The birth of the 'Windigo': The construction of Aboriginal health in biomedical and traditional Indigenous models of medicine

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This paper seeks to explore how biomedical models of health have generated Aboriginal health images that continue to culturally pathologize Aboriginal communities. Early health writing on Aboriginal peoples constructed them as primitive, superstitious, and incapable of complex thought (Waldram, 2004), and described Aboriginal communities as plagued with infectious disease, chronic disease, or social pathology (Waldram, Herring, & Young, 2006). Through the medical construction of pathological communities with primitive Aboriginals one can begin to imagine how biomedical definitions of disease are inextricably linked with the larger structures of authority and power in settler societies such as Canada and the United States, and arguably, around the world. O'Neal, Reading and Leader (1998) explain that "epidemiological knowledge constructs an understanding of Aboriginal society that reinforces unequal power relationships" (p. 230); they emphasise that "an image of sick disorganized communities can be used to justify paternalism and dependency" (ibid). Shields, Bishop and Mazawi (2005) refer to this cycle of construction of deviation from a norm being used to justify a need for paternalism and dependency as 'pathologizing practices':

> Pathologizing is a process where perceived structural-functional, cultural, or epistemological deviation from an assumed normal state is ascribed to another group as a product of power relationships, whereby the less powerful group is deemed to be abnormal in some way. Pathologizing is a mode of colonization used to govern, regulate, manage, marginalize, or minoritize, primarily through hegemonic discourses (p. x).

If research on Aboriginal health or other dimensions of Aboriginal life (e.g. culture or education) is to challenge pathologizing practices, researchers need to engage with the political economy of knowledge production through an analysis of the relationships between western power, biomedical knowledge, and the construction of Aboriginality and Aboriginal health. In order to explore the unequal relationship between settler and Aboriginal communities, engagement with post-modern, post-colonial, and decolonizing theories have proven useful (Ashcroft, Griffiths, & Tiffin, 2007; Tuhiwai Smith, 1999). Therefore, this paper takes a critical perspective based on postcolonial and decolonizing approaches to examine how the underlying codes of imperialism, colonialism and biomedicine have systematically classified Indigenous peoples as the 'other' within hierarchies of race and typologies of difference. The first part of the paper focuses on Aboriginal cosmologies and traditional Indigenous medicine. The second part outlines a critique of the biomedical model of health and its association with colonial practices. The final part examines some examples of research on Aboriginal Health and proposes a combination of approaches to support the resilience and revitalisation of Aboriginal culture, practices and communities.

Aboriginal Cosmologies and Traditional Indigenous Medicine

Aboriginal scholars have argued that Aboriginal ideas about the nature of reality, knowledge and being are fundamentally different from European ideas of the same phenomena. They argue, for example, that for millennia Turtle Island's Indigenous peoples existed within an organic universe (Cajete, 2000). This living universe flowed through the holistic consciousness that bound together a spider web network of relations that was in constant motion and flux (Little Bear, 2000). Kinship relations and ceremonial practices were conducted during spiritual pilgrimages along sacred paths to sacred sites. And this ceremonial life and transfer renewed the harmonious movement of spiritual energies through sacred time (Bastien, 2004). Ceremonial time was organized around the cyclical movements of bodies such as the planets, stars, moon and sun, and the rhythms of the sky offered signs as when to schedule ceremony, migrate, plant, harvest, gather and hunt. In this way, the celestial bodies, as living sacred beings, created spirituality and moral frameworks that became embedded within the Aboriginal world of seasons, ancestors, rocks, rivers, trees, animals, birds, sea creatures and peoples (Williamson, 1998).

In this cosmological framework, concepts such as health and disease are also interpreted differently than Western/European concepts (Clements, 1932; Duran, 2006; Duran, Duran, Brave Heart, & Yellow Horse, 1998). The Aboriginal medical system is built upon coherent, rational understandings of the universe and the place of people in it. Inherent in this system are ideas about how disease is caused, how to avoid illness, and what types of treatment are appropriate. Hollow (1999) compares Traditional Indian Medicine (TIM) with a Biomedical Model of Medicine (BMM). He argues that TIM is holistic in that there is no separation between mind, body and spirit (in comparison with a reductionist approach in BMM). He asserts that TIM is culturally sensitive as it takes the patient's tribal beliefs into account both in the diagnosis and the selection of treatment (while culture tends to be viewed as a 'problem' in BMM). In Hollow's comparison, TIM is about helping patients heal themselves (as opposed to healing patients in BMM), TIM takes account of the wider environment of the patient (his/her relations) in establishing the causality of the disease (while BMM individuates the patient), and TIM uses ceremony to teach patients and their families how to re-establish connections and balance and remain well (while BMM creates dependency on the medical system). While TIM honours the patient by emphasising healing and synchrony with one's environment, BMM honours the physician and his salvationist emphasis on beating the disease with his wit or technology.

Potential causes of disease from a TIM perspective involve both the physical and meta-physical worlds, as well as everything that is sacred in one's relationship with the land and with others (e.g. use of language, consumption of food, conscious and subconscious patterns, emotional responses, conflicts, imbalances, climatic conditions, environmental interferences, etc.). This interdependence of relations is perhaps best expressed in the concept of the 'soul wound' (Duran, Duran, & Brave Heart, 1998). The soul-wound is conceptualised as a collective-level illness category and process, which according to Duran et al. (1998) was first diagnosed in TIM after the arrival of Columbus. The soul-wound is a rupture of relationships of inter-related beings (i.e. coloniser and colonised) which affects both sides and all other relations – including the land itself. Like the severing of a limb, the soul wound produces continuous pain, imbalance and destructive self-harming or self-

indulging tendencies (which can be interpreted in addictions and suicide tendencies *on both sides*). A collective soul wound cannot be healed individually – in other words, healing the soul wound is a collective process. In order to help individuals live with the pain originated in the soul wound, Duran (using a combination of TIM and BMM) prescribes therapies that aim to re-establish his patients' relationships with their life-world and with the soul-pain itself (which implies that 'health' is not necessarily associated with the absence of pain from a TIM perspective). Duran's conceptualisation of mental and psychological disturbances moves from a BMM based on individualised pathologies to one where patients are supported to reinterpret and "form [new] relationships with their life-world [which] includes forming relationships with the source of their pain so that they can make existential sense of what is happening to them" (Duran, 2006, p. 15).

His approach emphasizes that "an understanding of historical context must underline the use of intervention strategies with Native people" (Duran, 2006, p. 17). This contextual-historical understanding, for Aboriginal communities, involves the acknowledgement of internalised oppression, or identification with the aggressor/perpetrator of violence. Duran uses Butz' (1993, cited in Duran, 2006) metaphor of vampire biting to extend the metaphor of the soul wound to make the reproductive effects of historical violence more explicit. The idea of the vampire emphasises that once someone is touched by violence, there is a poisonous infection of violence at a soul level, which means that "some of the vampire or perpetrator is already in the person after the person is victimised' (p. 18). He explains this concept in relation to the violence inflicted through colonialism:

> In essence, we have all internalised much of the personal and collective wounding of our [Western] culture. Our culture has been affected by a long history of violence against other cultures which continues to the present. The wounding that is sustained by the collective culture has an impact on the psyches of the individuals and in society. The fact that the soul has been eradicated from our healing circles is indicative of a collective wounding process that has never been grieved or healed. It is from this wounded inner self that we, in the mental health field, seek to wound others through the secrecy and darkness of our practice, and we attempt to ward off our shadow through exhaustive ethical codes [...] (p. 20).

In this section I have outlined conceptualisations of health, healing and illness in TIM in comparison with BMM. I have highlighted the fact that from a TIM perspective the causes of disease involve a breech of the relational, spiritual and/or environmental order. Therefore, repairs to the spiritual and social fabric of society become central to the healing processes in TIM. This holistic process may include creating individual-level spiritual, intellectual, physical and emotional balance, in relationship with family, community, society, ecology and the cosmic realm. From a TIM perspective, the narrow perspectives of BMM cannot diagnose or treat spiritual or social determinants of the Aboriginal life-world.

The Roots of BMM and Colonialism

The projection of BMM as an objective, universal and culturally neutral phenomena is rooted in historical processes that are an integral part of colonialism and the 'soul wound' that can be traced to the 15th century. It was around this time that the interconnected universe described in the previous section started to drastically change as Europe, armed with a

Cartesian perspective and Christian ideals began to fracture, transform and colonize the Indigenous people's world view, place, and body (Kelm, 1998). The transformation was grounded in several inter-connected meta-narratives, including Descartes' ontological division of mind from matter which led to a view of the universe as a mechanical system consisting of separate objects which provided

> a "scientific" sanction for the manipulation and exploitation of nature that has become typical of Western culture. In fact, Descartes himself shared [Frank] Bacon's view that the aim of science was the domination and control of nature, affirming that scientific knowledge could be used to "render ourselves the masters and possessors of nature" (Capra, 1982, p. 61).

The Cartesian paradigm and mechanistic consciousness became the dominant conception of the world that continues to have tremendous influence on many aspects of Aboriginal and non-Aboriginal lives and is the basis of most sciences, including BMM.

Traditional BMM regards the human body as a machine that can be analyzed in terms of its parts. Disease is seen as the malfunctioning of biological mechanisms which are studied from the point of view of cellular and molecular biology. This paradigm's 'mechanistic-individualistic' conception of disease focuses on smaller and smaller fragments of the body. In so doing, medicine often loses sight of the patient as an inter-connected human being, and by reducing health to mechanical functioning it is no longer able to deal with the phenomenon of healing (Capra, 1982). Its reductionist approach to healing usually involves physical, chemical or technological intervention in order to correct the malfunctioning of a specific mechanism. These types of intervention seem to interfere with the spontaneous healing process through the suppression of the symptoms which then re-emerge in a different form (Capra, 1982). In addition, the biomedical model's intervention cannot take account of the wider determinants of illness and healing that involve a complex interplay among environmental, social, physical, psychological, and spiritual aspects of the human condition. Thus BMM functions to divide Aboriginal peoples from their worldview. In addition, BMM also masks the historical origins of illness, and in so doing separates the responsibility for Aboriginal health from Canada's political and social systems that reproduce the conditions for illness (Bolaria & Bolaria, 2002).

How BMM has come to have such an important role in societies has been the subject of lengthy and important academic debates. Recently, post-modernists such as Foucault have offered some theoretical insights into how BMM, combined with other western theories, has managed to produce a powerful form of colonizing discourse. BMM's ontology (dividing practices), epistemology (mechanical processes) in conjunction with Darwinism provided the medical field from which a hierarchical binary (colonizer/colonized) classificatory system functioned to shape the relationship between imperial powers and Aboriginal societies. Foucault (1954, cited in Rabinow, 1984) explains how BMM's 'dividing practices' operate. His theory of govermentality suggests that the western medical field individualizes and transforms patients through the use of epistemes (defined as hierarchical structures of knowledge) and technologies of self-transformation (defined as dividing practices). Through the practitioner's use of 'dividing practices' (principles of exclusion or inclusion) the patient is either divided inside themselves or divided from others (Foucault, Faubion & Hurley, 2000).

This objectifying and dividing process fractures the patient's collective identity and categorizes the patient's individual identity in constraining ways. When medical discourse and practice are applied to Aboriginal peoples, their mind and body become the site of assimilation and identity transformation. The assimilation process (dividing practices) imposes the mind/body episteme upon the traditional person, thus fracturing the undivided mind/body/spirit/emotion 'way of being'. The dividing process separates the spirit (world view) and unbalances the being (being healthy), leaving the person susceptible to an identity transformation that will frame him/her as inferior or abnormal in the hierarchical order of things that is produced as 'natural'. According to Waldram (2004) and Tuhiwai Smith (1999) this identity transformation and pathologization (Shields, Bishop, & Mazawi, 2005) process is part of a larger imperialistic process that has its theoretical foundation in Darwin's (as discussed in Ashcroft et al., 2007) evolutionary theory of race [Tuhiwai Smith (1999) stated that the colonization process provided the means for which imperial power and western science systematically applied a classification system that ranked indigenous peoples as subhuman, nearly human and almost human. Even today the hierarchies of race and typologies of difference still shape the relationships between imperial powers and indigenous societies].

The concept of race is important for understanding the rise of colonialism. The racial division of human society can be interpreted as a need of colonialist powers to establish dominance over Aboriginal peoples and to legitimize the "dispossession of human rights, traditional territories and nation sovereignty status" (Stewart-Harawira, 2006, p. 65). According to Ashcroft, Griffiths and Tiffin (2007), the fundamental assumptions of race were established when Charles Darwin's (1859) *Origin of the Species* provided the foundational concept of natural selection which proposes that in competition for survival, superior, stronger and more sophisticated species are selected for survival, while inferior, weaker and less sophisticated species are selected for extinction. For Aboriginal peoples, Darwinism's 'natural' laws (amongst other conceptual constructions) contributed to the theoretical justification for the dominance and sometimes extermination of communities or peoples. Europeans' domination and extermination of Aboriginal people was seen as part of the unfolding of natural laws that were inevitable and desirable in an ideal society. In addition, racial advancement coincided with imperial ideology or more specifically, the 'civilizing mission' of modern man. The civilizing mission "encouraged colonial powers to take up the 'white man's burden' to raise up the condition of the inferior races who were idealized as child-like and malleable" (Ashcroft, Griffiths, & Tiffin, 2007, p. 183). Through a combination of meta-narratives related to the civilizing mission, imperial ideology, and Darwinism, amongst other meta-narratives (see for example Henderson, 2000; Murphy, 2009; and Turner, 2006), the dichotomous concepts of 'superior' and 'inferior' became attached with the binary distinctions between civilized/primitive, colonizer/colonized and White/Indian within the hierachization of human typology. This type of hierarchical thinking, however fictional, has had a huge impact on Aboriginal and non-aboriginal consciousness.

Fanon (cited in Ashcroft, Griffiths, & Tiffin, 2007) was first to notice that racial categories and ideas, however fictional, take on a psychological force during the process of self-identity construction, as well as during the process of social-interaction. Fanon further explains: "the self-image and self-construction that social pressure exerted might be transmitted from generation to generation, and thus the 'fact of blackness' [or redness] came to have an

objective determination not only in racist behavior and institutional practices, but more insidiously in the psychological behavior of the peoples so constructed" (Cited in Ashcroft, Griffiths, & Tiffin, 2007, p. 186). This process has been defined by Jones (2000) as internalized racism:

> [internalized racism is the] acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. It is characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable expression (p. 1213).

Internalized racism manifests itself in helplessness, hopelessness and mental illness. Battiste and Henderson (2000) have referred to this process as cognitive imperialism, while Duran (2006) has referred to this process as internalized oppression. But whatever the name of the process, Aboriginal scholars now believe that ethnocentric thought and the practices that emerge from it are the origin of many Aboriginal mental health issues that are rooted in or made worse by internalised oppression.

In this section, I traced the historical origins of BMM to a number of European meta-narratives related to mechanical thinking, individuation, racial supremacy and colonialism. I touched briefly on Foucault's critique of pathologizing discourses and on the construction of internalised oppression. In the next session, I engage with Aboriginal Mental Health research (AMHR) in order to explore possibilities for alternative and/or hybrid reconstructions of the field.

Aboriginal Mental Health Research and Trauma

The fact that Aboriginals are experiencing a health crisis is well supported in the social and medical literature (Archibald, 2006; Castellano, 2006; Frideres & Gadacz, 2006; Waldram et al., 2006). Thus my purpose, in a decolonizing approach, is to begin to critically examine this literature and discourse, and reconstruct it through an Aboriginal lens, in order to construct a more complex representation of Aboriginal people's health and trauma. There are currently only a few epidemiological prevalence studies of trauma with the North American Indigenous population [Although the Aboriginal mental health area itself is a major scholarly industry. "Between 1980 and 1995 some 2000 journal articles and book chapters on some aspect of the mental health of American Indians had been published" (Mason, 2000, cited in Waldram, 2004, p. 7)].

The studies that have been conducted show a greater prevalence of psychiatric disorders in Indigenous communities, as compared with non-Indigenous communities (Manson et al., 1996; Robin, Chester, & Goldman, 1996). Most of these studies have shown a high rate of co-morbidity (e.g. depression and alcoholism). The discursive images have a cliché story: for 500 years, Indigenous peoples have lived through a continuous series of traumatic events. These events are constructed as demographic collapses from influenza and smallpox epidemics and other infectious diseases, conquest, warfare, slavery, colonization, famine and starvation, residential school and assimilative policies (Churchill, 2004). These lived experiences "have left Indigenous cultural identities reeling with what can be regarded as a

pervasive and complex form of PTSD [post-traumatic stress disorder]" (Castellano & Archibald, 2007, p. 73).

PTSD is a very interesting object of analysis in the context of BMM. In the Diagnostic and Statistical Manual of Mental Disorders (4th edition, 1994) (DSM-IV) published by the American Psychiatric Association, PTSD is classified as an anxiety disorder and can be understood as the outcome of conditioned emotional responses of fear to an external event (Wilson, 2004). The DSM-IV diagnostic criterion A-1 confirms that an individual has 'experienced, witnessed, or been confronted by a catastrophic event'. A-2 criterion for PTSD addresses the person's reaction to an event, such as intense fear, helplessness, or horror. Criterion B consists of symptoms related to the re-experience of an event. For example, symptoms include "recurrent and intrusive distressing recollections of the events, including images, thoughts, or perceptions, that take the form of hallucinations, dreams, dissociation, flashbacks, or a sense of reliving the traumatic event [these] symptoms may persist for years" (Wilson, 2004, p. 10). Criterion C consists of avoidant/numbing tendencies which include emotional strategies by which the person attempts to reduce the likelihood that they will expose themselves to something that triggers a psychological and physiological response (e.g. avoid people, places or things that remind them of the event) or, if exposed, this lists the strategy that they will use to minimize the intensity of their physiological or psychological response. Criterion D includes the increased arousal symptoms that may resemble those in panic and generalized anxiety disorder. Symptoms include difficulty sleeping, outburst of anger, difficulty concentrating, hypervigilance and startled responses (Wilson, 2004, p. 10). The E criterion or duration criterion specifies how long symptoms must persist in order to qualify as PTSD. The F criterion or functional impairment criterion involves impairment of social, occupational or other important areas of functioning (Wilson, 2004, p. 10). From this delineation of PTSD criterion, one begins to understand the complexity of BMM's construction of the traumatized Aboriginal. But what is interesting about this relatively new diagnostic is its ability to contextualize the patient's cross-cultural factors. This involves the DSM's cultural formulation whose aim is "to elicit the cultural identity of the patient, the cultural explanations for the individual's experiences, and cultural factors relating to the psychosocial environment and levels of functioning" (O'Nell & Mitchell, 1996, 576).

However, psychiatrists and researchers working with Aboriginal theories, such as Duran (2006), Brave Heart (1999a) and Robin, Chester and Goldman (1996) consider the PTSD diagnosis to be limited and inadequate for capturing the influence and attributes of Indigenous trauma. The DSM categories have been criticized for focusing on the individual level, instead of the community or cultural level of trauma. In addition, the DSM-IV diagnostic for PTSD fails to describe the nature and impact of severe, multiple, repeated, and cumulative aspects of trauma (Herman, 1992) common within many Indigenous communities (PTSD only considers exposure to a single incident [Complex PTSD is not listed in DSM-IV. It is also known as a 'disorder of extreme stress, not otherwise specified' (DESNOS). It arises from severe, prolonged, and repeated trauma that is almost always of an interpersonal nature. Examples of such stressors are extended child abuse, torture, captivity as a prisoner of war or concentration camp internee, and chronic spouse abuse (Herman, 1992)]. In response, Indigenous health researchers have called for the need to develop more sophisticated measures that take into account cumulative, historically and

culturally based trauma theory, intervention and research (Duran, 2006; Manson et al., 1996; Robin et al., 1996).

Some progress has been made in the development of more culturally competent measuring instruments. For example Robin, Chester and Goldman's (1997) empirical study involved the measure of accumulated trauma within an Aboriginal community. The authors investigated the relationship between both the frequency and type of traumatic events (e.g., natural disaster, combat, car accident, physical assault, witnessing or receiving news about violence or death) and the prevalence of posttraumatic stress disorder in a South Western American Indian tribe. They found that the Indian community's "prevalence of lifetime PTSD and of exposure to a traumatic event were higher than in the general U.S. population" (p. 1582). The study also helped to move research forward through the development of an accumulative trauma response measurement. This enabled the assessment of collective trauma in Aboriginal communities.

A further important clinical and research development coincided with a major health paradigm shift and the release of Duran and Duran's (1995) book *Native American Postcolonial Psychology.* In their work they presented a post-colonial framework in which interpretations of the present conditions and future predictions were firmly embedded in historical events. Historical Trauma Theory underwent further development in Duran, Duran, Brave Heart and Horse-Davis's classical study (1998), *Healing the American Indian Soul Wound.* Historical Trauma was defined as

> trauma that is multigenerational and cumulative over time; it extends beyond the life span. Historical trauma response has been identified as a constellation of features to multigenerational, collective, historical, and cumulative psychic wounding over time, both over the life span and across generations (p. 342).

[Historical trauma: "A *symptom* is understood as a manifestation of maladaptive social patterns (for example, suicide, domestic violence, sexual abuse, interpersonal maladjustment). Symptoms are not caused by the trauma itself; the historic trauma disrupts adaptive social and cultural patterns and transforms them into maladaptive ones that manifest themselves in symptoms" (Wesley-Esquimaux & Smolewski, 2004)].

Historical unresolved grief was conceptualised as grief that was impaired, delayed, fixated, and/or disenfranchised. Another important element of historical trauma theory is its intergenerational transmission through the psychological transfer of a trauma response across generations (Brave Heart, 2004, p. 7). Historical trauma theory helped conceptualise trauma not only in its collective dimension, but also in its historical and inter-generational dimensions.

Soon other researchers developed instruments to assess trauma and translate historical trauma theories into statistical narratives that could start to have political weight. For example, Whitbeck and colleagues' (2004) research with American Indians presented a new empirical development that consisted of two scales. The first scale, the 'Historical Loss Scale' enumerated the frequency of perceived/reported losses of land, language, or culture. The second scale, the 'Historical Loss Associated Symptoms Scale' focused on feelings

pertaining to historical losses listed within the first scale. The purpose of the second scale was to identify emotional responses (e.g., depression, anger, or anxiety) that were triggered when reminders of historical losses or thoughts pertaining to historical loss came to mind. Their findings, with 160 American Indians, showed that the community had historical trauma symptoms as their "perceptions of historical loss lead to emotional response typically associated with anger/avoidance and anxiety/depression" (Whitbeck, Adams, Hoyt, & Chen, 2004, p. 127). Thus, for the first time health research offered an empirical measurement that could provide a statistical narrative/evidence that legitimated the historical nature of trauma experienced by the Aboriginal population. This enabled the creation of an empirical representation of the 'traumatized Aboriginal' that took into account collective, cultural and historical dimensions of human experience of trauma.

This seemingly benevolent 'advancement' can also be interpreted as a double edged sword. Duran and Duran (1995) warn against the power of this kind of diagnostic to pathologize individual people's lives. In the same way, the new cumulative and historical measurements may have the same effect of pathologizing the life-worlds of entire communities. This was the central thesis of Waldram's (2004) book *Revenge of the Windigo: The Construction of the Mind and Mental Health of North American Aboriginal People.* In his research he discursively traces the health literature to find a pattern where the 'traumatized Aboriginal' is constructed by academics, practitioners and politicians. What Waldram (2004) shows is that many Western medical measurements were constructed and refined through experiment and research on Aboriginal populations. Through time, folk legend, medical profile and academic writing merged into an image of a 'traumatized Aboriginal' that was used both to justify (neo) colonial intervention and the perceived threat of Aboriginal identity (associated with an aberration), which Waldram captures in the medical construction of the Windigo psychosis:

> [the] windigo in Algonquian folklore is a cannibal monster who roams the northern forest, preying on unsuspecting passers-by. The folklore also suggests that a human being, under the right circumstances, can transform into a windigo and feast on his or her relatives. Early historical and ethnographic reports of windigo lead to another kind of transformation, the transformation of this folk belief into a bona fide mental disorder, windigo psychosis, considered by many to be a cultural-bound syndrome. But no actual cases of windigo psychosis have ever been studied,…[windigo psychosis] continues to seek revenge for this attempted scholarly execution by periodically duping unsuspecting passers-by, like psychiatrists, into believing that windigo psychosis exists…Windigo psychosis may well be the most perfect example of the construction of an Aboriginal mental disorder by the scholarly professions, and its persistence dramatically underscores how constructions of the Aboriginal by the professions have, like Frankenstein's monster, taken on a life of their own (p. 181).

On the other hand, for Aboriginal individuals, families and communities, the medical, social, and spiritual concerns as seen from both TIM and BMM lenses are very real and material. Therefore, while we revive and revitalise Aboriginal worldviews and practices, empirical narratives that rely on holistic, collective and historical dimensions of trauma (although still constrained within BMM language and frameworks) will also help identify health issues and move political will to provide better support for Aboriginal communities. A combination of

approaches, including conceptual critiques of the limits of the TIM and BMM models, a revitalisation of TIM and culturally sensitive empirical narratives that can trace important trends in Aboriginal health are all of crucial importance for community empowerment and resilience. In this sense, there is reason to be optimistic. Historical trauma researchers have begun to rewrite the Aboriginal health discourse around issues of resilience and community. Reservations that were once depicted as disorganized and impoverished geographic locations where family relations were a source of stress and ill health are now constructed in the literature as sources of sustenance for both physical and spiritual needs; as places of strength and resilience where Indians go to find the continuity and revival of North American Indian culture and tradition. Perhaps this is a start towards the hybrid epistemological spaces that will enable the first steps for collective healing of the soul wound.

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