenyon, 2016), Programme Manager at the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation (an organisation which supports ngangkari) says she cannot see how ngangkari could ever integrate with mainstream medicine, as their approach to illness comes from a completely different cultural and belief system.

> The ngangkari here are part of an old belief system. They don't want regulation, but prefer to operate as a parallel health service …many are happy not to be part of the health system. (Lynch as quoted in Kenyon, 2016, p4).

The South Australian Government Department of Health (2014) has recognised the question of access to traditional healers, yet in their report, "Aboriginal Health in South Australia 2011-2014: A Case Study" it was stated:

> "In 2011 SA Health acknowledged there was neither a consistent way to access traditional healers nor a referral process, so stated it would review ways to support involvement of traditional healers by mid-2013. SA Health did

> develop a referral process through the Statewide Traditional Healers Program (Ngangkari Brokerage Program), but by the end of 2012, evidence could not be found, of how many people are accessing traditional healers through SA Health's brokerage program, nor when, in what region, or for how many visits. Without this information, it is not possible to determine if SA Health is meeting its intentions. The extent to which access needs are being met by the Aboriginal community-controlled sector is similarly unknown but one in every thirteen Aboriginal South Australians says they have seen a traditional healer in the last year." (p. 25).

This indicates a significant disconnect between intent and understanding as to how traditional healing is accessed. Traditional healing is accessed at the community level when outside of the system. It can only be accessed within a system when culturally safe space is created; (Maar et al., 2009).

2.4.6 Some international perspectives on Indigenous traditional healing

In Canadian research, Robbins and Dewar (2011) identify the definition of traditional healing from Velimirovic (1990), as modified by the Royal Commission on Aboriginal Peoples (RCAP, 1996), as "practices designed to promote mental, physical and spiritual wellbeing that are based on beliefs; which go back to the time before the spread of Western scientific bio-medicine" (Velimirovic, 1990; RCAP, 1996). When Indigenous people from Canada use the term *traditional healing*, they may be referring to specific ceremonies and rituals that promote spiritual, mental, physical, and psychological well-being as well as plant-based remedies (Bassett et al., 2012). Ermine (2007) describes traditional healing as coming from the community mind with intergenerational transmission of knowledge, and Osterreich (1998) details the practice of shamans in trance, healing, and ritual. The relationship between shamans and healing is outlined by Krippner (2007)

> "There are shamanic methods that closely parallel contemporary behavior therapy, hypnotherapy, family and milieu therapy, drug therapy, psychodrama, and dream interpretation. As a result of these similarities the psychological study of shamanism has something important to offer to cognitive neuroscience, social psychology, psychological therapy, and ecological psychology." (p 19).

Colonial authorities within Canada felt sufficiently threatened by Aboriginal ceremony that the Indian Act in 1884 banned ceremonies, such as the Sundance and the Potlatch, resulting in dislocation from cultural practice and loss of identity, causing unresolved grief (Mitchell et al., 2019). The Act also authorised the forced removal of

children to Residential Schools, significantly underpinning intergenerational trauma and oppression caused by alienation, starvation, and persecution (Brave Heart & deBruyn, 1998; Sochtung et al., 2007; Waldram, 2004). Resolving intergenerational trauma directs contemporary notions of Aboriginal healing (Kirmayer et al., 2009).

The presence of the Spirit World (Absolon, K. 2010; McIntyre-Tamwoy, 2001). and Spirit World messengers is embedded in Aboriginal understandings of healing. Waldram (1997) suggests that Elders are usually seen as special spiritualists, while Mandelbaum (1979) describes shamans as having supernatural powers, who heal others from spiritual afflictions that are limiting their connection to the Spirit World. Hatala and Desjardins (2010) make a distinction between Elders who are spiritual messengers, with a worldview directed by spirituality, and the "honorable Elders", who are influenced by the Spirit World in relation to moral precepts.

Wenger-Nabigon (2010) suggests that the Medicine Wheel, amongst Canadian Aboriginal peoples, is seen as "a symbolic cyclical interpretations of life and connectedness and provides for individuals to make sense of their world." Good health is perceived to be a "balance of physical, mental, emotional and spiritual elements. All four interact together to form a strong, healthy person. If we neglect one of these elements we get out of balance and our health suffers in all areas" (Malloch, 1989, p. 106).

In New Zealand, Ahuriri-Driscoll et al. (2012) found that traditional Maori healing involves a range of targeted practices. These include rongoa rākau (herbal medicine); mirimiri (a body work practice that rebalances, restores function and releases tension in the body, focusing on tissue, muscle, bone, and blood); romiromi, which stimulates the internal organs and systems of the body, releasing blockages; and karakia, Māori incantations and prayers that invoke spiritual guidance and protection. Whilst knowledge and practice of traditional Māori healing (rongoā) is well documented (Ahuriri-Driscoll et al., 2008), it is noted that healers/rongoā practitioners report limited acceptance for the holistic nature of their capabilities. Although some rongoā service contracts exist within mainstream health settings, there is a focus on complementing biomedical practice so that some rongoā concepts are selected over others in treatment regimes (Ahuriri-Driscoll et al., 2012)

A Maori healing and wellness framework (closely aligned to the Australian "wellbeing" frameworks) has been developed from the Maori world view (Ahuriri-Driscoll et al., 2012). A narrative consultative process was conducted with Maori traditional healers and mainstream health professionals described through imagery of the weaving of stories, "weaving the hau, the sacred breath and stories of many together" (Ahuriri-Driscoll et al.,

2012, p. 17). The agreed states of wellness cover a continuum from personal spiritual health through the capacities for nurturing and emotional healing to a sense of individual integrity, all in the context of healthy environments.

The presence of the Spirit World is also fundamental to Maori healing (Hardy & Hemi, 2019). The navigation of the Spirit World pathways through ancestral guidance is offered through a primary mental health care program called Mahi a Atua (tracing the ancestral footsteps of the Gods) (Rangihuna et al., 2018). Maori creation narratives underpin acknowledgement of "mental states of being" and "responses to distress and dis-ease." These "states of being" are illustrated by the Atua (Ancestor Gods) who experience a spectrum of family and social distress, demonstrating resilience, resolution, and well-being. Psychiatric care in this program is subordinate to reinforcing such culturally relevant understandings (Rangihuna et al., 2018).

A number of studies have examined different aspects of use of traditional Indigenous medicine and complementary medicine among Indigenous cancer patients. Struthers & Eschiti, (2004) find that culture, belief system, and interpretations of the meaning of illness have an important impact on peoples' approaches to treatment. Traditional healing acknowledges that healing occurs as a result of the connection with the spirit world and that the interconnection of life and healing in Indigenous culture is an understood phenomenon.

Adams et al, (2015) affirm that Indigenous people tend to have a holistic concept of health, which contrasts with the biomedical model. This differing perspective incorporates their need for connection to culture, heritage, land and the spirits of their ancestors, which alongside the social and spiritual support that traditional healers provide. Traditional medicine sustains wellness for Indigenous cancer patients, rather than solely focussing on curing the disease. (Ristevski, Thompson et al., 2020)

Healthcare providers self-reported that they struggled to communicate with their Indigenous cancer patients, especially when English was the patients' second or third language This is cause for concern given the complexity of information in cancer care regimes. Meiklejohn et al., (2016). Healthcare providers also reported difficulties in understanding Indigenous cancer patients' worldviews and the complexity behind their connection to land and family Meiklejohn et al., (2016). This finding corresponds with Shahid et al. (2009, 2010) that Indigenous cancer patients felt healthcare providers ignored the importance of their connections to land and family, which contributed to the breakdown of trust in the clinical relationship.

2.5 Aurukun - the Wik ethnographies

The Wik nation are saltwater Aboriginal people from the Western side of Cape York Peninsula (Smyth & Monahan, 2004). There are significant Wik ethnographies of seasonal natural resource use, language, custom, and genealogy (Sharp, 1937; McConnel, 1935; 1939; Thomson, 1939; Sutton, 1979; von Sturmer, 1978; Taylor, 1984).

Thomson (1939) observed the effect of the monsoon climate of Far North Queensland on Aboriginal custom and lifestyles, describing seasonal distribution of monsoonal wetland and the social organisation of exploitation of differing wetlands for food and other raw materials. People are mobile and move from place to place throughout the year as natural resources wane or come into fruition (Thomson, 1939) Scholars such as Chase and Sutton (1981), Sutton (1979), Taylor (1984), and von Sturmer (1978) elaborate on the modes of social organisation and the logistical strategies that people used in movement around their land and sea country in natural resource procurement. There are no distinctive descriptions within these ethnographies of healing practices. Mobility was observed to be socially organised, cyclical, and predictable, based on carefully prescribed routes between lagoons and rights of entry (e.g., to use water, or to hunt and collect attendant wildlife and vegetation). Formal and informal rights of access are assigned through the clan estates of the father's or mother's country (Stanner, 1965). Movement was also no doubt controlled by the exchange of information about environmental conditions and natural resource availability between neighbouring groups (Monaghan, 2003). Contrasting wet and dry season lifestyles described by Sharp (1937), Thomson (1939), Taylor (1984), Chase and Sutton (1981), and von Sturmer (1978) have been identified as a form of "strategy switching" between collecting and foraging modes of food procurement, and between relative sedentariness and high mobility in the wet and dry seasons respectively (Gould, 1991).

Thomson (1939) and Sharp (1937) describe late dry season gatherings that may have involved hundreds of people for ceremonial winter feasts at inland waterholes. There is no detail concerning the activities at those ceremonies other than generic commentary concerning the likelihood of arranging marriages and other kinship related ceremonies and performance of ritualised dance sequences. Specific linguistic identities associated with the clan estates in the region were identified by Sutton (1979) while McConnel (1957) published a map of sacred totemic centres in this region. This work was supplemented by detailed, culturally referenced ethnographic site recording (von Sturmer, 1979) and a range of ethnobotanical studies (Sutton & Smyth, 1980; Sutton, 1995; Smyth, 1981, 1982).

The result of this amalgamation of information, much of it collected in collaboration with traditional custodians' land, results in detailed historical perspectives of totemic affiliation, land and resource use, genealogy, and language. However, in focusing on natural resource access, this research did not collect details as to how daily life sustained or was influenced by totemic powers or the basic logistics of life in a challenging monsoonal landscape. Had such details been included, the extensive research of these scholars might have revealed information concerning healing practices.

2.6 Social and emotional wellbeing

2.6.1 Indigenous healing relationships

In an Aboriginal world view, the body, and health of one's body, is dependent on its relations with the spiritual, natural, and physical world (Poroch et al., 2009). Traditional healers play an essential role in the diagnosis and treatment of spirit-based illnesses whereas biomedicine is concerned with identifying and treating clinical symptoms. Traditional healers also reinforce levels of community knowledge regarding plant-based medicines including infusions and salves (Packer et al., 2019). Unlike many biomedical doctors, traditional healers are not strangers to their patients and are trusted and respected members of the community. The community and family are encouraged to take part in the healing process by being present during diagnosis and treatment, and providing feedback and support. A network made up of the healer and the community supports the patient, and healing is a highly interpersonal experience that reflects the spiritual and emotional needs of each patient. In general, the biomedical system is much less personal and the outcome, not the physician-patient relationships, matters in terms of treating illness (Hollenburg, 2006). As Lavis (2012) observes, processes of cultural recognition, the performing of ritual, the creation of adapted traditions and transmission of traditional knowledge contribute to enhanced self-identity and improved psycho–social resilience.

2.6.2 Status of Indigenous Australian social and emotional wellbeing

Social and emotional wellbeing is a holistic concept that includes mental health and illness, but also encompasses the importance of connection to land, culture, spirituality, and ancestry, and how these affect the wellbeing of the individual and the community (Gee et al., 2014). The notion of social and emotional wellbeing has been a fundamental part of Aboriginal health policy since 1995 (Swan & Raphael, 1995). These constructs connecting

the social with health are central to the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing (2017–2023) (Department of the Prime Minister and Cabinet, 2017). They are characterised thus:

> "Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and must bring about the total wellbeing of their communities. "(Gee et al. 2014, p. 56).

> "This holistic understanding of health and wellbeing involves the whole community throughout the entire life-course. It includes broad issues like social justice, equity, and rights, as well as traditional knowledge, traditional healing, and connection to country." (Australian Government Department of Health and Ageing, 2013, p10).

Merrill et al., (2016) noted that achieving improved psychological wellbeing requires the ability to conceptualise and narrate stressful events, in that:

> "Negative self-event connections are related to increasing psychological and identity distress, positive self-event connections are related to increasing psychological growth, identity exploration, and commitment." (p 1327).

This means that listening to the life story of a person, including their aspirations and needs, is vital to the healing journey. Aboriginal and Torres Strait Islander social and emotional wellbeing is part of a holistic definition of health (Garvey, 2008) and recognises complex life experiences, including cultural connections (Gee et al., 2014). Gibson et al. (2020) explain the value of talking about social and emotional wellbeing services with older Aboriginal people. The gathering of the narratives concerning experiences and perspectives of traditional healing within this research has used "yarning" (under the guidance of the cultural broker) to develop rapport with Aboriginal and Torres Strait Islander people (Lin et al., 2016).

Indigenous psychologists (Gee et al., 2014) present a social and emotional wellbeing framework drawing on seven key domains (Poroch et al., 2009; Department of Health and Ageing, 2004). Dudgeon et al. (2020) argue that the self is inseparable from, and embedded within, a range of interconnected domains.

(Dudgeon et al., 2017) described the framework as follows:

- Connection to Body

  The ability of an individual to feel a sense of wellbeing in themselves and in their interactions with others requires a positive connection to body, mind, and emotions.

- Connection to Mind and Emotions

Connection to mind and body refers to basic cognitive, emotional, and psychological human experiences and needs (including a sense of physical and cultural safety/security, secure relationships, belonging, control or mastery, self-esteem, meaning making, values, and motivation).

- Connection to Family and Kinship

  Family and kinship systems are central to the wellbeing and functioning of traditional and contemporary Indigenous Australians, providing rules that govern all social interactions, maintaining interconnectedness through cultural ties and reciprocal relationships. The "kinship" system provides a contemporary support network that links people to their culture and place of birth, providing them with a place of belonging (Austin-Broos, 2003).

- Connection to Community

  An individual's connectedness to community entails individual obligations to the collective and a tangible sense of belonging in the world. Community is a collective space where Aboriginal people develop their sense of identity, participate in family and kinship networks, and maintain personal connections and socio-cultural norms (Taylor, 2012; Walker & Shepherd, 2008). The notion of community is fundamental to identity and concepts of self within Aboriginal societies (Dudgeon et al.,2014). Community is a "given" within which one is situated as opposed to a social construct between individuals.

- Connection to Culture

  Connection to culture maintains cultural identity through practicing cultural rights and responsibilities and can be grounded in traditional forms of spirituality, or reconstructed on a more hybridised basis (Paradies, 2006). Nevertheless, even in instances of cultural fluidity, the notion of being Aboriginal—of being connected to family, kin, and community—continues to inform cultural identity.

- Connection to Land or Country

  For many Indigenous Australians, spirituality and sense of identity are closely tied to connections to land or country.From an Indigenous psychological perspective, country or land is an area or place where people have a traditionalor spiritual association (Dudgeon et al., 2014; Ganesharajah, 2009). Several studies have shown a link between feeling "connected to country" and a positive sense of wellbeing among

Aboriginal individuals and communities in diverse geographic contexts all around Australia (Ganesharajah, 2009; Garnett et al., 2009).

- Connection to Spirit, Spirituality, and Ancestors

  Dudgeon and Walker (2010) explain that understandings of spirituality broadly refer a cultural group's traditional systems of knowledge left by the ancestral beings, inclusive of the stories, rituals, ceremonies, and cultural praxis that connect person, land, and place. They argue that "traditional" practices are never static, but are dynamic responses oriented to contemporary situations (Dudgeon et al., 2017, pp 319-322).

2.6.3 The impact of psychosis on the wellbeing of Indigenous people

Levels of psychosis amongst Indigenous people are high with consequential impact on personal and collective wellbeing. In a study on Cape York, Gynther et al. (2019) analysed clinical psychiatric records from 1992 to 2015, extracted for all Indigenous patients who received treatment for a psychotic disorder. The results showed extremely high prevalence rates, which were approximately 5 times higher for men and 3 times higher for women than that of the national population. Prevalence had increased over time, with significant increased mortality risk for Aboriginal people living with psychosis in this region. Gynther et al. (2019) argue that environmental or neurodevelopmental risk factors predispose Indigenous populations to psychosis, while social factors increase vulnerability and premature mortality. Developmental adversity, such as childhood trauma or maladaptive family functioning, have been shown to increase rates of psychoses across all stages of the life-course (McGrath et al., 2017; Davis et al., 2016), with some researchers finding a dose–response relationship between increases in childhood adversities and increased risk of psychosis (McGrath et al., 2017; Kelleher et al., 2013; Heins et al., 2011). More recently, research conducted by Gynther et al. (2019) suggests that a history of obstetric complications, low birth weight, in-utero infections, developmental delay, sibling bullying, adolescent tobacco smoking, and severe infections are associated with increased risks of psychosis or schizophrenia. Risk factors for schizophrenia were shown to be cumulative and interactive, both with each other, and with critical periods of neurodevelopmental vulnerability.

Cultural uncertainties related to diagnosis, intermittent access to competent and trusted psychologists and psychiatric services in remote areas, and latent community belief of the causal association between Spirit World disturbance and mental health create a complex healing environment. This milieu is characterised by an Australian Indigenous emotional

response being frequently observed as a cultural indicator of mental health distress (Dunlop, 1988).

Within the phenomenon of cultural uncertainties related to diagnosis, biomedical practitioners may encounter Aboriginal people who describe illness by referring to emotional response. The *Dictionary and source book of the Wik-Mungkan language* as described by Kilham (1986) shows that the Wik language lexicon does not identify words for ill health, but the following examples are typical phrases describing personal feelings:

- ngangk kul /kulangam *adv.*: Really angry; anger in one's heart.
- kemp wir *adj*: dangerous from sickness or from a fright, or referring to the extreme weariness of body.

The likelihood of Aboriginal people using emotional descriptors in reference to health informs biomedical interpretations of prevalence of mental illness, often identified as disturbed behaviour (Dunlop, 1988). Within Australian Indigenous populations, examples of disturbed behaviour include: wandering around at night; talking incessantly; sleep disturbance; hearing voices; breaking taboos (e.g., mentioning the names of dead people); frequently moving between communities; keeping out of normal social interactions; sleeping anywhere; and appearing angry, restless, frustrated, mistrustful, bored, or lonely (Hunter, 2013). Many of these behaviours have specific descriptors in the Wik language (see above), and can be seen as a cultural currency unlikely to be expressed in English.

Such responses exhibit a strong correlation with the seven categories of disorders listed in the "anxiety disorder" section of the new DSM-5 criteria (Crome et al., 2015). Some of these disorders may be a fear of an object or situation (phobia); fear in response to certain social or performance situations (social anxiety disorder); chronic persistent fear with physical over activity (generalised anxiety disorder); sudden unexpected episodes of fear (panic attack); and the fear of experiencing anxiety or having a panic attack (agoraphobia). Many of these disorders have similar descriptions in the Wik language, in addition to those mentioned previously.

Within biomedicine, genetics, biology, and environment are integral to healthy development (Hernandez & Blazer, 2006), while cultural associations are not considered. Williams (1997), however, regards identification with culture as a central determinant of wellbeing among ethnic and minority populations, where issues of racism, place, and the circumstances of history are essential to understanding how physical and mental health are formed. The wellbeing of Indigenous populations cannot be fully understood without an appreciation of the events and processes that followed Australia's colonisation (Mazel, 2018).

Australian Indigenous health is a product of a history of dispossession, exclusion, discrimination, marginalisation, and inequality in various forms (Durey & Thompson, 2012). Racism has affected a high proportion of Indigenous people in contemporary Australia. It has created a lack of trust between Indigenous and non-Indigenous people and impeded the process of healing and reconciliation (Paradies et al., 2008).

It has been argued that these legacies are implicated in the unique stress profile of Indigenous Australians. Stress is highly prevalent across the spectrum of Indigenous society today, irrespective of socio-economic status (Silburn et al., 2006). The stresses faced by Indigenous children commonly include serious events such as the death or incarceration of a close family member (Milroy, 2004). Frequent and ongoing stress events in early life can have a damaging effect on the developing brain of a child and alter the functioning of important bodily systems. This type of stress can be particularly harmful to mental health and social and emotional wellbeing in childhood (Zubrick et al., 2005), with negative consequences for wellbeing throughout life (McEwen, 2003). The effects of stress and racism, and the related ongoing effects of colonisation, have created a burden that extends across generations of Indigenous families (Dudgeon et al., 2014).

Brown (2009) outlined a brief opinion piece on the distinction between treating disease and mind-controlled healing. The antecedents to the development of this unique approach to cross cultural medical care is described in Fadiman's (1998) *The Spirit Catches You and You Fall Down*, which identifies life threatening "collisions" over medical care between Hmong patients and medical staff, with a case study on an avoidable catastrophic outcome in a child. Brown's piece quotes the account by essayist, Fadiman (1998) in particular, and includes significant media commentary on the Mercy Medical Center Merced (MMCM) in California, which has a clinical guideline for Hmong spiritual visits. After pilot cultural broking programs in 1995 and 1996, a system combining medical training with recognition and authorisation of Hmong Shamans to provide spiritual support was introduced by the hospital. Cultural awareness training is given to hospital practitioners, delivered by a Hmong managed NGO.

Distinctive features of this initiative include the sourcing and delivery of Hmong spiritual visits, which are determined by clinical guidelines in the hospital's medical manual. This suggests strong and sustained support from the biomedical profession. While there is no formal evaluation of the effectiveness of this initiative with regard to improved recovery times and patient satisfaction, there is significant media coverage in terms of recorded interviews and life stories. The implementation of the Hmong spiritual visit clinical guideline

is presented as a "practice innovation" by The Health Care Innovations Exchange (HCIE) (2010) affiliated with the US Agency for Healthcare Research and Quality. This profile is accompanied by a comparatively recent examination of the program by Laws and Chiltern (2013) in their analysis of bio-ethics in psychology.

2.7 Strengths based models underpin social and emotional wellbeing

Strengths based models are the antithesis to the deficit discourse that situates Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency, and failure (Fforde et al., 2013). Fogarty et al. (2018) suggest that a deficit discourse is currently a primary influence on policy formulation and a key input to media representation of Aboriginal people and their way of life. According to Sherwood and Russell- Mundine (2017), indicators such as public health, mortality, and morbidity statistics within a discourse of deficit present "illness" as fundamental to Indigenous identity and disadvantage becomes a narrative of failure and blame. The argument put forward by Fforde et al. (2013) suggests that a deficit discourse reinforces the marginalisation of Aboriginal and Torres Strait Islander people's voices, perspectives, and world-views, impacting on their health and wellbeing by contributing to institutional and community-based racism. For example, Halperin and Pliskin (2015) argue that continual reporting of negative stereotypes and prevalence rates can reinforce undesired behaviour. If the view that Aboriginal people as groups or individuals are "deficient subjects" (see Altman & Fogarty, 2010) dominates academic and policy literature, then limited attention may be given to innovation or autonomy in program development and delivery. Indicators of "inequity" then become associated with Aboriginal people with expectations of lower educational achievements, overrepresentation in the criminal justice system, pathological violence, and propensity for addictive behaviours (Markwick et al., 2019).

The alternative model presented in the literature to counter the problems or issues associated with the deficit discourse model is the strengths-based model. For example, askew et al. (2020) suggest that Indigenous strengths-based practice must "resist oppression, to give voice, insight and political power (Askew et al., 2020, p. 2). This is a radically different approach to the "stay strong" message or unsuitable use of strengths-based language. Askew et al. (2020) suggest a dissonance present between the concepts of strength-based practices and the paternalistic and sometimes patronising practices of public health in Indigenous community settings.

2.7.1 Aboriginal Community Controlled Health Services

Campbell et al. (2017) explain how Aboriginal Community Controlled Health Services (ACCHSs) are a result of strong and sustained Aboriginal advocacy and demonstrate the strengths-based approach. The response to acknowledging Aboriginal rights in health has been to foster culturally acceptable services under community direction and management. Since the first ACCHS was established in 1971, ACCHSs have been supporting improved health and health care for Aboriginal peoples in Australia. There are now more than 150 ACCHSs across Australia, providing a range of health centre based, outreach, and mobile services (Davy et al., 2016). The National Aboriginal and Torres Strait Islander Health Plan (2013- 2023) demonstrates Commonwealth government commitment to Aboriginal Health and outlines actions to be taken by the Australian Government, the Aboriginal Community Controlled Health Sector, and other key stakeholders. In addition to the Health Plan, the Australian government has committed to the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, renewing the Social and Emotional Wellbeing Framework and the National Partnership Agreement on Indigenous Early Childhood Development.

These commitments provide opportunities to progress important areas of Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, and education, alongside the implementation of the Health Plan. Importantly, these initiatives prioritise ACCHSs and their human rights-based approach as an integral part of improving health systems for Indigenous Australians. The impact on overall health outcomes is subject to ongoing debate, however local success and community support for such services are already in evidence. Panaretto et al. (2014, p. 649) claim that the focus in Community Controlled Health Services on prevention, early intervention, and comprehensive care has reduced barriers to access and unintentional racism, and is progressively working to improve individual health outcomes for Aboriginal people. Research indicates that ACCHS outperform mainstream services in terms of treatment and prevention (Panaretto et al., 2014). Better health outcomes are ensured by providing holistic care, responding to individual, family, and community issues, and the underlying determinants of health alongside quality health care (Osborne et al., 2013; AHMAC, 2012; Vos et al., 2010).

Combined with strategies targeting housing, lateral violence, education and employment, this comprehensive approach provides an important foundation for improving health outcomes. Efforts to embed a human rights-based approach to improving the health and life expectancy of Aboriginal and Torres Strait Islander people have represented a multi-

decade commitment spanning policy cycles, funding agreements, and governments (AHRC, 2013, p. 2). In the words of Aboriginal activist Noel Pearson, "Too many white Australians think the door opens to opportunity from the outside, when you've got to be let into the door from the inside" (quoted in *The Australian*, 7 May 2015, as cited in Bita, 2015).

In their examination of self-perceived health determinants among Aboriginal people, Baba et al. (2014) found that participants considered ACCHSs to be community empowering and a positive determinant of health through acknowledging Aboriginal concepts of health and providing culturally appropriate care. Participants associated the ACCHS model with improved health care access and improved individual and community health and wellbeing.

As an example of the range of functions and activities undertaken by ACCHSs as part of their primary health care model, Larkins et al. (2006) found that consultations at ACCHSs were more likely to involve a range of health professionals, including Aboriginal Health Workers and nurses, in addition to general practitioners. Such consultations, when compared to those provided by general practices, were more likely to require management of complex or multiple medical conditions; to include seeing family members as part of routine consultations; and to involve home visits and case conferencing with other providers. This demonstrates that the ACCHS model of clinical services provision directly responds to the social determinants of health and can, therefore, ensure effective conditions of access from both physical and cultural perspectives.

In their review of primary health care access for Indigenous peoples, Davy et al. (2016) identify critical enablers in relation to the ability of a service to accommodate the social and cultural needs of Indigenous people and to ensure the provision of health care by Indigenous staff in an Indigenous friendly space. They also emphasise the role that communities and families must play within the care process (see also Gibson et al., 2015; Freeman et al., 2014). In a similar vein, Levesque et al. (2013) developed an access framework related to Indigenous engagement with health care. This framework encompasses the ability of people to recognise a need to seek care, coupled with knowledge of the availability of health care. People must then be able to seek out appropriate services when needed, consistent with local, social, and cultural norms. Furthermore, these services should be delivered by a culturally associated workforce with access to health care comprising a narrative between the patient and the health care provider (Entwistle et al., 2012). The acceptability of services depends on the extent to which health care providers understand the cultural, historical, and social fabric of the communities they serve (Davy et al., 2016). Place-based access is critical; this ensures that services are provided in a location accessible to the

community, along with a sustainable cost structure that reflects local ability to pay for the service (Levesque et al., 2013).

Ware (2013), in a report prepared for the Close the Gap program, identifies strategies that can improve physical accessibility to Indigenous health services, including the provision of transport; home visitation as part of a multi-faceted engagement and treatment strategy; the provision of services in non-traditional settings located closer to Indigenous communities; comprehensive health-care services in one location, which improves Indigenous access to, and utilisation of, health services (see also Hayman et al., 2009); flexibility in the appointment system (Herceg, 2015); and services provided away from the health centre, including community health promotion events.

Within the health centres setting, management of interactions between those attending the centre becomes important. For example, different waiting rooms and different entries and exits for men and women may be needed to help clients maintain avoidance relationships (Coffin, 2007). At the same time, the potential of waiting rooms as spaces that allow clients to provide positive support to one another, for example through conversing and sharing stories, should not be overlooked (Coffin, 2007).

2.7.2 Family connection

Family theory, according to KağıtçıbaşI (2005), suggested the terms *autonomy* and *relatedness* as two basic needs that can coexist within an individual. *Autonomy* refers to "the state of being a self-governing agent," and *relatedness* refers to "the degree of connection with others." These two dimensions of agency and interpersonal distance underlie the self, the relation of self with others, and social behaviour. KağıtçıbaşI (2007) argued that the autonomous-related self meets two basic human needs: separateness and connectedness in congruence with the cultural and family context. Research has shown that having these basic needs met is associated with better mental health (McGrath et al., 2017; Kelleher et al., 2013; Heins et al., 2011). According to KağıtçıbaşI, "*autonomy* has long been inappropriately equated with independence and assumed to be in opposition to relatedness, but in fact autonomy overlaps with *agency*" (KağıtçıbaşI, 2005, p. 404). She defines agency more in line with Bandura's (1989) social cognitive perspective, which conceptualizes agency as a motivated action towards a desired outcome. Therefore, one's degree of autonomy refers to the extent to which one has agency to act willingly and without coercion.

2.7.3 Concepts of recovery

Within mental health disciplines, there is debate that recovery is not about "getting better" or ceasing to need support – it is about "recovering a life" (Slade et al., 2014). Frequently, clinical endeavours focus on changing people through treatment (drugs and coercive interventions; cognitive therapy, skills training, etc.), to facilitate reduced reliance on support and services. Recovery-oriented care requires consumer leadership, a recovery vision, work-place planning, resources, and programmes supporting personally-defined recovery (Boutillier et al., 2011).

2.8 Some perspectives on Australian Aboriginal culture

2.8.1 The question of culture

The question of culture, "the whole complex of distinctive spiritual, material, intellectual and emotional features that characterises a society or social group," (UNESCO, 1982) occupies society across many disciplines and professions. For the purpose of this research, the definition of Australian Aboriginal culture is informed by the work of Salmon et al. (2018) and the earlier work of Bourke et al. (2018), both of which are used as the foundation for the Mayi Kuwayu Study (Jones et al., 2018). These studies use literature to define cultural elements which are important and distinct for Indigenous peoples. Salmon et al. (2018, p. 1) identify "culture, in the sociological context," as consisting of ideas and self-concepts of a group (for example, artifacts, attitudes, beliefs, customs, norms, symbols, and value." They suggest also that historical events influence cultural change and that standards of behaviour evolve and change over time (Berndt & Berndt, 1954, p. 39). Rather than a single definition, they determine that a synthesis of cultural domains is required, including: connection to country, Indigenous beliefs and knowledge, Indigenous language, family, kinship and community, cultural expression and continuity, and self-determination and leadership (Salmon et al., 2018). The work of Dudgeon et al. (2014) with eight Aboriginal communities provided important input to the conceptual indicators developed by Salmon et al. (2018). The analysis of their data indicated that the reintroduction and/or enhancement of understanding of spirituality, connection to country, and individual inner strength defined by kinship ties, was closely aligned to knowing and understanding one's own culture, including language and the traditional ways of healing.

These cultural domains include representation of social constructs that are believed to derive from the cosmogenic actions of ancestral beings. In mythological narratives and

songlines, such beings changed from animal and phenomenal forms into humans, and made journeys and created landscapes, establishing relationships between ancestral beings, place, and people (Clarke, 2015). These phenomena differentiate groups' rights to, and ownership of, particular tracts of land or countries and related kinship links. Across Australia, there is a moral ecology premised on attributions of intentionality, obligation, responsibility, and reciprocity (Rose, 1992) which is derived from ancestral beliefs and spirituality.

2.8.2 Connection with culture – the protective factors

Most research which mentions the concept of traditional healing focuses on the psycho-social parameters of an improved sense of wellbeing engendered by connection with culture. Guiso et al. (2006, p. 2) describe culture as "customary beliefs and values that ethnic, religious, and social groups transmit fairly unchanged from generation to generation." The term "traditional" can be taken to mean a distinctive set of practices that has its roots in the peoples' historical customs and experiences. However, the very nature of culture is that it adapts over time to new external influences and may be much removed from ancestral practices.

In their review of previous studies of "Indigenous spirituality" in North American populations, Fleming and Ledogar (2008) contend that cultural affinity or engagement acts as a protective factor against the problems of trauma associated with historical loss, discrimination, suicide or suicide ideation, and substance abuse that beset many Indigenous communities and populations. They state that "evidence is accumulating in favour of resilience from elements of a broad concept that includes cultural identity, participation in traditional activities, and spirituality" (Fleming & Ledogar, 2008, p. 61).

These findings are evident, for example, in the work of Bishop et al. (2006), conducted through semi-structured interviews with Aboriginal people in the north-west of Western Australia. It was found that kinship structure, language groups, and skin groups defined the Aboriginal social structure, while education and knowledge were identified as key themes associated with the maintenance of a sense of community. Similarly, Zubrick et al. (2010) observe that, for Aboriginal and Torres Strait Islander people, cultural concepts such as connection to land, culture, spirituality, ancestry, and family and community are common protective factors, which can serve as sources of resilience and can moderate the impact of multiple psychological stressors on social and emotional wellbeing. Indigenous traditional healing focuses on the importance of cultural identity and connection to country, to underpin both spirituality and access to medicinal resources (Zubrick et al., 2010).

These conclusions are further borne out in the research of Chandler et al. (2003), which explores the effect of culture on self-identity in the context of British Columbia's First Nations youth. They revealed that:

> Communities for which there is evidence of greater commitment to cultural continuity – in preserving a shared past and creating a collective future – are found to have significantly lower rates of youth suicide. The clear implication is that cultural continuity at the community level helps the young members of that community to develop a stronger sense of persistence of their self-identity through time. In addition to guarding against suicide, the importance of a strong sense of persistence of self-identity is likely to apply to other activities representing 'investments' in the future, such as education, health, a career, relationships with family and community; and the impact of losing that sense of self continuity is likely to transcend into adulthood. (Chandler et al., 2003, p. 2).

Dockery (2012), an epidemiologist, examined potential causal relationships between variables (e.g., connections with culture via language, participation in cultural activities and traditional economic activity) with regard to the wellbeing of Aboriginal and Torres Strait Islander people. His findings were reported in the ABS 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS). Dockery argued that cultural attachment is important to identity formation for Indigenous peoples, and a sense of self-identity is in turn important for mental health. His factor analysis of cultural variables contained in the NATSISS demonstrated that cultural identity is "one distinct element" of Indigenous Australians' attachment to, or engagement with, traditional culture, along with participation in cultural events/activities, language use, and participation in traditional economic activities. In summary, he found that cultural identity has robust associations with wellbeing.

The concept of using census data and enumeration to analyse access to and use of culture is likely to face significant challenges. Hughes and More (1997) revealed that, in the Aboriginal world, the value of things lies in their quality and relatedness. Hence, in a world made up of objects related through their spiritual essences, rather than their physical properties, counting is irrelevant (Hughes & More, 1997, p. 9). These findings suggest that researchers, health practitioners, and policymakers cannot rely on census data to inform their approaches to examining and improving health and wellbeing among Indigenous populations.

To address this deficiency, the National Study of Aboriginal and Torres Strait Islander Wellbeing (Mayi Kuwayu Study) (Jones et al., 2018) will be a national longitudinal study of Aboriginal and Torres Strait Islander adults, with linkage to health-related administrative

records. The baseline survey was developed through extensive community consultation, and includes items concerning cultural practice and expression, sociodemographic factors, health and wellbeing, health behaviours, experiences and environments, and family support and connection.

2.9 Aboriginal identities

2.9.1 Descent

Aboriginal identity is predicated upon descent and country of origin, about knowing and being a part of an Indigenous community and perceiving oneself as Indigenous (Dudgeon et al., 2010). Descent does not necessarily pertain "to genetics as inherited essential characteristics but to the historical connection that leads back to the land and which claims a particular history" (Morrissey, 2003, p. 59). Descent is about belonging to a people and community and describes Indigenous relationships with land as forming an "ontological belonging" (Moreton-Robinson, 2003, p. 31). Indigenous people's spiritual beliefs are based on systems that tie one into the land, to other members of the group, and to all things of nature. As Moreton-Robinson (2003, p. 310) notes, "our ontological relationship to land, the ways that country is constitutive of us, and therefore the inalienable nature of our relation to land, marks a radical, indeed incommensurable, difference between us and the non-Indigenous."

2.9.2 Indigeneity and resistance

Resistance may be considered an everyday act in the context of power relations in Indigenous communities. Practices of resistance emerge in response to dominant cultural and social arrangements together with practices and institutional operations of whiteness. This differs from considering resistance as extraordinary or momentous as it is traditionally considered in the social movement literature (Guidry et al., 2000, p. 18). In developing their typology of resistance in the context of social movements, Hollander and Einwohmer (2004, pp. 536-538) argue that the core features of resistance are the "act," the "intent," and "opposition." Nonetheless, they point out that there is a distinction between resistance as an act of collective mobilisation and resistance as an everyday act (Hollander & Einwohmer, 2004, p. 540). In considering resistance identities, Havemann (1998) points to the primacy of Indigeneity to resistance. Indigeneity is the primary identity that sits with Indigenous peoples' "right to define and perpetuate their traditions, culture and languages, hierarchies, customs,

modes of governance and mode of land use" (Havemann, 1998, p. 14). Practices of resistance involve expressions of Indigeneity as primary identity, and this resistance identity is "constructed by reinforcing the connectedness of kin with places, languages and traditions over time" (Havemann, 1998, p. 14). Similarly, David (2017) demonstrates how Indigeneity as a subject position is deployed to resist the practice and terms of citizenship, challenge historical norms, and resist the dominance of social and cultural practices of whiteness.

Foucault's *History of Sexuality* (1976) and *The Subject and Power* (1982) analyse power relations in the context of resistance, subjectivity, and identity. More recently, scholars such as Moreton-Robinson (2000, 2004) and Howard-Wagner (2009) have applied Foucault's ideas about power relations and resistance to explain Indigenous resistance to the social and cultural practices of whiteness. Moreton-Robinson (2000, p. 30) explains how power and resistance work through the articulation of alternative representations of Indigenous culture and Indigenous subjectivities, creating a different positioning of Indigeneity than represented in dominant practices. Resistance can be seen as empowerment and freedom, as Foucault (1982) illustrates. Likewise, Howard-Wagner (2009) explains how Indigenous discourses and practices as a form of resistance "expose and disrupt whiteness, as relations of power" (Howard-Wagner, 2009, p. 40).

2.10 Some difficulties in achieving culturally informed understandings

When the vested interests, practices, and expectations of health services and practitioners in advancing "recognition" of traditional healing within the biomedical sphere are explored in the literature (Stoner, 1986; Hollenberg & Muzzin, 2010), the challenges articulated consistently are that "biomedical practitioners in the field perceived science as the ultimate reference point for medical truth" (Mizrachi & Shuval, 2005, p. 1652). As we saw earlier, such perceptions are not conducive to integrating Indigenous approaches to, and beliefs about, health and wellbeing into healthcare practices. Ermine, (2007) calls this "the brick wall of a deeply embedded belief and practice of Western universality." (p198)

Jongen et al. (2018) discuss the advantages and imperatives of a culturally responsive model of care, constituted by a "culturally informed understanding" of how individuals and families regard their health care experiences. Yet when Jongen et al. (2018) explored the questions of cultural competency through a systematic review of practitioner intervention, they found that while improving practitioner knowledge is possible, changes to practitioner

behavioural outcomes and attitudes to both cultural knowledge and Indigenous people generally show limited ongoing adaptation.

The belief that a type of cultural understanding can transform the reach and effectiveness of health services defined by biomedical models of treatment is contrary to more recent understandings of Indigenous knowledge. It could be argued that even Aboriginal community-controlled health services acting as "agents" of the mainstream biomedical sector via Primary Health Networks (PHNs) are unable to use such knowledge to develop models of health care based on principles of intentionality, obligation, responsibility, and reciprocity, or to reflect the fine grain of kinship associations with place. This is due to lack of consultation in key Indigenous health decision-making processes (Coombs, 2018). Coombs concludes that "PHNs have had a negative impact on Indigenous self-determination and health services." (p S44)

Debates about cultural competency largely exclude, omit, or ignore specific reference to Indigenous knowledge and traditional healing. Rather, the emphasis is placed on encouraging health practitioners to work effectively in cross-cultural situations and to facilitate individual knowledge and empathy (Curtis et al., 2019). Cultural safety reinforces the obligation of health care providers to ensure that power relationships of knowledge and influence are not encountered in health consultations. There is also an obligation to ensure that those practitioners are actively aware and reflexive concerning cultural difference and that the patient determines whether a clinical encounter is safe (Laverty et al., 2017).

While this is all well and good, the intention is still to improve the delivery of biomedical practice rather than to develop any capacity to utilise or acknowledge radically different belief systems. To combat this inherent cultural bias, Bainbridge et al. (2015) provide a framework (or "grid") designed to assess how traditional healing knowledge might be recognised when culturally competent healthcare is an aspirational goal. The grid might include:

- Reforming health service and systems using bi-culturally developed indicators and a continuous quality improvement model to facilitate culturally competent healthcare to benefit local Indigenous populations (Chong et al., 2011; O'Brien et al., 2004, 2007; Reibel & Walker, 2010).
- Improving access to health care for Indigenous populations by bringing together the cultures of the health care organisations with those of the targeted communities (Dignan et al., 2005; Wetterhall et al., 2011). Useful measurement instruments

included client perceptions of practitioners' cultural competency, and measures of clients' cultural identity (enculturation) or similarity (Winderowd et al., 2008).

- Nurturing the development of cultural competence, comprising increased communication and interaction, respect for recipients of care, and individual assessments of cultural competence (Hearn et al., 2011; McRae et al., 2008; Mooney et al., 2005). These strategies need to be evaluated to determine whether they have a follow-on effect to health outcomes for patients. At the level of health practice, relevant measurement instruments might include tools to measure culture shock (Muecke et al., 2011), expectations of health care provision (Chong et al., 2011), and knowledge and skills in cross-cultural health practice.
- Embedding cultural perspectives and experiences in the health practitioner training curricula with the purpose of shifting preparedness for, and future commitment to, working for change in Indigenous health (Paul et al., 2006) and showing that field experience improves understanding (Amundson et al., 2008; Mak et al., 2006).
- Introducing culturally tailored rigorous interventions that are evidence-based, culturally and linguistically appropriate, and that incorporate community collaboration and mechanisms for sustainability and evaluation (Barnett & Kendall, 2011).

Indigenous people will seek to sustain traditional healing outside the mainstream health system, working instead within a culture of reciprocity at a community level (Rix & Rotumah, 2020). The cultural broker suggested the possibility of "commercialising" cultural knowledge in health, i.e., a "fee for service" approach. He commented that "traditional healing needs respect, recognition and recompense."

Creating a commodity of culture is already a common practice in the Indigenous consultancy sector (Blackwell et al., 2019) and includes a well-developed industry in Indigenous advice to program development and service delivery in the health and social service sector.

International examples exist of situations where health services use culturally directed health care models. For example, Maar and Shawande (2013) documented the integration of Western and traditional (Anishinabe) healing with an emphasis on ethical integrity and sacred trust between healer and client, on Manitoulin Island, Ontario, Canada. These Anishinabe concepts address issues that are also considered essential for the provision of Western medical services, such as patient safety and confidentiality, and provider accountability for misconduct. Macfarlane and Alpers (2009) demonstrate how access to health services is

conditioned by cultural and socio-economic factors with health knowledge and belief systems influencing treatment-seeking behaviour in PNG. Their focused ethnographic study in the Nasioi community found that Western medical concepts have been assimilated but have not displaced traditional understanding of illness. Beliefs about causes of illness, treatment-seeking responses to illness, and stated or hypothetical preferences for traditional or Western medicine are clearly stated.

2.11 Medical pluralism

Internationally, Indigenous communities continue to acknowledge practical medical pluralism, including specific recognition that the Spirit World and the practice of sorcery intersects with healing across many cultures. According to Flint (2015), "diagnosis, patient care, and treatment; double-blind testing and laboratory-based demonstrations of efficacy are inadequate tools for validating diagnoses acquired through communication with the spirit world" (Flint, 2015, p. 2438). He suggested that the two systems are not necessarily attempting to achieve the same goals or outcomes: biomedicine seeks to cure or remove disease from the body, whereas traditional healing restores "wellness" by addressing spiritual or mental health concerns (Flint, 2015). This is addressed by MacFarlane (2009) in her literature review of traditional medicine in Papua New Guinea, in which she explains the relationship between Western biomedicine and sorcery:

> "The perceived cause of illness may also influence treatment response. While biological explanations for illness are common, if spirits, sorcery or other supernatural agents are implicated as causes of an illness, a traditional healer will almost certainly be approached for treatment" (MacFarlane, 2009, p, 164).

2.11.1 Domains of belief

2.11.1.1 Aboriginal Spirituality

Hall and Hendriks (2008) suggest that Aboriginal spirituality can be explained across four domains of belief, as situated within Central Australia.

- ***Alcheringa*:** the contemporary experience of the natural world grounded in the spirituality of story, ritual, and song across generations.
- ***Dreaming:*** symbolic understanding, beliefs, and representations of the journeys of tribal or totemic ancestors.

- ***Corroboree*****:** ritual performance ceremonies including relating the myths and stories of ancestors, usually performed at times of increased fertility, rainmaking, initiation, and death.
- ***Dadirri*****:** a period of quiet and living contemplation of the Spirit World which sustains the Dreaming.

Crucially, these domains are not mutually exclusive, but intersect with one another to form a complex network of belief and sense of identity. Awareness of these domains and their localised representation within specific Aboriginal nations and language groups is critical to developing health practices for Indigenous people in ways that recognise and incorporate their beliefs. Specific commentary on Wik spirituality is given in section 2.11.4 and throughout the narratives.

2.11.1.2 Christianity as a construct of spiritual belief

Loos (2007) examined the growth of Christianity amongst Aboriginal people in Yarrabah. This growth of belief and practice was nurtured by the indigenous led ministry from the 1970's and embraced the "born-again" Christians of Yarrabah, whose life journeys were documented from the mid1980s (Loos, 2007; Hume, 1989). Under the ministry of Reverend Malcolm, a Yarrabah man ordained in 1978, the integration of Christianity and Aboriginal belief became accepted in the community (Hume, 1989). This Indigenous-led ministry was described as channelling healing powers of the holy spirit through prayer and counselling (Hume 1989). Reverend Connolly (Connolly, 1986), another ordained Yarrabah Man, described a healing event in 1986, where the traditional medicine waters at King Beach were demonstrated to contain the Holy Spirit. It was also suggested by Connolly (1986) that the power of Christ superseded the older healing rituals associated with the Medicine Waters.

2.11.2 Lived reality of sorcery

The question of the lived reality of sorcery has engaged ethnographers and researchers in many continents, but this has taken place across a largely Western cultural divide. Evans Pritchard (1976), in his work on Azande sorcery, and Peter Sutton, in his treatise *The Politics of Suffering* (2001), both express scepticisms as to the reality of sorcery. They suggest that the impost of sorcery is used to explain the unexplainable, i.e., occurrences for which remote societies have no other explanation. However, this view is not borne out in more recent accounts from Aurukun which demonstrate a very real concern amongst the community for

the perceived physical and spiritual effects of sorcery. In Aurukun, for example, Martin (2008) observed that all Wik actively and suspiciously monitor events for signs that a sorcerer may have been at work:

> "Virtually all deaths of Wik people in contemporary Aurukun continue to be attributed to human agency, either directly through physical violence or indirectly through the malevolent magical means of sorcery. The words of a dying person, their gestures, any twitches of their eyelids, the final position of their limbs in death—all are closely watched for signs by which the identity of the sorcerer can be divined." (Martin, 2008, p. 90).

Martin (2008) revealed that even where the immediate cause of death is recognised as physical trauma, sorcery can be implicated, if it is believed that the perpetrator has been ensorcelled. Wik accusations of sorcery, then, are a means by which causality is both externalized and personalized, social conformity is maintained, and relations between dominant family groups and marginalised individuals are defined.

Illness, the subjective experience, is understood as separate from disease, which has biological signs (Jackson, 2013). As such, scholars have been more disposed to study illness within its cultural context (Langdon & Wiik, 2010), based on subjective explanations from specific cultural frameworks, than has been the case for disease, which is seen as a fixed, universal phenomenon. Singer and Baer (2007, p. 65), for example, see disease in terms of biological objectivity. This perspective immediately shuts down the possibility of examining disease as a culturally specific experience, or of meaningfully incorporating Indigenous beliefs about disease into Western practices. While the concept of biological objectivity allows for the study of Indigenous understandings of disease, it does so from the point of view of Western curiosity about such beliefs, rather than seeking to meaningfully incorporate them into advancing cohesion between Indigenous and Western health initiatives.

If research in this area is to progress, it is essential that neither illness nor disease are regarded as singular, disconnected entities (Boyd, 2000). The present study intends to examine if and how these aspects of health are interrelated and are experienced subjectively, meaning that both must be studied within appropriately defined cultural frameworks.

Kernan (2019) describes ailment narratives experienced by Indigenous peoples within the Spirit World and as part of recounted mythologies but there is no parallel comprehensive literature of ailment narratives for Wik communities. In this research it is acknowledged however that ancestral power is instilled in contemporary thought and that spiritual relationships with land inform understandings of suffering. Langdon (2005) argues that place

can be represented in ailment narratives in a mythological sense that transcends into present Indigenous belief but is beyond the understanding of outsiders. Experiences of the "mythologisation of place" (Langdon, 2005) are found in Aurukun ethnographies (McConnel, 1935).

2.11.3 Contemporary sorcery – a product of community tension

Stewart and Strathern (2004) argue that community-based allegations of sorcery and witchcraft are responses to rising interpersonal and social tensions. Such tensions are interpreted in Aurukun from perceived inequitable access to resources (i.e., mining jobs, other employment, native title benefits, royalties) and situations where an "outsider" has "married in" from other Aboriginal or Islander communities. These "outsiders" are often viewed as having gained access to, or assumed positions of power and influence over, communities, with unfair advantage (Stewart & Strathern, 2004).

Smith (2016), researching a Wik diaspora, suggested that such local conflicts lead to increased fears and accusations of witchcraft and sorcery as people try to make sense of events that are hard to explain. Sorcery and witchcraft ideas are thus "deeply implicated in sequences of action" (Stewart & Strathern, 2004, p.xi) They should be viewed, historically, "as products of wide-scale changes running through people's lives" and "as sets of events that involve complex interactions between individuals constituting microhistories of their own" (Stewart & Strathern, 2004, p. 27). In Aurukun, sorcery is implicated in grievances and can give rise to situations of conflict and violence as accusations are made. This is frequently the case with violent deaths and suicides (Martin, 2008).

2.11.4 Ethnographic accounts of healing and sorcery practices in Aurukun

As we saw earlier in this chapter, influential Wik ethnographies, constructed throughout the 20th century, largely missed an opportunity to understand the role of healers and their influence in Wik communities (e.g., Von Sturmer, 1978; McConnel, 1934; Sutton, 1978). Healers in a structured ancestral world were part of the leadership accounted for in those narratives, being men and women who held knowledge and who controlled embodied experiences of place, ritualised fighting, insult behaviour, increase ceremonies, and the intricacies of love magic, childbirth, and naming and initiation rituals.

Martin's (1993) observations demonstrate how the Wik belief system in ancestral beings and totemic antecedents generates highly localised performative narratives. These are exhibited through initiation rituals, where the role of the Rainbow Serpent, Thaypan, as healer

is integral to the transfer of healing and ritual powers. Martin also makes a distinction between the belief environment of the Dreaming of "other Aboriginal groups" and the Wik people, suggesting that analogies with Indigenous healing practices elsewhere in Australia are of little value when it comes to understanding the cultural nuances and experiences of specific groups.

Wik ancestral landscapes have defined the performance of increase and initiation rituals for thousands of years, with complex song and dance cycles performed widely. These performances are pivotal to power and control over clan relationships. Yet the opportunity to understand how cultural power relationships influence access and control of natural resources in the landscape is disappearing. The rights of future generations to reinstate cultural access to totemic sites are not provided for under negotiated mining settlements with the increasingly frail Elders only offered access arrangements that do not impinge on mining activity (Rio Tinto Alcan, 2016)

The Wik ethnographies created within these landscapes over a period of more than 80 years are set out in Table 2.1, which shows the primary subjects examined and the date of publication.

Table 2.1: Development of Wik Ethnographies, Divided by Subject and Publication

Subjects examined	Publication
Ethnographic descriptions of kinship, language, territory, and subsistence	McConnel, 1934; Von Sturmer, 1978; Sutton, 1978
Territoriality/increase ceremony methodologies and the existence of pulwaia (totems) and auwa related to ethnographic landscapes	McConnel, 1934; Von Sturmer, 1978; McKnight, 1981; Frazer, 1910, reprinted 2009
Detailed linguistic accounting of Wik sub dialects	Von Sturmer, 1978
Analysis of power dynamics and relationships	Martin, 1993
Idioms of nurturing and responsibility in child-bearing and rearing	Von Sturmer, D., 1980
Insult behaviour and joking	Peterson, 1993
Reciprocity in relationships	Altman, 1987
Nganwi or ngeen-wiy (construct of totemic healing power)	McKnight, 1981

One reoccurring theme across a number of these accounts is of nganwi (McKnight, 1981) or ngeen-wiy (contemporary spelling, Wik Lexicon). Ngeen-wi is a construct of totemic healing power, associated with the Rainbow Serpent, Thaypan, who controls life and death. This ancestral being is considered a healer in Wik lore, and the Thaypan passage across the land to his auwa or totemic resting place is said to have left traces of menstrual blood. McKnight (1981) developed a complex hypothesis based on accounts of understanding of procreation and the concept of an "unseen child" inside a man who is "released" after initiation. These accounts were confirmed twelve years later by Martin:

> "People come from their auwa, places where totemic beings "sink into" such as lagoons or swamps, and when they die their spirit returns to their auwa. There are also taboo places that are mystically dangerous. The owners of a piece of land must put their smell on a stranger, or the pulwaiya will smell the stranger and make them ill." (Martin, 1993, pp. 92-93).

The terms nganwi or ngeen-wiy are also used to describe sickness and the practice of healing. The Wik Lexicon (Kilham et al., 1986) suggests a translation as "the unseen power within." The term is also considered to be the ritual name for Thaypan, who controls life and death. The powers of Thaypan can cause pain if certain behaviours are not observed, particularly in relation to the behaviour of small children. The term is used interchangeably to denote concepts of illness and the proscription of initiation rites leading to the assignment of

personal responsibilities. It can also refer to forms of punishment by illness if food gathering is incorrectly performed or if the exchange of goods is disrespectful.

McKnight (1981, p. 92) described how nganwi illnesses, such as withered limbs, skin ailments and "wasting disease" can occur if strangers gather food near another's auwa (totemic place). The application of sweat or smell (from underarms) can prevent this and can still be used as a form of Aurukun greeting. McKnight recounts several original narratives of sickness which comprise severe headaches, extreme stomach pain, and abdominal swelling, attributed generally to an encounter in a ritually tabooed situation. A cure includes the retrospective rubbing of sweat and ritual striking with a spear from a person with connection with the correct pulwaia.

2.12 Manifestations of life experiences

2.12.1 Conscious manifestations of life experiences

Consciousness, being the very source of subjective experience, is needed for our life experiences and for the working of our body; it is needed to perceive, cognize, and express ourselves (Pereira & Reddy, 2017). When consciousness is involved in healing, it manifests either locally or nonlocally (Dossey, 1989). Dossey suggests that a model of mind-based healing must account for "limit cases" such as nonlocal, distant healing effects, which are supposedly immediate, un-mediated, and unmitigated, with effects displaying time-displacement. Such characteristics of Wik healing are described by Martin (1993) as intimately associated with the Spirit World.

2.12.2 Unconscious manifestations of life experiences – emotion

Emotional responses, both conscious and unconscious, are embedded in Wik daily life. A useful conceptualisation of emotion is Scherer's (2009) component process theory. This theory includes five core components: cognitive (appraisal), neurophysiological (bodily), motivational (action tendencies), motor expression (facial and vocal), and subjective feeling. The brain-body state can be labelled as a specific emotional process, for example, to become angry. Another prominent theory of emotion is supplied by core affect theory (Russell, 2003; Barrett, 2006) where physiological body changes combine with stored representations (shaped, amongst other influences, by culture) to generate different emotional experiences. Contemporary psychoanalyst Joseph Le Doux (2012) suggests that emotions are conceptualised as outcomes of pre-cognitive systems of bodily responses to environmental

stimuli. Adaptive responses alter the chemical state of the body through the viscera and nervous system. Body memory and affective experience are the pre-cognitive foundation of self. Affective experiences are transmissible from body to body and can reinforce group identity through the affect resonance of the performing of ritual. Affect regulation maintains self-function in a group setting or environment, allowing for nonverbal and unconscious (but controlled) ceremonial participation in embodied affective spaces with a rhythmicity of pattern.

Affect is a non-conscious experience of intensity, and is always prior to and/or outside of consciousness (Shouse, 2005). Healers or shaman harness affect during soul retrieval, with healing events precipitated by a "feeling" or by "seeing" them in a Spirit World interface (Eliade, 1964; Krippner, 2012). Affect therefore influences diagnostic practice; patterns of thought, feelings, and behaviour are invoked in healing rituals as responses of the physical body (Borghans et al., 2008). This is in direct opposition to the application of structured scientific knowledge as learnt in Western medical schools.

Conceptions of affect emerge from the research of scholars such as Deleuze & Guattari (1987), Massumi (2002), and Leys (2011). Massumi (2002, pp. 30-31) stresses the connection of affect with "potential", introducing the virtual reaction of the body: "The virtual, understood as the pressing crowd of incipiencies and tendencies, is a realm of potential." Leys (2011, p. 436) argues that "humans are corporeal creatures with important subliminal affective intensities and resonances that are decisive in the way we form opinions and beliefs." Affects contain the potential for creativity and transformation, and occur before "intentions, meanings, reasons, and beliefs." They are "non-signifying, autonomic processes that take place below the level of conscious awareness and meaning." Finally, they are "'inhuman,' 'pre-subjective,' 'visceral' forces that influence our thinking and judgments," even though they are noncognitive and corporeal (Leys, 2011, pp. 437, 443).

Martin (2013) suggested that "affective states, characterized by intensity, are nonsemantic, nonlinear, autonomous, vital, singular, indeterminate, and disruptive of fixed (conventional) meanings" (p154.). There is a gap or "radical dichotomy between the 'real' causes of affect and the individual's own interpretation of these causes" (Tomkins, quoted in Leys, 2011, p. 437). In Tomkins's view, affects are "phylogenetically old, automatic responses of the organism that have evolved for survival purposes and lack the cognitive characteristics of the higher-order mental processes and are separate from them" (as cited in Leys, 2011, p. 437). The affects are located subcortically in the brain, meaning that "affect programs" are genetically hardwired responses – products of human evolution – that are

expressed in autonomic behavioural patterns, such as characteristic facial expressions for fear or disgust (Damasio, 1994; Leys, 2011, pp. 438–439; Sedgwick, 2003).

2.13 Indigenous governance and the cultural lens

2.13.1 Indigenous governance and cultural practices

Sullivan (2007) contended that governance and policy making must recognise the dangers in codifying, reifying, and "ossifying" cultural practices and institutions. He further warns that devising static policies and initiatives runs contrary to the processes of adaptation and negotiation by which Indigenous peoples have survived. The matching of Indigenous governance initiatives with local cultural interests and priorities has sometimes been represented in the governance literature in terms of "cultural legitimacy" (Jackson, S. 2019).

However, "culture" is not a list of attributes or practices which can be transported into contemporary governance processes in a simplistic way. Traditional values may be contradictory to the contemporary intergenerational values evident in many communities and so be subject to conflict or ongoing negotiation. Cultures of governance in Indigenous communities were directed by colonial interests for many years (Smith, 2008). Favoured or compliant Elders were nominated "kings" and "headmen" and often placed in positions of "authority" over their people, reinforcing state surveillance and control (Smith, 2008). Similar contemporary examples are seen when respected local elders are appointed to adjudicate over their peers in community settings such as within the Family Responsibilities Commission, operational in Aurukun. (Australian Department of Families, Housing, Community Services and Indigenous Affairs, 2010). The Australian state reasserts its own "culture of governance" in Indigenous communities through institutional and governance directions (Dodson & Smith, 2003).

Currently, legislative and policy frameworks governing Indigenous affairs require many social groups to become incorporated bodies (Morley, 2015). These organisations mandate "Western" principles of democratic elections and voting; assert the primacy of individual citizenship over collective rights; and create categories of people on whom are assigned decision-making rights, responsibilities, and authority. These categories include "traditional owners", "authorised claimants", and "native title holders", as well as collective bodies such as "bodies corporate", "land trusts" and "governing boards" who are required to operate under legal and constitutional guidelines. Government's own "culture of governance" in Indigenous affairs uses institutionalised forms of policy, program, and grant funding

underpinned by the tools of financial compliance and accountability, service delivery outcomes, administrative review, and technical audits (Hunt, 2008)

In *Making Two Worlds Work* (2008) developed by Mungabareena Aboriginal Corporation and Women's Health Goulburn North East, the concept of "an Aboriginal lens" is described in relation to Aboriginal health promotion with values based on Aboriginal self-determination principles; a definition of health that acknowledges connection to land and spirit; community ownership and localized decision-making; and recognition of the specific historical, social, and cultural context of the community. This project provides a model from which further endeavours to create cohesion between Indigenous and Western health practices can be built.

2.13.2 Localised community-based governance

The operation of an Indigenous community-controlled health service, Gurriny Yealamucka, in Yarrabah (one of the study sites examined in this thesis) is characterised by an established "elite" of professionally qualified, community connected Indigenous women. The existence of the service in its current form is a masterpiece of neoliberal practice. The handover of health services to community control was advanced to achieve a state budget bottom line. The health service was removed from State accounting, with Gurriny Yealamucka effectively functioning as a contractor to the State.

Promoted as the ideological pursuit of self-determination, this "state devolution of responsibility" (Howard, 2010, p72) produced a number of significant issues. The organisation has struggled with high levels of internalised lateral violence and bullying, resulting from failed efforts to define a unique way of recognising Christian spirituality together with the Indigenous traditions of multiple tribal groups in its service delivery. For Cahill (2007b, p. 226), a defining feature of neoliberalism is the transfer of resources from public services to private providers in the name of creating a market for such services, and of fostering choice. It remains to be seen whether Gurriny Yealamucka (local health service) has sufficient buying power to exercise a range of choices for the people of Yarrabah. The "doxa" of the Yarrabah health service management team (those elite high performing women) will be examined later in this thesis.

Navarro (2006) describes "doxa" (a term used by Bourdieu – see below) as referring to the learned, unconscious beliefs and values that inform an individual's actions and thoughts within a particular field. Doxa favours the particular social arrangement of the field, thus privileging the dominant and taking their position of dominance as self-evident. Those who

occupy dominant positions in fields and those who are in subservient positions share a silent acceptance of the field, their role in it, and the rules of engagement.

2.13.3 Social networks and power

Social networks are embedded in the exercise of power in Indigenous communities, influenced by the phenomena of Indigenous authority described in 2.13.1. This influence directs policy agendas decision making and resource allocation (Hunt, 2008). Such direction may result in choices being made that reduces opportunities for traditional healing to thrive if the healers are not embedded in a powerful lobbying situation. Similarly, localised approaches to wellbeing may be subsumed into mainstream interpretations of recovery that might include services in mental health, substance abuse treatment and child protection. Health services, may also be directed by State governments with minimal capacity to respond to locally directed policy agendas (Hunt, 2013). This reinforces the need to interpret localised social networks to ensure social policy including health needs and aspirations are recognised. Bourdieu and Wacquant (1992, p. 119) highlight the benefits of active participation in social networks in their definition of social capital as the "sum of resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition." Social capital is combined with an individual or group's economic, symbolic, and cultural capital to create and reproduce social hierarchy in particular fields (Bourdieu, 1986, p. 248).

Bourdieu's (1986, p. 249) discussion of power inequity argues that social networks are actively created and reproduced for the benefits of their members and the maintenance of power by dominant groups to exclude and retain control. This is actively observed in the alliances which control many Indigenous organisations. Bourdieu's proposition is that power is underpinned by doxa, which are unstated, taken-for-granted assumptions or "common sense" principles behind the distinctions we make. Doxa represents "an adherence to relations of order which, because they structure inseparably both the real world and the thought world, are accepted as self-evident" (Bourdieu, 1984, p. 471). Doxa, as naturalized beliefs and assumptions, define an individual's social origin and consequent social space position.

Bourdieu refers to "misrecognition" of power relations to explain why individuals are not aware of their own subordination to powerful agents and that symbolic systems help consolidate forms of domination. The search for accumulation of resources entrenches hierarchies that require a permanent vigilance to legitimise social differences – hence a continuous effort to keep "misrecognition" about their origins. Misrecognition expresses "the

representations of legitimacy [that make possible] the exercise of power" (Bourdieu & Passeron, 1990). Culture, in the form of dispositions, objects, institutions, and language, mediates social practices by connecting people and groups to institutionalised hierarchies. Thus, it necessarily embodies power relations. Whenever a given society changes and develops through social differentiation and growing complexity, cultural capital may perpetuate social differences and hierarchies. In an Indigenous community, the right to perform a "welcome to country" may be one example of such differentiation.

Social capital controls interactions at the community level in Aboriginal Australia (Foley & O'Connor, 2013). There is a paucity of literature defining the activation of social capital in health systems management and examples from the field will be examined to identify the social relations of power amongst Indigenous organisations.

In his book *Distinction*, Bourdieu (1984, p. 101) offered the now widely quoted formula of his main concepts and their relationships: *Habitus x Capital + Field = Praxis*. According to one of his main interpreters, Wacquant (2005), habitus is:

> "The way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel, and act in determinate ways, which then guide them in their creative responses to the constraints and solicitations of their extant milieu." (Wacquant, 2005, p. 316).

Through habitus, social practices are:

> "…the product of a dialectical relationship between a situation and a habitus, understood as a system of durable and transposable dispositions which, integrating all past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions, and make it possible to accomplish infinitely differentiated tasks." (Bourdieu, 1977, p. 261).

Power and power relations are unique to their situation and influential in shaping healing responses at local level.

2.13.4 The medical gaze

In the context of knowledge and power within the medical field, Foucault (1980) argues that power is not the property of any particular social group, or something exercised through a structural instrument such as the state. Rather, power is conceptualised as "a relationship which was localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local and covert level through sets of specific [discursive] practices" (Turner, 1997, p. xii). In the case of medicine, power is embodied in, and comes

with, the day-to-day rational-scientific practices associated with the work of doctors in the hospital or clinic, which Foucault (1973) termed the "medical gaze". Such everyday practices contribute to the construction of the biomedical discourse. Institutions such as medicine exercise power through the moral authority over patients associated with being able to explain individual problems (such as an illness) and then provide solutions (i.e., treatment) for them. Miller and Rose (1990) state that medical experts play a mediating role between authorities and individuals, "…shaping conduct not through compulsion but through the power of truth, the potency of rationality and the alluring promises of effectivity" (Miller & Rose, 1990, p. 93).

In this conceptualisation of medical practice, power is essentially relational rather than something that is possessed by individual doctors or the medical profession as a social group. This moral or disciplinary approach means that power is exercised most effectively as the subject of the discourse interiorizes this gaze "…to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself" (Foucault, 1980, p. 155). It is in this context that Foucault discusses the place of medicine in the monitoring and administration ("surveillance") of populations and their bodies. This disciplinary form of power is not seen as openly coercive; rather, it might be thought of "…as a facilitating capacity or resource, a means of bringing into being the subject's 'doctor' and 'patient' and the phenomenon of the patient's 'illness'" (Lupton, 1997, p. 99).

Thus, whilst there is a recognition of the role of the state in the reproduction of this medical dominance, it does not follow that the medical profession simply serves the interests of the capitalist state. One criticism of Foucault's theorisation of medicine as discursive practice is that it is overly deterministic. It focuses attention almost exclusively on the ways in which the discourse of medicine (as represented in official texts, medical notes, etc.) both subjects and subjugates patients. This is the "docile body" view of the patient, subject to the medical gaze; there is very little discussion of the ways in which this discourse might be resisted by patients. As Lupton argued, this approach tends to "…present a consonant vision of a world in which individuals' lives are profoundly experienced and understood through the discourses and practices of medicine and its allied professions" (Lupton, 1997, p. 94). However, such medical discursive practice is negotiated by Indigenous populations through non-compliance with biomedical therapeutic regimes. Amongst Indigenous communities there are strongly expressed desires to resist subjugation and removal from community settings for treatment. This, together with Indigenous experiences of casual racism in the

hospital system, reinforces demands for culturally responsive systems of care, based in community settings with localised cultural knowledge sustaining treatment regimes.

Foucault (1972, p. 89) argued that the modern clinical experience increasingly becomes "a simple, conceptualized confrontation of a gaze. Under the scrutiny of the gaze… the patient becomes the passive and silent object of knowledge." The passivity of Indigenous patients in mainstream settings is frequently influenced (inter alia) by lack of understanding of health information, poor communication skills of health professionals, and limited cultural competency in patient /biomedicine service delivery.

Foucault's notion of the medical gaze is developed further in *Discipline and Punish* (1991) where the concept of "disciplinary power" (Foucault, 1991, p. 23) is introduced as being exercised on bodies in disciplines "such as the army, hospitals, schools, and prisons (Foucault, 1991, p. 137); in other words, a form of institutional power. Disciplinary power controls and invests in subject bodies through the techniques of surveillance, normalization, and examination. The medical gaze becomes an instrument of this disciplinary power and a central feature in the "disciplinary society" (Foucault, 1991, p. 209). Like other surveillance techniques in respective disciplines, the medical gaze observes, normalizes, examines, and ultimately makes docile the bodies in its sights/sites (Foucault, 1991, p. 138).

Foucault (1980) argued that if power is a cluster of relations, then "the only problem is to provide oneself with a grid of analysis which makes possible an analytic of relations of power" (Foucault, 1980, p. 199). The analytics of power, therefore, is concerned with power's multiple functioning (i.e., how it is exercised and its effects) within specific networks of relations. Power relations, even those that are unequal and ill-coordinated, have reciprocal movements that define "innumerable points of confrontation, focuses of instability, each of which has its own risks of conflict, of struggles, and of an at least temporary inversion of power relations" (Foucault, 1975, p. 27). Using Foucault's concept of the "grid of intelligibility of the social order", it becomes possible to examine the ways in which "power relations, knowledges, discourses and practices cross each other", (Andrews et al, 2008, p. 110) in Indigenous health service delivery when acting in tandem or in opposition to mainstream biomedicine.

2.14 Conceptual constructions of social ecology

Woodgate et al. (2017) describe social ecology as an interdisciplinary field that merges diverse theoretical perspectives and methodologies towards solving complex real-

world problems, such as those related to the various social factors affecting health and wellbeing (McLaren & Hawe, 2005; Ungar, 2012). Social-ecological frameworks can assist understanding of how confounding social factors, such as stigma and discrimination, affect the lives and systems of care around individuals (Newman et al., 2015). Such frameworks are based on Bronfenbrenner's (1977, 1986) ecological theory of human development, which describes the way in which human development is created through interactions with interconnected environmental contexts. Bronfenbrenner's social-ecological model places environmental contexts into different levels reflecting the size, proximity, and ability for interaction, and level of formality of the environmental context or setting. Each environmental context or layer has the ability to facilitate or impede the development of the individual.

Bronfenbrenner's social-ecological model is a nested system with the individual at the centre, surrounded by the microsystem, mesosystem, exosystem, and macrosystem (see Fig 2.1)

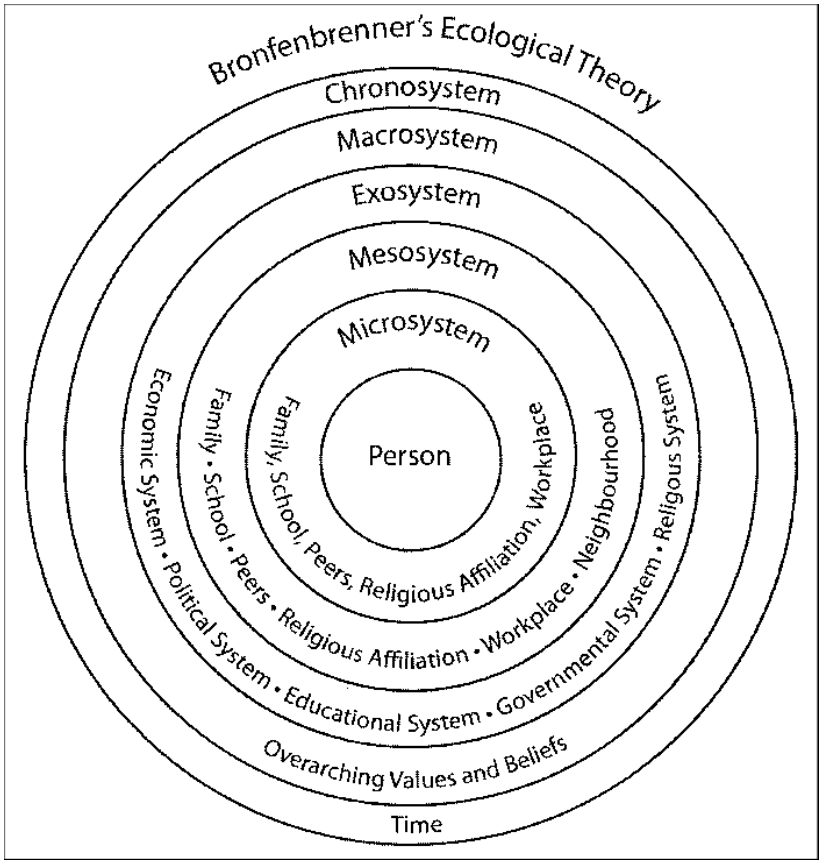

Figure 2.1: Adapted Model of Bronfenbrenner Ecological Theory from Berger, 2007; Stanger, 2011.

Each system provides a structure for explaining the social world around, and which affects, the individual. At the individual level, socially constructed stigma and discrimination exist as internalized structures based on misconceptions of the self, affecting a person's

wellbeing, and often resulting in unsettling self-treatment (Yebei et al., 2008; Mittal et al., 2012). The microsystem is the immediate setting in which the developing person is situated. Interacting factors that are typical to the microsystem are the individual's family, home, peer group, and school (Eamon, 2001; Campbell et al., 2009). The next level, the mesosystem, includes the interactions among two or more microsystems. Links between microsystems can be numerous and, as Eamon (2001) explains, such linkages can provide much of the context for socio-emotional development. An example of a mesosystem would be the relationships between the individual's peer group and family. The layer beyond the mesosystem is the exosystem, which contains two or more settings; however, only one interacts with the individual. Exosystems are typically organizations and, in the context of health research, includes health services, such as hospitals and clinics (Campbell et al., 2009). Such systems are typically influenced by bureaucratic systems that an individual (i.e., patient/client) seldom has access to. The part of the system that interacts with the individual is generally facilitated through service providers. The outer layer of the social-ecological system, the macrosystem encompasses the broader societal and cultural norms and socio-economic influences on development. Examples of factors within the macrosystem include policy domains, as well as lifestyle, customs, and knowledge systems and cultural beliefs (Eamon, 2001; McLaren & Hawe, 2005). Bronfenbrenner (1995) referred to the macrosystem as the blueprint for social structures. The chronosystem provides the overarching context consists of all of the environmental changes that occur over the lifetime which influence development, including major life transitions, and historical events.

2.15 Conclusion to Literature Review

This literature review has examined disparities between Indigenous and non-Indigenous health within Australia to provide context for discussion of the health related experiences of the participants of this study. Inequity in health outcomes is attributable to a broad range of social determinants of health, including the history of abuse of human rights and social exclusion. Indigenous viewpoints of human health and an overview of extant knowledge on traditional healing practice have been identfied, including from Aurukun ethnographies. An exploration of the status of Indigenous Australian social and emotional wellbeing and concepts of social recovery are used to interpret contemporary cultural belief in healing. The practices of localised Indigenous community-based governance provide a basis for understanding how concepts of social recovery equate to healing.

Literature that relates specifically to the current practices of traditional healing is limited and generic. There is very little accounting for the Indigenous voice in developing practice initiatives. Nor is there any acknowledgment as to how contemporary cultural transmission is understood in securing healing knowledge. This research provides a window into a world of Aboriginal spirituality and belief related to healing, demonstrating how yarning and consequential narratives of healing explain unique health viewpoints at community level. The methods for eliciting and understanding Indigenous viewpoints are described in the next chapter.

Chapter 3: Research Methodology

3.1 Introduction

This chapter outlines and provides a rationale for the choice of research design to best answer the research question, as well as discussing the methods employed to conduct the study. This includes sampling/engagement with the setting, recruitment, data collection, management, and analysis, and a discussion of the ethical dilemmas raised throughout.

The "spiral research journey" diagram (Fig. 2) provides an overview of the approach and key stages. The concept of the spiral research journey was influenced by Mao et al. (2016) who suggests that the research process is a spiral where critical reflexivity on the part of a researcher "is constantly changing and is dialectically interwoven with methodology development as well as the entire research journey" (p 6). The research spiral enables "researchers to make meaning of power dynamics and relationships" (p 5) in their social context.

Figure 3.1: The Spiral Research Journey

3.2 Research question

The research question asked in this study was:

What are the perceptions and experiences of Indigenous people in North Queensland regarding traditional healing?

3.3 Theoretical frameworks that underpinned this study

3.3.1 Symbolic interactionism and identity theories

Symbolic interactionism is based on the presupposition that our social world is constructed through everyday social interaction, through which individuals, as part of social groups, create symbolic and shared direction. Blumer (1969) outlined three core principles for symbolic interactionism: meaning, language and thought. Snow (2001) explained these principles as follows: that people act toward things, including each other, on the basis of the meanings they have for them; that these meanings are derived through social interaction with others, including though language, and that such meanings are interpreted as people make sense of their social worlds (Blumer, 1969, p. 2). This research sought the perspectives and experiences of Aboriginal people in relation to traditional healing in their own words rather than using other people's constructions of what they believe about traditional healing. Components of symbolic interaction encountered included language, gestures, and expressions, together with the conceptualisation and communication of ideas and belief.

The theory of symbolic interactionism (Blumer, 1969) sheds light on the specific nature of the interactions within and between systems. Blumer suggests that human beings subjectively construct the meaning of their experiences through linguistic and behavioural interactions with others and so society is continuously constructed through peoples' perceptions and their experiences. There are alternate views that suggest a focus on individual actions in such conceptualisation places too little emphasis on social organisation and social structure (Stryker, 1988, Snow, 2001). The holistic Indigenous worldview is fundamental to Indigenous social structure and was expressed through symbolic interactions of connections to ancestors within spiritual belief systems; the physical, biological, and ecological context of relationships with country; and the placing of self within family, kinship, and community networks (Ali et al., 2021; Buergelt et al., 2017; Smith et al., 2008).

The nature of ritual within which Aboriginal communities interpret their environment through dance and song cycles is a visible demonstration of symbolic interactionism (Charon,

2007). Hausmann et al. (2011) explore interaction ritual theory using Durkheim's framing of ritual and emotion to explain the intensity of group interaction with totemic symbols. Collins (2004) further elaborates that interaction ritual is comprised of physical presence of performers, shared awareness of intent, and rhythmic synchronicity of action releasing emotional energy. This analysis has resonance for the researcher as a methodological construct. In the Indigenous community settings of this research, there was significant emotional energy expended as participants explained their personal experiences of healing. Using English as a third language in Aurukun influenced the communication of some experiences, but unspoken behaviours and choices for preferred locations for storytelling gave context and symbolism to such communications. In Yarrabah, the language and symbolism of wellbeing has a history derived from social activism and a moderated belief system created through the embracing of Christianity. In addition, in both communities, the rituals of traditional life are symbolised through art and dance.

Symbolic interactionism enmeshes concepts of self and identity processes (Serpe & Stryker, 2011). Self is defined by the series of identities that individuals reinforce through interactions with others. Recognition or validation of those identities can generate positive or negative emotions (Burke & Stets, 2009). Ricoeur (1984, p. 48) emphasises that "narrative identities are not static structures, but the product of an ongoing integrative process." According to Ricoeur (1984), referenced by Ezzy (1998), narratives about human pasts interweave historical events and fiction in a narrative plot within which events are interpreted. Ezzy (1998, p.247) suggests that "narrative identities are produced as part of an internal dialogue, constructed in interaction with others, transformed through the influence of social relationships as mediated by institutional structures." The research participants shared their stories from such personal understandings and constructions of self, informed by their historical and contemporary societal positions. A model of Indigenous-centred framing of identity developed by Rata et al. (2014) acknowledges the importance placed by Indigenous people on cultural connections, recognising that power structures operate through identity definition. The current research encountered the identity of individuals in dynamic situations, with their identities continuously navigating mainstream life circumstances in the context of cultural, kinship and community obligations, attributing collective and personal understandings to those interactions.

Mead (1934) proposed that an individual's sense of self emerges from such interactions with others and that the interactions among several selves create societies. In contemporary Indigenous community settings, such interaction may be informed by cultural

historic and traditional understandings. However, these understandings are nuanced by, and adjusted through, the exercise of power and authority derived from non-Indigenous governance structures (Smith, 2008). Social and kinship-based support systems and the interplay of gossip, innuendo, and blame also inform these interactions (Gooda, 2011). Such interactions are revealed in participant narratives. Owens et al. (2010, pp. 480-4) suggest that place serves to shape localised and collective meanings of identity. This is borne out in the current study, where affinity with places of spiritual and mythological belief was strongly expressed in the participant narratives.

It has been suggested that non-Indigenous theoretical constructs of Aboriginal identity are commonly used in attempts to seek understanding of Australia's Indigenous people from non-Aboriginal perspectives, methodologies, and measures (Carlson, 2013). However, the participants were far from passive in their experiences. Rather, the symbolic interactionist framework applied in this study gave voice to identity rather than seeking to define it. Social identity theory (Tajfel & Turner, 1986) emphasises "culture and situational context" and investigates how "cultural meanings associated with identities are imported by actors into local interactions." Throughout the research, the participants acknowledged either personal or the recognised roles of others as holders of knowledge. This reflects the thinking of Bodkin-Andrews and Carlson (2016), who highlight the need to recognise that Aboriginal and Torres Strait Islander people should not be considered as being "known", but should be recognised as "knowers" (see also Fredericks, 2013; Martin, 2008; Moreton-Robinson, 2011; Nakata, 2012; Walter et al., 2013). The reality of "knowers" is overt in the case studies of the present research, comprising both keepers and creators of cultural and contemporary beliefs, theories, and practices. The practice and beliefs of these "knowers" hold the key to revealing the practices of traditional healing in community settings.

3.3.2 Intercultural space

Using a conceptual model of an intercultural space, both Bhabha (2004) and Nakata (2007b) independently develop rationales for a complex arrangement of concepts, theories, and commonality, rather than positioning cultures in opposition to each other. The concept of intercultural space moves cultural differences from being problematic to a discourse that promotes sharing of ideas, and which encourages engaging with, rather than, resisting cultural differences (Haynes et al., 2014). Willis et al. (2015) present the notion of hybrid "third spaces" in Aboriginal healthcare, where intercultural care might engage with cultural differences. Other theories of intercultural space that underpin this

research include Ermine's (2007, p. 193) notion of the "ethical space of engagement", which is "formed when two societies with disparate worldviews are poised to engage each other." Similarly, Durie (2005) describes the "interface" where two different knowledge systems come together and new knowledge is created that can advance understanding in both worlds. Collaboration can be sought in this intercultural space, although distrust or anxiety regarding expressions of culture and identity can persist. Indigenous people may believe that collaboration implies relinquishing control of knowledge and being (Willis, C. et al., 2015; Somerville & Perkins, 2003). Dudgeon and Fielder (2006, p. 399) define liminal places as sites for "managing" the domination, while "hybrid spaces" are created through tactics for subverting or transforming domination. The third space/culture is "intensely ambivalent, full of struggle, insecure and unstable, but it is also at the cutting edge of translation and negotiation" (Bhabha, 1996).

A key point made by Nakata (2007b) is the need for cross-cultural interface which leads to "intercultural space". This is a theoretical expression of engagement between worlds operating with different knowledge conceptualisations. Nakata (2004) argues that what is required is:

> "Recognition of the complexities and tensions at the cross-cultural interfaces and the need for negotiation between Indigenous knowledge, standpoints or perspectives and Western disciplinary knowledge systems so that meanings can be reframed or reinterpreted [as] practice." (Nakata, 2004, p 14).

Nakata, (2002) described the "cultural interface" as:

> "The intersection of the Western and Indigenous domains…the place where we live and learn, the place that conditions our lives, the place that shapes our futures and, more to the point, the place where we are active agents in our own lives – where we make our decisions – our lifeworld." (Nakata, 2002, p. 285).

Just as Nakata refers to cultural interface, Bhabha uses the term "third space" to describe the liminal, intercultural space between cultures (Bhabha, 1994, p. 208). This "third space" requires different ways of relating to other positions, views, and identities that emerge through interaction, negotiation, and translation. In her 2012 Boyer lecture series, Langton (2012) suggests that the intercultural space has the potential to encourage individuals or agents to test and repeatedly readjust preconceptions of the "other" as a strategy to better understand each other. This includes partners critically reflecting on factors that inform their

own cultural and racial positioning and its impact on sustaining or undermining the partnership.

Haynes et al. (2014, p. 8-10) develop a comprehensive summary of theoretical approaches outlining how an intercultural space might develop. This summation introduces concepts of both individual and organisational opportunities and responsibilities. It suggests that working through an understanding of power relations and personal boundaries should inform a process of intercultural exchange and reflexive interactions. Navigating uncertainty is a pathway to an intercultural space. Morphy (2008) suggests that an intercultural space should engage rather than resist cultural differences.

Defining the workings of an intercultural space in the current study relies in part on acknowledging the social ecology of the community settings in which such space is situated. This allows for a greater understanding of the relationships and proximal processes that sustain an intercultural space. Foremost though is the recognition of the potential synergy between disparate knowledge systems. Bala & Gheverghese (2007) discussing Agrawal (1995) outline that:

> "Knowledge systems are dynamic entities that change through contact, exchange and communication as they are improved in the light of counter-perspectives and new evidence." (Bala & Gheverghese, 2007, p 43)

They advocate that we must be wary of keeping such knowledge systems static or confined in their "current ontological commitments," (p.44). Rather, the cultural interface should allow those knowledges to sustain and complement each other; this requires a privileging of Indigenous voice in policy and public health program design to redress prior subjugation of traditional knowledges (Rix & Rotumah, 2020).

3.4 Research design

3.4.1 Ethnography

Ethnography, as a research methodology, encompasses the practice of reflexive fieldwork techniques, including participant observation, which leads to the creation of constructed narratives that attempt to authentically reflect the perspectives and situations of participants and informants.

The process in the field was very much like Geertz's description of ethnography:

> "Doing ethnography is like trying to read a manuscript – foreign, faded, full of ellipses, incoherencies, suspicious emendations, and tendentious commentaries, but written not in conventionalized graphs of sound but in transient examples of shaped behaviour." (Geertz, 1973, p. 10)

This quotation was illuminating for my personal experiences in fieldwork. In Aurukun and Yarrabah each participant was their own manuscript. To understand their experiences of knowledge keeping and healing, I needed to enquire, sometimes indirectly as to the life path or trajectory, that is, their ellipse that had resulted in them sitting with me. This was primarily due to their status as cultural leaders. Their interpretations of healing and knowledge keeping and transmission were certainly "tendentious commentaries," that is, partisan as to personal circumstance and with changes of subject matter, rhythm, and pace in delivery. While this style of communication was far from incoherent, it was certainly subject to back tracking and clarification which could be classified as "suspicious emendations." Above all, the "point in time" nature of the exchanges could be classified as "transient examples of shaped behaviour", in that I was hearing their opinions at that moment. This situation was modified by the fact that I met several participants on more than one occasion and over a period of up to three years. This enabled narratives to be interpreted in a range of circumstances, including in periods of community stability and instability.

In Yarrabah the "manuscript" was an anthology of stories contributed to a collective understanding of achieving wellbeing as healing. This was defined through workshop and meetings that created shared assumptions as to progressing social recovery. Each participant contributed their own circumstances and interpretations as to the community dynamics of social fragility. These narratives were also "tendentious commentaries," ranging over opinions, gossip, and professional experiences through to analysis of power relationships with government and tactical responses to achieve acknowledgment of local Indigenous viewpoints. As "transient examples of shaped behaviour" their opinions at those moments in time showed the importance of sharing circumstance to define the potential pathway to social recovery from multiple viewpoints.

Biehl (2013) argues that ethnography should aim "at keeping interrelatedness, precariousness, curiosity….in focus." Ethnography, as a research methodology, encompasses the practice of reflexive fieldwork techniques, including participant observation, which leads to the creation of constructed narratives that attempt to authentically reflect the perspectives and situations of participants and informants. This dynamic of interactions has informed and influenced this study. The experiences and personal history of the cultural broker with

informants and their extended families in both communities was a fundamental to the ethnographic process and "filled in the gaps" in the conversations and resultant field notes, becoming part of the broader narrative analysis that informs this study.

Within the first two days of fieldwork in Aurukun, I encountered what ethnographers have referred to as "moments of unstructured potential" (Shouse, 2005, p. 2443) and "deep histories grounded in place and kinship" (Clifford, 2013, p. 17). These moments of delight informed the techniques of ethnographic fieldwork used in this research. To demonstrate the impact of "moments of unstructured potential" (Shouse, 2005), within thirty minutes of starting our first conversation, TH1 in Aurukun had introduced me to the reality of Spirit World interactions in his healing practices and the foundational nature of ancestral belief. He further explained his expectations of healing as performance in navigating the Spirit World interface. His subsequent continued elucidation of the Spirit World interface, its manifestations, and the psychodynamics of community beliefs created possibilities for recognising how narratives of healing were informed by moments of recollection and cultural sharing of ancestral lore in everyday life. In Yarrabah, preconceptions of interpersonal and interfamily dynamics from "deep histories grounded in place and kinship" (Clifford, 2013) are articulated clearly. Such preconceptions provide a backdrop for contemporary recounting of ingroup favouritism and outgroup discrimination (Abbink & Harris, 2019) in progressing a social recovery agenda.

Fieldwork techniques included observing, being present and accepted in the communities with the assistance of the cultural broker, then learning that cultural safety can be initiated by the vouching and direction of the broker, but that personal reflexivity as to impact and conduct of the research must be continuously mindful of safeguarding knowledge. These techniques informed the data collection methods that best enabled understanding of individual and collective perspectives and experiences. I was continuously aware that I was interpreting "what is at stake for particular participants in particular situations" (Kleinman, 1991). He also considers that the complexity of "experience" may be hard to express at the personal level of interaction between an observer and a participant, but that a broad historical view of collective experience may be discerned. Whilst the researcher notes that in in the Yarrabah research, collective experience was garnered, this was largely due to the nature of group-based data collection. In Aurukun, the immediacy of the expressed or discerned experience gave definitive voice to personal experiences in the narrative-based discussions.

Ethnographic research is generally conducted over extended periods and I made a commitment to repeat visits to both communities over three years in Aurukun and an

intensive six-month period in Yarrabah. Taking this approach allowed me to observe and experience some of the rhythms and changes in community and personal opinions over time. Other methods would not have been as useful in gaining access to those experiences or understandings. To capture such cross-culturally shared elements and rhythms, it was important to use more than one data collection method over extended periods. Unstructured interviews were used together with the keeping of a research diary, which included observations on personal experiences and opinions, as well as participation in local events. Opinions formed through participant observation, which generated insights into sociocultural relationships, were recorded with in-depth descriptions in field diaries and memoranda. This in-depth and nuanced approach to data collection captured the diversity and individuality of participants as well as revealing a complex network of behaviours and beliefs in the research settings. Ethnography's reflexive nature was highly relevant to this study and the extended research time frame allowed exploration of diverse views and experiences, both of the researcher and of participants. Participants voices are included in Chapters 4 and 5 within narratives constructed from field notes.

Krumer-Nevo & Sidi (2012) discuss forms of writing, particularly narrative that create othering and suggest writing styles that "resist portrayal of others as different" (Krumer-Nevo & Sidi, 2012, p. 301). This reduces the risk of assessing or judging cultural difference. I used narrative, so that the subjectivity of the participants appeared and reflexivity, which embedded my own feelings, experiences, and history in understanding the research participants. These participants and their personal situations were in the foreground of the writing which was contextual and specific. My interpretation added a new source of knowledge reinforcing the personal relationship developed with the participants.

Krumer-Nevo & Sidi (2012) indicate that: "narrative is a mode of presentation that situates the participant in the context of a story, experiencing and controlling events" (p. 300). They also explain that narratives offer insight into how the researcher might navigate her "subjectivity, agency, and the social, classed, and gendered context that is beyond her control" (p. 301).

In seeking to achieve reflexivity, I exercised inquiry, critical thinking, and questioning, to enable myself to present a variety of perspectives on the lived reality of healing in the subject communities. Krumer-Nevo & Sidi (2012) also suggest that reflexivity places the interviewer/researcher inside the text—the object-subject of examination and study. Reflexivity is a cognitive process that focuses on one's own thoughts, memories, emotions and bodily experience and analyse these in response to the research encounter. They argue

that the research encounter is a place of interpersonal relationship where both the interviewer and participant exchange feelings, emotions, or experiences through words and implicit communication. I demonstrated this by being open to the diverse topics and interpretations of healing activity as explained by the participants. This approach minimises othering by making space for research participants' voices and knowledges, acknowledging their theories and analysis regarding their circumstances; with the author's presence offering an interpretative element as part of the text. I sought to give an embodied sense of the lived experiences of healing.

The "self-reflexive fieldwork account" became vital to my practice as an ethnographer. This process is characterised by Clifford (1986) as "confessional and analytic" and is described as "an important forum for discussion of a range of issues, epistemological, existential, and political" (Clifford 1986, p. 7). This was critical in the context of the current study, as reflexive accounts specified the discourse of a participant who then "becomes a speaking subject, who sees as well as is seen, who evades, argues, probes back; and with this acknowledgment gave voice to the primary informants of this study" (Clifford, 1986, p. 14).

Anthropology has been presented as relying on both an emic (internalised) and an etic (externalised, objective) understanding of the phenomena being researched. These dual understandings have often been portrayed as two separate interpretations of what is required for the conduct of good research (Pike, 1990). An emic account (the insider's view) is considered to be a culturally specific description of a belief or behaviour that was meaningful (either consciously or unconsciously) to participants, allowing them to reflect on their belief or behaviour and present an interpretation of this to the anthropologist (Seymour-Smith, 1986). In contrast, an etic account (the outsider's view) is a description of a belief or a behaviour by an observer, e.g., the anthropologist herself (Seymour-Smith, 1986).

The ethnographer's position is considered to be a fluid, layered, and continually negotiated status (Baddeley & Andrade, 2000). This is in accordance with Simmel (1950, p. 2), who sees the ethnographer as, "…the wanderer... who comes today and stays tomorrow." From this perspective, the ethnographer's position within a field location is not viewed solely as insider or outsider, but is understood as multi-faceted, whereby the ethnographer can create an emic and etic account of a particular experience. My privileged access, facilitated by the cultural broker, created unique opportunity to experience the emic viewpoint.

Allen et al. (2008) discuss how critical ethnography examines power relations in research by considering political and social imbalances in advantage and influence. Such analysis may then be used to justify required change to redress disadvantage. Successful

critical ethnography requires an understanding and analysis of the ideological, political and institutional structures that influence the ethnographic settings and the broad sociocultural context. The fact that ethnographic feedback is experiential in nature and limited to a context and time period means that findings should be moderated by insider and outsider viewpoints and a longer-term contextual view. Critical ethnographers then, take into account the ethical responsibility to address unfairness or injustices and attempt to achieve positive social change (Brown & Dobrin, 2004; Madison, 2019). They contend this is achieved by conducting their examinations of culture through the analyses of power, prestige, privilege, and authority (Creswell, 2007), in response to an ethical responsibility. Initially, I attempted to act as advocate for the role of traditional healing with the sponsor body Apunipima. However, it soon became clear that this advocacy was not conducive to the aims of the research. Rather, simply allowing the research to follow the lead of community members in recounting their experiences proved to be the most effective method of ensuring, across both study sites, that the significance of place, time, kinship, belief, and personal values were understood and respected.

3.5 The study sites: a brief summation

There were two phases in the study associated with two distinct sites, Aurukun and Yarrabah, discrete Aboriginal communities over 1,000 miles apart from one another within North Queensland (see map next page).

Before European settlement, the Wik (Aurukun) and Gunggandji people traversed their ancestral lands in seasonal patterns of natural resource exploitation, in a manner defined through conditions of their unique Aboriginal spirituality, ritual, and beliefs. Since the late 19th century, community settlement in both locations was disrupted by the influence of, and interaction with, European missionaries and missions. The remoteness of Aurukun allowed William MacKenzie (appointed superintendent of Aurukun Presbyterian mission on Western Cape York Peninsula in December 1923) more autonomy, with traditional practices such as initiation continuing until the 1960's (Kidd, 1994).

However, Aurukun land tenure was subject to government intervention to secure exploitation of high value bauxite resources (Kidd, 1997; Brennan, 1954). Mining access to those lands was continuously facilitated by successive governments from 1958 onwards (Howitt, 1992). Wharton (1996) provides a detailed discussion of the physical impact of

bauxite mining, which has resulted in wholesale disruption of the ancestral landscapes (also recounted in earlier ethnographies of place; see Sutton, 1979 and Von Sturmer, 1978).

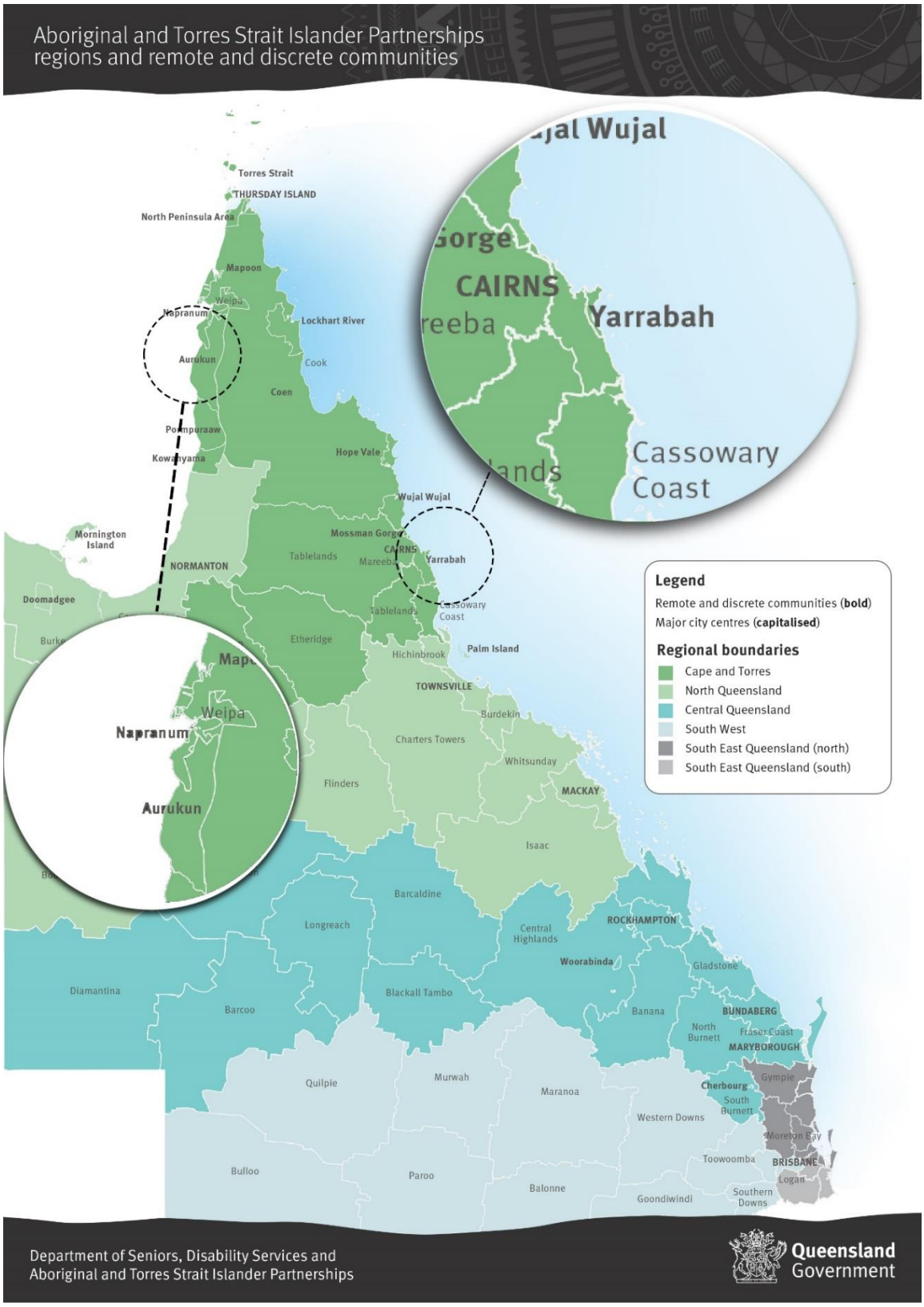

Figure 3.2: Map showing location of study sites – source Queensland Government
(https://www.dsdsatsip.qld.gov.au/contact-us/regional-service-centres)

In contrast, Yarrabah has a history of the traumatic "removal" of children under successive segregational and assimilationist policies, as documented in the Bringing them Home Report (Human Rights and Equal Opportunity Commission 1997). By the 1930s, the local Gunggandji tribes had suffered considerable dislocation from traditional lands, as attested in contemporary reporting (Bottoms, 1993). In Yarrabah, from the 1930s onwards, legislation changed the management arrangement for the reserve, but Aboriginal people were still subject to control of their movement and management of their own financial and personal affairs (Anti-Discrimination Commission Queensland, 2017). There were prohibitions on exercising their own cultural traditions, while being encouraged or coerced into "English" institutional activities, such as participation in the Yarrabah Brass Band and a girl guiding troop (Menmuny-museum, n.d.). Yarrabah Aboriginal people were amongst those providing vital capability in the agricultural sectors during the war years, 1939-45, and there was some improvement in conditions for Aboriginal people, who were paid award wages (Miller, 1986). By the 1950s, tensions over management of the mission escalated and over the next decade, individuals established a pattern of leaving the community for shorter and longer periods, either with formal exemptions from legislative control, or for schooling, education, and family support (Loos, 1991). From 1960, the Queensland Government initiated legislation which ultimately removed all missions in the state from the control of the Church to government control (Hume, 1991). The Department of Aboriginal and Islander Affairs, a government department, continued running the affairs of the community under this Act. In 1987, under the *Community Services (Aborigines) Act 1984*, a Deed of Grant in Trust was given to the Yarrabah community over the Cape Grafton area. Like other DOGIT communities of the time, Yarrabah had a Community Council elected by Aboriginal people living in the community (Department of Aboriginal and Torres Strait Islander Policy, 2003).

Gunggandji people hold native title rights over country, including Yarrabah township, the foreshores of Mission Bay, Cape Grafton, Turtle Bay, Wide Bay, Oombunghi beach, part of Malbon Thompson Forest Reserve, and land on Fitzroy Island, covering more than 7000 hectares around the township as determined by the Combined Gunggandji People's Native Title Determination, 2011 (**N**ational Native Title Tribunal, 2011). A series of Indigenous land use agreements ensure the continuation of local government services, while protecting state

land, natural resource management, and the rights of historical lease holders (Gunggandji Land and Sea Country Plan, 2013).

The non-Indigenous records of the two localities reflect many viewpoints, and were located, inter alia, in a range of government reports, personal diaries, books, and theses (Meston, 1896; Gribble, 1930; Ganter, date unknown; Annual Reports of the Chief Protector of Aboriginals 1904 onwards; Annual Reports of the Chief Protector of Aboriginals 1958 onwards; Kidd, 1997; MacKenzie, 1981; Sutton, 2009).

The study sites were chosen in consultation with the cultural broker with consideration given to the practicality of access and likely acceptability of the research to the community. The purpose was to seek understandings of traditional healing that were potentially different due to variations in the histories and settings of the respective study sites, but which were nevertheless overtly Indigenous. The cultural broker's contacts in Aurukun demonstrated significant interest in the study, and the research was actively supported by several community leaders.

3.6 Ethics

3.6.1 Ethics approvals

Ethics Approval HREC/12/QCH/53-792 was granted by Cairns and Hinterland Hospital and Health Service Human Research Ethics Committee (HREC) in December 2012 (See Appendix 1). Apunipima Cape York Health Council was the Cairns based authorising body and is an Indigenous community-controlled entity representing the health interests of Cape York Indigenous communities through locally/elected representatives. Board approval was given for the study (see Appendix 2).

Subsequently, ethics approval was obtained from the ANU Human Research Ethics Committee (Protocol 2020/294, 26th June 2020) (See Appendix 6). This approval recognised the Cairns HREC approval as evidence of local support and was satisfied concerning the ethical conduct of the research.

Both Human Research Ethics Committees acknowledged that data from Yarrabah was obtained pursuant to a contract (in confidence) entitled, *Support to the Yarrabah Leadership Forum Project*. This was entered into between the researchers, Jacqui Lavis and Bernie Singleton and the Yarrabah Leadership Forum on 19th August 2018.

Clause 26 of the contract, entered into in August 2018, provided for a mutual intellectual property exchange between the Yarrabah Leadership Forum, Bernie Singleton,

and the researcher and states that if:

> (a) the Contractor needs to use any of the
> (I) Yarrabah Leaders Forum Material; or
> (II) Auxiliary Material provided by Yarrabah Leaders Forum,
> for the purpose of performing its obligations under this Agreement, Yarrabah Leaders Forum grants to the Contractor, subject to any conditions or restrictions specified in the Agreement Details, and any direction by Yarrabah Leaders Forum, a world-wide, royalty free, non-exclusive, non-transferable licence (including the right to sublicense) to use, reproduce, adapt, modify and communicate such Material solely for the purpose of providing the Services.
> In this case the Services are an assessment of community feedback about perceptions of health and illness in the context of cultural constructs and the deficit discourse which was derived from the workshop notes.

3.6.2 Seasonal rhythm of community access and interviewing

Of particular note was the rhythm of Aurukun over the course of a year; how the seasons dictated the availability of people in the community, locations where people were prepared to have conversations, and the point at which information was regarded as being complete. June to September are dry season months. Historically, Wik people used sand ridge and woodland country for foraging during these months (Thomson, 1939). A number of out–stations remote from the "mission" setting of Aurukun, sometimes established from the remnants of cattle station camps, are used for time "on country". Bush tucker is harvested, fishing undertaken and marine resource such as mudshell (*geiorna expansa - mangrove clam*) collected. This period coincides with mid-year school holidays when children can reconnect with aspects of traditional life. Trying to conduct a community-based interview or consultation at this time is non-productive.

April and May are post wet season months and a sense of anticipation of the period of out-station activity is evident at these times. It was no different during this research. There was palpable community energy at this time; the country was refreshed through the wet season monsoonal rain, and damage from cyclonic winds had been repaired. Hence, this was generally a good time to communicate, make plans, and hear stories, as there was obvious community anticipation of activity generally. October/November are "wind down" months – every day is slightly hotter and more humid than the previous and communication typically slows. In the world of government services, there is a sense of "getting things finished before Christmas". It can sometimes be useful to provide field reports and briefings to government

service agencies at this time. Given these seasonal considerations, contact with participants in this study followed the seasonal rhythm of the local communities.

3.6.3 Localised response to National Health and Medical Research Council: Guidelines for Researchers and Stakeholders

Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities was a fundamental prerequisite for this research. Stakeholders and community settings are located on Aboriginal land with the majority of participants of Aboriginal descent. The National Health and Medical Research Council (NHMRC): Guidelines for Researchers and Stakeholders (2018) set parameters for ensuring respect for autonomy within such communities and ensuring the cultural safety of participants.

The research proposal was discussed with Apunipima Cape York Health Council staff, elected members and community advisory groups, (see p 105). Practical suggestions were made concerning research conduct and likely opinions that might be encountered and these helped shape the research approach in the field. The research was formally endorsed by the Apunipima Board who expressed the view that exploring healing capacity in the Aboriginal and Torres Straits Islander communities would be of overall benefit to a community-controlled health system. The project sponsor was confident that the input of the cultural broker would ensure personal and community confidentialities and cultural sensitivities would be recognised and respected.

Bernie provided on-going commentary and advice as to how the research was being received at community level and was instrumental in assisting with ongoing support being offered by Apunipima Cape York Health Council. His endorsement of the research procedures is found in Appendix 5.

Each deliberative action in the research process sought to fulfil the intent of the values and practice guide of the ethical conduct *g*uidelines. These six core values are: spirit and integrity, cultural continuity, equity, reciprocity, respect and responsibility.

3.6.3.1 Spirit and Integrity

Using the guidelines in practice required a high degree of personal reflection. Due and Riggs (2012, p. 10) suggest “those of us who identify as white Australians…. do not have a right to publicly discuss and debate the lives of Indigenous Australians indiscriminately (and certainly not without equally examining our own complicity in ongoing forms of colonisation that contribute to the marginalisation of Indigenous people).” As a white

Australian and mindful of this responsibility, it was the intention to seek to give "voice" to the participants with *spirit and integrity*. It was hoped this could be achieved through a commitment to relationship building with Indigenous participants. The involvement of a cultural broker directed ethical practices in conducting the study, in particular noting hesitancy to speak or engage and advising the researcher to change her approach or to politely take her leave from the potential participant. This approach met the core value of s*pirit and integrity* through recognition of the personal circumstances of participants and the privileging of the choice to decline to be involved. Apunipima Cape York Health Council as the sponsor organisation did not seek to express opinions as the research progressed, allowing an organic development of community-based opinions. This involved regular feedback and conversations with participants, and a continuing commitment to ethical research practices of confidentiality and respect (Beneviste. 2018).

3.6.3.2 Cultural continuity

Cultural continuity within the research was shown through the process of developing the research protocols, over a period in excess of fifteen months. Emerging interest was discussed with the Chief Executive Officer and Chairman of Apunipima Cape York Health Council, the peak advocacy body for Indigenous health on Cape York. The response and expression of support was immediate. A pivotal conversation scoped the study around "respect, recognition, and recompense," with an eventual aspirational aim that traditional healing would be integrated with primary health care.

Starting informally with Apunipima Board members, and facilitated by the cultural broker, I began to hear ongoing anecdotal stories of power relationships sustained in the delivery of biomedical services. Failure to understand the damage that can be caused by non-Indigenous biomedical staff, who were perceived as having an inadequate understanding of appropriate cultural behaviours, proved to be a particularly common theme. During these initial conversations, encouraging support was received from Board members who, despite initial reservations about "cultural privacy", resolved that the research could proceed to application for ethics approval. This was with the proviso that Elders in each community should have the final say regarding access to healers and their "patients" in community settings. This requirement helped set the standards for reflexive ethical ethnography in the field, and was reflected through the processes of engagement that took place throughout

the research and the continued interest amongst Indigenous participants and contacts that arose from research activities.

3.6.3.3 Reciprocity and responsibility

Reciprocity and responsibility were demonstrated in the relationship developed between myself, as a white researcher, and Apunipima Cape York Health Council (the premier Indigenous representative body for health services on Cape York). The facilitating role of Bernie, the cultural broker, was fundamental to ensuring cultural continuity in this space, given his ongoing role in facilitating inputs that contributed to development of the research protocols.

During the ethics approval process, formal discussions were held with the Apunipima Board of Directors and Health Services regarding the research project. The Board commentary included observations that communities should be able to exercise choice as to how information on traditional healing was to be used, and that at all times communities and individuals had the right to access traditional healing practices. These conditions implied that the research should identify impediments to the exercise of such choice. Some Board members advised that community members frequently attributed unexplained disease or death to traditional sorcery or "black magic", providing examples such as ongoing illness of individuals with no symptoms detectable by Western clinical practices. Events of unexplained death were recounted where autopsies could not find identifiable viral or infectious causes, and where death appeared unrelated to any underlying evidence of chronic disease. This commentary was significant in directing the research towards consideration of the imperative of belief in sorcery in community settings and how such beliefs tied to constructs of healing and behaviour.

Auger (2016) defines cultural continuity as the integration of people within their culture and the methods through which traditional knowledge is maintained and transmitted. In the course of conversations with the Apunipima elected members, matters raised by the Board included views that cultural continuity was adversely affected by certain non-Indigenous clinical practices or standards of care in the primary health care system. Examples given included birthing routinely taking place in regional urban centres, rather than in settings with connections to ancestral lands. Children were registered with a birthplace of Cairns rather than by community of parental origin or residence. Traditional practices such as burial of the placenta on traditional country were unsupported at that time in a biomedical

environment, causing potential dislocation of the child's spirit. It was noted that the South Australian Health Service was considering a practice note for the management of the release of placenta for private use; this has more recently been confirmed as a clinical directive (South Australian Public Health Services, 2016).

Other examples of lack of cultural continuity mentioned by the Apunipima Board included the prevention of traditional healers from attending patients who are terminally ill or in intensive care, due to lack of recognition of the need for spiritual support. The failure of clinical care plans to advance care planning with Aboriginal & Torres Strait Islander people, and the absence of living wills to recognise traditional healing, were identified as issues that required further scrutiny. It was noted that GP Mental Health Treatment Plans do not facilitate access to traditional healing and that generally, the concept of tailored treatment implicit in advance care planning or in GP Mental Health Treatment Plans was not promoted with Aboriginal people.

These specific examples of lack of cultural awareness had the potential to disenfranchise Aboriginal people from access to their cultural beliefs during health care. In such situations, there was a strong signal to myself to actively enquire of both Aboriginal participants and of health care professionals, as to the use of cultural practice and knowledge in healing. Comments from personal contacts working in hospital and general practice heath care settings obtained during the ethics approval process suggested that traditional healers were generally unable to attend patients. Particular mention was made of the distress suffered by Indigenous people enduring psychotic episodes or ongoing mental health conditions, where both families and individuals sought cultural rather than clinical support.

The Apunipima Board (the elected representatives of the Apunipima Cape York Health Council) noted that precedents existed in other states (e.g., Northern Territory, South Australia, and internationally) that could serve as examples for collaborative practices of healing for Cape York. They also referred to their broad understanding of traditional healing as practiced by First Nations people in North America and in some South American countries. Evidence-based research on the application of traditional medicine was anticipated by the Board to inform the future development of such collaborative relationships between Indigenous traditional healing and mainstream primary health care. Board members from Kowanyama stated strong support for advancing the research discussed, noting that their own community had "documented" traditional healing practices (Luke et al., 2011). Another Board member however was not in favour of the research, stating that "traditional healing is private." To accommodate concerns related to this view, a clear statement was made that

specific cultural knowledge would not be sought, that participation had to be completely voluntary, and that the cultural broker would be available to discuss any participant concerns.

A subsequent discussion with community based advisory groups auspiced by Apunipima Cape York Health Council acknowledged this very legitimate sensitivity regarding access to cultural information, especially relating to traditional healing. The representatives suggested that entry points to discussions in communities might include bush medicines and plant usage, together with women's views of traditional healing, and that such conversations could facilitate greater understanding of potential cultural sensitivities. It was expected that Elders would define the extent of consultation with traditional healers that would be considered acceptable by each community, and that is how the research was conducted. The Apunipima Board members broadly expressed concern about the lack of understanding or respect for the importance of traditional healing in the lives of community members. Support for research confirmed by letter dated 9th May 2012 (see Appendix 2) states:

> "We feel that the results of the research have the potential to create real benefits, both for Aboriginal and Torres Strait Islander people and the health services you visit by strengthening communication information and understanding between traditional healers and mainstream clinical services."

3.6.3.4 Equity, reciprocity and shared responsibility

With respect to the commitment to understanding concepts of equity, reciprocity and shared responsibility within Aboriginal clan and kinship networks, much of the narrative from participants centred on family support and obligation in healing and maintenance of cultural continuity. Participants talked freely about a "long view" of benefit from the research with aspirational expectations as to improving understanding about situations when traditional healing practices may be beneficial. Some participants saw themselves as autonomous and in charge of the research agenda, and were clear as to when matters were private or could be shared. This was in conjunction with a clear view that any form of recognition was on their own terms. Research for the ethics process revealed some of the risks and caveats of attempting to gain access to cultural knowledge in these communities. Such risks related primarily to potentially vulnerable participants, and to the fact that individual communities have opinions that potentially conflict with the practices of biomedicine. The field notes incorporated Guillemin and Gillam's (2004) approach to reflexivity by ensuring that self-monitoring was part of my personal deliberations. Such self-monitoring was an intuitive part

of working with the cultural broker and maintaining close relationships with study participants. Hence, it was important to ensure that experiences were documented as part of "real life contextualisation of fundamental ethical standards" (Chenhall et al., 2011).

3.6.3.5 Ethics in practice

The study encountered a classic dilemma of qualitative health described by Guillemin and Gillam (2004) as "ethics in practice". They describe the process of reflexivity in developing "informed consent through interactions between the researcher and participants "respecting the autonomy, dignity, and privacy of research participants", and that "it is in these interactions that the process of informed consent really occurs – not on the pieces of paper that an ethic committee peruses" (Guillemin & Gillam, 2004, p. 275). The CHHHS Human Research Ethics Committee (HREC) was not familiar with the conduct of research in Aurukun; as such, there was some lack of knowledge about workable options in the field. At one point, a requirement was made that informed consent forms should nominate contacts that participants would not have heard of such as the CHHHS HREC committee or the Australian Nurses Union, rather than Apunipima Cape York Health Council. This requirement was later altered when it was suggested that the cultural broker, as a known person in many Cape York communities, could be the contact point. This extended his role in keeping track of the dynamics of interviews and community-based conversation to ensure that consent to participate was managed within local cultural protocols.

Queries from the Cairns HREC were wide ranging and indicated that the topic had not been investigated previously. They asked whether the research was seeking to investigate the eventual integration of traditional healing with evidence-based medicine, and if so, whether this might raise queries about the efficacy and possible harmful effects of traditional healing, or present traditional healing in a negative light. It was confirmed to the HREC that questions of therapy or treatment were not being raised and that the research concerned attitudes to healing. It was also confirmed that no detailed information was to be sought concerning culturally sensitive practices. In response to queries relating to local community-based control of the research, it was confirmed that there was to be involvement of the community in decisions concerning whom, when, and where the research was to be undertaken, and that Aboriginal people and communities participating in, or directly affected by, the research would be fully informed and would control the directions of the project.

This was achieved through ensuring the agreement of locally based elected officials as well as those in senior governance roles as to how research could be conducted and enlisting their support to nominate participants. The researcher and cultural broker were then attuned to any feedback during the conduct of research as to whether the direction of research required modification. An example of this included acknowledgment that it might not be possible to talk to the most senior knowledge keepers for reason related to their frailty and the guardianship by their families. Whilst there was the possibility of gatekeeping by influential community members affecting access to potential participants, the research did in fact attract a diverse range of participants by age and background and gender balance.

Responses from the Cairns and Hinterland (CHHHS) Human Research Ethics Committee demonstrated that a comparative lack of understanding of Cape York community dynamics had led to a failure to fully appreciate the role of Apunipima Cape York Health Council as a community representative health organisation, which provided primary health and allied health services as well as advocacy for community control of health services. One of the concerns of the Human Research Ethics Committee was the management of intellectual property, which resulted in needing to make contact with an Indigenous advisor to discuss knowledge sharing. The expressed opinion was that, when prior informed consent is given to access traditional knowledge from Indigenous peoples and their territories, mutually agreed terms and benefit-sharing arrangements become a part of contractual agreements between the local community and the researcher/collector. In discussion with the Human Research Ethics Committee, I presented a case that benefit sharing opportunities were beyond the scope of a PhD thesis where there is no capacity to engage community-based researchers. It was eventually agreed (with the input of the cultural broker) that the community based consultative dimension of the research would establish how communities might discuss access to traditional healing and the barriers to such access. Detailed cultural knowledge of sacred or ritual practices that might be deemed intellectual property were not to be sought during the research.

In conclusion, the ethics approval process raised important questions about the need to be respectful of local context in research with Indigenous communities, and this responsibility transcends the role of any committee, becoming a vital component of reflexive ethics research practice.

3.6.4 Bernie as cultural broker

Bernie Singleton [5] has been my research sponsor for eighteen years, first as co-researcher and cultural mentor within Apunipima Cape York Health Council, and then as cultural broker for this research. His endorsement of research procedures is found in Appendix 5. James Cook University (JCU) (2021) in their web-based ethics application background material entitled "Best Practice in Aboriginal & Torres Strait Islander Research" suggest that the term "cultural broker" is defined through common usage as a person who facilitates the border crossing of a person from one culture to another.

He has had continuous involvement in the field of Indigenous health and welfare for more than thirty years, both in operational roles and in strategic governance as Apunipima Cape York Health Council Chairman. His other health governance roles have included Queensland Aboriginal and Islander Health Council, National Aboriginal Community Controlled Health Organisations, Northern Aboriginal & Torres Strait Islander Health Alliance Queensland Disability Board (Queensland. His stature as Cape York leader places him in a position of cultural authority with no social risk likely to be ascribed to his actions.

He also has close kinship connections with cultural practitioners; amongst his close relatives, one is a *noyan* or healer, one a *dumbun murri* or sorcerer. He is a recognised elder and traditional owner.

Culture broking is described as "the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change" (Jezewski, 1990, p 497). Bernie calls this process "opening doors." The JCU advice goes onto suggest that a cultural broker can play a crucial role at the start of the research process by bridging the cultural divide to facilitate a smooth introduction and interaction between the researcher and the Aboriginal and/or Torres Strait Islander community. Bernie continued to nurture the research over a number of years, suggesting new contacts, finding their whereabouts and facilitating conversations. He suggested when it was appropriate for me to visit an informant's house, or where an informal "sit-down" in a community setting might be more suitable. He always insisted on a debrief following a conversation to address instances where my understanding of a comment or phrase needed clarification. He has played the broader role of mentor by inserting knowledge of the politics of Cape York and the social factors that influence cultural values, beliefs, and practices in the different Cape York communities. The protocols of working within communities, capturing

[5] Bernie Singleton has consented to be identified and has endorsed the conduct of the research, see Appendix 5

opinions, and general behaviour all require a watchful eye, which Bernie provided, consistently with grace and humour.

Bernie recounted his life as being defined, influenced, and directed by many key events in the world of white and black Australia. His grandparents were part of the Stolen Generation. Bernie was born and lived his early life in Yarrabah. As Stolen Generation descendants and mission residents, his family experienced jurisdictional control of their lives as well as a range of unjust and racist practices. His sister features as an "unresolved case" in the report of the Royal Commission into Aboriginal Deaths in Custody (1991). His father staged an on-going campaign against racist practices with the mission authorities of Yarrabah, and his wife grew up in Mona Mona mission, after relocation with her family from Djabugay homelands, in the vicinity of Kuranda, north-west of Cairns. Like most Aboriginal people of his generation, Bernie has no birth certificate or passport and his employment history is littered with circumstances where full entitlements have been denied. In his later primary years, he experienced the end of the mission and Anglican Church control of daily life; he also witnessed his father's involvement in a strike concerning unfair working conditions in Yarrabah in 1958 and the subsequent "walk off" when exemptions (from control of personal movement by the Protector of Aborigines) were given to a large number of people. The greatest number of people who left between 1957 and 1959 moved to Bessie Point (Long, 1970, p.131) just beyond the outskirts of mission territory. Bernie's recounted tale of this event is compelling; "My Dad had been complaining about wages and food and the like and went in with his friend to see the Mission Superintendent. They asked for their exemption papers to be signed. When this had been done, the Superintendent looked through the door and asked why a large mob was outside." Bernie's father replied "They [are] all waiting for exemption too." The official narrative talked about "large numbers" being given exemptions to improve "assimilation."

As a Traditional Owner on his father's side, Bernie speaks for Yirriganydji [Salt Water Djabugay], and is an Elder for the Umpila language group on Cape York. On his mother's side he speaks for the Birrigubba and Juru-Bindal peoples of Townsville area and the Woppaburra Land Trust (Great Keppel Island). Yet "you can only claim one blood," he says when talking about a person who moves between statutory positions on different native title bodies. Bernie has not had access to ancestral knowledge, that is knowledge of mythological connection to country. Neither has he had the opportunity to access significant areas of land over which he now holds traditional ownerships, with much of his cultural knowledge defined by his exposure to anthropological research through the course of his

working life. His maternal Cape York connections were established from knowledge obtained when he worked as a cultural broker with an anthropologist on his homeland Umpila country. His construction of his Cape York connections is an example of multiple identity affiliation, common amongst North Queensland Aboriginal populations.

His signature story is of his grandmothers, Grannie M and Granny L, who met as little girls and formed a lifelong friendship in the dormitories of Yarrabah sometime between 1904 and 1912. I spent some hours searching the old government archival data bases to find records of these two girls – the first from Umpila country in the vicinity of Nesbit River, Cape York. Some years later, Bernie retold this story, filling in a few crucial pieces of information. I was made to understand after this narrative that he might have regarded the "real story" ("maybe I didn't tell you quite right, that first time") as having information that I might not have been trusted with on that first occasion.

This girl, later known as Grannie M, from Nesbit River area, is described in official records as the daughter of "Night Island woman". My reaction to this evocative identity, which I had taken to be cosmological, was deconstructed during personal communication with anthropologist Athol Chase, who referred to his field notes for me and explained that "Night Island" was a staging post where lighter-skinned children were assembled after removal from parental care. Perhaps "Night Island woman" was on the island (situated off Lockhart River) to find her child. From Bernie's narrative, we learn that "one came on a truck, one came on a boat." The second girl, from Great Keppel Island, was first removed to Bogiilubah Mission on Fraser Island and then to Yarrabah. "Them girls were wailing on the beach at Fraser Island…they were told they were going pictures at Maryborough; they knew that wouldn't happen." I cannot identify Bernie's Great Keppel grandmother in the government records, so I settled for the story as he told it. I have come to realise that it is his telling of his ancestry, rather than historical accuracy or validation, that is relevant to his place in his world and mine. As Biehl (2013, p. 577) observes,

> "In our returns to the encounters that shaped us, and the knowledge of human conditions we produced, we can learn from our experiences anew, live them differently, acknowledging an inexhaustible richness and mystery at the core of the people we learn from…our ethnographic subjects have a future—and we become a part of it, in unexpected ways."

The self-definition of identity relies on fragments and reconstructions, creating a validity of evolving culture and "authenticity," (as interpreted from a white perspective.)

Everett (2008) describes a political-cultural process of group identity formation and development as a product of political strategising and manoeuvring, as well as extensive social relations. The "authenticity" that the Australian state demands for native title claimants, that is, ongoing connection to Aboriginal traditions and customs, is delivered on demand. Within the Coen sub region, where Bernie's traditional lands are located, the Aboriginal system of land tenure has shifted from a patrilineal clan estate system toward that of cognatic descent groups. These "language-named tribes" are the primary social structural units by which people identify with country and around which their ownership of land is organised and conceptualised (Chase et al., 1998, p. 35–9). However, the extent to which these transformations have occurred varies among different groups, so that patterns of land tenure, social organisation and identity are not uniform.

One of my early experiences of the self-deprecating sense of humour of many Cape York men was an introduction to Bernie's world; a world where "not quite humour" (that is, wry responses to casual and less than casual racism, mingled with throw away lines of commentary that often reduced or understated what might happen) was the norm. "I'm just going to muck about at the beach for a bit," he said, referring to a meeting by the National Native Title tribunal, convened to agree about the scope of a major land claim. This was Bernie's way of saying "I'm not expecting much to come of this."

Bernie's style was to give the conversational lead to others and elicit information and support through creating collaborative intent in responses. It stemmed from the shared narrative of people and place: where you came from, who you know, who you married, where your children are, what's happening in your life. In contrast to watching Bernie's inclusive behaviours, I watched others show rebellion against authority through non–communication. Scott (1985) characterises "weapons of the weak" as forms of resistance that can be demonstrated in subtle forms such as in contesting the public record. He suggests that marginalised people participating in a public discourse may use "rumour, gossip, disguises, linguistic tricks, metaphors, euphemisms, folktales, ritual gestures, anonymity" to resist the imposition of authority (Scott, 1985, p. 137). According to Scott, "everyday resistance" comprising cultural resistance and non-cooperation is employed over time by the disenfranchised. I encountered all of Scott's examples during communication over the period of fieldwork.

"Sing out me and I'll find you". There is sometimes a moment of irresistible syntax in an ethnographic encounter, an evocative phrase that encapsulates an emotion, an expression of confidence or support, something funny, sad, or simply so perfectly expressed that the

exchange stays with you. This statement of commitment by Bernie Singleton occurred some years into our association. Since then, it has been used in any situation where I felt uncertain. Not only was it a metaphor for Bernie's support, but also a situation occasionally invoked in real life. We know where to find each other, if needed, and will call each other when the Spirit World bends a little and needs repair.

Bernie was a cultural broker for this study, and therefore was overtly acknowledged as co-researcher not only in practice but in the formal documentation within the ethics application and approval process. The nature of the research, requiring access to cultural leaders within remote community settings is unlikely to have been possible without his introductions. With Bernie as cultural broker, the protocols of working within communities, listening to their opinions, and behaving respectfully all required a watchful eye, which Bernie consistently provided. In practice, he provided a bridge for me to gain entry to the communities and demonstrated that a cultural broker as an insider can ensure that an outsider researcher can be assigned a legitimacy for "being there" in the field.

He ensured cultural safety for all participants (including me as a researcher) by ensuring that matters discussed sat within culturally acceptable boundaries of access to knowledge and that confidentiality regarding the detailed subject matter of conversations was maintained within community settings. In the context of the broad conduct of the research topic being widely understood and acknowledged, he continued support for the research by providing clear advice on study progress to the Apunipima Board. He generated understandings of the complexity both of kinship affiliations and those obligations that are not kinship derived but related to the balance of power in community settings. He created a window into the world of Indigenous leadership and governance to demonstrate how new interpretations of healing had arisen. His view on questions of intellectual ownership of knowledge reflected his belief in creating common goals for improvement of health equity across Cape York communities, that is that knowledge is "everyone's business". His view was also that participants would tell their stories so that their meanings could be interpreted in multiple ways, so that the way in which a story was told provided an inbuilt "protection," related to the capacity of the listener to understand.

3.7 Reflexivity in the role of the researcher

"Reflexive practice can be some of the most challenging and important work in qualitative research" (Mitchell et al., 2018, p. 673). From my perspective as an older white

woman, tertiary educated and from an Anglo cultural background, I recognised that personal beliefs and experiences might influence the interactions within interviews and conversations. Experience in the field in Aurukun and other Cape York communities, and also in Yarrabah, in an earlier phase of my professional career was important preparation for understanding nuances of communication and how to be respectful of participants' preparedness (or lack of) to talk about cultural or personal matters. I also noted that having been employed by Indigenous organisations while working in the field in Aurukun and Yarrabah gave me personal credibility, as did my close personal working relationship with Bernie.

Participants within the Wik nation experienced the dissonance of maintaining cultural connections while existing within a high degree of community welfare dependency and scrutiny from the Commonwealth and State governments (Campbell, 2019). The community context in which the participants live is subject to regular censure and sensationalised reporting in the media, examples of which are analysed by Carden (2017) who reviewed journalistic reporting of violence perpetrated by young people against the teachers and principal of the Aurukun school. Her analysis showed how responsibility and blame were apportioned in relation to these events from White perspectives.

Accordingly, there might have been a reluctance on the part of the participants to share cultural knowledge concerning traditional healing, but the case for the research, as supported by Apunipima Cape York Health Council, was recognised by participants. The validation of the research by the cultural broker proved particularly significant. These contextual intersecting relationships between myself and the participants were constantly monitored by the cultural broker. I explained to him that occasionally I "might not have been told what I thought I had heard," suggesting a situation where an explanation in English had multiple cultural layers of meaning. An instance of this occurred when I interpreted a comment made by a participant that he needed "to keep his family close" as an example of family bonding. However, this was recanted by Bernie, who explained that the phrase meant enacting specific protection against the potential impact of sorcery (see Chapter 4 for a more detailed account of this).

The participants in Aurukun were compelling story tellers, particularly in recounting the presence of the Spirit World in everyday life, and there was always a possibility that "unconscious cognitive errors" might have prompted me "to see and value highly what we expect to find or what fits with our pre-existing beliefs" (Buetow, 2019, p. 9–10). However, the broad consistency of commentary concerning Spirit World interactions, over multiple conversations, enabled a level of confidence in the results to be established. In both Aurukun

and Yarrabah, the researchers' position was as an outsider invited in; she was privileged that participant frequently shared deeply personal experiences of their own healing journeys or those of family members. Fears and hopes for the lives of themselves and their families were shared by participants as well as recounting experience of workplace racialised bias, community bullying, and situations of personal grief and shame. Occasionally, a participant might ask for help in discussing situations where they clearly believed either the researcher or cultural broker might be an effective "go between" with a government agency or where particular assistance was sought. In these cases, the limits of authority of the researcher or cultural broker were explained, although advice on appropriate contacts were offered on occasion.

Berger (2015, p. 220) determines that reflexivity "means turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation." There was a level of reflexive tension in the belief by some participants in Aurukun that advocacy in favour of instigating traditional healing in the health service was being achieved through the research. "Get your foot in the door" was one comment made, reinforcing this expectation that the research "could make something happen."

3.8 Briefings concerning research findings

The timetable of briefings concerning ongoing research findings to Apunipima Cape York Health Council and the Yarrabah Leaders Forum both acting as research sponsors is included in detail in Appendix 2. Whether research was conducted over an extended time period as in Aurukun or over an intensive period as in Yarrabah, detailed briefing and conversations were conducted to gauge changes in approach were required. Advice from these community controlled and directed entities ensured observance of community protocols of research conduct and feedback

3.9 How the research progressed

My experiences in designing and instigating the research process in Cape York led to a conceptual awareness that barriers existed to the recognition and acknowledgement of traditional healing. From the Indigenous viewpoint, these barriers included cultural issues concerning the security and privacy of traditional knowledge. There was also the issue of fragmentation of the knowledge base at a community level, and whether access to the extant knowledge keepers could be achieved. The perspectives of health services were supportive at

the research design stage and management staff and health workers offered commentary and observations throughout the research.

The use of the term traditional healing was not queried or challenged by participants and in fact the term sat comfortably with older Aboriginal participants in this study. Kowal et al. (2015) have suggested that use of the term "traditional" can reflect situations where Indigenous knowledge is routinely ignored, suppressed, and undermined, implying that Indigenous beliefs are inferior to objective science. There are also scholarly (Bruchac, 2014) and legal debates (Australian Law Reform Commission, 2014) concerning this matter. I chose to continue use of this term given its broad acceptance at community level.

Throughout the research process, the Aboriginal traditional healers sustained their identities within unique knowledge systems and were frequently ambivalent about collaboration with mainstream biomedicine. Negotiating their own space was a requirement for continuity of practice. Exogenous factors (such as vested biomedical and research interests) and endogenous factors (such as community reticence about access to cultural knowledge and the level of trust in biomedicine and its practitioners) became visible in the interrelationship of diverse health systems and beliefs.

3.10 Phase 1: Ethnographic practice in Aurukun

3.10.1 Participants and field work in Aurukun

The participants have been de-identified in accordance with ethical principles of cultural respect and safety outlined in the Guidelines for Researchers and Stakeholders (NHMRC, 2018).

As detailed in Table 3.1, the following three categories of participants, all Wik knowledge holders, provided much of the detailed narrative through unstructured interviews and long conversations, often evolving over three or four occasions.

- Practicing traditional healers are identified with acronym TH.
- Specific self-nominated cultural roles are identified as a songman SN1 (see 4.2.14) and a sorcerer S1 (see 4.2.13)
- Male (MLE) and female (FLE) elders are so identified

Female commentators (FC) arranged meetings with senior knowledge keepers and provided contextual advice as to approaches to participants. They occasionally expressed opinions concerning healing practices.

Staff within community-controlled health organisations operating in Aurukun contributed to the research through group and individual conversations and unstructured interviews. These participants have been identified as health professionals (HP), health administrators (HA) and general practitioners (GP). Further detail as to length of stay and how community approaches were conducted is provided in Appendix 2.

Over a three-year period, eight weeks of intensive fieldwork were conducted in Aurukun to develop the research proposal, to conduct unstructured interviews, and undertake observation of community interactions in healing and other community-based activities, such as the art programs and school activities. This was with the purpose of eliciting the views of participants concerning traditional healing. The literature review, conversations with Bernie, and passing commentary by health professionals indicated that there was little published knowledge about the number of traditional healers actively practicing and their potential or actual engagement with health care services. Interviewing in this setting required good listening skills, astute observation (including attention to nonverbal cues), and the ability to react sensitively to participants (DeJonckheere & Vaughn, 2019).

3.10.2 Preparation for field visits

For each visit, Bernie and I reviewed the material gained to that point, to determine how to approach either the continuation of conversations or to determine if additional contact opportunities might arise. Phone conversations with established Aurukun contacts confirmed locations where fieldwork and interviews should commence and enabled arrangement of a primary contact. Briefings to the sponsor body, Apunipima, and conversations with health service contacts in Cairns occasionally revealed extant community pressure such as situations of community violence or police and justice interventions, but as Bernie had spent many years as a Cape York community mediator, he rarely believed that community contact was inappropriate in those situations. Establishing trust with the people of Aurukun was significantly assisted by being overtly nurtured by Bernie acting as a cultural broker. After the first research visit for orientation to the community, he frequently introduced me as the researcher “looking at traditional healing”, sometimes with his signature comments of, “do youse want Murri Medicine in the clinic”. He would then sit back, saying “you can go it alone now.”

3.10.3 Sampling and recruitment in Aurukun

Over three years, in Aurukun, seventeen community members (Table 3.1), including acknowledged traditional healers, provided in-depth and on-going commentary in response to open-ended questions regarding the presence of traditional healing activities and access to cultural knowledge and the performance of ritual. I met with some of these informants several times. After Bernie's initial introductions to sentinel informants, other participants emerged through what I describe as "tumbleweed" sampling[6]. Bernie was not only a cultural broker, but was also himself a sentinel informant, having had a lifetime of experience in negotiating the boundaries of community control of health. I was contacted by healers and cultural practitioners from other Cape York communities during the fieldwork stages. A number of them sought involvement in the research and were eager to tell their stories. In all cases, contact was followed up with a conversation about options for future research or activities related to traditional healing. In particular, this broader contact enhanced understanding of how individual and collective identities within Aboriginal and Torres Strait Islander peoples affected experiences of healing and biomedical practice.

The gender breakdown amongst Wik participants was nearly equal – although throughout the fieldwork, there was a sense of information being withheld by women in these community settings, and an experience of male participants being more forthcoming. This may have been in response to the presence of the cultural broker and his involvement in most of the conversations.

Within health services settings in Aurukun, fifteen people, including locally based Indigenous and non-Indigenous staff members and senior management, participated. In Cairns, briefings and conversations were conducted over three years, with senior management and clinical staff (all but one of these people is Indigenous), and with staff members of Apunipima Cape York Health Council.

The referral networks through which I made contact with potential informants are indicated in the diagram below (Fig. 3,3).

[6] The imagery of snowballs seemed so inappropriate in the tropical heat of northern Cape York. There is an endemic tumbleweed (salsola australis) on Cape York which provides a more locally relevant analogy for the sampling and recruitment processes that occurred in this study.

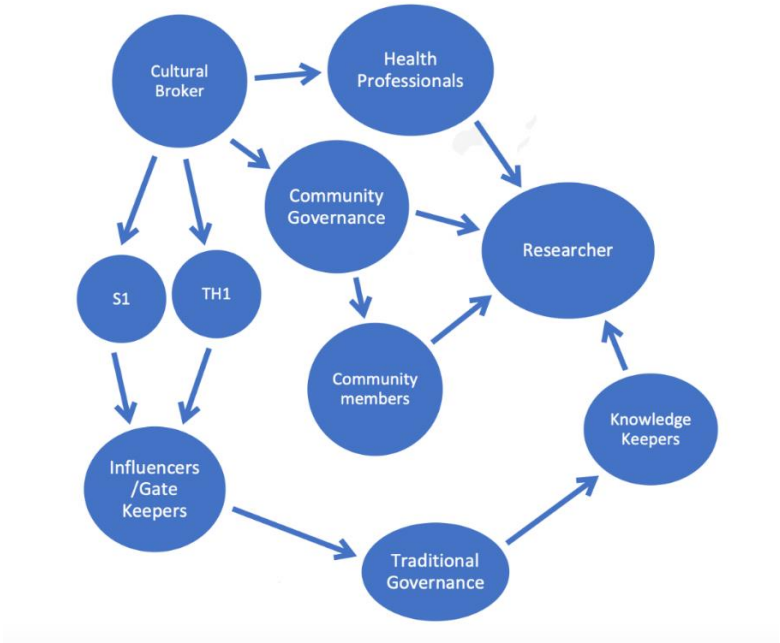

Figure 3.3: Aurukun community research referral networks

Table 3.1: Fieldwork Contacts: Deidentified Participants

Wik Knowledge Keepers: Long Conversations /Unstructured interviews
Deidentified
TH1 TRADITIONAL HEALER 1
TH2 TRADITIONAL HEALER 2
TH3 TRADITIONAL HEALER 3
FC1 FEMALE COMMENTATOR
FC2 FEMALE COMMENTATOR
S 1 SORCERER
SN 1 SONGMAN
MLE MALE ELDER 1
MLE MALE ELDER 2
FLE 1 FEMALE ELDER 1
FLE 2 FEMALE ELDER 2
FLE 3 FEMALE ELDER 3
FLE 4 FEMALE ELDER 4
FLE 5 FEMALE ELDER 5
FLE 6 FEMALE ELDER 6
FLE 7 FEMALE ELDER 7
FLE 8 FEMALE ELDER 8
Community Controlled Health Services in Community Fly in (FI) and Community based (CB) HP = Health Professionals
Unstructured Interviews
FIHP C 1 FEMALE
MCBHP 1 MALE
Health Services with Management outside Community (Apunipima Cape York Health Council) community controlled SCCHA =SENIOR COMMUNITY CONTROLLED HEALTH ADMINISTRATOR Unstructured interviews CCGP = GENERAL PRACTITIONER: brief conversations
SCCHA 1 MALE Ex
SCCHA 2 FEMALE
CCGP MALE
CCGP FEMALE
SCCHA 3 FEMALE
Health Services with Management outside Community (Apunipima Cape York Health Council) Group Conversations Fly in and Community based MHP = MENTAL HEALTH PROFESSIONAL
MHP 1 MALE
MHP 2 MALE
MHP 3 MALE
AMHP1 (Aboriginal Mental Health professional) FEMALE
AMHP2 + MHP, 4,5,6. MALE

3.10.4 Referral networks within sampling – the talisman list of knowledge keepers

During the first fieldwork phase, I sought to understand the identities of "knowledge keepers" who could inform the research. From listening to conversations between Bernie and his peers, it became clear that Aboriginal lines of descent were regarded as fundamental to position, power, and influence in traditional ownership linked to native title, co-management of natural resources, mining royalties, and positions of authority within institutional governance. This understanding informed the approach to sampling, with active attention paid to seeking out those who might sit outside such positions of power and influence.

Increasingly, emerging generations have redefined their expectation as to how these roles affect participation in decision-making and how traditional culture is valued in contemporary life, such as in the spheres of, art, performance, health, education, justice, and the broader concepts within reconciliation and truth telling. Credibility is established in part by such self-recognition of personal roles and in part by cultural credentials that are acknowledged both in broader Indigenous community settings and in formalised governance roles. Relationships within a community setting are a complex mixture of influence, obligation, and cultural guardianship of knowledge as demonstrated by the development of the talisman list of knowledge keepers.

In seeking advice as to who might talk to us about the relationship of cultural knowledge to healing, MLE1 asked to meet "secretly", away from the gaze of the professional colleagues associated with his community leadership role. His handwritten note of names of "old ones" was supplemented by Bernie's "joking" persona of the "dumbed down" 'murri from the Cape, as he cajoled two younger Wik (FC1 and FC2) women to contribute to the list of knowledge holders. I later called this the "talisman list" as it assumed a significance in its own right. On the one hand the process of recognition of individuals and the inscription of their names represented an ongoing expectation by community members that Elders would continue to be responsible for knowledge transmission. On the other hand, it came to represent the reduced community presence of knowledge keepers and hence the diminution of processes of cultural transmission.

Eighteen of the suggested cultural practitioners were women (Table 3.2), demonstrating that Indigenous women maintain community leadership including keeping families and cultural practice and women's traditional therapeutic practices intact (Dudgeon & Bray, 2018).

Table 3.2: The Talisman list of Knowledge Keepers

DEIDENTIFIED /GENDER **FLE = FEMALE ELDER** **MLE = MALE ELDER**	**WIK AND COMMUNITY AFFILIATIONS** **TO = TRADITIONAL OWNER**
FLE	ARTIST / ELDER
FLE	COMMUNITY GOVERNANCE /CONTEMPORARY LEADER
FLE	TO GOVERNANCE/CHURCH ELDER
FLE	TO GOVERNANCE/EDUCATOR
FLE	TO GOVERNANCE/ CONTEMPORARY LEADER
FLE	TO GOVERNANCE/
MLE	COMMUNITY GOVERNANCE /CONTEMPORARY LEADER
MLE	TRADITIONAL OWNER (TO)
FLE	COMMUNITY GOVERNANCE TRADITIONAL OWNER
MLE	COMMUNITY GOVERNANCE/ TO GOVERNANCE/
MLE	ARTIST
MLE	TO GOVERNANCE/
FLE X 2 (SISTERS)	ARTISTS/CHURCH ELDERS
FLE X 2 (SISTERS)	ARTISTS
MLE	MALE ELDER
FLE	TRADITIONAL BIRTHING EXPERT
FLE	ARTIST /WIK LANGUAGE EXPERT
FLE X 2 (SISTERS)	ARTISTS
FLE	ARTIST /WIK LANGUAGE EXPERT
FLE	ARTIST /WIK LANGUAGE EXPERT
FLE	ARTIST /WIK LANGUAGE EXPERT

Initial contacts to those on the talisman list were facilitated by the cultural broker, either by approaching them himself or by seeking introductions from the principal informants, healer TH1 and sorcerer S1. Their cultural authority stood “inside” the select influence of cultural gatekeepers (frequently family members) who controlled access to the most senior knowledge keepers. Some of these knowledge keepers also held elected representative roles within native title governance entities. Others held appointments in government entities variously nominated by Queensland State or Australian government legislative provisions. Two of the most significant community governance informants were highly influential both in contributing their own narratives and experiences and in introducing other community members who contributed opinions and anecdotes concerning cultural practices, including healing in daily life. Some of those informants who were also traditional governance representatives did not favour personal or individual contact, deferring to their place as spokespeople within the collective identity of those organisations. Access to some of the older men seemed to be “controlled” by the native title organisations. This was indicated by

comments such as “you have to talk to them in Cairns”, and when Bernie stopped one of these men in the street, he was unhappy to have a conversation. The oldest living knowledge holder on the list was not available for comment. He had moved away from the community and had publicly stated that he fears for the future of the community and even his safety given prevailing levels of violence (Bernie Singleton pers comm). The list also included a number of artists, indicating the high regard by community members for tangible demonstration of such skills. This supports Ware’s (2014) finding that art practice is a strong indicator of cultural connection.

After several days of attempting to reach those on the list, the significant degree of family and community protection (gatekeepers) became apparent. This gatekeeping, often rationalised by the physical and mental frailty of such elderly people secluded them from contact. Family members frequently deflected our enquiries by providing messages such as “gran isn’t feeling well”, or “she doesn’t want to remember”.

3.10.5 Interviewing as data collection – cultural validation and rapport

As the cultural broker, Bernie was present at the majority of interviews and was able to comment on his perceptions of the interview content and the demeanour of the interviewee. This may have affected the interviewees, both positively and negatively. In a study, using cultural brokers to conduct interviews, Kowal et al. (2017) indicate that,

> “The brokers, and interview participants, exhibited various relationship dynamics during the consent process of the qualitative interviews. Perceived power imbalances might have existed causing social desirability biases and restricting participant voluntariness.”

Using the broad interview guide, a rhythm was created whereby there was an “establishment of commonality” (Sloane, 2004) so that after initial introductions, Bernie recounted common lineage connections. As he is not of Wik descent, although highly respected in the community for his advocacy roles in health, he needed to establish his own credentials for “being there” before introducing me. After this, he would re-introduce the topic and me as the researcher. This was the initial process for establishing rapport with participants. The techniques of ethnographic fieldwork used in this study included observing and developing understanding, being present and accepted in the communities, as well as securing cultural safety for the participants and myself. None of this would have been possible without Bernie’s significant skill, presence, and credibility.

The interview questions were developed to cover a range of participant experiences. Certain conversation prompts were effective in eliciting additional information, particularly questions about family. Sharing anecdotes about my own children helped build rapport. Discussing the relationship between Elders, older relatives, and children frequently led to discussions about being on country, using routine healing practices for headaches, stomach complaints and minor wounds, gathering bush foods and fishing or hunting. This mode of developing rapport and trust also frequently elicited accounts of encounters with the Spirit World.

3.10.6 Data collection

3.10.6.1 Unstructured interviews

Participants were available to the researcher at points in time that suited their daily lives. Bernie, as cultural broker, was essential to negotiating arrangements and places to meet. He was present at approximately 60% of the interviews, and was on familiar terms with most of the Wik knowledge keepers. His earlier role as Chairman of Apunipima Cape York Council had meant he had spent significant time in Aurukun. His engagement with older men, healers and knowledge keeeprs often involved extended preamble and debate concerning shared experiences, local political observation and family narratives.

He was highly engaged with older women, his peers in age and experience. In our contact with younger women, particularly the female commentators or health professionals, he was comfortable to leave detailed interaction to me. The older female knowledge keepers enjoyed his company, joking and sharing reminiscences but also seemed comfortable with the researcher in terms of giving direction as to how to navigate community settings, sharing stories from a female perspective

From time to time, prevailing community unrest or other events such as “sorry business” or community commitments with the church or school precluded such access. Interviews with different participants were undertaken sequentially and over intensive fieldwork periods.

Sequential interviewing occurred with eight of the Wik knowledge holders and nine of the combined grouping of health professionals, health administrators and general practitioners. This interview technique would take the form of a brief recap by the researcher as to previous conversations which then would lead to further commentary being offered by

the participants. Such follow up opportunities enabled observation and interpretations to be expanded to confirm the researcher's understanding of experience of healing and a level of member checking of the finding. In some cases, participants were keen to provide updates concerning broader community dynamics such as matters relating to community justice, situations of community unrest or disquiet or general observations on community events. The researcher was able to observe how the personal circumstances and health status of individuals affected their perception of healing practices and cultural observance at community level.

Data were collected as interview notes made during the conversations and immediately afterwards. The findings from each interview were also discussed and checked with Bernie Singleton, when he had been present, to ensure accurate and sensitive interpretation of the exchanges. This material formed extended written narratives.

In-depth unstructured interviews were conducted with community members to explore community perceptions of traditional healing. All interviews were carried out face-to-face, but in accordance with participant preferences, none were audio-recorded (see discussion below). In this context, when asked if audio recording was permissible, one participant very clearly responded "I expect you to remember what I tell you". Over the course of four years of fieldwork, interpreting culturally similar and different non-verbal cues became easier as they were repeated regularly. This included body movements like stretching and yawning, the shifting of eye-contact, the selected preference of side-by-side seating and the importance of, or reason for, silences. The interviews took approximately 60 to 90 minutes each. After an explanation of the research, and academic affiliations to ANU, as well as an affirmation of Bernie's role as cultural broker, the question "what are your experiences of traditional healing in Aurukun?" initiated interview conversations. I sought to ensure a balance of informality with intellectual engagement (Minichello et al., 2008). I was frequently successful in hearing participants' construct their subjective experiences and interpretations of situations where healing practices had held significant meaning in their lives. Such unstructured interviews enabled the interviewed participants to discuss experiences and knowledge of which the interviewer had not previously been aware. This allowed the interviewer and interviewee to create knowledge through conversation. Many of the interviews had the characteristics of oral history (Fontana & Frey, 1994), in that an in-depth interview becomes an oral history as the interviewer elicits responses to clarify time frames, situations, and by making connections between recounted events.

The use of open-ended questions enabled both the researcher and the interviewee to shift the direction of the interview to bring in unanticipated information, with greater detail and depth. Silence within the conversation was an important part of knowledge retrieval. Many conversations that took place outside research parameters included silence, which could indicate many things from taking a pause to breathe to withholding information. In some instances, silence was interpreted as indicating withholding information, either as a form of resistance or as a cultural mode of self-representation, indicating that the interview had strayed into material not to be revealed due to the "unequal status of the researcher".

Relevant follow-up or probing questions were asked, such as, "could you explain that to me, please," or with a query such as "have I understood that correctly?" Some participants were interviewed more than once, while others held formal roles in health care settings and preferred to participate in general "round table" contextual discussions.

3.10.6.2 Field notes and interview settings

After an initial interview with TH1, he indicated his preference not to be subject to audio recording, saying "I expect you to remember." Bernie then suggested that I should take this comment as a key learning and not seek to audio record in the future.

After this, rough field notes were taken during interviews, with a focus on observing and listening intently. There is a strong cultural tradition amongst Wik people of learning by listening intently and repeating or mirroring those learnings both in oral recounting and in manual creation of cultural artifacts. It is considered high disrespectful not to pay attention. Bernie believed that the procedure of audio recording might imply that I was unable to follow a conversation and understand concepts being discussed.

Syntax, grammar, and expression when an interviewee is expressing themselves in their third language required careful comprehension. Accordingly, it was important to conduct a more comprehensive compilation of field notes on the same day as the interview. Based on the ideas of Corbin and Strauss (2008) my field notes contained observations of the interactions/conversations with participants and contained descriptions of the interview setting and context. In Aurukun, participants often recalled feelings experienced during healing encounters, whether as healer, in the course of being healed, or when considering their healing options. Deep insight into the participant's perspectives, worldview, or life conditions was gained by cultivating empathic resonance with participants and "reading" their non-verbal cues. These experiences were recorded as analytic notes during or after an interview.

The field notes were initiated with recalled observations usually made within the few hours of the interview. Careful consideration was given by the researcher to the methodological relevance of interview settings; in other words, how those settings might have influenced interview conduct or even the content of conversations. For example, control of space by the participant was frequently an important prerequisite. Situations, such as at an informant's home, were always conducted sitting outside, where the researcher, cultural broker, and participants were visible to others. This was another principle derived from the example and suggestion of TH1 to ensure that cultural safety was observed with no possibility of undue influence "out of sight."

Interviews were also conducted by invitation at the workplaces of some participants. In this case, participant control of the space was indicative of their work-related status. The location might be a personal office if a participant had some form of supervisory or defined role in that space. In a group meeting of participants, the preferred spaces were closed-door meeting rooms. In one instance, an interview was conducted in a working kitchen where the participant was involved in a community nutrition program. As I stirred a pot of stew, the participant and I conducted the type of side-by-side conversation style often favoured in Aurukun, indicative of connection and collaboration but avoiding the confrontation of eye contact. The Central Adelaide Local Health Network Mental Health Directorate (2018) suggest that avoidance of eye contact may represent a continuum of personal comfort ranging from observing respect through to shame or fear. This preference for limited eye contact manifested itself frequently in Aurukun.

Some interviews took place at the informal meeting space between the major shop (supermarket) in Aurukun and the Council Office. In this location, there were a number of seats and tables where people congregate in the mornings before the heat of the day drives them inside, or to find a sleeping spot. The dynamics of this space constantly changed and were often a barometer for broader community wellbeing. In times of community unrest, the space would generally be empty, people keeping to the safety of their homes. On calm days, however, you would be sitting side by side with your participant watching the movement into and away from the shop. Their narrative might be interrupted by their sudden movement away with comments like – "that's my poison cousin – I have to go", but generally, a mixture of observations, gossip, and inquiry emerged – often with a "referral" recommendation; "you should talk to…" In this way, these exchanges sometimes acted as precursors to extended conversations, conducted elsewhere.

After lunch, down time was always useful for compilation of the morning's notes, and activity restarted around an hour before sundown – at that time, a favourite pastime was to seek a ride in the truck (the hired 4WD), usually with a soft drink or ice-cream and to head to the landing where the day's fishing activity could be observed and commented upon.

The emotional experience of the first encounter was palpable; at the first conversation with people, there were substantial "unguarded" moments of exchange. In most cases, there was only one encounter. Occasionally, attempts at follow up might be rebuffed. It is possible that some participants may have been embarrassed by their initial "outpourings" and others may simply have felt they had recounted "enough" of their thoughts or memories. Clark (2008) used the term "research fatigue", but in this case it may have been because participants perceived the study as failing to benefit themselves or the community. There may also have been a level of impatience that the issues discussed were not formally responded to. Frustration was expressed on two occasions, that no statement about traditional healing had been made publicly by health services.

3.10.7 Some practices encountered during research engagement

Two of the stages discussed in Yunkaporta's (2019) Wik learning cycle were embedded in the research cycle created with Wik participants. The first of these is *Konangam pi'-pi'an* (remember and memorise: linking to the existing schema), which uses place-based and visual pedagogy including cultural metaphors to organise and memorise key information.

In this research, the constructed narratives convey personal experiences of healing and Spirit World encounters. Place-based and visual pedagogy is embedded in the narratives with the imagery of the mythologies of place around Aururkun, situating healing and Spirit World encounters in the landscape. Cultural metaphors amongst the Wik people of Aurukun include common beliefs in the manifestation of sorcery practices. Physical cultural metaphors include the distinctive carved artworks, recreated from totemic carvings used in ritual dance ceremonies. For women, the art of weaving was indicative of processes of knowledge acquisition and sharing where repetitive mastery of tangible skills is accompanied by companionship, connection with the physical world, utility, and productive work.

Another stage in Yunkaporta's (2019) learning cycle that proved significant in compiling and analysing the information obtained from interviews is *Ngantam Ngeeyan* (think and understand: reflection and demonstration of mastery). This concept describes the process of producing purposeful texts with real-life audiences, applications, and feedback.

Although developed as a Wik case study, the philosophies are as relevant to workshop situations in Yarrabah.

Writing this thesis and "telling the story back" through creation of narratives was assessed against the context of the lived experience of the participants in both communities. Through reflexive practices guided by the cultural broker and "being there" I was able to hear and experience the resonance of ancestral and mythological belief underlying the anecdotes, stories, and observe contemporary constructs of healing. This enabled the creation of purposeful text securing these moments in time as records of timeless and enduring healing activities.

3.11 Phase 2: Ethnographic practice in Yarrabah

3.11.1 Context and setting of Yarrabah

Yarrabah received many members of the Stolen Generation, currently representing more than 32 tribal groups, but as many as 43 tribal groups counted in 1938 (Tindale, 1974a). From across Queensland, the legacy of dispossession and imposition of colonial power permeates the life stories of many residents, some of which were relayed during my previous periods of working in Yarrabah.

The extended involvement of both the researcher and the cultural broker with Yarrabah organisation for a number of years created an understanding of the leadership typology within the community: traditional owners who have a power structure that controls land dealings, and historical owners who are significantly represented in Yarrabah leadership roles in health services, local government, aged care, and education (that is, governance entities that receive direct funding from State and Commonwealth government). A number of these managers and team leaders are tertiary educated and there are also a number of those who have "returned home" after successful careers in other parts of Australia. At the beginning of the research, it was anticipated that these voices might have specific opinions as to whether traditional healing practices could or should be incorporated in health services. By the conclusion of the research, more nuanced opinions about culture in healing had emerged.

3.11.2 Participation observation in Yarrabah under contractual arrangements

Participant observation was used to try to better comprehend and/or identify competing pressures and barriers to the recognition of traditional healing and the associated cultural knowledge in health services operating within that Indigenous community setting. In

June 2018, an invitation was received from the Yarrabah Leaders Forum to undertake a short-term paid contract, participating in the development of a Social Recovery Plan for Yarrabah. This was to contribute to an Indigenous controlled governance model for Yarrabah and provide research support to the Yarrabah Leaders Forum (YLF). The invitation included a request that Bernie Singleton provide cultural brokerage and assist in the gathering of "grass roots" response from community members regarding their expectations and understanding of social recovery.

The activities involved providing background research and facilitation of community "inputs" about a range of social recovery options and proposals. This included observation of reactions to, and recording opinions about, the intent of social change agendas. With permission to use the material for research purposes provided through the contractual arrangements, this thesis was able to incorporate information relating to participant observations of the ways in which members of the Indigenous leadership group in Yarrabah perceived "social recovery", and whether or how the role of traditional healing was perceived to be included in that set of processes. Suggesting methods through which the ideas that emerged from community discussions could be practically implemented was considered an essential part of reporting to the Executive Officer. The strategic planning process, informed by a two-day workshop, sought ideas to reinforce the principles of community control and direction for family well-being, law and order, education, and economic development initiatives. The contractual terms provided opportunities to observe how locally based leaders of community services support each other in a coalition of interest to pursue what were considered to be community advancement goals, and whether the practice of traditional healing was potentially considered of value in this arena.

There are two significant community-controlled entities in health in Yarrabah. The first of these is Gurriny Yealamucka Health Services Aboriginal Corporation (GYHSAC), referred to as Gurriny in this research, which provides clinical and general practice services within a strongly defined family well-being framework, and which has been operational in the community for more than twenty years. The second is Gindaja Treatment and Healing Centre, referred to as Gindaja, which provides drug and alcohol rehabilitation and recovery services, both as an in-patient and residential service, and also as community outreach. Gindaja also facilitates access to mental health services as part treatment options and has an established interest in ensuring that cultural connection is part of a treatment program (Gindaja Strategic Plan and Model of Care).

The population has representatives of the traditional Gunggandji clan estates which include both the built settlement of Yarrabah and the surrounding wilderness areas which lie beyond the original mission settlement boundaries. There are also traditional owners of land and cultural knowledge from other Aboriginal nations including Djabugay, Umpila, Kuku Yalanji, Djungan, Birrigubba, Juru-Bindal peoples and others. Many of these are self-identified descendants of Stolen Generation children brought to Yarrabah. Bernie's knowledge of lineage and descent was invaluable in placing or making sense of the "social constructions" of family groupings aligned by influence rather than genealogy.

3.11.3 Recruitment/sampling in Yarrabah

Access to participants was controlled by the Yarrabah Leadership Forum and initially took place under more formal processes of meetings and workshops. The cultural broker was, however, able to facilitate more "informal" contact with some of the participants. Such one-to-one conversations elicited candid observations, often concerning personal reservations about the effectiveness of their role and their private reticence and uncertainties concerning social reform initiatives.

Fifteen people provided commentary during a series of workshops and meetings convened as part of this strategic planning process. Material from these events have been analysed using thematic analysis. The intent of the Social Recovery Plan development process was to identify priority actions that could be progressed at the community level, with Commonwealth and State funding allocated to community-controlled entities. The participants were established leaders fulfilling multiple roles across community-controlled entities.

3.12 Yarrabah data collection

Research was conducted in Yarrabah to explore contemporary perceptions and expectations of any relationship between traditional healing and social recovery concepts and practices. The period of participant observation was between July 2018 to November 2018; during that time there was regular contact with Yarrabah participants in community settings outside more structured workshops. This contact included regular meetings with executive management for the Forum. Accompanied by the cultural broker, invitations were received to attend meetings and planning sessions to explore the funding and logistical support for community driven change available from Commonwealth and State governments.

In order to develop collaborative networks of support for social recovery initiatives, the researcher and cultural broker were asked to conduct one-on-one interviews with participants who wanted to initiate social change agendas in their own workplaces. These conversations included personal histories and perceptions of community life in Yarrabah, as well as frequent discussions of the community dynamics of influence, shame, boredom, and resistance. These contacts were supplemented by "grassroots" casual "on the street encounters" (facilitated by the cultural broker) which provided insights into the personal, family based, "survival" strategies, including how bullying and intra-family discord and rivalry were dealt with.

The opportunities to observe participants in different situations, such as workshops and meetings, enhanced observation of the ways in which social welfare entities dealt with issues related to the exercise of cultural authority. This included whether traditional knowledge (including traditional healing knowledge) had relevance for contemporary policy formulation regarding social solutions for vulnerable people.

There were four main events where in-depth notation of discussions concerning social recovery was undertaken. The initial event was a strategic workshop involving thirty participants where a series of opinions, thoughts, and feedback against the themes of education, law and order, employment and economic development were generated. This material was created in round table discussions in groups of between 8-10 people and reported back to the whole group. Community feedback about "what are the inhibitors to change in Yarrabah" was also discussed, both from the viewpoints of individual participants and from a grass roots community dialogue developed by the cultural broker in the lead up to the workshop.

There were four follow up meetings and exchanges of information in order to develop a dialogue between service providers and government entities as to change initiatives. These were:

- A meeting of fifteen of the Strategic Workshop participants with a further three invitees (who had first-hand recent experiences of the impacts of crime) concerning Yarrabah police obligations and responsibilities in response to the Law-and-Order feedback component of the Strategic Workshop.
- A meeting to initiate a collaborative intensive family support process through integrated case management amongst Gurriny, Yarrabah State School, and Gindaja, attended by nine people with a further five people seeking future involvement, but unable to attend that meeting.

- An information exchange on a Community Healing Centre proposal developed in 2014, under the aegis of the Healing Foundation, to assess the continued relevance of the centre proposal as a focal point for trauma healing.
- An information exchange, including a costed proposal for a community night patrol to respond to increasing levels of youth criminal activity and property damage.

With a goal of "normalisation" of behaviours within the community (sending the children to school, going to work, and staying out of trouble with the police) and collective awareness of the complexity of managing community expectations, there was little space or inclination for discussion of recognition and integration of traditional culture in community service operations. When questions were asked about whether traditional culture can or should be integrated into community advancement, some interesting answers were received; "we're not talking black now", "we are working through a cultural lens", "the community just argues amongst themselves" (about cultural practices), and "one lot will always say the others don't tell it right". These points became pivotal to the discussion about how cultural identity is enacted within Indigenous communities, including the perceived value of traditional healing.

As can be seen from these examples, participant observation is a qualitative and interactive experience and can be relatively unstructured (Guest et al., 2013). It is generally associated with exploratory and explanatory research objectives uncovering cognitive elements, rules, and norms that underlie observable behaviours (Guest et al., 2013).

Schensul et al. (1999, p. 91) describe the following reasons for using participant observation in research:

> "To help the researcher get the feel for how things are organized and prioritized; how people interrelate and what are the cultural parameters. Also, to show the researcher what the cultural members deem to be important in manners, leadership, politics, social interaction, and taboos; to help the researcher become known to the cultural members, thereby easing facilitation of the research process; and to provide the researcher with a source of questions to be addressed with participants."

Kawulich (2005) suggests that an "observer as participant" enables the researcher to generate an understanding of the group dynamics of information-sharing and decision-making. Merriam (1998) pointed out that, while the researcher may have access to many different people in this situation from whom he/she may obtain information, the group

members control the level of information given. As Adler and Adler (1994, p. 380) note, this "peripheral membership role" enables the researcher to "observe and interact closely enough with members to establish an insider's identity without participating in those activities constituting the core of group membership." The position of consultant enabled taking on such a role for the purposes of the current research.

Operating with a "dichotomy of otherness" risks ignoring and denying the cultural nuances that exist within any group (Downing & Kowal, 2011, p. 8). Rather than making a distinction between "us" and "them", this research placed an emphasis on participating as an equal member of the group. By offering opinions, asking questions, and recording and reporting back in group sessions, greater insights into interactions and their meanings were reached in relation to community-based interpretations of concepts of social recovery.

3.12.1 Observing Indigenous health services and power relations

Participant observation explored "the social conditions of possibility" (Bourdieu, 2003) within the Yarrabah Leadership group. An intent to "improve" family responsibility, personal achievement, and general conditions of community safety and security underpinned the practice of the Yarrabah leadership group. My defined role was to assist the Executive Officer to observe and record the opinions, expressed needs, and preferred direction of social change amongst both leaders of social institutions, key case -workers in those settings, and the broader views of community members (assisted by the cultural broker).

Observing this process of attempting to initiate social change generated an understanding of the tension between the directions of government and differing community priorities, and how cultural knowledge regarding kinship and family obligation, connection to country, and ancestral lands, together with the community practices that reinforce social and emotional wellbeing, are referenced in decision making. There are key learnings from Yarrabah governance as to how culture informs contemporary life, which are discussed further in the following chapter.

3.13 Background to data analysis in Aurukun and Yarrabah

A grounded theory approach to analysis was employed in writing and interpreting field notes, recognising recurrent commentary and patterns and interpreting those patterns to form theoretical propositions. Eckstein (1975, p. 100) described this process as:

> "The chain of enquiry [that] runs from comparatively tested theory to case interpretations and thence, perhaps, via ad hoc additions, newly discovered puzzles, and systematised prudence, to new candidate theories. Case study is thus tied to theoretical inquiry—but only partially, where theories apply or can be envisioned; passively, in the main, as a receptacle for putting theories to work; and fortuitously as a catalytic element in the unfolding of theoretical knowledge."

Grounded theory is a commonly used qualitative method in health research (Pawluch & Neiterman, 2010), and is a systematic set of techniques and procedures that enable researchers to identify concepts and build theory from qualitative data (Corbin & Strauss, 2008; Charmaz, 2014, 2017). Researchers move from the specific to the general to explain situations and context evident in their data and create connections leading to theory.

As field note data were coded, significant congruities in themes emerging from interpretation of the data were noted, so identification of patterns was possible. The grounded theory approach to data analysis used in this study was the one expounded by Corbin and Strauss (1990). All three forms of coding they outlined were used: open coding, axial coding, and selective coding. Open coding is the interpretive process by which data are broken down analytically. The purpose is "to give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data" (Corbin & Strauss, 1990, p.13). They go on to state that, "in axial coding, categories are related to their subcategories, and the relationships tested against data" (Corbin & Strauss, 1990, p.13). Selective coding is the process by which *all* categories are unified around a "core" category, and categories that need further explication are filled-in with descriptive detail (Corbin & Strauss, 1990, p.14).

Coding of results was undertaken manually taking into consideration place and time of data collection. Data in Aurukun were collected through face-to-face interviewing. The language was rich and underpinned by cultural concepts of Wik ancestral belief. Manual coding more appropriately allowed these particularities to be reflected.

Data collection in Yarrabah took place eighteen months after the completion of data collection and analysis in Aurukun. It was influenced by the governance structure of Aboriginal community-controlled organisations who provided group feedback and hence the material for coding. Conversational flow was forthright and focussed on the social and cultural influences that inform the Yarrabah constructs of wellbeing. The data were distinctively focussed on social recovery and change agendas and hence yielded significantly different coding categories to Aurukun.

In constructing the coding tables, I found that the dominant concepts and themes emerged initially from perspectives of the individual's relationship with healing activity and healers. In Aurukun, coding reflected viewpoints as to how the lived belief and presence of the Spirit World influences the performance of traditional healing, the malevolence of sorcery and the disconnect of belief between biomedicine and traditional healing. Other codes reflected a unique language of healing, conflict between traditional and mainstream life-worlds, and how understandings of healing are communicated outside Wik culture. By comparison in Yarrabah, healing was viewed through the lens of social recovery. Codes referenced the dissonance of status between traditional owners, who have power assigned as successful native title claimants and historical owners, many with a significant reputation as community leaders, yet not influential in land and tenure matters. These insider/outside constructs of influence were noted in coding. Coding in Yarrabah was also redolent with ideas about "what might work" in healing regimes of social recovery.

Memos and diagrams from the data analysis recorded comparisons between data and expanded understanding of emerging categories, together with development of theories (Corbin & Strauss, 2008). During coding, reflexive and theoretical memos were written as a record of developing thought. These memos also took the form of field reports and updates to the research sponsor. Memos are an important component of the grounded theory method (Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 2014). Gordon-Finlayson (2010) emphasized that "coding is simply a structure on which reflection (via memo writing) happens. It is memo-writing that is the engine of grounded theory, not coding," (p. 164.) Glaser and Holton (2004) further clarified that "Memos present hypotheses about connections between categories and/or their properties and begin to integrate these connections with clusters of other categories to generate the theory," (p. 61.) This technique enabled visualisation of concepts.

3.13.1 Coding of Aurukun Results

Qualitative data included my field diary accounts of place, travel, arrival, formal and informal briefing regarding the research process, people encountered and interviewed, and general observations. Data also comprised rough notes taken during interviews and more detailed transcripts and observations, demeanour and behaviours of participants, settings, group dynamics and body language. The processes of coding were informed by an understanding of the process of thematic analysis (Javadi & Zarea, 2016). The following steps and procedures were used to interpret the findings, divided into open coding and axial coding.

Open Coding

The first round of coding ("open" or "initial" coding) involved constantly comparing categories and concepts evident in the field notes and research diary. Raw interview data were categorised into 74 codes using narrative analysis. Data coding revealed that healing is a psycho-social process; participants described themselves as doing, feeling, and being during interviews and conversations concerning their healing experiences. Conditions that shaped participants' experiences and similar contexts added unique meaning and variation to categories that were emerging in the data. An example of this is seen in the consistent reference to the significance of spirits and the Spirit World in healing encounters. My open or inductive coding was undertaken manually on notes from each participant interview. If a participant was interviewed more than once, each occasion was coded separately. Longer interviews generally had conversational breaks, often when a change of topic occurred and in this case each section of data related to a topic was also coded separately. As subsequent subsets were analysed, additional codes were often noted.

Axial Coding

Axial coding investigates the relationships between concepts and categories that have been developed in the open coding process. To work out the relations between the categories, Corbin and Strauss (2015) suggest examining the data and the codes based on a coding paradigm based on "conditions", "actions-interactions", and "consequences or outcomes". In this research, the categories grouped theses codes broadly against the components of a social ecology of healing which had been identified as a potential coding frame for the data. The iterative process of open coding identified a category of an intangible microsystem as a unique feature of these Indigenous social ecologies.

Selective Coding

Selective coding integrated categories of data from axial coding into thematic categories. At this point, it was decided that the results would be relayed in narrative discussive thematic format with two themes broadly aligned to each of the study communities (four themes in total). A fifth theme, concerning the dynamics of an intercultural domain of healing was broadly considered as an overarching concept to be discussed in the conclusions.

Table 3.3: Example of Coding Process (Aurukun)

Preliminary selective coding steps		
Themes for Discussion Aurukun	**Alignment with Social Ecological Model**	**Grouping of Codes into categories**
Aurukun sustains Wik Culture through traditional healing and knowledge keeping	Individual-Centric Codes	Cultural Identity, skill, recognition
	Tangible Microsystem Centric codes	Family /kinship/language / lineage /place
	Exosystem Centric codes	Discourses of deprivation – healing constructs/experiences in health services, media (blame and moral panic)
The Spirit World of Aurukun is close at hand	Intangible Microsystem Centric codes	Spirit world, beliefs, culture, sorcery observance of tradition
	Mesosystem Centric codes	Negotiating between life worlds

3.13.2 Coding of Yarrabah results

Qualitative data included my field diary, with accounts of travel, meeting schedules, people introduced through the Yarrabah Leadership Forum, interviews, and general observations. Data also comprised rough notes taken during workshops and meetings and the more detailed transcripts and workshop feedback subsequently developed for the Yarrabah Leadership Forum CEO. Member checking of workshop feedback occurred as a part of the CEO's review of workshop feedback.

Other material included observations concerning the demeanour and behaviours of participants, settings, and group dynamics.

The processes of coding were informed by an understanding of the process of thematic analysis (Javadi & Zarea, 2016). The following steps and procedures were used to interpret the findings, similar to those set out for the Aurukun case study (section 3.10.1).

Open Coding

The first round of coding involved constantly comparing categories and concepts evident in the field notes, workshop transcripts and research diary. Raw data were categorised into 48 codes using narrative analysis. Due to the nature of the ethnographic process, collecting data in Yarrabah revealed collective viewpoints and strongly defined discourses of deprivation. These broadly concerned the social determinants of health, including early life experiences, poverty, poor education, overcrowded housing conditions, and limited access to services. These viewpoints countered the discourses of deprivation by identifying social conditions of possibility for recovery.

The first cycle coding revealed concentration on family interactions, community responses to youth crime behaviours, a broad level of concern over school engagement and distrust of the local police and justice system. There were strongly judgmental views over perceived lack of parental responsibility. Constructs of healing focussed on the value of the Family Wellbeing program, established in Yarrabah for more than twenty years. Whilst cultural connection was valued, it was regarded as contested space at the local level, with traditional owners having power to control land transactions within the community and having access to traditional land management funding. A Gunggandji tradition of healing was known to have been associated with men's business (Mayo & Tsey, 2009). Elkin (1938) refers in passing to Gunggandji sorcerers, but no comprehensive analysis of Gunggandji knowledge keepers and their activities is available to the general public, although some information may exist in Native Title connection reports.

Axial Coding

As explained in section 3.10.1, axial coding investigates the relationships between concepts and categories that were developed in the open coding process. In this research, the categories grouped these codes broadly against the components of a social ecology of healing, identified as a potential coding frame for the data. The iterative process of open coding identified a category of the exosystem of the cultural lens as significant a feature of the Indigenous social ecology of healing within Yarrabah.

Selective Coding

Selective coding integrated categories of data from axial coding into thematic categories. It had been decided that the results would be relayed in narrative discussive thematic format with two themes broadly aligned to each of the study communities (four themes in total). Han-Pile (2016) suggests that the concept of conditions of possibility (derived from Foucault, 1972) can be considered as *constitutive* of possible knowledge. In the narrative analysis of Yarrabah themes, the concept of social conditions of possibility explains how Yarrabah workshop participants contribute to the creation of knowledge regarding how social recovery might be progressed. A fifth theme, concerning dynamics of an intercultural domain of healing was broadly considered as an overarching concept to be discussed in the conclusions.

Table 3.4: Example of Coding Process (Yarrabah)

Themes for Discussion Yarrabah	**Alignment with Social Ecological Model**	**Grouping of Codes**
Healing through social recovery, constructs of wellbeing in Yarrabah	Individual-Centric Codes	Cultural Identity, skill, recognition
	Tangible Microsystem Centric codes	Family /kinship/language / lineage /place
	Exosystem Centric codes	Discourses of deprivation –healing constructs/experiences in health services, media (blame and moral panic)
Not talking black – communicating social conditions of possibility in Yarrabah	Intangible Microsystem Centric codes	Wellbeing constructs rely on creating personal and collective resilience
	Mesosystem Centric codes	Self-determination, advocacy and community control

3.14 Overview of coding results

Table 3.5: Extract from Data Coding

Selective Coding – Both Communities				
THEME 1 **Individual's identity and understanding of dimensions of traditional healing (the self; family, kinship, place; a tangible microsystem)**	**THEME 2** **How spiritual belief affects community-based decision making in health service delivery (constructs of health; the Spirit World; an intangible microsystem)**	**THEME 3** **Health definition through concepts of social recovery and wellbeing (the mesosystem of alternate viewpoints)**	**THEME 4** **Indigenous governance may not "talk black" in community-based cultural positioning (the exosystem of the cultural lens)**	**THEME 5** **Inputs to the third space (macrosystem of the intercultural domain)**
Axial Coding – Both Communities				
Category: Individual and tangible microsystem centric: Family, kinship, language, lineage, place, personal experiences, identity, skills	**Category: Intangible Microsystem Centric: Spirit World, beliefs, culture, sorcery**	**Category: Mesosystem Centric: Interactive space among microsystems, tension between life-worlds: ancestral belief and modernity, insider/ outsider conflict**	**Category: Exosystem Centric: Integrating cultural knowledge into healing and social recovery; alternate understandings of relationship between mind, body, and spirit; recognize Indigenous viewpoints**	**Category: Macrosystem Centric: Discourse of deprivation, healing constructs; experiences in health services; media (blame and moral panic)**
Open Codes - Aurukun				
Ancestral belief /guidance Personal identity/Credibility and acknowledgment of personal roles Observance of ritual and tradition Cultural Identity Personal stress in travelling two worlds / Survival* Language of emotion and healing Local definition of traditional healing	Sorcery in everyday life /fear Spirit world presence Acknowledgement and explanation of impact of sorcery (purriy, purriy) Safety net of the spirit world Devil angels (spirits) are present Negotiating the spirit world Granny sent the little dwarf – spirit world protagonist There's a sorcerer on the roof eating frogs	Influences of white governance and institutions on knowledge keepers Wik language has no words for illness or cure – uses emotional descriptors for "dis-ease" Outsiders don't know the community or pressures of everyday life Outside health professionals not always trusted with stories of spirit world in everyday life	Inside/outside traditional healers Journey to researcher understanding Researcher 'may not have been told' what she thought she had heard Looking, listening learning "researcher is expected to remember" Wik learning cycles Expectations of social norms – how culture men break away Conflict between life-worlds	Discourse of deprivation (Deficit discourse) Survival* Healing constructs (cancer care) Treatment /gave body with trust to surgeon Trust in practitioner not reciprocated Cancer diagnosis – healer to healer Limited understanding or explanation of healing process by doctor Media and blame Murri medicine in the clinic*
Open Codes - Yarrabah				
Personal identity Credibility and acknowledgment of personal roles Obligations Self-knowledge and self-regulation Personal Autonomy Multiple personal roles Performative Cultural Identity, commodification Language of emotion and healing	Descent and lineage complexity of the multiple Yarrabah narratives about association with land, based on 'the mother's blood, fathers land theme' Culture used as a commodity to establish one's worthiness or validity in the community, "You don't tell it right,"	Negotiating the worlds of spirituality and belief Christianity informs healing community governance. Reacquisition of cultural knowledge through native title claims Genealogical "melting pot" of Yarrabah historical owners – many N. Qld Aboriginal communities are represented	Insiders/outsiders "We're not talking black"' – positioning of individual and organisations – looking though the cultural lens Everyone needs "skin in the game" and suggests that "social recovery" will only be accepted if the leadership group can offer, "something for everyone."	Discourse of deprivation (Deficit discourse) Media reports & blame Cultural lens/examine theoretical propositions about relationships between constructs of behaviour (cognitive, emotional, practical) understanding of health "treatment" and its relationship to community settings

3.15 Data storage and management

In accordance with the terms of the ethics approval, field notes and diaries were stored securely while in the field, locked in a secure container while in transit, and otherwise kept within my personal gaze. Notes were transcribed within one week of observation in the field of a community and electronic files were stored under password protection.

3.16 Summary of chapter

The goal of this chapter was to outline the research design and methods used to answer the research questions. A discussion of the design, study participants, data collection, ethical dilemmas, and analysis procedures, was presented to clarify how and why the study was conducted in the way it was. The "spiral research journey" diagram (Fig. 3.1) provides an overview of the approach and key stages. The next chapter provides the results and discussion of their meaning and relevance in relation to what is already known in this field.

Chapter 4: Aurukun – The Spirit World is close at hand

4.1 Community experiences of healing in Aurukun

This chapter explores the themes emerging from data analysis from Aurukun. These themes relate to how the traditional healers represented the continuation of ancestral belief, particularly in mitigating the impacts of sorcery. The Spirit World is articulated as a place of fear and refuge. A sorcerer and songman confirm their lineage and contemporary life and describe how their life journeys have negotiated an intrusive world. Reconciling ancestral beliefs in contemporary settings of public health and the justice system is a conscious, challenging activity.

4.2 Sustaining Wik culture in Aurukun through traditional healing and knowledge keeping

4.2.1 Healers and healing in Aurukun

In Aurukun, traditional healing is still actively practiced, valued, and sought after. However, there is acknowledged ambivalence within the Indigenous community as to its currency in the context of biomedical practice. The role of a healer combines cultural and personal identities, ensuring the continuance of ancestral belief. For some community members, situating personal experiences of healing in a cultural context results in conflicted views concerning the efficacy of different healing practices.

Most participants talked about the role of healers in relation to mitigation of the impacts of sorcery, known locally as "purriy purriy," including managing the interface with the Spirit World. I encountered the term "purriy purriy" in the first fieldwork interview with TH1, who referred to "the bad man," and went on to explain the broad impact of purriy purriy as a practice that involves using spirits or "little men" for harm. This may involve a series of "bad events" occurring, such as ill-health or death of a victim or their immediate family. Alternatively, the spirits may enter the bodies of others who commit violence. The term "he was had" is a common reference to such occurrences. During my first fieldwork period, the impact of purriy purriy was also referred to by FLE2 who said, "If I don't believe in it, it can't

hurt me." The nomenclature and practice of purriy purriy was noted by Martin (1993), but is on record as being used in the 1970s (Higgins, 1977) and features in early Wik language studies (Kilham, C. 1986).

4.2.2 Older participants

Generally for the older participants (TH1, S1, SN1, MLE1, FLE7, FLE8), community expectations of healing were situated within the cultural domains of the Spirit Worlds, Wik mythology, and language. TH1 said, "The Spirit World is close at hand, I can see both sides." The significance of places of ritual and belief, and the everyday presence of the Spirit World, defined how traditional healing was experienced. Healing is emmeshed in spirit world beliefs with the interaction of malevolent spirits believed to cause harm. As the antithesis to this, spirit beings can also be "helpers" who may accompany a healer and create pathways through traditional healing and recovery. Traditional healing is still active and sought, but seen as private, separate by some.

When some of the older community participants (MLE1, FLE7, FLE8) were asked about access to traditional healing, their responses were occasionally indirect or questions were deflected by changing the subject. Over time, it became apparent that this was a means of deferring to recognised knowledge keepers. In the context of discussing traditional healing, older generations also expressed continued desire to access traditional foods and to use bush medicine. Younger, emerging leaders (FLE1, FLE2, FLE5, MLE2) frequently acted as spokespeople for older relatives and phrases such as, "granny said she'd feel good if she could get some mudshell," gave rise to several possible interpretations. While there was no specific Aurukun commentary made to the researcher about the use of mudshell for traditional medicine, Khan and Liu (2019) find evidence that marine mollusc extracts and body parts are used in traditional medication. In particular, efficacy is noted in medication derived from mollusc in treating gastrointestinal ailments, inflammation, and cancer (Chakraborty & Salas., 2019). Another interpretation of this type of comment might imply the desire of younger members of the community to actively listen to the Elders so as to retain understanding and reinforce their connection to country. The rhythm and collective behaviours critical to traditional food gathering are part of a continuum of healing knowledge.

Another significant anecdote by an Elder exhibited the strength of reassurance in the transmission and continuation of cultural knowledge. It was particularly significant in demonstrating the desire of the older generation to ensure that modern experiences do not always countermand traditional knowledge. On his return from boarding school, the

participants' grandson was expected to fulfil this ritual, described in an extended account of the protocol and techniques of catching, preparing, and cooking a stingray and summarised as follows:

> "My grandson cooked me a stingray special way – means he's nearly a man. They easy enough to spear, come in shallows for fish scraps, big though. Spear me, pull on sand – you have to have fire going – mind out for that tail – big one spine. Put flat on fire (no flame – hot coals) – stomach up wards – skin scorches off. You scrape fat off, cut out liver. Mix fat with liver cut up – roll in little balls…."

Her grandson, in undertaking such an arduous process of catching and preparing the stingray, was offering her evidence of his own growth.

4.2.3 Younger participants

The younger generation of emerging leaders, as represented by MLE1, FLE1, FLE6 and FC2, acknowledged both traditional and mainstream healing. All were able to recount personal experiences of the older generation, usually close relatives, expressing preferences for using traditional knowledge or access to country in a healing regime. For younger generations, the dissonance between cultural beliefs and expectations regarding the efficacy of biomedicine leads to complex navigations of health services. FLE2, who had a son who was seriously ill and required medical evacuation, had also noted that a spiritual presence – a little dwarf – "was sent by the aunties" on the emergency flight. She asked, "Who saved my son, the doctors or the little dwarf?" Others noted that Elders had effectively used healers for them when younger. "Aunty said a visit from a healer made me calm," noted one young person – indicating the use of a healer to manage distress in childhood.[7]

These younger participants often talked about "seeing granny" use plants and natural substances both for food sources and medicinal purposes, though it was indicated that they were not actively using this knowledge themselves. This suggests that traditional healing practices are valued from a kinship perspective, but that continued access to bush foods and medicines was not actively sought as an ongoing practice. Despite this, a number of participants suggested that they "knew someone" who could procure bush medicine plants or that when "on country" they would both hunt and fish, gather molluscs and prawns, and use

[7] It is possible that the healer the Elder recalled had effected a cure of an acute illness – an alternative meaning for calm (see 4.2.5).

easily accessible fruits. The practice of yam gathering, collecting a staple bush food, did not appear to be undertaken regularly.

4.2.4 How traditional healing is viewed in Aurukun

The description of traditional healing put forward here was developed early in the fieldwork by Bernie and myself based on our conversations about ethnography and the words we were hearing from Wik participants. As a work of hybridity derived both from archival research and from the descriptive comments given by participants, we feel this description has validity in demonstrating both ambiguity and congruence in healing domains from Indigenous and non-Indigenous healing viewpoints. The description was useful in discussions with the research sponsor, Apunipima Cape York Health Council, outlining the scope of how healing could potentially be approached and understood.

As discussed in Chapter 2, a distinction is often made between traditional healing and medicine. From a non-Indigenous viewpoint, traditional or bush medicine comprises plant materials and natural substances used in preparing salves, lotions, and substances for inhalation or consumption for ailments such as fever, congestion, headache, skin sores, digestive problems, and tired or swollen aching limbs (arthritis, rheumatism) (Flint, 2001; Che et al., 2017). The Wik perspective on bush medicine was illuminated by FLE7, who stated that,

> "Some of those things you get in the bush, an itch, sore throat, a sore (*boil or lesion on the leg or arm*) clear up pretty good with a tea (*a plant infusion)* or a paste *(poultice).* One of them paste, you take bark and chew it, put it on sore, tie on with leaves, grass, leave it till it falls off. Better than Band-Aid. Sometimes that stuff might taste bad or look funny and it might be slow – I'll get back and get some antibiotics, thanks."

Traditional healing is regarded as counteracting the supernatural, where sickness is blamed on such things as sorcery, breaches of tribal sanctions and social rules of behaviour, and intrusions of spirits. In the statement by TH1 that he can "see both sides" of the supernatural and mundane worlds, he intimates that the boundary of the Spirit World, for him, "is thin." The soul is seen as the key animating substance; people who have lost their souls were described as "the dead but walking" (TH1). The first stage of "soul loss," is when you have "wandered off." In this situation, you are more easily retrieved. The healer's set of special skills (massage, singing, performing of ritual, insertion or removal of disease objects (Martin, 1993) is considered fundamental for treatment in cases where sickness is blamed

upon sorcery, contact with spirits, and the breaking of taboos (narratives from TH1 & TH2). "Tricks", that is, talismans, are created to provide protection (TH2). Healers draw upon the ancestral powers of their kinship network when treating the seriously ill (Clarke, 2008). TH1, when healing, positions himself in relation to ancestors, who can be found actively seeking connection with the healer "those old ones will know where I am," (TH1).

4.2.5 Wik language of healing

As previous studies have shown, the Wik Mungkhan language of healing is unique within Aurukun and is inextricably linked with expression of emotion in relation to symptomatic descriptions (Kilham, 1986; Martin, 1993, 2008; McKnight, 1981). Idioms of distress (Desai & Chaturvedi, 2017) appear to reflect disharmony between mind and body, while states of core affect (how we feel at any given time) permeate the Wik Mungkhan language of "sickness". In this language, supernatural forces are disturbed by sorcery *(purriy purriy)*, breaches of clan and kinship sanctions, and social rules of behaviour. McKnight (1981, p. 102) indicates that the word "*nganwi*" is used for negotiating "dangerous, abnormal, ambiguous or ritually tabooed situations, e.g., birth, initiation, hunting, collecting foods from the *pulwaia* of others, visiting a strange country..." This word is also used to broadly represent Wik spiritual belief and can also describe the nature of control of one's situations. This suggests that the practice of sorcery and healing sit on a continuum of cultural practice. This continuum is referred to in the narrative of TH1, who explained that "*kemp wir*" (nervous from sickness or from a fright, or referring to the extreme weariness of body) may be caused by intrusions of spirits/disease-objects. TH1 further explained that there is no Wik word for cure, indicating that the term *ngangk kuchar* (meaning calm) is used instead.

4.2.6 Who are the healers in Aurukun? Questions of identity and knowledge keeping

Wik healers and knowledge keepers have experienced their personal identity formation through pivotal national milestones in being Aboriginal within Australia. In recounting their life histories to me, a number referred to such events as enlisting into the armed forces, recognition of citizenship, obtaining rights to vote, rights to equal pay, land rights and recognition of native title. These knowledge keepers described personal consciousness raising concerning human rights abuses and acknowledgment of racism, segregation, and dispossession (including the national exposure of the trauma of the Stolen Generation). There was also first-hand experience of the shifting policy grounds of self-determination, reconciliation, and the present policy agenda of Closing-the-Gap (Department

of Prime Minister & Cabinet: Closing the Gap Report, 2020). Bernie, TH1, and S1, three significant representatives of exemplars of healing and knowledge keeping, were all in the age group that have worked within the White world. Collective stories of army service and employment in mining camps, cattle stations, and railways were revealed. All experienced some level of discrimination in the work force or daily life; "I was told I couldn't have a company house", "I was told I couldn't clam native title and work on the land", "they told me to have the rental house fumigated before I left", "I've never had a birth certificate or passport". Equally, however, cultural connections and social positions have been used to some advantage in terms of employment as rangers ("I got a house and a truck. I could go where I wanted") and as cultural advisors, being involved in, and setting up, new cultural initiatives ("we just found that land for a dance ground, now it's a festival").

The self-definition of identity may be viewed as "relying on fragments and reconstructions, creating a validity of evolving culture and authenticity" (McAdams, 1999, p. 486). Identity is defined as "the internalized and evolving story that results from a person's selective appropriation of past, present, and future" (McAdams, 1999, p. 486). The "authenticity" that the Australian state demands in a legislative or institutional context relates to ongoing connection to Aboriginal traditions and customs that can be delivered on-demand (Bauman & MacDonald, 2011).

There is power at stake, however, in mobilising identity in dealings with the mainstream, particularly when it comes to native title related mining access claims; "if we say no, that land can't be taken" (MLE2). The Native Title Act 1993 (Cwlth) requires negotiations in relation to mining impacts with native title holders on land or waters that would affect native title rights and interests and is likely require a Native Title determination to allow mining to proceed.

In relation to health services, Bernie says, "I can thump the table when I get wild about poor health services." Yet under the intent of the proposed health equity policy of Queensland Health and the Queensland Aboriginal and Islander Health Council (2020), he is likely to be chairing that meeting and ensuring that design of health services has mandated Aboriginal representation, improving cultural capability across all health interactions.

James Clifford (2013, p. 18) summarises the power of this form of identity politics:

> "Deep histories grounded in place and kinship, take new forms in political mobilizations and in the creative second lives of heritage…the challenge is to acknowledge the new command performances of identity politics while tracing the persistence of older practices: oral transmission, social continuity, embodied

> experiences of place…lucid ambivalence needs to be maintained, something is always being gained, something lost."

Based on my observations and field notes, it seems possible that Cape York healers have a more diverse provenance than the cohesive category of spiritual entities of the *ngangkarri* in Central Australia. *Ngangkarri* are spiritual entities in the form of men, women, and children who act as conduits to Spirit World healing, (Dudgeon & Bray, 2018). Their capabilities are frequently identified in early childhood. McCaul (2016) describes a story of getting of powers by a Central Desert healer (ngangkari or minparu) as a series of events where visitation by a spirit, rendering of the subject into a dream state and then a period of isolation when the body suffers burning sensations. After this the spirit accompanies the healer to assist in diagnosis.

There are some ethnographic accounts of male initiation ceremonies conducted within the Wik nation which create healers through a ritual of rebirth (Martin, 1993). It is not clear how potential healers were selected or identified to participate within these ceremonies.

My analysis of Wik ethnographies, included ethnographic interpretation of seasonal natural resource use, language, custom, and genealogy (Sharp, 1937; McConnel, 1935; 1939; Thomson, 1939; Sutton, 1979; von Sturmer, 1978; Taylor, 1984). This analysis suggested that healing was among the responsibilities of the most influential people (clan leaders, "boss men" and senior women). These people held knowledge of natural resources, seasons, spirits, and lore, and who directed healing and ritual depending on clan dynamics in place and time, as well as controlling access to land, resources, spirits, and ceremony. In line with these findings, I observed that current healers have combined skills, both the self-identification of skills with family and community validation but also the capacity to exercise contemporary influence in the complexity of community governance and management of Indigenous affairs. Additionally, I observed the capability amongst healers to nurture change and personal growth and hence amongst those within their sphere of influence.

Previous ethnographers identified power dynamics by place as shown in accounts of ritualised fighting and insult behaviour (Thomson, 1935). The intricacies of love magic and childbirth rituals, which include the naming and introduction of babies to the kinship structures (Von Sturmer, D. 1980), sustained the relationships between life and landscape, being situated in totemic places. This relationship or association features in the narrative of TH1 as he gravitated to recounting his spirit world retrieval narratives in a location of known spiritual power. At the same location, the association is also heard in the narrative of S1 as he

validated his powers in relation to such totemic power. FLE7 echoed this in her complex weaving analogy of place, totemic belief, and cultural changes.

There is a distinct social categorisation of knowledge keepers of health. This was revealed through participants' accounts of healing encounters. Knowledge keepers self-identified as either a traditional healer, sorcerer, or songman. There were preferences amongst community members to use Wik language names for each of these types of knowledge keepers. These might include the noyan (healer), or occasionally, "witch doctor" to denote a "good" healer, and the ma'wop (sorcerer) or "the bad man".

The "songmen" self-identified with that name, taking ritual ownership of maintaining story and song lines related to place and custom. Song lines trace the journeys of ancestral spirits as they created the land, animals, and such proscriptions assigned meanings to the journey of life including rituals for birth, healing, and death. Integral to Aboriginal spirituality, songlines are deeply tied to the Australian landscape and are represented by customary songs, dances, painting, and stories (Chatwin, 1987; Lilienthal & Ahmad, 2017). The melody and rhythm of the song describes the land over which it passes, so that listening to the land's song is cognate to travelling the songlines over the physical landscape (Bradley, 2010). No Wik language name was heard during my fieldwork for the role of songman, although the ritual of song is prevalent in Wik custodial and ceremonial actions, with an associated vocabulary of songs and associated kinship responsibilities identified in the Wik dictionary (Kilham, 1986).

Narratives developed from the fieldwork in Aurukun revealed clear pathways for the identification of healers, transmission of knowledge, and the personal acceptance of responsibility as a healer. Three men of Wik descent volunteered extended commentary related to constructs of their healer identity from the perspectives of ancestry, lineage, and contemporary lived experience. TH1 said, "you can be responsible for yourself. You work it out what you want to be (a healer, a songman); you are trusting yourself; you want to be some good." The elements of the conversations that follow show a flow of narratives from healers and other knowledge keepers that demonstrate how traditional healing is underpinned by kinship, cultural knowledge transmission, and the everyday presence of the Spirit World informing personal consciousness and self-identity.

4.2.7 Identifying the healers

4.2.7.1 Identity as cultural commodity

The majority of participants in this research in Aurukun could be considered "culture men and women" (a term suggested by Bernie to describe those who sustained strong traditional and cultural skills and behaviours). This included the capacity for identification of ancestral story places, and familiarity with, and understanding of, correct cultural protocols of access to totemic sites. This ancestral knowledge base was evident during interviews and was also observed outside of these semi-structured settings. Transmission of such cultural knowledge can be reinforced by expertise in performance and teaching of ritual dance sequences and song lines, which are integral in defining the passage of totemic beings. Culture men and women recounted how such cultural practices survived and were integrated with mission life. In addition to their roles as healers, sorcerers, and song men, they maintained contemporary interpretation of cultural skills, recreating Wik ceremonial sculptures (carved art works) and crafting traditional weapons and implements, sometimes substituting contemporary materials for enhanced functionality.

For Aboriginal people, the cultural influence of cosmological belief is fundamental to identity. Cultural belief is inextricably linked with varying levels of acknowledgement of the influence of the Spirit World of ancestors and totemic beings in Aurukun. Dudgeon and Walker (2015) state that in Aboriginal Australia, personal hybridity can be informed by a unique cultural identity that withstands the pressures of contemporary societal expectations. However, constructs of insider or outsider status and questions of "authorised authenticity" within community settings remain contested. Psychologist Arama Rata suggests that Maori people may hold different views over what constitutes an "ideal" Māori identity (Rata et al., 2014), while Meredith (1998) suggests that "hybrid" identities, encompassing Māori identity with professional status, have advantages in contemporary life. Bronfenbrenner (1977), Day (2011), and Sebastien (2020) argue that individuals develop identity from interactions with significant persons, place, and cultural symbols of ritual and belief.

4.2.7.2 Building trust with healers

In the process of identifying healers, questions of trust in myself as researcher needed to be established with community members to provide reassurance as to the respectful use of any information obtained and a sensitivity to Indigenous viewpoints. Without such situations of trust, it was unlikely that perceptions and experiences of healing would be shared. During

the first fieldwork session with TH1, introductions were made by Bernie, who activated his personal friendship and cultural connections to this family of healers (with three active male healers aged 62, 27, and 8 years). A line of direct descent between healers across different generations was seen to play an important role in sustaining intergenerational transmission of healing knowledge. The associated female family members (wife, daughter, sister, mother) surrounded the healers with barriers or portals of murmuring words, gestures, and glances. Bernie said to me later, "they were just keeping an eye on you; they would have come in (intervened) if they weren't happy." I understand this to mean that as a White female outsider, my behaviours were closely observed for appropriateness and respect and it is likely that commentary was being relayed during my conversations with TH1. A level of trust was clearly established as I would encounter these women as I moved around the community and I would be advised as to the whereabouts of a participant or told where not to stop and observe. Even if this was a form of control of my movements, there was no overt veto exercised.

4.2.7.3 Lineage and destiny amongst healers

At the start of our first yarn, Bernie and TH1 repeated the reassurances of connectivity and lineage as a common-ground starting point of many conversations with older Aboriginal people. For my benefit, TH1 described the complexity of clan and family relationships, explaining that in each interaction, everyone takes a little from their overlapping heritage of clan and family interactions, and that there is very little continuity of clan descent given a high degree of inter community mobility and intra clan partnering. He suggested that each individual has their own "centre," referring to his moralities and implicit self-definition of identity; "be true to yourself".

During this early phase of fieldwork, Bernie had not yet introduced TH1 as a healer. However, when a story about spirit possession was recounted, I realised that he was pivotal to the story. Without thinking, I suggested, "so you are the healer." The healer smiled, paused, then the story continued. I felt as though I had passed an almost indiscernible test of acceptance. On reflection, I believe also that being able to articulate my understanding was significant to TH1, indicating that I could be trusted with knowledge concerning healing (under Bernie's guidance) in an environment where healers are "private" and where in the mainstream, traditional healing practices can be met with scepticism.

As the conversation progressed, there was immediate, forthright, ebullient engagement, and when Bernie asked, "do youse want Murri medicine in the clinic?" TH1

immediately responded, “get your foot in that door girl.” Whilst this response made it clear that TH1 believed in the potential for advocacy concerning the presence of traditional healing in clinical settings, it also suggested his prior thought and understanding of the topic, particularly in other Indigenous settings. His response I think also reflected a level of impatience that health services in Aurukun had been slow to see the potential of traditional healing. His engagement with the subject and his enthusiasm were palpable, and he suggested that he would like to take his son, TH2, to visit Canada to see how their First Nations people managed. This was the first example of how TH1 sought to nurture the healing capabilities of his son.

The daughter (FC1) of TH1 sat close by, listening to her father. She told me about her second child, a son 3 months old, born six weeks premature, on country. This was the first Wik child born on country for several years. Under usual pre-natal practice, women are taken to Cairns, six weeks before due birthing date, as a risk management measure. FC1 said the family declined medical evacuation for herself and the baby after his birth, saying, “he was strong enough.” Not knowing or experiencing your birth country is a major cultural deficit for Wik people and this issue had been identified in early conversations with Apunipima Board members. Birthing, name giving, and immediate post-natal care have had specific ritual proscriptions related to land and totemic power, broadly observed until the 1970s (Von Sturmer, 1980). As my relationship with the family developed over the next three years, I watched the little boy grow up. He would listen intently to his grandfather’s conversations and often accompanied us on short drives while fieldwork was in progress. It was made clear from conversations with FC1 and TH1 that this child was destined for greatness within the healer lineage, as he had been born within totemic influence of his clan group lands.

4.2.7.4 Emerging expertise

On the second fieldwork phase, TH2, second son of TH1, took control of recounting his emerging expertise as a healer, having recognised his personal healing skills under paternal guidance. After two years of sitting a little distance away from conversations, he began to move his chair closer on occasion, each time getting a little nearer to TH1, Bernie, and myself. This appeared to demonstrate some level of trust in the research and enquiry process and also the tacit approval of his family. TH1 repeated his desire for TH2 to understand the potential of his emerging healing talent. He told a story of how TH2 restored a young girl to health after TH2 told his father, “Dad I know what’s wrong with that girl.” No further details were given, other than that the patient was “close to death”. Sometime later,

TH2 saw a "snake" in the belly of a neighbour who was doubled up with pain, and removed the snake. In line with agreed ethical protocols of knowledge sharing, detailed commentary as to how the snake was removed was not sought, although both TH1 and TH2 refer generically to massage and chanting in their healing activities, so it is possible that these were used. The explanation of complex Wik spiritual terms is frequently simplified in English expression, so the description of a "snake" could well represent the influence of sorcery or other concepts of disturbance of the spirit.

Confirming the continuity of the dynasty of healing, TH1 also describes his eight-year-old nephew as a healer, saying "I've never seen such a young child healing." This child apparently also saw pain and internal obstructions, including the "snake in the belly[8]," and "doesn't need help to heal someone." An offer was made to introduce the child to the researcher, but this offer was declined for ethical reasons (the ethics approvals and study protocols identified that interviews would only be undertaken with adults).

In a subsequent conversation, TH2 explained that he now "goes his own way" in healing, and implied that he does not always agree with his father over techniques of traditional healing. TH2 relies more on the symbolism of healing items than his father and articulates his interactions with the Spirit World in more detail. This might be a feature of his self-examination of his emerging capability.

Father and son are self-declared healers, and both describe their work in healing as dealing with the impacts of sorcery, having recognised when people are suffering dissociated behaviours. For TH1 and TH2, such behaviours included describing people being "dead but walking." This may include those who perpetrated violent acts, without understanding their actions. This indicated internal spiritual disturbance. In such situations, both TH1 and TH2 described the need to act quickly when such a condition is observed; "You need to get them fast, before they go too far." People may also have "wandered off", which was described in relation to cases of anxiety or depression, rather than more serious psychosis. A shared skill base between TH1 and TH2 emerged as both talked of recognising pain and suffering by a person's "colour", which sometimes showed as "yellow."

Working with TH2 involved overcoming his cultural reticence in being thought to be associated with a white woman. Through Bernie's interpretation of the situation, that it might be rumour or innuendo concerning his reputation that was at stake, we found a compromise.

We sat side by side, in full community view, in a public place. A friend brought him a soft drink and TH2 proceeded to whisper softly to me, describing influential spirit figures, such as the "Bossman", discussed further in section 4.3.4, and explaining some of his approaches to healing and protection, such as using tricks, talismans, and placating of spirits. He also indicated alternate views to TH1 regarding how to "reach" people; "Dad might follow people, but I can call them back." This suggests autonomy of practice as a feature of healing.

Just as the youthful friends of TH2 were watching him, I was conscious that the women were also observing from a distance. Being watched, corrected, ignored, and welcomed in equal measure by these women was by then the norm for the researcher. It became something of a ritual of resonance to be observed; the women appeared and disappeared as I was directed to my next encounter or corrected as to a community interaction. An example of this is when I stopped to watch a group of young girls playing "knuckle bones", where small, shaped animal bones are used in a throwing game, and where meaning is derived from the patterns displayed. Thinking this was a good example of self-directed amusement, I took out my field notebook to make observations. However, I was quickly escorted away by an older woman, who said, "no good, they practice magic." I later discover the connection between playing knuckle bones, divination, and protective magic (Mazzorin & Minniti, 2013), a tradition that was manifest in the archaeological record across the globe over thousands of years (Mazzorin & Minniti, 2013).

4.2.8 Healers navigate ambiguity between traditional healing and biomedicine

An example of how treatment in a biomedical setting strengthened the desire to use traditional healing is presented below. TH1 defined his perspective of the relationship between traditional Indigenous and non-Indigenous healing by affirming his healing credentials. This experience of personal and cultural ambiguity in the gap between traditional healing and clinical practice occurred after his diagnosis with prostate cancer. TH1 had an operation four months prior to the conversation in which he told this story. When TH1 met the surgeon, he indicated his own healer status and skill and sought "healer to healer" recognition of status and response. This reinforced his personal sense of identity, status, and skill as a healer. To represent himself as a healer and thought leader in community settings, he needed to take control of this encounter. In relating this story, he made it clear that he was concerned at the time about healing "inside", implying that he was still suffering from some of the known after-effects of prostate cancer surgery. His philosophy was that he had given his body to the surgeon with trust and that this trust had not been reciprocated in terms of

receiving information. He recounted that the surgeon did not appear to take note of their conversation, suggesting that poor communication had a negative impact on his recovery.

As TH1 explained how he articulated his expectations of "healer to healer" recognition, he said, "that doctor didn't know who he was dealing with." He said that he told the doctor, "We are not guinea pigs so take out what you need to under the blade of the knife, but I'm not just giving myself." The healer said he was told after the operation that "they got all the cancer." What was significant was his concern that he did not understand how long the healing would take or whether he would return to normal function and feeling.

He asked the clinic doctor to ring the surgeon and then spoke to him personally to get some answers. He seemed satisfied when told that return to function could take 12 months, and indicated that he would tell the specialist that he would not have further treatment; "you can cut it out but don't poison me", referring to radiation, chemotherapy, or other drug treatments. At the time of interview, he was sourcing noni fruit (Morinda citrifolia) and described its use thus: "you can grab it and squeeze straight in mouth but its bitter; better to mix with orange cordial though – you can squeeze and leave in fridge for a day." Noni fruit is known to have anti-cancer properties (Brown, 2012). During the conversation, he referred to other bush medicine, including his own understanding of a clinical trial being conducted in Cairns, of a cancer treatment derived from the Blushwood Tree. The company, based in Cairns, is conducting clinical trials in Brisbane, Sydney, and Adelaide (Panizza et al., 2019). This suggested that TH1 has an eclectic understanding of healing and clearly seeks information from a broad range of sources to reinforce his healing knowledge.

This conversation took place after TH1 completed his treatment for prostate cancer. He reiterated how he insisted all his family went to Cairns during his surgery and post-operative recovery; "I wanted my family close, it made me feel strong inside." This comment was taken at face value, until Bernie later explained that to "split the family up" leaves those remaining vulnerable to sorcery attack, and that being on "another person's land" can increase risk. TH1 continued his train of thought about hospital and health care, remote from the community. People going to Cairns can "think they are already dead", "they see people leave but come back dead." He also indicated that visiting the traditional lands of other Indigenous people (i.e., Cairns) without proper connection or invitation by the traditional owners is disrespectful ("you need a reason to be there") and that this disconnect /disrespect might cause sickness, not to mention causing anxiety in the minds of the patients. In this situation of unease, people look for portents or signs of sorcery ("if you're not in your place, anything can happen") with that vulnerability of dislocation being in the forefront of their minds.

As part of this extended narrative, TH1 also talked about purriy (purriy and its current level of activity, which he regarded as "out of control" amongst "young boys", and as outside his "powers" to control. Some examples of extreme "out of control" behaviour where sorcery might be implicated included practices of physical and verbal violence, often in relation to jealousy about personal relationships or envy concerning possessions. TH1 said that dealing with unexplained illness or malaise might be "outside his power." This comment related to his belief that he could only intervene when sorcery was deployed with Spirit World and ancestral guidance; so, he could act in Spirit World disturbance but not in day-to-day events in community settings. Bernie suggested, "It's just a lot of forty-year-old boys running around then," referring to an earlier conversation that he and TH1 had concerning the issue that, without a process of initiation, "boys do not become men" (and assume ritual and ceremonial responsibility).

In a further account of the relationship between cancer treatment and traditional beliefs and healing, one family achieved a level of engagement with spiritual and ancestral connection without the benefit of specific traditional healing intervention. The fact that some families have confidence to provide a spiritually connected end of life experience suggests that levels of community knowledge concerning healing practices are sustained.

A family member of an older female Aboriginal health worker, suffering advanced lung cancer, said that she was unable to obtain hospital centred advice about diet and self-care after surgery and radiation therapy. She and her family attempted to take control of this situation and the participant mentioned the use of noni fruit and other (unspecified) bush medicines. Her prognosis was poor, and one of her relatives later offered a moving account of her "at home" palliative care and death. That family was "keeping close", with immediate relatives travelling some distance to spend time with her in the final month of her life. The family rented a home close to the "ancestral" birth place of her grandmother, with members of the family referring positively to the "comfort" of such cultural linkages; "she could look out of the window and know where she was, and we were with her."

4.2.9 The little man inside

TH1 described his healing powers as being determined by "the little man inside." Thus, the healer remains unaware as to whether someone can be healed "until you hear the little man inside." The term "little man" is used interchangeably to refer to both "good" and "bad" spirits. Wik language terms for these beings include *aak-ngeeyan, komp kath, kon puchalam* (Wik lexicon), sometimes manifesting in pairs "like brothers" (Kilham, 1986;

Martin, 1993). TH1 introduced a narrative referring to such beings, interwoven with commentary about the lineage of healing.

Berndt (1947) also describes the Wuradjeri medicine-man's use of spiritual helpers or familiars as "assistant totems" that lived inside the body of the "clever man" (knowledge keeper). This shows that the Wik phenomenon of internalised spirits, is part of known Aboriginal experiences. The Wuradjeri totemic being was derived patrilineally and was only given to those young men, and occasionally young women, who were chosen to be trained as "doctors." The spirit being that inhabited the "doctor" was important as a protector that would wake him/her if a stranger or any sign of danger approached (Berndt, 1947, p. 63-64).

TH1 talked about traditional healers in the community who are "outside of me". He said that occasionally healers arrive from other places (stories of wandering healers were recounted to the researcher while she travelled to other Cape York communities). Two had arrived recently. One brought a "devil angel" (spirit being) with him, but when "strangers are around, they (the visiting healers) act innocent like." This part of the narrative seems to suggest that TH1 sought to establish a distinction between himself as a recognised holder of Wik knowledge as opposed to those wishing to do harm, although he did not use the word "sorcerer" when referring to those others. The little man comes at a price: "it's like playing cards; it's best if you are a neutral type of person and play your hand the way you want." He continues, "if you start wearying, that little bloke inside can control you. If the little man is making you think this way, don't worry, keep him well down inside."

TH1 concluded this conversation by referring to the complexity of clan and family relationships in community interactions; "everyone takes a little blood", meaning that within Aurukun, there is an overlapping heritage of clan and family connections with limited continuity of clan descent, given the high degree of inter community mobility and intra clan partnering. Despite this, he was confident that "everyone has their own centre," referring to the process by which Indigenous people craft their identities, mingling culture and skills.

4.2.10 Communication of cultural knowledge

In Aurukun, the construction of ritually informed artworks and the connected process of learning the skills through non-verbal observance and participation to complete these works, is observed to be a vital part of cultural transmission (Allain, 2011; Yunkaporta, 2019). The relationship of this close collaboration and interpersonal exchange was observed during my experiences in Aurukun, as women sat together in their own art space, weaving, painting with a woman Elder (FLE7) consulted or participating from time to time. The respite

and quiet time from everyday life was clearly therapeutic. MLE2 also confirmed the significance of the sharing of space between the Men's Shed, the Men's Art Centre and a Council run workshop, "sometimes you just need to be busy while you talk," "sometimes you can make something (a symbol) to explain."

Wang (2011, p. 101) suggests that through communication "we learn our languages, develop our worldviews, establish our values, and subscribe to our beliefs, communication is the sole process by which humans acquire and transmit their cultures." Borden (1991, p. 7) places less emphasis on spoken language, proposing that we understand human communication as a system for "the sharing of information through meaningful symbols." In Borden's (1991) view, a person is considered culturally literate when he/she possesses both the language codes and contextual knowledge of a social environment. Language codes include both verbal and non-verbal ones. Contextual knowledge of a social environment refers also to cultural symbols and cultural processes, whilst songs encode detailed cultural instructions acquired through deep listening and memorising the content.

Yunkaporta (2019) would not agree with Wang's assertion that "communication is the sole process by which humans acquire and transmit their cultures," (p. 4). Borden's (1991) model of non-verbal cues and the significance of cultural symbols is closer to the Wik lived experience of cultural transmission (Yunkapoorta, 2019).

4.2.11 Sorcery, unexplained death, and illness

Wik accusations of sorcery are often a means by which social conformity is maintained, and by which relations between dominant family groups and marginalised individuals are defined. As discussed previously, TH1 described "keeping his family close" as a means of avoiding the effects of sorcery.

Even where the immediate cause of death is recognised as physical trauma, sorcery is often viewed as the origin. During fieldwork in Aurukun, a story was told about an event nearby which involved a young man who collapsed during a football match and later died. Participant accounts suggest strong community sentiment that sorcery was involved, with a complex explanation for a chain of events arising from interfamily and clan group friction. In another case, the sudden death of a community leader was similarly regarded and widely reported as such in the local media (Petrinec, 2012). Community comments describing this latter event claim that "bad man got him", and a description of his symptoms stated that, "he just came out in boils all over, nothing could stop it," and again, "he came back dead" after an emergency evacuation.

Aurukun ethnographers such as McKnight (1981), Taylor (1984), Sutton (1978), and Martin (1993) describe illness narratives through sickness and cultural sanctions arising from the transgression of cultural proscriptions, often based on the breaches of totemic spaces. One ritual of protecting visitors from cultural sanctions related to breach of totemic spaces remains current. This entails the wiping of underarm sweat from a totem (pulwaia) guardian on the arms and forehead of a visitor to country, so that their association with such a guardian can be recognised. Without this protection, an individual risks an encounter with a vengeful pulwaia, leading to wandering off, becoming dead but walking, or actual death. This action "introduces" a person to a totemic space and is sometimes modified by a "widearmed hug" – where the underarm of the guardian touches the body of the visitor. This appears to be an acceptable alternative in some situations.

4.2.12 Contemporary sorcery in Aurukun

Contemporary sorcery manifests itself in Aururkun as a product of community tension. Acknowledgment and identification of sorcerers and sorcery practices is frequently mentioned in participant perceptions of healing (as derived from field notes). Situations of violence that arise in Aurukun frequently stem from attributions to sorcery. These include grievances over relationships or possessions, or are based on retribution in the case of a death (where there might be an alleged perpetrator or a set of circumstances believed to prove intended harm) or suicide. The phrase "he was had" means that *purriy purriy* is implicated and is used when sorcery is viewed as the explanation for disease, illness, or death.

In the ethnographic record (McConnel, 1934; Thomson, 1939; McKnight, 1981), Aurukun sorcerers were described as taking their victims' bodily matter, such as hair, blood, or faeces to subject them to rituals designed to inflict harm, including reinsertion of ensorcelled matter. Diagnostic ceremonies are believed to be undertaken by healers to determine the provenance of unexplained body "blockages" or "swellings" which may have been caused by such sorcery. TH2 confirmed this understanding by telling a similar story of a "lump in the chest, it was just feathering and stuff when we got it out."

A sorcerer may also direct a spirit familiar to possess a victim. TH1 said, "that little man inside, might have come from the bad one, might be that devil angel." He also said, you might get "*ngangk kul wampan"* (temptation to explode), "you might be screaming." He again used the concept of "following" to redress such situations, "I just have to follow them."

TH1 conceded that other systems of belief can be effective when recounting a story, told to him by an Indigenous community-based nurse. This story affirms his view that belief underpins healing, including the Christian faith.

> "A woman was in the clinic, seeing the psych doctor and he got her worked up. She started to scream. Nothing would calm her. They tried to find a noyan (traditional healer) but no-one…The pastor was there though, he just sat down with her – he prayed for two hours with her – she calmed down and someone took her home."

4.2.13 Can a sorcerer retire?

The first fieldwork session with S1 was conducted in the same week as the first encounter with TH1, with introductions again made by Bernie. Bernie later told me "I wanted you to see both sides at once," referring to the counterbalance between healing and sorcery. Although not encountered in this research, Bernie had earlier described his "cousin – brothers" (Umpila Elders, now deceased) as "good healer" and "dumbun murri," colloquial term for sorcerer, explaining that the actions of one could "change what that other one did." TH1 and TH2 also refer to the counteracting of sorcery by healing.

Bernie introduced S1 to me as a sorcerer. S1 was initially self-deprecating about his identity and any consequences of his "powers", saying he was "not a sorcerer", having retired from this position. He further stated that his retired status meant that he was "not a threat". Bernie commented that we watched people in the street "cross to the other side" as S1 walked towards us. "Why was that then?" he asked. Implicit in this comment is that there is broad community recognition of his reputation, together with a level of fear and suspicion, reinforcing his status. S1 explained that this reputation came with too much suspicion, hatred, and fear in the community, with tensions experienced due to his cultural powers being known but not understood. However, his broader narrative, provided soon after our first encounter, made it clear that he came from sorcerer descent and was proud of his heritage.

S1 explained his cultural credentials, including his fluency in three Wik languages; Wik Mungkan, the community language, together with the respective dialects of his mothers and father. He sang a song in his father's language about storm clouds gathering, after recounting a story about the visible passage of the "spirit" or soul of a deceased person. This passage takes the form of unusual clouds or darkening of the sky, S1 explained:

> "When someone dies, the thunderclouds come, the sky gets dark. When the soul leaves the body, it can look like a sky rocket going into the sky. It's a flash of light."

Bernie told a similar story later,

> "Yeah, I seen that too – we didn't know that old man had died but we saw a light in the sky, going up, when we got back, we heard he had died."

The belief in the passage of the soul suggests some resonance with Christian belief of the soul departing the body, intertwined with Wik mortality beliefs that tend to focus on the "spirit" or "totem" returning to its auwa or totemic "home". This is an example of a construct of healing with implications for end-of-life care.

S1 acknowledged that outsiders, situated within the community settings "wanted to keep him in one place." There seemed to be some potential sanitisation of his sorcery credentials by seeking to ensure that his presence in the community had strong associations with a health centre. The sorcerer described significant ambivalence regarding a role he had been offered within the health service, indicating that he would not wish to deliver pre-determined public health narratives; "I'd have to talk about FAS-D [Foetal Alcohol Syndrome Disorder], it's not my place, I know the grog makes the brain change, but I have no kids, I can't tell people about their kids" (meaning he could not be authoritative). S1 seemed to want to continue to validate his cultural credentials and proceeded to recount narrative ancestral histories about the crocodile sorcerers of his male line of descent;

> "These crocodile sorcerers could swim a river unharmed but anyone else gets attacked" "My uncles had crocs like pet dogs. They'd lift the crocodiles to either shoulder to show mission superintendent MacKenzie."

The chronology of this story suggested that this might refer to a grandfather or great uncle of S1 and an extended explanation of the mythology of crocodile sorcerers is related in section 4.2.19.1.

The sorcerer's self- identity is strong, yet he clearly felt unsettled. As an engaging story-teller with a charismatic personality, he was in demand to perform at community events, though under conditions that could not acknowledge his cultural power. These conditions of misrecognition deny the validity of his Indigenous knowledge, while illustrating the fear and ambiguity surrounding sorcery and those who practice it.

4.2.14 The Songman and his ritual responsibilities

Bernie introduced a songman (a cultural knowledge holder), who provided insights into the nature of his power and his experiences of sharing knowledge with Western researchers. According to Marett et al. (2013), songmen are so identified because they "sing or chant" legends, ritual welcomes, or challenges to passage across country. The songman was grieving for what he regarded as theft of significant cultural knowledge. He described his pivotal role in an ethnobiology research project, led by an international PhD scholar; "they wanted to know about using plants as medicine." He had developed detailed knowledge of the sacred, ritual, and healing use of plants in Wik lore, which he shared with researchers engaged in what was described by him as an ethnobiology study (Edwards & Heinrich, 2006). However, the researchers left Australia and he was not informed about what use was to be made of the knowledge he shared. He was also deeply saddened that there was no financial compensation for sharing his cultural knowledge. "They take my culture; I just need a bit a money. My wife is very ill, she needs some things…. I am getting too old." When asked how his specialist knowledge is handed on, he said, "no good, no-one." Bernie later explained that this meant that the songman did not consider anyone worthy of using the sacred knowledge of song and ritual.

The songman was observed at the height of his powers, offering a ritual invocation to totemic ancestors, in the context of extended discussions concerning the prevalence of suicide and substance abuse. Bernie later asked him to explain the intent of his performance. The songman explained that when individuals are unable to take responsibility for maintaining ritual associated with totemic landscape, particularly the "auwa" or spirit resting places, he believes they are *"kaakthuthan"* (hang their heads down, are ashamed). The failure of such responsibility may be caused by lack of cultural knowledge, inability to access totemic sites, situations of family unrest, or personal ill health; "they don't know how to find their way." He said he has seen that the associated "shame" may result in the use of drugs, but that they "can't stop" being "no good, have no house, no money." The songman believed that connection with the ancestors must be sustained and that the practice of his skills is a visible demonstration of the practice of culture, recognisable to the Wik community, and that this would have protective value, increasing personal resilience. On a subsequent field visit, the following year, the cultural broker and I learned of the death of the songman. His grandson (who carries his name) formed a dance group around that time which was immediately embraced by the community. Within two years, I watched this young man perform extended

ritual chants and dance, having determined his personal responsibility for cultural transmission.

This narrative is consistent with the findings of Kelly (2016), who indicated that songs and stories explain ancestral journeys as represented by story places and that such songs carry encoded cultural processes that function as explicit procedural texts for cultural behaviours. For Wik people, the connection with ancestors both defined the country and clan group affiliations with sandridge, estuarine, or coastal home lands, created totemic affiliations with animals and birds, and set the context for intra-clan relationships. Such affiliations and relationships have continuing relevance to contemporary community life, as community members seek to access country.

4.2.15 Priorities other than traditional healing - Wik women in community life

The significance of personal and community priorities other than traditional healing was demonstrated by Wik women in community life. These women also showed how identity dynamics develop in an intergenerational context, when women sought validation of their "contemporary" persona.

The first contact was a local Wik woman, FLE6, who is a recognised traditional owner, but has chosen a contemporary career path. She undertook considerable effort to initiate contact so that younger women might have an opportunity to talk about traditional healing. However, at a pre-arranged meeting, several young women were not interested in any conversation about cultural knowledge or healing even when prompted by FLE6. Over lunch, which FLE6 cooked for about 20 people in a community setting, she recounted the experience of her daughter, seeking advice from the great-grandmother (FLE6's grandmother) about bush foods and gathering strategies for a school project (at her elite boarding school in Brisbane). When FLE6 was asked if she ever collected bush foods, she said that she never did this with her mother, but could recall doing this with her grandmother.

The second contacts, FL5 and FC2, have taken a similar career path. Both are employed as teachers' aides at the Aurukun school. FL5 is recognised as an opinion leader in her own right, being actively sought by outside media as able to give a women's perspective, including in relation to the 2016 "riots" at Aurukun State school, where women were portrayed in the media both as instigators of riots but also named as mediators (Carden, 2017). When FL5 did not wish to talk, Bernie and TH1 conferred over a suitable contact. "That one might talk to you", said TH1 as we stood outside the community store, when FC2

passed by. She was called over by TH1 and agreed to talk. Since she was just going shopping, I asked to walk around the supermarket with her.

She was happy to share her perspectives about life as a single mother with her son and the toddler girl she is "growing up" for a family member. She talked mainly about minutiae of daily life, particularly her concern about her son, who was unengaged with his peer group, preferring to be with adults and seeking to "talk to the ancestors." She expressed concern about his future experience at boarding school, given these differences. Later, we sat outside her house and talked about life in Aurukun and her work as a school teacher's aide; "they need to hear us," she said, generally referring to State Government decision-makers, local power brokers, and the media and community concerns over school practices, including failure to teach in the Wik language. At the time of our meeting, the school had been in national headlines over the "riots", and she was angry at the continuing media coverage which she believed to be out of proportion to the events. Carden (2017) analyses media discourses emerging from newspaper reportage of this violence perpetrated against school teachers in Aurukun, with blame for this event largely attributed by the media to Indigenous parents, who are spoken about in relation to discourses of deficit and failure. "They didn't even thank us," FC2 says, with a touch of suppressed anger, describing a community event to acknowledge the "re-opening of the school." "We kept it going, no-one would ever have gone back." She was also upset that the "peacemaking" role of local women during this period of community unrest had not been recognised fully in the media or by the government agencies who developed a "crisis response", particularly since the teacher's aides "kept the school running" for those who wished to attend, while the government dealt with "safety for them outsiders" to the community. In response to queries about traditional healing, she says, "grandmother might talk to you". This was an example of the "referral" process which both deferred to knowledge keepers but also acted in a "gatekeeping" role for protection of privacy, and also for the safeguarding of that knowledge.

FC2 then sent her son with the researcher to another house to introduce me to his grandmother. He was an articulate, clearly academically gifted boy and asked questions about the research. His grandmother, however (who is on the talisman list) was not feeling well enough to speak to me that day. On the next visit to Aurukun, FC2 did not remember me when I greeted her, perhaps the polite way of not wanting to take the relationship further. Bernie had a separate brief conversation with FL5, who also did not wish to talk; she told him, "The women will speak out when threatened."

4.2.16 Brief glimpse of the Aurukun Indigenous health professional view of traditional healing

An insider or outsider narrative has been explored in academic research relationships, demonstrating professional expectations as to roles, relevance, and respect for those employed in the community with strong local cultural connections, but who live "outside" the community (Lai et al., 2018). The influence of community as a strong personal motivator and a source of stress when work/life boundaries could not be maintained have also been examined (Roche et al., 2013; Watson et al., 2013). These themes were certainly apparent in the present research, as discussed below.

Extended conversations were conducted in Aurukun with five health professionals (three of them fly-in) and all Aboriginal, with Cape York and North Queensland family connections (MCBHP1, MHP1, MHP2, AMHP1, AMHP2). They made varying observations concerning how being an Indigenous health professional raises challenges for discussing the role or issue of traditional healing. Varying levels of trust are clearly shown by community members towards Indigenous health professionals working in the mainstream clinics when there are kinship connections. "They wait until I'm not in the clinic," said one participant, referring to the fact that inter-family or "poison cousin" tensions and avoidance proscriptions may preclude them treating those they believe could benefit from their knowledge. Further commentary suggested that this may even prevent access to essential care; "I know they've seen a (traditional) healer but they won't tell me," Affirming that access to traditional healing is "kept private". This relates to a fear that health practitioners will not be respectful of cultural knowledge, believing that it may undermine biomedical treatment. "The bosses don't always see how we can be used," said another participant, referring to their potential value as cultural mediators across biomedical and traditional healing systems. A community-based health professional described his early internship training as a paramedic as a good example of the importance of such mediators.

> "I just learned most of it on the job, went to school for science, the instruments and stuff, but my main job was to talk to old ones, kids, mum, and dad so they'd know what's going on… The others (referring to his fellow team members) said I'd get let inside the house when they wouldn't, so we saved people… They don't teach it like that now… so you get out on the job and have a hard time."

These comments confirm the challenges of working across cultural settings, and the need to allow time for trust to develop in constructs of cross-cultural healing.

4.2.17 Talking about healing

4.2.17.1 Subtle diversions – lets go for a ride

The significance of place and context for conducting a conversation about healing and the Spirit World was subtly revealed through avoidance or diversionary behaviours. Older women participants in particular tended to use these behaviours, either by choosing not to talk about experiences of healing, or when seeking to talk in a location deemed appropriate to the subject matter. In this context, it was observed through interaction with two older women of Wik ancestry (FLE7 and FLE8) that the distraction of contemporary community pressure restricted discussion concerning cultural knowledge. They might also have sought to divert the attention of the white researcher from talking about such knowledge. In the following narrative, FLE7 did not provide any comments on traditional healing, but she indirectly revealed concepts of transmission of knowledge that operated in Aurukun.

FLE7 is a significant artist, painting and portraying country, particularly the relationships between women's access to wetlands and the cultural symbolism of resource use. When the research topic was explained, FLE7 was delighted to learn that Bernie was the cultural broker. She said, "Ring Bernie, I want to go for a ride." The location of choice for a conversation was the landing. Bernie drove us to the landing at the confluence of the Archer, Watson, and Ward rivers known as Archer Bay – a water body of 30,000 hectares (see 4.3.2 for the ritual significance of this place). Walking on the shoreline, FLE7 indicated that she has seen an albino crocodile basking on the other side of the lagoon and alluded to a belief story; "those are special, guardians." Sorcerer S1 had already introduced the tale of his uncles and their relationship with crocodiles, as we saw in section 4.2.15. This ritual symbiosis is believed to control the killing urges of the reptiles and their power which can then be directed to good or evil (Koonutta & Short Joe, 2013).

Koonutta and Short Joe (2013) quoted in an Pormpuraaw Arts & Culture Centre publication (2013, p.7), describe the beginning of a long relationship between a sorcerer and his crocodile: "He will go to his secret place at certain times and communicate with the young croc in his special sorcerer way. He can use his croc to kill someone. A bad sorcerer uses his croc for bad reasons. A good sorcerer uses his croc to kill a bad person."

The crocodile belief story was first recorded by McConnel (1930) as one of the Wik Myths and Legends, and was retold in detail by Conrad (2014), in the context of an arts project situated at the southern end of Wik country in Pormpuraaw. Conrad (2013), working

with Pormpuraaw Arts & Culture Centre, and quoted in the above publication, explained the ancestral clan relationships with crocodiles.

> "This is a story about a great journey taken by two of my ancestors from two different clan groups. One ancestor's clan came from the west coastal country, making them saltwater people. He was the saltwater crocodile or "minh pinch" (Min- Pikuw). He came from the mouth of the Mungkan River a place called "munurpa". The second ancestor came from freshwater country the eastern top end of the Mungkan River. We call this place "Min-ngik". He is the freshwater crocodile or "minh kenhe" (Min-Kena) …They headed inland and were followed by one bronze wing pigeon. The pigeon flew on ahead of the travellers telling all the animals that these two cousins were travelling inland through freshwater country. Warriors still dance the freshwater and saltwater crocodile dance which defines clan territories. My ancestors held ceremony and communicated with the crocodile cousins. Their spirits gave the cousins travelling song lines. Once they learned the song lines, they were able to travel through this new land and not get lost. Song lines tell the totems that belong to the country and work like a map to help the travellers navigate… The song line gave them strength and courage to continue their journey. The journey was physically challenging and caused them to become angry and stressed. Singing their song lines gave them strength to face their challenges." (p 8)

These stories of crocodile sorcerers are mirrored by the narrative of informant S1 in 2015. The cultural broker verified with the informant that a "white" or albino crocodile is considered to have particular spiritual "power" and may be a "warning" or "reminder" for observance of cultural respect in the clan. Whilst the narrative about story places, spirits, and crocodiles did not appear to be specifically linked with healing, it is indicative of the significance of ancestral memory within personal identity, which relates to sense of self and associated wellbeing.

Following the trip to the landing, in a spirit of reciprocity, FLE7 introduced me to her sister FLE8, a prominent weaver and holder of cultural knowledge, saying "she might have something to tell you." FLE8 was in town for a Presbyterian Church meeting to discuss the selection of a new pastor. Not wanting to be distracted from her purpose, she made only a passing comment, "country is about culture," making it clear that there is only a finite amount of cultural energy you might choose to make available to a random white researcher. FLE7 was somewhat annoyed by her sister's lack of interest and commented that "she doesn't weave much now anyway." This suggests an implicit assumption that weaving can be a metaphor for sharing of knowledge; at the time, the analogy made perfect sense. The perspectives of "what works" in healing in Aurukun shows that visualisation and creativity is significant. This is reinforced by Yunkaporta's (2019) construct of patient mastery of cultural

skills as being integral to transmission of cultural knowledge. He argues that the learning of language and transmission of knowledge in Wik contexts is embedded within the learning of other modalities, such as weaving, fishing, carving, and with creating stories and images. This provides context to the commentary that expertise in weaving is indicative of the constructs of learning and sharing of knowledge. Allain (2011) describes an Art in Health initiative in Aururkun that engaged Indigenous people with mental health issues in weekly visual arts workshops to improve social and emotional wellbeing. In these workshops, the company of others in a self-supporting group enabled visualisation of connection to country. Participants could respond creatively with cultural stories remembered and shared with children and grandchildren. Caregivers consistently reported improved sense of self amongst Elders as participants.

4.2.17.2 What health knowledge is valued?

Analysis of field notes suggested ineffectiveness of a didactic regime of health promotion, which raises issues about what health knowledge is valued, and why, in the Aurukun context. An example of ineffective health promotion, which failed to analyse how understandings of nutrition are culturally informed, was evident in an interchange at a "healthy eating" workshop, convened by an outreach team. Three older women who were sitting with grandchildren were introduced as "knowing about traditional healing". The intent of the workshop was that an individual would visit three stalls where healthy foods such as vegetables, hummus dip, rice crackers, and fresh fruit were available for tasting. The individual would then fill in a questionnaire about their learning and as a "reward" would be given a backpack and water bottle. If they then followed up with a health check at the clinic, they would be given a T Shirt.

After listening to a brief explanation of the research concerning traditional healing, the women conferred amongst themselves and then asked me to "get hold of more of them backpacks", as some children within the group "didn't get one"; qualifying this by saying, "we are just going home now anyway." I experienced conflicting personal views about this action, including a viewpoint that the program was patronising in its assumption that a reward would be an incentive to change eating habits, particularly amongst these older women. Despite some reticence, I obtained three backpacks after explaining to the program staff that the women were about to leave. Reciprocity from the older women then generated an invitation to "sit down". A brief set of comments ensued about the health promotion event;

"The grannies (grandchildren) don't really like that food", "I don't buy that stuff much", and "We used to go bush for food". One brief comment with a broad inference to the topic of traditional healing explained that, "before a girl has a baby, there used to be rules about what you could eat", with such sanctions detailed in an ethnography by Von Sturmer (1980) concerning nurturing and child-bearing.

On reflection, as a setting for a conversation about traditional healing, the workshop location had no resonance with the subject matter. The exchange showed that encounters that are patronising in terms of expectations of Indigenous behaviours still continue in the context of health promotion. Where situations demonstrate disrespect and lack of understanding of Indigenous knowledge and behaviours, collaboration in healing ventures is unlikely to be achieved.

4.3 The Spirit World of Aurukun is close at hand

4.3.1 Wik people and the everyday presence of the Spirit World

In Aurukun, there is an immediacy and significance of the Spirit World in everyday life that underpins both spiritual and more mundane experiences, including health and illness. Traditional healers are considered essential in managing the interface with the Spirit World. Analysis of field notes and interview commentary suggested that healing and traditional knowledge for people in Aurukun is intertwined with Spirit World consciousness, informed by ancestral belief but an active part of everyday life. The majority of participants referred explicitly or implicitly to Spirit World interactions when discussing healing. Some participants suggested they "turned away" from such beliefs or regarded them as inconsequential, since managing access to the Spirit World as a means of healing "doesn't work for everyone," whereas others sustained a pluralism of beliefs, "there's both ways."

4.3.1.1 The boundary with the Spirit World is thin

The significance of the everyday presence of the Spirit World to Wik people was first explained by TH1 during the first fieldwork period. As stated earlier, he described his approach to healing as a reference to entering the Spirit World; "First I look and then I might see they [those that need healing] have wandered off." The term "wandered off" was used by other participants to refer to situations of agitation or mental health distress. TH1 made qualifying comments about how he can see an entry point to the Spirit World, "the boundary with the Spirit World is thin – I can see both sides," (he referred to this concept of being thin

(or permeable) several times, using slightly different forms of expression). This concept of permeability or a parallel world gives context to the range of commentary relating to connection between ancestors, the Spirit World, and the individual. Early ethnography of Aurukun and the Wik country detail stories and legends of the appearance and behaviours of spirit figures and sorcerers (McConnel, 1936). Stories of spirit influence describe possession as "dead but walking" and may identify those who have "wandered off" or been abducted to the Spirit World. The concept of wandering is recorded frequently in older ethnographies, with both McKnight (1981) and McConnel (1936) describing "pulwaia" or ancestor figures as "wandering restlessly".

Over the course of subsequent conversations over three years between myself, Bernie and TH1, several examples were discussed concerning this boundary with the Spirit World. This included a story of "retrieval", in which TH1 recounted an extensive narrative describing his role in preventing an attempted suicide. On the first fieldwork visit, TH1 took the cultural broker and me on a drive to the landing (location described in section 4.2.19.1).

> "I cut down a young man, hanging here [who had attempted suicide]. When I drove to that place, I saw the two worlds, with a line like, hazy; that boy, he was on both sides…I got him back, but later, he was dead but walking."

The boundary between the Wik Spirit World and contemporary Aurukun is described by traditional healers as "thin", with spirit manifestations visible, frequently as harbingers of ill will. The Wik healer's TH1 and TH2 tell other stories of seeing "both sides", with Spirit World protagonists including "little men", "the bossman", and a "sorcerer on the roof, eating frogs." Within these conversations there are a number of possible interpretations/meanings of the concept of "thin" in the Wik language. *Olmp*, used as an adjective, means thin but in bad condition, mostly used in relation to animals being "too thin to be good eating." The broader concept of "thin" is not necessarily pejorative in Wik terminology – it can be a good thing, congruent with a condition of good health (*telgnk or pepan*). A boundary being thin is, therefore, just possibly a statement of fact. In more conventional interpretations, we might use a concept of a parallel universe, maybe in Wik territory; the two worlds exist side by side, and the boundary is simply thin, permeable, transparent.

4.3.1.2 Dead but walking

Wik language and nomenclature categorises sorcerers as those who exert malign influences, including controlling the Spirit World, where you may get "trapped" with healers who can counteract those influences and retrieve you. The theme of "apparent death" was reaffirmed in subsequent conversations with TH1 and TH2, who repeatedly describe potential patients as being "dead but walking" or they're "dead but don't know it", and who can undertake violent acts without understanding their actions. One example described by TH1 was of a young "ensorcelled" man, who committed a violent crime for which he was criminally charged. The explanation for this was to hypothesize how this "sorcery attack" might have occurred; TH1 said, "I might come at you with a knife, I slash your stomach and you die but you don't know it."

There is no research available (as far as this writer is aware) for the concept of possession or dissociative disorders amongst Wik people. The diagnostic capabilities of TH1 may, however, match the significant research efforts defined below, in particular the association between psychiatric disorders and violent crime. Craffert (2015) sees possession as a state that can be cultivated or can be the result of uninvited spirits. In cases where invading entities are uninvited, they can either be exorcised or, if considered useful, employed, and a relationship with the spirit can be cultivated (see Giles, 2004, p. 229; Leistle, 2014, p. 77). Wik mythology is based on the capability of traditional healers and sorcerers to direct good and evil via the practices of dwarf familiars or little men, and accordingly influence the social causations of illness and health (McConnel, 1930; Martin, 1993).

However, there may be extremes of somatic delusions where the affected person may deny their own existence and that of the external world. Patients might believe they were already dead, or that they were unable to die and doomed to live eternally. This ailment narrative is identified in the ethnography of Thompson (1935, p. 54), who described the Wik people's belief that "sorcerers mesmerise their victim so that he forgets that he has been ensorcelled and drain people of their blood without them realising it…The victim may walk about in apparent good health, but all the time his insides are rotting and he suddenly falls down dead." [9]

[9] This has parallels with Cotard delusions which can appear in cases of organic brain disease and functional psychiatric disorders (Berrios & Luque, 1995). The syndrome can occur in association with psychotic states and other mental disorders and is described in the context of major depression with psychotic symptoms (Cipriani, et al., 2019; Machado et al., 2016). The syndrome may also be associated with schizophrenia (Ghaffari-Nejad et al., 2007;

Explaining the need to protect others from the uncontrolled actions of the "dead but walking", TH2, described the need to act quickly with "tricks" or talismans to protect those not yet affected:

> "I can make tricks to protect people from the dead but not dead (i.e., ensorcelled are not aware or responsible for their actions). I make them of plants and like and put a spirit inside – you have to keep them for a while."

Bernie confirmed this form of spirit or sorcery protection with his own talisman story:

> "I was working as an Aboriginal Relics Ranger, I had to move some bones (This occurred in the context of a mine site being 'cleared' for operations). An old bloke (traditional owner) met me there and told me where they could go, be moved to. He gave me a 'packet,' that one was bark and sticks but all wrapped up; he told me 'Never lose this.' That night, after I finished, I put it under the house, later I saw a blue light under there. I left it in there, twenty years now, I saw that light, once more when my cousin brother died (a sorcerer from another community on Cape York). I've always been safe I reckon."

4.3.1.3 Spiritual protection, healing journeys diagnostic dilemmas and

The omnipresence of the belief in sorcery manifested itself in quite mundane situations. This was often expressed as warnings about inadvertently being at risk of bad things that might catch you unawares. As Bernie and I prepared to return to our accommodation one evening, TH1, clearly attuned to giving Spirit World warnings concerning sorcery, said of our accommodation, "be careful, there's a sorcerer on the roof eating frogs." As we approach the accommodation, I told Bernie, "I want to see the sorcerer", to which he replied, "trust me, you don't – don't look up."

This incident reinforced the importance of spiritual protection in this setting, so profoundly defined by Wik cosmology with active spirit protagonists. TH1 was not available to answer questions about the meaning of eating frogs and whether it represented a particular story or belief. As Bernie is not of Wik descent, he had no further opinion other than a clear desire to heed the warning. In an attempt to find out more about this apparent phenomenon, I

Huber & Agorastos, 2012), out of body experience and depersonalization (Ghaffari-Nejad et al., 2020), bipolar disorder (Soultanian et al., 2005; Consoli et al., 2007), pathological gambling (Cipriani et al., 2016), and violent and criminal behaviours (Cipriani et al., 2017a; Cipriani et al., 2017b).

examined one of the early ethnographic studies of myths of Wik people (McConnel, 1936). There is a reference to the Legend of the Frog (Min Tata) and the Fly (Nei'anya), yet the literal translation is brief (obtained from the archives of the South Australian Museum). No other references to the frog in Wik ethnographies has been found. Those Wik people whose mother tongue is Wik Mungkan use "eating" as a classifier for their dialect (*Wik Mungkan* literally means "language-eat"), so the concept of "eating" might mean calling to or talking about frogs, *min tata,* in the Wik language. This may be the language of half remembering the old ways and integrating the imagery in everyday life. Whatever the case, the significance of frogs remains elusive.

4.3.2 A place of spiritual belief

The "landing" referred to in participant narratives continued to emerge as a locus of ritual ancestral significance and this is restated here to underscore the significance of the continuum of myth, place, ritual knowledge and contemporary communication. Participants sought to talk about healing and Spirit World interaction at this location, consistent with known mythologies (McConnel, 1935).

Connections to country are a fundamental pillar of social and emotional wellbeing frameworks (Dudgeon et al., 2014; Ganesharajah, 2009) and this place is defined "via myth and ailment narratives…so powerful that the environment becomes radicalised, remythologised" (Kernan, 2019). Wilson (1984) and Kellert (1996) explain the biophilia hypothesis which asserts a fundamental, genetically based human need and propensity to affiliate with other living organisms and the land. Kingsley et al. (2009) extrapolate that this also reflects ancestral connection back to country as an affect driven response, with Indigenous people feeling a sense of belonging, obligation, and spiritual connectedness to care for land.

As a focal point of ancestral and spiritual activity, participants often elected to talk or elaborate on their conversations regarding sorcery and/or traditional healing, at the landing. The narratives of TH1 concerning Spirit World boundaries were focussed on this location, suggesting that healing powers were most effective here. When a participant asked to "go for a ride, for a talk," this location, just outside the Aurukun township, was close at hand. A conversation could be "seen" but remain "private". In this way, the research was validated at a community level by visibility, while detailed content was known only to the researcher, cultural broker, and participant. Most importantly, this area was identified by TH1 as a location of the permeable boundary to the Spirit World (see above). With this permeable boundary, the location was also one of haunting, where ghosts and spirits resided. Connection

with location or place is fundamental to maintaining linkage to totemic ‘auwa’ in Wil cosmology.

An example of this phenomenon was recounted by S1, told to the researcher in several parts across two days, in a manner too complex to be condensed into quotations. The story focused on his father, adopted father, mother, and brothers, and a violent attack. His adopted father was fishing and was attacked by three men, while his mother was left hanging in the mangroves for several hours, calling out until rescued. Her husband made it back to the community and walked down the street to show his many wounds before collapsing. His body was already in the morgue when his wife was brought back to town. She maintained strongly and for many years that her son should not “avenge” the death because she did not want him shunned or feared as a sorcerer. The story as recounted seems to have an elusive timeline and was more allegorical than actual in its oral delivery.

There are echoes within this narrative that seem to draw on the location of the bonefish myth (McConnel, 1935). In the myth, WolKollan, the bonefish (a Wik totemic figure, integral to increase and initiation ceremonies) visits his sister Mai Korpin, the mangrove woman. They quarrel and he hits her on the head with a spear (the spear now seen as the stalk of the mangrove seed). She strikes him with her yam stick, making the mark seen on the back of a bonefish. There is an extended initiation ritual linked to the bonefish “auwa”, the ground-based location where a totemic figure returns to the ground (ancestral resting place) (McConnel, 1935). The weaving of the story of the “mangrove woman” with an authority figure defined by adoption could be a conceptual reference to the spirituality of ancestral lineage (Westerlund, 2012), and perhaps be a means of confirming a line of descent for the sorcerer who was telling the story.

4.3.2.1 Lost in translation

As narratives like this unfolded, it became clear that communication in the field in English used words that have alternate layers of meaning from a Wik perspective. For example, the word “adoption” potentially proves descent through spiritual connection in a manner distinct from an English language interpretation. Time also has a different meaning in Indigenous storytelling; it is not uncommon for a narrative such as the sorcerer’s story, just recounted, to appear to be talking about an event using imagery and concepts derived from *ngamparamang*, a concept invoking the ancestral past, with ancestral beings (*meatal*) appearing and disappearing as myths and legends are re-enacted in current settings.

Shifting concepts of time and totemic affiliations might mean that disease attribution can be grounded in the past, present, or future and this may have implications for treatment. A mental health dissociation may be linked to Spirit World disturbance among ancestral totemic figures. The transformative healing journey (Dudgeon & Bray, 2018) required will need to look into the past, perhaps through the Spirit World boundary under the guidance of a traditional healer.

Sharifian (2006) suggested that "language does not always encode an objective reality, but largely communicates and embodies constructs and conceptualisation of various experiences." He goes on to suggest that, "Aboriginal English encodes conceptual mappings that are entrenched in Aboriginal worldview and Aboriginal cultural cognition." He uses the example of "medicine" as a cultural category that is encoded in Aboriginal English, and may refer to a range of spiritual powers and experiences. He describes a case study where an informant describes being given ''medicine'' while asleep by ''them'' (referring to the ''spirits'' of ancestors).

Similarly, in the present study, when consulting Wik language-speakers about words for illness, the following terms (and their translations) were suggested: *kemp wal way* (cannot sit up and talk), *kemp way ngeechanan* (body aching or sore, tired), *kuchek way pikang* (iiy-iiyan) *(*not in right mind), *kuchek way wunan* (worried over something), *kemp wir* (nervous from sickness, fright, or extremely tired or weak).

4.3.3 Granny sent the little dwarf

Another significant narrative about the Spirit World occurred in discussions with a local woman, FLE1, when she was asked for the meaning of the phrase, "the bad guy is after me", often heard during fieldwork as an explanation for being unwell. She explained that this refers to *purriy purriy,* the Aurukun term for sorcery that has been inflicted by a ma'wop (sorcerer). Her explanation about sorcery in the community was detailed; "There are people accused every day of sorcery and black magic." She had heard of two such cases in the preceding fortnight to the discussion. According to her account, accusation means that people are shunned and excluded even if innocent. She indicated that her uncles were accused of being *purriy purriy* men, being strong and influential in the community. In addition, she pointed out that she had to "educate" her work supervisor about *purriy purriy.* She says, "real sorcerers are active but not named." She explains that healers are good and sorcerers generally manage evil and magic. Some healers or "witchdoctors" can heal the effects of sorcerers with techniques that may include ritual massage and removal of foreign objects from the body.

They can "send back" those items to the sorcerer, but cannot name the instigators. The subsequent story she told gave some insight into how she perceived/constructed her own belief (or otherwise) in sorcery at the same time as her belief in biomedicine.

Her son was to be evacuated to hospital with high fever. She recounted that, "The 'aunties' or 'grannies' (she uses the term interchangeably) arrived at the airstrip" and said, "we need to send the little dwarf", upon which the *komp kanth* spirit apparently boarded. FLE1 could not travel with her son and by the time she and her husband arrived at the hospital (two flights – a five to seven-hour journey), the child was in intensive care in an induced coma. After multiple attempts at diagnosis, a visiting doctor suggested melioidosis on the basis of experiences on Palm Island. Heavy antibiotic treatment resulted in relief of symptoms, yet a six-month rehabilitation period was required due to brain injury from the infection.

She recounted that when she returned home, one of the "grannies" (old ladies) told her "That little dwarf was with him, (her son) and helped him." FLE1 thanked her but stated that "I don't believe it". While agreeing about the significance of spiritual and cultural comfort, she still made it clear that her son was cured by clinical means and most importantly that, "if I don't believe in *purriy purriy* it can't hurt me." She commented on her strong Christian spirituality and her mother's teachings, and clearly recognised the ambivalence of her position.

4.3.4 The Bossman – ancestral blending

TH2 shared some of his experiences and approaches to healing amongst the Spirit World and describes the "bossman", an eight-foot-tall spirit figure who needs regular placating in his clan group lands; must be "talked to," doesn't like to be disturbed particularly by guns, and those without a connection to that country must be introduced with underarm scent, smeared on the arms and neck. This forms protection and a link to a known identity who has totemic responsibility for that country.

The term "bossman" is intriguing. More commonly used to identify the head stockman on cattle stations, it may have resonance with the pastoral history of the station, which encompasses the totemic lands of TH1 and TH2. These healers bear the surname of an early manager of this cattle station (although there is no suggestion of genealogical descent). It was apparently common for a surname to be "assigned" from European "bosses" or based on the European names for areas of traditional lands. This may be seen as an example of the argument that colonisers and the colonised are mutually dependent in constructing a shared culture

(Bhabha, 1994). Accounts of brutality are anecdotally associated with this particular bossman, but there is detailed corroborating ethnographic evidence. Stories of the frontier wars of Far North Queensland are unambiguous about the prevalence of such behaviours, yet only fragmentary accounts of the events appear in the documentary record.

Tutchener (2018), however, identifies pastoralists, colonial officials, loggers and squatters from this part of North Queensland who may have been complicit in such behaviours. Based on this assemblage of material, it seems that intergenerational ancestral memories can be blended with personal experiences of colonised life in Wik country and become part of an amalgam both of the cultural record and everyday life. This adaptive process suggests that Wik people rationalise experiences of colonisation in the context of spiritual belief. This capacity to create hybridity of belief (Anathias, 2001) informs transmission of cultural knowledge and manifests itself in participant experiences of healing.

4.3.5 Stars and sickness spirits – the cosmology and imagery of traditional healing

A traditional healer, TH3, visiting Aurukun had heard of this research and wanted to contribute. His Yalanji ancestry (from a traditional country about 300km north of Cairns) was defined by the story of his "acquisition of powers". He was about 8 years old, "camping out" near his grandfather's house in the Daintree rainforest, Kuku Yalanji country. He was teased by the older boys and left behind on the far bank of a creek when they crossed by canoe. It was dusk, with no lights, and in the heart of crocodile country. He stood still, frightened, asking himself, "how will I get home?" He waited, and after some time, he was engulfed in light, picked up and "taken to the other side of the creek" – he made his way home but did not divulge the details of his "rescue" for some years (and no one asks). His grandfather "knew" what happened. He described how his grandfather "took him through lore" and encouraged the use of his talent. TH3 explained his belief that his healing skills "came from the stars." He uses the Kuku Yalanji word "mulawajar" word for star. "The mulawa guides me", "I know those people in the stars, they tell me what to do".

His commentary was closely linked to cosmologies of his Kuku Yalanji ancestry; reference to stars and sickness spirits have been discussed in the ethnographic accounts of Tindale (1974b) and in a broader analysis of Aboriginal astronomy and cosmology (Clarke, 2014.)

The antecedent ancestral healers of TH3 are identified by Anderson (1983, p. 477), who states that,

> "The maja maja were particular individuals of high achieved status and power ... who by virtue of their connections with the supernatural forces emanate in the ngujakura ('law' or 'dreaming') ...were charged with the 'minding' and 'looking after' of their respective countries and the people associated with them. They ensured the health and wellbeing in the human world and order in the natural world."

Also, Rothwell, (2014, p. 7) confirms the concept of light and the giving of powers:

> "The peak behind the gorge is Manjal Dimbi, the mountain that protects the community and brings it faith, strength, and resilience. Near its crest stands the most sacred of all the region's story sites, the place that marks the first appearance of the man whose body shone like lightning, Kubirri, the great law-giver of the rainforest. He taught the Yalanji everything: what foods to eat, how best to prepare them. Even after he left their world his presence watched over them and protected them."

In the following extended narrative from TH3, the presence of birds as harbingers of healing reinforces links between the natural and spirit worlds. Birds were prominent as spirit messengers and clan ancestors (McConnel, 1935) and credited with establishment of law and custom (Clarke, 2016). TH3 also indicated that a bird may represent a "sickness spirit" and hence have to be sent away. Their presence confirms spiritual continuity in healing, possibly reinforcing the stature of a healer who can interpret this manifestation of the Spirit World. The narrative runs as follows:

"That man rang me – says bro, I've been working on Mornington Island – I'm feeling crook." Sorcery, or *purriy purriy,* is freely practiced on Mornington Island so the possibility that the contact has been "caught" is real. When the patient arrived – TH3 "took him inside and something followed us in. I told him – "I can't stay inside – you must meet this yourself. I will be outside". The patient was frightened but stayed. TH3 said "two birds arrive and sit outside"; they represented good spirits. Both TH3 and the patient heard wind noises. Then another bird arrived – "I've never seen that one before, he is black like a butcher bird but has a long tail, with white spots all down the tail. He flies around the door. The patient hears him and calls out "what is that.'' TH3 told the bird to leave. He then told the patient to go down to the sea (close by), put his feet in the water, and wash his hands and the back of his neck with seawater.

4.3.6 Healer skills and continuity

Considering the nature and practice of his vocation, TH3 pointed out that each healing event is different and that he has "X-ray" vision and can see "inside" people. He often started a healing session with smoking or cleansing "herbs" if the source of sickness was not

immediately obvious, as this "clears" the spirits from around the person, allowing the healer access. His determination to ensure continuity of healing practice confirmed his sense of purpose, recalling that his grandfather told him he had a "reason to be here." His desire to be a role model to younger aspiring healers was underpinned by a strong resolve (spirit) as an individual to be informed by his culture and to step away from the mainstream. He explained his concerns regarding the difficulty of maintaining culture, using phrases such as "not enough support" for the young, no knowledge or transmission of lore, dislocation of education practices, particularly boarding school, and the consequent possibility that not enough healers may continue to emerge. While he enjoyed his work as a counsellor, protocols and guidelines constrained any opportunity for him to use his culturally based healing knowledge in a non-Indigenous context. Due to these restrictions, he sought to establish his own practice.

4.3.7 Aboriginal spirituality

Central Australian categorisations were a useful conceptual antecedent when making sense of the Aurukun traditional healers' descriptions of spirituality or their "domains of belief". The parallel and interrelated worlds of spirits, death, illness, and ancestors were evident in the communications of several of the study participants. As we saw in Chapter 2 (section 2.11.1), Aboriginal spirituality has been explained as occurring/existing across four domains: Alcheringa, Dreaming, Corroboree, and Dadirri (Hall & Hendricks, 2012.)

A similar categorisation can be envisaged of the parallel domains of belief described by traditional healers in Aurukun. Using Wik language descriptors discussed in the field, the following descriptors of the domains of the parallel and interrelated worlds of spirits, death, illness, and ancestors were discerned. These concepts have been confirmed by TH1.

Aak won wuut manganate - translated as "this is our way" refers to the relationship with the natural worlds which is handed down in story, ritual, and song across generations. Embedded in this set of beliefs is the Wik concept of the individual relationship with *auwa* (personal totemic place) and *aak pulwaiya* (the sacred place of one's totem and to which one returns on death). *Pulwaiya* and their totemic attributes are actively referred to in daily life including the naming of individuals.

Ngeen-wiy *or nganwi* (McKnight, 1981) - this is a powerful concept and the researcher only noted its use on one occasion, where FLE7 made an observation about sorcery, "that nganwi can control them bad men,"

The English translation (Kilham, 1986) is given as “the unseen power within” and the word is also used as the ritual name for the Rainbow Serpent, Thaypan (Martin, 1993). McKnight (1981) confirms that the term is used interchangeably between concepts of illness and the proscription of initiation rites leading to the assignment of personal responsibilities. It can also refer to forms of punishment by illness if food is gathered incorrectly, or if the exchange of goods is disrespectful. Some cultural proscriptions related to food are still referred to but cannot be ritually reinforced. Restrictions on certain food during pregnancy were referred to by two older women. One woman Elder, employed as a health worker, was referred to as follows, “she sometimes goes down the back (outside the community) with them young ones having a bub. She gets them special food, but they don’t stay long.”

The fact that the word ***Ngeen-wiy*** or ***nganwi*** was not used as part of the narratives of healing suggests that participants may not have wished to refer to deeply sacred spiritual beliefs in the presence of the white researcher.

Uchanaam and winchanam - Ritual ceremonies of song and dance which relate the myths and stories of ancestors. Sacred dances take place at times of increase, initiation, and death in accordance with laws of Thaypan and other totemic figures, such as the Bonefish.

Ngangk kuchar - A period of quiet and living contemplation of the Spirit World. TH1 referred to this concept and was active in this space. He said, “that word, ngangk kuchar means I can get into that other place, but I need to be careful.”

4.4 The spirit world and social ecology of healing in Aurukun

To contribute to the interpretation the perceptions and experiences of healing in Aurukun, a social ecological model of development was considered, as delineated by Bronfenbrenner (1977, 1978, 1986). Bronfenbrenner regarded the environment as an arrangement of four interconnected systems; *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*. He later added the temporal component of the chronosystem (Bronfenbrenner, 1986, 1988, 1989).

On the basis of the findings of the research I have created a diagrammatic representation (see Fig 5.6) of a social ecology of health. This also references a Social Ecology Model for Health Promotion (Stokols 1992; Stokols et al., 2003), which suggested that health behaviour is influenced by our social, physical, and actual or perceived environments. The characteristics and settings of those environments and how people negotiate the social dynamics of their situation create unique ecologies. To elaborate on my interpretation of this

adapted model, I use Bronfenbrenner's definitions and the diagrammatic representation of the dynamics between the systems. The individual sits within a tangible microsystem of family, kinship, and place, where interpersonal roles and relations are played out. Prevailing conditions within this microsystem may vary between deprivation, cultural cohesion, and strong social support networks. Individuals develop identity from interactions with significant persons, places, and cultural symbols of ritual and belief. Within Aurukun, Wik ancestral belief underpins an intangible microsystem, experienced only by those of Wik descent and which can alter the trajectory of experiences of healing. Similar to the experiences within Yarrabah, the mesosystem of alternate viewpoints is an interactive space between microsystems in which individuals participate. This space encompasses tension between life-worlds of ancestral belief and modernity, insider and outsider conflict and influence, and disconnect between neoliberal and Indigenous viewpoints.

4.5 Conclusion

This chapter has explored how traditional healing is experienced in Aurukun from the perspectives of cultural knowledge keepers, including healers, with some commentary from Indigenous and non-Indigenous health professionals. A complex continuum of belief and spirituality, good and evil influences healing. The ecology of healing must acknowledge the Spirit World presence with transformative healing journeys initiated by traditional spiritual healing practices (Dudgeon & Bray, 2018). Traditional healers such as TH1, culturally attuned to behavioural disturbance, lead such journeys. They may follow the songlines of SN1 and respect the nuanced and adapted behaviours of contemporary sorcerers such as S1. Cultural validation of diagnostic systems within these healing journeys help identify psychiatric disorders, as part of the wider construct of social and emotional wellbeing in Indigenous communities (Littlefield & Dudgeon, 2010).

Chapter 5: Healing for wellbeing in Yarrabah

5.1 Social recovery and wellbeing as healing in Yarrabah

Having explored Aurukun healing beliefs and practices in the previous chapter, this chapter focuses on the social world of healing and recovery in Yarrabah. This is achieved through a detailed consideration of the community as a locus for healing, drawing on a series of workshops. The chapter provides an explication on the sets of community and personal actions implied by "talking black" and the circumstances when "not talking black" is required. It concludes by addressing the conditions of possibility for community healing reflecting the social determinants of health.

Over a five-month period of fieldwork in Yarrabah, fifteen people provided commentary during a series of workshops and meetings convened as part of a strategic planning process, developing a community based Social Recovery Plan. The Plan sought to address risk factors associated with social determinants of health. The participants were established leaders fulfilling multiple roles across community-controlled entities. This research explored contemporary perceptions/expectations of any relationship between traditional healing and social recovery concepts and practices. During the period of participant observation there was also ongoing contact with Yarrabah participants in informal community settings to seek grassroots views as to concepts of social recovery.

5.1.1 Community perceptions of social recovery

From observations and notes taken in Yarrabah Leadership group briefings, workshops, and general community conversations, it became clear that social problems were (and remain) regarded as dis-ease. This was reflected, for example, in concerns over ineffective parental responsibility, which permeated unrest regarding local education. Problematic school behaviours, such as disruptiveness, bullying, and harassment, created intra-family anger and anxiety. One participant said, "there is handed down family conflict and cyber violence right through." The community articulated the conditions of possible social recovery that might lead to improved wellbeing and, consequently, to better health. It was stated that "we need to heal ourselves, before we can heal others." The argument, or proposition, that emerges from these results is that the ecology of healing in Yarrabah

requires a response to the social determinants of health (outlined in Chapter 2), including early childhood nurture, adequate nutrition, safe housing, education, and equitable justice. While this is not a new concept in Indigenous health and wellbeing, Yarrabah governance has a unique capability to define and sustain this ecology through its Indigenous leadership, as shown in the model below (Fig. 5.1).

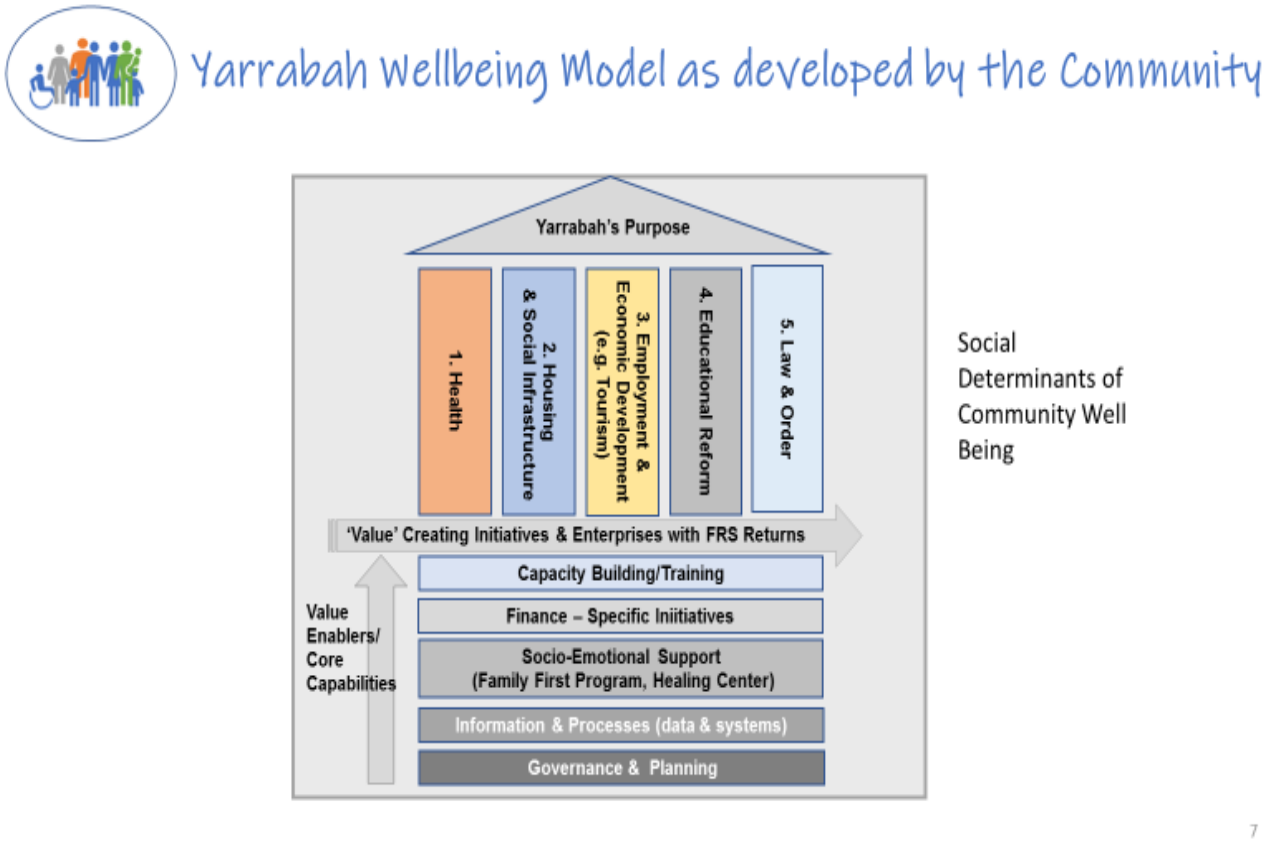

Figure 5.1: Briefing Paper: Yarrabah Leadership Forum 2019 – reproduced with permission

The Yarrabah Wellbeing Model identifies community wellbeing as pivotal to social recovery. The community broadly believes that family influence must be acknowledged and that grassroots opinion of the extent, nature, and pace of change is respected. As part of social recovery, the Yarrabah community seeks provision of socio-emotional support to facilitate human agency and build personal resilience.

Resilience is the process of adapting to adversity, trauma, and stress, including family and relationship problems, health issues, and workplace and financial stress (Southwick et al., 2014). Resilience underpins learning and adaptation that is part of personal growth, while fostering self-esteem and independence (Flach, 1998; Ungar, 2012). From feedback during

workshop discussion, it became clear that Yarrabah leaders understood that developing resilience, required addressing the context in which the individual experiences adversity, for example in the conditions of the community setting. Improving personal motivation or self-esteem amongst adults was believed to account for only a small portion of change. Intuitively also, Yarrabah families understood the need for consistent parental care (suggested by phrases such as "family is everything") as a building block for growth. Studies of resilience in children's psychosocial development have shown that early deprivation thwarts development, but those certain strengths have a disproportionately large impact on future growth (Masten & Barnes, 2018). The greater the risk of exposure to deprivation, the more beneficial a secure attachment (Sroufe et al., 2005) and school engagement (Dotterer et al., 2009).

Using a social ecological approach to understanding health, the concept of wellbeing for Yarrabah combines both the "classic" definitions of wellbeing (Gee et al., 2014; Dudgeon et al., 2020) and the aspirational goal of social recovery linked conceptually by the Yarrabah Leadership forum (Social Recovery Plan). The Conceptual Blueprint for Social Recovery (reproduced with permission of YLF Executive Officer) shows the scope of this goal (Fig. 5.2).

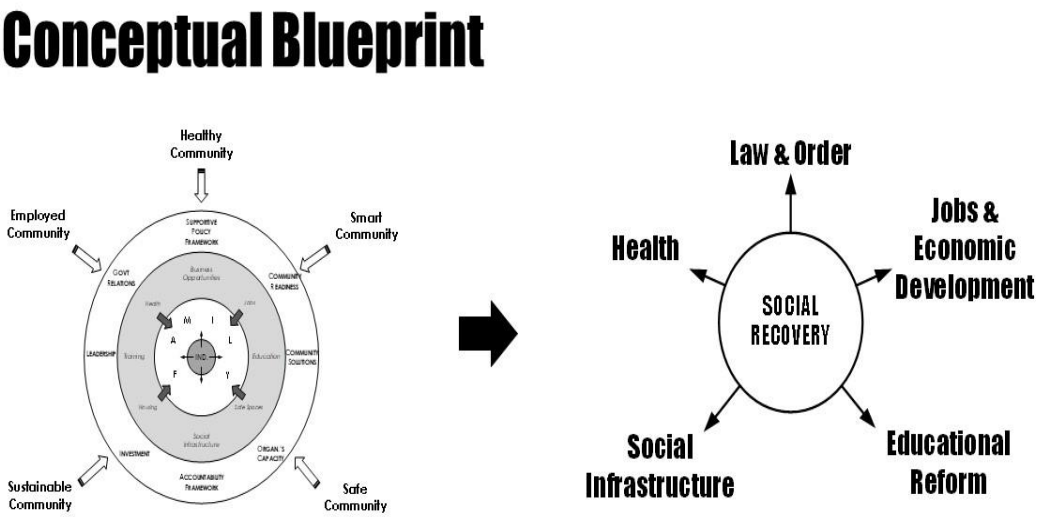

Figure 5.2: Conceptual Blueprint for Social Recovery – Source YLF 2018

People living in Yarrabah access education, health, aged care, employment assistance and other specialised community-controlled services, but their experience of community unrest, violence, and crime have created a sense of vulnerability and "lack of control," which has resulted in families withdrawing from community involvement.

Yarrabah community members recounted the elements of social disturbance as manifesting through anger, violence, and mistrust on the ground, described by some specifically as evidence of "dis-ease". Using the language of both sociology and social recovery, the improvement of wellbeing and family functioning were recovery goals within the narratives. Creating a social structure of healthy families was considered fundamental to social recovery within the workshop narratives. A specific discussion about encouraging new rules of social behaviour in Yarrabah through family support generated a dialogue about "handed down family conflict." Underpinning this debate was a narrative about the old ways of cultural continuity and traditional values that ensured community monitoring. The older Gunggandji people (Yarrabah traditional owners) in particular recount memories of the "right ways", "them old men and women, used to tell us how to behave", "we used to walk with granny to the healing place", "there was an old man, used to know how to kill turtle, dugong, properly", (i.e., in accordance with ritual proscriptions), "I think grandad might have been initiated." There may be potential for exploring whether such recollections were grounded in a period when cultural authority was enforced or whether this was simple nostalgia, or both.

5.1.2 Wellbeing inside and outside the school gate

The theme of community perceptions of social recovery and its role in creating a healing environment of wellbeing was introduced in 5.1.1. For parents and teachers an essential component of such recovery was to redress situations of ineffective parental responsibility that contributed to problematic school behaviours. A number of the narratives in the workshops were concerned with how to keep one's family "close" – that is, functional, healthy, culturally and physically safe. This may have some connection with earlier cultural mores of family and kinship but is expressed in Yarrabah in contemporary language, "We like to move around as one mob." This protection may affect school attendance and consequential educational performance. In some cases, parents may "keep kids home from school," if they believe that they may be subjected to bullying or behave badly themselves, "if they are going to muck up, they might as well be at home."

Other dominant narrative themes concerned significant dissatisfaction with the dynamics of school. Guenther et al. (2019) have outlined concerns regarding the mismatch between the current national curriculum, teachers' pedagogic practices, and the aspirations of Aboriginal families for their children's schooling. For schooling to be meaningful and culturally responsive, it must be critical and transformative, where personal experience becomes a resource that gives students the opportunity to relate and reflect their own narratives, social relations, and histories against what is being taught (Giroux, 2010).

Yarrabah narratives demonstrated concerns about education practices and the need for community relevance of "what happens behind the school gates." This point is reinforced by Lowe (2017), who argues that one of those underpinning issues that has plagued Aboriginal education centres is the depth of the socio-cultural disconnect between Aboriginal students and their communities and teachers. He also argues that, too often, teachers are appointed to schools with limited social, political, and professional knowledge about the particular needs and aspirations of Aboriginal students, such that it impacts on their capacity to establish authentic connections to students. Social dynamics within school were analysed within the Yarrabah workshop settings and articulated how a sense of belonging is fundamental to personal wellbeing. Teachers at Yarrabah understood that a good classroom experience is vital to educational engagement and consequential success. Parents spoke openly of their fears concerning children that "didn't fit in." Stehlik (2003) assessed perceptions from teachers concerning young people at risk of educational disengagement. These young people may not be manifesting learning or behavioural difficulties, but may be failing to develop social connections

Such nuances of school engagement were explained through an insider/outsider construct elaborated by Yarrabah school staff and parents in a workshop setting. They described how this concept can "place" children, inside and outside the school gate, along with a fine grain of understanding demonstrated by teachers as to where individual children "fit" in a continuum of engagement with education.

A teacher explains this concept as follows; "a child might enter the school building but only participate on their own terms, rather than participating in learning." She goes on to say, "you can be inside with potential for full learning engagement but also being capable of being distracted by outsiders." This is further described as follows; "some kids don't mind coming to school to socialise, they sit in class, chat, play on phones, will take part with right sort of activities." The narrative continues with "insiders"; "some want to learn", demonstrating learning willingness but sometimes disrupted in class. "We can take them away", meaning to

separate them for specific learning exercises. The “good ones” who have consistent attendance and achievement level were mentioned only in passing.

The second part of this concept describes those regarded as “outside”: “Some just get inside school gate, get breakfast when it’s there, don’t come to class.” “They want to be social, use Wi-Fi.” “We will see them if they want a feed”, referring to the fact that a breakfast program had been intermittent in recent months but offered without attendance conditions. This group are regarded as outsiders, but are possibly not yet engaged in, or are only on the margins of, potentially criminal behaviour.

The second outside group, “some just make trouble”, are considered disruptive and abusive children, generally regarded as engaging actively in anti-social or potentially criminal behaviours; “They might want to pick a gang”, referring to “grooming” of younger children by older students for low level criminal activity.

Truants as an “outside” group, particularly amongst older children, were the subject of an extended discussion, and were regarded as a community responsibility. However, it was made clear that this responsibility would require support from other agencies, particularly for counselling and diversionary or motivational activities. There was also concern those penalties for non-attendance are not enforced consistently. Within workshop dialogues, some Yarrabah community members suggest that disruptive behaviour at school reflects failure of parental responsibility to reinforce the importance of education and that the impacts of handed down family violence creates an environment of fear in relation to bullying and shaming, creating a disincentive for school attendance.

Lippman et al., (2011) suggested that “the school context has a strong influence on positive emotional and social development, as well as cognitive development,” and that “positive classroom climate is related to higher academic performance. There is a well-established link between a classroom climate characterized by positive student-teacher relationships and enthusiasm toward school and academic achievement.” (p 432) There was broadly a sense from the Yarrabah narratives that such positive classroom experiences were not consistently achieved.

These nuanced analyses of life at school fit within the concept of social ecology derived from Bronfenbrenner’s (1979) ecological systems theory and associated theories of child development. The “activities” attributed to students fit within the overlap of the microsystem and mesosystem. The microsystem provides a base for direct relationships with students and for lateral adult-to-adult relationships with teachers, administrators, and parents. Bronfenbrenner suggests that student development would increase “as a function of the

number of supportive links existing between that setting and other settings (such as home and family)" (Bronfenbrenner, 1979, p. 215). This relies on roles, activities, and relationships in both settings that "encourage the growth of mutual trust, positive orientation, goal consensus between settings and an evolving balance of power" (Bronfenbrenner, 1986, p. 214). Involvement of community partners with the school, especially in a remote, inwardly focused community such as Yarrabah can sustain a positive life path for students and within the community. This is given effect in Yarrabah through collaboration with local police and sporting groups who provide activities and awards related to appropriate behaviour at school. To further this aim, open communication with elements of the police and justice system, youth focused health screening and services, and the active involvement of sporting clubs, is actively undertaken. Health messaging from such communication reinforces active lifestyles, staying out of trouble, and taking control of personal health.

Community members were keen to express that, while parental obligations regarding education existed, they were not uniformly reinforced across the community and lacked nurturing of parental involvement. Yet, it was acknowledged by workshop participants that further exploration was needed to develop practical strategies that respect parental choice without patronising their efforts (as with the "free lunch" program) or exacerbating difficult home life conditions such as overcrowding, food insecurity, disrupted sleep, and predatory sexual abuse. This reflects that localised response to the risks associated with social determinants of health is understood as part of a healing culture.

Disruptive behaviours at school were regarded as an expression of lack of parental interest and "handed down" family violence. One participant said, "there are some parents I never see, never can get them on the phone." A culture of bullying and shaming amongst pupils and their parents can emerge; "you might just hit back, if someone calls you out." With high levels of strife and conflict reported in Yarrabah schools, community members seriously considered that school "could be too much trouble." This was encapsulated in the workshop comment that children bring family and community disharmony to the "boiling pot of school, add flavour and take it home. The ripple effect of that is damaging." There were a range of comments from both workshop and grassroots settings concerning the realm of inadequate "sanctions" or "punishments", and the prevalence of bullying within the school. Lack of responsiveness of schools to child focussed issues of performance and wellbeing was considered to be frequently unresolved. "My kid was bullied yet the school counsellors were the wrong family so nothing happened."

Through explicit discussion, it was revealed that community aspirations for education were not homogenously shared and generally fell along binary lines: opportunity or constraint; relevant or useless. School may not be worth the effort, said one workshop participant. Broadly though, Yarrabah leadership forum members viewed education as fundamental to a lifelong pathway of success and health. The connection and role of intergenerational transfer of cultural knowledge was highly valued and participants sought the incorporation of culturally-relevant studies; for example, dance, art, hunting and bush tucker collection, and teaching Yarrabah studies (including language). It was suggested that these and other skills had a place in school and could be led by Yarrabah Elders. Some participants felt locating these activities, "outside the school gate" would minimise "talk about who tells which stories," And minimise disagreements such as "that's not your story to tell." A number of Yarrabah families only became aware of the substance of their connection with their Gunggandji ancestral past through the Native Title Claim determined in 2001 (Gunggandji Land and Sea Country Plan, 2013). Stories of ancestral connection therefore have a high degree of contemporary community ownership and are regarded highly, so inappropriate or unsanctioned telling of stories is a contested space. This was viewed as potentially placing the historical owners of Yarrabah in a "subordinate" position, despite the community leadership role of many of them over past decades. These discussions serve to demonstrate that the insider/outsider dynamic has a significant effect on community collaboration.

5.1.3 Understanding personal cultural history

The workshop narrative diverted from a debate about the role of school and the education system in creating access to culture, to feedback about the lack of comprehensive knowledge about personal cultural history, which was viewed as contributing to "handed down family conflict." One participant suggested that there was active fear of uncovering some aspects of one's past.

I encountered this apprehension when Bernie and I discussed our respective grandfathers. One of Bernie's grandfathers was an Afghan camel trader (glossary). When I told Bernie, I had found archival records about Afghan camel traders in the locality where he understood his grandfather to have lived, and could find out more about his life, Bernie replied, "leave him where he is, I like him there." Bernie was happy, however, to explore the detail of his Aboriginal descent and was a source of considerable gossip about Yarrabah families. He particularly enjoyed explaining about "wrong side ones" – children brought up in family settings where the male household head may not be the biological father. This issue

was not raised as moral judgment but rather that it could be significant in native title or other cultural claims in cases where patrilineal descent is a qualifying factor, and is therefore closely observed by community members. Bernie made the comment, "You should leave yours be too," when we discussed the fact that my own grandfather and grandmother were not married, making my own mother a "wrong side" one.

During the discussion on native title in relation to cultural knowledge, several workshop participants felt that being "paid to access culture" is often "taken too far." Several participants also continued the dialogue in calling for "a proper view of Yarrabah history and stories." This is not a question of availability of material; there are numerous books, theses, and archival records on Yarrabah, some of which are held in the Menmuny museum (Richards, 2010). Rather, this was a question of ease of access and format of materials. When this issue was canvassed, a suggestion was made in the workshop whether cataloguing material by current family names would be a possibility. The Indigenous Knowledge Centre (IKC), run by the State Library of Queensland, is in an "uncontested" community location and was favoured as a location for archival storage rather than the museum, which until recently had a guardian family who managed access and offered unpredictable opening hours. Oral recording of stories commenced through the IKC. This was supported by community members as an important component of intergenerational knowledge transmission, contributing to a sense of identity and connection – important components of both personal and community wellbeing.

5.1.4 Community opinions about ways to improve wellbeing in Yarrabah

Improving wellbeing in Yarrabah is regarded as a combination of personal responsibility for self and family, together with responsive governance. When asked specifically, "what should change in Yarrabah?" grassroots community members were quick to identify ongoing community concerns spanning educational and school reform, ineffective policing and an unresponsive criminal justice system, a mismatch between the community skill base and available jobs, and longitudinal struggles for resources such as land, social services, and community-led programs. A frequently expressed view was that external agencies working in Yarrabah but not community-controlled "do not understand what works in Yarrabah." This referred to a collectively expressed view that responsive, personalised action to "look after yourself and your family" was required to improve wellbeing. One participant explained, "I live in Yarrabah with my family so my mum and dad can see grandkids and I can keep an eye on the old ones. My kids go to school outside (the

community) and I work in Cairns. There are people I don't want to see in Yarrabah." Living outside the community, even for those with strong family connections, but travelling in to work in Yarrabah, was another response to "taking control, put your family first."

Local interpretations and adaptations of services were expected to meet "the Yarrie way." One example of this approach was seen in an extended workshop conversation on employment when one participant said, "there are lots of jobs" in Yarrabah. "Carers who are unpaid, there are natural helpers (referring to an informal but well-established suicide prevention watch capability); unpaid Board members and directors, people going fishing, fixing cars…" Another participant talked about what he called the "black economy" based on exchange of goods and skills; "you stitch up my pig dog, one day, I'll bring you fish tomorrow; or maybe fix your motorbike." The workshop discussion talked about the Centrelink definitions of "activity" in this context, noting that time spent in barter or exchange of services as described above is definitely not included in the activity test and so does not fulfil the mutual obligations applicable to welfare recipients.

5.1.5 The impact of crime on wellbeing

The workshop narratives discussed the impact of property crime and theft on personal and community wellbeing at length. Much of this impact was felt at a deeply personal level. A young woman who had started a takeaway food business described her shop as "trashed." "Someone rang me, saw them breaking in, I raced down. called police but they were too slow to get here. I knew one of them who got in …I can't afford to fix it (damage) and restock, it's going to close." In another account, a break in at the women Elders' centre, was described, "I just can't believe anyone would do that to those old ladies, they have so little there, just mainly sewing stuff, I think they were just looking for food." With this and other similar examples, there was a palpable sense of betrayal within the community leading to mistrust blame and unease. This in turn undermined the preparedness of individuals to act as entrepreneurs and innovators Entrepreneurs are considered to enjoy a level of freedom and control that can enable them to derive more meaning from their work, use their unique talents and skills, and initiate self-directed tasks (Shir et al., 2018; Wiklund et al., 2019).

There was an expressed view that it was inappropriate that compensation was not available or enforced for criminal damage inflicted on others. An example of breaking into a takeaway food shop was given: "The police saw CCTV of the kids that wrecked my shop, they are too young to be charged, their parents should pay." The shop in question closed permanently after this event. A continuation of this theme included commentary that no

restorative justice program is available. Participants actively sought involvement of Elders as mediators, both between family disharmony and in the context of the juvenile justice system. Others argued that sanctions should be exercised against parents to require clean up or payment for damage when their children have been involved in criminal activity. “The police should sit down with kids offending and get Elders to talk to them, they just take them home, they never even have to clean up, next night they are out again.” To address or mitigate such concerns, the comment was made, “Elders have offered to be on a night patrol, but no-one can set it up.” The pivotal role of grandparents as carers was described with concern, including that they receive limited support and “grandparents getting too old to keep eye out.”

Queensland Police (2021) has the following operational policy with respect to vulnerable people (with legislation defining both Aboriginal people and children as vulnerable). These policies are not operational in Yarrabah, for reasons not stated by Queensland Police.

- If suspected as being a perpetrator, a child may be cautioned by a “respected Aboriginal person” where the community has identified and agreed such a person can act.
- A restorative justice process may be used (involving family and other community members) where apologies or similar are made to victims.
- If a child is determined “guilty” - orders for community service, or compensation or restitution may be made (this includes orders against parents).

Inequitable application of sanctions related to “unsocial” behaviours included expressed concerns that fines are rarely levied for truancy, so that “some just get away with it” and “takes too long to get that paperwork for no school.” There was also a view that this concept of inequity lead to a perverse cycle of reward, “kids that muck up at school are rewarded, boat trips, camping, lollies.” The alternate view strongly expressed that “kids that are good should get a treat too.” This reflects the strongly expressed opinion in Yarrabah that personal responsibility for health and wellbeing is paramount and needs to be nurtured amongst children as well as adults.

5.1.6 Food, care, and nurture in the tangible microsystem

Through community discourse, local representatives highlighted the conflict between parental/family caregiving and social services support, using the pivotal imagery of food. Poor food security underpins this commentary. The cultural and historical connotations of

food deficit, together with the way food symbolises care and nurturing in Yarrabah, is part of the dialogue of healing. Contemporary forms of food allocation, sharing and procurement are controlled by mainstream, white corporations and government and have replaced traditional practices. The community has been coming to terms with these changes over many years, and seeks much more influence as to how food distribution and supply occurs in Yarrabah. Adequate nutrition and its cultural relevance are essential to good health.

An example of how food allocation practices can be divisive was discussed in a workshop group setting regarding the Remote Schools attendance program, operational in Yarrabah. In this program, truant behaviour was identified in one hundred and forty children, with a significant number having "no food for lunch," and this being given as a reason for truancy. The program responded by offering emergency school lunches as an incentive to attend. Yet, this initiative created resentment and conflict, where poor caregiving was seen as "rewarded" with "free food." In Yarrabah, comments were made by participants that providing food and nourishment is fundamental to caregiving with strong aspirations to continue traditional hunting and fishing. Yet daily availability of high-quality, nutritional food is still problematic and further exacerbated by memories of mission rationing, low food supply, and "forced" labour on a successful market garden enterprise, with produce being sold "outside" the community. It is difficult to access basic daily needs (e.g., fresh food and transport) in Yarrabah at affordable prices; "we need a bus over the hill to go to supermarket."

The imagery of food was prevalent in a number of conversations as a metaphor for leadership and assignment of resources. One senior female leader described Friday night dinner; "that spaghetti is insurance, if I make a big pot, it'll get eaten, people turn up, but if they don't I freeze it." Then, "but if I don't make it, someone might have gone hungry, but I won't know." She used this analogy to explain the assumptions of a cost benefit analysis;

> "it's ok to put a value on something that you prevent from happening (in this case costing an intervention that reduces substance abuse); like my spaghetti stops someone being hungry, this thing [the intervention] stops someone being in rehab.*"*

Food insecurity is a common experience for Aboriginal people across Australia, but particularly in remote areas like Yarrabah. Davy (2016) uses the findings of the National Aboriginal and Torres Strait Islander Health Survey (1994) and the Australian National Audit Office (2014) to show that nearly 30% of Aboriginal adults are concerned about going without food, with greater numbers in remote areas. Among Indigenous people living in remote areas, 36% are likely to run out of food, compared to 20% of Indigenous people living in non-remote areas (Browne et al., 2009). Continuing logistical difficulties related to the

stocking of remote stores, cost of food, and the disconnect from traditional food sources are contributing factors.

Obtaining food or not having food is a frequent topic of conversation. Fishing and hunting are still regular activities for men, as is gathering prawns in tidal creeks or Wirral (an edible mollusc, similar to the mudshell of Aurukun). Watching groups of children collecting wirral on the mudflats of Mission Bay, Yarrabah, Bernie said, "Just like when I was a boy, big kids make the fire on the beach, send the little ones into the mud, then cook up them wirral, maybe let the little ones have some."

With large families, limited storage and refrigeration space in overcrowded houses, and no supermarket in Yarrabah (it is an 80 km round trip to the nearest supermarket), food can run short frequently. The women's group have persuaded a local vegetable wholesaler to bring produce rejected by retail outlets to Yarrabah, but availability is not predictable.

The question of food insecurity is ongoing as the following example, two years after the conclusion of fieldwork, attests. The biosecurity related community lockdown of Yarrabah during the first phase of the Covid19 pandemic, 2020, created near panic concerning food supply, with a protest staged at the policed road block site. A Yarrabah Shire council submission to the Australian Government House of Representatives Standing Committee on Indigenous Affairs (August 2020) highlighted the complexity of managing food supply during this biosecurity related community lockdown due to the Covid19 pandemic. It outlined both the immediate response capability and the longer-term options for supply and retail distribution. The submission expresses the specific community feelings of anger and marginalisation when food supply was disrupted.

5.1.7 Community influence in Yarrabah

Dialogues with community-based participants and amongst the Yarrabah Leadership Forum raised issues concerning the negative effects on wellbeing of gossiping, bullying, and family feuding. Bernie is alert to the undercurrents of discontent, implied rather than explicit when people talk to him. He encapsulates this in a comment that, "there needs to be something for everyone in it, if you want carnage in Yarrabah."

These behaviours were seen as particularly problematic in the context of activities concerning the education and wellbeing of children, as discussed in section 5.1.2. Envy or anger towards power and privilege were also seen in relation to the perceived advantage of some families over others in terms of obtaining jobs, allocation of housing, or other benefits. "There's one or two families, always in it." Certain positions of authority were considered

unduly powerful or influential. Behaviours described or alluded to broadly fall within the ambit of lateral violence as described by Mick Gooda (2011) in his role as Social Justice Commissioner.

Clark et al. (2017) describes a detailed case study in Adelaide, which suggests that community coping mechanisms include disengagement or avoidance of certain interactions within Aboriginal community settings or workplaces, but that cultural connection is often actively sought for self-knowledge and building resilience. There was broad agreement in Yarrabah that the Family Wellbeing program was effective in improving individual empowerment to create bonding and bridging of differences which could assist in resolving family and community dysfunction. Formal staff training in Family Wellbeing and program delivery activities to patients are delivered within the health services, with participants speaking positively about these experiences, “Once I could sort my own head out, I could really help others.” An ongoing understanding of changing needs was also mentioned, “We need to keep refreshing that training, I first did that Family Wellbeing, 20 years ago and a lot has changed, online bullying is a really big problem now.”

The question of how to identify those with greater or lesser influence in progressing social change was considered highly significant in determining effective communication strategies to progress social recovery. Community influencers lead or direct public opinion and are looked to for direction and problem solving at the community and family level. Understanding community influence in the process of social recovery was a key priority for the Yarrabah Leadership Forum. Using Bernie’s unique advice of the cultural broker and in consultation with the Yarrabah Leadership Forum regarding the complexity of relationships and obligations in the community, a community influence model was developed. The following sections summarise the role of “inside and outside” community influencers.

5.1.7.1 Outside community influencers

In response to conversations with the YLF, the researcher developed the following diagrams to summarise the role of “within” and “outside” community influencers (Fig. 5.3 and 5.4). Community wellbeing relies on allocation of resources to Yarrabah to respond to the social determinants of health.

The key influencers identified outside the Yarrabah community setting represent those who determine allocation of resources to Yarrabah within a national, state, and local context and control broader public opinion. The Yarrabah Leadership Forum expect high importance

"influencers" to act in accordance with an evidence base of "what works within the community setting". Specifically, the facilitation of financial and logistical decision-making regarding service allocation and delivery was expected to be made by or through the local governance of "community control". The balance of influence is an overriding concern; for example, the "moral panic" agenda (Cohen, 1972,1980) of the media reporting of violence, murders, and riots is damaging, both to community cohesiveness and to the willingness of service delivery agencies to engage with Yarrabah residents, without overt security protocols.

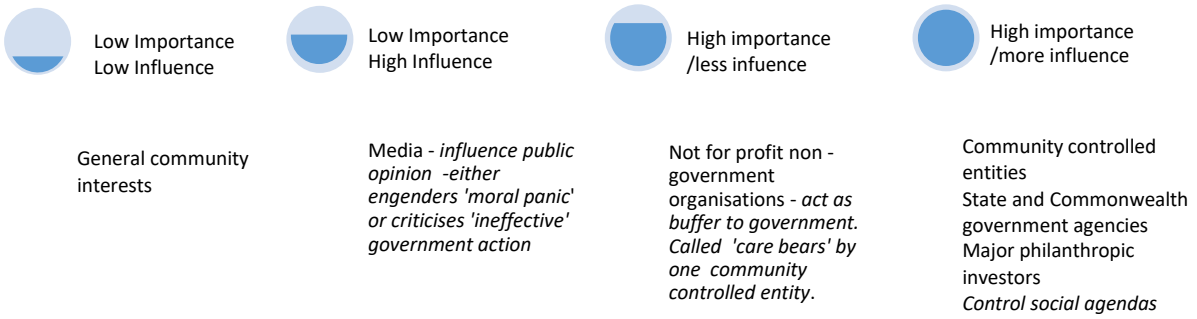

Figure 5.3: Outside community influencers

5.1.7.2 Inside community influencers

The key influencers "inside" represent those who control both local access to resources and who exercise community influence as opinion leaders. As we saw in Chapter 2, security and safety in family and community settings with equitable access to personal and family-based resources sufficient to sustain housing, nutrition, and education are fundamental "determinants of health". Community influencers are expected to take leadership roles to ensure such conditions for health are achieved and maintained in their community or family.

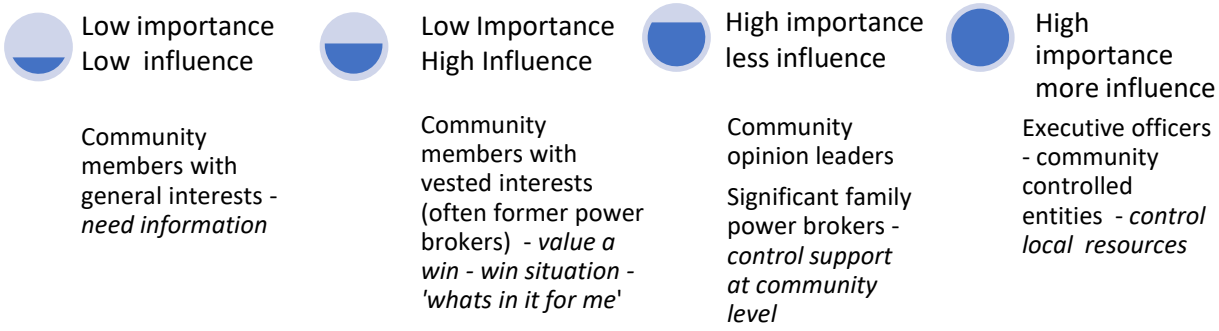

Figure 5.4: Inside community influencers

There is limited research concerning the influence of insiders and outsiders in health systems or community settings but the Yarrabah findings suggest potential to develop understandings as to how such pressures of influence impact on health behaviours.

5.2 On not "talking black" – communicating the social conditions of possibility

5.2.1 Not talking black

The concept of social recovery (whilst implicitly understood in community and governance settings) was not specifically defined by the Yarrabah Leadership Forum, which allowed some flexibility when advocating change agendas. Borrowing from the language of mental health treatments and recovery, the concepts of differentiation of self, resilience, and community-based recovery orientated care were intertwined in local responses to distress and disadvantage. When I asked in a workshop setting about whether community-based recognition of traditional cultural knowledge was envisaged as significant to conditions for recovery, a workshop participant advised, "we're not talking black now."

These underlying concepts and the disciplines from which the concept of social recovery is derived, support the fundamental relationships between mind, body and spirit which are pivotal to Indigenous wellbeing (Poroch et al., 2009). An analysis of the language of community-led recovery as defined in disaster responses (Mitchell, 2019), together with social work and mental health practice (Kourgiantakis et al., 2020) suggests that community partnerships can define a language of recovery that contributes to the creation of an intercultural domain of healing, working across disciplines. Workshop discussions revealed that choices were consciously made regarding acknowledgment of cultural sensitivities. "We're not talking black now" refers in part to the avoidance of overstating claims that cultural knowledge should drive policy change. This phrase was used in response to a question about integrating cultural knowledge into the operationalisation of social recovery. The response was qualified by the respondent saying, "this case is to government", implying that cultural knowledge may be considered irrelevant in the context of negotiating funding agreements or similar, with a choice made to use Indigenous identity selectively in the political arena. It could also be argued that a sophisticated understanding of hybrid strategic actions and decision-making processes had emerged to create the tools to help heal the community. There is a uniqueness of Yarrabah expression and syntax evident within this

phrase, and there is no comparative literature using this specific term within Australia. The cultural broker also suggested that "not talking black" might also in part mean ignoring the community "chatter" of differences of opinion over family "entitlement", and the disjunction between the historical and traditional family connection, in favour of a Yarrabah place-based approach.

5.2.2 The language of social recovery

I identified "social conditions of possibility" in Yarrabah through the workshop narratives and conversations. Bourdieu (2003) describes "social conditions of possibility" as an inevitable outcome of ethnographic research where "idiosyncratic personal experiences constitute irreplaceable analytic resources," (p. 282). I have used this term to suggested interventions by the Yarrabah Leadership Forum members that might contribute to social recovery. I regard these as "irreplaceable analytic resources" derived from workshop debate.

The cultural broker indicated that in conversations with community members outside the leadership circle, there was some level of suspicion about whether social recovery had any "hidden agenda." His view was that everyone needs "skin in the game" and suggested that "social recovery" would only be accepted if the leadership group could offer "something for everyone." The grassroots responses collected by the cultural broker, however, suggested a level of community support for full "enforcement" of noncompliance in school attendance, driving offences, and criminal damage. One of the workshop sessions agreed a theoretical proposition that "legislative and statutory compliance in law and order in Yarrabah is expected to be culturally valid and enforced in accordance with community expectation." This was confirmed in workshop discussions as an example of how resilience can be fostered from a community wide perspective to reflect expectations of social regulation as a contribution to social recovery.

Given the Yarrabah leaders are "not talking black", their specific language of social recovery used language from social work and mental health profession was unequivocal; "it will require changing community's social norms, Indigenous behaviours, the way we do things and the establishment of foundational platforms" (Yarrabah Social Recovery Plan, 2018). In Yarrabah, there was differentiation and acknowledgement of self-informed resilience and recovery, with social recovery viewed as a positive response to distress and disadvantage. Social recovery in the non-Indigenous Australian language of psychology has been more personalised and hence characterised by clinical intervention, i.e., medication, therapies, and skills training so that community members could become independent from

services. Using an Aboriginal cultural lens, recovery has been seen as being based on the relationship between mind, body, and spirit and recognised as a collective responsibility.

Workshop participants suggested that social recovery priorities were to "keep kids in school ('and get them there first')", that "family and school must work together", and sought to "look after our families, get rid of anger and neglect", suggesting that "everyone takes control of violence and damage." They also sought "more jobs started in Yarrabah", and to "look after the care givers, get them some money." From an insider perspective, my observations were that to the Yarrabah Leadership Forum members, "changing the way we do things," included taking back "community control" of services and re-focusing them on Yarrabah principles and values, acknowledging a deep connection to land, community ownership, and a contextual understanding of historical, social, and cultural factors which underpinned the community.

Data obtained during my fieldwork showed that the YLF advocated for a framework of social recovery based on human rights. A social model of inclusion was discussed, recognising that basic needs (housing, education, employment, peer support, etc.) are a prerequisite to deeper emotional and psychological development that may lead to significant social recovery at the community level, together with the creation of personal hope and a sense of self for the individual. A recovery-oriented vision that centres the lived experiences of community members in service delivery and social recovery was sought (Harper & Speed, 2012).

In Yarrabah, I found that lived experience was fundamental to the success of the women's group as a stable influence in social recovery over many years; "we are just here (at their meeting place) every Tuesday; anyone can drop in and talk." "We have been around a long time, we know everyone, we know what happens." The founders and active participants comprise Elders who are also traditional owners and also long-standing historical residents. Their leadership role in restitution initiatives for the Stolen Generation survivors in Yarrabah and in developing suicide watch and prevention, has been respected for more than twenty years, confirming that respect for Elders is fundamental to the recognition of healing. The men's group members were pioneers in early Family Wellbeing training and work by the principle of healing within yourself. I found that men's and women's support groups function as experts-by-experience to heal their communities in this mode. These findings are consistent with previous research, such as Dudgeon et al., (2020).

Within mental health disciplines, there is debate that recovery is not about "getting better" or ceasing to need support – it is about "recovering a life" (Slade et al., 2014). Clinical endeavours tend to focus on changing people through treatment (drugs and coercive interventions; cognitive therapy, skills training, etc.) so that they become "independent" of support and services. The alternative requires a framework predicated on human rights and a social model of inclusion; fostering personal hope and sense of self, integrated with services that respond to the social determinants of health discussed above. The nuances of these experiences are so specific to Yarrabah people that resolution requires locally driven advocacy sustained by in situ governance networks.

5.2.3 Yarrabah directed approaches to governance

The Yarrabah governance entities engaged in service delivery for local government, health, justice, education, and employment utilise their governance platforms as cognitive tools of compartmentalisation. This process enables people to organise practices, events, and networks into discrete units or categories, which have their own "properties of separation" (Spiro & Jehng, 1991; Strauss & Quinn, 1997).

Cognitive compartmentalisation in practice between these organisations isolates conditions of potential conflict or dissonance. This allows alternative ideas or behaviours to be observed within each organisation, without either being undermined or elevated over the other in Indigenous governance and cultural practices. Cultural referencing for healing practices and the possible use of traditional healing are not explicitly aligned with either the drug and alcohol rehabilitation service or the community-controlled health service. However, these services have overlapping obligations in the recovery process with the specialised addiction management services of the former, allowing a personalised respite service. This can serve as a circuit breaker in family tension and personal recovery. While a family member is in residential rehabilitation, it is not uncommon for them to receive family-based therapy and intensive personal health management. However, taking a holistic approach to recovery is not without pressure on the organisation, with participants identifying that "we have to take responsibilities beyond our role, like transport, food, personal care," and "we provide a lot of diversion in the justice system, our funding doesn't recognise value of this." The independence of each organisation is highly valued, "we can work together or separate." The concept of a healing and life course journey across service delivery boundaries is a Yarrabah aspirational goal expressed in the workshop series.

5.2.4 Condition of possibility – address discourses of deprivation and create healing journeys

Health and wellbeing are given cultural depth within Yarrabah through the language of the Family Wellbeing programs in both the drug and alcohol rehabilitation service and the community-controlled health service. These programs seek to define the components of healing outside a clinical space. Exploring personally held barriers to, and enablers for, change creates narratives where emotional responses are paramount. This personal empowerment approach which creates focus on human needs, life journeys, relationships, conflict resolution, dealing with emotions, crisis, loss, and grief, is linked to personal beliefs, attitudes and responsibilities to family and community. The potential healing journeys are conceptualised within the workshop material as "pillars" – "they will hold up the community." A sketch example is reproduced below (Fig. 5.5), showing the conceptualisation of the dynamics of the journey, in this case, family support, with multiple inputs and interaction with government, local governance, and community settings.

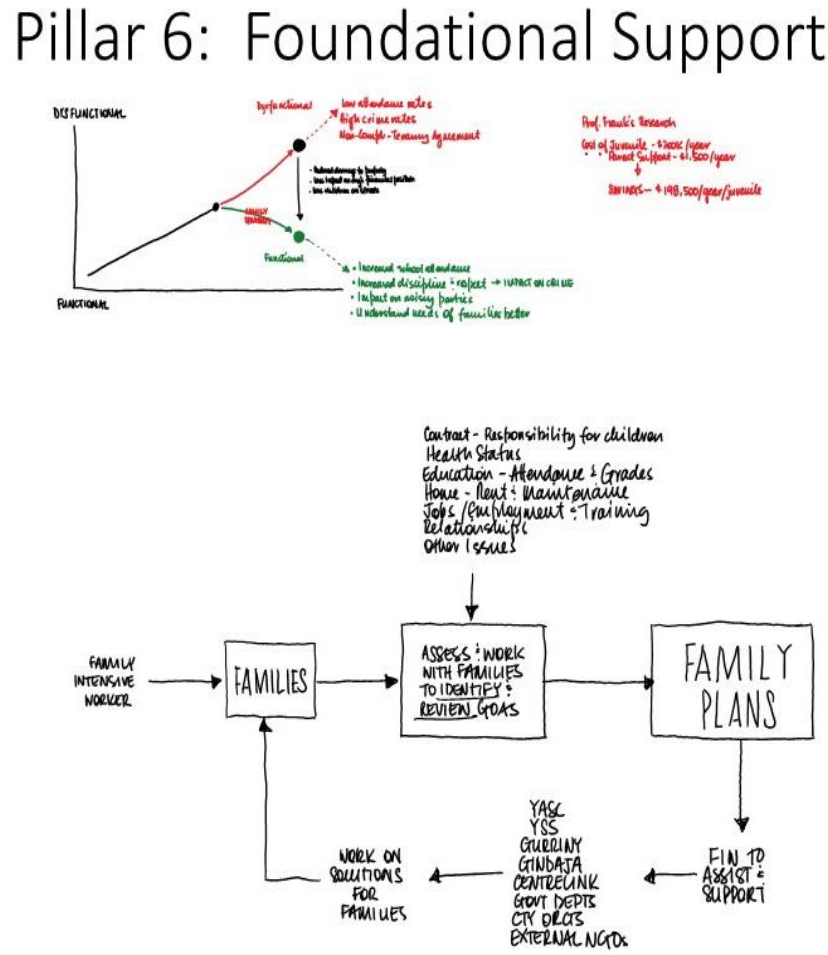

Figure 5.5: Extract from Workshop Briefing Paper: Yarrabah Leadership Forum 2018 – reproduced with permission

This diagram shows how deficit discourse that situates Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency, and failure (Fforde et al., 2013) can be articulated so that "we can take control."

Fogarty et al. (2018) suggest that a deficit discourse is currently a primary influence on policy formulation and a key input to media representation of Aboriginal people and their way of life. Within a discourse of deficit, indicators such as public health, mortality and morbidity statistics suggest that "illness" is fundamental to Indigenous identity and disadvantage becomes a narrative of failure and blame (Fogarty et al., 2018). This negatively affects the health and wellbeing of Aboriginal and Torres Strait Islander people by contributing to institutional and community-based racism (Fforde et al., 2013).

Halperin and Pliskin (2015) argue that continual reporting of negative stereotypes and prevalence rates can reinforce undesired behaviour. If the view that Aboriginal people as

groups or individuals are deficient subjects (see Altman & Fogarty, 2010) dominates, then limited attention may be given to innovation or autonomy in program delivery. Indicators of inequity then become associated with Aboriginal people with expectations of lower educational achievements, overrepresentation in the criminal justice system, pathological violence, and propensity for addictive behaviours. There is also a danger, however, that the alternative narrative of strengths-based approaches may place too much obligation on individuals and small groups at the community level to participate in or deliver resilience focussed programs or else overtly adopt stances that exhibit externally defined notions of resilience. Such programs fail without structural attention being paid at local or State governance level to address the fundamental inequities of poor housing, education, and employment (McLachlan et al., 2013). In this space, the Yarrabah Leadership Forum maintained strong advocacy positions concerning the need for social investment.

To discuss perceived deficit further, the terminology of *discourses of deprivation*, suggested at a Yarrabah workshop, is preferred, rather than further substantiate a deficit discourse narrative. These workshop participants displayed an in-depth understanding of legislation and governance processes that would influence how services were planned and delivered from "outside". The expressed desire in the meetings was to reframe the deficit discourse to one of equity and justice. Yet, rather than engaging in a discussion nuanced towards an Indigenous knowledge framework of kinship and connections to place integrated to service delivery, the workshop participants sought what they referred to as "real-time, localised data"; "We want to know, who's in school, jobs. We want to know, who's got qualifications but sitting at home? Who could afford to buy a house but takes up a public (Council owned) place?" This desire for the fine grain of (possibly) personalised data suggest that considerations of "internalised blame" or perceived unfair advantage amongst community members might still disrupt social recovery aspirations, unless such data are used positively for targeted support.

Within that frame of targeted support, community-based workers in social recovery agencies in Yarrabah displayed a detailed and unambiguous understanding of the scale of need in family welfare and how this affected health and wellbeing. This included the personal capacity of individuals and families to nurture healthy children. Local agency representatives met to discuss development of an intensive in-home family assessment and life skills education program. The meeting had a proactive dynamic, with attendance by representatives from a number of agencies and entities involved in employment and education support, together with community driven bodies facilitating wellbeing programs.

Support offered by these entities ranged from integrated case management for families with identified risks (including child protection and domestic violence) through to day-to-day support in access to employment and education. These included improving job ready skills, countering the effects of disrupted education, and meeting the emotional needs of very young parents who experienced boredom, through providing structured activities. The intergenerational ripple effect where the care of small children frequently fell to grandparents was identified as a gap in services. Many of these older carers were described as being in poor health, functioning with poor personal mobility, and receiving limited targeted financial and practical support. New expectations of cultural authority, family leadership, and challenges of caring responsibilities as younger men become fathers were also discussed as areas of unmet need.

5.2.5 Condition of possibility – "call out crime" -the priority of community safety

The Yarrabah Leadership Forum believes that healing is embedded within concepts of Indigenous justice, as is evidenced by the integration of the community justice support function within the drug and alcohol dependency rehabilitation service within the Yarrabah community. This demonstrates the intent that healing and recovery must be part of a collective approach that responds to community dysfunction and disharmony (Cuneen 2018, p 17) while nurturing self- identity, kinship and spiritual responsibility (Cuneen 2018, p 16). To achieve this harmony the police and court systems are expected to respond to community aspirations as to how criminal behaviour is dealt with in the Yarrabah setting.

Community opinion in Yarrabah on the impact of crime and theft on personal and community wellbeing has been discussed in 5.1.5. Yarrabah workshop participants sought fair and responsive approaches by the police to crime within the community. Anecdotally however, stories were told about slow and ineffective response times to emergency calls and failure to initiate cultural protocols of reprimand for underage alleged perpetrators of crime.

Dwyer et al., (2021) confirm that

> "In discrete Indigenous communities, the strong police presence and distinct racial differences between police and the community assist in the formation of an exclusive and 'closed' police culture. Often the police see themselves as strangers who merely pass through such places. This can present significant barriers to integration and localistic policing styles." (p. 220).

Dwyer et al. (2021) also observe

> "Relationships between police and discreet Indigenous communities remain symptomatic of the deep and fractious wounds of colonisation, which are yet to be meaningfully resolved in Australia." (p 221).

Yet Yarrabah participants persisted in seeking resolution of the troubled relationship between Yarrabah people (especially the youth), police and the criminal justice system generally. Community members identified issues, ranging from community operations of the police to court proceedings and prison systems. Disruptive, antisocial youth behaviours, including late night noise, excessive drug and alcohol consumption, theft, violence, property damage, and assault were ongoing conditions of community unrest. Community-based workers iterated how issues such as ineffective parental care, generational family conflict, violence, and marginalization, significantly contributed to criminal activity amongst the youth population. As a result, participants were keen to report that their expectations of the police and real-time responses to crime were not adequately met. For example, where a twelve-minute police response time is the mandated regulation, anecdotal evidence reported an average wait time of 30-60 minutes. One suggested solution included a substantial after-hours task force led by respected community members. The group would be responsible for maintaining social responsibility in the wake of a youth offender in a restorative justice process that would involve both the youth and their families. Complementary programs, including the addition of a safe haven (drop-in centre) as well as a mentoring program for emerging generations, complete the vision. There are expectations that the recently opened Youth Hub may provide these capabilities. Additional community empowerment models that were suggested included delivering court proceedings in Yarrabah, ensuring adequate Yarrabah support within the court systems and at the point of reintegration. These suggested enablers for change could provide pathways for Yarrabah employment, much-needed representation in the criminal justice system, and equitable support for some of Yarrabah's most vulnerable citizens. To that end, the workshop call was for a re-evaluation of the intersection of Yarrabah community expectations, social justice, and the role of the criminal justice system, namely the police. This was considered to be fundamental to a shared understanding as to how agreed direction as to how community safety can be secured was implicit in a healthy community.

A number of other detailed suggestions were identified regarding court procedures in Cairns, including identifying cases and situations suitable for Murri Court. This included

asking if that court system could be delivered in Yarrabah; reviewing the effectiveness and supervision of community service orders; ensuring adequate court support through the Community Justice Group; and providing for community reintegration after prison. A review of the Alcohol Management Plan was suggested with a view to making Yarrabah a trial dry community. However, results from investigative work and community surveys in Queensland communities with Alcohol Management plans by Clough et al. (2017) found that, whilst residents agreed that violence against women had reduced and that personal safety had improved during alcohol restrictions, criminalisation and binge drinking had increased. Other community interests in Yarrabah are ambivalent concerning stricter measures than the restrictions on alcohol carriage limits that currently exist. Any wellbeing argument therefore requires a localised assessment of net health benefit.

Workshop participants discussed the profile of criminal offenders as being very young, with early intervention (including outreach, mentoring and community education) described as tools to ensure "reach" to emerging generations. Discussion ensued as to whether a curfew, night patrols, and/or fully monitored CCTV might at least identify children and families at risk of criminal behaviours. Reinforcing social responsibility together with enforcement of domestic violence and child protection orders, along with monitoring patterns of truancy, was mentioned. Creation of diversionary activities such as holidays, camps, and after school hours activities have shown success in crime rate reduction during hours of operation.

5.2.6 Condition of possibility – 'the effort is worth it in school'

The Yarrabah Leadership Forum sought statistical evidence on school attendance, behaviours, academic performance, and post school achievements (such as vocational and tertiary education entrance and attainment). This would contribute to a community dialogue that "the effort is worth it" in supporting children through the school years and to understand the extent of failure in the system. The group suggested that targets and personalised learning/achievement plans were important, with particular mention made of identifying the number of children leaving school having participated in school-based training. Participants also recognised that involvement in sports teams and individual representative activities, together with extracurricular activities (e.g., music), should be valued. There was a clear understanding and high expectations expressed concerning the activities of those bodies responsible for the "cradle to career" pathway, including health and early childhood providers, those supporting school attendance, and the response of institutions regarding

improved training and academic pathways. There was a frank discussion that Yarrabah community aspirations concerning education are not uniformly shared, and that school curricula may be seen as irrelevant or useless. It was considered that an aspirational framework for school should be developed, reinforcing the need for preschool and school attendance to set lifelong pathways, and emphasising self-identity and the core values of telling right from wrong, together with providing a safe space to celebrate success.

The place of school in delivering child and adolescent health checks was confirmed, with out of school initiatives such as breakfast programs and culture camps mentioned positively. The group believed broadly that learning cultural skills such as dance, art, hunting and bush tucker collection had a place in school time alongside working with Elders. The concept of teaching "Yarrabah studies" was also suggested as an extension to the Gunggandji language program taught in primary school, so that language is embedded in traditional cultural practices and knowledge of the history of Yarrabah. The question of particular skills acquisition was again reinforced with vocational trade training pathways, specifically craft, woodwork, and mechanics mentioned as desirable school activities.

There was broad agreement that dysfunctional families "stay outside the gate." A number of opportunities for more effective management of school education were suggested, including that identification of attainment and learning abilities need to be identified from early childhood, in partnership with parents and responded to by individual attention through school years. Parental involvement must be nurtured and options clearly stated. For example, a kindergarten attendance model where children attend on different days over a fortnightly cycle was considered confusing, resulting in sporadic participation.

5.3 Conditions of possibility and a social ecology of healing in Yarrabah

5.3.1 Changing life course trajectories.

The paradigm of conditions of possibility suggests that the community of Yarrabah believe that exerting different levels of influence can change life course trajectories. Research into life course epidemiology addresses complex interactions over time between a range of social determinants and outcomes (Burton-Jeangros et al., 2015). The interdependence of linked life circumstances and health behaviours suggests a synergy with the propositions of models of social ecology, which analyse system dynamics within the life course.

To elaborate on my interpretation of this adapted model, I vary Bronfenbrenner's definitions and the diagrammatic representation of the dynamics between the systems. The

individual sits within a tangible microsystem of family, kinship, and place, where interpersonal roles and relations are played out. Prevailing conditions within this microsystem may vary between deprivation, cultural cohesion, and strong social support networks. Individuals develop identity from interactions with significant persons, places, and cultural symbols of ritual and belief. Emotions are intuitive responses and caregiving and peer relationships determine resilience and self-esteem (Tugade & Fredrickson, 2004). The identified mesosystem of alternate viewpoints within Yarrabah is an interactive space between microsystems in which individuals participate. This space encompasses tension between life-worlds of ancestral belief and modernity, insider and outsider conflict and influence, and disconnect between neoliberal and Indigenous viewpoints. The discourse of deprivation is manifest here, turning disadvantage into moral failure rather than constrained opportunity. Within Yarrabah's exosystem of the cultural lens, "not talking black" ensures that local leadership create a community referenced language of healing and social recovery, based on Indigenous viewpoints of historical, social, and cultural disadvantage. This leads to the macrosystem of the intercultural domain, an "in-between" space, characterised by hybridity where "new signs of identity, and innovative sites of collaboration" exist. Yarrabah's chronosystem references the cumulative community impact over recent time of mission establishment, forced relocations, and human rights infringement.

5.3.2 Creating holistic space for healing in Yarrabah

Within Yarrabah, the Leadership Forum fostered a notion of healing where treating disease defined by clinical parameters was only part of the healing journey. The holistic space of Yarrabah healing does not fall within the category of traditional healing as seen in Aurukun. Yarrabah participant comments suggested that their framing of healing could be viewed as a wellbeing focused, social recovery approach that closely responded to the model developed by Stokols (1992, 2003). The empowerment of community members was an integral part of this social recovery. My analysis of field observations and workshop notes suggested that within a construct of social recovery, programs of personal and family wellbeing work first through understanding personal situations of ongoing grief and trauma that influence coping styles. Such situations may lead to mental distress and anxiety. Self-medicating such conditions may be sought through drug and alcohol use, which can become out of control. Stress, anxiety, and/or mental health disorders can trigger associated anger or lack of control that can lead to criminal behaviour. The dynamic of family interaction in the

narratives derived from Yarrabah participants show that strong families nurture personal and community development that can withstand such pressures or at least provide support for healing. Despite this, there are strongly judgmental opinions about family function, repeated at peer-to-peer level within the community. Where these opinions are publicly aired, they create divisiveness and mistrust, reducing the opportunity to create a healing environment.

At leadership level, however, collective physical and social expressions of commitment to better health are evident. An example is a co-located health hub which combined facilities to provide clinical services, counselling, and social and emotional wellbeing programs, with youth hub providing age-appropriate outreach, medical, and social development services. The drug and alcohol service are now additionally and collaboratively seeking funding to co-locate a specialist outreach service providing screening, addiction management outreach, and pathways from rehabilitation into the community. This is an example of a community coming together to give substance to a "healing centre vision", first developed in 2015 under the aegis of the Healing Foundation (KPMG, 2012). The advantage of this "cognitive compartmentalisation" in implementation means that there is something for everyone, and that family and intra community political allegiances can align with the different governance structures. At a professional level, the services can interact whilst maintaining unique reporting focus.

Bernie expressed his own view of what this holistic third space might look like in a physical setting:

> "You walk in the door. You are greeted in your language and it's explained that you can turn left for traditional healing or right for Panadol or needle for babies. Your family might be with you. You go left and you can lie down a while, then the healer comes. He can growl at everyone to go away if he wants. He looks at you and finds something in your belly to be taken out. So, he sings and puts his hand on your belly and you feel better. You can lie down for a rest before you go home. Or sit by a fire out the back. If you turn right inside that door, there might be a queue, but you will get some medicine, you might have to travel for a scan or to see a specialist, you might not know the doctor, you might have to go alone. You have a choice anyway."

5.4 Conclusion

This chapter has explored how Yarrabah leaders define healing through a wellbeing focused, social recovery approach. The spirituality of the Yarrabah community members has been closely aligned with Christianity and the evangelical practice of being "born again," created some disconnect with the healing beliefs of the Gunggandji traditions. However, the creation of strong ecumenical leadership in Yarrabah provided a sense of self identity for the descendant of the Stolen Generations who are regarded as historical owners. Traditional ownership is now defined by native title determinations with Gunggandji language and traditions reclaimed including in traditional land and sea management practices.

Social and emotional wellbeing initiatives have become an integral part of holistic healing which manifests itself in healing hub. Co-location of health services responds innovatively to youth health, creates pathways for recovery from drug and alcohol abuse and ensures that clinical services are designed and delivered from Indigenous viewpoints. The ecology of healing in Yarrabah is characterised by the resolution of alternate viewpoints which encompasses tension between life-worlds of ancestral belief and modernity and conditions of insider and outsider conflict and influence.

Yarrabah leaders are aware of their responsibilities to create a collaborative healing dynamic by addressing the social determinants of health, seeking a supportive school environment and a collective approach to crime prevention that involves mainstream justice partnerships. This is sought to be achieved through Indigenous direction and control.

Chapter 6: Conclusion

6.1 Overview

The research sought to explore the perceptions and experiences of Indigenous people in North Queensland regarding traditional healing. This study was conducted across two disparate Indigenous communities with the aim of gaining access to a breadth of experience and opinion. Narrative and commentary from participants were interwoven to privilege the indigenous voice. The findings are detailed in chapters 4 and 5, presenting the constructs of healing explained by healers, knowledge keepers, leaders, and community members in Aurukun and Yarrabah, together with discussion as to congruence or alterity of the findings with those from scholarly literature.

6.2 Answers to the research question

What are the perceptions and experiences of Indigenous people in North Queensland regarding traditional healing?

By listening to the stories, opinions, and perceptions of those involved in healing in these two Indigenous communities in North Queensland, the significance and meaning of language, belief, and experiences of dispossession and dislocation from culture were identified.

In Aurukun, there is clear evidence of active practice of, and access to, traditional healing, which is defined by ancestral spiritual beliefs. Some research participants were practicing healers who self-identified and were also acknowledged as such by community members. Other knowledge keeper participants included a sorcerer, a songman, and Elders as guardians of indigenous cosmology. Participants also included emerging leaders and all provided extended narratives concerning life, ancestral belief and healing.

Personal constructs of healing within the Wik belief system accommodated pluralist interactions with biomedical services, but there was also an awareness of the presence and influence of the ancestral Spirit World. Such beliefs significantly differentiated individual expectations of healing. clinical practice, creating tension or uncertainty.

The place of traditional healing in Aurukun was overt and specific, yet it is precarious in terms of knowledge retention and intergenerational transmission. The research was unique

in its access to the opinions of healers and knowledge keepers, who may have hidden identities, and finite energy or interest in revealing their expertise. It is clear from the narratives that core Wik values and practices around identity, social relationships, cultural and spiritual norms, and the nexus between land and people, have been altered by the disconnection from spiritual landscapes and associated traditions. However, such values have not disappeared. The status of knowledge keepers is safeguarded within community settings by a strong intergenerational presence and is redefined through art, performance, education, and cultural governance. The continued primacy of Wik Mungkhan as the first community language provides an opportunity for the unique language of dis- ease or "not being yourself," including expression of idioms of distress, to be recognised within health systems operating in Aurukun.

In Yarrabah, a community heavily influenced by its mission history and the Stolen Generation assimilationist policies, illness or dis-ease has been identified as a series of social conditions and risks. Therefore, healing was defined by the community through a series of conditions of possibility that informed responses to those risks associated with social determinants of health. These responses have been and continue to be represented through narratives of social recovery that underpin approaches of local Indigenous governance in the health and wellbeing arena. In Yarrabah, healing functioned in amongst the dynamics of traditional and historical connections with community history, family affiliations, and those who "speak for the land" through native title governance. Cultural transmission of knowledge was a contested space, aligned with traditional ownership. The practice of "not talking black" gave recognition to the strategic value of non-Indigenous forms of expression in making "a case to government." While considering issues of wellbeing, the language of wellbeing and social recovery was collectively acknowledged in health services and embedded in creating individual resilience.

6.3 Commentary on key findings

Within Aurukun, the presence and influence of the spirit world was fundamental to personal understanding of healing. Broad recommendations for recognition of Indigenous spirituality in healing exist in Australian literature (Dudgeon, 2017; Fleming & Ledogar, 2008; Poroch et al., 2009; Tripcony, 1996). The difficult next step is understanding whether the continuum of Indigenous spirituality, traditional healing, ritual practices together with use of traditional medicines might be recognised by primary health care and hospital clinical

treatment regimes. Ohajawuna (2019) presents a comprehensive case for positioning African Indigenous spirituality within formal health care practice, whilst overtly stating that a significant barrier will be negative or stereotypical views of Indigenous spirituality and traditional healing from mainstream health care professionals. Yet his research leads him to state unequivocally that "within Indigenous communities, there is no separation of spirituality from healing practices" (p 307).

This statement would have resonance within Aurukun. Practices of traditional healing are inextricably linked with managing the interface with the spirit world, recognising the roles of the ancestors and acknowledging places of totemic power as focal points for healing. Extant knowledge provides strong base from which to build an intercultural domain of healing. Data from field notes, narratives and observations of this research demonstrate that cultural continuity exists, and that new representations of culture and hybrid constructs of healing are able to emerge. However, it was observed that during the fieldwork that opportunities to sustain cultural power relationships and the skills to control of ancestral forces are abilities that are disappearing as Elders die.

Indigenous communities such as Yarrabah were established after forced removals from ancestral land. Reconciling the consequences of historical and traditional association with place appeared to shape the localised construct of healing, which was informed by concepts of enhancing social and emotional wellbeing at both family and personal levels. This construct seeks to reduce risk associated with social determinants of health such as criminal behaviour, addiction, poor housing conditions, and food insecurity. The Yarrabah model of social and emotional wellbeing is compatible with Indigenous psychological frameworks which evince interconnectivity between body, mind, emotions, family, kinship, community, culture, and country (Gee et al., 2014; Dudgeon and Walker, 2015; Poroch et al., 2009; Social Health Reference Group, 2004).

In Yarrabah, cultural continuity may be defined by family connection, rather than cultural knowledge, with insider/outsider status determining power and influence. To accommodate these social dynamics, the research created a nuanced examination of insider and outsider influence at the community level. It was found that the question of influence and power in terms of jobs, decision making, and financial advantage is closely scrutinised by community members. The literature (Bruskin, 2019; Naaeke et al., 2011) tends to regard insiders as having connections within their ethnic group, while outsiders are perceived as (non-Indigenous) externalised actors and influencers. Conversely, this study demonstrated that an outsider can be a valued and influential community member, yet not embedded within

power structures of traditional ownership of land and maintaining a separation of family life. Likewise, an insider can be from a "power- broking" family with a history of significant influence in community leadership, but with no ancestral connection to country. The question of influence and agency is embedded in the Yarrabah narratives, related to community opinions of equity of access to localised resources that impact on family safety and security and, implicitly, on potential to live a life better connected to the opportunities of a healthy life course.

6.4 How the research informs a social ecology of healing

Grzywacz & Fuqua (2000) describe the value of articulating social ecologies of health to identify unique leverage points within the psychosocial environment that influence healing across the life course. Within this research such leverage points are the focal points shown in Diagram 5.6. These leverage points may act as barriers or enablers to change in health systems. This adaptation of the social ecology model informed by this research shows enhanced thinking concerning the components of microsystems and mesosystems. This adaptation sought to re-contextualise the existing models of Bronfenbrenner (1986) and Stokols (1992) by incorporating findings that concerned the detail of interactions in healing together with perceptions and observation as to how healing might work.

Diagram 5.6 seeks to capture the dynamics of ecologies of healing at community level Within both communities the proximal processes of the tangible microsystem of family, kinship, and place, where interpersonal roles and relations are played out were explained through narratives and feedback. Particular focal points then differentiated the perceptions and experiences of participants.

Within the Aurukun focal point, Wik ancestral belief underpinned an intangible microsystem of interaction with the Spirit World in a manner unique to those of Wik descent. The circumstances of this interaction altered the trajectory of experiences of healing, specifically in relation to mental health disorders but also in relation to belief as to the causes of ill health and the nature of treatment.

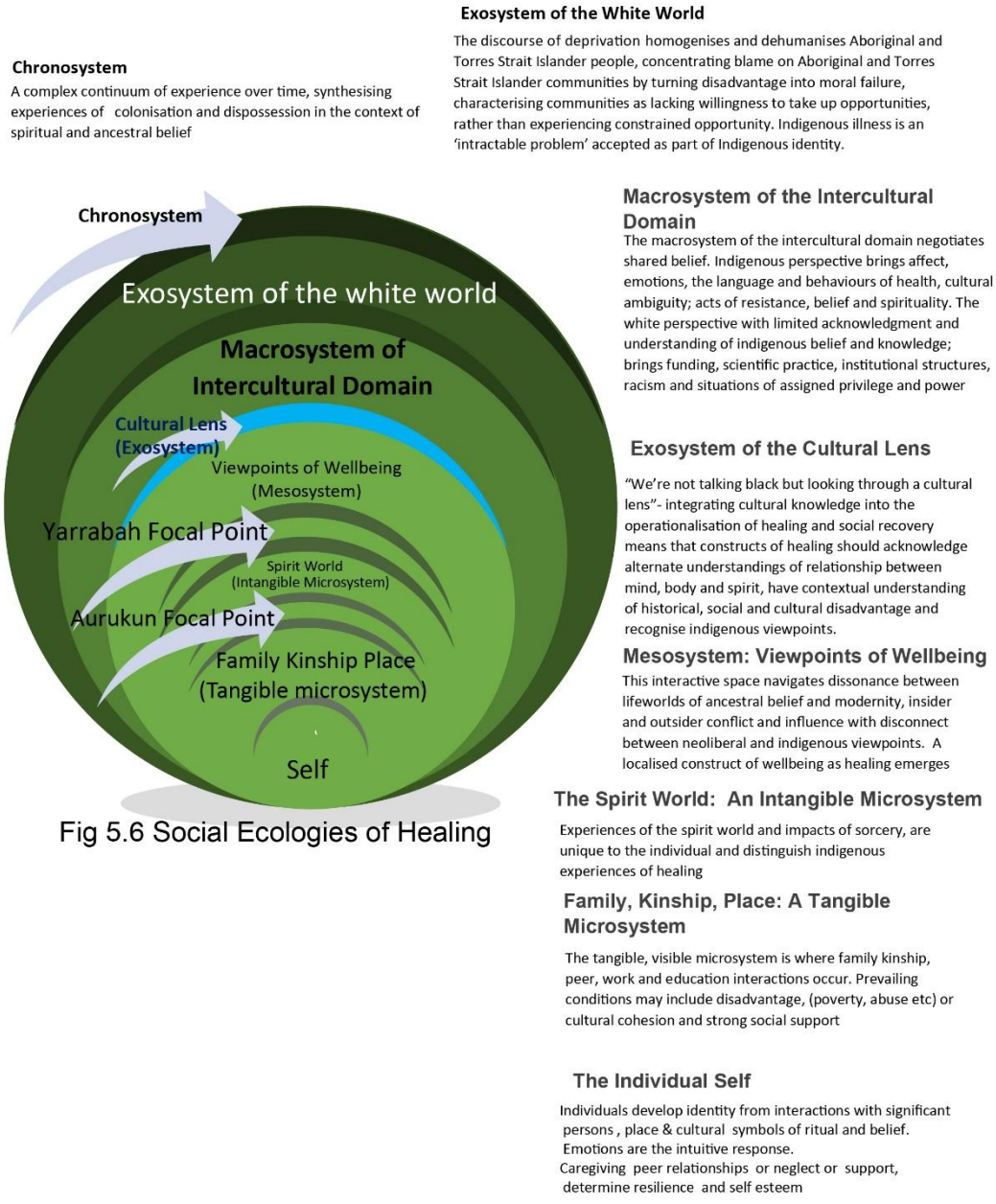

Figure 6.1: Social Ecologies of Healing

Within the Yarrabah focal point, I identified the mesosystem of alternate viewpoints as an interactive space between the microsystems in which individuals participate. This space encompasses tension between life-worlds of ancestral belief and modernity, insider and outsider conflict and influence, and disconnect between mainstream and Indigenous viewpoints. Within Yarrabah's exosystem of the cultural lens, "not talking black" ensures that local leadership create a community referenced language of healing and social recovery, based on Indigenous viewpoints of historical, social, and cultural disadvantage.

For both community settings, there is macrosystem of the intercultural domain, an "in-between" space, characterised by hybridity where "new signs of identity, and innovative sites of collaboration" exist.

6.5 Seeking Indigenous viewpoints regarding components of an intercultural domain of healing

The research created a number of findings and potential discussion points that could be explored in further community-based research. There are also key messages about how the importance and meaning of spiritual beliefs and the languages of healing in community settings are communicated to mainstream health systems. Indigenous communities may wish to withhold or sequester cultural information.

6.5.1 Discussion point: can an intercultural domain of health be created in local settings?

Within Yarrabah, the research found that the transition to community control and Indigenous leadership of services has traversed the intercultural space for the last twenty years, moving cultural differences from being a "problem" to a discourse that promotes the sharing of ideas, robust discussion, and practical solutions that engage cultural differences. In Yarrabah, this is almost certainly the space where you are "not talking black". An intercultural domain of health has already been created at the Yarrabah community-controlled health services level, creating an interface between biomedicine and culturally defined healing practice, based on the Yarrabah model of wellbeing. Haynes et al. (2014) recognise that within an intercultural space, communication will be effective if grounded in place and relationships. In an intercultural domain of healing, healers and knowledge keepers both Indigenous and non-Indigenous, must be able to protect their own spaces professionally

and culturally. A psychology of expression and language could be used to address emotions such as anger or fear in creating partnerships, but a vocabulary must be established.

6.5.2 Discussion point: how can the language of healing at the local level be recognised?

Wik language descriptors that frequently describe their condition in terms of emotional responses to everyday life (as identified and explained by Martin, 2003) and as idioms of distress were encountered during the research. Wik language does not identify words for ill health and an Aurukun informant explained that there is no Wik word for cure. Wik language demonstrates congruence with descriptors for diagnosis of disorders by traditional medicine practices as included in the International Classification of Diseases, 11th Revision (ICD-11) (Regier et al., 2013). Wik people, during interviews and conversations, frequently described illness by referring to an emotional response such as *ngangk kul /kulangam (adv.* Really angry; anger in one's heart); *kemp wir'* (dangerous from sickness or from a fright, or referring to the extreme weariness of body) (Dictionary and Source Book of the Wik-Mungkan language; Kilham et al., 1986).

The likelihood that Aboriginal people are using emotional descriptors in reference to health informs biomedical interpretations of the prevalence of mental illness which is often identified through what is defined as disturbed behaviour. Within the Indigenous population, indicators of disturbed behaviour include: wandering around at night; talking incessantly; sleep disturbance; hearing voices; breaking taboos (e.g., mentioning the names of dead people); frequently moving between communities; keeping out of normal social interactions; sleeping anywhere; and appearing angry, restless, frustrated, mistrustful, bored or lonely. any of these behaviours have specific descriptors in the Wik language, which suggests a “cultural currency of idioms of distress. In Aurukun, such behaviours may be attributed to disruption to ancestral relationships between individuals and place that adversely affects identity and wellbeing. Such behaviours are unlikely to be expressed in English in a community clinic. There are seven categories of disorders listed in the “anxiety disorder” section of the new DSM-5 criteria (Regier et al., 2013), which closely parallel descriptions in the Wik language. This reinforces a recurring theme throughout this research, which recognises that Indigenous and Western healing practices and understandings of health are not mutually exclusive.

In Yarrabah, the question of the language of wellbeing and social recovery is no less significant. Using their own experiences of promoting and teaching wellbeing over more than thirty years and creating new meanings for language derived from psychology and sociology,

a collective understanding of wellbeing that underpins much service delivery has emerged. The principle of health equity to be espoused in Queensland health system redesign would suggest that understanding how good health and healing are defined and expressed at local level to be a priority in progressing intercultural partnerships, (Queensland Health and Queensland Aboriginal and Islander Health Council 2021)

6.5.3 Discussion point: Should bush medicine continue to be used and under what circumstances?

The Wik perspective on bush medicine, supplied by FLE7, was as follows; "some of those things you get in the bush, an itch, sore throat, a sore (*boil or lesion on the leg or arm*) clear up pretty good with a tea (*a plant infusion*) or a paste *(poultice).* One of them paste, you take bark and chew it, put it on sore, tie on with leaves, grass, leave it till it falls off. Better than Band-Aid. Sometimes that stuff might taste bad or look funny and it might be slow – I'll get back and get some antibiotics, thanks." Another respondent (MLE5) said of bush medicine, "There is something in it . . . that is good for your insides, just as a cleanser. Makes all your body organs healthy and strong, it gets rid of all your internal stress."

In Yarrabah. bush medicine is believed to relieve stress and to act as a cancer therapy that simultaneously prevents, treats, and palliates (for terminal patients). There was some debate about climate related changes to bush and forest structure that was believed to affect availability of some key plants. A complex supply chain of favoured plants was being sourced from remote locations. It was generally stated that mainstream doctors would not be advised if bush medicine was being used.

6.5.4 Discussion point: Know that the practice of sorcery can be implicated in illness, mental disturbance, suicide and the perpetration of violence, including murder

Health services need to ensure that contemporary clinical Indigenous psychiatry and psychology recognises the traditional practices of Spirit World retrieval and protection. Fear and suspicion of sorcery were prevalent within the Wik community, as observed in ethnographic research (Martin, 2008). Sorcery was consistently referred to by participants in the context of illness or misfortune, either from the victim's experience or the healers' mitigating actions. Aurukun sorcerers are generally considered to steal the victim's bodily matter, such as hair, blood or faeces, and subject them to rituals designed to inflict harm (TH1, pers comm.). Wik healers are known to counteract such actions and to discern when sorcery has been at play, although no exploration has been undertaken through research as to

the comparability of diagnostic regimes with biomedical practice. The Wik healing process is esoteric; finding the source of the stolen matter and destroying it is most common, and there are a few comments about the removing of foreign objects from a person's body. More frequent are stories of spirit influence and possession, and the "dead but walking" characteristics of those who have strayed or been abducted to the Spirit World. Here, the current Wik healers talk confidently of retrieval of those that have "wandered off" into the Spirit World.

One example from this research is found within the potential of traditional healing practices to lead psychiatric screening and diagnosis. Many of the narratives implicitly or explicitly referred to culturally conditioned beliefs or unique idioms of distress. The healers interviewed focussed on treating spirit possession and Spirit World soul retrieval or dealing with psychosomatic conditions such as abdominal bloating.

6.6 Limitations of the research

One of the most obvious limitations of this study is that as a white researcher I do not have an Indigenous viewpoint, by virtue of my cultural background. While every effort was made to ensure that the participants were given a voice, and that this voice was understood with the help of the cultural broker, there is nonetheless a subjective element involved in this type of research. It may be that I unconsciously gave too much weight to some opinions over others, which may have slipped through the safeguarding measures intended to prevent this challenge of representing opinions.

The main focus of the study was to investigate Indigenous opinions and beliefs about healing. As these beliefs were extant within settings where biomedical services were the dominant form of health service delivery, an effort was made to gain insights from biomedical practitioners regarding their views on Indigenous culture and healing. General practitioners encountered by the researcher offered limited support for contributing to the study, citing other more pressing priorities although in community settings, health practitioners were prepared to offer commentary on their personal encounters with traditional healing practices. Finally, the Traditional Owners and native title holders of the regions discussed in this report have not yet had the opportunity for comment on this document. The discussion points outlined in section 6.5 are a starting point for such dialogue which can potentially form part of a future research agenda as to support for the integration of traditional healing within biomedical services in Indigenous communities.

6.7 Practical Implications of the Research

The practical implications of the research are that culturally responsive practices by mainstream health services must be defined. Conversations with healers have clearly indicated that their personal mobilisation to attend to situations where their skills are required is a fundamental component of their work, as is response to family and community-based circumstances. Health services must then acknowledge that traditional healing will be utilised at the preference of the individual.

Mainstream health practitioners working with Aboriginal and Torres Strait Islander peoples should develop an understanding of the history of the community in which the practitioner is working, talk to the Aboriginal Health workers and recognise family dynamics. Cultural brokers and elders can be engaged with elders paid an honoraria to participate and advise on health service practices. Changes in approach might include: inviting family members to be part of long consultations for diagnosis and agreement to treatment regimes; (Shaid, S. et al 2013), recognising that the concept of diagnosis is culturally defined and perceived; (Smith-Morris, C. 2015), making time for the conversations about how patients feel and understanding their expectations of wellness, recovery; offering the opportunity to use community languages and training Aboriginal Health workers or others to translate and interpret "idioms of distress;" (Parsons C.D. 1984) explaining diagnosis and treatment with images, pictorial concepts (Fredericks et al., 2015) and descriptions that are visually compelling.

6.8 Policy Implications of the Research

Queensland Health and the Queensland Aboriginal and Islander Health Council (QAIHC) place Aboriginal and Torres Strait Islander peoples and voices at the centre of healthcare service design and delivery through *Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework.* The Queensland Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021 provides the legislative framework. Making Tracks Together seeks to actively eliminate racial discrimination and institutional racism, and influence the social, cultural and economic determinants of health by working with Aboriginal and Torres Strait Islander organisations, health services, communities, consumers and Traditional Owners to design, deliver, monitor and review healthcare services.

The partnerships required to implement Health Equity Strategies promote community driven and place-based solutions, self-determination, collaboration, co -design

and co- implementation of services using holistic concepts of health. Co-design processes should actively enquire about traditional healing at community level within Hospital and Health Service districts to accommodate specific cultural beliefs and behaviours. Queensland Health and the Queensland Aboriginal and Islander Health Council (QAIHC) place Aboriginal and Torres Strait Islander peoples and voices at the centre of healthcare service design and delivery through *Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework.* The Queensland Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021 provides the legislative framework. Making Tracks Together seeks to actively eliminate racial discrimination and institutional racism, and influence the social, cultural and economic determinants of health by working with Aboriginal and Torres Strait Islander organisations, health services, communities, consumers and Traditional Owners to design, deliver, monitor and review healthcare services.

The partnerships required to implement Health Equity Strategies promote community driven and place-based solutions, self-determination, collaboration, co -design and co-implementation of services using holistic concepts of health. Co-design processes should actively enquire about traditional healing at community level within Hospital and Health Service districts to accommodate specific cultural beliefs and behaviours.

6.9 Recommendations for Future Research

Given the limitations of this particular study mentioned in the previous section, future research that examines the experiences of non-Indigenous health practitioners and health services providing care in these regions would offer a counterbalance to the Indigenous viewpoints discussed here, presenting further opportunities to examine potential areas of cohesion between Western and Indigenous healing practices. Whilst this study incorporated a range of views from participants of different genders, there is also scope for further research into the gendered dimensions of healing, which take into account the potential issues related to different elements of these practices.

Perhaps the most pressing need with regard to furthering knowledge of traditional healing is for research about these issues to be carried out by Indigenous researchers. As well as truly giving voice to Indigenous perspectives, this would counter the likelihood of knowledge being withheld from non-Indigenous researchers. Finally, research that provides participant observation of the interaction between clinicians and patients in the non-Indigenous clinics, as well as those run by the communities, would build on some of the

perspectives presented here, which were communicated from the participants' memories rather than from observation.

6.10 Final thoughts

Indigenous knowledge in North Queensland is a dynamic living culture, nurtured by emerging leaders, derived from ancestral belief, and incorporating traditional skills. Healers are part of the Indigenous cosmologies of place, time, and philosophy. They may be Elders grounded in traditional practice, or younger people creating new ways of being. In each case, they adapt to prevailing circumstances, including navigating situations where Indigenous viewpoints may not be valued.

Traditional healing includes the restoring of balance between Indigenous viewpoints and daily reality, which involves intuitive and emotional responses characteristic of healing practices. Using narratives collected through fieldwork, the study examined the identity of healers as leaders, marshalling "living attention", and as performers of ritual and negotiators seeking influence in social change across contemporary and traditional life-worlds.

The future of Wik healers in Aurukun appeared precarious, in the sense of fragility and fragmentation of knowledge, experience, and opportunity. The precarity of these healers was found in their social vulnerability; "a condition of existence without predictability or security, affecting material or psychological welfare" (Butler, 2009, p. 21). The potential for their cultural authority to be exercised in an intercultural domain of healing was explored. The scope of such cultural authority includes the obligations of Indigenous identity in relation to differentiation of self, the holding and mastery of cultural knowledge, and the tensions associated with multiple personal roles, when kinship association may conflict with community leadership responsibilities.

In Yarrabah, healing traditions which seek to restore personal and family wellbeing have emerged in the last thirty years through the actions of community control of health services and associated services which demonstrate cultural obligation as part of personal care. There is acknowledgement of the legacy of healing of the Gunggandji people, Traditional Owners of the land on which the Yarrabah township is situated, but extremely limited evidence of active traditional healers. It may be that the concepts of achieving wellbeing have subsumed the old ways into this adapted tradition.

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Appendix 1 Cairns HREC Approval

Queensland Government

Ref: HREC//12/QCH/53 - 792
23.11 PC:mg
Telephone: (07) 4226 5312
Email: Cairns_Ethics@health.qld.gov.au

Human Research Ethics Committee
Cairns & Hinterland, Cape York,
Torres Strait & Northern Peninsula
Hospital & Health Services

3rd December 2012

Ms Jacqui Lavis
69 Nolan Street
WHITFIELD Q 4870

Dear Ms Lavis

HREC Reference number: HREC/12/QCH/53 - 792
Project title: Traditional Healing in Cape York Communities
Protocol number: n/A

Thank you for submitting the above project for ethical and scientific review. This project was first considered by the Cairns & Hinterland Hospital & Health Service Human Research Ethics Committee (HREC) held on 14th June 2012. I now refer to your correspondence of 9th November 2012 and I am pleased to advise that **final approval** is now granted to your application.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007)* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Attached is the HREC Composition with specialty and affiliation with the Hospital (Attachment I).

I am pleased to advise that the Human Research Ethics Committee **has granted approval** of this research project. The documents reviewed and approved include:

Document	*Version*	*Date*
Application		
Covering Letter: Cover letter as specified		18 May 2012
Letter from Sponsor: Letter of Support from Apunipima Cape York Health Council		09 May 2012
Patient Information Sheet/Consent Form: Participant Information Sheet		18 May 2012
Patient Information Sheet/Consent Form: Consent Form	3	09 November 2012
Protocol: Study Protocol		18 May 2012
Statement pursuant to the National Statement, Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research		18 May 2012
Application NEAF		
Response to Request for Further Information		09 November

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		2012
Research Agreement	2	09 November 2012
Opened Ended Questions	2	09 November 2012

(If you are a student researcher you are obliged to advise your Supervisor/s as to the current status of your research application.)

Please note the following conditions of approval:

1. If relevant to your project, your attention is drawn to standards for clinical trials reporting as enunciated in the CONSORT statement *(hhpt://www.consort-statement.ort/?o=1001)* and a requirement by many journals for certain categories of clinical trials to be registered (see: *hhpt://www.actr.org.au*)

2. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
    a. Unforeseen events that might affect continued ethical acceptability of the project. Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

3. Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be reflected in a revised online NEAF (accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study). Hard copies of the revised NEAF, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC coordinator as per standard HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/cpic/documents/ethics/researcher_userguide.pdf

4. Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Office/r (by-passing the HREC).

5. Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted firstly to the HREC for review and, once HREC approval has been granted, then submitted to the RGO.

6. Amendments which do not affect either the ethical acceptability or site acceptability of the project(e.g. typographical errors) should be submitted in hard copy to the HREC coordinator. These should include a cover letter from the principal investigator providing a

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brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.

7. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

8. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.
9. The District administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside Cairns & Hinterland Health Service District.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a *Queensland Health site* until separate authorisation from the District CEO or Delegate of that site has been obtained.

A copy of this approval must be submitted to the District Research Governance Officer/Delegated Personnel with a completed Site Specific Assessment (SSA) Form for authorisation from the District CEO or Delegate to conduct this research at the Cairns & Hinterland Health Service District. Send documents to: Research Governance Officer c/- Ethics Office, Cairns Base Hospital.

HREC approval is valid for three years from the date of this letter.

Should you have any queries about the HREC's consideration of your project please contact Margaret Grasso, HREC Administrator on 07 42 26 8012. The HREC terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/cpic/ethics/reagu_homepage.asp

Once authorisation to conduct the research has been granted, please complete the Commencement Form (Attachment II) and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Yours faithfully

Dr Paul Cullen - Chair
Human Research Ethics Committee
Cairns & Hinterland, Cape York, Torres Strait &
Northern Peninsula Hospital & Health Services

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Appendix 2 –Description of Field Visits to Aurukun and Yarrabah and briefings to Apunipima Cape York Health Council & stakeholders

Date	Stage of the Research or Research Activity	Outcome
2002 – 2004	Community Familiarisation Visits to Aurukun Working with Bernie Singleton – Apunipima Chairman as Cultural Broker	With Apunipima Cape York Health Council. Developing Community Health Plans under Council of Australian Government initiative.
May 2014	Apunipima Cape York Health Council Board letter of support for research issued	Board discussion and commentary regarding conduct of research
May 2014	Briefing to Far North Queensland Medicare Local	Indigenous Community Engagement officer nominated as research contact for briefings
August 2014	Detailed briefing to ACYHC Senior Management Team	Discussion concerning potential community validation of healers and mobilisation of local researchers
November 2014	Pre- PhD Research Commencement: Visit to Aurukun Introductions to potential key informants Briefing to Aururkun Council members and Family Responsibilities Commission Community familiarisation	Research Progress Report to Apunipima Feedback re support for research in community
September 2015	Contextual conversations – Healing Foundation – "talking about culture"	Yarning circle and unstructured interview approach discussed
October 2015	Field Work Aurukun for Thesis Proposal Development Discussion with Aurukun Council. Participant recruitment and unstructured interviews	Research Progress Report to Apunipima Preliminary analysis of participant feedback & discussions on further contacts
May 2016	Briefing to Royal Flying Doctor Service	Meetings at Wellbeing Centre with Indigenous and non-Indigenous mental health professionals
August 2016	Field work Aurukun – participant recruitment and unstructured interviews	Research Progress Report to Apunipima Preliminary analysis of participant feedback & discussions on further contacts
October 2016	Field Work Aurukun – participant recruitment and unstructured interviews	Research Progress Report to Apunipima Enhanced analysis of participant feedback & discussions on emerging themes Mental health professionals feedback
August 2017	Aurukun Field work with Wik Womens' Group members and Apunipima Primary Health Care centre	Research Progress Report to Apunipima Enhanced analysis of gendered issues concerning healing, spirituality, community violence and wellbeing
July – December 2018	Participant observation and workshop feedback note taking Research support to Yarrabah Leaders Forum	Research support to Yarrabah Leadership Forum - monthly reports re participant feedback
May 2020	Feedback to Yarrabah Leaders Forum Executive Officer	PhD content and approach re Yarrabah themes discussed and agreed

Research process in Aurukun

In Aururkun, I made six field visits between 2014 and 2017 The nature and intent of these visits and their outputs is outlined in Appendix 2. On each of those occasions, I stayed approximately two weeks in the community, at purpose-built accommodation made available for visiting workers. This accommodation is situated within the centre of the community. A typical daily routine would be to start the day with conversations with other workers visiting the community, then to visits the community meeting place outside the general store. Being in this location was an indication of visibility and availability of Bernie and the researcher. Many casual conversations initiated here led to extended participant interviews and creation of narratives of healing, ancestral power and community dynamics.

I also made appointments with key community members both those working in health-related services, with Bernie as cultural broker, suggesting a number of those to be contacted. Such appointments often led to suggestions for further conversations and in some cases to follow up conversations, " in private," i.e. outside a formal work setting. I became known in the community and offered assistance, respect and safety in moving around various locations. On a number of occasions, Bernie and I would travel outside the community into traditional Wik homelands, at the request of participants who felt it more appropriate to talk about healing in locations of known spiritual power.

Research process in Yarrabah

In Yarrabah, I worked with the Yarrabah Leadership Forum for six months in 2018, two to three days a week, within the community. This was the third occasion on which I had been engaged on a short term basis by a Yarrabah community controlled organisation to provide strategic management support to Indigenous governance. This involved close contact with the Chief Executive Officer who over a period of five years has provided significant guidance to this research. The activities involved providing background research and facilitation of community inputs about a range of social recovery options and proposals. This generated participant observation of the ways in which members of the Indigenous leadership group in Yarrabah perceived "social recovery", and whether or how they perceived the role of traditional healing in that set of processes. Suggesting methods through which the ideas that emerged from community discussions could be practically implemented was considered an essential part of reporting to the Executive Officer. The strategic planning process, informed by a two-day workshop, sought ideas to reinforce the principles of community control and direction for family well-being, law and order, education, and economic development initiatives. The contractual terms provided opportunities to observe how locally based leaders of community services support each other in a coalition of interest

to pursue what were considered to be "community advancement goals", and whether the practice of traditional healing was potentially considered of value in this arena.

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Appendix 3 – Apunipima Cape York Health Council – support for research

9 May 2012

Jacqui Lavis
Wuunta
69 Nolan St Whitfield
Cairns 4870

Dear Jacqui

RE: Traditional Healing Study

We are delighted to give you support for this project. It has been developed over a long period of time and incorporated suggestions from many Apunipima staff from the Board to Community Engagement to clinical services.

The subject is very important to our Board and we are aware of the important role they are playing as cultural advisers in your research. We hope that your project stands as a great example of taking on priorities of Aboriginal and Torres Strait Islander people and involving them in the research at every step of the way, building capacity and understanding of the processes involved.

We feel that the results of the research have the potential to create real benefits both for Aboriginal and Torres Strait Islander people and the health services you visit by strengthening communication information and understanding shared between traditional healers and mainstream clinical services.

We support this project on the understanding that the research results will be fed back to the Board Health Action Team, clinic, and Council of the involved communities and will assist you where needed with this process.

Yours sincerely

CLEVELAND FAGAN
Chief Executive Officer

Apunipima Cape York Health Council Aboriginal Corporation
ABN 26 089 437 717
PO Box 12045, Cairns DC QLD 4870 (186 McCoombe Street, Bungalow Cairns QLD 4870)
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Appendix 4 – Example of research briefing note to Apunipima Cape York Health Council

Jacqui Lavis and Bernie Singleton -Briefing to Apunipima Cape York Health Council
Proposed Research Visit to Aurukun 8th – 11th August 2016

"What are the barriers to the recognition of traditional healing by bio-medical practice in Cape York and Far North Queensland"

Bernie is Cultural Broker for Jacqui Lavis for this PhD topic which she is undertaking through the Australian National University (ANU) Research travel is funded by the Australian National University (ANU) The research undertaken within the ANU Medical School and is considered to have significant potential both for medical school training and health systems research.

The research seeks to understand the current nature and potential reach of traditional healing, how it co-exists with biomedicine and whether there are therapeutic situations where access to cultural knowledge and practices are beneficial.

The research considers how treatment choices are determined by institutional and professional practice but also examines how community members safeguard access to cultural knowledge and their views about traditional healing access and efficacy.

Two previous research visits to Aurukun in November 2014 and October 2015 have generated the following responses:

- Ritual and powerful beliefs are embedded in community responses to trauma, ill health, serious life events.
- Retribution (payback) sorcery (purriy purriy) and sorcerers (ma'wop) are believed by some to have significant community impact and can create serious illness or cause death.
- Some individuals definitively "turn their back " on purriy purriy – "if I don't believe it can't hurt me"
- For individual patient journeys - "purriy purriy," traditional healing and clinical treatment are navigated with extended family support, with some community members recounting significant conversations held with mainstream practitioners in an effort to ensure that their cultural preferences and expectations are respected.
- No culturally validated treatments for mental illness are currently made available.
- Limited biomedical understanding exists of cultural continuity in life stage, health seeking behaviours (birth, terminal illness, death).
- "White man's diseases" are unlikely to respond to traditional healing practices, but "hybrid" treatment regimes can be negotiated.
- Unexplained conditions can exist beyond scientific explanation; common occurrences are abdominal pain, fevers and skin lesions and these conditions do frequently respond to traditional healing practices.
- Indigenous diagnostic or treatment regimes for serious conditions are not actively sought by the biomedical profession.
- There is significant interest in "healing on country" in outstation settings, recognising traditional healing both through bush medicines and through the healing/protective effects of access to cultural tradition and country
- Individual services occasionally "allow" access to traditional healers where it is believed that this will enhance treatment options but no clinical protocols exist for such access

Appendix 5 – Cultural Broker Endorsement of Research Procedures

To whom it may concern – Jacqui Lavis PhD Research and Thesis October 2014 to June 2021

Topic: Perceptions and experiences of traditional healing in two North Queensland Aboriginal communities

I confirm that I have been nominated co -researcher and cultural broker for the above research for the entire duration of Jacqui's work.

I helped her present her research proposal to the Board of Apunipima Cape York Health Council in 2014 and accompanied her on research field trips to Aurukun in 2014, 2015 and 2016. I kept her safe and helped her obtain access to the participants, I was present at the majority of her conversations and interviews. She was always well received by community members who spoke fully to her. The narrative accounts she has put together from the fieldwork show that belief in traditional healing and the use of cultural knowledge is still strong. We discussed the accounts with Apunipima senior management on several occasions.

I confirm that there is nothing in the research material she has produced that could cause harm to any participant or community member. In fact I believe her work is important in showing how the Cape York communities need to be heard in health matters.

In 2018, we had the opportunity to work with the Yarrabah Leaders Forum on a strategic plan on social recovery and felt it was a chance to talk about culture in healing. We could see whether Aboriginal community governance might have a role as supporters of traditional healing or how culture was thought about.

Her work on the workshop feedback is detailed and shows how Yarrabah people have made their own way of healing. It has been discussed at length within the Yarrabah Leaders Forum as being used for research purposes.

She was well thought of in Yarrabah which is my home community and has worked on other significant projects there, with my guidance.

I can be contacted for any further comment.

B. Singleton

Bernie Singleton 0438517450 bernielsingleton@gmail.com

Appendix 6 – ANU Ethics Approval

From: aries@anu.edu.au
Date: 26 June 2020 at 16:10:02 AEST
To: u4824544@anu.edu.au
Cc: human.ethics.officer@anu.edu.au, u1052543@anu.edu.au
Subject: Human Ethics Protocol 2020/294 - Approval

THIS IS A SYSTEM-GENERATED E-MAIL. PLEASE DO NOT REPLY. PLEASE REPLY TO human.ethics.officer@anu.edu.au.

Dear Ms Jacqui Lavis,

Protocol: 2020/294 Traditional Healing in Cape York Communities [E1]

I am pleased to advise you that your Human Ethics application received approval by the Chair of the ANU HREC on 26/06/2020.

Approved, as discussed. The prior approvals of the Hinterland, Cape York, Torres Strait & Northern Peninsula Hospital and Health Services HREC, Approval HREC 12/QCH/53 - 792, and the Far North Queensland Human Research Ethics Committee (FNQ HREC, EC00157) are noted and acknowledged.

For your information:
1. Under the NHMRC/AVCC National Statement on Ethical Conduct in Human Research we are required to follow up research that we have approved. Once a year (or sooner for short projects) we shall request a brief report on any ethical issues which may have arisen during your research or whether it proceeded according to the plan outlined in the above protocol.
2. Please notify the committee of any changes to your protocol in the course of your research, and when you complete or cease working on the project.
3. Please notify the Committee immediately if any unforeseen events occur that might affect continued ethical acceptability of the research work.
4. Please advise the HREC if you receive any complaints about the research work.
5. The validity of the current approval is five years' maximum from the date shown approved. For longer projects you are required to seek renewed approval from the Committee.
All the best with your research,

Human Ethics Officer Research Services Division Level 1, Geography Building 48A Linnaeus Way, The Australian National University Canberra, ACT 2601

Appendix 7 – Conference Presentations by Jacqui Lavis

May 2016

Resistance & riots in Aboriginal Australia- on racism and cultural legitimacy: Paper to Warwick University -The Matter of Resistance Conference
Why Reconciliation is failing North Queensland: Presentation to Unpacking Reconciliation: ANU Chancellors Reconciliation event

February 2017

The Power of Healing Places in Aboriginal Australia – can indigenous knowledge challenge mainstream medicine. Paper presented to Place Politics and Privilege Conference. Swinburne Identity Research Network/Victoria University Melbourne

March 2018

Affect experiences of Aboriginal healers in remote Australia: Paper presented to Materializations of the Political conference Institute of Ethnology and Cultural Anthropology University of Warsaw (Vice Chancellors Travel Award)

November 2018

The Precarious Identity of Cape York healers: Paper presented to Australian Sociological Association Conference "Precarity, Rights and Resistance." Alfred Deakin Institute of Citizenship and Globalisation at Deakin University, Melbourne.

Appendix 8 – Demographic data for Yarrabah and Aurukun

Yarrabah

In the 2016 Census in Yarrabah, there were 2,494 Aboriginal and/or Torres Strait Islander people. Of these, 49.7% were male and 50.3% were female. It is commonly held that there is significant underreporting of resident populations in Indigenous communities due to mobility of people and preference for privacy in relation to government business. Aboriginal and Torres Strait Islander peoples are heavily over-represented on every negative socio-economic indicator. Data that might provide information on the distinctive nature of Indigenous Australian lives, aspirations and experiences is not collected.

Kukutai & Walter, (2015) suggest that:

> "Population statistics are not a neutral counting. Decisions of what and how to count reflect particular assumptions about Indigenous identity, ways of life and wellbeing. More often than not, the requirements and priorities of government take precedence over the informational needs and priorities of Indigenous communities. (p.317)."

An indication of this disconnect is given by the fact that there are 3034 registered patients at Gurriny Yealamucka Health service suggesting possible underreporting by 16 % of Aboriginal and Torre Strait Islander peoples in the community. In Yarrabah, the median age of Aboriginal and/or Torres Strait Islander people was 22 years. Of the Aboriginal and/or Torres Strait Islander people 34.3% were children aged 0 to 14 years and 3.5% were people aged 65 years and over.

In Yarrabah, 16.0% of Aboriginal and/or Torres Strait Islander people were in a registered marriage and 17.1% were in a de facto marriage. Of Aboriginal and/or Torres Strait Islander people in Yarrabah, 34.3% were attending an educational institution. Of these, 49.1% were attending a primary school, 26.3% were attending a secondary school and 2.5% were attending a tertiary or technical institution.

Of people aged 15 and over in Yarrabah, 15.2% reported having completed Year 12 as their highest level of educational attainment, 11.2% had completed a Certificate III or IV and 3.3% had completed an Advanced Diploma or Diploma.

Population data is not routinely collected to count or portray Aboriginal nations but estimates from membership of native title bodies suggest that approximately 500 people identify a connection with the Gunggandji nation and 150 people identify a connection with the Mandingalbay – Yidinji nation. English was the only language spoken at home by 84.9% of Aboriginal and/or Torres Strait Islander people in Yarrabah. Indigenous languages spoken at home were Kriol (also known as Yarrie), 6.9%, Gunggandji 0.5%, Kuku Yalanji (Mossman and Wujal Wujal) 0.4%., Guugu Yimidhirr (Hopevale) 0.2% and Djabugay (Kuranda) 0.1%.

For Aboriginal and/or Torres Strait Islander people in Yarrabah, the most common ancestries were Australian Aboriginal 87.9%, Torres Strait Islander 4.3%, Australian 2.2%, Australian South Sea Islander 1.5% and English 0.7%.

30.1% were employed full time, of those who reported being in the labour force in the week before Census night in Yarrabah. 15.0% were employed part-time and 47.8% were unemployed.

For Aboriginal and/or Torres Strait Islander people in Yarrabah, the most common occupations were Community and Personal Service Workers 28.8%, Labourers 15.5%, Professionals 12.7%, Technicians and Trades Workers 11.4%, Clerical and Administrative Workers 11.1%, Managers 6.6%, Not stated 6.0% and inadequately described 3.2%.

For Aboriginal and/or Torres Strait Islander people in Yarrabah the most common industries of employment were Local Government Administration 25.7%, Primary Education 7.5%, Combined Primary and Secondary Education 7.2%, Other Social Assistance Services 7.2% and General Practice Medical Services 6.5%.

The median weekly personal income for Aboriginal and/or Torres Strait Islander people in Yarrabah was $284 and the median weekly household income was $1,115.

In Yarrabah, 66.4% did unpaid domestic work in the week before the Census. During the two weeks before the Census, 38.8% provided care for children and 8.9% assisted family members or others due to a disability, long term illness or problems related to old age. In the year before the Census, 9.7% of people did voluntary work through an organisation or a group.

Aurukun

In the 2016 Census, there were 1,269 people in Aurukun. Of these 49.9% were male and 50.1% were female. Aboriginal and/or Torres Strait Islander people made up 90.2% of the population.

The question of underreporting has been suggested to be influenced by high levels of community mobility and general concern over scrutiny of individuals by public agencies but limited specific data to establish discrepancies exist.

The median age of people in Aurukun was 28 years. Children aged 0 - 14 years made up 28.9% of the population and people aged 65 years and over made up 4.1% of the population.

In Aurukun, 7.5% of people aged 15 years and over, were in a registered marriage and 29.1% were in a de facto marriage.

In Aurukun, 27.0% of people were attending an educational institution. Of these, 53.2% were in primary school, 22.4% in secondary school and 0.0% in a tertiary or technical institution.

Of people aged 15 and over in Aurukun, 7.6% reported having completed Year 12 as their highest level of educational attainment, 10.8% had completed a Certificate III or IV and 2.9% had completed an Advanced Diploma or Diploma.

The most common ancestries in Aurukun were Australian Aboriginal 79.9%, Australian 5.5%, English 4.3%, Torres Strait Islander 3.9% and Scottish 1.7%.

In Aurukun, 95.8% of people were born in Australia. The most common countries of birth were Fiji 0.5%, Papua New Guinea 0.4%, England 0.2%, Thailand 0.2% and Philippines 0.2%. In Aurukun, 93.2% of people had both parents born in Australia and 2.7% of people had both parents born overseas.

The most common responses for religion in Aurukun were Uniting Church 44.3%, No Religion, so described 29.3%, Presbyterian and Reformed 11.0%.

In Aurukun, 10.6% of people only spoke English at home. Other languages spoken at home included Cape York Peninsula Languages, NEC (not otherwise coded) 61.6%, Wik Mungkan 14.7%, Fijian 0.9%, Yumplatok (Torres Strait Creole) 0.3% and Samoan 0.2%. These figures are somewhat misleading. The Australian Society for Indigenous Languages (2011) identified that Wik-Mungkan is spoken by about 1000 people, either as a first or second language.

Community commentary suggests that the category of Cape York Peninsula Languages, referred to above may in fact be interpreted by respondents as including matrilineal and patrilineal dialects in common use in Aurukun. Overall, it is estimated up to 76 % of people may be speaking a Wik language at home and in everyday use.

There were 376 people who reported being in the labour force in the week before Census night in Aurukun. Of these 41.0% were employed full time, 17.0% were employed part-time and 37.2% were unemployed.

Of employed people in Aurukun, 7.9% worked 1 to 15 hours, 3.7% worked 16 to 24 hours and 37.5% worked 40 hours or more.

The most common occupations in Aurukun included Community and Personal Service Workers 24.1%, Technicians and Trades Workers 16.2%, Professionals 15.8%, Labourers 15.4%, and Managers 8.3%.

Of the employed people in Aurukun, 21.7% worked in Local Government Administration. Other major industries of employment included Primary Education 7.8%, Police Services 5.1%, Hospitals (except Psychiatric Hospitals) 4.6% and Supermarket and Grocery Stores 4.1%.

The median weekly personal income for people aged 15 years and over in Aurukun (was $260.

In Aurukun, on the day of the Census, the most common methods of travel to work for employed people were: Walked only 67.4%, Car, as driver 18.3% and Car, as passenger 5.8%. Other common responses were Bicycle 2.2% and worked at home 2.2%. On the day, 0.0% of employed people used public transport (train, bus, ferry, tram/light rail) as at least one of their methods of travel to work and 24.4% used car (either as driver or as passenger).

In Aurukun, of people aged 15 years and over, 83.6% did unpaid domestic work in the week before the Census. During the two weeks before the Census, 44.0% provided care for children and 20.6% assisted family members or others due to a disability, long term illness or problems related to old age. In the year before the Census, 7.9% of people did voluntary work through an organisation or a group.