A Narrative Inquiry into the Experiences of Aboriginal People Living with HIV and Previous Incarceration

by

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Abstract

HIV and AIDS are diseases that are increasingly diagnosed in incarcerated and previously incarcerated Aboriginal persons with little academic inquiry having been done in this field. In this study, I engaged four previously incarcerated Aboriginal men and women in order to understand their experiences of living with HIV and AIDS through personal, human, cultural, and healing domains of being. The four participants resided in Saskatchewan, Canada at the time of the study.

I utilized a form of narrative inquiry (Clandinin, 2014; Clandinin & Connelly, 2000) as a relational methodology to guide the research. Through the use of narrative inquiry, I co-constructed multiple stories about HIV and AIDS and determined factors that contributed to the strength and resiliency of my participants. I engaged in 5-6 audio-taped conversations with each participant, lasting between 1-2 hours per conversation. Through a process of moving back and forth through field, interim, and research texts, a synthesis of the 4 participants' life stories is presented.

The dissertation is divided into 8 chapters. The first chapter provides a recount of my first exposure to HIV, Aboriginal people, and reasons why I have chosen to engage in this research. My second chapter is a review of the literature. The third chapter provides a discussion on the use of narrative inquiry as a methodology and a discussion on the relevant issues that arose with this methodology. The fourth, fifth, and sixth chapters are my findings chapters. In these findings chapters, I share my four participants' stories as well as present beginning narrative threads at the end of each chapter.

In the seventh chapter, narrative threads from the findings chapters are pulled together in three common overarching narrative threads. The three threads are traumatization, stigma, and transformation. In the eighth chapter I provide four important key insights from my analytical interpretations. These insights are: 1) that health care providers and participants come from different worlds; 2) children are motivators for the participants to improve their life situations; 3) institutions and historical use of power have contributed to the powerlessness that participants have experienced; 4) culture and healing are linked together. Finally, I provide recommendations for nursing practice, corrections, education, and research.

Preface

This thesis is an original work by Anthony Villano de Padua. The research project, of which this thesis is a part, received ethical approval from the University of Alberta Research Ethics Board, Project Name: "A Narrative Inquiry into the Experiences of Aboriginal People Living with HIV and Previous Incarceration," No. Pro00023810, October 25, 2011. No part of this thesis has been previously published.

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Chapter One: Introduction

This research project was borne from a desire to better understand the challenges facing Aboriginal people living with HIV and AIDS (APHAs), based on my experience in corrections. I have worked in the correctional system counseling individuals who are living with HIV and testing those who are at risk for contracting the disease. I recall that the first person I diagnosed with HIV was a young Aboriginal man. I will call him Herman. Herman had recently been sentenced to prison for 3 years for physical assault. He was aware that he participated in a life full of risks that exposed him to HIV. His life included having unprotected sex and using intravenous drugs. He was quite sure that he had contracted HIV from sharing an intravenous needle with a family member who was already HIV positive. Before I gave him his positive HIV results, I had some concerns. Would he get angry? Would he become violent? These were all possible reactions in my mind.

The day I told Herman he was HIV positive, I observed his tough correctional façade dissolve in front of me. Tears welled up in his eyes as he began to absorb the news that he was HIV positive. His first concern was whether his children and partner would be okay. He inquired if living with his children placed them at risk for acquiring HIV and asked if it was likely that he had passed the virus onto his partner. We discussed the risks of HIV transmission and explored how the virus might change his life. Through all of our discussions, what struck me was his concern for his family. When Herman reflected on how he contracted HIV, he said, "If you play with fire, sometimes you get burned." Later that day, I considered his words, and my mind was full of questions about the factors that had led him to contract HIV. Why did he

share a needle? What type of family member knowingly or perhaps unknowingly places a loved one at risk? What type of past did Herman have, and how did it contribute to him acquiring HIV? How long had he been involved in street life and drug use? Herman's story was the first of many stories from offenders that motivated me to want to learn more about their experiences with HIV.

My First Encounter with HIV

When I was a youth, I heard about HIV and the warnings about how it was spread, but, at that time, I did not believe it could affect me or the people around me. However, my thinking changed when I was in grade 12. I had a close friend whose brother had died, and the manner in which he had died was not something my friend comfortably discussed. We were driving around one evening, as was common for 17 year olds in my community, and I asked him directly how his brother had died. He was hesitant to talk about it at first but eventually shared that his brother died of AIDS. His brother had most likely contracted HIV while he was living in downtown Vancouver. His reluctance to reveal how his brother had died left a lasting impression on me because I realized that being associated with HIV could silence people. Little did I know that this initial exposure to HIV would get me thinking about a disease that would be a large part of my professional nursing practice.

My Focus on Aboriginal People

Working with Aboriginal people is something I am passionate about. Growing up in Prince Albert, Saskatchewan, I had the opportunity to interact with a variety of people of various ethnicities including Aboriginal people. These interactions gave me an appreciation of the

diversity of Aboriginal people. My interactions with Aboriginal people started when I was in elementary school. As a child in the Prince Albert school system, I was one of only a handful of Asian people in the system. Being of Asian descent set me apart physically from the other students in my classrooms. I was a 'brown' face sharing a classroom with many 'white' faced children. I experienced racism in school.[1] As I met other 'brown' faced students, including Aboriginal students, I felt that I did not stand out as much. I became curious about these other brown faced individuals. Who were they?

During my early elementary school years, I developed friendships with both Aboriginal and non-Aboriginal students. Often those of Métis descent were considered Caucasian by some and Aboriginal by others. I did not know until later in my teenage years that they were also considered Aboriginal. Perhaps they did not act 'Indian' or, for whatever reason, did not disclose it to others in school. In high school, I had the opportunity to interact with many more Aboriginal students because junior high schools merged into larger high school institutions. It was during this time that I made many friends who were of Aboriginal descent. We shared common experiences, such as playing on sports teams, participating in clubs, or just going out for coffee. Socially we could relate to one another's experiences and, in doing so, we understood

[1] Racism is defined by the Canadian Oxford Compact Dictionary (Bisset, 2002, p. 841) as, "1. A belief in the superiority of a particular race, 2. prejudice based on this, 3. Antagonism towards other races, esp. as a result of this prejudice, 4. the theory that human abilities etc. are determined by race." However racism is more complex and can be viewed through other perspectives. For example, Browne, Smye, & Varcoe (2005) discuss the relevance of postcolonial theoretical perspectives to research in Aboriginal health. Postcolonial theories look at the legacy and history of colonialism from a social, moral, and political perspective (Young, 2001). Postcolonial perspectives influence how racism is viewed by focussing attention on inequities based on culture, class, race, and gender and how history has shaped present day experiences and in turn new inequities (Browne et al., 2005).

each other better. We shared our worlds with each other, and we had common worlds to dwell in.

Having these shared worlds reminds me of Ermine (2007) who argues that researchers must consider the ethical spaces in which to engage others. For example, people with a Western worldview need to create an ethical space of engagement with someone who has an Aboriginal worldview. Both parties need to be open to sharing parts of their world in order for understanding to be possible. As I interacted with Aboriginal friends during my childhood, we shared our worldviews and created spaces for understanding.

During high school, I developed an especially close friendship with a Métis boy, Jeremy. He lived very close to my family's house. We found that we had a similar sense of humor and that our personalities meshed very well. I felt fortunate that his family welcomed me into their world and shared much of their culture and perspectives. During this time, I heard many endearing phrases from his parents and relatives, such as "come here, my boy." This phrase is something that one hears when he or she is welcomed by family members. It meant a great deal to me to be treated this way by his family. I also had opportunities to participate in hunting and fishing outings with Jeremy and his relatives. I recall going on an ice fishing excursion with him to Montreal Lake, a very large lake in north central Saskatchewan. I still recall hearing the ice cracking under the weight of the truck as we travelled across the lake. I was so nervous that I considered jumping out of the truck for safety and self-preservation. However, I was reassured by Jeremy that the cracking of the ice was normal and that I had nothing to be concerned about. Trust had been established between us, and we continued on our journey.

It was also a privilege to be able to listen to Jeremy's daily conversations with his family and to observe their life without feeling like I was an intruder. There were times when I appreciated how they joked, laughed, and teased each other around the kitchen table. Perhaps it was the laughter and humour that helped my friend and his family get through some difficult times. They had multiple stressors in their lives, including financial struggles and serious personal issues. These situations involved not only my friend's immediate family, but also his extended family and friends.

As I got to know Jeremy better, I was also exposed to some aspects of his life which were not so positive. I witnessed incidents of violence that were used to dominate others and to obtain alcohol and drugs. He had relatives from correctional facilities who were seen as 'cool' and were, at times, admired by other family members. These early interactions with his previously incarcerated relatives made me ponder the world of crime and street life. I realized that there were many aspects of the world that I was sheltered from and my eyes were being opened up to this unfamiliar world.

Returning to my thoughts on Aboriginal people, my friend taught me that there is a great deal of diversity in Aboriginal cultures. Jeremy confided in me that he felt caught between the 'white' world and 'Aboriginal' world because of his Métis background. At times, he was not sure what world he belonged in. Being Métis meant that he felt he did not belong to either a First Nations community or culture, such as Cree, or to a 'white' culture. Instead, he saw himself as an outsider in both worlds. He did not have the same rights and privileges afforded to First Nations people, and he was not considered 'white'. He identified partially with his

Aboriginal background yet at the same time also felt ostracized by that same culture. For myself, as an immigrant in Canada, I felt like I could relate to his story because I was a Filipino Canadian. Other Filipinos identified me as Filipino, but, when they got to know me, they did not necessarily accept me because I grew up in Canada. This occurred despite being born in the Philippines to two Filipino parents and continuing to understand the Filipino language and traditions. It seemed because I did not live the exact life experiences of other Filipino Canadians that I was not fully accepted by them. I realize my own experiences with racism came from a different place and in a different context than Jeremy's, but my experiences helped me appreciate what Jeremy may have gone through. Like my friend who was Métis, I also did not feel that I belonged to and was welcomed into the Filipino Canadian culture.

Aboriginal Teachings

While I attended university and shortly thereafter, I worked with elders at the Regional Psychiatric Center in Saskatoon and the Saskatchewan Penitentiary in Prince Albert, both Federal correctional facilities. The Regional Psychiatric Center is a newer facility than the Saskatchewan Penitentiary. It feels like a clinic or hospital as opposed to the archaic feel of the Saskatchewan Penitentiary. The Saskatchewan Penitentiary is one of the older penitentiaries in Canada built in the early 1900s. When I first entered the institution, I still remember how it felt like I was in a jail where bad people were supposed to be housed. Perhaps it was the noise of the gates opening and the stares from both offenders and guards that made me feel that I was an outsider. Their stares were warnings for me to be careful because they were always watching. However, in the cultural center, I found that I felt more comfortable and welcomed. The staff

were not dressed as guards, and the offenders seemed much more relaxed as they visited with each other and with the elders and staff in the center. The elders I met at the cultural center ran programs, and they invited me to attend and participate in some of them. I was pleased to accept their invitation, and they taught me a great deal. One particular elder at the Saskatchewan Penitentiary pulled me aside to talk about the medicine wheel from his Cree perspective. The medicine wheel is a teaching tool based on a circle paradigm (Kavasch, 2002; Hampton, Baydala, Bourassa, et al., 2010). The circle is divided into four equal quadrants, and each quadrant has an important, but different meaning. In this particular teaching moment, the elder shared that the four colors of the medicine wheel, yellow, black, white and red, represented the races of people. The yellow quadrant represented Asians, the black quadrant represented people of African descent, the white quadrant represented people of European descent, and the red quadrant represented Aboriginal people. The elder emphasized that all races of people, as represented by the four colors, are important because we all have our own skills to contribute to society. He believed that we all have an important place in this world through living together. These teachings made me feel like I belonged. The explanation given by the elder was that the medicine wheel represents harmony and connectedness between different groups of people. It felt deeply satisfying to think about the connections existing between myself, as an Asian Canadian, and other cultures living in Canada, particularly Aboriginal cultures. Therefore, when people ask me why I work with the Aboriginal population, I say it is because I see a connection between myself and Aboriginal people. We can learn from each other and, by understanding each other's perspectives, we can work at improving our lives on a variety of levels, including

financial, cultural and educational. As I think about the teachings that have been shared with me, I am humbled by the fact that my teachers, both elders and non-elders, in corrections and at the First Nations University of Canada where I work, have taken the time to share their knowledge and perspectives with me. Miller (2000) commented that, "We [Aboriginal people and non-Aboriginal people] have a rare opportunity to gather strength for a better future. In partnership, we can all succeed." (p. 412). I fully agree with his words which have prompted my interest in this research.

Increasing HIV Rates among Aboriginal Peoples

Another reason I chose to focus my research on Aboriginal peoples is due to the work I have done as a nurse with individuals living with HIV in corrections. During my work as a nurse, I have seen a disproportionate rise in HIV in the Aboriginal population. Aboriginal people in Canada make up 4.3% of the Canadian population (Statistics Canada, 2013), but they are infected with HIV and AIDS in disproportionate numbers (Duncan et al., 2010; Zakaria et al., 2010). The Public Health Agency of Canada [PHAC] (2014) reports that the HIV incidence rate for Aboriginal people is 3.6 times higher than the incidence rate for people of other ethnicities.

Tragically, Aboriginal people are also overrepresented in the correctional system. PHAC (2007a) reported that there are high numbers of Aboriginal people housed in federally run institutions. Aboriginal people make up only 4.3% of Canada's population (Statistics Canada, 2013); however, they make up 18% of federally incarcerated people (PHAC, 2007a). In Saskatchewan between 1999 and 2004, the overrepresentation was even more alarming: 10% of the Saskatchewan adult population was Aboriginal, but they comprised 57% of people in the

Saskatchewan adult correctional service (Johnson, 2005). Having an overly disproportionate number of Aboriginal people in Saskatchewan prisons provided solid rationale for the current study to take place in Saskatchewan. My work in corrections also peaked my interest in this population because most incarcerated people are released back into the community with their family, friends, and other community members. My experience working in corrections and my history of working in the field of HIV also made my role as a researcher in this area more credible. In the literature review chapter, I will provide more information about both HIV infection and corrections.

Choosing Narrative Inquiry

I have observed firsthand the power of stories. As a child, I listened to my parents share stories from books and from their past. I learned many things from them. More recently, I have come to appreciate how Aboriginal elders use the power of stories to teach students and staff at my place of work, First Nations University of Canada, and at the Saskatchewan Penitentiary.

I recall one of my visits to the cultural center at Saskatchewan Penitentiary. During my visit, an offender stopped by the office where two elders and I were talking. I stood up to make my way to the door to provide privacy for the elders and the offender, but one of the elders asked me to sit and listen. Both of the elders listened attentively to the offender and his concerns and then afterwards shared a story with the offender. The way the story was presented by the elders addressed the offender's concern, but it also gave him more to ponder once he left the office. Having had an opportunity to watch the use of storytelling as a teaching and counseling tool was

a powerful experience. I felt honored that the elders wanted me to stay; I felt that they trusted me.

When I consider the use of storytelling in research, I recognize that this approach is congruent with the use of storytelling by Aboriginal people in the past. Aboriginal cultures have a strong oral history. Their history is passed through stories from the older people in the community to the youth. Most often in the past, the stories were shared verbally, not in writing (Miller, 2000). The use of narrative in my research is very appropriate to the way in which knowledge is transferred in the Aboriginal world through the use of stories.

On a more formal level, I chose narrative inquiry as a methodology because of my exposure to a variety of qualitative methods. Initially, in my PhD studies, I was confused with all of the different approaches to qualitative research. However, after a number of qualitative classes, I felt that narrative inquiry was the best methodology to explore my research puzzle which is: What are the experiences of Aboriginal people living with HIV who have previously been incarcerated?

The methodology fit well with the Aboriginal population I work with because many of them prefer to communicate orally rather than through other methods. I recall speaking with a participant who was so pleased that someone wanted to hear her story. Actually, all of the participants felt that others could learn from their stories. Having worked as a nurse in and out of corrections for the past 15 years, I have learned that stories are not shared unless there is a trust that has formed between a health professional and client. I wanted to choose a methodology that emphasized the importance of building trust and developing relationships; this

is why I was drawn to narrative inquiry as a methodology (Clandinin, 2013; Clandinin & Connelly, 2000). Meeting with participants at least 6 to 7 times over the course of the research was critical to building these relationships, and our conversations were not limited to my research puzzles. The participants were welcome to take their stories to areas of their lives they felt were important.

The work of Clandinin and Connelly (2000) reaffirmed for me that narrative inquiry was the most appropriate methodology to explore my research puzzles. Clandinin and Connelly (2000) posed the question, "Why Narrative?" To answer this question, the authors presented a number of different dimensions to consider when contemplating narrative inquiry. The dimensions are interaction, continuity, and situation (Clandinin & Connelly, 2000). Interaction refers to both the social and personal contexts in a person's stories. There are relationships that are considered in those stories. My participants would often describe their social context of interacting with health care providers in prison or with family members in the community. Continuity is a concept that refers to how experiences build upon other experiences. An example of this is that adult experiences such as drug abuse are often a result of experiences that an individual may have had as a child. An individual may have been abused as a child and, therefore, their experience of abuse is associated with their experience as an adult abusing drugs. The final dimension is place or situation. Location is significant because it provides a rich context to the story and contributes to understanding the story.

In the following chapters, I will present my literature review, explore in greater depth the tenets of narrative inquiry as a methodology, including my rationale for choosing it, and share

my four participants' stories. In chapter 7, I will synthesize and pull together the common narrative threads from the stories of all four participants. Finally, in chapter 8, I will discuss the implications of these threads for nursing, corrections, and future research and present four key insights based on my analytic interpretations.

I now turn to my literature review.

Chapter Two: Reviewing the Literature

In this study, I worked with research participants to explore the experiences of Aboriginal PHAs who have a history of incarceration. The purpose of the literature review was to examine Aboriginal HIV trends and risk factors for disease, the history and current realities of Canadian Aboriginal Peoples, Aboriginal research in HIV, and the correctional system and HIV. I searched four databases to complete my review: CINAHL; Cumulative Medline; PubMed; and the Cochrane Database of Systematic Reviews. The key search terms used were Aboriginal, HIV, and prison. I also searched the University of Alberta library databases for particular Indigenous authors who have worked in the area of HIV and/or are connected to the Canadian Aboriginal AIDS Network (CAAN).

Aboriginal HIV Trends and Risk Factors for Disease

HIV was discovered in the early 1980's and has spread to become a worldwide disease with an estimated 35.3 million PHAs in 2012 (UNAIDS, 2013). In Canada in 2011, the HIV prevalence rate was 208.0 per 100,000 (Public Health Agency of Canada [PHAC], 2014) with an estimated at 71,300 people living with HIV (PHAC, 2014). The HIV prevalence rate in the general population increased by 11.4% between 2008 and 2011 (PHAC, 2014).

Aboriginal people in Canada make up 4.3% of the Canadian population (Statistics Canada, 2013) but are infected with HIV and AIDS in disproportionate numbers (Duncan et al., 2010; Zakaria et al., 2010). PHAC (2014) reports that in 2008 the estimated number of Aboriginal people living with HIV was 5,440 and by 2011 this number had increased by 17.3% to 6,380. In addition, the HIV incidence rate for Aboriginal people was 29.9 per 100,000 which

is 3.6 times higher than the rate for people of other ethnicities (9.2 per 100,000 population). In 2011, the estimated number of new HIV infections among Aboriginal people was 390 which is slightly lower than the estimated 420 in 2008 (PHAC, 2014).

The risk factors for HIV infection among Aboriginal persons tend to differ from those of non-Aboriginal persons. For example, in 2011 HIV infections attributed to men having sex with men [MSM] was 46.6% of new HIV infections for non-Aboriginal persons but only 8.5% among Aboriginal men (PHAC, 2014). In 2011, 58.1% of HIV infections among Aboriginal individuals were attributable to intravenous drug use, 30.2% to heterosexual contact, and 8.5% to men who have sex with men (MSM). In comparison, among Aboriginal persons in 2008 63.4% of HIV infections were attributable to intravenous drug use, 28.3% to heterosexual contact, and 6.0% to MSM. Interestingly, in 2011 58.1% of HIV infections among Aboriginal persons were attributable to intravenous drug use, compared to 16.9% in the general population (PHAC, 2014). A systematic review by Duncan and colleagues (2010) reported that Aboriginal persons who used illicit drugs and practiced unprotected sexual intercourse had a higher HIV incidence and prevalence when compared to non-Aboriginal individuals. Aboriginal people living with HIV also tend to be younger than non-Aboriginal persons. PHAC (2010a) reported that between 1998 and 2008, 33.5% of positive HIV test results for people under 30 were among Aboriginal people as compared to 21.2% for non-Aboriginal people.

To address highly sensitive risk factors for HIV, including drug use and unprotected sex, the Canadian AIDS Society (2002) has advocated harm reduction to decrease and prevent HIV transmission. The Canadian AIDS Society lists the following examples of programs and policies

that contribute to harm reduction: needle exchange programs; access to detoxification and counseling services; methadone programs, education and outreach programs; and an acknowledgement that people who use drugs are capable members of the community. Harrowing, Mill and Birse (2009) also advocate the use of barrier devices such as condoms to mitigate exposure to HIV during sexual encounters.

The History and Current Realities of Canadian Aboriginal Peoples

In this section, I concisely describe the history of Aboriginal peoples in Canada, including the influence of colonialism and imperialism on Aboriginal peoples and the current realities of Canadian Aboriginal peoples. I also focus on the significance of Aboriginal people's experiences in relation to incarceration, including historical and colonial events, such as residential schools, the Sixties Scoop (Comack, 2008), and the Indian Act. The term *Aboriginal* defines people in Canada who are of First Nations, Inuit, and Métis descent (Statistics Canada, 2008). Inuit, Métis, and First Nations peoples are considered very diverse individuals with cultural backgrounds that differ from each other. First Nations peoples are even more diverse than other Aboriginal groups as reflected in their 615 First Nations communities and 10 distinct First Nations language families (Statistics Canada, 2008). The number of Aboriginal people is growing at a faster rate than non-Aboriginal people; in 2005, birth rates were 1.5 times higher than the overall Canadian rate (Michalowski & Verma, 2005; Statistics Canada, 2005). In the 2011 Canadian Census National Household Survey, there were 1,400,685 people who reported that they were of Aboriginal identity (Statistics Canada, 2013), which represents 4.3% of the total Canadian population. This proportion has increased from the 2001 census reporting 3.3%

and the 2006 census reporting 3.8% of Canadians were of Aboriginal descent (Statistics Canada, 2013).

Aboriginal people of Canada have had a long history of colonialization (Adams, 2000; Laliberte et al., 2000; Barlow, 2009), which has negatively affected them. Eurocentric beliefs associated with colonization were extremely harmful because they ignored traditional lifestyle practices such as living in balance with nature and spiritual belief practices through ceremonies (i.e. Sun dances, sweats, and pipe ceremonies) (Adams, 2000). The colonization process involved mainstream non-Aboriginal Canadians imposing their values and beliefs on Aboriginal people (Adams, 2000; Laliberte et al., 2000). The establishment of residential schools during the 20th century is an example of a social policy that has been associated with harmful outcomes in Aboriginal communities (Barlow, 2009). The living conditions in residential schools, for example, had a detrimental effect on the health of their students (Barlow, 2009). Residential schools contributed to the spread of diseases such as tuberculosis, because the institutions were densely populated (Lux, 2001; Sproule-Jones, 1996). Dr. Peter Bryce, Chief Medical Officer for the Department of Interior and Indian Affairs, released a shocking report in 1907 which cites that 24% of residential school students died of tuberculosis, and the death rate among the Aboriginal population was almost 20 times higher than the rest of Canada (Sproule-Jones, 1996). In residential schools, diseases were directly spread from student to student.

Comack (2008) described another example of the poor treatment of Aboriginal people called the ‘Sixties Scoop’. The ‘Sixties Scoop’ occurred when Aboriginal children were apprehended from their parents and bands and adopted by non-Aboriginal families mainly from

outside of Canada. Between 1970 to 1982, more than a thousand children were taken away from their families, with many private agencies profiting from these adoptions. In 1982, out of province adoption stopped as the government was accused of cultural genocide through the sale of babies (Comack, 2008).

As a result of experiences such as residential schools and the 'Sixties Scoop', many Aboriginal people within that generation lost a sense of their history and identity (Laliberte et al., 2000; Comack, 2008). Rather than learning about their Aboriginal culture and traditional ways of life from their parents and grandparents, these children were instead subjected to the assimilation attempts of governments and churches. This resulted in a disconnect between many younger and older Aboriginal generations due to the loss of traditional cultures, languages, and notions of spirituality. As a consequence, some of these individuals were susceptible to the misuse of alcohol and drugs, as well as violence, in order to numb the pain of what was missing in their lives (Comack, 2008). The complexity of such experiences has contributed to the different ways in which Aboriginal people interact with the legal and correctional systems.

The past experiences of colonialism and the mistreatment of Aboriginal peoples by some governments and churches have resulted in health, social, economic, educational and political inequities (Adelson, 2005; Gracey & King, 2009; King, Smith, & Gracey, 2009). The PHAC (2007a) suggests that colonization and residential schools have resulted in the loss of language, the loss of a land base, and the lack of economic opportunities that culminated in an "Aboriginal reality" (PHAC, 2007a, p. 2). The current "Aboriginal reality" includes many Aboriginal people having lower educational attainment (PHAC, 2007a) despite Aboriginal people staying in school

longer (Adelson, 2005). Lack of education, coupled with very high unemployment rates among Aboriginal groups, has resulted in increasing levels of poverty (PHAC, 2007a). Gracey and King (2009) argue that the "fabric of traditional societies was shredded by colonization" (p. 66). Another Aboriginal reality is the poor living conditions that many Aboriginal people are experiencing, which is linked to poverty and a lack of social support. Specifically, there is a lack of adequate housing, safe drinking water, appropriate sewage disposal, and adequate sources of heat for Aboriginal people, especially those living in non-urban locations (PHAC, 2007a). In 2007, Phil Fontaine, former national Chief of the Assembly of First Nations, stated "we [First Nations communities] rank no better than a Third World country, and that is simply unacceptable" ("Living conditions," 2007). Fontaine's sentiments were echoed by Gracey and King (2009) who reported that living conditions for the majority of Indigenous peoples worldwide are very poor.

In addition to poor living conditions, Aboriginal people also have poor access to health services. An analysis of the 2006 Aboriginal Peoples Survey revealed that the Inuit were much less likely than the general population to have seen or talked to a physician in the past 12 months (Tait, 2008). Only 56% of Inuit adults contacted a doctor in the 12 months prior to the survey compared to 79% of the general population (Tait, 2008). Aboriginal people may experience higher rates of illness and poor social conditions as a result of inadequate access to healthcare and an array of other deprivations. PHAC (2007a), for example, reported that Aboriginal people have higher rates of Fetal Alcohol Spectrum Disorder (FASD), suicides, substance abuse, homelessness, and mental illness.

Similar to disadvantaged non-Aboriginal people, extremely disadvantaged Aboriginal people also make up an unacceptably large percentage of people who are living on the streets or involved in the sex trade (PHAC, 2007a). Reasons for living on the street and being involved in the sex trade are complex but usually involve experiences of severe grief and loss sustained and unresolved over long periods and the need to belong to a familiar social network (Comack, 2008). These 'high risk' activities can contribute to an increased susceptibility to acquiring HIV due to sexual transmission of HIV and drug use on the street. In addition, vulnerability to HIV infection increases considerably when Aboriginal people who grew up in residential schools, or their children who have witnessed the effects of these schools, turn to substance abuse or destructive social groups. Grekul and LaBoucane-Benson (2008) discuss how gangs satisfy a sense of belonging for many members. Unfortunately, chronic substance abuse and gang affiliated lifestyles are synonymous with a high level of violence and daily encountered risks of injury and trauma, resulting in a host of emotional, mental, and physical illnesses. In addition, social factors such as a lack of housing, inadequate social services, and low economic status can also contribute to higher incarceration rates and a decrease in the health of offenders (Trocme, Knoke, & Blackstock, 2004; Blackstock, Trocme, & Bennett, 2004).

Aboriginal Canadians are a very diverse group of people who share a history of colonialism, which has damaged their traditional ways of knowing and being. There have been limited attempts to explore Aboriginal people's unique ways of knowing regarding health and wellness (King et al., 2009). For an Aboriginal person who has lived through the residential school system or experienced the effects of residential schools from other family members, there

is a perplexing and confusing sense of cultural and personal loss (Barlow, 2009). Under such circumstances, they are highly vulnerable to acquiring HIV as a result of participating in high risk behaviors such as intravenous drug use (IVDU), prostitution, or gang lifestyles, all of which may potentially lead to incarceration. Thus, it is important to recognize that Aboriginal people need to be asked for their opinions and thoughts regarding their own health and views of the healthcare system.

A Focus on Aboriginal Research and HIV

In the field of HIV, there has also been work done by a number of researchers to understand the experiences of Aboriginal people and HIV. The Canadian Aboriginal AIDS Network (CAAN) is an organization in Canada that focuses on Aboriginal HIV research. The mission of CAAN is to provide:

> a National forum for Aboriginal Peoples to wholistically address HIV and AIDS, HCV, STBBIs, TB, Mental Health, aging and related co-morbidity issues; promotes a Social Determinants of Health Framework through advocacy; and provides accurate and up to date resources on these issues in a culturally relevant manner for Aboriginal Peoples wherever they reside. (CAAN, 2015, p. 1)

CAAN brings together both Aboriginal and non-Aboriginal researchers in the field of Aboriginal HIV through their publications and journal[2]. CAAN has called for concerted actions at both the National (Mashing, 2009) and International (CAAN, 2011) levels. Both CAAN researchers and other HIV researchers have focused on a number of Aboriginal HIV issues. The three most relevant issues in relation to this dissertation are the following: the focus on relational care, issues of marginalization, and the effects of colonialism.

[2] Canadian Journal of Aboriginal Community-Based HIV Research

Barlow, Reading and Akan (2008) produced a work on relational care for Aboriginal people living with HIV. The document discusses relational care which "is an interactive, caring, respectful path for culturally competent services leading to the well-being of the whole person" (p. ii). The related research explores the experiences of Aboriginal people living with HIV (APHA) and the experiences of health care providers. APHAs described the importance of being able to connect and form relationships with health care providers. In the study, the service providers identified that having culturally relevant skills and knowledge is important but not sufficient when working with APHAs. To engage in relational care also meant respecting the individual, building trust, considering Aboriginal and holistic approaches to wellbeing and being open to alternative types of care. The authors also frame the relational work from an Aboriginal philosophy based on *all my relations*. From teachings that I received from Dakota and Cree elders, I have learned that *all my relations* is a term or greeting that indicates individuals are all related to one another. As relations, we have a responsibility to care for each other. Utilizing an Aboriginal philosophy underscores the importance of valuing other viewpoints rather than the reliance on Western philosophies and perspectives.

I also view relational care as being present and more developed in HIV communities and organizations. CAAN supported a project (Zoccole, Ristock, Barlow, & Seto, ND) that addressed homophobia in relation to HIV/AIDS in Aboriginal communities. Researchers in this project suggested that non-Aboriginal organizations could be more culturally aware to help lesbians, gays, transgendered, bi-sexual and two-spirited people feel more comfortable by "scaling up education and resource-sharing activities" (p. xi) by having more two-spirited staff

and relevant support groups. Having a focus on communities and organizations shifts the spotlight and often blame from individuals by revealing attitudinal problems in communities and organizations.

Relational care also entails the meaningful inclusion of individuals living with HIV in research projects and the planning of their own care. A number of studies (Cain, Collins, Bereket, George, Jackson, Li, Prentice, & Travers, 2014; Patterson, Jackson, & Edwards, 2006; Worthington, Jackson, Mill, Prentice, Myers, & Sommerfeldt, 2013) have either evoked the Greater Involvement of People Living with HIV/AIDS Principle (GIPA) (UNAIDS, 2007) or have directly engaged health care service users regarding their involvement and experiences with HIV services (i.e. HIV testing). Involving people who directly utilize HIV resources is an important strategy in addressing the issues around service utilization because it inevitably focuses attention to marginalized populations in need of these services. Hawkins, Reading and Barlow (2009) conducted a project that focused on the role of sexual violence in the lives of Aboriginal women living with HIV/AIDS. Their study gave voice to Aboriginal women living with HIV/AIDS to understand the role of gender, culture, HIV and sexual violence in their lives. Many of the results from the study were profound, including the link between violence and violence-related exposure to HIV. This study also supported the findings from Barlow and colleagues (2008) that racism and the links to cultural identity were important factors in how Aboriginal research participants experienced living with HIV.

In another research article, Cain and colleagues (2013) describe their research with some Aboriginal people living with HIV; their research focused on individuals living with depression.

In their study, they conducted interviews with APHAs who reported feeling depressed and discovered that drug and alcohol use, stigma, social isolation, and prior depression shaped how participants experienced their HIV diagnosis and depression. The authors also provide suggestions on how to support individuals by ensuring culturally competent care, addressing substance abuse issues, and considering how Western health care services shape how individuals understand their health conditions.

The CAAN website also has links to articles that discuss the effects of residential school and colonialism. For example, Smillie-Adjarkwa and colleagues (2006) discuss the effects of colonialism with Aboriginal youth regarding HIV prevention work. In their research, youth discussed the links between colonialism, problems with their communities, and HIV vulnerability. In another article by Barlow (2009), there are connections made between residential schooling, prisons, and HIV among Aboriginal people. Barlow discusses the complex nature of residential schools as an institution that removed children from their families and communities and wounded a generation of Aboriginal people. Colonialism is an important concept in these papers because the fragmented relationship between individuals living with HIV and their communities caused by colonialism has significant links to higher rates of incarceration as will be discussed later in this dissertation.

The Correctional System, Aboriginality, and HIV

Aboriginal people are overrepresented in Canada's correctional system (PHAC, 2007a; Statistics Canada, 2013). In Saskatchewan, between 1999 and 2004, 10% of the Saskatchewan adult population was Aboriginal, but they comprised 57% of people involved in the

Saskatchewan adult correctional service (Johnson, 2005). However, according to data provided by representatives of provincial corrections facilities on Federal/Provincial/Territorial Heads of Corrections Working Group on Health, in 2008 77% of adult male and 90% of adult female offenders in Saskatchewan were Aboriginal (PHAC, 2010b). The over-representation of Aboriginal people in Saskatchewan prisons provides solid rationale for carrying out this study in Saskatchewan. In addition, the high Aboriginal incarceration rates indicate that there are critical social issues requiring urgent attention.

One such social issue is the prevalence of violence in pre-prison and prison culture. Comack (2008), for example, suggests that pre-prison and prison violence occurs when boys and men witness violence in their lives and subsequently utilize violence to adapt to their social situations. Violence is used to demonstrate and exert power over people and to gain attention, even negative attention, from family members or friends as well as to obtain property. Comack (2008) states that violence is not limited to just one or two aspects of a person's life but is carried into many areas. One such area is the correctional facilities.

In addition to Aboriginal overrepresentation in correctional facilities, Aboriginal people also have a higher recidivism rate than non-Aboriginal people. Johnson (2005) examined the case histories and correctional outcomes of Aboriginal and non-Aboriginal people under Saskatchewan provincial supervision. The data was from the Integrated Correctional Services Survey collected from offenders between 1999 and 2004. Aboriginal people had twice the recidivism rates (50% versus 25%) of non-Aboriginals within the 5 year study period. Johnson

(2005) concluded that "Aboriginal over-representation in the Canadian criminal justice system is an important social and criminal justice issue in Canada, particularly in Saskatchewan" (p. 18).

Another concern in correctional centers is that the incidence rates of HIV are higher than in the general public. A recent research report by the Correctional Service of Canada (CSC) indicated that the HIV infection rate for offenders sentenced to federal institutions was 4.6% (4.5% men and 7.9% women) (Zakaria et al., 2010). The prevalence rate among the general population in 2011 is 0.208% (PHAC, 2014) and the 2008 federal prison prevalence rate was 1.72% which is considerably higher. The higher rate of HIV in prison is due partly to the poor response of prisons to prevent both HIV and hepatitis C (CHALN, 2010; Jürgens, 1996). This problem is exacerbated by the lack of harm reduction tools in prisons, including condoms, clean tattooing facilities, and needle exchange programs (CHALN, 2010; Jürgens, 1996). Zakaria and colleagues (2010) conducted a survey of men and women in the Correctional Service of Canada (federally sentenced offenders) to explore their health risk behaviors, use of health programs, and knowledge of HIV and hepatitis C. The authors reported that inmates shared used needles or syringes to inject drugs with others, including those known to have been contaminated with HIV and hepatitis C. The Canadian HIV/AIDS Legal Network [CHALN] (2010) argues that the rising rates of HIV and hepatitis C could be remedied by providing prison-based needle and syringe exchange programs, as well as by considering "doing away with crime bills that incarcerate people with addictions" (p. 2). The proposed crime bills have mandatory sentencing policies. In the United States, these same policies have shown a record high rate of incarceration

for non-violent drug users (CHALN, 2010). Incarcerating people with addictions does not guarantee that the problems associated with crime will be resolved.

In the correctional system, there have been efforts made to include spirituality and culture within specific institutions, but there are examples of when good intentions have increased the possibility of harming the people they intend to help. Hayman (2006), for instance, described an initiative at the Maple Creek Healing Lodge in Southern Saskatchewan to incorporate Aboriginal culture and spirituality into the prison environment. The Maple Creek Healing Lodge is a prison under the Correctional Service of Canada (CSC). The location of the Healing Lodge is within the Nakaneet First Nations due to a successful proposal by the Nakaneet First Nations Band and the small town of Maple Creek, Saskatchewan.

The initial intention of the CSC was to build an Aboriginal Healing Lodge for women. The idea behind the Healing Lodge was to embrace a new philosophy whereby Aboriginal women would be able to receive spiritual teachings and healing from elders. The prison environment in the Healing Lodge was different than a regular correctional facility. The female prisoners were able to live in an Aboriginal environment supervised by staff knowledgeable about Aboriginal issues, such as residential schools. The prisoners were also able to take care of their children at the Healing Lodge and the usual security measures, such as typical prison walls to confine the women, were absent. Elders were available to provide spiritual and cultural support (Hayman, 2006). The use of elders has been shown as a benefit to help inmates deal with personal challenges and heal spiritually (Waldram, 1994, 1997).

Hayman (2006) discusses how essential it was to have a planning committee that respected Aboriginal perspectives in the creation of the Healing Lodge; however, there were concerns that arose. The planning committee and associated Aboriginal groups tried to ensure that Aboriginal influences were apparent in the lodge as they believed:

> that the Nekaneet and their Elders should be fully involved; that Aboriginal staff needed to be employed at the heart of the lodge; and that Aboriginal governance needed to be maintained, with the result that CSC could not be the ultimate philosophical influence, even though it remained the paymaster. (Hayman, 2006, p. 211)

Even with these beliefs, there were many concerns that became visible during the development and implementation of the Healing Lodge, such as how CSC, a government department, could incorporate Aboriginal perspectives into the creation of the Healing Lodge (Hayman, 2006). For example, there were budget requests that CSC wanted to curtail, such as the additional expense to have buildings with Aboriginal symbols built into their design and the use of smaller living units that were recommended by elders to help with the healing process (Hayman, 2006).

The beliefs associated with the Healing Lodge were that the Nekaneet Band and their elders should be fully involved in the lodge; Aboriginal staff should guide the heart of the lodge; and Aboriginal governance should be maintained. Despite these intentions, these beliefs were compromised. It was perceived by the Aboriginal participants that the Federal government expropriated Aboriginal culture by limiting the influence of elders and the Band in regards to how the lodge was to be managed (Hayman, 2006). This was to be accomplished by having the Kikawinaw, the highest placed Aboriginal member of the staff, answer directly to the CSC and

Euro-Canadian employees, instead of abiding by the original vision of having the Kikawinaw answer to "other Aboriginal people" (Hayman, 2006, p. 211). By changing the reporting structure from the elders and community members, those governing the Healing Lodge became answerable and accountable to mainly CSC and non-Aboriginal workers. This resulted in the agenda of the government taking precedence over the vision of the Aboriginal committee, and Aboriginal leaders were not given authority to oversee the management of the Healing Lodge.

The failure of this endeavour to embrace a vision of Aboriginal influenced healing within the context of corrections shares similarities with other failed correctional reforms. For example, asylums were initially viewed to be a Utopian vision of a perfect social order, but instead developed into institutions that became merely custodial in nature (Cohen, 1985; Rothman, 1971). In the Utopian vision, criminals and the insane would be changed by taking them away from the bad influences of society and placing them in asylums where they would be regulated and disciplined in order to change them. The reality of this vision was that an overcrowded institution was corrupt and did not rehabilitate (Cohen, 1985; Rothman, 1971).

The approach of the Canadian government to Aboriginal treatment in correctional institutions has also been critiqued. Martel and Brassard (2008) describe how 'Aboriginality' has been defined by the Canadian government within correctional institutions. The federal government has treated Aboriginal peoples as a homogenous group, recognizing them as diverse, yet treating them as if all Aboriginal people within the group are the same. An example of this may be understood through the inclusion of elders. In some institutions, the elders hired may relate to only a few of the Aboriginal groups, with other Aboriginal groups in the institution

unable to benefit from appropriate elder relationships. This can result in a Dene First Nations person, for instance, refusing to attend the cultural center because she/he may not be able to relate to the Cree elder at an institution.

Martel and Brassard (2008) also critiqued the traditional "identity marks" (i.e. sweat lodges, medicine pouches, and sweet grass) that are used to define Aboriginal people in prison. They claim that, by the act of defining a person, the government treats Aboriginal people as a homogenous group and fails to recognize individuals who may not identify with these traditional practices and values. When the government arbitrarily defines 'Aboriginality' in correctional institutions, Aboriginal people must conform to these pre-conceived definitions in order to receive institutional programs that may aid in their earlier release. Hayman (2006), for example, talks about the choice women had to make when they considered attending the Healing Lodge. If they wanted to attend, they had to take the total package of "environment, spirituality, and culture" or they could stay in a prison with "relatively few Aboriginal inmates" (Hayman, 2006, p. 225). The problem was that, in order to be with other Aboriginal people and away from the dominant culture, the women had only two choices available to them; this forced them to conform to the government's definition of 'Aboriginality'. This policy has the potential to further marginalize and stigmatize non-traditional Aboriginal people.

It is questionable whether Aboriginal culture and spirituality are effectively supported in correctional facilities throughout Canada (Hayman, 2006; Martel & Brassard, 2008). Hayman (2006) reminds us that prison, which also includes Healing Lodges, are "not places of healing: they are sites of coercion, repression, and pain" (p. 257). With this in mind, it is important to

remember the history of prisons and how prisons have affected their inmates, family members, and the general community despite attempts to include culture and spirituality in prison (Hayman, 2006).

The literature was also examined for information on previously incarcerated Aboriginal people and their experiences with the healthcare system; however, I could find no literature on this topic. Based on the literature review, it is evident that HIV is a serious health issue for incarcerated and previously incarcerated Aboriginal persons.

Literature Summary and Discussion

Aboriginal people in Canada are a fast growing population with HIV prevalence rates higher than their non-Aboriginal counterparts (Statistics Canada, 2013). Aboriginal people have experienced mistreatment from non-Aboriginal people, based on a history of colonialism and manifested in more current times through residential schools. This has contributed to a type of Aboriginal Reality. This reality includes disparities in health and economic status, increased incarceration rates for Aboriginal people, and decreased access to health care services. There are gaps in the literature, such as the access and utilization of health care services by Aboriginal people living with HIV. These gaps can be better understood by co-participating with Aboriginal people in culturally appropriate and sensitive research. Much of the research highlights the challenges that surround HIV positive Aboriginal persons but fails to explore the strengths these individuals have displayed. Bartlett (2003) argues that, "little effort has been put into understanding and describing the essential substance of Aboriginal communities; substance

that has supported them to remain vibrant and future-oriented despite the many challenges" (p. 111).

Several researchers have documented numerous strengths in the Aboriginal culture that have enabled Aboriginal persons to negotiate life situations. Van Uchelen and colleagues (1997) examined Indigenous views of wellness and existing strengths of First Nations people in Vancouver's downtown eastside and uncovered a variety of wellness and strength themes. For example, the authors mention that their participants talked about a connection between culture, the earth, the spiritual realm, and the importance of "living in balance, having respect, and avoiding alcohol, and drugs" (p. 45). Creating connections between culture, the earth, and spirituality are strengths because they promote a healthy lifestyle. Another important point cited by Van Uchelen et al. (1997) was the strength that their participants received by having a connection to their community. The connection to community was not based on a particular formal community such as a city or a First Nations reserve, but, rather, participants viewed their community, the street, as having "more fluid and less formal structures" (p. 46). Having a street family provided participants with a connection, interdependence, and a sense of community which provided such things as the ability to access food, activities, and the opportunity to laugh. The importance of having community connections such as on the street, as described by Van Uchelen and colleagues, is a strength that is often overlooked by health care providers.

The review also highlights many articles that cited the importance of holistic viewpoints versus the more mainstream medical or illness model of health care. A holistic view of health is a strength because it does not focus on only one aspect of a person's life, such as illness, but

rather looks at the different resources that can support a person. Studies on pregnancy and parenting (Smith et. al., 2007), the conceptions of health and well-being for Métis women in Manitoba (Bartlett, 2003), and the experience of Aboriginal women following the suicide of a family member (Goin & Mill, 2013) have also described the importance of holistic viewpoints. Bartlett (2003), for example, states that Aboriginal women in her study developed significant insight and strength into the spiritual, emotional, and intellectual/mental dimensions of their lives. Developing these insights and recognizing them as strengths helped the women to develop positive ways of perceiving illness rather than just focusing on negative reports and attitudes of poor health.

In nursing, there has also been recognition that Aboriginal culture and particular behaviours are viewed as positive strengths to help people work through their personal challenges. Barton (2004; 2008) describes the strengths of Aboriginal culture and epistemology as her Aboriginal participants were living with diabetes. Mill (1997) looked at HIV positive Aboriginal women's risk behaviours as survival techniques rather than behaviours that were solely negative. Caine (2002) described the important connection to children. Finally, Smith and colleagues (2010) challenged nurses to utilize more holistic principles such as Indigenous frameworks, capacity building, and cultural safety when considering best practices for isolated Aboriginal communities. These principles are also congruent with the principles of ownership, control, access, and possession (OCAP) of information (First Nations Centre, 2007) and the discussion of ethics in Aboriginal research by Patterson and colleagues. (2006).

In nursing and in other disciplines, there is a need to identify challenges for individuals, but the discussion of the challenges should not take for granted the strengths that have helped these persons to cope and lead resilient and meaningful lives. Bartlett (2003) sums it up nicely when she states, "the health sector can also play a role in beginning to remedy negative description by, at minimum, providing context appropriate and culturally grounded services, programs, and research" (p. 112).

Before I turn to the important life stories that the research participants shared, I will discuss the reasons why I chose narrative inquiry as my methodology.

Chapter Three: Relational Methods through Narrative Inquiry

I chose Clandinin and Connelly's (2000) form of narrative inquiry as the most appropriate methodology to understand and explore the experiences of four previously incarcerated Aboriginal people living with HIV. By engaging in narrative inquiry through the consideration of 12 touchstones as defined by Clandinin & Caine (2013), I describe the importance of the methodological and relational commitments required to meaningfully work with the participants through narrative inquiry. As I worked with each participant and listened to their stories I appreciated more deeply that:

> Human beings have lived out and told stories about that living for as long as we could talk. And then we have talked about the stories we tell for almost as long. These lived and told stories and the talk about the stories are one of the ways that we fill our world with meaning and enlist one another's assistance in building lives and communities. What feels new is the emergence of narrative methodologies in the field of social science research. (Clandinin & Rosiek, 2007, p. 35)

As a narrative inquirer, I was interested in studying experience, specifically exploring the lived HIV experiences of four participants who had been previously incarcerated. I was particularly interested in how the participants made sense of the world through their stories and I recognized that their lives have been built upon their previous experiences. Dewey's (1938; 1981) theory of experience is recognized as a major philosophical underpinning of narrative inquiry (Clandinin & Connelly, 2000), and he discusses how experience is built upon experience. Dewey (1938) presented a theory of experience that acknowledges experience as a basis for

interaction and continuity located in a particular situation. For Dewey (1938), people are understood as individuals and through their interactions in a social context within their environment. This results in the ontological notion that experience is continuously interactive and results in changes to an individual (Dewey, 1938; 1981). Dewey's view of experience is described as pragmatic because of his position that "our representations arise from experience and must return to that experience for their validation" (Clandinin & Roseik, 2007, p. 39). An example of returning to that experience is the process of describing life events through narratives or the description of artifacts (i.e., writings, photos). The narratives and artifacts may not necessarily mirror the exact participant experiences but are representations of the interactions between the individual, their environment, and others. Clandinin and Connelly (2000) further discussed Dewey's work through the use of a variety of researchers and authors who demonstrate the links between narrative and life.

Two anthropologists, Geertz (1995) and Bateson (1994), reflected on their life work in relation to narratives. Geertz (1995) discussed the importance of having narrative understandings. He recognized that the world was changing and so were the perceptions of the world. Since the world and the way we understand it are constantly changing, researchers need to locate themselves in the stories they describe to more fully explain how their work came to be. In this way, others can understand how the research was influenced by the experiences of the author. Bateson (1994) also contributed to narrative by recognizing that there are elements of uncertainty between the researcher and those that they are observing. To address this uncertainty,

she appeals to researchers to reflect more on their relationship to the stories and to those they are observing and working with.

The view of narratives has also been influenced by health care providers. Coles (1989) writes and reflects on the practice of psychiatry. In his book he contributes to narrative considerations by describing the importance of learning from his patients. The patients become teachers and their words and stories reveal aspects of themselves that have taught him about their life and situations. I concur with Coles (1989) that it is important for health care workers to understand individuals through biographies and stories rather than through a list of their complaints.

Polkinghorne (1988), a psychotherapist, furthers our understanding of narratives by suggesting that narratives are not merely to describe lives and apply them to a particular clinical field. Polkinghorne (1988) wants to be able to build a narrative theory that would be able to do two things. The first is to use narratives to describe a situation and the second is to be able to use narratives to explain or create connections between particular events and how they have influenced the narratives. In this dissertation, I not only recount participant narratives, but I also use these narratives to more fully explain the different aspects of the participants' worlds and the factors that relate to their world and their experiences. In this dissertation, narrative inquiry was used to study the experiences of four Aboriginal participants with the intent of making sense of their experiences of living with HIV and previous incarceration through the co-construction of life narratives and stories. This dissertation describes the participants' lives but also creates links

to help understand the relationship between particular life events and participants' life trajectories.

Clandinin and Connelly (2000) identified three sets of considerations related to method in narrative inquiry: theoretical considerations; practical, field text-oriented considerations; and interpretative-analytic considerations. There are also twelve touchstones (Clandinin & Caine, 2013) that must be considered when carrying out narrative inquiry: in the midst; relational responsibilities; narrative beginnings; negotiating relationships; negotiating entry to the field; commitment to understanding lives in motion; moving from field to field texts; moving from field texts to interim and final texts; and representing narratives of experience in ways that show temporality, sociality, and place. The remaining three touchstones are the following: personal, practical, and social justifications; attentive to multiple audiences; and relational response communities which are discussed under the headings of rigor and ethical issues related to my research.

Theoretical Considerations

In the midst.

The first phase in a narrative inquiry is the development of the research puzzle, which in other methodologies is referred to as a research question or problem. The concept of a research question implies that there is an answer to the question; however, a research puzzle may not necessarily provide an answer to the inquiry but rather uncovers questions to "illuminate the social and theoretical contexts in which we position our inquiries" (Clandinin & Connelly, 2000, p. 124). Clandinin (2013) argues that as narrative inquirers "we begin in the midst, and end in

the midst, of experience" (p. 43). As the researcher, my role was to enter into the midst of my participant's life and not make conclusions about who they were, but rather to deeply understand their lived experiences.

As I entered into the midst of my participants' lives, I too was in the midst of my own life. I negotiated my own world thinking about the different aspects of my life that affected me. These included my own work and responsibilities as a faculty member, my responsibilities as a father and husband, and the balance that I tried to maintain as I worked on this dissertation.

Relational responsibilities.

Upon embarking on this research as a narrative inquirer, I needed to first make sense of what experience was by thinking narratively and understanding Clandinin and Connelly's (2000) views of experience. Thinking narratively means that participants' lived experiences are considered the focus of the inquiry and understood through the three-dimensional inquiry space of the following: interaction - personal and social; continuity - past, present, and future; and situation - place (Clandinin & Connelly, 2000).

The dimensional inquiry space of interaction refers to both the social and personal contexts inherent in the participants' stories (Clandinin & Connelly, 2000). Through the use of narrative inquiry, I explored the stories that the participants shared and lived. These stories were based on their surrounding circumstances, inner lives, and complex social realities. There was an interconnectedness between those elements that created a lived reality by which the existence of relationships between those in the stories became visible and understood as core narrative threads within the stories.

The next dimensional inquiry space is continuity of experience (Clandinin & Connelly, 2000) and refers to how experiences are built upon one another. This dimensional space is based on Dewey's (1938) theory of experience. The concept of continuity is reflected in the development of relationships with others over time. The participants' stories were based on a particular time in their life and a set of experiences built upon the next set or future experiences. A participant's current experience with respect to their HIV health care, for example, is built upon experiences with health providers and institutions from their past. If a person has a positive experience within a health care setting, this can contribute to a positive outlook about what health care can offer them in the future. As a result, past, present, and future experiences can be linked to one another in profound and revealing ways.

The final dimensional inquiry space considers where the participants' stories take place (Clandinin & Connelly, 2000). Location is a significant element because it provides rich contextual features to the stories. If narratives take place in a particular institution or within a specific political climate, there might be greater understanding of what factors contributed to the experiences of the participant.

Narrative beginnings.

As a narrative inquirer, my narrative beginnings refer to why I have engaged in this work. As described in chapter one, I described and located my first encounter with HIV with my work as a nurse in corrections. In addition, my narrative beginnings can be traced to my time as a high school student trying to make sense of how HIV affected my friend whose brother died of AIDS. My personal experiences with HIV fuelled my questions about how HIV affected the world of

previously incarcerated Aboriginal people living with HIV. However, to begin this process, I also needed to explore why I chose narrative inquiry as a methodology in relation to my own experiences and how I viewed and experienced the world.

As I considered the use of narrative inquiry, I also needed to consider the place of theory in narrative inquiry. I came to understand that narrative inquirers begin with experiences as expressed in life, whereas formalists begin inquiry in theory (Clandinin & Connelly, 2000). During my PhD studies, I explored a number of philosophies; critical theory was one that intrigued me because it was helpful to critique macro social structures within society. Macrosociology is used to examine "the wider structures, interdependent social institutions, global and historical processes of social life" (Scott & Marshall, 2005, p. 374). Examples of macrosocial structures include: Marxism, functionalism, and systems theory. As a community health nurse who currently practices within and outside correctional services, I recognized the effects of macrosocial influences on clients; some examples include clients experiencing low socioeconomic status, having a history of residential schools, and being a product of colonialism (Adams, 2000; Chrisjohn & Young, 2006; Miller, 2000). I have read a number of articles by authors who have discussed critical theory in their work (Coyte & Holmes, 2006; Holmes & Gastaldo, 2002; Mill et al., 2001; Morrow, 2005; Trocme, Knoke, & Blackstock, 2004). This has resulted in my ability to more fully appreciate the presence of macrosocial structures through more astute observations within society.

During my narrative beginnings, I considered whether the analysis of my research could perhaps be aligned with Marxist-influenced scholars or critical theorists, while still looking

through a narrative inquiry lens. I have been exposed to a number of critical theorists, and, therefore, I was aware that it would influence how I reflected on my participants' stories. How could I reconcile these different ways of viewing the world? Could I attend meaningfully to the participants' stories while also considering how these stories related to larger views of the world? In order to make that decision, I read and reflected on both narrative inquiry and critical theory. Clandinin and Rosiek (2007) discuss the similarities and differences of narrative inquiry and Marxist-influenced scholars:

> Narrative inquirers and Marxist-influenced scholars working in the applied field of social sciences often share an interest in analyzing the way large institutions dehumanize, anesthetize, and alienate the people living and working in them. They also share an interest in resisting those effects by producing a scholarship that intervenes in this process by helping people develop a more robust sense of the reality around them and their agency within that reality. What is different between their approaches is their underlying conception of reality. (p. 47)

As I discovered, Marxist-influenced scholars focus on a conception of reality that includes the large scale social arrangements and a critique of ideologies. Narrative inquirers, on the other hand, conceive reality as privileging individual lived experience (Clandinin & Rosiek, 2007). Narrative inquiry has also been critiqued by Marxist-influenced scholars (Clandinin & Rosiek, 2007) who suggest that beginning the inquiry in the lived experience of individuals is overly burdensome and that narrative inquiry fails to analyze the real cause of oppression.

However, Clandinin and Rosiek (2007) counter this view of Marxist-influenced thoughts by stating that:

> Scholarship grounded in Marxism is at best condescending. It approaches people's experience with the presumption of deficits that only the Marxist academic can remedy. At its worst, the narrative inquirer can find scholarship grounded in Marxist theory to be imperialist and self-defeating. By preemptively dismissing the lived experience of persons as a possible source of insight, it simply replaces one totalizing source of external authority - be it church, state, or post-positivist social science - with another. (p. 51)

Thus Clandinin and Rosiek (2007) highlight significant differences between a critical theory approach and a narrative inquiry approach. As I became clearer in my understanding of narrative inquiry, another consideration that contributed to my decision to use this approach related to what I valued in my own work experience – being invited to share in the storied experiences of the participants.

Practical, Field Text-Oriented Considerations

Negotiating relationships.

Research participants were recruited from in and around the Prince Albert community. Prince Albert is an ideal site because there are three First Nations communities located close to the municipality. Prince Albert also serves at least six other First Nations bands in Northern Saskatchewan and surrounding areas and is home to four prisons: the Saskatchewan Federal Penitentiary (medium and maximum security); Riverbend Institute (men's federal minimum security); Prince Albert Correctional Center (men's provincial); and Pinegrove Correctional

Center (women's provincial). Often families of offenders relocate to Prince Albert to be close to their loved ones.

The eligibility criteria for participants were men and women of Aboriginal ancestry who were HIV positive, over the age of 18, had a history of being incarcerated within the previous two years, and were willing to participate in at least five to six conversations. For the purpose of this research, I defined Aboriginal heritage as identifying oneself as First Nations, Inuit, or Métis (Statistics Canada, 2008; Waldram, Herring, & Young, 2004). This definition of Aboriginal is congruent with Section 35 of The Canadian Constitution Act 1982 and with the Canadian Institutes of Health Research Guidelines for Health Research Involving Aboriginal People (CIHR, 2007). I decided to recruit four participants into the study. This decision was based on similar narrative inquiry studies in which four individuals provided detailed stories (Barton, 2004, 2008; Clandinin & Connelly, 2000). After recruitment, I conversed with each of the four participants between five to six times; each conversation lasted between 60 to 120 minutes.

I used my personal knowledge of the Prince Albert area to recruit participants. I have worked in the area of HIV prevention and AIDS care in Prince Albert for over 15 years, and I am familiar with many of the community health and support service facilities. This insider knowledge assisted with recruitment, allowing me to focus on two key organizations in Prince Albert that have regular contact with HIV positive clients: the Prince Albert Sexual Health Clinic and 601 North. The Sexual Health Clinic (SHC) in Prince Albert has an infectious disease office located in the clinic and has an extensive history of providing service and support to HIV-positive clients and their families. The organization known as 601 North is a non-government

organization which provides direct support to people living with HIV and AIDS. In addition, I asked the health clinic managers and nurses in the four prisons mentioned above to refer any potential participants to me using the study information poster. I was not involved in the immediate HIV care of any of the participants; therefore, a refusal to participate in the study would not affect their care.

Negotiating entry to the field.

Two of my research participants, Mary and Lauren, were initially approached by a Sexual Health Clinic staff member and invited to join the study. After they provided permission to be contacted, I made arrangements to meet with them. With respect to the third participant, Winston, I was aware of his HIV status and history because I had previously done some HIV counseling with him at the penitentiary. I unexpectedly ran into him on the street after he had been released and provided him with the information about the research project. He contacted me one week later by telephone, and we subsequently discussed the research project at a local fast food restaurant. The fourth participant, Janelle, was recruited though Winston. After the conversations had been completed with Winston, he recommended that I talk to his partner, Janelle, who also met the study criteria. Janelle and I met at the end of one of my conversations with Winston, and she agreed to participate.

All of the more formal taped conversations took place in my office at First Nations University. However, I still had many opportunities to converse with participants when I gave them a ride to the university, had lunch or went for coffee with them, or met them on the street. In my office, I made sure the participants were comfortable by offering them a drink of water

before the interview started. I also had snacks available. My office is conveniently located on the street level of the university. Two of the participants preferred to knock on my window to announce their presence at the university rather than accessing me through the receptionist at the front desk.

Working with participants who have a criminal history raised the question of personal safety. Having worked in corrections, I realized that I had been conditioned to automatically think about positioning myself when talking with an inmate and to consider the potential for situations to change quickly and inmates to become violent. I had experienced this during my work at the penitentiary when an inmate raised his voice and tried to block my access to the door. He became angry because his hepatitis treatment had not been initiated. This experience also influenced my own initial assumptions about the participants that I met with. As I reflect on my research, I realize that this assumption was uncalled for as all the meetings went very smoothly and safely. The way I addressed the issue of safety was that I sent a text message to my participants at the outset of the study to make sure we could meet in public locations. In addition, there were two participants who were referred to me by health care workers in the community; therefore, I felt comfortable being in conversation with them given that they were already known by other health care workers. During our initial conversations, I had to trust that my participants were meeting with me in good faith and that they wanted to learn about the study and were not planning to manipulate me for other purposes. I also drew on my experience working with inmates at the penitentiary to maximize my safety during the interviews. I positioned myself close to the door in case there was ever a threat of violence. No such threat

occurred. I was frequently reminded by a phrase expressed by inmates at the penitentiary: "if you show respect, you will get respect." I earned the respect of my participants by discussing openly why I was interested in the research and explaining the work I had done with individuals living with HIV. In turn, all the participants agreed to share their stories and at no time did I feel unsafe during our conversations.

Before our conversations, the participants and I negotiated the purpose of our relationship and aims of the inquiry (Clandinin & Connelly, 2000). Research agreements were developed with the participants to document what they wanted to achieve from the research experience (Appendix A). I was honest about the purpose of the narrative inquiry and assured them that the research proposal had been ethically approved by the University of Alberta Ethics Board, Panel B. I continued to renew my ethics yearly because I have maintained contact with my participants well past the initial research interview dates. The additional conversations have allowed the participants to review their stories and to reflect on their feelings regarding the research process. In addition, having the opportunity to continue the conversations with the participants allowed me to be part of their lives and let them know that I continued to care about their well-being. The Prince Albert Parkland Health Region Ethics Committee also granted permission for me to recruit participants from the health region.

I was in contact with the participants for several weeks before formal conversations took place in order to talk about the research process. Our contact was via text messaging or short telephone conversations. There was an initial *feeling out* period. Participants shared that they had talked to people who knew of me to make sure that I was "okay" to talk to. They talked with

health care workers who knew me and to other people who knew who I was in the community. Winston and I previously knew each other from my work with him in corrections and he had always expressed an interest in sharing his story with me upon his release from prison. I had walked alongside Winston for over two years as he lived his life in the penitentiary. When the opportunity presented itself, he not only reconnected with me but also made sure that his partner, Janelle, and I would have an opportunity to speak with each other. The other two participants, Mary and Lauren, connected with me through my co-worker who mentioned to them the research I was conducting.

It was easy to maintain relationships with all participants during the intensive four week period that I spent in conversation with each of them; however, maintaining the relationships afterwards was somewhat challenging. My research took longer than anticipated; the participants changed their phone numbers regularly and, at times, moved away and then back into the community. However, the relationships we built during the intensive conversations were meaningful and withstood the time we were apart. When I encountered the participants on the streets, they did not hesitate to share their new contact information with me.

Commitment to understanding lives in motion.

In creating relationships and meaning, I paid attention to the importance of building relationships, the importance of being invested in the research, and learning to step away from the participants. I paid particular attention to the significance of building relationships with the participants. Wilson (2008) and Smith (2006) discuss the importance of relationship building in Aboriginal and Indigenous cultures, and the significance of the participatory nature of

Indigenous research paradigms. Other Indigenous authors (Goulet & Goulet, 2014; Lessard, Caine, & Clandinin, 2015) have described the importance of participatory Indigenous paradigms but have also focused on the importance of place in Aboriginal/Indigenous research. The participatory nature of Indigenous research is based on principles that are complementary to narrative inquiry. In narrative inquiry, the stories belong to the participants just as research in an Indigenous paradigm belongs to the community involved in the research (Smith, 2006; Wilson, 2008). The conversations became richer in detail as the participants felt more invested in the research, an outcome of wanting to share their stories with the researcher.

Clandinin (2013) refers to four key processes in narrative inquiry which are important to consider in story co-construction—living, telling, retelling, and reliving. People live their stories and retell them. Individuals are often changed when they retell their stories and may relive their stories when they tell them. In subsequent conversations with the participants, I noticed that they might retell the same story differently. However, what I found interesting was that their stories would change slightly between retellings. Even between our meetings, the participants seemed more aware of the stories that they had previously shared and changed them slightly by adding additional details when they reflected on our previous conversations. Clandinin (2013) would consider this as an example of how participants relive and then retell their stories. Story-telling is not linear but instead is perhaps more circular as participants continue to retell, relive, reconsider their stories, and then retell their stories again. As each story is retold the participant is not necessarily the same as they were when they last told the story and this again restarts the process of retelling and reliving the narrative inquiry process. This is similar to Dewey's (1938;

1981) concept of experience; he argues that experience is transactional and is transformed by interactions in the world. When I first started the research, I assumed that I would understand what the participants were living through. I had worked in the field of HIV and corrections since 1998 and felt I had a good understanding of my potential research participants' life situations. However, when I met the first participant, I realized I needed to be more open to how each individual uniquely lived their lives. I attended to their life because narrative inquiry is about life and living and not merely about the stories being told (Clandinin, 2013).

Clandinin (2013) describes the importance of relational living alongside participants. This meant I needed to try and understand or live alongside the participants' stories as they told them. I considered the three dimensional narrative inquiry space and how it affected their lives. I did not witness or experience what the participants went through firsthand, but I felt like I walked alongside them as I tried to understand what they were going through as they shared their stories. Having worked as a nurse in the community and in corrections, I felt I could relate to them better. My experiences in corrections helped me to understand what the participants meant when they described the oppressive atmosphere of corrections. When the participants spoke of the community, I could relate to their lives on the reserve. I have had opportunities to visit First Nations reserves and directly observe the conditions of poverty that exist within First Nations communities. In addition, when they referred to Prince Albert, I knew the exact locations they spoke of because I grew up in Prince Albert. Even though we met in my office to conduct the taped conversations, I still walked alongside them when we met for coffee and had lunch at a restaurant in downtown Prince Albert. I also had follow up meetings with participants in the

park and on the riverbank since they often felt more comfortable meeting outdoors. I felt they wanted our worlds to mesh when they brought their children into my office so that we could meet each other. Through these less formal conversations, I could feel our relationship deepen as we continued our conversations outside of my office and in the community that we shared.

As it was important to establish a relationship with the participants, I also reminded myself that I needed to step back and reflect on what the participants were saying. Clandinin and Connelly (2000) discuss feeling emotionally close to the participants but still needing to be able to step back from that position of relationality. I considered the difference between what was being shared with me verbally and what remained unspoken, particularly when difficult topics were addressed and a participant did not want to explore or provide details about a topic. Sometimes participants would pause when a subject was broached or did not want to clarify when asked a question. These silences gave me pause to consider why a participant would not discuss certain issues. In addition, there were also topics, such as racism, that were not mentioned that made me wonder why they were not more fully discussed. Authors such as Bamberg (2011), Clandinin and Huber (in press), and Neumann (1998) contribute to our understanding of what silence(s) means. Such an understanding was required when participants seemed uncomfortable talking and when I needed to ask more questions. I had to be respectful of this response and let that silence take its place within the conversation, always considering and making note of it.

Moving from field to field texts.

The first step in collecting stories was identifying the participants. I met with each of them to ensure that they met the eligibility criteria. I also provided them with more information about the purpose of the research. I reviewed the information letter and obtained informed consent (see Appendix C and D) prior to the conversations.

For each participant, I conducted six to seven conversations over a four week period. Before these conversations took place, I met with each of the participants in the community to discuss the research process. We met in areas that the participants chose. For example, I would pick up Lauren, and we would talk in the car as we sat in the park drinking our coffees.

I finished the set of taped conversations with one participant before I began conversations with another participant. This process allowed me to immerse myself in the stories and life of a single participant and keep their stories separate from one another. After each conversation was completed, I gave each participant $20 as a thank you for their participation to help cover the cost of their childcare, travel, and time spent with me.

I relied on conversations to elicit both HIV and life stories and utilized an approach called "identity moments" (Schlosser, 2008, p. 1502). In this approach, Schlosser recommends asking participants to construct a timeline of historically important moments in order to explore life experiences and histories. This technique was helpful because it allowed me to identify moments in my participants' lives that were significant to them. In addition, I experimented with a technique described by May (1991) that uses a more focused approach to clarify aspects of previous conversations. In subsequent conversations with the participants, I brought up previous

topics which I felt were important and needed further exploration. This focused approach (May, 1991) helped to clarify information and expanded the conversation topics. I also asked the participants if they had other topics from the previous meetings and drew additional information such as readings from outside sources into these follow up conversations. These readings would often elicit opinions and comments from the participants.

Field notes were written during and immediately after each conversation. The field notes taken during each conversation were brief and used to help me remember meaningful points. More detailed field notes were verbally recorded after the conversation was completed. The goal of the field notes was to obtain a rich description of the participant and the environment in which the conversation took place, to record my thoughts about significant happenings in the conversation, and to reflect on my own thoughts and feelings about how I related to their stories and memories that this called forth for me (Clandinin & Connelly, 2000).

I also asked the participants if they had artwork, writings, or other items with special meaning to them that they wanted to bring to the meetings. My intention was to use artwork to enrich our conversations. The items could be, but were not limited to, beadwork, paintings, sketches, songs, honours they had received (i.e., an eagle feather), and journals. One participant shared her journal writings, pictures, songs, and poetry with me. In addition, she had program materials from the penitentiary that had significant meaning to her. I also discovered through my work at the penitentiary that stories about people's tattoos could be both interesting and valuable sources of information to enrich their stories. The participants were particularly pleased to

discuss the significance of their tattoos. Clandinin and Connelly (2000) highlight the importance of exploring the meaning of these items.

The conversations were transcribed. I sent digital recordings of the conversations to the transcriber by registered mail in a protected password format. The transcripts were returned to me by email as a password protected file. All names and location identifiers were removed from the transcripts. Once I received the transcripts, I confirmed their accuracy by listening to the original recordings and filling in any unclear or missing portions.

Moving from field texts to interim and final research texts.

Field texts are diverse and can come from a variety of sources such as research conversations, journal writing, family stories, photographs, and memory boxes (Clandinin & Connelly, 2000). Field texts also document the relationship between the researcher and the participant and are part of an interpretative process (Clandinin, 2013; Clandinin & Connelly, 2000). My initial field texts that I created were personal stories written as part of a narrative inquiry course when I pondered my motivation for conducting research in this field. I wrote about my past and what I was currently experiencing in my work with people living with HIV. My initial personal field texts were an attempt to determine where I was positioned within the research. As I studied and worked on my course assignments, I kept track of my thoughts in three journals. I recorded articles I had read, personal thoughts I had about the research, and challenges that stood out to me. Once the conversations started, I developed field texts through additional journal writing, field notes, and transcribed conversations with the participants, their photographs, and other things that they had shared (i.e., obituaries, their personal work from the

corrections centre). The field texts reflected the complexity of each participant and provided a more complete picture of who they were. The journal writing that I engaged in also provided me with an opportunity to engage with my own thoughts on the meeting. I would not only make note of the physical location, but I also would make note of the tensions that both my participant and I had with topics that were discussed. The field notes also challenged me reflect on the tensions that this research created for me. For example, when I heard about challenges participants had experienced during their encounters with nurses, I considered if individuals I worked with in the past might perceive me negatively. In this way, the tensions made me look inward and contemplate my practices as a nurse. The field texts contributed to the development of the research texts.

Interpretive-Analytic Considerations

There is no specific step-by-step guide to analyzing data in narrative inquiry; however, Clandinin and Connelly (2000) provide a set of guidelines and suggestions. The first suggested step in data analysis is the transcription of the conversations which includes reviewing field text notes and documents and removing people's names from the narratives to ensure confidentiality.

After the conversations and observations were transcribed, I read and reread the field texts to explore a variety of narrative inquiry considerations. I contemplated more deeply Clandinin and Connelly's (2000) three-dimensional narrative inquiry space—interaction (social), continuity (past, present, and future), and situation (place). During this initial analysis, I considered influences such as the "character, place, scene, plot, tension, end point, narrator, context, and tone" (Clandinin & Connelly, 2000, p. 131) for each conversation. These areas

were significant because they provided the context for the participants' stories. I also questioned the meaning and social significance of the field texts before writing narrative accounts. Once the narrative accounts were composed and negotiated with participants, I began to look for resonant narrative threads.

Representing narratives of experience in ways that show temporality, sociality, and place.

Clandinin and Connelly (2000) make it clear that there is no single way to transform field texts into research texts. They suggest developing interim texts which are "texts situated in the spaces between field texts and final, published research texts" (Clandinin & Connelly, 2000, p. 133). The interim texts, or narrative accounts, are designed to be texts "shared and negotiated" with participants (p. 133). In this way, the analysis of the narratives became a shared process with the participants. There should be a sense of "moving back and forth between being in the field, field texts, and research text . . . as we negotiate the inquiry" (Clandinin & Connelly, 2000, p. 135). I experimented with interim texts, incorporating my field notes and selected texts that I wrote from previous conversations. I negotiated these texts with my participants, but I found out quickly that the participants preferred me to read these interim texts to them rather than reading the interim texts themselves. When I presented them with drafts of their narrative accounts, they were more eager to discuss and negotiate changes related to what I had written.

As I wrote my participants' narrative accounts, I deliberated on how to use my voice in the project. I wanted to ensure that the participants' experiences were the focus of the inquiry. Chase (2005) suggests that the researcher's voice can affect the meaning and flow of the

narratives; I reflected on this as I wrote the participants' stories. Since narrative inquiry is a participatory process between the researcher and participants (Clandinin & Connelly, 2000; Riessman & Speedy, 2007), it was essential to be mindful of the language used to describe the collaborative work. I described the co-composition and participatory nature of narrative inquiry to my participants. I felt it was important for them to understand and negotiate how we would approaching the research. They agreed to provide feedback on the interim texts that I created through our conversations.

Another issue I considered was the cross-cultural nature of the study; in other words, what were the principles that guided the interpretation of field texts and honored that they are Aboriginal. Were there cross-cultural world views that might require contemplation? Authors including Lugones (1987), Ermine (2007), King (2003), Bhabha (1994), and Clandinin and Connelly (2000) have highlighted the need to be mindful of a variety of world views when working across different cultures. Lugones (1987), for example, presented the notion of world travelling which involves keeping an open mind when considering differences between others. King (2003) and Ermine (2007) place a strong focus on First Nations stories and perspectives. I was aware that working with individuals with viewpoints different than my own could place me in an uncomfortable and unfamiliar situation. I reflected on my position within the research process. Was I judging the participants? Was I surprised to hear their stories? Did I need to discuss my feelings with the participants or someone whom I could rely on? Andrews (2007) supports confronting oneself in these situations. It was helpful to dialogue with the participants as we each made sense of their life narratives. There were times during the conversations when I

listened to the stories and felt shock and disbelief. By showing emotions and sharing my own sense of wonderment, I opened up an opportunity for the participants to view me as a person who was also affected by the human conditions within their stories.

Because I was working with participants from another culture, I also paid attention to relevant ethical considerations. Ethics in one culture may mean something different in another culture (Andrews, 2007; Wilson, 2008). The topic of ownership was brought up and discussed at a number of points in the research process. We negotiated what ownership meant. I shared that the research was part of my doctoral work and would be part of my PhD. The dissertation would have my name on it, but it would contain their stories. We discussed how that made them feel, and they seemed genuinely happy to be able to help me. I asked them what ownership meant to them and what they would like from this research. All participants talked about wanting to be able to take their stories, which they felt strongly belonged to them. They wanted to be able to do whatever they choose with those stories. Lauren, for example, shared that she planned to use her narrative accounts as part of a book she would one day like to publish. For others, like Mary and Janelle, they wanted to be able to share their stories with their children and families. We also negotiated what ownership meant as I asked permission to take their negotiated narrative accounts to conduct public presentations. All of them were fine with this, and some participants expressed an interest in helping with the presentations.

During our meetings, all of the participants stated that they wanted to share their stories with others in order to highlight the strengths and challenges in their life and their experience living with HIV. Our discussions of story ownership were not limited to the consent stage but

also occurred during a number of occasions over the five to six more formal taped conversations with each participant and also during our follow up conversations months after the formal conversations. The stories that are presented in this dissertation are a culmination of co-composed narrative accounts that the participants have agreed to share with the public. All of the participants were given a copy of their narrative accounts.

The participants required a level of readiness before the final stories were written. During this time in the narrative process, participants needed to feel comfortable to voice their experiences, which for some meant reliving some of their past experiences. For all of them, this was often a difficult process. Once the stories were told, the participants reviewed their narrative account so that we could further discuss and negotiate how to represent themselves. The participants negotiated what these stories meant to them and decided whether they were ready to share them with others.

Rigor

Rigor refers to how researchers demonstrate the legitimacy of the research process (Aroni et al., 1999). There has been some debate regarding how the legitimacy of qualitative research is evaluated (Emden & Sandelowski, 1999; Rolfe, 2006). Rolfe (2006) states, for example, that the evaluation of qualitative research can be divided into three positions (p. 304):

> those writers who wish qualitative research to be judged according to the same criteria as quantitative research; those who believe that a different set of criteria is required; and those who question the appropriateness of any predetermined criteria for judging qualitative research.

Rolfe (2006) reminded me of the difficulty in appraising the quality of research. The difficulty in evaluating qualitative research arises from an assumption that all qualitative research is the same. Narrative research is varied and the multiple approaches reflect different ontological and epistemological stances (Riesmann & Speedy, 2007). Caine and colleagues (2013) focus on the ontological and epistemological commitments of narrative inquiry. These commitments highlight the importance of how experiences are viewed narratively and the building of relationships within the research framework. These commitments form the foundation of what Clandinin and Caine (2013) term the touchstones of narrative inquiry, touchstones that are meant to assess the quality of narrative inquiry research.

Justifications—personal, practical, social.

Meleis (1996) also provides criteria that can be used to enhance rigor in qualitative work. Meleis (1996) suggests that culturally competent scholarship is based on substance and thoroughness and can be evaluated through the use of eight criteria: contextuality, relevance, communication styles, awareness of identity and power differentials, disclosure, reciprocation, empowerment, and time.

One aspect of rigor outlined by Meleis was particularly important when I considered my identity and the power differentials that existed between the participants and myself. Meleis (1996) states there is never an equal level of power between the researcher and participant, but this does not mean it cannot be acknowledged. To help me acknowledge these power differentials, I reflected on the notion of power and wrote about my observations in a journal. The fact that I am a nurse and have a different racial background (Tang & Browne, 2008) could

both contribute to an unequal level of power. I considered how I would relinquish some of this power, if necessary. This meant listening more and talking less. To help decrease the power differential, I made sure to disclose the purpose of the research. Prior to the conversations, I described the research process and continuously obtained or reaffirmed informed consent from the participants.

Reciprocation is another criterion to enhance rigor (Meleis, 1996). Reciprocation refers to ensuring that the goals of both the researcher and participants have been considered. As mentioned earlier the participants and I openly discussed the benefits of the research. In this study, reciprocation was explicitly considered through the use of a research agreement between each participant and me. The research agreement (Appendix A) clearly indicated what participants wanted to get from the research process and how it could potentially benefit them. During the act of obtaining consent, I shared with the participants what I wanted to get from the research process.

McNiff (2007) presents a values based approach to rigor and suggests that the realization of values is one criterion of validity in narrative inquiry. McNiff states, "I wish my work to be judged in terms of whether I tell a good (valid, meaningful) story of good (valid, meaningful) practice" (p. 321). Throughout the study, I wondered if the values that I held as a narrative inquirer were realized.

Ethical Issues

In considering ethics, I turned towards the work of Ermine (2007) to understand ethical spaces. I too always attended to the importance of developing relationships in narrative inquiry

as described by Clandinin and Connelly (2000). To create a respectful research relationship, Ermine (2007) asks researchers to consider the ethical space of engagement. He argues that researchers must examine the influence of Western perspectives on their understanding of the world. These perspectives often provide only one viewpoint. A broader examination of cultural, social, and political factors is important when working with and caring for Aboriginal persons. It is critical for researchers to recognize and critique the historical relationships between Aboriginal worldviews and Western thought (Barlow, 2009; Ermine, 2007; Patterson et al., 2006). I utilized Ermine's (2007) concept of ethical space to think about the process I engaged with and consistently made reflective notes prior to, during, as well as after my close work alongside participants. I asked myself and was asked by Willie Ermine, one of my dissertation committee members, why I wanted to engage in this work and if I was positioned to do this work effectively. I was neither Aboriginal nor living with HIV. Upon much reflection and discussion with Willie, I realized that I needed to create a common ethical and relational space for both the participants and myself for meaningful work to occur. The development of relationships between myself and the participants through narrative inquiry (Clandinin & Connelly, 2000) promoted the development of a relational space whereby the participants and I could negotiate respectfully with one another the purpose, intentions, and processes of this research.

Attentive to multiple audiences.

The participants are considered a vulnerable and marginalized population because of their HIV illness, history of incarceration, and status as Aboriginal people. Participation in the research project had the potential to benefit the participants by promoting a feeling of

empowerment and providing a catharsis through sharing their stories. However, there were some risks associated with their participation. By sharing their stories, participants were at risk of revisiting and opening up emotional wounds. There was the potential for this to lead to psychological distress and self-harm. In order to address these psychological issues, I had prepared a list of professional counseling and support services, which I had previously contacted, in case I needed to refer participants to them (see Appendix B). None of the participants expressed a need or want to talk with an elder or counselor after our conversations. The support services that were available included elders, healthcare counselors, and various community resources.

Relational response communities.

I also utilized two sets of ethical principles for conducting research with Aboriginal people. The first set of principles was developed by the Canadian Institutes for Health Research [CIHR] (2007) and provides a collective set of guidelines to "assist researchers and institutions in carrying out ethical and culturally competent research involving Aboriginal people" (p. 2). The second set of principles is referred to as the OCAP (Ownerships, Control, Access and Possession) principles (First Nations Centre, 2007). These principles are important when conducting research with Aboriginal communities. Ownership is described as challenging the academic notion of intellectual property and refers to the community ownership of data. The concept of control challenges the notion of academic control of the research process. The principles that guide community access and possession require that the community have full

access to and possession of the research information. I worked with individual participants to ensure that the OCAP principles were applied to individuals rather than to a community.

By focusing on individuals instead of a community, the question arose as to whether the spirit of OCAP principles could be applied. To answer this question, I considered what the intent of working with a community was: working with a community ensures that the research benefits the community because the community is fully involved with the research process. Chrisjohn and Young (2006) described researchers swooping into an Aboriginal community and taking information that was not given back to the community; I ensured that the participants did not feel this way about the research process. The participants had ownership over their stories. I only shared the participants' life narratives after we had negotiated these. I also provided all participants with both draft and final copies of their narrative accounts. Participants were able to modify and change their narrative accounts. Participants were also able to request, at any time during and after the research, additional copies of these to use in whatever manner they choose.

CIHR guidelines (2007) are important when working with a community, but they are also relevant to working with individual participants. CIHR (2007) outlines a number of principles for research with Aboriginal communities. The first principle suggests that the researcher must understand and respect Aboriginal worldviews and that the researcher "has an obligation to learn about, and apply, aboriginal cultural protocols" (CIHR, 2007, p. 5). I made sure that I offered elders tobacco when I asked them to be available to work with any participants who requested seeing them or that I recommended to them. I also made sure that the elders I approached were ones that I had previously worked with. In my practices with elders, I have found it important

and respectful to develop relationships so that they are aware of who I am as an individual before the research project even begins. I have experience working with Aboriginal people in my position as a project nurse at the penitentiary and in my academic positions at the First Nations University of Canada. I have been invited and have participated in Aboriginal cultural and spiritual activities such as sweat lodge ceremonies with the offenders in the Federal correctional institution. At First Nations University of Canada, I have participated in cultural workshops with elders and staff, and I have had discussions with students on their perspectives and cultures. I have also had the opportunity to act as an elder's helper during pipe ceremonies, feasts, and talking circles.

The next principle I considered was whether or not I was touching on the traditional or sacred knowledge of an Aboriginal community (CIHR, 2007). I did not target the knowledge of a particular community but was interested, instead, in the particular experiences of participants. These experiences may overlap with the traditional or sacred knowledge of a community. My participants shared their stories regarding their experiences with their Aboriginal culture, but none of the stories they shared were considered sacred according to the participants.

The next principles that are important include concerns of privacy, anonymity, and confidentiality (CIHR, 2007). Anonymity is an important concept in research. I explained to the participants the concept of anonymity as well as the advantages and disadvantages of anonymity. After reviewing their stories in both draft and finalized format, they elected to use their first names in the study. They recognized that these were their stories, and they wanted to have their first names included. The topic of confidentiality was discussed in both the consent (Appendix

C) and information sheet (Appendix D) that the participants received. In addition, the research information sheet also stated that the intellectual property generated by the research was a product of the work of both the researcher and the participant. At any time during the research project, the research information sheet could be reviewed and revised through a discussion between the researcher and participant.

Concluding Remarks

I selected narrative inquiry as my methodology because it enabled me to make meaningful connections with, and understandings of, my participants' experiences. We have co-composed and negotiated their narrative accounts. Lauren and Mary have their own chapters. Winston and Janelle have their own separate stories; yet I cannot ignore how their stories are intertwined with one another. To respect both their individuality and their connectedness, I presented their lived experiences in a single chapter whereby I focused on both their stories individually and then tied their stories together.

I now turn to my first participant, Lauren.

Chapter Four: Belonging in the World: Discovering a Dynamic Identity

In this chapter I discuss the life experiences of Lauren. Lauren is an Aboriginal woman living with HIV who had been previously incarcerated. Within the context of narrative inquiry, I relate these narratives to research puzzles that we explored together. In building a trusting relationship, Lauren exposed the details of her life through her narratives and revealed the meaning and significance associated with understanding her identity and resiliency while living with HIV. I begin this narrative with Lauren's experiences living with HIV and being incarcerated; these experiences were entwined with many other life narratives.

Childhood Stories of Lost Innocence

My first introduction to Lauren was by a co-worker at the Sexual Health Clinic. The Sexual Health Clinic is a diagnostic and treatment facility for sexually transmitted infections. My co-worker informed me that she knew someone who might be interested in the research. I was both excited and nervous, especially as I began to think more concretely about how the research would unfold. I wondered if Lauren would feel comfortable sharing her stories with me. Was I going to ask her the appropriate questions, questions that would invite her into conversation? Would my own thoughts and ideas dictate the conversations, or would Lauren feel she could shape the conversations as well? Our first conversation was a phone call and Lauren did not seem nervous at all. During our call, I had the feeling though, that she was trying to figure out who I was and what the research was about. Our first phone conversation resulted in a number of other calls and text messages that allowed us to finally meet. Our first face-to-face meeting occurred on a cool spring day.

When I picked Lauren up at her home, I noticed that she was in her late 20s, wearing a black hooded sweatshirt and windbreaker pants with the word SIAST written down the side of her pant leg. The acronym, SIAST, was familiar to me and stands for Saskatchewan Institute of Applied Science and Technology. As she got into my car, I noticed that her dark brown hair framed her face, and she shared a smile with me. Later, in a conversation, I would discover that her asymmetrical smile was the result of sustaining a broken jaw caused by her ex-boyfriend and his friends. As she made herself comfortable in my car, she shook my hand and hugged me. I was surprised by this affectionate gesture. She stated, "the health care worker from the Sexual Health Clinic knew you well and said you were a good guy." I smiled and her words reminded me of how important reputations were. It also reminded me just how important it is for my work and who I am to be connected to the community. I asked her how long she had lived in this neighborhood. She pointed to the windows of a basement suite and told me she had been living there for only a few months. She described her residence as a modest place but said she was happy to be there. Her comments made me think about the conversations I have had with a housing worker in Prince Albert; she stated that it was often difficult for people who had been previously incarcerated to find affordable places to live. As we headed off to my university office, Lauren asked me if we could stop by her pharmacy so that she could take her methadone there. Once we arrived at the pharmacy I waited in the car until she returned. After about 15 minutes, we settled into my office and went over the information letter and consent form for the research. Lauren looked around my office with intrigue. A large dream catcher hangs over the window, and on the wall hangs a large painting of an eagle flying over four teepees in a purple

sky with smoke rising into the night air. An inmate from the penitentiary painted it for me. I recalled when he asked me what colors I liked and I chose purple. First Nations people say that purple is a healing color. I hoped that, today, Lauren might experience some healing in her journey. I could see that physically she was healing from her broken jaw, and I wondered if she too was healing from the violence she might have been exposed to.

The "invisible guy."

Lauren spent many years in a foster home. I was interested to know if she remembered her life before foster care. I asked, "Lauren, can you tell me about your life before foster care?" Lauren responded, "Yeah, before we got put in the permanent foster care, we [her family] lived out of a station wagon in downtown Calgary when we were kids. I was probably only about 3, my one brother was 4, my other brother was 5, and my parents were alcoholics. We used to go park in parking lots to sleep and stuff, and they would park our station wagon in the parking lot where the bar was. I remember we would spend hours at night, me and my two brothers, crying, waiting for Mom and Dad to come out. We would usually just end up sleeping in the parking lot until the bar closed. My mom would always come out of a bar and show up, beaten, bloody, and swollen to the point where I couldn't even recognize her face. And we would be so scared to see her like that. Then, whenever we would try to ask what had happened, my dad would say, 'It was an invisible guy. That's what happens when you're not good.' He'd say stuff like that. So we believed it, and we believed in this, in this invisible guy, and we felt we needed to be careful. We had to protect Mom because the invisible guy was after her, stuff like that. We made a little

mission out of it that we were going to save her from him. We didn't know that it was really my dad that was beating her up. He would never admit to it. He had too much pride."

"Because of this foster home, my spirit left me as a child."

At one of our meetings, I asked Lauren about whether she had any pictures or writings that had some significance in her life. I knew she lived a transient life, but she also talked about keeping important keepsakes close to her. Lauren shared with me that she had a booklet filled with writings, poetry, and picture collages that she had completed in a federal penitentiary program. I was very surprised at all of the materials that she had kept and as she began to flip through her booklet, I noticed a picture of a Sesame Street character and asked, "Do you remember Sesame Street?" Lauren replied, "We loved Sesame Street when we were kids. That's all we used to watch. I remember that kind of stuff. And my nickname was Big Bird!" I asked, "Who gave you that nickname?" She stated, "My brothers. Yeah, my brothers gave me that nickname and now my whole family knows me as Big Bird." I enquired, "So you were 5 or 6 when they gave you that nickname?" Lauren replied, "Yeah, this is when we got put into foster care, and we got put into the home that we got abused in."

Lauren then read the words using letters that had been cut from magazines on each collage. They included: *living in fear, flashback, fears, soul, getting beat, strapped, a victim of abuse,* and *a band of brothers*. Lauren continued, "It was just me and my two brothers, and we protected each other." Then I noticed the word *soul* on her collage and asked her, "What were you thinking when you wrote down that word, Lauren?" She answered, "I felt like I lost my innocence in this foster home. I lost my spirit, my soul, my happiness. I lost it in this house

[foster home] because of the abuse I experienced. They say that when you're a child, you have a beautiful spirit, a happy spirit. And when a child is hurt, traumatized, their spirit leaves them, their body, because it doesn't want to be hurt. So I think that because of this foster home, my spirit left me as a child, and somehow, it never came back. 'Cause I grew up through all of that, and it didn't get any better as I got older. So that's kind of why I put that there, 'cause I felt like I lost my innocence and my spirit." I asked, "Would you like to get your spirit back again?" Lauren replied, "Yeah, that's kind of why I went to this program, *Spirit of the Warrior*, and did a lot of this recovery work, just to get that back."

She read some other words on her collage: *children suffer, mental illness,* and *youth suicide,* and stated, "Mentally, I was gone. I was there in body but my mind was gone. I used to imagine somebody in my closet, like an invisible person that I used to talk to and play with, a figment of my imagination. And I remember sitting in front of a closet, talking to nothing and feeding this nothingness, and playing with it, but there was no one there. Because psychologically, I was messed up." I asked Lauren, "Did that happen over a span of years, or was it over a shorter period of time?" She answered, "It was the whole time I lived in that house when I was 5 and 6 years old."

Lauren scanned the pages of her journal and read out loud these words: *scared, child soldiers, like survivors, survivors remember, being brave alone, long way home,* and *I will get through this darkness.* On the collage there was a picture of a little child with the saying, "*I will get through this*." After a short pause, Lauren shared, "It's been going on for a year. Like a whole year, we were getting abused, and nobody knew about it. My brothers' names are in that

collage. It was really hard living in that house, 'cause there was the three of us, and there were two other little girls. One of them was younger than me and the other was the same age as me." After a slight pause, Lauren took a deep breath and stated, "the other girls went through the same thing as me." I confirmed later with her that she was referring to the mental, physical, and sexual abuse that she had suffered in foster care. Lauren explained, "I was abused. It's kind of an unwritten rule. Keep your head down and exist quietly. That's what it was like living in that house. We couldn't say nothing, we couldn't. We had to do as we were told or else we'd get hit."

Lauren read some other collage words: *innocent, surviving abuse together, frightened children, victim,* and *no trust.* As she looked at the pictures, she stated, "*this child* was abused and there was no protection growing up." I wondered who *this child* was and realized that Lauren was referring to herself and the other abused children. She continued to describe the feelings of *this child*, "It's so hard, and she feels like a victim because of all the beatings that we used to get. We used to get hit every single day for a year and a half. We were beaten with the foster parents' hands, their belt, or they would use whatever they could find. They would use whatever was handy such as electrical cords, wooden spoons, wires, hangers, and a broom handle. It makes you really wonder how people like that can be foster parents. That's very scary." I understood at that moment that *this child* was Lauren's inner child, yet she was unable to use the word "I" in place of *this child*. But, together, we understood the unfathomable experience of an innocent child being beaten with no excuse at all, and how this could be perpetrated by foster parents. As I considered my own life as a father and after hearing Lauren's

story of her abuse, it frightened me to think about how easily children could be abused by the people who were supposed to protect them. The use of the term *parent* in foster parent did not seem justifiable to me based on how I felt a parent should act. I could feel the tensions of Lauren's world and my world colliding together as I made more sense of the stories that she shared.

"We got starved: Our foster mother wouldn't feed us for days . . ."

Lauren continued with her childhood stories and described a time when she and the other children in foster care were neglected. "We got starved. Our foster mother wouldn't feed us for days, sometimes, and we used to steal food. I remember the foster mother made bannock one time, and she put it in the cupboard. I saw where she put it. She used to leave the home often, and we were left at home alone a lot. One time when she was gone, we made a plan to steal some bannock so that we could eat. I went to the kitchen and stole a whole loaf of bannock, a big bannock, the whole thing. I ran up to my room and we closed the door and all of us kids just tore it apart, devoured it. It was just dry bannock with no butter, nothing. We ate the whole thing because we were so hungry. Then she came home and found it missing. She and her boyfriend put us all in the living room and questioned us, but none of us said anything. Nobody would say nothing. She said, 'Who took it?' We still wouldn't say anything. So she turned us all around, pulled our pants down, and she just started whipping the heck out of us, her and her boyfriend. And I remember my brother jumping on top of me and my other brother blocking us. I remember screaming and crying. She was just telling us to shut up or she'll hit us harder. They were just whipping us, whipping us, and whipping us. I remember just hearing everybody

screaming, because nobody would say it was me who took the bannock. We were starving and that's what it was like in that home."

This story touched me deeply. The fact that children were not being fed made me reflect on how important food is in my culture and in other cultures. Food symbolized caring and nourishment. Food comforted me as a child, and as I got older, I noticed that food was used to greet people when they came to visit or to celebrate and show appreciation to others. People gathered around food and the sharing of food was an act of kindness. Food was kept away from Lauren and the other children, and it demonstrated not only the physical neglect but also symbolized for me neglect on an emotional and spiritual level.

Bedtime routine: "I would just go numb."

Being hungry was only one of many negative experiences that Lauren lived through in foster care. In telling me about her foster mother's boyfriend she stated, "He would go into the boys' room, my brothers' room, and we would hear laughing, because he would tickle them and play. Then all of a sudden it would go quiet. As soon as it would go quiet, we knew what that meant. We knew what he was doing. Then I remember, I was on the bottom bunk bed and the other girls were on the top bunk bed. Sometimes, we would switch. I remember curling up into a tight little ball in my blanket, thinking, 'I'll pretend I'm sleeping. He won't bother me tonight.' And I wrapped up really tight in a little cocoon, and I heard the door open, and he came straight to my bed, and he just pulled the covers right off me, and . . . he molested me, he abused me. This happened every night for over a year. I was sexually abused. I never thought it could happen to me, not again. I just knew that every time it happened, I'd go numb. My body would

just clench, and I would just go numb. And I couldn't scream. I couldn't say anything. I was so scared. I didn't know what to do. I was so small and helpless. I was only 5 or 6 years old. And when the authorities found out about the abuse, they separated me from my brothers."

"I had that mentality of survival."

At the age of 10, Lauren wondered about her ancestry and stated, "A lot about who I was and where I came from, my family, I just didn't know anything about. I started getting in trouble and I was having problems in school. I was always getting in trouble in school." I asked Lauren about what type of trouble she was getting into, and she said, "I stole money. I forget what grade I was in, but I was pretty young. And I don't even know why I took it. I thought I needed it. Like, I had that mentality of survival. Even though I was in a different foster home and we were fed, we had everything. But I still had that thought that we needed money, and that I needed to steal to survive. The school was doing a fundraiser and we ordered from Scholastic Books. The teacher sent me to the office to go hand in the envelope of money we had collected. And I remember taking it to the bathroom and taking the cash, putting it in my pocket, and throwing the cheques in the garbage. And I don't know why to this day, I thought that I needed it for my brothers, for my family. And I went back to class and I got caught and sent home. This was when my foster mother [a different foster mother] started putting me into counselling because she knew something was wrong. Why did I think that I needed that money to survive?"

A family tree: "I had a place with my family."

During one conversation, Lauren proudly pulled out a piece of paper and unfolded it to reveal a picture of her family tree. I was intrigued by her past. Hearing about her family gave

me some additional insight into Lauren's life. She pointed to names on the paper and stated, "This was my dad's sister and my dad's brother, and my uncle. And I hadn't seen them since I was a baby. I got a hold of my uncle by phone while I was in the penitentiary and I told him, 'I'm doing a family tree and I need help.' And he says, 'Sure, I'll help you.' And I asked my aunty, too, and she's, like, 'Yeah.' So they gave me all this information about my family, way back to my great-great-grandfather. So it turns out that my great-great-grandfather fought in the Rebellion with Louis Riel. My great-grandfather married a Mexican woman, so we have Chicano blood in our bloodline. So my great-grandmother was a Mexican woman. Her name's still unknown and she died giving birth. There was just so much that I didn't know. And after getting all that information, it made me feel like I had a place in my family and that I belonged. That was the best feeling. So I put it all down on my family tree. My whole dad's side was all filled up but my mom's side was empty. My mom and all my aunties and most of my uncles had died. They all died one after the other, boom, boom, boom. All within 2 years. It was hard on my family and my mom. My *Kohkum* and my one Uncle were the only two who were still alive that I could get information from. I didn't have any information about my mom's side of the family, the years, the dates of birth, their ages, nothing. So that had to wait. But just knowing this stuff about my dad's side felt really good. I felt connected and I felt proud. When I presented it to my group [in the penitentiary], my teacher said, 'We could tell when you were presenting that you were really proud of yourself and that you felt like you belonged. We could see it in your eyes.' And I was very proud."

I could see and feel Lauren's emotions as she told her story. She sat up straighter and her smiled widened with pride as she shared more with me. Lauren added, "And I have now talked to my grandma and she gave me information right back to my great-great-grandfather, and my great-great-grandmother on my mother's side. So now I have my whole family tree history done. It just makes me feel so good to look at it. This is my bloodline. My great-grandfather was a war veteran and he cooked in the war. There's just so much stuff that was amazing to me that I never knew. And it felt good to know all of that and to get all the dates. They were born as far back as the 1800s."

I have often heard of others wanting to know their history and past in order to get a sense of who they are. For Lauren, it was important to understand who her family members were because they gave her a sense of pride. It helped her realize that she was not alone in her life but that she was connected to a past and to people. She better appreciated where she came from and also she shared how she wanted to create a meaningful change for her children. She wanted more for her children than the life she lived. As I considered what Lauren went through, I felt fortunate to know about aspects of my family's past through stories shared by my parents and relatives. The connections between families are important because stories of hardship and success are passed from one generation to the next. I have heard stories of my own family's travels from the Philippines to Canada and stories of relatives who have struggled with illness but also celebrated successes in life through educational achievements. Like Lauren, I appreciated learning about my own past and having the opportunity to share these stories with the next generation, my family.

Surviving Self Harm, Violence, and HIV

"My chemical romance."

Early trauma resulted in Lauren using strategies to cope with the pain that she now considers harmful. During one of our conversations, Lauren and I were looking through her collage and the other papers that she wanted to share. On one paper it said *chemical romance*. I asked her what it meant and she replied, "Drugs. I started falling in love with my drugs, because they took the pain away. It was at the end of my first real serious relationship and I was really upset. Never seeing my son again, that's what I was worried about, because I was taking drugs. It almost makes you forget when you get high. Love is pain and it is dysfunctional. I gave my baby to my ex-mother-in-law because I knew that I wasn't able to look after him. I didn't want him to go into the welfare system. I told her I am an addict. My ex-mother-in-law stepped in and took him. I was also selling weed [marijuana], and I broke up with one guy and started going out with another. I was just 18 and I went downhill. I got hooked onto IV drugs heavily. I stopped selling weed because I used all my money to buy drugs. And that was when I found out that I was hepatitis C positive, and in less than a year, I was wired [addicted to drugs]. That's how I hid my pain, with needles and drugs."

I asked, "So the drugs helped you escape reality?" She replied, "Yeah, it was my biggest coping mechanism. That's how I hid my pain. It was the end of my innocence. I was really stressed out when I was 19 or 20 years old and I was going in and out of jail for stupid things." When I think about alcohol and drugs I contemplate their destructive properties, because they mask people's pain instead of addressing it. In Lauren's collage she wrote, *There's relief for*

pain like this. When I asked her about the phrase, she expanded, "That's referring to doing drugs to get rid of the pain, to numb it out. That's what I would do to feel better. I started working the streets, prostitution, when I was in my 20s. I had a gun held to my head. One of the girls I knew on the street was being beat up by two guys. I went in to try and help her out, but I didn't know she had stolen one of the guy's wallets. That's why they were roughing her up. I didn't know that. So she got away and then they started beating on me. One pulled out a gun and held it to my head, and I remember just crying, and I got on my knees, and I said, 'Go ahead. Do it.' I said, 'Do me a favour.' And then he turned the gun around, and boom, boom, knocked me out. I felt so dirty when I was on the streets. That was the lowest point for me, selling my body."

I asked, "What got you involved in that?" Lauren replied, "When dad died, I had no one else to get drugs from. I needed to sell myself. I tried to steal things but I was not good at it, because I always got caught. All my dad's friends are drug addicts or drug dealers. They showed me the ropes and trained me. This is my drug hell. I was on a 'Most Wanted' list a couple of times. No one wants to believe it, but a lot of family violence is committed by women."

Her statement that women committed a lot of family violence intrigued me. In my personal experience I view women as caregivers. My experiences were different than Lauren's and this highlighted to me just how our worlds differed. It made me consider and ponder more why women committed family violence and Lauren explained it to me. When I asked her to elaborate she said, "That stuck out to me because I was really violent. That was my survival tool. To be violent and be aggressive so that nobody could hurt me. So if anybody tried to come

at me, I'd be, like, 'C'mon, do this, let's do this.' I was crazy. I had that crazy attitude. I would fight guys. I was fighting guys and I was fighting girls and I didn't care. I was fighting, like, three, four people at a time. I just had that crazy attitude. I was in so many bad situations where I could have died, and I didn't care. It amazes me that I'm still here."

"Fighting with giants."

On her collage another phrase that Lauren had used was *Fighting with Giants*. I asked her about this phrase and she said, "Yeah, I was involved in something way bigger than me, and I couldn't stop thinking, 'I'm going to watch my brother die.' It turned out the gang turned on me and my brother. We were in that gang, and my brother got chopped in the head with a machete in front of me from our own gang. I robbed a dealer for four grand, and they were mad because they didn't get any of it. We had the money and they wanted some. So they rolled up on us, they surrounded us. There's six of them, and they had, like, knives, chains, bats, and there was just me and my brother. So we argued with them and I wouldn't give them my money. I didn't have all the money on me, I was smart. I only had maybe $400. The rest of the money I kept it in different places and with people who I trusted. There were six of them. My brother being as brave as he is, tried to protect me, like the good brother he is, picked up a two-by-four, cracked the guy in the head, opened the door, and told me to run. And right away, all the guys jumped up and surrounded my brother. I ran to the door and I shut it, and then I got back-to-back with him. I put up my fists and I said, 'I'm not leaving you. I'm going to stand here and fight beside you.' So we started fighting them off, and then boom, the guy pulls out a machete. Chop, chop, he hits my brother on the head with the blade flat down. He hits him and he hits

him again. The third time, he turns it with the blade down. I put my arm up to block it and then I stopped. It chopped my brother, cutting his head open. Blood just started gushing. Everybody backed off, and my brother hit the ground. I was holding onto him, he was bleeding all over me and I was just screaming. Then I pulled the $400 out of my pocket and I said, 'You guys want money? Here, and I threw it at them, and all six of them scrambled for it. I said 'I hope you're happy. Four hundred dollars between the six of you. You guys are really cruel, man.' And then they let us go. Then I laughed and I said, 'You guys think you got the best of me? I still got three grand and you don't. You're not going to get it, you'll never see it.' That was when I left the gang. My brother and I left them, we went solo."

On the collage there was a saying, *Enemy Within.* Lauren explained the saying meant that, "I'm fighting my own demons. I was fighting my own temptations. My urge was to really retaliate and to be this person that I knew I wasn't. So I took more drugs and it got worse."

"Power struggles."

Lauren and I continued to talk about her gang life and she said, "Gang politics are about power struggles. Like, everybody wanted to be on top, everybody wanted my top spot, everybody wanted money. You know, it was a power struggle and that's why we left the gang because they turned on us. Drugs were my stress reliever. I had feelings of disgust that borders on self-hatred. I was really hating myself. One day while I was prostituting I got raped out of town. He tied me up and raped me, and left me out of town. He was around 24 years old. It's funny how it happened. He picks me up, takes me out of town, he ties me up, he does what he does with me, all at knife-point. Then I asked him, 'Why are you doing this?' He says, 'Cause

you f..... deserve it, you little bitch.' That's what he said. So he leaves me out of town. He drives off. I go running after him, and just as I went running after him, an RCMP was pulling someone over. That RCMP saw me running, waving, and he came and picked me up. I said, 'Go! He's right there in that red car. You just passed him.' The RCMP wouldn't even speed up to go chase that car. Instead, he radioed another car. They couldn't find him. So they take my statement and they took me to the hospital.

Two weeks later, I went into the 7-11 up on 2nd Avenue up the hill, it's closed down now, and guess who works there?" I answer her, "that guy." Lauren states, "The guy who raped me worked at the 7-11. I walked in and I looked right at him. I said, 'Do you remember me?' He said no. He knew who I was right away when he saw me. I said, 'Oh you know who I am?' He says, 'No, I don't.' I say, 'Yes, you do, you f...' I was just mad. He takes off to the back. I asked the woman behind the counter, 'I need to use your phone.' She says, 'No, you're not allowed to use phones for emergency.' I said, 'The guy that you have working for your store raped me 2 weeks ago, so I need to use your phone, and I want his name!' So right away she grabbed her phonebook and handed me the phone and I called the police. I also got his name. The car that he picked me up in was parked outside and I got his license plate, make, and model. I phoned the city police. They told me, 'We can't do anything because it's an RCMP matter.' I said, 'Well, why can't you send somebody here to arrest him? I'm charging him for rape and assault.' They said, 'We can send a car, but you have to phone the RCMP.' So I phoned the RCMP. They said, 'We can't do it because you have to get a hold of the officer that took the information,' blah blah blah, 'and he's not in till next week.' So I wait. I sat there for 40

minutes. The cops didn't even show up and to this day the police haven't done anything. I think it was because I was a prostitute at the time doing tricks. I felt just dirty." Lauren took a long pause. And then she said, "I felt just dirty. After it happened, I tried to kill myself. I tried to overdose, it didn't work. It was just ugly."

"My decision to change my life."

Lauren's life experiences have been violent, and, in this story, she shared some of the reasons why she decided to change her life as she reflected on a collage created in prison that she freely shared. "Jail was like a big part of my life since I turned 13. I was in and out, in and out, in and out, in and out, all the time, all the time. I had a reputation in jail, too. They knew I was one of the bad ones that rolled with a gang. Although I wasn't in a gang, I still rolled with them. This one day I met this guy and fell in love with him. He did 10 years for manslaughter for killing someone and now he was out on parole. He finished his sentence and that was when I started going out with him. People called us Bonnie and Clyde because we were robbing people and we were crazy and in love. We did a robbery together and that's how I got my penitentiary sentence and that's also when I found out I got HIV. When I told him that I was HIV positive he didn't sound surprised."

I asked, "Was he HIV positive?" She replied, "I don't know but the first words out of his mouth were, 'Who did you tell?' He said again, 'Who did you tell?' and I said, 'What do you mean? Who should I tell?' He's, like, 'Well, who are you telling? Don't be telling everybody this.' And I knew right there he gave it to me. So I left him. That was the day I got my 3 years for the robbery, because he had stabbed a drug dealer and took his money. I covered the drug

dealer's mouth from screaming. I just freaked out because I didn't know he had stabbed him, I thought he just hit him. After it was over, I realized that he stabbed him. I got scared because I know what he was capable of doing. I've seen him stab people before and I've seen him beat people before. He used to beat me up a few times. He's crazy, he doesn't care. He's dangerous and I was scared of him."

I looked down at her collage and I read the phrases, *Wrong Man, Love and War, When Love Turns Lethal*." Lauren elaborated, "And that is when we got caught for the robbery. We're on the run and we were on *Crimestoppers Most Wanted* list. We were on the run for 2½ weeks. He got caught and then I turned myself in. When we went to trial and he got 8 years and I got 3 for my lesser role. I wouldn't have received that much time, but I had a lot of priors for violence and stuff."

I read the words off of her collage, S*he Puts a Brave Face On. She's Had It. She's Held It Together But Something Just Felt Off. She Wanted to Feel Great Again. Living with HIV and Dying.* Lauren shared, "I was really scared. This is about a year and a half ago. This is when I made my decision to change my life." On the collage other words were written, *I Don't Want to Die. I Was in a Deep, Dark Slump, and I Needed to Get Myself Out of It. I Can't Go Back to Where I Was and I'm Afraid to Make Changes, but I'm More Afraid Not To. Inner Strength is Her Destiny. The Real Me. I Would Like to Stop Worrying So Much, Because I Worry All the Time, and I Feel—and To Learn How to be Happier, Just In General. Why Do I Feel Pain? Life Doesn't Have to Be This Hard. Endurance.*" And "*I Want to be Happy.*"

My Parents: Searching, Learning, and Letting Go

"Taking drugs: I just wanted my dad's acceptance."

Lauren was reunited with her father around the age of 12 after being separated from him at the approximate age of 4. I asked her about her father and she said, "My dad was a drug dealer. I found out when I was 13." "How did you find out he was a drug dealer?" I asked. Lauren replied, "Well, my brothers were always gone at the pool hall or something and I was close to my father. I stuck to my dad like glue. Once we were reunited with him, I never left his side so I was always home with him. I'd sit there and I'd watch and I just realized all these people coming in the house saying 'Hi' to my dad. I put two and two together, and I went up to him and asked him 'Do you sell drugs to bad people?' and he said to me not what a real father should say, but he said, 'I knew you'd be the one to figure it out.' Then he taught me everything there was to know about dealing drugs. I started selling coke [cocaine] at the age of 14. He would take me to Edmonton, we'd pick up a kilo of coke and he would strap it to my stomach or my waist. He also strapped money and pills there. Because I was a minor the police couldn't search me. I was like a mule bringing all these drugs back for him. It would just be me and him and we would go out to our farm. We'd unload all these drugs. There'd be a plate and a big pile of coke and I'd sit there with my dad, tearing up my magazines that I'd collect. I'd cut them up and make flaps with my dad at 14 years old."

This is the first time I've ever heard of a flap so I asked her what a flap was. Lauren clarified, "It's a little package to hold the cocaine, to deal the drugs. They were $40 each and I was making hundreds of them. That's the kind of dad he was to me, he was teaching me that.

And then I was out there on the streets selling for him, and you know, doing all this business with him, answering the door and handling and counting his money. I tried drugs for the first time when I was 14 and I puked my guts out. I was sick as a dog and puked my guts out."

I was pulled into Lauren's stories because this was a world so new to me. I was definitely an outsider in her world. I remember reflecting on my field notes and thinking that the stories I will eventually co-compose with Lauren will be used by others to consider and judge Lauren. This worried me because I know that individuals reading about the participants' lives were much like me, just visitors to their lives, and, without being open, they may not try to understand more than what is written. This limited understanding could easily lead others to misjudge who Lauren was or the reasons she did what she did to survive.

I asked Lauren who she was with when she was doing drugs. She replied, "A few kids that I hung out with. We were all, like, 13 or 14. Just young kids. We were experimenting. There were older women, prostitutes, that have now died, who worked for my dad for drugs. They showed me a lot, but they also put needles in my arms. They were at my dad's place, and he didn't know what they were doing. Yeah, they were all getting a 14-year-old kid high."

"When you were 14, what did you think of the drugs?" I asked. "I didn't—I just wanted my dad's acceptance," replied Lauren. "Just your dad's acceptance?" I asked and was confused about how taking drugs could achieve any type of acceptance from a parent. She responded, "Yeah, because I didn't see him for 10 years. So I thought if I could be like him, if I could do stuff like him, he would love me more and accept me. And if that's what I had to do to get his attention, then I did. Once he found out that I was doing drugs on the street he was mad, but he

didn't stop me. He still sold me drugs." I restated, "He sold drugs to you? So he was mad at you for doing the drugs, but he would still sell you the drugs?" Lauren's voice became quieter and she paused briefly before stating, "Yeah, and I never understood that."

My Mother and Father's Death

In this conversation, Lauren reminisced about her mother and father, particularly her recollection of when her parents died. "When I found out my dad died, I had a needle in my arm. I was in a downtown bar bathroom and this woman came in, I knew this woman. She said 'I got to talk to you. I got to tell you something.' And I told her, 'I'm busy, I'm busy.' I was trying to do my drugs. She said, 'No, it's important. Stop. I got to tell you this.' I put the needle in my arm and I pushed my shot in. Then I heard her say 'Your dad is dead.' I just froze. I freaked out and I pushed her aside. I went out of the bathroom and there was a bunch of people that knew my dad and me, and they're, like, 'Don't let her leave.' And then right away three guys went to block the door. They knew that I was going to freak out. So I started freaking out, and I just started swinging at everybody trying to fight everybody in there. Then finally, a friend grabbed me and put me in a bear hug. I was still trying to fight with him, and he said, 'Just let it out. Just let it out. Just grieve. Let it out, let it out.' I fought hard not to cry, then I screamed and that was when I started crying. I hit the ground and I just cried and cried, and I didn't stop crying."

I asked Lauren, "What's the thing that you miss most about your father?" After a long pause, Lauren tearfully told me, "Just talking to him. The way he used to joke around. He used to tell me stories." Lauren tearfully told me, "He used to play the guitar. He always tried to

teach me how to play the guitar, I wanted to learn because I was always too busy. I always used to love listening to him sit there and play it and then he would tell me stories and stuff. He used to make every holiday and every birthday special for me. 'Cause I'm the youngest out of nine brothers, I'm the baby. I was really close to my dad 'cause I was there through all his sickness and I was there when he died. I was the one that looked after him when he was sick. My one brother was in the penitentiary and my other brother was in jail and was always drinking. I was the one that watched him suffer."

I asked, "I know we talked about some things about your dad, like he taught you about drugs and stuff and that he's had a big impact on your life. What were some of the really good things that he's done for you?" Lauren composed herself, and after taking a long pause replied, "He taught me about medicines and how to pray. He taught me how to smudge. He taught me how to hunt. He taught me how to drive. Yeah, he taught me a lot." I could clearly see that she was emotional and she continued, "When my son was born, he was so proud. When he saw my son he said "He's got the nose!" Her son had the family nose. We both shared a laugh and the room seemed to lighten up. Lauren continued, "You know, he was just proud of my son. My son used to call him "Pop." My dad used to bounce him on his knee and my son would say, 'Hey, my Pop, my Pop, my Pop!' And my boy just laughed. My dad always used to try to teach me how to play the guitar but I'd get too frustrated. So when I went to the penitentiary, I spent a lot of time in the chapel with the chaplain, talking and stuff, and he lent me a guitar. And I taught myself how to play a guitar." I remember telling Lauren how impressed I was that she had taught herself to play. Lauren continued, "I also know how to sing and I can sing good. So I

play the guitar now. I got a guitar for Christmas last year from my ex-in-laws because they know how much I wanted one."

Lauren stated, "My father loved me more than anyone. My dad raised me. I don't have an idea of who mom is. I never really had a female role model. I was a tomboy growing up. I never started dressing girlie because I never felt right. I grew up with boys."

Lauren was very sad when she thought about her father's death. She leaned back in her chair, took a deep breath and said, "When I think of my dad, I get a lump in my throat, and I remember all of the advice that he gave. He said I should be strong and never give up. He always used to say, 'We don't cry,' and I believed that for a long time. That's what he always said, "We don't cry and are too strong. If you've got a strong heart, you can outlast anything."

Lauren also found her mother's death difficult; however, the experience was different than when her father died. "When I found out my mom died, it was my birthday. I was downtown in front of this hotel trying to pull a trick, because I was still sick. A stranger, a complete stranger, a guy I'd never seen before in my life, was walking a dog across the street and he kept staring at me, and I got freaked out. So I kept walking, and he started walking towards me. So I walked a little faster, and then he came running up to me. I turned around, I was, like, 'What do you want?' And he's, like, 'Whoa, whoa. Is your name Lauren . . . by any chance?' And I said, 'Yeah. Why?' He's, like, 'Lauren . . ." I said, 'Yeah.' He said, 'I'm sorry to tell you this, but your mom died yesterday.' He just stood there. I didn't know what to say. I wasn't close to my mom and she was never there in my life. She was an alcoholic for many years. She also had brain damage because my dad used to beat her really bad. I remember him beating her

to a bloody pulp, just unrecognizable. I just stood there on the street, and he was saying stuff to me, and I couldn't even hear what he said because I was just zoned out. Then he walked away and I never saw him again after that. I remember I just screamed in the middle of the street. I just didn't know what to do. I went to her funeral."

Together, Lauren and I looked at her collage that she had made about her mother. Lauren shared, "This is my mother. I adored my mother and craved her company, even though her presence made me feel small. What she wanted from me was what I wanted for myself, which is having a better life than she had. She was so beautiful." Lauren then pointed to her mother's obituary and to the date her mother died.

I felt very honoured that Lauren openly shared her memories with me. Lauren pointed to her booklet and said, "I wrote this for her. You can read it out loud." I read, "Dearest mother, You're a woman unlike no other. A beloved sister, daughter, friend, and mother. We will miss you always, day by day, and may God bless your spirit, we pray. Your smile, your laugh, your beautiful eyes. Although you're in God's grace, your spirit never dies. We'll cherish you in our hearts and memories in our mind, and forever we will love you until the end of time." It was beautiful, and I let Lauren know that her mother would have been proud knowing that she wrote that for her.

As she went through more of her papers, she pointed out, "And then this is all the names of the people who died and meant something to me. Every now and then I'll say them out loud just to give them recognition and respect so that they're not forgotten." The list was long and

she let me count them. There were 37 names of people who she had lost. I was also struck by knowing that Lauren was only 27 years old.

When I heard about all the people that Lauren lost, I reflected on my life. I am more than 10 years older than Lauren and I have never lost anyone who was extremely close to me. I could only imagine how difficult it must have been for Lauren to have lost so many people in her life while being incarcerated or away from people she felt connected with when they passed.

Narratives of HIV

HIV diagnosis: "HIV was my punishment."

Lauren found out she was HIV positive in prison. I asked her, "So when you got your HIV diagnosis, how did things change for you in prison?" She stated, "I went through a bad depression. I found out the day after I got my penitentiary sentence. I got my 3-year sentence and when I was back in jail I found out I got another sentence. It was a sentence of being HIV positive, and I was going to have it for the rest of my life. I felt that 3 years in jail wasn't bad but when I got my HIV diagnosis, now that was a death sentence, now I am doing life for that. Jail is nothing. Going to the penitentiary felt like it was very small thing when I found out I was HIV positive. Jail was something minor. In jail I was gone from my family for 3 years. When I found out I had HIV I wondered how I was supposed to tell my family. How am I supposed to explain this to my son? I thought I accepted it right away. I didn't cry. I tried to be strong about it. I was shocked and in disbelief. I was like 'give me all the info on it.' The nurse visiting the correctional institution grabbed all the pamphlets and gave me a big package in a big envelope. She sat there with me and she said, 'Do you want to see anything?' I just stayed silent, I was in

shock, and I was in mourning. It was okay to cry, but I didn't. I was in disbelief and I was numb. The nurse said, 'You're not able to deal with it, right now. When you do, don't be by yourself. If you are on the unit go and talk to someone, like your friends. If you are locked up, call for someone.' " Lauren continued, "It happens to people, right? It doesn't hit them right away. It doesn't hit them. That's when suicide happens. That was what the nurse was worried about. In the past I had suicidal intentions."

I inquired about her suicidal ideations. She said, "I felt suicidal before I went to the penitentiary. It was the second or third day and I finished telling my family about my HIV. I remember sitting in my cell and just crying, crying. I felt that I had no purpose. I had been through all this pain and hardship in my life, foster care, and jail. What is my purpose in life? Is it to just to be tortured and go through all of this? I just didn't understand. HIV was my punishment. I thought of giving up. What's the point of living? I started thinking about my son. I phoned my son and he was happy, because I was trying to work out my last visit with him before I was moved from the correctional center to the penitentiary. The guards said you're getting transferred anytime now. Unfortunately, it takes a month to clear the visiting list, and I wasn't sure if I would have enough time for my son to be approved to visit. I put my request to see my son in late. When my son was 2 or 3 he stopped visiting me in jail. I didn't want him to see me in jail because he was getting old enough to know what was happening. I would just phone and he just thought I was in school or something like that. As he got older he knew I was in jail and he understood. I phoned him and he was happy. He said I can't wait to come see you

and have that special visit. Unfortunately my request to see him was not approved and I really felt like hurting myself."

When I work with people living with HIV in prison, I often think about how important having HIV is to them. Do they always think about living with HIV? I asked Lauren this question, and she responded, "It's right up there, it's important. I want to be around as long as I can for my kid. I want to see him graduate. I want him to have his first girlfriend. I want to be a grandma." We both shared a laugh when I teased her that she just wanted to give her son's girlfriend a hard time. However, as we talked, the conversation became more serious as Lauren shared, "I have a phobia of death. I'm scared to die. I have watched people die in hospital. I'm scared of what is going to happen when I die."

Attitudes to HIV

Lauren found out that she was HIV positive in jail. "Finding out that I had HIV totally changed my whole world. It turned it upside-down. I was convicted on a robbery charge and got a 3-year sentence for that and the same day I found out I was HIV positive. It felt like my world was over. The penitentiary staff offered me methadone when I got to the pen. They knew that I was an addict and HIV positive. I refused it, I said, 'No, no, no. I'm clean and healthy. I can do this on my own. I'm able to do it.' There's a lot of stigma around being an addict and having HIV. A lot of stigma. In the penitentiary there are so many people in there that are so scared to tell people they are HIV positive. People don't understand and they treat you like you're a walking disease, like, 'Ew, get away from me, don't touch me or I better not drink from your

cup.' Stuff like that. Some staff were not good but many were actually understanding and health care was great."

I remembered from another conversation that there was a difference between provincial and federal corrections, so I asked Lauren about that difference. She confirmed that it was in the federal system where she felt like she was most supported. She told me, "The federal jail actually changed my way of thinking, it changed my life. Before being in the pen, I didn't care about myself, I didn't care about my life, and it was just kind of do-or-die and I thought 'Who cares about me.' There's a lot of counselling in the federal system. They have a lot of programs available like violence prevention programs. I took a program there that dealt with violence and abuse and child neglect, stuff like that as a child. They basically cover your childhood, your teenage years, your adulthood, and your addictions. They go through all that. I took all those programs, I took counselling, and I worked with the elders. All of that helped me get better."

I asked her about her experiences with others in prison and how they reacted to her being HIV positive and she said, "The thing that really bothered me the most is the back talk and gossip. People talk behind your back." I asked, "Are you referring to both nurses and inmates?" Lauren answered, "No, it was mainly the inmates. They whispered like it was some big secret. I'm thinking to myself what's the big deal? Almost 75% of the population in jail has an illness. A lot of them have hepatitis C, probably 60 to 70% of them. They also might have HIV. These numbers are getting higher. Someone might have an illness and they are just too scared to tell other people. I would tell people I have it. If a person was giving another person grief about it I would just say, 'Who are you to judge that person?' They are dealing with something, it's just

like diabetes or cancer. Would we go around saying that a person has cancer or has diabetes? Would you do that? HIV doesn't make a person a dirty person. I know high-class people who are sick. Having HIV makes people automatically think that that person is dirty or gross."

Life on the Outside

Since Lauren had been out of jail for a number of years, I was curious to know if she had any significant health challenges with her HIV since her release. She responded, "Not really. My doctors keep a close eye on me. Whenever I go for my checkups they ask me if I am getting any of these side effects. They asked me how my moods are, how's my eating, how's my stomach. Or if there's something bothering me the doctor will act on it and look into it for me. He'll try to do whatever he can do to help me with it. They really do listen." I was pleased to hear her say this and stated, "So when you were living on the street, it sounds like health care was better for you there than in jail." Lauren replied, "Yeah, it was awesome. The doctor on the street really supported me. Even at the clinic they were really good with the methadone. They supported me. It's a totally different experience in jail than when you are on the street. In prison you're only permitted certain things. There are so many walls and doors that are locked in prison. You can't get the best healthcare there. They can only do so much in there. To the prison staff the inmates do not deserve the same healthcare as people on the streets. In prison you get different healthcare and different medications than we get on the street. Part of this is because of all the addicts and criminals in jail. There are a lot of drug dealers in there. They still don't provide a methadone program in provincial corrections. In the penitentiary they give you a choice on whether or not you want to get on the methadone program. Withdrawing from drugs

in provincial corrections is tough, because they don't give you anything, no methadone, and that's really hard. It's hard to tough out withdrawals. People also don't have a choice or a chance to see a drug and alcohol counselor in provincial jail, and they don't have a choice to start the methadone program there. It has been years since I have been in provincial jail so maybe they have it there now. The doctors are really a lot nicer to you when you are out of prison than when you are in."

"I believe strongly in karma: They'll get what's coming to them."

I asked Lauren if she openly told people that she was living with HIV. Lauren replied "The first thing is I'm not shy to tell people. When I'm with a dentist I tell them that I'm HIV positive. When I was using drugs, after I got out of prison, I was still telling people, I have HIV. I lost a lot of friends because I told them that I was HIV positive, but the true friends are the ones that stick around. As far as relationships go, I don't have a boyfriend. Boyfriends have said, 'Oh, my God, she has HIV, and I can't be with her.' I had a boyfriend in the past and he's the one that broke my jaw. He didn't have HIV. We were together off and on for years, and one day I told him that I had it when I was in prison. He told me, 'Well, that doesn't change anything.' It made me feel good that he accepted it. He's, like, 'It doesn't change anything. I'll still love you.' But when I got out of prison, everything changed. As soon as I went to see him he wouldn't go near me. He treated me differently. We broke up before Christmas and I knew he was ashamed. He didn't want anyone to know that we were together because everyone knew that I was HIV. He didn't want people thinking he was positive. I think that's why."

I recalled from an earlier conversation with Lauren that this was the same boyfriend who recently broke her jaw. I asked, "Do you think that being HIV positive was the reason why he broke your jaw, or was it something else?" Lauren replied, "I don't know why he did that. He's never hit a woman and I never, ever thought he would do that to me, but he did." Lauren took a deep breath and paused. I waited for a few seconds but it took her a long time to answer. Then I asked, "So you told me a while ago that there were three guys and one girl that were beating you up? I'm sorry to hear about that." Lauren replied, "Yes, and everyone I talked to said I should call the cops and charge them, and I said, 'No, I'll let the streets handle them." The streets—I wondered what she meant by that. It was a stark reminder to me of how our worlds were so different. I did not live in a physically violent world where the threat of violence was an everyday occurrence. Lauren elaborated, "'Cause they all live on the streets. They're all drug dealers, drug addicts, whatever. I also believe strongly in karma. And sure enough, my boyfriend ends up going to jail, looking at 15 years. The other guy's in jail, hiding. He got his teeth knocked out and the girl with them hasn't been seen since, but I heard that she got beat up by somebody. None of the things that happened to them had to do with me. Everybody told me, 'Give it to them back,' and I thought it was best if I left it alone. They continued to ask me, 'What happened?' I told them, 'It doesn't matter, I don't want to talk about it. It's over and done with, leave it alone. You know, karma will get you. They'll get what's coming to them.'" As I thought about her story, I had my own thoughts about karma. Karma is something that I cannot easily describe, but a particular picture and quote comes to mind. On a poster hanging on a wall at the Sexual Health Clinic, there is a young fox peacefully asleep and curled up under his

mother's chin. At the bottom of the poster I recall reading the words of author, Dr. R. Goddard, "Resolve to be tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant with the weak and wrong. Sometime in your life you will have been all of these." As I consider karma I am reminded by this quote that how we treat others will be how others may treat us one day.

I shared the poster comment with Lauren, she stated, "I believe in karma. I believe that karma came back on me. That is why I received my broken jaw. I'm the type of person that speaks my mind and speaks strongly and sometimes I say a little too much, I mouth off. I mouth off because I have fears, certain fears. Fears like all of the abuse that I went through as a child. The fears made a stone wall around my heart, and it made me fearless to pain." I asked her, "To physical pain?" Lauren responded, "Physical pain, emotional pain. It made me numb to all of that. I walked around with this attitude, I'm not scared of anything. I've been through everything, every kind of pain, so there's nothing you could do or say to me that's going to ever hurt. That's the attitude I had."

I asked, "Was that a defense mechanism for you?" Lauren replied, "Yeah, it was, and it worked for years. People were scared of me. Girls were scared of me 'cause I fought so much. I was known for fighting. I had a reputation in jail not to mess with me because I'll drop you [hurt you]. I built it up. My reputation followed me on the street. I didn't care. I had that attitude, that 'I don't give a f***' attitude. A person like that is dangerous because it's like messing with dynamite. If you come across somebody like that, they're unpredictable. That was me." Lauren built these walls around her.

Relationships with Health Care Workers

Lauren and I explored her experiences with health care workers. I asked Lauren, "What kind of health care workers do you see regularly?" Lauren responded, "I see the staff at the STD [sexual health] clinic a lot. They are totally supportive. The housing coordinator and the nurses are very helpful. I also go to addictions service. I have a drug and alcohol counsellor there. I also use another housing organization, an elder, and an old facilitator from a community program that I was in before."

I was curious to know if Lauren had met with any physicians since she did not mention them earlier in our conversation. She stated, "Yeah, I see the hepatitis C and HIV specialist. He's really good. You could tell that he actually cares about his job, 'cause he treats everyone the same, and he actually cares and tries to help. These doctors are way better than the other doctors I have had in the past. Every day I think I'm so blessed. I'm lucky I have a dentist and doctor who are the two best in Prince Albert. My doctor has experience with everything, and he knows so much about diseases and infections and it just amazes me. Sometimes I'm really iffy with doctors. I don't trust or I don't think that they really make the best calls at times. But with this doctor, I feel really safe and I trust him. I really trust his advice.

I asked Lauren, "What made you feel a little leery about doctors in the past?" Lauren responded, "Probably because I spent a lot of time in the hospital as a kid, I got hit by a car. I also got my head split open picking bottles on the side of the road. When I was a kid I was getting abused and having to go to the hospital. I guess those visits made me afraid. I also watched my dad and a lot of family and friends dying in the hospital. I felt like a lot of doctors I

have seen are really not in it for their patients' well-being. They don't seem to put much effort in their care. I've had a few doctors that are like that."

I enquired further, "Do you have a story that you can remember when you just felt like that?" Lauren responded, "The jaw thing, that's probably the best story that I have about doctors just being lazy or just not caring enough to do their job. They made me wait 9 hours in the emergency room. Our hospital never used to be like that. There was also a guy waiting there for 12 hours. He was before me and he got in before I did. He had a lot of pains in his stomach. He was there for 2 minutes and then he was gone. It just baffled me. But yeah, some doctors, just don't seem to care. I asked her, "If you were to see some doctors in front of you right now, what would be the advice you would give to the doctors to help them improve?" Lauren said, "Probably to have a little more consideration, especially for the ones that are in really bad health. They could be sick from AIDS, diabetes, and cancer."

I was also interested in Lauren's experiences with nurses. She shared, "I don't have a lot of problems with nurses, but some of them were ignorant. When I was using and I was on the streets I'd end up in the hospital. I would hear comments from these ignorant nurses like, 'Oh, this is going to be a while before we find a vein' - stuff like that, you know, saying stuff like that that doesn't need to be said, the cheap shot because I was a drug user.

When I started on the methadone program, the woman at the pharmacy gave me a rough time and was really snobby. She denied me my methadone the first day I was supposed to start, because someone gave me the wrong time to be there. I didn't know I was supposed to be there by 1:00. I showed up at a quarter to 3:00, and she told me, 'No, you're supposed to be here by

1:00. You're not getting it.' I said, 'Well, I didn't know. It's different from when I was last on it.' She had a snobby attitude with me and started making rude comments. She made me feel like a total piece of garbage, like trash, and put me in tears. I was actually crying. And a support worker from the Sexual Health Clinic was with me that day. The worker complained about her and had her transferred out of the methadone clinic. Apparently she was also doing this to other people. It's just attitude-wise. You don't know what somebody's living through, you don't know what they've been through, you don't know what they've gone through to cause them to be an addict. Just because they're doing drugs doesn't make them any less of a human being or any lower than anyone else. We're all on the same level and nobody's higher than anybody else. Just because a person has a vehicle, money, job or whatever doesn`t make them any better. Some people are on the street as an addict and you don't know what they've been through. Who are you to judge, right? Just because they're not as perfect as you are? It just gets me every time when that happens. I've been through that so much. I'm a real sensitive person, but yet again, I'm very defensive, and I will stand up when I see stuff like that happen. I'll be there and I'll say something. I won't let people get s*** on, especially myself, I'll speak up for myself and it's the type of person that I am. Whereas when I was younger, I was shy and scared, and I didn't want to cause any trouble. But all my experiences on the street, with drugs, when you're near death, overdosing, almost being stabbed and shot made me concrete inside. Nothing can get to me."

Post-Traumatic Stress

In the midst of our conversations, we talked about Lauren's experience with depression. In this particular story, Lauren had become very emotional when we talked about her depression.

She felt she was over-prescribed pills for her depression, and she talked about her experience with prescription drugs, “I feel pills are a way to control people. In some cases they are a way to block what really needs to be felt. In another way I can see that they are needed. However, some people have been misdiagnosed. In jail I’ve been misdiagnosed and I was just given pills that were supposed to be for schizophrenia. I really didn’t like those pills. I was also depressed at the time and those pills helped but I didn’t want to be on those pills. I used the pills to hide my depression. The pills made me feel better. It helped with my anxiety and I really needed that. I had a really bad anxiety attack last month. I felt like I was having a heart attack. I phoned the ambulance because I didn’t know what was happening. My heart felt like it just came out of nowhere. I was just watching a movie and something in the movie really got my anxiety up.”

I inquired about which movie she was watching? She stated, “The Girl with the Dragon Tattoo. It was a scene when the girl in it was getting raped. When I saw that, it caused me to panic and it made me freak out.” This sounded like posttraumatic stress so I mentioned it to Lauren, and she said, “I’ve been diagnosed with that. My doctor diagnosed me with that. As a child I was also diagnosed with that and also ADD [Attention Deficit Disorder] and FAS [Fetal Alcohol Syndrome]. The doctor wanted to put me and my brothers on medication when we were kids, but my foster parents said, ‘no they will grow out of it.’ I don’t think I did grow out of my ADD. My attention span is quite short. You can explain things to me 100 times but sometimes I won’t get it.”

A Healing Journey

Hate and healing.

In this story, Lauren shared how hate affected her life and how her healing had occurred through her understanding certain aspects of her life. Lauren stated, "Because of growing up in foster homes and that, I didn't know who I was. I didn't even know my middle name or my dad's full name until I was 12. Like, for years, I grew up not knowing who I was and where I came from and who I belonged to. So many questions. And over the years, little by little, stuff got answered and I learned more and more and more. And now I'm at a point where it's not that important to know all of that any more. It's just important to know that I'm cared about, that I have my son, I have my family, that I survived what I've survived. I'm still here, and I have another chance to make things right. So when I got out, I got out with this new attitude, and I ran into the people that I robbed. I apologized to them. I told them, 'You know what, I'm really sorry for what I did to you. I was a different person in my addiction.' I explained it to them and they forgave me. The guy that I robbed, who charged me, I talk to him now. I see him now and then, and he'll stop and have a smoke with me, and we talk. It feels good to me to be able to do that, because whereas before, the angry stubborn side of me, I would see him and I would want to get even. I would send somebody to go beat him up or do something to him, or I would just walk right by and give him a dirty look and I wouldn't talk to him. Like, that's how hateful and spiteful I was. But it wasn't towards them, it was towards myself. I was angry at myself, I was hating myself, so I projected it onto other people, that hatred. The more that I learned about myself, the more ugly I felt about hating other people and using that word hate. It's such an ugly

word, because I hated myself for so long, and I wanted to stop hating myself. So now when I hear my son saying hate, I always stop him and say, 'That's a strong word. Think about what that word really means before you use it in a sentence, or say that you hate someone for something.' Because that's a big word, to hate, and it's not very positive. I think hate is the root of a lot of evil, and it's a poison. It poisons the soul, it poisons the mind, it poisons people, and it just spreads, to everything."

Being a mother.

Lauren has a teenage son, and she shared that being a mother was a powerful experience because it provided her with a new perspective that involved considering and caring for someone else in her life. Lauren shared, "When I was with my son's father we were seeing each other for 2 months and then I got pregnant. Right after my 17th birthday, my son was born. He was 7 pounds, 4 ounces. He freed me. Freed me to be the best human I can be, to be a true mother." I could see that Lauren was very happy when she talked about her son. This was love.

Lauren continued, "And when things are changing a lot, and quickly, it's scary, but it also opens the door to unexpected possibilities, and I started realizing I can laugh again. I can even enjoy myself without drugs. When I got pregnant, I quit everything. I smoked cigarettes, but I quit everything. I wanted my son to be healthy and I also quit drinking."

I asked Lauren, "So what made you realize that you needed to quit everything? Was it just stuff that you heard from school?" Lauren replied, "No, I had a maternity class. I went to the maternity prenatal classes and that really helped. They supplied me with milk and they gave

me all the information I needed to know. They gave me rides and they prepared me, you know, for being a mom and stuff."

Native spirituality and Christianity.

Lauren and I had just finished talking about her father and her experiences helping sell drugs when the conversation changed to religion and spirituality. Lauren stated, "A lot changed when I moved from Alberta to Saskatchewan. Everything totally changed. My morals, my beliefs, changed, because in one foster home, we went to Bible camp every year. And we went to Catholic schools, we went to church, and then when I moved in with my dad, there was none of that. It was the total opposite. But I still had that belief in God, it was the way I was brought up before I met my dad again.

When my dad and I were reunited, after I was in foster care, he started teaching me about Aboriginal spirituality and smudging and sweet grass, stuff like that, and I never knew anything about that. So he asked my brother to build a fire. We were out on the farm working on a barbecue, and he told my brother, 'Go build a fire.' So my brother goes and grabs a gallon of gas, and my dad looked at him and said, 'Whoa, what are you doing?' 'I'm building a fire,' my brother told him. "That's not how you build a fire," he said. Then we kind of realized how city-slicker and how out of touch we were with our roots, how badly out of touch we were, that we didn't even know how to build a fire from kindle and wood. Here my brother was just grabbing gas, and he was going to throw it on the fire and light a match. He could have blown himself up. So my dad taught us a lot about that, about the bush and about native spirituality as well."

Thinking about the tension between Christian religions and native spirituality I asked Lauren, "Do your Christian beliefs and Aboriginal spirituality work together? Lauren replied, "I struggled with that. I still struggle with it, because I was raised being Christian, and then being Aboriginal and getting into my culture. It really made it difficult for me to really believe in God. You know, Aboriginals, they pray in a sweat with rocks and animals and stuff. I thought it was contradicting everything that I learned from the Bible, so I felt like I was idolizing another God. But people were telling me no, the Creator is God. So you can, you know, pray and do this smudge and that, and still believe in God. It doesn't mean that you're idolizing another god. So I struggled with that. But now, I smudge and I pray and I do all that, but I pray to Creator God and that's how I believe."

Setting boundaries: "It is important to separate your old life with the life you want."

Being released from prison has many challenges that a person needs to overcome. Lauren talked about some of her challenges, "When I got out of the penitentiary, my home was supposed to be back on the Reserve, to stay with my son and my ex-in-laws. But they're looking after, like, five other kids, too, and they have a three-bedroom house, so it was pretty small. I was on the HIV treatment, so I was always having to come into town for appointments and everything like that. I was always taking the medical cab or getting rides from my in-laws, and it cost money, plus I was getting bored, and when I get bored, I want to use drugs. So I was getting frustrated and bored, and I was getting tempted. So I was telling my counsellor, telling people and reaching out to elders for help, whoever was there. So I enlisted in a community program because I needed something to do. I was also waiting to take some technical courses so I could

get a job in the mines. So my option was a community program. I enlisted, and then I was talking to my parole officer about housing. I was scared to move into town because I didn't want to get back into drugs and my old friends. But on the other hand, I needed to go to school and get this program. I got accepted into the program. I was worried about where I was going to live and what I was going to do. I knew the elder at a community housing organization and she pulled some strings. She put me at the top of a list for a bed because she knew how important it was for me to take that program. So the same week, the week I got accepted into the program and I got my room in this community organization and I had a slip. I was with my brothers and I used morphine. And I felt guilty about it. I felt like I was throwing everything I worked for away, so I confessed. I told my parole officer. He wasn't in the office, so I told the guy who was there and his boss decided to throw me in provincial correctional center for a weekend and revoke my parole. They threw me in jail and that was the worst weekend of my life. I was just crying and I was a mess. I was being honest and punished for being honest. I was just really being hard on myself. But then the next Monday, he let me out. That was the day that the program started and that I got into a support house. So I was just happy. Then the next day, I started my program and I was staying there. But it was stressful, because there's a lot of users downtown, and I'm staying right downtown, so I'm seeing them every day while I'm going to my appointments and stuff like that. Then I knew that I was going to get into using and stuff because I was just feeling the pressure. So I put my name in for the methadone, 'cause you know, I thought, 'If I'm going to use, I want to be prepared, and I don't want to feel this way, all this pressure and stress.' I didn't want to go into a full relapse and just go back to where I was

and throw everything away. So I was smart and I did plan ahead. So I got myself on the methadone, and then after that, it was okay. I got all my certificates in the program. I maybe missed 1 day or 2 days of class."

I asked, "How important is it to separate your life out completely from people in your past, or people from prison? How important is it that you can do that and is that realistic?" Lauren replied, "That's really important. That is a biggie for anybody that's trying to quit drugs. That's the main thing that has to be done. You have to separate it, because it's not possible to have the people that you used drugs with and be reintroduced to the community. It's not possible to have those people in your life while you're trying to stay clean. It's hard, because you served a purpose to those people. I had a reputation with people on the street. I was an angry person, so I was known for fighting and never losing a fight. A lot of girls were scared of me and people won't come near me. That was my street reputation. I felt I had to fill those shoes when I met up with people I knew on the street. When you are trying to stay clean and sober it is important to separate your old life with the life you want. Your old friends will see you as phony. I was called phony for trying to be clean and stay clean and trying to be happy. I lost a lot of friends and I made enemies. My old friends were really not friends, they just cared about what you have and what you can do for them. So in my mind, I had to make that distinction. It was easier for me to detach myself from certain people. But the ones that were there since day one that I really had strong attachments to and I kept those people in my life, despite their using drugs. I just turned a blind eye to it, and I felt that I was strong enough. But at the same time, these people could also be my drug triggers, and they were stealing from my house, bringing people to my

house, causing problems at my house. Even my own family, my own brothers were doing this and it was so hard because they're my brothers, right. They're people that I care about, they're close, like family, and I don't want to shut them out of my life. I had to find some kind of balance, because I was starting to use again, getting into old habits, old behaviours, the old me was coming back around these people. And plus, I was trying to create a safe place for my son to come every weekend and there was no balance between it. So I had to choose and finally I just had a breakdown. And then when this happened, when I broke my jaw, it just did it for me. I just said, 'No more. I have to cut these people out of my life, and I have to let them know, no more. This can't happen anymore.' So I did. I told who I had to tell, 'This isn't happening any more. My house is not a drop-in centre, it's not a shooting gallery [a place to inject needles], and it's not a place for you to bring your friends to come chill and relax and bring drugs and alcohol and stuff. It's not for that.' I had to set that boundary."

Late for Christmas.

Lauren shared a Christmas story with me. It's not a traditional Christmas story but one that still had the key elements of family, love, and sacrifice. Lauren stated, "My son was 8 when I got arrested, and then I missed his 7th, 8th, and 9th birthdays. And before that, I would have never missed a Christmas. But until I went to the penitentiary that was the first Christmas that I ever missed. Until then, I never missed a Christmas. It didn't matter if I was in Saskatoon. I remember one time I was in Saskatoon and I hitchhiked on Christmas Eve, and it took me 4 hours to get a ride. There was a blizzard out and there was no traffic and I walked. I had a whole garbage bag full of his presents and my duffel bag of clothes. I was determined to get to

the city and I said, 'I'm going to make it, I'm going to make it.' Hours went by—9 o'clock, 10 o'clock, 11 o'clock, midnight. Finally I got a ride, and sure enough, the people that picked me up were going straight to town, so I was glad. They dropped me off right where they lived, and I was just so determined to be there, because my son knows that I never miss Christmas. He was just small, I think he was only 5. I showed up and everybody was sleeping which made me feel horrible, I missed Christmas. But when I got there, everybody was in bed. My ex-mother-in-law, his grandma, opened the door and she said 'He waited as long as he could for you. He waited until he fell asleep at the table.' I just started crying, I felt so bad. She said 'He knew you were coming, he knew, and we all knew you'd make it.' I didn't phone them, they didn't know, but they knew that I would make it. And my boy knew. He waited for me and waited. Then she asked me 'Do you want me to wake him up?' and I said 'No, just let him sleep.' But she went and woke him up, and I had all his presents there. He was just tired, and he said, 'Mom!' And he was in my lap and it just felt so good! Then I put a present on the table, I remember it was a truck, and it was just the sweetest, he was so tired, he couldn't even open it, and he was just pawing at it. I was, like, 'Aw, he's too tired to open his presents.' But he was just happy that I was there."

Correctional Experiences

Health services on the inside.

I asked Lauren if her health care needs were addressed in jail. She stated, "In the federal system, the penitentiary, yes, but in the provincial jail system it wasn't. In the federal system we had access to the nurses, actually we had access to everything. In the provincial jail, the doctor

working there doesn't really care much about the inmates. It's not really good, I remember the way he was talking to me when I had HIV. He rolled his eyes. It was like he was thinking that it was just another inmate who didn't care about her health. I remember asking him about what is a CD4 level and all of that other HIV info." The CD4 level is a measurable indicator of how strong a person's immune system is and decreases with HIV. Lauren continued, "A year before this visit I had a chance to talk to him about hepatitis C treatment. He mentioned that I should go on hepatitis C treatment before I get HIV. When he saw me with HIV he just rolled his eyes at me. He was like 'you know I warned you.' That's all I got from him. I couldn't believe it. Then he starts ignorantly explaining it to me. I was just ashamed how this doctor was treating me. How am I any less of a person? After that, I didn't see any doctors until I went to the penitentiary. The doctors at the penitentiary were more respectful. They were very confidential. They have a good team of staff over there. I felt safer over there."

Lauren had the opportunity to work with other inmates on issues such as infectious diseases and harm reduction. She shared, "When I went to the penitentiary I had a job. I was supposed to teach other inmates about HIV and other infectious diseases. I talk about dental dams, condoms, safe tattooing, bleach kits, and how to inject safely." Lauren was referring to the harm reduction approach used to decrease the likelihood of infections associated with intravenous drug use and unsafe sexual practices. Lauren continued, "I was teaching the other inmates all the stuff. That made me feel good doing that every day. I was really into it. When I was doing it I felt like I was really listening and believing in the stuff [HIV information]. I felt

that most girls did not take it that seriously. Sometime you don't, not until it hits you in the face. That's real life."

Connecting with Aboriginal traditions.

I asked Lauren about the importance of working with elders in prison. Lauren said, "When my brother died in Edmonton, all the Elders reached out to me, but there was one that I really clung to. To this day I still talk to her. That's who gave me my bear claw. She helped me get through my grieving in a good way. In our culture, it's tradition to cut our hair if a close sibling or family dies. I believe in that and I made a promise to my brothers that if any of us died we'd cut our hair. When my brother died, I cut my braid in a ceremony. I smudged it and tied it with leather and put feathers and beads on it. The elder helped me with that. Before I got out, she did a ceremony to help me take my spirit with me when I left the penitentiary. She did not want me to leave my spirit in jail. That was really something that I needed. It seemed like every time I went to jail I always left a piece of myself there. She also taught me a lot of songs. Being with her was really good." I observed a sense of peace that came over Lauren as she leaned back into her chair and reminisced about that elder.

Lauren said that she had left a little of herself when she went to jail. When I asked her about it, she said, "Probably some of my emotions, because in a place like provincial jail there's nothing there for women. It doesn't help them, so it's, the worst jail for women that I've ever been in. They just strip everything from you, they take everything, a piece of your freedom. Some people let the jail take control of them and they just feel so small. They don't seem to have any hope. And that's how I started feeling. I started feeling that I was no better and jail

was where I was always going to be. I wouldn't find anything better than jail and every time I left I always said, 'Oh, I'm going to be back.' I felt that way for so long, like I'm never going to achieve anything better and I don't deserve anything better. So when I say I leave a piece of me, I think it was mostly that fear of how I would cope out of jail or that lack of confidence that I could stay out. I'd be out on the street, I would try my hardest to stay out, and then I would have that fear of how to cope. The stress of not having a place to stay, my family, and a bunch of other stress would make me go back to using drugs. It was that cycle that I was just stuck in for so long. I just thought of myself as always going to be in prison or on the street, never achieving anything. That's what I thought. It really drained me hard."

I asked Lauren, "Did the elders really help you think outside that cycle, breaking that cycle for you?" Lauren replied, "Yeah, in Federal corrections taking that Spirit of a Warrior program offered by the elders really worked on our self-esteem and our self-confidence. My self-confidence was low and I felt shattered. The elder would work with me and ask me stuff like, 'Why do you believe that you're just good for jail? Why do you have that belief that you're never going to make anything of yourself other than jail?' I started talking to the elder about that and I felt that I didn't belong in the world. I remember times where I'd just be out of it, high and on the street, and I used to walk around and see people going to work, living everyday lives, taking their kids places, stuff like that. I used to watch them and think that I was invisible to them and I would say to myself, 'I bet you these people don't even see me. I don't even exist in their world.' I always used to wonder and wish what it would be like to live in their world. I wish I could be in that world and that I wasn't invisible. The elders worked hard to build my

self-esteem. In our program, we would get daily group compliments and this made me feel more appreciated by people. People started noticing my talents and my gifts. That made a difference and started making me feel better about myself."

Since I have familiarity with both provincial and federal correctional facilities, I asked Lauren what we could learn from her about them. She shared that, "At provincial jail they have an elder, but it's not enough because the inmates don't have access to do ceremonies all the time, because of restrictions and policies. The segregation unit just breaks a person." The segregation unit is a unit where offenders are physically kept away from other offenders for the safety of the offender or others. Lauren continues, "Girls end up in segregation. When you are new to segregation, it can really take a toll on a person. In segregation you get nothing down there, you get nothing. You don't get any clothes, soap, nothing. A person gets one shower a day and sometimes only 20 minutes of exercise outside. And it's hard because you're locked up all day. Sometimes being out of segregation and being on the units is no different. You've got to live with all these other women who have all these other problems, and it's hard to do it. In provincial jail, there is a counsellor, but I really didn't get a lot out of the counselling. I took the counselling and it's a good release if you need to talk to someone. There's an elder in the jail but for some units, like the gang unit, they have limited access. There is only so much the elder and a chaplain can do. I've taken many programs and they're just programs out of a book. They are not long enough and hardly deal with any of the stuff that the women need to be dealing with like substance abuse. What these programs deal with is only the tip of the iceberg. Inmates go to programs to deal with stuff, but they end up leaving the programs as empty as they went in."

I inquired of Lauren, "So what would you recommend for the provincial jail to do to improve?" Lauren replied, "I would say to not make it so confined. Reach out to the women and find out what's really going on. Deal with their addictions issues, get them into better counselling, and get to the root of their substance abuse problems and their pain. A lot of them are going through grief, a lot of them are struggling on the street, they have no home. They need to deal with those issues. Like, homelessness, set them up with case managers who can help them set up a place to go before they get released. Where I am from, a lack of housing is a big issue. There's not enough shelters, there's not enough places to rent that are affordable because welfare doesn't pay enough. It's a struggle. The biggest struggle and stress for me was where am I going to live when I get out of prison. So why do you think all these women go back to drugs and stuff when they get out? It's because they get thrown back on the street where they came from. Provincial jail made no difference, there was no help. Maybe they set up counselling, but what's counselling when you have nowhere to sleep and nothing to eat, right?"

Becoming "institutionalized."

In this conversation, Lauren and I discussed the topic of institutionalization and what it meant to her. Lauren responded, "I'm institutionalized, because I've been through foster homes, I've been through the system all my life. And then going through youth facilities like corrections, youth jails, young offenders, provincial jail, and then to federal jail. I've been in institutions all my life. I've been bound by rules and mentally abused, I'm institutionalized. I still feel incarcerated in my mind. Because it doesn't matter, wherever I go, it feels like I have to follow a certain routine. I've spent so much time in jail getting used to the routine and getting

used to doing time. I haven't had to worry about where I am going to eat, where am I going to sleep, and what am I going to wear. I haven't had to worry about any of that for so long. Then I get out of prison and I have to worry about it, it's really a big difference. Being institutionalized means that you're afraid and nervous to get out of jail. You feel like you won't fit into society. A lot of these women and men go through that and they don't know how to deal with that. They need to work on their self-esteem. Corrections should help them with their self-esteem, make them feel like they're better than jail. They deserve more than jail. If you can make offenders understand that they deserve more than jail then they won't come back. I know how that feels and it takes a lot to break through that. These women are all getting out and then they're going back to what they're used to and reoffending. Judges and lawyers, everybody's wondering why these people are reoffending. Well, nobody's helping them learn otherwise. Going to provincial corrections doesn't do anything. Sure, it makes society happy that they're going to jail for their crimes, but then they're going to get out the same way they went in. So how is it helping society, and why are they putting so much money into making stricter jails if they're just going to get out and do the same thing? The crime rate is going to stay the same if they don't deal with issues that they need to deal with, and then get that person off the street and make them believe that they're worth something other than what they're into now."

Harm reduction.

Lauren shared her thoughts about how corrections could do a better job of addressing the issue of intravenous drug use. "There are hardly any needles in corrections and when there is one, that needle is going to be shared with at least 10 other women. I'm not sure how many

women out of 10 have hepatitis and HIV but they're all sharing that needle. That needle's going to sit there for months, and it's going to go through how many people's hands sharing that equipment. I've seen it. Needles don't get into jail very often, so when one does, it stays there till it's out of use or when the needle point is down to nothing. There are so many sick people who aren't going to care and they're going to use that needle. HIV and hepatitis is just going to spread, it's just going to be worse. So when you think about it, yeah, it's that person's choice to use needles. If the jail doesn't want to spread disease then maybe the nurse could give them access a clean needle. After the inmates are done with it they can give it back or whatever. But they'll probably end up getting charged with contraband anyway."

Being caught for using drugs is not always a negative experience. If the jail system addressed the drug use more effectively, it could result in helping a person quit drugs. Lauren shared, "So out of that punishment [getting caught for drugs] could come out some good. A person can start working on their addictions. The jail could work with the inmates about 'Why did you use?' and this and that. There could be benefits. Every time that I got charged for dirty urine screen or drug paraphernalia, I did my time in the hole [segregation], and then I got out. I felt my time in the hole was a joke. There was no one coming to me, like, saying, 'Why did you have a dirty urine test?' and working with me about it. They should think about that if they want to stop it." A dirty urine test indicates that a person tested positive for an illegal drug in their system.

Taking charge of my life: "My turning point."

Lauren lived in a penitentiary with housing units that required inmates to cook. "For a long time, because of my addiction, I never cooked, I never had to worry about that, because there was always fast food or soup kitchens or stuff like that. So cooking my own meals, it was just, like the best thing, the best feeling, because I felt like I was in charge of my life again. People in my jail unit were saying, 'My God, you're such a good cook.' Pretty soon, I became the cook of the house and I was the one that was cooking supper all the time like, Christmas dinner and Thanksgiving. I was the one that would cook the meals. My dad taught me how to cook a turkey. Everything was homemade from scratch. I passed on how to cook to the girls at the penitentiary. The whole time I was doing cooking at the pen, I was thinking that I can't wait to go home and do this for my family. I can't wait to cook for my son. I can't wait to go home and help out and cook, like, turkey dinner for my family at home. So I started thinking like that and putting those ideas in my head. When my son was born I considered writing. I wrote in the journal everything that I remembered from when I was pregnant to the time that I gave birth to him and until he was 2 years old. I did all this programming to try to get my head back on straight, to get it out of the addiction mode. I learned how to live again, how to care about myself, how to love myself, and how to be a 'normal' person. I also could see how I could fit in the world and that I had a place somewhere."

I asked Lauren, "And you found the penitentiary actually helped you that way?" Lauren responded, "Yeah, that's something I never expected. I think everybody has a chance to decide how they're going spend their time in jail. It depends on the person how they want to spend their

jail time. If you want it to be hard, then you're going to have a hard time. If you want to get picked on, if you want to get beat up and stuff like that it will happen. If you want to have a good experience and get something out of jail and actually learn something and better yourself, it's up to you. And that's the choice that I made when I got there. My 3-year sentence and finding out that I have HIV was my turning point. Right there I made the decision, 'Okay, I'm not going to be scared. I'm not going to go to the pen with an angry attitude and be like how I was in provincial jail, and end up getting into trouble. I'll end up hanging out with all the gang members and stuff that I was doing before. The other girls who went to the pen told me before I went that you live in houses and you get to wear your own clothes. You also get to cook your own meals. I heard what they said, but at the same time, I was scared of the unknown because I heard stories of bad things happening in the penitentiary like people being raped and stuff like that. But it's not true for women, it's not. Men, yeah, I can see a lot of that because I've heard stories of men's penitentiaries. It's totally different from the women. The women's penitentiary is just one big gossip ring." We both share a little chuckle and then Lauren continues, "Everybody likes to talk and tell stories and you know, get into other people's business. That's all it is over there. But as far as watching your back and stuff for physical attacks, naw, it was nothing like that, not as hard as it is in provincial jail. You could get jumped [physically attacked] in provincial jail at any time. You could get thrown in your cell and get beat up any time. That's never happened to me but I've seen it happen. I've also been involved with stuff like that before."

Case management in federal corrections.

Lauren and I had a conversation about case management in federal corrections and what her experiences were. She stated, "You get a case management team, you get three case managers - you have your primary, your secondary, and your third. Your primary is the main worker that helps you deal with whatever. This person gets you into programming, gets you a job, helps you with whatever you need help with, and they assess you. From the time you go in, they assess you. It's your choice if you want to tell them about what you need help with. If you want to tell them nothing, then you'll get nothing out of it. The managers told me, 'You'll just do your time and you'll get out of prison the same way you went in. If you want to get something out of your experience here, you can either tell us the problems you're having now with addiction or whatever problems you're having, like housing, your friends, or whatever. Or you could tell us nothing and we can just guess, and we can just put you in a violence program. You could do your program, play along, pull the strings, and then get out the same way you came in. Or you can actually try and be honest and tell us what you want help with and we will do the best we can to help you. You'll get out as a different person.' So that's how they put it to me. So I said, 'Okay, this is my addiction, this is what I'm addicted to, this is how long I've been addicted.' And I told them my whole story. I told them, 'I have problems with, like, my friends—my circle of friends is a big problem. Housing is a big problem because I had nowhere to live. My addiction is the main problem. I also have grief issues, stress issues, and I don't cope well. So those are the areas I need help with.' So my worker worked around that, and she got me into programs and suggested programs that would help me with those issues. They give

you an option if you want to go to counselling and they have awesome therapists there. They have addiction counsellors and they have the methadone program. You can actually get on methadone right away. And they have awesome doctors and they have awesome nurses that you can talk to. There is also a hepatitis C and HIV nurse. In fact, that nurse is just a blessing. She really helped me with my self-esteem and helped me deal with my HIV and got me on the hepatitis C treatment and everything like that."

I asked Lauren why she liked working with the penitentiary nurse and other penitentiary staff. Lauren said, "She treated me like a regular person. She didn't treat me any lower or any higher, and that made a big difference. I tend to move towards people that treat me as equal as they are, and I shy away from the people that act like they're better than me because of where I've been and where I've come from. So that really helped me latch onto her because she treated me just like a regular person, not as an inmate, not as a drug dealer, a junkie or anything else. She treated me like a person. She saw past everything that I had done and she saw past my crime. So that's what really drew me to her. My team and my case management are also like that. They don't hold your crime against you."

Getting control of anger: "My triggers, my downfalls, and my good qualities."

Lauren shared her reflections about how she came to terms with her anger and actions in the following story: "I was a shark in jail, in provincial corrections, and everyone else was the fish. You're either a shark or a fish and I was the shark. When I first started going to jail, I was a fish because I didn't know much and I was always scared. But then I stopped being a fish and I started being a shark. So when I was in the pen I had that shark attitude but I noticed that the

penitentiary was different than provincial corrections. The penitentiary was more laid back so I didn't have to worry as much about fighting. I noticed that I didn't have to wear that big intimidation mask and I could be me without trying to be phony. I hate phoniness in people. I could never see myself as putting on a front for people. I am what I am. You either like it or hate it. You know, I'm not going to pretend to be someone I'm not. That's how my attitude was when I went to the pen. I started working on myself, trying to heal myself, and trying to get that chip off my shoulder that nobody could hurt me. I had an attitude and toughness that I carried in me and I was angry. I still got into a few fights in the pen and I ended up beating up a couple of girls. I ended up in segregation. In there I realized that I'm not done working on myself, I still have that chip on my shoulder because I'm still here. I'm going back to the place where I didn't want to go back to. I did a mediation thing with the staff and I apologized to the person that I hurt. I've never apologized before. I found myself very vulnerable and I found myself equal to that person that I ended up fighting instead of feeling more dominant. Instead of being enemies, we ended up becoming friends and actually talking to each other. What I didn't realize was that she was going through what I was going through and that she had that same chip on her shoulder. She was just trying to survive the way I was trying to survive. The only way we knew how was to act was like we were untouchable." Lauren took a pause to consider what she just said. Then she continued, "Our role towards other people was that we couldn't be touched or nobody could mess with us. She had that same attitude, and so did I. That's why we clashed and fought. The fight was instigated because words were said and rumours were being spread. She came up to me first and threw some words at me, and then used the word *punk*. When you're an inmate and

you go through jails, there's certain things, it's a code of conduct, a rule with inmates, people that go to jail, you don't call somebody a *goof*, you don't call somebody a *rat*, you don't call somebody a *punk* unless you have the proof. That's just a no-no in jail, an unwritten rule. In corrections you don't do that. Even on the street, you don't do that. When she threw that word at me, my defense went up. The old me came out and instantly I started swinging, and I ended up bruising her up pretty bad. We got right in the middle of the yard, that old me just came out and I didn't care anymore. I just beat her up right in the middle of the yard in front of the whole institution. Guards came out, pulled us apart, threw us in segregation. They kept us down there for 10 days and then they did a panel with the warden and other people, like other officers or whatever, and then they put us both in the room together. They got both of our sides of the stories about how it happened. And I was totally honest about it all and so was she. So they put us in the room, and they said, 'Okay, you guys have a chance to resolve this. If you don't want to resolve it, one of you are going to get maxed.' And they were referring to me, they wanted to label me a maximum security level inmate because they saw my record in provincial corrections with all my fights, all my charges, and how many times I've been in segregation."

"My security rating was high and when they transferred me to the pen they put me in one of the worst houses there. That's where they put all the bad apples. I didn't know that until I moved into that house. I didn't see myself that way, but everybody else did. The words on paper speak louder than actual words and actual actions. Guards treated me different. It doesn't matter how I approached them or how they saw me as, what's on the paper, that's who I am, that's what I am. They knew me before they even met me, and they judged me before they even

knew who I was. So they thought that I was just this crazy person; they didn't care that I was going to give them trouble, so they stuck me in a house with all the troublemakers. But little did they know I had the goal to change myself. So when I was down in segregation with this girl we started talking to each other, we apologized, we ended up both crying and hugging after that, and I felt better about it because that's something I never did. With all the people that I fought and that I beat up and that I've hurt, I never got that chance to say sorry, 'Hey, you know what, I'm sorry for hurting you, and it was stupid. It was over something dumb.' Like, you know, I never had that chance. So I learned something out of that. And we both were let out of segregation and we got moved into different houses. We went on with our lives and doing our time. Then I started doing good again and then my brother died, and that angriness came back, that old me came back. So I got into another fight, and I had a chance to use drugs in there, and I did. Then I got caught, got thrown back in segregation, and then I realized again, 'Here I am again. I'm going down the same way that I didn't want to go down.' So again, we went through the routines and I talked to my workers about why I used and stuff, and I told her, 'I'm not dealing with my brother's death the way I thought I could. I'm not handling it. I know that if I stayed in segregation and if I get maxed out, I'm going to get out worse than when I came in. I'm going to get out angrier, I'm going to get out madder than I was when I got here.' "

I asked Lauren, "So did they listen to you?" She said, "They said, 'You spoke the words we were just going to tell you. You've already been here a year.' The warden came down to segregation and talked to me. She said, 'You know what, I see something in you that you don't see in yourself. I see a brave person, a person that is smart and capable of getting out of jail and

staying out. But you have no self-esteem. Do you know why you put yourself down here?' And I told her, 'No.' And the Warden replied, 'You sabotaged yourself.' She pulled out my record of all the charges that I had in institutions. She told me, 'Look at the dates. Every single time you got charged and you got thrown in segregation, something happened before that. You either got into an argument, or something happened. Your brother died and then you went back to the only way that you knew how to cope, your old coping mechanisms. You don't realize that you're in recovery and that as a recovering addict you have your slips. Every time we've let you out of segregation, you've picked yourself up and you kept going forward, you kept moving on. But then something else happened that made you fall and that made you believe that you weren't any better. You would then go back to your old ways and your angry side took over. You don't realize that?' I did realize when she showed me. So then I noticed she's right, that I have a pattern. When things start getting bad, I go back into my shell, into my old coping mechanisms, and then I turn into my old self again. But once I get through that time I can keep going forward. I move out of it and I break out of that, and then I see where I went wrong and I fix it. So the Warden asked me 'How can we get you to stay in that state, to keep fixing things, to keep healing, to keep going forward without letting things stop you? What if you lose someone else in your family? What are you going to do differently than what you did with your brother?' She gave me a lot to think about. I couldn't even answer that. Still it's hard to answer and I'm still picturing it. So I got, like, little stepping stones to help me to learn about myself. I learned a lot about myself. I learned about my triggers, my downfalls, and my good qualities. I never noticed

these things when I was using drugs and when I was letting my angry side take over, I never noticed any of that."

Reflective Beginnings on Narrative Threads

In what follows, I present a focused interpretative analysis related to the research puzzle in order to make sense of the meaning and significance of Lauren's life narratives and stories of HIV and previous incarceration. My research puzzle focuses on the experiences of Aboriginal people living with HIV, and who have been previously incarcerated. In response to this puzzle, I examine notions of stigma, incarceration experiences, cultural identity, trauma, family, and healing. I begin with the notion of stigma.

Stigma.

I recall a story that Lauren shared about experiencing stigma while in corrections. She was poorly treated by a provincial jail physician after informing him that she was HIV positive. According to Lauren, the physician rudely answered her questions and reminded her that a year earlier, he had warned her of the dangers of contracting HIV. Lauren felt belittled and marginalized by his words. She felt that the treatment she experienced from the physician created a barrier between them. Thus, Lauren refused to access the healthcare system in provincial corrections. She did not want to risk being in contact with this physician and felt she had few opportunities to access health care until she was moved to federal corrections. This story provides a moving example of how Aboriginal people who are incarcerated can be marginalized by negative treatment within the health care system. Having worked in corrections, I still recall hearing people, both in and out of corrections, speak about how "those" inmates,

Aboriginal inmates, deserved to get treated poorly because of who they were and the crimes they committed. Lauren did not speak about racism directly, but I recognize its presence with the people that I have been in contact with. I wondered why Lauren did not directly mention racism.

A study reported by the Health Council of Canada (2012) revealed a variety of challenges that Aboriginal people face while engaged in the health care system. Lauren's example is a reminder of the kind of interpersonal experiences that may occur within such systems. Unfortunately, people working in healthcare still knowingly or unknowingly marginalize and stigmatize Aboriginal people in their care. It is not surprising, then, that the Health Council of Canada report (2012) indicated that due to widespread racism and stereotyping by healthcare workers, many Aboriginal people in Canada do not seek health care treatment. This lack of trust combined with a history of trauma associated with residential school (Blackstock & Trocmé, 2005; Kubik, Bourassa, & Hampton, 2009) requires health care providers to be acutely aware of these issues in order to provide compassionate health care. Thus, authors of the Health Council of Canada study (2012) highlighted the importance of developing health profession curricula that includes theoretical notions of cultural competency. The Aboriginal Nurses Association of Canada (2009) has created a document titled "Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing" for this purpose; and The Canadian Association of Schools of Nursing (CASN) (2013) recently published "Educating Nurses to Address Socio-Cultural, Historical, and Contextual Determinants of Health Among Aboriginal Peoples." Both documents provide a framework to guide the development of more culturally competent and culturally safe curriculums.

Stigma was evident among Lauren's peers in the correctional system in the form of gossip and negative, discriminatory comments. Lauren felt that stigma was due to misinformation about HIV and believed that there still was a need for HIV education in order to address pervasive gaps in knowledge. Currently, there is no literature that indicates how much education is occurring in the prison settings. However, I surmise that some HIV education is taking place at different levels across institutions and that peer-to-peer support could improve education delivery and support. Specific studies (Dutcher et al., 2011; Garfein et al., 2007; Tobias et al.; 2012) describe and demonstrate the importance of peer-to-peer support to promote more effective education. In the field of nursing, it has also been identified that there is a lack of HIV education occurring in undergraduate nursing education (Canadian Association of Nurses in AIDS Care, 2013; Mill, Caine, Arneson, Maina, de Padua, & Dykeman, 2014). In the synthesis chapter, this lack of education will be further discussed.

Incarcerated experiences.

In Canada, correctional services are operated by both the federal and provincial governments. The difference between the federal system and the provincial system is that inmates in the federal system are incarcerated for more serious offences for 2 years or more (Correctional Service of Canada, 2013). Lauren shared stories that highlighted some of the differences she experienced in the two systems, such as the support available from elders. In provincial corrections Lauren had noticed a lack of support with minimal use of elders to compliment the prison health care system. Elders were present, but they were not able to provide the full range of support they were capable of, including performing cultural ceremonies. Within

the federal system, on the other hand, Lauren found that elders were more readily available and accessible and felt that the support from them was essential to her healing journey. She believed that she had learned more about her culture through her interactions with the elders than she had learned from anyone else before. The elders seemed to understand the absence of First Nations cultural exposure in her life; therefore, they knew how to support and guide her in culturally relevant ways. For example, the elders in the federal system supported Lauren as she grieved the death of her brother. She felt a strong connection with her Aboriginal culture and thus wanted to honor him in a hair cutting ceremony. Lauren was not entirely sure how to conduct the ceremony, but the elders at the federal prison were able to help facilitate her learning. By being with the elders at this critical life moment, Lauren was able to deeply connect with Aboriginal cultural ways.

Lauren believed that reconnecting with Aboriginal traditions helped with her healing process; however, some authors (Hayman, 2006; Martel & Brassard, 2008) have challenged the concept of healing and the definition of Aboriginality in prisons. Martel and Brassard (2008) argued that the type of Aboriginal programs and services offered by people working in corrections produces an "institutionally imposed hegemonic aboriginality" (p. 349). This means that there are stereotypes placed on Aboriginal individuals with the assumption that they should potentially subscribe to Aboriginal-focused programs (Martel & Brassard, 2008). Martel and Brassard (2008) critiqued this imposed hegemonic Aboriginality by stating that this type of viewpoint could result in a failure to recognize the diversity within Aboriginal people. It imposes a set of assumptions that Aboriginal offenders should all be required to take a set of

Aboriginal focused programs. For Lauren, the opportunity to reconnect with her Aboriginal traditions was beneficial. However, for others, they may not feel the need to access elders and traditional programming. A qualitative review of these programs and their effectiveness may be needed to determine the best way to implement these programs.

Lauren recognized that the correctional system could be designed to create an environment that could lead to meaningful change in the life of an inmate. If Lauren chose to, she could abstain from drugs and discover skills to provide stability in her life through structured routines and self-discipline. This could be as simple as wanting to get up at a specific time in the morning to be ready for the prison's workday. However, as Lauren described in her stories, she faced many difficulties when dealing with her drug addiction in the corrections system—being able to access drugs while in corrections, going through severe withdrawals, and dealing with her cravings for different kinds of drugs. It was not until Lauren explained her methadone treatment that I understood more about her illegal drug use and her struggle to overcome it.

Lauren explained that methadone programs were one type of harm reduction strategy that was available in many correctional settings. Lauren came to understand that corrections dealt mainly with immediate medical concerns rather than preventative measures. For example, there were opportunities to receive information on safe tattooing, discuss safe sex and sexual health, and to understand that safe injection drug use had the potential to decrease the spread of HIV. Kerr et al. (2004) support the use of harm reduction strategies in correctional settings and argue that providing harm reduction strategies such as access to clean needles and safe needle disposal have the potential to decrease the spread of HIV.

Cultural identity.

A person's culture influences the formation of their identity. A lack of cultural knowledge combined with negative social influences can result in a display of unconstructive behaviors. Gangs, for instance, can seem attractive to young people since the appeal for social inclusion may appear to fill an emotional void and provide a sense of belonging (Comack, 2008; Grekul & LaBoucane-Benson, 2008). Lauren shared stories of her involvement in gangs. Unfortunately, these gang members turned on her and her brother by viciously attacking them. From Lauren's perspective and our discussions together, it became apparent that a lack of cultural identity formation contributed to her participation in gang life.

Elders have shared with me that they are concerned many Aboriginal youth have lost their connection with their Aboriginal identity. One elder believed that the residential school system and pervasive colonialism resulted in many Aboriginal men not learning from traditional role models what it meant to be a man. I remember his words: "Men need to know how to be men again." When I asked the elder to explain further, he indicated that men needed to learn how to respect their partners, their children, themselves, and how to provide for their families. Several authors (Laliberte et al., 2000; Miller, 1996) have highlighted the adverse effect of residential schools, the '60s scoop, and the reserve system on generations of Aboriginal people. These traumas have resulted in a great loss of first-hand teaching and knowledge that parents and grandparents have for centuries passed on to their children through oral and artistic traditions. This loss may not have occurred if the children had not been taken from their communities,

deprived of their language and cultural ways, and returned to their communities as traumatized souls (Lalibete et al., 2000; Miller, 1996).

Trauma.

Foucault (1977/1995) argued that individuals involved in medicine, prisons, and institutions defined and labeled people as deviant in order to control them. The labels required individuals to act and be treated in a particular way, such as being an institutionalized person or person requiring punishment. *Deviants* needed to be under the surveillance of institutions in society. Based on my observations and experience, Lauren is considered deviant by many people in society since she has worked as a prostitute and used illegal drugs at different times in her life. These labels limit some people from seeing an individual in any other way. Lauren, for example, recalled that she felt quite invisible when she was in public. At the time, she was living on the street as a prostitute and using illegal drugs. She felt people would drive by her and not notice her. Lauren felt that mainstream society had labeled her as not worthy of their attention because of her status as a prostitute. She felt she was being looked down upon, not listened to, degraded, and, at times, dehumanized.

In one of her stories, Lauren described that she felt the police and justice system had failed her. She had been sexually assaulted, and despite identifying her perpetrator to the police on two occasions, her pleas for justice were ignored by the police authorities. Lauren was uncertain if the police had completed any investigation into her case. She received no follow-up to the case and thus felt further marginalized from mainstream society. One ramification of these experiences for Lauren, and others like her, is that she is less likely to work with the police and

other organizations whose purpose is to address crime. As a result, polarization and division between those considered not in mainstream society and those in mainstream society is further deepened.

Lauren's stories about her childhood describe the trauma she experienced at a young age and suggest that her behaviors may be modeled. Her experiences of adversity and trauma shaped the formation of her identity. Lauren witnessed the violence and abuse that her mother suffered at the hands of her father. She recalled witnessing and experiencing abuse while living in foster homes, while on the streets and selling drugs, while prostituting, and while engaging in interpersonal relationships. The abuse and trauma she experienced was painful.

Lauren may have suffered from post-traumatic stress disorder (PTSD) as a result of witnessing this abuse and violence. She recalled watching a rape scene in a movie and seeking medical attention for her heightened anxiety after the scene was over. I wondered if this might be PTSD. When I asked Lauren if she had ever heard of PTSD she told me she had been diagnosed with it. I have often associated PTSD with soldiers who have experienced and witnessed human atrocities in war-torn countries. But, in talking with Lauren, I realized there are similarities and that Lauren too suffered sustained violence, abuse, or degradation.

Lauren carried her childhood, marked with drug use and violence, into adult life. She developed an identity shaped by drug seeking behavior, social violence, and self-abuse in order to obtain drugs. As a youth, she lived with a father who taught her how to package and deal drugs. At times, she was a violent gang member and drug dealer. At other times, she was a prostitute making money to buy drugs. While all these experiences are harmful, several authors

have suggested that, rather than consider them risk behaviours, they should be reframed as survival strategies (Linton, Singh, Turbow, & Legg, 2009; Mill, 1997; Mill & Anarfi, 2002; Shannon, Bright, Gibson, & Tyndall, 2007). Mill and Anarfi (2002) found that some Ghanaian women survived challenging economic environments by picking a boyfriend that could support them and their children; this sometimes resulted in these women being exposed to HIV. Similarly, Mill (1997) reported that Canadian Aboriginal women often ran away from foster homes and institutions following physical and sexual abuse. These women were able to avoid the physical and sexual abuse but running away placed them in a "high risk" environment that involved intravenous drug use and taking boyfriends for survival. For Lauren, helping her father package drugs at an early age was more about filling a need to be a part of her father's life than participating in something that was against the law. It fulfilled in her a sense of belonging and hope that she could be emotionally close to her father; this allowed her to survive, barely. However, exposure to drugs and the people who used them, including prostitutes and drug dealers, became normalized over time and ultimately may have contributed to Lauren's own early personal experiences with intravenous drugs, sexual abuse, and prostitution. The environments and opportunities for drug use were readily available to Lauren as she grew up, and, in this environment, she struggled with the notion of family and tried to figure out its meaning and significance.

Family.

Throughout Lauren's difficult and unstable childhood, there were many reasons for her to cling to what she perceived as her family. Over time, her brothers proved to be a source of

support for her. As a child, she sought out her brothers when they were separated in different foster homes. She and her brothers provided each other with support and love because they shared a common past. As she got older, Lauren strengthened the ties with her father and was able to build a life with him. She believed her father taught her how to survive by selling and dealing drugs, but she felt he also provided her with love, support, stability, a sense of culture, and protection.

These same attributes of love and support were displayed by Lauren when she herself became a mother. She proudly shared a story of how she travelled over 100 kilometers in cold and wintery weather just to be reunited with her son at Christmas. The thread of being reunited with family was prevalent throughout her stories. Lauren viewed family as a positive aspect of her life which she further recognized and appreciated by completing a family tree assignment while incarcerated. In doing this, she learned a lot about her past and was proud to learn about her ancestors and where they came from. The family tree exercise demonstrated that much Aboriginal culture and history had been missing in Lauren's life. She was not aware of her history and ancestors. As a result of the exercise, she became aware of her rich heritage. Several authors (Barlow, 2009; Comack, 2008; King et al., 2009; Laliberte et al., 2000) have described the loss of identity in Aboriginal culture and history as a result of residential schools and institutionalization. The residential school system has not only directly affected multiple generations of Aboriginal people, but it has also left a legacy of loss for future generations. Lauren is part of a lost generation that is craving to find itself within an ancestral home; this may be possible for Lauren through her own healing journey.

Healing.

As I listened to Lauren tell her stories, I could hear in her voice that she was trying to heal from many past injustices. One of the most important things she believed she needed to do was to rebuild her self-esteem, which she worked on while in prison. She revealed that her self-esteem was so low that even after she was released from prison, she still felt that she belonged there. With the help of correctional staff and elders, Lauren came to the realization that she deserved more from life than just being incarcerated. She worked on her self-esteem as she explored the pathways which connected her to the spiritual values and beliefs of her Aboriginal ancestry.

Lauren's moral strength grew out of a life that combined a mixture of native spirituality and Christianity. These values and beliefs gave her hope that she had a purpose in life. She was introduced to Christianity by one of her foster parents who remained a positive influence in her life, even after Lauren moved away from the foster home. After reuniting with her father, she learned about native spirituality. Lauren talked about a tension she felt in trying to believe in both native spirituality and Christianity. She was not sure if these two beliefs were compatible. She asked, "Would believing in native spirituality mean that I believed in false gods? Would native spirituality clash with my Christian beliefs?" After discussing these questions with others, Lauren discovered that it was possible to believe in both native spirituality and a Christian god.

Lauren talked about working with both the pastor and the elders while she was incarcerated. However, she described in greater detail her work with the elders who helped her deal with many of her personal issues. Lauren also was concerned about the drug-using friends

in the community she had previously belonged to. She came to recognize that she needed to sever ties with her old street friends and acquaintances before she could continue improving her life and begin healing. Lauren struggled with severing these ties. Her street friends expected that, after being released from prison, she would be the same person she had been in the past: ready to party, drink, do drugs, and get into fights. Distancing herself from her former friends meant that her social supports needed to change in order for her to feel she had a place in the community. Lauren distanced herself from her old friends, who then shunned and resented her for changing. She felt she was caught between two worlds—a world where she was working towards getting healthier and more stable, and another world that tempted her to return to drug use and violence. I felt concerned for Lauren as she described having to tread carefully between these two worlds. I also appreciated the sacrifices that she had to endure in order to get herself to a healthier and more balanced place.

Chapter Five: Narratives of HIV, Street Life, Drugs, and Incarceration

In this chapter, I present the life narratives of Mary, an Aboriginal woman living with HIV. The stories were shared in the context of previous incarceration and took place during conversations with Mary over a period of 4 weeks. Through the use of narrative inquiry, I relate these stories to the research puzzles Mary and I discussed together. I begin this chapter with Mary's narratives of her experiences living on the street, being involved with drugs, and coping in a corrections environment. I then focus on her stories and experiences with HIV and the grounding strength her family has provided. The chapter ends with a discussion on narrative beginnings regarding her sense of community, notion of harm reduction, and acknowledgement of trauma stories.

Negotiating Street Life, Drugs, and Incarceration

Getting to know Mary.

Mary was my second participant, and our first contact was by telephone. Her voice was soft and melodic. When we met in person, I observed that she had a slim build and carried herself with movements that did not denote a rough character. Rather, her movements appeared gentle and smooth. She did not have that same paranoid look and demeanor as others who have also lived and worked on the street; however, the way she talked revealed that she had experienced life on the streets.

Mary and I usually communicated with each other through text messages to set up our meetings. Unlike my other participants, she liked to check in with the receptionist at the university. The others would either knock on my office window, text me when they arrived at

the university, or arrange for me to pick them up. In one of our conversations, Mary shared that she wanted to feel more like she was a part of mainstream society. I wondered if that was why she always chose to check in with the receptionist before seeing me.

Mary was in her late 20s and was a mother of three children ranging in age from 3 to 11 years, but she did not have regular contact with them. She stated that her visitation arrangement with the children was a choice she made and understood. Mary lived with her boyfriend in the downtown area. She viewed living in the downtown to be convenient, providing her with access to many of the services she needed to use such as pharmacies and clinics.

Being open with my HIV status.

Mary and I were talking about HIV, and she mentioned, "HIV is like a plague. Many people have it and they are scared to say they have it because they think people will shun them. That's where people like myself have to come in and start talking about HIV to make them feel more comfortable about it." Just to confirm, I asked, "So you see that as a role that you can take on?" Mary replied, "Yes, and I am willing to take it on, 'cause I know a lot, a lot of girls out there know they have HIV. I know this because they tell me. But yet if you ask them, they'll say they don't have it. I'm so open with my HIV status I'll tell anybody. Girls feel comfortable coming up to me and saying, 'Yeah, I'm sick, too.' So I think it makes them feel better to actually say it to somebody who has it. They tell me because they also know I am not going to tell anyone about it." As a nurse working with people living with HIV, I recognize how important it is to establish trust before talking to someone about their HIV status. I said to Mary, "It takes a lot for people to trust you with their information." Mary replied, "Oh, yeah, they trust

me. I don't know why; maybe because I'm not two-faced and I would never back-stab a person. I can't do that 'cause, what goes around comes around."

I posed another question, "So in your mind, what do you think are reasons why they don't want to tell anybody that they're HIV-positive?" She took a minute to reply, and then she simply said, "money." She took another few seconds and then explained, "A lot of the guys out there wouldn't pick up the girls if they found out they were HIV-positive. And if the girls tell the wrong person then word can travel and the john will find out."

It takes two people to have sex.

Mary and I talked about the girls who worked the streets, and now she focused on the johns [men who pick up prostitutes]. Mary said, "The johns are just as much at fault for it. It takes two people to have sex. A lot of the girls don't look healthy but they still have sex with them. They don't have to have sex without a condom. When I was working out on the streets two summers ago, every car I got into asked if I could not use a safe [condom]."

I was not sure what she meant by a "safe," and Mary said it was a condom. It was also a street term indicating that a person was safe or clean. Mary explained that the term *safe* had a pretty loose street definition, and it could refer to many things. Mary said, "So technically, johns should just come out and say, 'Are you sick? Are you HIV-positive?' They don't usually ask that because they just don't want to know if a person is HIV positive. They're just thinking of themselves. So if a person says they are safe, some johns pretend that also means that person does not have HIV. I think picking up girls is an addiction, too. Many of the johns talk to me and I asked them, 'What do you get out of it? You have a wife at home? Do you not get laid at

home?' The majority of them say, 'Yeah, I do, but it's the adrenaline.' I was surprised by this and she further explained, "Yeah, it's the adrenaline of getting caught. It's the excitement of being with someone else. I would ask the johns, 'Why would you want to do that if you got a good life at home?' But some of them say they don't have a good life at home. I told them that being with me is not going to make your home life any better." I said to her that these johns probably have other issues as well. Mary said, "Yes, and picking up a girl is not going to help it. It is really messed up out there. The girls are the ones that are being labelled for the outbreak of HIV. But technically, it's really not our fault. I'm saying our, because I was there. It is not our fault. It is also their fault, too. Johns don't have to f*** you without a condom. There are so many free condoms. They just have to go get it at the Sexual Health Clinic. They don't even have to pay for them." We continued our conversation about prostitution. Mary stated, **"**It's just as much the john's fault as it is ours [prostitutes]. It's crazy." I asked, "So what happens if you're in a situation where a john does not want to use a condom, but you want to use a condom?" Mary replied, "I don't usually have sex with them. But then a lot of times, they'll put more money in front of you. And to tell you the truth, I've done it. I was really low and I really didn't give a s***, and I didn't care about anything. I didn't even care about myself. So I've done it. I was in this situation with a guy who was with a girl who was sick [living with HIV]. I told him, 'you have to use a condom.' Then I looked at this girl and she shook her head. She said, 'No, it's okay.' She made me believe that he knew that she was sick. I said to her, 'Okay, so it's all good.' Later on we were talking and I realized he didn't know she was sick. She

looked at me and I could tell she didn't want me to say anything. I didn't, but I got my stuff and I left."

Coming from a family of drug addicts.

After we talked about her experiences on the street, Mary and I talked about her experiences with drug use. She shared that her family members were drug addicts and lived on the street. She said, "Many of my family members were drug addicts. That's actually where I used intravenous drugs for the first time. I was really heartbroken when I was 19, because my baby's dad cheated on me with one of my best friends. For 2 weeks straight I was just crying, crying, crying. Then my brother came in one day and he went downstairs to his room and I followed him. I saw him using drugs. I said to him, 'I want some. Give me some.' I used to get mad at him for using drugs, but at that time I didn't care. He wouldn't give me any drugs. I told him, 'If you don't give it to me, I'll go get it somewhere, and God knows what I'll be getting. I have no idea. I've never done it.' So I manipulated my brother into giving me drugs and he gave me my first shot of morphine. I felt gross afterwards and I didn't like it, but yet it helped me not miss my ex any more. That's how my IV drug use started. It is easy to get addicted. After even just a week of doing it every day, your body starts to need it. I was on morphine for quite a long time, maybe 2 years. I've been on methadone for 11 years." I congratulated her on being on methadone. She explained, "I was clean for the first 4 to 5 years and then I'd relapse, and then I quit again for a couple of years. But I always ended up hooked. It was really within the past 8 months that I really cut down on the drugs. Well, I quit doing coke over a year now. I don't like that s*** now."

Not feeling scared anymore.

Mary and I were about to continue talking about her experiences with drug use, but she wanted to change topics before continuing, "Well, it's my birthday tomorrow." She was happy, and then she shared, "I'm not scared and I don't feel 30. I don't know how you're supposed to feel when you're 30, but I don't feel it. I'm actually really, really humbled I'm turning 30 because there were three times I almost died. So it's a blessing I actually even made it up to 30." I asked, "Can you tell me about those times?" She shared, "Oh, yeah. Each time was a pill overdose. The first was when I was 12 years old." I was surprised and said, "Twelve years old! Oh, wow." Mary stated, "I don't know where I got all these pills from. God only knows. I can't remember. I just know that I had all these pills on me. It was Valium, Tylenol 3s, and something else. There were six of us in a little group and each of us took way too much. The next day we went to school and then this one girl started doing the funky chicken in class. I also remember going unconscious and next thing, I wake up in the nurse's station and they're trying to keep me up. I just wanted to go to bed. One of the nurses told me, 'We almost lost you once, don't go to bed.' My friend, who was also using drugs with me, was there and she was puking. I turned around and her lips were going blue. It was really, really scary. I went unconscious again and then I woke up to find myself in the hospital. That's when they had equipment hooked on me and I had tubes down my throat. They put the tube down 'cause there was something about me not drinking the charcoal and they had to make me drink it. Apparently my heart stopped there. I fall back asleep and I woke up again. My dad was standing there talking to the cops. The police told me that if any of those people died I would have been charged."

I inquired, “So were the pills yours?” Mary replied, “I got them from somewhere. I knew what they were and I knew they were really good pills because it said on the label, ‘Drowsiness, may cause drowsiness operating a vehicle.’ “I asked, “So why did you take all those pills?” She said, “I don’t know. I think the plan was just to experiment with them. For myself, it was an escape. I was trying to get away from my thoughts of home.”

I asked Mary to tell me about the second time she overdosed. She said, “The second time was actually a cocaine overdose. I was about 20. I was on methadone and I had really bad cravings. I was clean for a few months and then I found a bunch of coke at my brother’s house. He was selling cocaine and I started dipping into it. Then I started selling it. Anyways, I was in my apartment and thank God my sister came and picked up my son. She took him because I was strung out on drugs. What pissed her off and what made her take my son was that she opened the bathroom door and I was doing a needle. If that would have been my son opening the door, he would have seen me. I’m grateful my sister took my son or else he would have been in the house doing drugs with other people. I remember when I overdosed I did a 30-pack, and I had two eight-balls on the table. There were a couple of people there and I overdid the pack. My plan was to do only half. I was already using drugs 2 weeks non-stop when I overdosed on the drugs. One of my ‘bros’ started talking to me. I looked at him and I thought I stopped pushing [injecting] the syringe full of drugs in my arm. I overdosed on those drugs and started doing the chicken [seizure]. A woman in one part of the apartment heard someone knocking at her door. Nobody was with me in the hallway and she said that I was there all by myself. When she opened the door and she looked down the hallway, she said I was doing the chicken. Somebody

knocked on her door. I really believe it was a guardian angel. If she wouldn't have come to the door when she did I would not be here. When the ambulance showed up, I was already blue. They did CPR on me and then I came back."

I told Mary she was very lucky to be alive and asked her about her belief in guardian angels. She said, "I strongly believe in guardian angels. I truly and strongly believe the guardian angel was my mom. I believe that because I was the only one there when my mom died. Every time I've come close to something like that or when I experienced getting raped by my trick [john], I'm still here. It's just odd. It's not odd, it's miraculous. It is like, there is somebody there. There's more to God than we give him credit for. And the third time I almost died it was another cocaine overdose. It was cocaine and morphine. That time I died and came back. That was really f******* scary. What made me stop using cocaine was when I looked into the mirror I saw a really ugly face looking back at me. I am still haunted by that face."

Seeing the demons.

We continued talking about the ugly face in the mirror. I asked Mary, "What did you see? Did it just suddenly pop in front of your own face or was it in the mirror?" She said, "In the mirror, but it wasn't my face. It was somebody else's face. My face was there and someone else's. I looked back behind me, but I was the only one in that house. That's what really scared the s*** out of me. I know there are demons all over the place. Everybody can see them lingering, 'cause there's so many of them in hell. I even took pictures. I took pictures at one trailer I was staying at but I lost that camera. I'm really grateful I lost it because I started looking at the camera all the time and seeing new things." I asked, "What things did you see?" Mary

said, “Paranormal things were happening in the place.” She paused and then she asked me if I had ever seen a ghost. I told her I did not think I had ever seen one. She shared, “I’ve seen ghosts three times. I’ve touched them. There’s this one place . . .” Mary paused and shook her head but didn’t want to tell me about that particular place. She continued her story, “My God, there’s just something in this place and there’s a lot of evil there.” I asked her, “When you say this place are you talking about Prince Albert?” She said, “This world in general. There is a fight for our souls. It’s a war for our souls.” She paused again and her eyes fixated above me as she contemplated what she had just told me. She continued, “I had this dream that the Lord was coming. I saw what was going to happen. I was told to tell people he’s coming. People are going to see changes in me and it is going to help them. I walk down the streets at three or four o’clock in the morning. I won’t get robbed and people will even ask to help me. ‘Why are you out here? Let’s go home. What are you doing? I’ll take you home,’ that kind of thing.” I told her that I was really interested in her perspectives on good and evil in the world. I said it seemed that she had seen a lot of evil in the world. She responded, “But then there’s also a lot of good in people too. I try to see the good in people, not the evil.” I asked, “So you think people can be both good and evil?” She replied, “We are all God’s children. That is why Satan is trying so hard to take our souls.”

Reflecting on Mary’s tattoo.

When Mary mentioned Satan, I recalled her sharing an earlier story about an ominous tattoo on her body. During our earlier conversation, I explored the meaning of tattoos with Mary. Tattoos can often be a reflection of a person’s life at a particular time, and I stated to

Mary, “I see you have some tattoos. When some people get tattoos there are certain meanings behind them. Do yours have special meanings?” Mary shared, “Just this one.” Mary laughed a little. She showed me a tattoo of a menacing demon on her right lower leg. “I had a dream about that face and I couldn’t quit dreaming about it. Then I drew it out and you know, I never dreamt about it. As soon as I got the tattoo on my body, I quit dreaming about him.” I asked, “So what kind of dreams were you having about that demon?” She said, “Well, one of them would be that I couldn’t breathe. When I’m lying down and when I started using cocaine really bad, my dreams were about the demon. Every time I’d wake up in my dream I would know I was dreaming, and when it came back I say to myself, ‘Wake up, wake up.’ But I can’t move, I can’t yell, and I can’t talk. All I could go is, ‘Ugh, ugh.’ So people, if they’d be beside me, think I’m just making noises and they won’t wake me up or anything. But what I’m yelling is, ‘Help! Help me!’ And I can’t breathe, I can’t move. And as soon as I woke up, I don’t know; it’s just odd how it happened. It’s like it would let go of me for a second and then I wake up, but I’m not up-up, I’m up in my dream again. It’s like a rerun. I haven’t had one of those dreams since I last did cocaine, which is why I don’t like that cocaine.”

I asked her more about what or who this demon was or what it represented. She said, “The demon represents hate. I think I just had so much hate inside me towards my stepmom and my stepfamily. Where I was just progressing to the point where I’d be thinking evil thoughts, like how to kill her. I’ve told lots of people this, but I know for a fact I would never do it. I used to think of ways to poison her. I really don’t know why, ‘cause later if she died, she’d be the one winning. I would be the one in hell and she’d be the one in heaven. The demon represents evil

thoughts. Sometimes my stepmom would cheat on my dad. My dad ended up catching her in bed with a man and beat the living f*** out of her. But you know what? I felt more pity for my dad than I did for her. I felt more remorse for my dad, because my dad did not deserve it. He did not deserve to get hurt like that."

I asked Mary to elaborate more about her anger toward her stepmom and stepfamily, and she stated, "when I was growing up my stepmom she would pretend that she was the best mom in front of my dad. However, when my father went to work she would yell and hit me. I was molested by my stepbrother and sister and my stepmom knew about it. It's like, my stepmother knew, and she would hit me because of it. I knew she was hitting me so I wouldn't talk about it. And then to this day, she's really phony and doesn't admit to it. She's one of those people that are two-faced, one of those people I would truly never, ever want to be. I don't know how to tell my dad that I was molested by my stepsiblings."

Living in the women's provincial facility.

Mary and I switched the topic of our discussion. I asked her which correctional facilities she had spent time in, and she told me it was the women's provincial facility. Mary shared that she had been in and out of provincial corrections approximately 10 times mainly for shoplifting and avoided spending any time in a federal facility. We talked about her experiences in provincial corrections. Mary stated it was, "mainly a good experience. I didn't mind the jail at all. When I first started, I enjoyed it. I got along with everybody there. I was in and out of people's houses [cells] and I was a social butterfly. That's what I called myself, a social butterfly 'cause I could talk to anyone whenever I wanted." I asked, "Did this facility help you

with addictions or any of your issues?" Mary said, "I took a few courses in there and it did help." I asked her if she remembered the programs and she replied, "I took a holistic parenting program and another program, but I can't remember the name." I asked, "Were these programs run by just the workers or were they run by elders?" She said, "Oh, one of them was run by an elder. And there was another woman who ran it. She did an awesome job. She's probably still there." Mary lets out a little chuckle. "I took that Woman's Substance Abuse program in there. I enjoyed doing all of them."

Living with HIV

Finding out I was HIV positive.

"About 3 years . . . well, 3 years and 9 months ago I was getting really f***** up on the coke[cocaine]. I didn't know I was pregnant, but when I felt my daughter move I went and got a pregnancy test and it came back positive. I was pregnant. I was on methadone at the time and I was getting ready to cut off the methadone because of all the cocaine that was in my system. Anyways, I quit drugs after I found out I was pregnant with her. I was still with her dad, my ex-common-law. I never told him I was raped, but he had a feeling that my daughter wasn't his. I just wasn't ready to come out and talk about it with him. The first time I ever talked about it was at a treatment centre this past May. This was the first time I actually came out and said I was raped." Mary took a long sigh and continued. "Anyways, after I found out I was pregnant I got checked for HIV. But 8 months prior to that my partner went and got himself checked, because he had a bleeding nose and it wouldn't stop bleeding. That's one of the signs apparently, that a person is HIV positive. He just wasn't healing." I told her that just having a nose bleed was not

an indication of HIV, but she continued, “That’s what I was told, anyway, and his nose bleed wouldn’t stop. Then this other time one of our friends was using a needle and it clogged on him. He got frustrated and he threw it on the table and he said, ‘Here, sister, go put this away, but don’t you ever do it, ‘cause, I’m HIV-positive.’ I told him it wasn’t a problem and I put that needle in the discard container, which was a tin bin. That night I heard some movement in the kitchen and I heard someone in the needle container. I was, like, ‘Oh, f***’ The next morning I went and checked, and sure enough, his needle was gone. My man took that needle. I never did bring it up with him, but God knows how many times he’d done that before, using someone else’s used needles. So then I lied to him. I was just, ‘Go get yourself checked. I’m HIV-positive. I just found out.’ But I didn’t really know.”

“I didn’t know if I was HIV positive, I lied. The reason why I did that was so that he would go get checked. If he was positive, then I automatically knew I was. So that’s what he did. He went and got himself checked and he came back positive. He asked the doctor about my HIV status and the doctor looked at him and said, ‘She’s not positive.’ Mary chuckled as she found that part of the story humorous. “And then he looked at me and I didn’t say anything. Then 8 months later, after I got pregnant, that’s when I got checked and that’s how I found out.”

The meaning of HIV in Mary’s life.

Mary’s diagnosis with HIV was not her first encounter with the illness. Mary had an adopted sister who was living with HIV. However, what complicated matters for Mary was that she and her stepmom never got along. I was interested in this relationship and asked, “With your relationship with your stepmom, does she know you’re HIV-positive?” Mary stated, ‘Yeah, but

she thought I was lying about it. She thought I was lying about it to get pity. For crying out loud, why would you lie about something like that?" I asked, "What was the reaction of your family when you told them?" Mary stated, "Actually, my family was pretty cool about it, because my older relative has it. My dad adopted his cousin's daughter, so she's my sister now and she is HIV-positive. They knew all about it. That's why my stepmom thought I was lying, because my sister had it. She probably, to this day, probably still thinks I'm still lying about it."

I asked, "When you think about HIV and your experience with it, how important is HIV in your life?" Mary took a long pause and then answered, "It's part of me now, so it has to be important. It's got to be something I've got to look after. It's a virus in me but it's not me. Maybe having HIV is a positive thing. I can talk about it and maybe help other people talk about it too. I really think of it in a good way instead of poor, poor, pitiful me." I asked Mary if she had any positive stories. She shared, "My daughter. She's a positive story, because she doesn't have HIV. I was positive when I found out I was pregnant with her. I was also Hep C positive back then, but I don't have Hep C now." I said, "Excellent. So you're one of the lucky ones who were able to fight Hep C off, that's great. There are a small percentage of people, about 10 to 15 percent who are able to get rid of the hepatitis C virus on their own." Mary said, "That's a blessing. My daughter doesn't have HIV and she got tested and she is 3 years old now. It is a good thing and that is the most positive thing I can come up with right now. I hope and pray that more positive things will come out of having HIV."

I also asked Mary if she was taking any HIV medications, and she responded, "Yeah, just recently. And I'm doing well on them. The only problem is I can't sleep at night." I asked her

if she had any other side effects, and she did not respond. She wasn't able to tell me the exact medications she was taking, but she said she felt that they were helping her. I tried to explore more issues regarding her HIV status and her health, but she always said she was doing fine with the HIV.

Searching for Something in Relationships

I miss and love my children.

Even though we both agreed that the world can be pretty 'crazy' and unpredictable, Mary talked about the importance of love. Mary said, "there's always a better way to look at things. There's still love. Other people can love us. I had a dream of God coming. He told me to tell people he's coming, to try to talk about my story. 'Cause if I start making things right, good things will happen, and my main goal is to start talking to my children again. I haven't talked to them for a long time." I asked her, "Where are they now? Do you know?" She replied, "They're in a foster home. All three of them are together. It is a blessing because the family that took them has never had a child under the age of 5. Initially they had two of my children. One of my sons got really sick when he found out his brother was in foster care and his grades fell, and everything went poorly for him. The foster mom asked him, 'How can we help you and how can we make this better?' and he said, 'Get my little brother,' so that's what they did. The foster parents have had my kids since then." I asked, "Have they been good to them?" She replied, "I believe so. I pray they are."

Mary had taken care of her kids at different times in their lives, but, for the majority of time, foster parents raised them. I asked Mary if she kept in contact with her children, and she

responded, “No. That’s all my own doing. I don’t know what I’m going to tell my oldest son, but that I was selfish. My children need me just as much as I need them, and it’s a lot.” I was interested by what she meant by selfish and she said, “Not knowing what to tell my son *[long pause]*. I think he thinks I love the drugs more than him *[long pause]*. And yet I don’t want him to get his hopes up if I start contacting him, ‘cause if I fall again and start taking drugs. There’s this negativity where my past just keeps haunting me. How do you change the past? You can’t.”

After a pause, Mary revealed, “I really miss my babies. My son doesn’t know I’m HIV positive. I never told him and he is 11. Part of me would love to fight for them, but a part of me is scared of fighting,” she stated. I ask her about why she was scared. She explained, “The cocaine and the drugs, I’d be fighting that more than Social Services. I’ll be putting more into fighting that, than fighting for my children. So I think I’m better off where I’m at in town and I’m close to my dad. And all the resources are here for me to be successful. If I wanted to visit my children, Social Services would pay for my room and a bus ticket while I am there.”

I was interested in her relationship with the Ministry of Social Services. I asked her, “So with Social Services, they’re not trying to prevent you from seeing them?” Mary stated, “It’s not them or the foster family that are trying to stop me. The foster family would love me to get them back but I am scared. I’m scared that my children won’t talk to me. But if they are anything like me, they will not hold anything against me. Oh, I miss my babies so much. I think of them every day. Every moment that I open my eyes, they’re the first people I think about. And the moment I close my eyes, they’re the last ones I think about.” I said to her, “I remember you saying that your babies were very important to you.” She replied, “They really are and . . .” she

paused, “I don’t want to hurt them again.” She pointed out that the drugs were difficult for her to quit. “I really do not have a problem with alcohol. I can quit that no problem but I’m addicted to drugs.”

Mary and I continued talking about her experiences with drugs and also her reflections on how drug use has affected her life. “When I was a kid, a lot of girls and guys did Ritalin. They get all jittery and flail around. When I use Ritalin I just want it to keep me awake. It doesn’t have the same effect on me as cocaine does. Maybe that’s why it [Ritalin] has such a hold on me so far, because it does not do the same thing as cocaine did to me.” I asked her if she injects it into her body. Mary stated, “Yes I inject it. I inject it where it hurts the most, which is right by my son’s name.” I asked her if there was any significance to injecting it there. She said, “It reminds me of spending more time looking for a drug than looking to see him.” I asked for clarification, “And then by putting it right by his name, it reminds you of that?” She replied, “It definitely does. I still don’t have a good explanation why I inject drugs in that spot. When my son is around me, he knows about my tattoo. It’s on my hand, and he’s going to see that I have been using drugs. I have his initials on my hand.”

Having a good partner in a good community.

Mary has a partner that she has been with for the last few months, and it was evident that he provided her with strength to stay away from drugs as much as possible. Every time she mentioned him, it brought a smile to her face. I asked her, “You and your partner seem like you have a good relationship going. How has this relationship been different than other relationships?” Mary responded, “I can talk to this man, and he knows when I’m sad and knows

when I'm mad. We can talk things over. Even if we're upset with each other, we still tell each other we love each other and we never go to bed angry. My dad also loves him. He's kind of got my dad's personality. My man said he's willing to come with me when I start talking to people about HIV. He's a shy dude and not the type of guy that would come up on the stage or that sort of thing. As long as he's there with me, I'll be good." Mary had mentioned that he is the one that encouraged her to come and see me.

Mary's partner provided her with support, and she also received support from her community. We talked about her downtown community, and I told her, "It seems like the people in the downtown area have a sense of community." She replied, "We do have a community. It is all of the drug addicts, alcoholics, the panhandlers, the people who have nothing, and also the homeless ones. We try to help each other, but there's always the odd person that only helps out if you give them something." I asked, "What kind of things would they want?" Mary replied, "Those people would say, 'Oh, I'll help you find your drugs, but you got to help me out.' Or 'I'll help you move your things into your place, but do you have a smoke or a couple of cigarettes?' These people were always trying to get something from you."

I was still curious about the downtown community and asked Mary to tell me more. She said, "Everybody has their own little clique but people still help each other out. There are always a few buildings where people will let you sleep on their floor, but then you have to pay them. There are a lot of good-hearted people in the neighborhood that will let you sleep on their floor."

Mary and I also talked about her son in greater depth, and she described role modeling to him the importance of service to the community. Mary said, "It's not right, but if you get bullied you have to protect yourself, especially if parents are not there. When the parents aren't there, what are you going to do? Stop there and pray? If you do, you'll be made fun of. I would say you have to stick up for yourself somehow. But you can stick up for yourself and also do good things for that person. That is what I told my boys. If a bully ever bullies you really bad and if you have to fight, then you do it. But try to do other things first like being nice to that bully. Every day I sent my son to school with this kid, the bully would try to take my son's lunch. When I had my son, I would send him to school with a cupcake and I would always send something extra for this little boy. Now those two are the best of friends when they were together. I really believe in doing kindness unto people that do badly unto you. That person will eventually get sick of acting bad and say, 'I'm going to be your friend' or just leave you alone. My son and his friend learned a lot from each other. I would also take my son to the soup kitchen and different places where I volunteered. Then one day, that little boy who was bullying my son said, 'Where are you guys going?' and I told him, and he said, 'Can I come?' I said, 'Yeah,' and I asked his mom and she was fine with that. Anyways, every Saturday that boy would be knocking on our door. 'Can I come with you guys?' Mary laughed and I commented on how nice it was for her to do that for her son and the neighbor boy. She paused and reflected on her son's new friend, "I really hope that that kid is still volunteering. That's just awesome."

I thought about Mary's life and how she had struggled with addiction and life on the street, wondering how she could find the time to volunteer at the soup kitchen. I was interested

in her volunteering and asked her more about it. She said, "I love volunteering. I love it. I used to do it every Christmas, every Thanksgiving, every time where they would have a big dinner at a community center. Whenever they had a big dinner, me and my boys would be there. Volunteering was a thing I would do with my kids. It taught them to do good things unto others and not expect anything back, just a smile." I was so impressed by that and told her so. She responded, "I just like volunteering. I have to do good things for my soul, too. A person's got to do good things for their soul to keep their soul happy and strong."

Reflective Beginnings on Narrative Threads

In what follows, I present a focused interpretive analysis related to my research puzzle. In doing so, I begin to make sense of the meaning and significance of Mary's life narratives and her stories of HIV and previous incarceration. My research puzzle focuses on the experiences of Aboriginal people living with HIV and previous incarcertation. In exploring this puzzle, I examine notions of community, harm reduction, and traumatization in the context of Mary's experiences. I begin with the notion of community.

Community.

The downtown area was Mary's community, a place where she was able to access important services related to filling prescriptions, attending health clinic appointments, and benefiting from social service resources. The people living in the downtown area, like in other urban communities, provided support to one another and often shared their resources (Van Uchelan et al., 1997). Mary's description of her community reminded me of a study by Van Uchelan and colleagues (1997). The authors describe people in the downtown core of

Vancouver, a large urban city in Western Canada, providing each other with an important support system and depending upon one another for many things. In particular, they suggest that people outside the downtown core tend not to recognize the significant roles that people play in relation to each other within an inner-city environment.

Van Uchelan and colleagues (1997) also suggest that there is a tendency to see only the problems of a community when applying a needs assessment model. Such a needs assessment model examines the needs of a community based on what is perceived to be its deficits. The focus on deficits does not recognize the strengths that are already present in a community. For Mary's community, it was noteworthy that people shared their homes so that others could have a warm place to stay and worked together if a person needed to move homes. These identifiable community strengths provide evidence that members of Mary's community supported each other in their day-to-day existence and shared personal resources.

Importantly, these same community members also helped other members deal with loneliness and hopelessness. Flicker and colleagues (2005) reported that loneliness, hopelessness, and isolation were dominant factors in a group of youth living with HIV. Mary's story of walking around at night to talk to people in her community is an example of how she connected with community members around her in order to alleviate her feelings of loneliness and isolation, emotions that she was intimately familiar with.

When I consider the challenges of focusing on people's strengths within community, the work of Ermine (2007) comes to my mind. He reminds us that our Western perspective influences our view of others. He emphasizes the human need to find common ethical spaces in

order to understand each other. As health care providers, we need to be mindful that our biomedical models and Western philosophies may negatively colour the way we view our clients. By viewing others from a primarily singular, deficit, or negative perspective, we may not appreciate the strengths that also exist in the human condition. In Mary's community, for example, the challenge for those not living there is to see past the homelessness, drug use, and violence and to recognize the unfolding identities and acts of resilience within the dynamic support systems that existed. The question should not only be what supports are missing in the community, but rather how we can also work with the community to determine what strengths are present and how appropriate resources can be negotiated to enhance these strengths.

Mary demonstrated her contribution to the community through the provision of peer support. In her narratives, she clearly demonstrated that she had the ability to work with women in corrections and on the street since they felt more comfortable sharing their stories and issues with her. Mary felt that her personality and her ability to empathize with these women's life situations encouraged them to share themselves openly with her. As health care providers, it is important to recognize the valuable potential contributions that people like Mary can offer when creating and evaluating new and pre-existing inner-city community-oriented programs.

Harm reduction.

Mary believed that the spread of HIV was the responsibility of both the person buying sexual services as well as the person selling sexual services. In Canada, condoms are usually made free and accessible within inner-city communities by public health organizations, but access to condoms is only part of the issue in preventing HIV transmission (Canadian HIV/AIDS

Legal Network, 2011). In prison, a range of services are available to offenders such as condoms and dental dams, but access to these resources varies across provincial and federal institutions (Betteridge & Dias, 2007). Betteridge and Dias (2007) advocate access to methadone treatment and needle exchange programs to prevent HIV and Hepatitis C in prisons. They also highlight 30 promising projects in corrections and, interestingly, the anonymous HIV testing program that I created at Saskatchewan Penitentiary was one of those projects. Mary argued that attitudinal changes were required among those participating in the sex industry (both 'johns' and 'prostitutes'). However, promoting change is difficult and more complex than once realized. For example, Mary identified that there are incentives for sex trade workers to lie to customers. By lying about their HIV status, they are still able to sell their body for sex to secure money to sustain an addictive lifestyle. Thus, if sex workers reveal that they are living with HIV, they risk losing customers. At the same time, they may be stigmatized for having HIV and other sexually transmitted diseases. Therefore, it is important to acknowledge that an array of drug use and high-risk social interactions may promote the continuation of self-destructive, adverse, and traumatizing behaviors.

As I reflected on Mary's life stories, I thought about the stigma of HIV and realized that this phenomenon may not always allow sex trade customers to hear public health messages clearly. Some seem to listen only to what they want to hear. Mary provided an example by using the word "sick" to explain that when customers ask sex workers if they are sick, the customer may be referring to HIV, but the sex worker may interpret that word much more broadly in a way that may not have any connection to their HIV status. Superficially, this

appears to be a matter of rhetoric, yet on a deeper level this may promote miscommunication between both parties. Individuals seemed to avoid talking directly about HIV or their health status. This might be due to fear, but is likely more complex than that. Nevertheless, by addressing HIV by its name, it does become more real. The reluctance to talk about HIV highlights the need to increase efforts to de-stigmatize HIV and create safe spaces for HIV to be talked about in the community. There are also larger societal discussions related to legalizing the sex industry with specific legislation that addresses the issue of safety. The Canadian HIV/AIDS Legal Network (Betteridge, 2005) produced a report that provides substantial rationale for challenging the current legal treatment of prostitution in Canada. This document also brings to the surface the negative public health outcomes for both prostitutes and their clients in Canada (Betteridge, 2005).

Clearly, HIV needs to be talked about more in communities. There have been recent court decisions indicating that people living with HIV are criminally responsible if they expose people to HIV (Canadian HIV/AIDS Legal Network, ND). Mary stated that there were times when she did not care if she had sex with or without a condom. This occurred before she was diagnosed with HIV, but it raises the question of criminalization of people living with HIV. The Canadian HIV/AIDS Legal Network (Betteridge, 2005) and O'Bryne et al. (2013) argues that public health interventions should be considered first before criminal action is taken. Mary talked about the current practice of criminalization of HIV and believed this would not open up discussion into the sensitive issues that need exploring to address the transmission of HIV. Rather, Mary believed that the criminalization of HIV might make people avoid getting tested

for HIV or dealing with other HIV issues. Even with the possible avoidance of criminalizing HIV, McCall and Pauly (2012) reported that Aboriginal women avoid accessing health care because of judgmental and discriminatory attitudes by health care workers. There is still much work that needs to be done in this area.

Traumatisation.

Mary experienced a significant trauma in her life which affected not only herself but others. Dayton (2000) describes two basic types of trauma. The first type is situational. This type of trauma is derived from a specific situation, such as experiencing someone's death or being physically assaulted. The second type is cumulative. Cumulative trauma is a series of traumatic events such as long-standing emotional, physical, or sexual abuse. Cumulative trauma may also occur as a result of persistent school or family problems. One of Mary's first situational traumas occurred with the loss of her mother at an early age. Mary recalls being the only one with her mother when she died. Afterwards, her father and her stepmother raised her. Mary always felt at odds with her stepmother, resulting in a life with ongoing physical and emotional abuse. This abuse was cumulative and resulted in a point in time when Mary felt like she truly hated her stepmother. This was manifested when Mary's stepmother cheated on her father. Mary felt more sympathy for her father than her stepmother, who was severely beaten by her father.

Drug use is often a symptom of previous trauma (Dayton, 2000; Walton et al., 2011). Mary recalled starting to take drugs at the age of 12. Her reasons for taking drugs at that age were to experiment and to find a way to escape her emotionally disturbing thoughts of home.

Her first drug experience resulted in an overdose. She also described overdosing twice more, later in her life. Although she was trying to escape a traumatized reality, she ended up creating a multitude of other problems such as selling drugs and selling her body to support her drug-addicted lifestyle.

Dayton (2000) discusses the relationship between addiction and trauma. When a person experiences trauma, they numb the pain by engaging in behaviors, such as excessive drug use, sex, spending, over eating, etc. These behaviors allow the traumatized person to feel better for a short period of time. Over time however, the frequency of these behaviors needs to increase for that person to feel the same amount of comfort. This is when the individual is highly susceptible to addiction. Mary wanted to feel good about herself and escape her traumas. These traumas resulted from cumulative family trauma and situational traumas such as the break up with her boyfriend and her sexual abuse.

Mary was not the only one traumatized. Her family members were also traumatized, including those who were forced to deal with Mary's drug overdoses. Seeing Mary unconscious and fighting for her life must have been difficult for them. For Mary's children, the initial trauma was most likely as a result of the separation from their mother, with subsequent traumas directly related to Mary's drug use. Mary talked about her sister removing Mary's son from Mary's home to prevent him seeing Mary abusing drugs. Mary appreciated the actions that her sister took to protect her son.

Even though Mary experienced trauma in her life, she also demonstrated resiliency in dealing with her problems. Mary struggled with her drug use but was able to use methadone to

balance her drug cravings. Mary's children had been removed from her care, but she recognized that they were strengths in her life. Her children provided her with a compelling reason to stay healthy and drug free and gave her hope for a better future.

Chapter Six: Two Paths Crossing: Winston and Janelle

In this chapter, I present the storied experiences of both Winston and Janelle as they shared their worlds with me through our many conversations. Winston and Janelle have been in a relationship with each other for approximately 2 years and met while attending a community program. It did not take long for them to start living with each other and for their lives to become intertwined. It is because of their close relationship with one another and the overlapping of their stories that I present them in one chapter that presents both their individual lives as well as their lives together.

I first begin with the life narratives of Winston as he recounts his traumatic past, including living with HIV, experiences with corrections and health care, and his conflicted struggle to "straighten out." After Winston's stories, I present the life narratives of Janelle and, within them, her abusive past, her experiences with HIV, and how she was working to transform her life. Finally, in the 'reflective beginnings on narrative threads', I discuss briefly how their stories intersect, providing discussion points that are further analyzed and synthesized in the final chapter. I begin with Winston's stories.

Winston's Past

I heard a knocking on my window and looked up to see Winston waving and pointing to the chair in my office. Because my office had a large street level window, it was convenient for Winston to announce his arrival. He was wearing a black hooded sweat shirt and black track pants that I would often see him wearing when I met him on the street. I nodded my head in recognition and walked around to the side door of the building to let him in. This was the usual

routine when Winston came to meet me. I remember thinking how good it was to see Winston away from the walls and bars of the Saskatchewan penitentiary and the smell of ammonia that I associated with the cleaners passing by. That ammonia cleaner smell still transports my mind directly to the health care clinic at the penitentiary where I have seen many clients. We shook hands and made our way to my office to talk.

A life of violence.

At the beginning of our first meeting, I noticed Winston had a stressed look on his face. He obviously had experienced a difficult day, and I asked him about it. He was quick to share that he was upset with a person who owed him and his partner, Janelle, money. Winston shared his perspective about how he planned to handle the situation, "I went to my place, my apartment, and I got things ready. I got my knives ready, my locks, and a saw. I was ready to go back to my old ways. I told the people who I was arguing with that 'You guys won't see me coming. I'm very nonchalant about it.'" I asked him what he meant by this and he said, "I just kick back and let them think that they think they won the battle. I let the puddle settle for 3 or 4 months before I jump in. I let them screw over many people so that when I strike or come after them, they won't know it is me. They won't know who hit them because so many people may already be mad at them." I wondered about what he would do with locks and a saw. He told me the locks could be used as a weapon, and the saw was used to break into buildings.

I asked Winston, "What prevents you from acting now?" He replied, "My job and going back into that life. You know, just remembering how rough it was being on the streets. It was hard surviving on the streets and only the strong survive. I've had to fight my way out of houses

and out of parties, stuff like that. Sometimes when we were fighting I would tell them that 'If you guys are going to pile on me [fight me all at the same time] be careful because I'm sick, I've got HIV. Sometimes this would make them think twice. I also told them that I won't kill you, I'll paralyze you. All I have to do is cut the back of your neck and you're f*****' I don't know how I got like violent like this. I feel jail is a breeding ground for criminals because you learn to be a better criminal. Also in jail, you do a lot of reading. I read an assassin book in prison. I used to be really intrigued with assassins. I also thought about how assassins would be on the street. When they go into a house, they look at the windows and for potential weapons. They also look for the shortest and fastest escape route. That's how I was on the streets and I had to be smart. When I was downtown I'd never carry a knife on me, but I'd have a bunch of different knives stashed in different areas. I did this because if I was getting chased by someone, I'd lead them to that spot and I'd grab my knife. I just don't want to think about my old street life anymore." There was a pause in the conversation and I said, "You don't want to think about your street life anymore?" Winston replied, "Yeah, that's right, I went to my different spots and I grabbed those knives and I threw them away, I got rid of them. If I end up killing someone, I'm gone for life."

Winston mentioned the use of knives, and I was interested to know if he had ever been stabbed. He said, "I got stabbed in my left wrist, my left forearm, my right forearm, and in my stomach. I have had a very violent life and I am just tired of it. I don't want to live like that no more. I'm lucky to be alive." Hearing about all his stab wounds and visualizing his scars was a reminder of the violence in his life. To add to this, he mentioned having other injuries from

blocking baseball bats and from hand fights. He shared, "I've got old injuries that are still haunting me now. There were cocaine dealers that came into town. They were these White guys and they had three 13- or 14-year-old girls who they were giving cocaine to. They had them hooked on the cocaine and then they started trading them for sex, which is sick. My friends and I heard about what they were doing and we planned to rob them. But what we didn't know was that they were setting us up. The guy who was supposed to set up the robbery for us acted like a double agent. He was working both sides. So they were waiting for us to come and when we got there 10 guys were already there and there were only three of us. We were up four stories and we fought our way to the balcony. These guys came out with bats, blades [knives], and a couple of them had guns. We tried to climb down the balcony and we fell straight down the building. I cracked my pelvis in two places, sprained my left ankle, and broke my right heel. Also my leg just fell into my hips. I just about broke my back. I was out of commission for 6 months. Sometimes when I wake up in the morning I can still feel those same injuries." I asked Winston about his two friends and he told me they were fine and were able to help him get to his aunt's house. I was interested to know what happened to the out-of-town drug dealers. Winston said that a number of other boys from the "hood" drove by and shot their windows and that the following morning those White drug dealers were no longer in town.

Bikers and drugs.

When Winston was younger, he was addicted to drugs and involved with biker gangs. His job was to collect money and debts for the bikers. Winston said, "I thought collecting would be easy, I thought it would be fun and games. The first guy I went to collect off of almost kicked

my ass. This isn't fun and games. This is real serious shit because no one wants to give up their money. I don't want to be beat up. It would be an embarrassment to the bikers and then I would get really hurt by them. I got myself out of that right away because they were trying to get me to go to the clubhouse and stuff like that and I couldn't go. I would say to them, 'No, no, that's okay, I'm not going to the clubhouse.' The bikers would say to me, "C'mon, free beers, free drugs." I checked with Winston, "Do you mean the bikers wanted you to come to their clubhouse to hang out with them?" Winston said, "I told them no thanks because I knew what their plan was. They were trying to get me there so they can take control of me. They'll give you this, give you that, and it will seem like it's for free but nothing is for free." I was curious to know if Winston had seen people being controlled by bikers. He stated, "Yes, lots. I've seen this happen to people. I saw a person become their bitch. Those people would do anything for those bikers. They tried to get me to sell coke [cocaine] for them, and you know what I told them? I said, 'I would but I'm a junkie. I'll screw up. I'm not going to take that coke.' The biker said, 'Well, I'm giving you an extra couple of grams, here, 30 grams. That's $2000 worth.' I still refused. He said, 'Give me $2000, you take any extra coke for yourself, and it's all good." I told him, 'It's not like that. It's not as easy as you think it is. I'm a junkie. I'll screw up. I'd rather have you as my friend than my enemy, than have you on my ass." You know what he did? He grabbed me and gave me a hug, and he said, 'Right on. Thanks for being honest. A lot of other guys would just take the extra drugs.' If they're junkies, they'll take it and go get high, and they'll screw up. And then they're always looking over their shoulder. For me, I don't want that. So I used my head—not this one!" We both laugh as he points to his groin and he

continues, “You know what I mean? You got to use the head on your shoulders, not the one below the belt! Because a lot of guys, they use their head below the belt, they can get into a lot of trouble. They’re not thinking right. For me a lot of girls tried to trade themselves for drugs. When I sold drugs even pretty girls would try to come up to me and try and make deals, they would trade sex for drugs.”

HIV Stories

Receiving my HIV diagnosis.

Winston was diagnosed with HIV in May 2008. He shared, “The exact day was May 8th, 2008, I found out I was HIV positive. I was in the Saskatchewan Penitentiary at the time. And I was sitting in there, I was sitting in the waiting room in the medical area. They let me talk to one of my best friends at the penitentiary for support. It was hard at first to hear that I was HIV positive, but I suspected it because I was living a very dangerous lifestyle. I was doing a lot of intravenous drugs or I may have gotten it from a girl who has just passed away about 2 months ago.”

Winston’s friend who supported him was also living with HIV. I inquired about his friend’s support, and Winston replied, “He helped me lots, big time. ‘Cause he told me when he first found out he was HIV positive that he was also in jail. That was in 1992 and he’s been living with HIV for a long time.” I commented on how fast time had gone by and he stated that, “I can’t believe it’s been 20 years and I think he has full-blown AIDS now. He’s in Provincial Corrections right now. He’s doing really well but I wish he’d get out and stay out. What’s making me stay out of jail is that I have a little boy now and I got a common-law who’s going to

be my wife—I call her my wife, ‘cause she’s just like my wife. And I’m really happy right now. I have a job. I just want to spend what time I have left with my family because I don’t know, I shouldn’t think like this but death is around the corner and that’s how I see it. I’d be dead if I wasn’t taking my meds or if I continued working the way I used to work which was outside in the cold. I’m not scared to die but I am scared to get sick. The first thing that goes through my mind about me dying is my son. He is the main one that I’m worried about. I want to be able to sit and talk with him, man to man, you know what I mean.” I confirmed that I understood. He continued, “He is now 16-months-old and when he’s 4 or 5 years old I’ll be able to talk to him more seriously.”

Taking medications.

Winston and I talked about his health. He told me that he now had AIDS and his CD4 count was very low at 46. He shared a story that highlighted the challenges of taking his methadone medication and also balancing his work. Winston said, “I’m taking my medication every day faithfully and I go for blood tests. But the only problem is that I miss work. I don’t want to miss work because I already went for appointments for my methadone. I kind of blame having to arrange getting methadone for me getting full-blown AIDS. Last year when I was working for a roof contractor we had to go out of town. I told the methadone coordinator that I was leaving for work. When I was out of town I called the methadone coordinator to please transfer a prescription to the city I was working at. I told her that I was really, really dope-sick and I wasn’t able to sleep. It’s horrible, it’s really horrible when you’re coming off methadone. You think coming off dilaudid is bad? Try coming off the methadone. When I came off the

methadone in the correctional jail for 19 days I didn't sleep. I'd sleep for, like, a minute, 2 minutes, and I'd wake up. That was pure hell with aches and pains. Throwing up and being unable to eat. But anyways, they kept doing that to me—like, they wouldn't give me my methadone. When I was released from prison they cut me off before I got back to town [released from prison]. And then—like, I kept getting dope-sick at work, and the doctor said that's why I got full-blown AIDS, 'cause I kept getting dope-sick. That's not very good for your body."

I asked him if he was on HIV medications. He said, "Yeah. But I had to hide them. Sometimes I couldn't take them because there's always someone around me. I didn't want people at work to know, because then I'd be discriminated for sure, I know that. But now I don't care who knows. If I'm sick, I really don't care. Before I quit doing the drugs, I was *[pause]* like, when I'd fix [used intravenous drugs] with someone, I'd tell them, 'Hey, just to let you know, I have full-blown AIDS. I got AIDS. Not HIV, I got AIDS.' Some of them would say, 'Holy shit, really? What are you doing?' and then I would tell them, 'I'm just letting you know for your own safety.' "

Being judged.

Winston and I talked about how society and health care workers view people living with HIV or people who have been in prison. Winston commented, "People in society should not stereotype us. They should give us [people who are living with HIV or have been incarcerated] a chance. We're not all bad, we're not all that bad. But when you really start to give us a chance, when you really get to know us, then you'll learn to understand more where we're coming from. Just give people that are living with AIDS and HIV a chance to speak. I know it's not always

easy for the person that's not living with it to understand, because I know they're scared of it. And I totally, totally understand that. 'Cause I was scared of HIV and AIDS before I got it. I would say to people, 'Whoa, get away from me.' If you're going to be involved with people living with HIV or if you feel like you're going to end up working in that kind of field then try to get to know more about it before judging someone. Don't judge people living with AIDS and HIV and if you do, don't judge them harshly. Give them a chance first, that's all I'm asking. I've been judged harshly before."

I asked Winston if he could remember a particular story when he was judged harshly. The story was about a man who worked up in the mine. An incident occurred between Winston and the man when the man returned to the city. He said, "It's not a very nice story, I ended up having a fight with a guy who was bigger than me and he called me a junkie and a piece of s*** and an AIDS case, and I just told him, 'F*** you, man. What makes you think you're so much better than me? Just because you don't have it, or what?' The other guy said, 'Yeah, because I know what the f*** I'm doing in my life.' I told him, 'Well, you don't know what I went through when I was a kid, you don't even know how this all came to what it is now," He said, "F*** you, you're just a goof,' or something like that, and I just lost it. I called him on to fight, and he laughed at me. So I ended up punching him out because I was angry because he called me a junkie, piece of shit, AIDS case, stuff like that. I was trying to be nice to him, trying to talk to him about it. I remember saying to him, 'You don't even know what's going on with me, man. You don't even know me, man. How can you judge me?' He just yelled back to me and said, 'You're just a piece of shit. All you street people are pieces of shit.'"

Not only did Winston experience verbal abuse from people on the street because of his HIV status, but his HIV status also affected his employment. He shared that he lost his job because he was HIV positive. Winston stated, "I got out prison and 10 days later I got a job for a construction company. I told my foreman that I was sick with HIV, and it seemed like days after that, I was laid off. After I told the foreman I had HIV he said, 'You got AIDS, right?' and I said, 'Yeah. Why'd you say that?' The foreman told me 'Cause you look sick.' How can I be looking sick when I'm eating, I'm looking after myself, I'm taking my meds, I'm eating all the time. How can I look sick? I think one of the guys I work with may have said something but I'm not sure."

Experiences with Health Care in Corrections

The doctor broke the rules.

Winston started off, "Do you know what the Correctional center did to me? Can you believe this?" I asked him what happened. He replied, "Okay, the day I found out I had full-blown AIDS, one of the correctional doctors put me back on methadone and morphine. He was talking to one of the nurses from the Correctional center. He said, 'I've got a young man named Winston. I got him with me right now. I don't think he's going to live to see Christmas'—that's what he was telling the nurses—that's also what he told me. When he told me that I might not be able to make it to see Christmas he said 'I want you to make a choice right now. Do you want to live or die? Because you have full-blown AIDS.' I was worried and the first thing that came to my mind is my son. I cried, because my poor boy, I was thinking he's not going to know me, not really know who I am. Just pictures, that's it. That's why I cried. I'm not scared to die

because you know, there's no pain after you die. There is nothing to be scared of. But anyways, I was just worried about my son because he wouldn't know me, his dad. The doctor repeated, 'Do you want to live or die?' and I said, 'Well, I'll live.' He said, 'Okay, you got to start taking your medication now.' And he said, 'I'm going to put you back on methadone, and we're going to put you on morphine.' So he talked to the nurses about his treatment plans. The nurses got mad at him because he was going to put me on methadone and morphine. They said nobody is allowed to start while they're in provincial jail. Like, if they come here dope-sick, they got to go through the withdrawal, they need to shake it off. And doctor said, 'I just finished telling you he's got full-blown AIDS, he might not even live to see Christmas. I'm going to try to save his life here, and you're telling me you don't want him put back on methadone or morphine? He's going to die,' he told them. He said, 'I don't care what the nurses say, he's going back on methadone and morphine.' I was placed on both drugs."

Institutional life.

After Winston shared his experiences being on methadone and morphine in corrections, I asked him about his other experiences with the correctional system. He said, "I think they're [correctional nurses] dirty, to be honest with you." I was not sure if this was his experience with all the nurses and health care workers so I asked for further clarification. He explained that he was referring to only some of the nurses in the provincial correctional facility. Winston also added, "Provincial nurses are totally different from the nurses at the pen [federal corrections]. The nurses at the pen are awesome. They're the best nurses I ever dealt with while incarcerated. They're more caring and they actually want to help you. And even if someone's been rude to

them, they'll try to calm them down and talk to them. They won't charge them for a violation right away. These other correctional nurses [provincial] just charge a person or else they'll call the goon squad [guards] on them right away. The nurses at the pen are, like, 'Please settle down. There's no reason for this, there's no need to be like this. If you're having a bad day or you're having problems, just talk to me about it.' That's what's awesome about them."

Winston and I talked about what could be improved in corrections. He shared, "Nurses in federal corrections are more caring than provincial nurses. Because in federal, they show that they actually care, and they'll come and get you, get you to do your blood count and all that HIV monitoring stuff. Whereas in the provincial jail, you have to put in a request form and it took them about 19 days for them to get me in to see a doctor. It's like they didn't give a shit. I kept bugging them and bugging them and bugging them, I told them 'I need my HIV meds, I need my meds.' They said 'No, we can't give them to you. You have to see a doctor first." I said, "Well, how long is it going to take me to see a doctor? The nurses said, 'When it happens, it'll happen.' Responses like that are bullshit and they're rude."

I asked Winston about differences in programs between the two correctional facilities, provincial and federal. He responded, "the penitentiary is more in-depth. They do more research I think. In the correctional center it just seems like the staff just want to finish their shift as soon as possible. In the penitentiary they are just nicer." When I asked him which staff he was referring to, he said that they were the nurses and other institutional employees such as the guards, health care workers, and psychologists. He added that he learned some good cognitive skills in the penitentiary and stated, "I really like learning about cognitive skills. Cognitive skills

taught me how to think. I still would be into the street mentality if I didn't take any cognitive skills. With cognitive skills it taught me how to think normal. For example, if you saw a purse on the ground and you saw money sticking out of it, what would you do? Take it or leave it? I told the instructor, "If I'm trying to live a normal life and I am trying to straighten out my life, I'd grab that purse and I'd go to the woman and I'd tell her, 'Hey, your money's sticking out here. Someone's going to steal your purse.' But if I wasn't trying to straighten out, I'd take that purse. I'd take off right away because I know I could use the credit card within the first hour, I can still use it and get lots out of it, and the money.' But nowadays, I wouldn't take the money, I would just leave it or else I would look for the person, the owner, and I'd say, 'Hey, man, that's your wallet here.' "

I asked Winston if the cognitive skills helped him make better life decisions. Winston stated, "I think about my decisions more before I take action. I think first before I act. I don't know, I'm just trying to be normal. I'm just glad I took those skills." Another program Winston mentioned was the Offenders Substance Abuse Program but laughed a little when mentioning it as he said, "I've taken that one [Offenders Substance Abuse Program], too, and it taught me a lot, but *[chuckles]* obviously, I still didn't learn, because I ended up getting HIV. But I still learned a lot from it."

Straightening out.

Straightening out for Winston meant trying to live a life that was more stable. He talked about the challenges and tensions of achieving this stability which included dealing with his past

and also working with others. Winston shared his experiences regarding his finances, employment, housing, and his dreams for his son.

Financial challenges.

Winston talked about his constant struggle with his finances which impacted both his and his partner's ability to meet basic needs. Winston shared, "It's really hard right now. I'm really struggling. One night Janelle and I went shopping and she was rushing. She didn't buy the stuff that we really needed. Janelle was more or less worried about my lunches, and that kind of pissed me off because she didn't buy cleaning stuff. I tried to buy a mop and broom, dustpan and she ended up telling me to put it back. I went to buy a DVD player, she told me to put that back. She didn't buy enough groceries, and now we're out of meat and stuff, and that just pisses me off. We just don't have any money."

This lack of financial means was a constant struggle for Winston and Janelle. Both had a history of selling drugs and knew how to make money on the street. It was often tempting for both of them to consider falling back to illegal practices to make money. In one conversation, Winston shared a situation when Janelle considered selling drugs to make money for them. Winston stated, "Yeah. I almost said yes to her selling drugs. I sat there looking in the fridge, and all we have is a bunch of bread and lunch meat. The only real thing she really bought was a roast and I took the leftovers to work. All I ate was roast beef leftovers for a while so now I'm just getting sick of it. It also doesn't last us that long."

Winston was also approached to sell drugs. He stated, "Last night there was a guy that asked me to sell dope for him. I had some different plans. What I was actually going to do was

get the money, I was going to go buy groceries, and I'd pay him back on payday. That's what I was going to do. But I told my partner, 'I'm not doing that shit, f*** that. We're just going to be in a big hole. You dig yourself deeper and deeper in a hole when you owe people money and favors. Whenever you try to sell dope [cocaine, dilaudid, or morphine], and you're a user, you're not going to f****** do anything right. It's just going to get worse and worse. And I said to my partner, 'Then we're going to end up getting tempted to use drugs.' I don't want that to happen so refused to sell drugs."

Challenges of finding employment.

Winston talked about the importance of being able to support his family and the ability to live his life away from the influences of the street which involved drugs, alcohol, and violence. Being able to work was an important part of his plans. I asked him about his experiences working at a tire and hardware store where I had previously met him. Winston stated, "I used to work there. The store laid four of us off because it was a seasonal work. I wasn't laid off because I had HIV. I actually told my boss that I was on parole and that I was from the penitentiary. I told her 'I'm trying to get my life back together.' She told me she understood and she had no problems with that. Afterwards she hired me." I told Winston that it was great that she did not discriminate against him. He continued, "I was with my Mom and we went to that store for a vehicle part. I just told my mom, 'Hang on, Mom. Wait for me. I'm going to go and apply for a job here.' My Mom laughed but I ended up getting the job. Another thing that happened when I applied for the job was that my interview was at the same time as a dentist

appointment. I told my boss I missed my dentist appointment so that I could make it to the interview. That really impressed her and she knew that work was my priority."

Housing problems.

At times, I found it difficult to contact both Winston and Janelle to arrange meetings because they often moved back and forth between the reserve and the city. They moved frequently because they had trouble obtaining safe and affordable housing. Winston shared, "I want to get out of this apartment we're in right now, 'cause it's too rough. For example, today when we were going to go to the bank, I stopped at our apartment and there was a pack of needles by our window. These were needles people used to inject IV drugs. I thought to myself, 'F*** sakes people, there's a garbage can right around the corner. They should just take a few steps and throw it in the garbage bin.' I was just pissed off. Why throw the needles at our window. Sometimes I think people do that purposely 'cause they're jealous of us. Some guys are, 'F*** whatever when they talk about me. Just 'cause he has a f****** job he thinks he's all that.' You know? I tell them, 'F*** you guys. Go get a job. I did and I didn't give up until I got a job. I didn't stay on the f****** streets like you guys.' I went and dropped off my résumés all over, and I said to myself, 'Something's got to give every now and then. Someone is going to give me a chance.' I applied at ten places last year and McDonald's hired me. I asked, 'You guys can't work at McDonald's?" They were quiet and didn't say anything."

Moving forward.

After the story about the challenges street people had finding work, Winston and I switched topics. We discussed who he perceived was in his community. He responded, "Right

now, I see people on the street as my community. I'm right in the mix, but I'm still trying to stay away from them." Winston's definition of the 'street' are the poorer people living in the core downtown area of Prince Albert. Some of these people live in their own homes or live directly on the street. From my discussions with Winston the people on the street seemed to share a set of common characteristics such as having some involvement with drugs, violence, and a history of abuse.

I made the comment, "You still walk the streets so you must still have contact with people on the street. Winston said, "I don't walk the streets, I have no choice but to walk through it, I have to put up with it. For example, somebody was trying to stop and talk to me. I told him to leave me alone. That person apologized because they knew me and they knew that if I flipped out, all I would see is red, and it's hard to settle me down and I don't like that. My violence has got me in trouble before with different people."

I thought about Winston's story regarding his violence and asked, "What if your son told you that some kids were pushing him around in school, what would you tell him to do?" Winston took a few moments to think about this and said, "I'd tell him go talk to the teacher. Tell the teacher. 'Cause I don't want him growing up like me. There's no fricking way my son's going to grow up like me. He'll probably get a lot of respect, yeah, from the old school way of doing things. You know, an eye for an eye. What I'm shooting for is for my son to grow up and be somewhat like me. I want him to remember me working and supporting my family and that's what I want my son to do. I want to work at the saw mill for a long time, because there are two sets of fathers and sons working there right now. When I'm on my deathbed, I just

want to tell my boss, 'Please give my son a job. That's all I'm asking you.' I know if I talked to my boss he would say, 'Yeah, for sure, we'll hire your son and get him working.' I know my boss is really awesome and understands me."

I also asked Winston, "So what else would you like to see for your son?" He said, "Security, I want him to be secure and have a good home. That's why I want to try leave him as much money as I can before my time comes. When my time does come he'll be comfortable. I want him to live in comfort."

I asked, "What would you like him to remember you for?" Winston responded, "As a hardworking man and a good man. I don't want him to remember me as being violent or anything. I don't want him to know anything like that. But I know he's going to end up hearing stuff like that. I want my son to also grow up as a good person in the community. I want him to go to church. I don't want him to grow up selling pills. There's young kids out there selling Ritalin at school, and I don't want him doing that. If you want me to be honest, I want him to be a little wimpy." I was surprised by that. Winston continued, "Yeah, I don't want him to be trendy, tough, and all that. I don't want nothing like that for him. I want him to be kind and gentle, he is a shy kid. But that's how I want him to be. If he gets hurt, I'll tell him to shake it off and if he gets out of line, I'll put it on him, damn rights—but I won't hit him. I'll punish him by taking away his games or I'll ground him but I'll never ever lay a hand on him. I don't believe in spanking your children. It just brings out hard feelings. Kids want to still love you and respect you and you don't get that by hurting them when you hit them. When you do punish them you sit down and you tell them, 'The reason why I'm doing this is because I have to. I

have to put my foot down, because if I don't, then you're going to end up being too spoiled, you're not going to know any better, and you'll end up being a wild child and then you're not going to grow up right. You'll end up getting into all kinds of s*** if I don't punish you.' I'll explain it to him to help him understand. 'We want the best for you, my son. I'm not doing this so you hate me and I'm not doing this to hurt you. I'm just doing this so you understand and so that you grow up right.' That's what my plan is. I think about him every day I miss my son so much. I can't even see him because I'm often at work."

Janelle's Stories

In one of our earlier conversations, Winston asked me if I had recruited all of the people I needed for the research project. I told him I needed one more person, and he suggested that I consider his partner, Janelle. I agreed to meet her. Janelle came at the end of one of my meetings with Winston and was introduced. After our introduction, Winston left us alone and we discussed the particulars of the research. I was very interested to know if she would be comfortable knowing that some of her stories might be shared with her partner, Winston. She was absolutely fine with the prospect that Winston would one day read her stories. We discussed each of our expectations of the research, and she agreed to share her stories. In the following sections, I present some of Janelle's stories that reflect her past, her current experiences with HIV, and her experiences in moving forward in her life.

Janelle's Past

I remember meeting Janelle in my university office. Much like Winston, she liked to knock on my window to announce her presence. At our first meeting, I heard Janelle knock on

my window. Looking out, I saw Janelle and Winston standing at the window waving to me. As I had done with Winston, I made my way to the side building entrance where Janelle and Winston waited. I greeted both of them with a handshake and thanked Janelle for making it to the meeting. Winston and Janelle briefly kissed as they said their goodbyes to each other, and Janelle made her way to my office.

Abuse behind closed doors.

I asked Janelle about her youth, and she shared, "My life started to get messed up when I was 13. On my 13th birthday, my stepbrother was trying to touch me. My real brother was looking for my stepbrother in the house. He said, 'Where are you, where are you?' He came and checked in my room and my stepbrother was hiding in the closet. He said, 'What the f*** are you doing in here?' He got mad at him and said, 'If I catch you in here again tonight you're out of here.' I wish my brother would have caught him before then, or caught him in action. My stepbrother raped me the night before my 13th birthday." I was shocked and I just said "rape." Janelle responded, "No, he was touching me down there and stuff. I was scared to get up and tell anyone because I was only 13. I was scared of him, scared of what he would have done if I said anything. The next day when I woke up and he pretended like nothing happened but I just felt miserable. I was hurt, I wouldn't even smile, and it was an ugly feeling. He only did it one time to me. However, one day my dad got him to babysit my younger sister when my parents went to bingo. They forgot their bingo dabbers so they turned around. They walked in and my stepbrother was trying to get my 7-year-old sister to give him a blow job. My dad kicked his ass

and beat him up and he deserved it." I asked her how old her stepbrother was, and she told me he was 27 at the time.

Janelle shared another story about abuse. She stated, "There's a lot of things that happens on reserves that adults really don't know about because they're into their own thing or drinking. There's a lot of sexual stuff that goes on with young kids." I asked her if she had a story she could share. She said, "One day when my Mom and stepdad were drinking a whole bunch of adults came over and partied with them. We lived in a party house and people would always come over, even if it was a weekday to drink. I locked the door to the room where me, my little cousin, and my little sister were in. I had this little cousin who was like my little sister and I never wanted anything to happen to her. I put a bunch of knives in the door so people couldn't open it because I knew that bad things would happen to kids if people were drinking." Janelle became quiet and then shared, "The next day after a party, I woke up in the morning to find somebody touching me. I thought to myself, 'Oh, no, please, please, please. Don't let this be happening.' I felt somebody touching me. I was worried because I remember locking the door when the adults were partying. It should have just been me and my cousin and my little sister in the room. I rolled in bed and my heart just broke. My Mom was sleeping right beside me and my cousin and little sister were on one side and my stepdad was on the other side. He had his hand over my Mom touching me. I started moving around and I woke up my little cousin. I said, 'Wake up.' I said, 'Come, come, come.' I was holding back my tears. She came downstairs and I just started crying. I said, 'Did he touch you? Did he touch you?' and she said, 'Did who touch me?' and I said, 'My stepdad. Did my dad touch you?' and she said no. She

asked me, 'Was he touching you?' and I said yes and then I started crying and she hugged me. She was just a little girl but she wanted to go upstairs and get mad at him. I said, 'No, don't say anything, don't say anything.' A week later, my Mom ended up going to Las Vegas and my stepdad had to babysit us. I was okay about it because I thought my sister was going to be there. But my sister ended up telling me she was going to leave, and I told her, 'No, I don't want you to leave. I don't want to be here.' She asked why but I wouldn't tell her. I locked myself in the room. I didn't eat or drink nothing for 4 days because I was so mad at my stepfather. The next day I fainted and I was brought to the hospital because I didn't eat or drink anything for 4 days. I didn't tell the nurses what happened to me with my stepfather. I was probably around 13 but I tried to block it out of my head until I went to school one day. I was talking to my mother's friend who promised me she wouldn't tell anybody about my stepfather's abuse. I told her and she broke her promise. I was taken away to a foster home. I was the only kid out of nine in my family that has ever been to a foster home. I was there for about a year and I never saw any of my family. I was lonely and I was sad. However, I got along really well with my foster mom and she wanted to keep me. Right now, I think my life would have been so much different if I would have stayed with her. She wanted to keep me. She said I would have everything, I'd be graduated, and she'd pay for my schooling and I could have been a nurse."

Becoming a mother.

Janelle was a mother of four children. Her oldest child was a boy who lived with his father on a reserve but often came to the city to spend time with Janelle. Her second child was a stillborn baby boy, and her third child was a girl. Unfortunately for Janelle, her daughter's father

did not allow Janelle to have access to her daughter. Janelle and Winston were also fortunate to have a healthy son together [Janelle's fourth child] who was living in foster care; it was their goal to get their son living with them again. He was about 18 months old at the time of the interview.

I asked Janelle about motherhood and if she had any stories she wanted to share about first becoming a mother. She stated, "I remember having sex when I was only 14 years old. I was very young. I was pressured into it. My best friend introduced me to her friend and he got me pregnant. My son's about 13 and I'm only 28 years old. When I was giving birth I thought I was going to die. I was in labour for 3 days and I really thought I was going to die."

I asked her how the nurses were, and she said, "They were really good and very caring and they asked me how old I was and I told them I'm turning 15 soon. They said, 'You're still a baby.' I told them, 'I'm not, I'm a big girl.' I remember them being very good with me. When I had my son, I was a really, really, really good mother. I was an awesome mother because I never left him." Her smile widened, and she seemed to glow; I could see how proud she was thinking about her past with her son.

Janelle always talked about her son, and, in one of our conversations, she brought her son to meet me at the university. I remember meeting this very polite First Nations boy carrying a backpack and a computer tablet. We met in my office and I shared with him that I really enjoyed meeting with his mother and listening to her very important stories. He did not speak much but smiled politely and asked a few questions about items in my office. Janelle wondered if he could sit in the office while we talked. She promised that he would be quiet and would play on his

tablet with his headphones on. I considered it, but I knew that some of our conversation topics were becoming deeper, and I did not want Janelle to feel like she could not speak to those topics with her son present. Alternatively, I asked if her son would be okay sitting in an empty classroom playing with his tablet, and he was. At our next meeting, the first thing Janelle shared was that her son was very proud that "good people" were wanting to talk with his mom. I thought about this comment, and it highlighted the negative environment that Janelle's son was exposed to. Janelle described this environment as the downtown streets her son walked through to get to their apartment. In addition, the negative environment was also Janelle's home where strangers knocked on the door looking for drugs. Janelle was worried about her son's welfare since these individuals had a history of violence and were often armed with some type of weapon. After hearing that, I realized that Janelle's participation in this research project was already making a difference in how her son perceived his mother.

Drugs and prostitution.

Addiction to substances had always been a prominent aspect of Janelle's family life. She shared, "Our house was a party house. Everyone would know to go there to party. Even on a weekday there was always alcohol there. Our house was just known as a party house. Everyone was amazed when my mom decided to quit drinking. She'd tell people, 'No, I'm turning into a Christian. Can you please leave with your alcohol?' And they'd be surprised and tempt my mom to drink. My mom would get mad at them and say, 'No, can you at least respect *no*?' And they'd be really shocked. Anyways, I was 16 and I was drinking at my friend's house, and I remember being really ashamed of myself. I remember my mom coming over, that was before

she stopped drinking. We were drinking together and fighting together and I didn't think that was normal. I knew it wasn't normal and I was embarrassed to say, 'Yeah, I'm drinking with my mom.' 'Cause my friends didn't—people I hung around with, they didn't drink with their parents or anything. I just knew it wasn't right."

Janelle also described her escalating experiences with intravenous drug addiction which led to a number of dangerous situations. Janelle told me, "being a prostitute is so sick and it's also really scary. I was so much into my addiction, this one time I woke up and I was in a field in the middle of nowhere in this truck with a guy. And these were the times those girls were going missing. I started crying. I was like 'Please, please don't kill me, don't kill me. I don't want to die, I don't want to die.' He said, 'Don't cry, don't cry. I'm not going to hurt you, I'm not going to hurt you.' I stopped crying after he said 'Do you want to get high?' That's how sad it is and that's how bad your addiction is when getting high is more important than your safety. You don't worry about dying. After we got high, he started talking about aliens and stuff and about this light, and he really had me believing in my head that there was a light hovering over us. That was crazy. If he wanted to hurt me he could, that's the risk you take. I used to stay up for 4, maybe 7, days at a time and when I jumped in his truck he said I fell asleep right away. He said, 'You are so lucky I'm not a bad person.' "

Janelle shared another story about the dangers of surviving street life. She said, "I met this Black guy and I jumped into his car and it felt so creepy. He was so Black and his teeth and the white parts of his eyes were so white. When I jumped into his car he looked at me and said, "The boys are going to be so happy." I was so scared. I thought to myself, 'Oh, my God, what

did I get myself into?' So as soon as we hit a stop sign I jumped out of his car and I jumped into a vehicle behind me. It was a single White guy. I told him that other guy was trying to take me to his friend's house and I didn't want to go. The White guy told me everything will be fine and we drove around. For 45 minutes that Black guy followed us."

Janelle revealed another story about an experience she had with a john. She said, "I jumped into another car and at that time, those girls were missing, and this huge White guy in coveralls picked me up. He had dried blood on his pants and a couple of fingers were missing from each hand. I looked behind in the back seat and he had the two back seats torn out. There was cardboard laid there, and there was rope. I said, 'What do you have those there for?' He started stuttering. He said, "Well, well, I—I—I haul wood—wood. I put the cardboard on top and then the wood, and I tie the rope." And I was thinking, "Okay, something's wrong here. There's no wood chips around, and obviously, if you are involved in wood, there's obviously going to be wood chips or sawdust. I was thinking there's something wrong here. And he started driving straight out of town, right. I started freaking out. I said, 'If you don't turn around and stop right now, I'm jumping out. I don't give a shit how fast you're going, I'm jumping out.' He said, 'Okay, okay.' He kind of laughed at me because I was playing it smart, and I think he laughed at me because my actions actually saved my life. I made it back to the city. I had a feeling somebody was watching me and I turned and looked around and he's following me. That was so creepy because it was 2 hours later. I just thought to myself that there were so many times I could have died, and my kids would have been left alone. It's all for addiction. It's stupid."

Janelle shared, “when my son was on the reserve there was actually no one looking after him. He was looking after himself. He was only about 8, maybe 10, years old at the time. He just loved it when I was at home because I was on a down.” I was not sure exactly what she meant by a “down” and she explained that “a down drug that you have to have every day. You have to use it every 5 hours otherwise you sweat and have a fever [withdrawal symptoms]. You also get the runs [diarrhea]. I was on the down [experiencing withdrawal symptoms], and you had to have the pills every 5 hours, so I’d take enough pills home with me to last me for 2 days or get as much as I could. I’d go home and my son would be happy because his mom’s home sending him to school, cooking for him, and bathing him. When I wasn’t there, he wouldn’t bath, nobody would make his lunch, and nobody made sure he got to school. He’d have to look after himself. That’s not a life for a 10-year-old kid. One thing that stuck in my head was when I had to leave to get more drugs. I would tell my son, ‘My boy, I have to go. Mommy’s sick. Mommy has to go to town and get her medicine. He would say, ‘No, Mommy, you don’t have to leave. You just want to leave.’ He started pulling his hair and started punching himself. Then he grabbed a stick and he started hitting himself with it and would bang his head against the wall. He did not want me to leave. That’s a really ugly thing to have in my heart and my mind. It was like all those addictions caused that. That’s how ugly addiction is. I still left him for the drugs because my addiction was so strong. It really spills into other parts of your life. I remember when my addiction was gone I never got into any trouble.”

Experiences with HIV

Contracting HIV.

Janelle and I talked about contracting HIV from Winston. She stated, "When I found out I had HIV, I felt sick. Winston and I were together for about a year and a half and I never got sick. I got pregnant but I never got sick. I knew he had HIV and I was thinking that maybe he was not contagious. When I found out I was positive I was heartbroken. I thought it couldn't happen to me." I asked her if she caught it from having unprotected sex or from sharing intravenous drug equipment and she said yes to both. Regarding the intravenous drug equipment Janelle further explained, "We lost track of whose needle was whose. We were too high."

Before she tested positive, Janelle said she was tested for HIV every month. She stated, "All my HIV tests were negative until 'that' test." I asked how long she had been negative before her positive test. She answered, "year and a half, almost 2 years. That was when the doctor told me I have to go in and see him. I was kind of thinking, 'Oh, shit, please don't let me be sick.' I prayed to God to not be sick."

I asked her what happened at the doctor's office when they told her she was sick. Janelle shared, "he just told me 'I've got to talk to you. All this time you were clean [negative], how come you're sick now? Do you know why?' I said, 'Maybe because we weren't being clean with our equipment, or maybe because we're not using condoms.' The doctor asked me why I wasn't using condoms and I told him, 'Because I want to have a baby.' I was kind of mad at myself because Winston asked me, 'What are you going to do if you ever get sick?' I said, 'Well,

we can get better together.' It made him happy that I thought like that. I always thought that anything can be healed by God. But I'm still mad that I still got it."

I asked her if she was angry with Winston. She replied, "No, he told me he was HIV positive. But it just kind of sucks that the doctors aren't giving any medication. Winston gets all these medications and I asked the doctor when I would start the meds but he said I was just at the beginning stages of HIV so they couldn't give me anything." Based on my experience counselling about HIV illness, I explained to her the importance of follow-up appointments and that a number of doctors treat patients in slightly different ways. We also talked about viral loads and CD4 counts to make sure that she understood these markers. When I reiterated that she was in the early stages of her HIV illness she stated, "I hope it's that. I hope I can't pass it on to anybody."

As we ended this conversation, I asked her if she felt tied to Winston. She replied, "A little bit. It kind of makes me feel like, if Winston and I don't work out, then it's going to be harder for me to find another companion."

HIV stigma.

Janelle shared a story about how her mother reacted to Winston. Janelle stated, "My son and I left the apartment for a minute one night and mom came over. Winston was there and she was so rude to him. When I got there I asked her if she wanted some fresh bannock. I gave it to her and she ate it right away because she thought I cooked it. She said it was good and then Winston said, 'I cooked the bannock.' Mother said, 'What? You cook? Aren't you supposed to

not cook because of your sickness?' And then she said, 'Let me see your hands. Do you have any cuts?' She totally insulted him and this was not the first time."

I mentioned that her mother did not seem well educated about how HIV is spread. Janelle said, "Maybe I should talk to her or maybe I should get somebody to talk to her." I offered to get some resources for her at our next meeting. Janelle then switched topics, "Even when I was in jail the HIV worker came in and she taught us a lot of things that I didn't know. One time when the nurse was doing a presentation I said, 'I have a kid with my common-law who is HIV-positive. And the baby and me aren't HIV-positive.' Of course, this is when I wasn't HIV-positive. One of the girls in prison right away said, 'That's not possible.' The nurse said, 'Yeah, that is possible.' You know, that girl just couldn't get it through her head that it was possible. After she said that, we had a problem right off the bat. We were really rude to each other and it was just stupid."

How am I going to tell my family?

Janelle told me that her family does not know she is HIV positive. To confirm, I asked, "So your son doesn't know you're HIV-positive, does he?" She said no. I was curious about how her son viewed Winston and his HIV status. She said, "You know what, when my son first found out Winston was HIV positive, he said, 'Mom, why would you want to die and just leave us just over him? You know HIV kills you.' I said, 'Well, not if you look after yourself.' My son replied, 'No, Mom, HIV kills you and you're picking him over your kids." I asked how she felt when she heard him make those comments. She said, "I just kind of felt real shitty. He doesn't even know I'm sick, too. Imagine how he would hate Winston if he found out."

I asked Janelle when it would be a good time to tell her son. She hesitated and stated, "Hopefully, they'll find a cure and then tell him. Even if that happened he'd be mad. My mom said, 'You know what? Winston is totally taking advantage of you. You are taking him in knowing that he's sick. That should have just been enough for him, and now he's cheating on you.' My mom told me that she caught him holding hands with some girl, and that's what she refers to about cheating. My mom also said other things like, 'He shouldn't even be sleeping with you, knowing that he's sick. He's just selfish and he grosses me out.' I told my mom I don't want to hear that and she still gets mad. She doesn't know that I'm my own person too. I can say no. It's just she's so stubborn. That's how moms are, I guess."

The Struggles of Moving Forward

Breaking trust: Experiences with counselling.

Janelle had previously used a counsellor to discuss issues from her past and the trauma she had experienced. Unfortunately, not all of her counselling experiences were positive. She shared her experiences and thoughts about counselling, including one particular counsellor. "If I talked to a counsellor it would have to be a woman counsellor. I went to rehab for 28 days. My brother passed away and [before he passed away] he told me when he first found out that I started doing IV drugs, he was very, very hurt. He said, 'If you don't stop, I'm going to start.' I didn't believe him. But when he started I felt like it was my fault. When I talked to him about it he asked me why I didn't quit. I told him I was in rehab for 28 days and really loved it there. It was so awesome because I got in touch with myself. I talked one-on-one with a counsellor. I talked to the counsellor a lot and I told him a lot of things that happened to me. Then my

counsellor broke my trust. He tried to make me go home with him. I just thought, 'What a waste of time.' Maybe that's where my trust in professional people broke."

I asked Janelle if she felt she could trust me. She said, "Oh yes. You can tell how different people are. I have never really studied people before but you can tell when a person's phony or not, but I can tell you are not phony!" I smiled and told her I tried not to be. I wondered why I had asked her whether she trusted me. It mattered to me. Hearing her story really highlighted how health care professionals could influence whether or not a person reached out to others. I also felt angry thinking about what that counsellor tried to do. I wanted to reach out and report the counselor, but Janelle did not want me to and would not give me his name.

We continued to talk about her experiences with counselling. I asked, "So did you feel that one to one counselling helped you before that counsellor acted unprofessionally?" Janelle said, "Yeah. I remember feeling so much better after we talked. Even when I leave here talking to you I feel better." As a health care professional, I was interested in how other health care workers could help Janelle. She responded and said, "They shouldn't try to fix us, but help us."

Getting into a routine.

Janelle wanted to be able to do more for herself; however, one of her complaints was that she lacked energy and slept all the time. She shared, "Winston tells me to get up and do things. He says things like, 'C'mon, babe, wake up, spend some time with me. You're always sleeping.' He asked me why I sleep all the time. He wonders if it is because I want to get away from him and stuff. But I don't know why I sleep all the time. Maybe I am depressed because I sleep so much." When I asked her if she could give me an example of how long she sleeps, she stated, "I

lay in bed all day. If I didn't have this appointment with you I'd still be in bed. I should really be doing my income tax right now because I have a babysitting job. The job is good for me because I have no choice but to wake up in the morning and to do that. So I really, I don't know, I should start getting up and enjoying life instead of sleeping it off."

I asked her to tell me about her babysitting job. Janelle said, "I'm babysitting for a nice Christian lady. I babysat for her before. Her kids are 4 and 8 and her kids really like me. They're really cute beautiful girls. I decided to babysit in the mornings. I send one to school and wait for the bus with her while the other one's sleeping. Then I send the other one to school in the afternoon. She's just starting school. Then I wait for them after school. It kind of goes with the responsibility. I know I have to be there for them, because nobody else will be there for them. It's kind of good that I'll be learning how to get up in the morning. I really have to get into a routine. I'm kind of sick of sleeping all the time 'cause that's all I do is sleep."

I asked her how Winston felt about her sleeping so much. She stated, "He gets mad when I sleep so much but he is happy that I am babysitting. When it comes to sleeping he'll say things like, 'Spend some time with me. All you do is sleep. Can you please get up?' I'll be, like, 'No, I'm still tired.' He'll get frustrated and then leave to go somewhere else because he is used to working all day and that's a good thing. That's a really good thing. I also really have to get to rehab so that I can start my life. I know my life is going to start after I get to rehab, 'cause then I'll work on getting my kids back. Right now, I'm working on getting clean urine samples. That's not a struggle, but it's just something I have to do, that I know I have to do." A clean urine sample indicates that Janelle is not on any type of illegal drugs. I asked her how often she

has to provide these urine samples. She states, "Usually weekly. But when I got out of detox I used right away. I used because I was so mad at Winston. I was so upset with him, 'cause he never called me when I was at detox. Then I had to walk home all the way from the hospital. I was just mad so I ended up using again. Back then there was no other way to take out my anger other than using drugs, but now I found out a different way to take out my anger. I'm thinking of maybe beating him up!" We both share a laugh as she joked. Janelle did not provide me with any details, so I suggested that she look for other ways to relieve her stresses like going for walks or listening to music.

Drugs are all around us.

Janelle believed that her home was a place where she encountered stress and potential harm. One day, Janelle and her son were sitting in their apartment when they heard a knock on the door. Janelle recalled, "This guy knocked on my door asking for water and I didn't know him at all. I went to get him some water. I had the door closed and I didn't hear him coming behind me. I turned around and he's lying on the bed. I said, 'Hey, get the heck off of there. My old man's going to be home and he's going to be really mad.' And he was, like, 'Who's your old man?' I said, 'Never mind. Get the heck out.' That same guy peaked in my apartment today. I don't want to tell Winston, 'cause he would have freaked out. He's a young guy, maybe about Winston's age but he's big."

Janelle switched stories and talked about another visit from a person with whom she was not familiar. She said, "Somebody knocked on our door with a bunch of money. You know about people who just got their *residentials*, eh?" I asked her if she was talking about people

who received residential school settlement money, and she nodded. She continued, "This guy knocked on our door at 7:00 in the morning and asked if Winston was in. I told him he just went to work. He asked, 'Do you guys have anything for sale?' and I said, 'No, we quit a long time ago.' He said to tell Winston he had a job for him. He told me, 'I'll give Winston money if he sells for me.' So there's still people coming up to us and trying to get us to sell drugs for them. It's hard, we have to get out of that place otherwise one of us is going to fall. It's just a matter of time."

I asked Janelle if she felt tempted by the easy money and drugs. She said, "One day, I did. We had 80 bucks or whatever. I asked Winston, 'Hey, babe, can we go get a half?' He said, 'No, we're going to stay away from it.' " I asked what a half was and she said it was a half an ounce of cocaine. She continued, "that feeling of wanting that drug went away. I said to Winston, 'Oh, babe, I'm so glad you said no. I don't know why I got tempted.' Drugs are all around us and it's so hard to quit."

Janelle asked if Winston had told me about the girl who just came over to their place. I told her I did not think so but I would like to hear about it. Janelle shared, "this girl came to our place and said, 'You guys all messed right up. I took 10 Restoril [sleeping pills] and I'm just drugged. I'm real hungry and I have nowhere to go." She is a friend of ours and we said, 'Well, come in and you can sleep on the couch and you can get yourself something to eat.' So she was making herself some pizza or whatever and she's just making a big mess. Then she starts talking to Winston and looks at me and says, 'You better get your son out of here.' I thought, why does my 13-year-old boy need to leave? I asked her. She said, 'Because my boys are coming here.

I'm telling my boys to come here." Winston wouldn't give her money and that is why she was mad. She's said earlier to Winston, 'Just give me 50 bucks and I'll give you 80 bucks back.' Winston told her, 'we have no money and we're out of the game, we're out.' " I asked her if the game she was talking about selling drug and she said yes. Janelle also added that "the game is all that stuff like him collecting money for people.' And she also said to us, 'You guys just don't want to give me money because you guys aren't doing it, so you guys don't want me to do it.' We didn't care if she did drugs but she was mad at us. She told us again to get my son out of the apartment before he gets caught up in a fight. She was telling us that her son was in a gang and that there was going to be some retaliation since we wouldn't give her any money. Since her son is in a gang he had support in case he ever got into a fight. Fighting a person in a gang is never a one-on-one fight. With gangs it is all about winning and getting what they want. I told her that my son was not going anywhere and that she could just leave my home. She sat there putting on makeup and we kept telling her to leave. Winston had to flip out before she left. She was standing there putting on her makeup, and we're, like, "Get out. Like, get out. Winston broke the frigging table. He pushed over the table and told her, 'I'm sure I'll have to f****** flip out for you to leave, get the f*** out!"

I asked Janelle if her son was there the whole time. She said yes. Janelle continued, "after she left Winston said to my son, 'I'm sorry you had to see that. I'm sorry I had to flip out right in front of you.' My son said, 'It's okay. You didn't hurt us.' My son's 13, but he's small for 13."

After the story, I had a few questions for Janelle. First, I clarified whether this woman was, in fact, her friend. Janelle said, "I met her in jail, probably, like, 5 years ago. It was at the women's provincial jail. Winston used to go out with her little sister, so Winston knows her for about 10 years." I was amazed that, after Janelle had helped her out, she threatened them. I asked her if the guys came to their home later on. She said, 'We don't keep big knives in the house and stuff like that so Winston had to go get a knife and a bat and stuff like that. He just had to get ready just in case they came. Then we told my son 'Here's a knife just in case these guys come in. You have a right to hurt any of them because they're coming through our door. My son said, 'Okay, Mom, but nobody's going to hurt you."

Janelle's home was not a safe place, so we talked about whether she considered living on the reserve a safe place. Janelle and Winston moved back and forth from the city to the reserve sometimes making it difficult for me to be able to get in touch with them. Janelle shared, "If we lived in a better place and Winston and I were able to live normal it would be better. On the reserve we would wake up in the morning and I'd cook breakfast, dinner, and supper. Over in the city you just feel lazy. You just don't feel like even cleaning up and I'd rather go out and eat than cook. I'd like to live out at the reserve, but we just need a vehicle again. I really want to move back to the reserve. I just want to get out of P.A. [Prince Albert]. I think P.A.'s not a place for somebody that's trying to quit drugs. The reserve is a healthier place. My family is out there telling me, "Don't do this or that." If you're high or something they look at you in a different way and I don't like that, so I don't do it. I didn't like the way my brothers looked at me when I was high, so I stayed away from them when I was high. I stayed in the city when I

was high. The city's just got more places you can hide if you want to. Many people are high in the city so you don't stand out as much."

Finding my strength and support.

Living in environments with many temptations and dangers requires support. I asked Janelle whether she received support from Winston. She answered, "Yes I do. I really, really loved it when Winston said, 'No, let's not do drugs.' I was really craving them one day and he told me we should avoid them. I think I told you this story before about wanting to pick up a half of coke. We had the money and stuff, and he's like 'No, let's not. Let's just go pick up some weed and some tobacco and watch a movie. We'll also grab some pizza.' First I was mad because I thought he was just doing what he wanted. After that feeling went away and I was like, 'Oh, babe, thank you so much. I'm so happy.' " I told her that I thought his support for her was great. She responded, "It's like hard love. Winston said, 'I know you want this, but we're going to do this instead.' It was awesome that he said that and I was so happy. Sometimes it is him wanting to stay away from the drugs and sometimes it's the other way around. I tell him we should stay away from the drugs. We help each other out."

I told Janelle that it was good that she was communicating with Winston. In one of our conversations she said that it was sometimes difficult to talk to Winston. She said, "Sometimes I don't talk to him because I don't want to say the wrong thing and piss him off even more. I tend to say things that end up just hurting him but sometimes some things just need to be said."

Having Winston in her life was a source of support and strength. I asked her what other sources of strength could she rely on. Janelle said, "I find strength from my kids. I would have

been dead a long time ago if it wasn't for my kids. When I was in Edmonton I would have given up a long time ago if it wasn't for my kids. I think about happy times with my kids. For example, I tried to quit methadone and I had my daughter and my son on the reserve. We didn't have any power because it got cut off. We were really cold and I had to go to my neighbor next door to cook for them [the children]. I found it sad that all I did was sleep and try to sleep off the sickness [withdrawal], but at the same time I stayed home with them for a whole week. I was only on 30 mls of methadone, so it was easier than coming off higher doses. I just laid in bed all the time and the kids just played all the time. I can't remember what type of entertainment they had, but they had something since they wouldn't have stayed in bed all day. We didn't have power, so they had something that they had to do together. I just remember I tried to come off the drugs for my kids. I really tried, but the surrounding that we were in was not good. If we had power and stuff I think I would have been able to beat it."

I asked her if she had gone back to her drug use when she was on the reserve. Janelle said, "Yeah, I did. I got babysitters to look after the kids and I came back to town. I was hooked again. It was not a happy time for me except when I thought about my kids. I was happy when I stayed home with my kids and they were happy I was with them. We all slept together and I'd cook for them even though I was sick. I also remember being really happy just driving around with my kids. We would go for ice cream. It was just the three of us. At that time my son didn't like Winston so we left him at home. I really miss those times."

Reflective Beginnings on Narrative Threads

In what follows, I present my reflective beginnings on narrative threads for Winston and Janelle related to my research puzzle. To do so, I make sense of the meaning and significance of Winston and Janelle's life narratives, their stories about HIV and, in particular, Winston's previous incarceration. My research puzzle focuses on the experiences of Aboriginal people living with HIV and who have been previously incarcerated. To address this puzzle, I discuss these topics: living an addicted life, living with HIV, transformation of self, and loss and grief.

Living an addicted life.

Janelle and Winston have both lived addicted lives. Their addicted lives started well before they took their first sips of alcohol or felt a needle slipping into their arm. It occurred while they were in their early home environments surrounded by family members who were drinking and using drugs. Being exposed to an environment filled with drugs and alcohol can have a negative effect on a person's relationship with themselves and others (Csiernik, 2002; Dayton, 2000). For Winston and Janelle, these substances were readily accessible in their environments. They did not have to actively seek out others to start experimenting with alcohol and drugs. Rather, the opportunity to engage in alcohol and drugs was just a matter of connecting with friends or family members. Janelle shared stories of her home being a venue for family members to party, both on the weekends and during the week. Janelle acknowledged that her home life was not normal and, in one story, she described realizing that drinking and partying with her mother was not a normal activity that other children would do with their parents.

Janelle's early and frequent exposure to alcohol by her parents made me consider whether this exposure contributed to her early alcohol use. However, some studies (Yu, 2003; Zhang, Welte, & Wieczorak, 1999) suggest that early parental alcohol use is not a cause of early alcohol use in the children. Rather, it is the amount of parental control that parents exert on their children that has a greater impact on whether their child will drink. In Janelle and Winston's narratives, it is unclear whether their parents encouraged or discouraged early alcohol use, but their stories do suggest the potential link between parenting styles and substance use in children. The possible link between parental drinking and children's alcohol use reinforces the importance of a family centered approach (Csiernik, 2002; Dayton, 2000) to address addiction issues.

Csiernik (2002) and Health Canada (2011) argue that substance abuse treatment for individuals and families is also the responsibility of the community. Health Canada (2011) provides a number of strategies that focus on the strengths of First Nations people in Canada. This includes a comprehensive strategy focusing not only on substance abuse, but also on community development and mental health. Janelle's stories indicate that substance abuse issues involved many people in her community; in her situation, perhaps a community focus would have been beneficial. Janelle and Winston's childhood lives evolved from early exposure to alcohol and drugs to using and abusing substances themselves. In one of Winston's stories, he spoke about his sensitivity to his drug addiction. He had the opportunity to sell drugs for a biker, but he realized that his drug addiction would become a liability if he became involved in selling drugs. He was concerned that selling drugs as an addict would have led to him stealing drugs or money from the bikers, leading to harm or even death. Janelle believed that her addiction to

drugs resulted in her selling her body to support her drug addictions. By doing so, she put herself in a position of potential physical danger.

Living an addicted life is not only about taking drugs, but also about the challenges of dealing with drug temptation and relapse. Both Winston and Janelle were on methadone. Winston shared his struggles with his access to methadone outside of his home community where he had established a routine to access his methadone. However, when he went to work in another community, he ran into problems when he assumed that his methadone access would be smoothly transitioned to the new community. This resulted in Winston going through intense withdrawal; he experienced pains and aches throughout his body and suffered a lack of sleep for many days. His experience highlighted the lack of communication between his employment health plan and health care providers to ensure that he had timely access to methadone.

Janelle also struggled with an addicted life. Her addictions not only affected her but her children as well. In her stories, she described how her children suffered because of her absence from their lives, and she suffered because of the emptiness she felt without her children. The drugs relieved the pain but, at the same time, took away the most important people in her life. Janelle recognized this. In order for addiction treatment to be fully effective and recovery to be sustained, treatment of the family and the community to which Janelle and Winston belonged was required.

Living with HIV.

Living with HIV was a challenge for Winston and Janelle. Winston found out about his HIV-positive result in corrections. Fortunately for Winston, he was able to access peer support

through a friend in corrections already living with HIV. His friend helped him negotiate and reconcile with the fact that Winston was now living with HIV. A study by Dutcher et al. (2011) described the effectiveness of HIV peer education programs and advocated their implementation. This is similar to the support that Winston's friend provided. Dutcher et al. (2011) also argued that peer support was successful in their study because individuals living with HIV shared their HIV status, a set of common characteristics, and self-care habits with those that they were supporting. Winston's friend was a very good peer support mentor for Winston because Winston could relate to this individual, and there was also a level of trust that had been previously established. In Saskatchewan, formalized peer counselling is relatively new. In Saskatchewan's 2010-2014 HIV Strategy (Saskatchewan Ministry of Health, 2010), the establishment of peer-to-peer networks with intravenous drug users is mentioned, but there is little discussion with regard to the high risk population of incarcerated and previously incarcerated individuals. It is important to include incarcerated individuals in peer counselling since they represent a unique group of individuals. Individuals planning future HIV programing need to consider the importance of peer-to-peer in initiatives.

In addition to peer counselling, informal counselling may also be provided by non-trained peers. Winston's friend who helped counsel him when he discovered his status at the penitentiary was an informal counsellor. As health care providers, we need to consider how effective these informal counsellors may be, but there is also the chance they may be communicating inaccurate information. To decrease the inaccurate information from being disseminated, health care workers need to consider how they can support these counsellors.

Other studies have also provided important rationale for using peer educators and providing peer support in the community (Garfein et al., 2007; Tobias et al., 2012). However, in these studies, the background of participants was different from the participants in the current study. These differences will affect the type of peer support offered and accepted. From my personal experience working at Saskatchewan penitentiary, I have approached and asked offenders living with HIV to consider acting as a support person for newly diagnosed HIV positive offenders. There is significant hesitancy by offenders living with HIV and by those newly diagnosed with HIV to disclose their status to one another. Layered stigma (Daftary, 2012; Mill et al., 2009), particularly related to previous incarceration, being HIV-positive, living an addicted life, and being Aboriginal may impact peer participation. The trust required to reveal a positive HIV status in corrections is likely higher than the trust required to disclose within a community setting. In the community, it is easier to avoid seeing a peer if the relationship does not develop as anticipated; however, in corrections there are levels of power and potential coercion that may influence why people do not want to openly identify to others that they are living with HIV. These differences reinforce the importance of appreciating the diversity of individuals who are living with HIV.

Janelle and Winston lived as a discordant couple at the beginning of their relationship: Winston was living with HIV, and Janelle was HIV-negative. Winston shared that they initially used condoms, but, as time went on, condom use was forsaken. The reasons for not using condoms were not directly provided, but I suspect that it was due to a number of factors. In a recent article, Garnett and Gazzard (2008) argued that one of the main reasons why discordant

couples fail to use condoms, is that they would like to conceive. As I reflect on Winston and Janelle, I believe that their desire to conceive was a major reason for them avoiding condom use. This practice resulted in the birth of their healthy son, but the continued lack of condom use may have also resulted in Janelle contracting HIV. However, it is not clear whether Janelle contracted HIV solely from unprotected sex since she revealed that she had also shared intravenous needles with Winston.

Janelle and Winston also experienced stigma while living with HIV. Winston shared that he felt he lost a job because he disclosed that he was HIV-positive. A few days after he confirmed his HIV status with his supervisor, he was let go from his job. He also experienced negative feedback from Janelle's mother who berated him for being in contact with her food because she believed he could spread HIV to her in this manner. It was obvious to Janelle that her mother did not understand how HIV is spread.

One of the narratives I felt was particularly interesting was that Janelle did not reveal her HIV status to her family. Her reluctance to reveal her HIV-positive status is consistent with another study (Petrak et. al., 2001) that reported that individuals share their HIV status less often to their family members than to their partner and friends. I suspect that Janelle was also hesitant to share her status with her family, particularly her son and mother, because of the negative comments she had heard them make about Winston's HIV status. She may have been concerned about the potential stigma she could be exposed to by revealing her diagnosis. Being unable to share her HIV status with her family members created the potential for Janelle to feel isolated and suffer from mental health problems such as anxiety and depression. For Janelle, having

Winston as a support was particularly important because she had not shared her status with her mother and son.

Transformation of self.

Despite their many challenges, Janelle and Winston's experiences revealed a major effort in self-transformation. Self-transformation was not a linear process for either Janelle or Winston. Some authors (Prochaska & DiClementi, 1983; Prochaska, DiClementi, & Norcross, 1992) argue that addiction change occurs through a process of contemplating, preparing, acting on, and maintaining change with the possibility of relapse occurring at any point in the change cycle. These stages were apparent in Winston and Janelle's stories. Janelle contemplated change as she struggled with her addiction to drugs and the impact that it had on her children. Janelle acted on her plan to quit drugs and to maintain her abstinence from illegal drugs through a methadone program and counselling. Winston shared a similar strategy by using the methadone program. They also relied on each other to stay away from drugs, a struggle they faced on a daily basis, to help them maintain change. As I contemplate change and the stages of change, I am reminded that health care workers need to meet clients where they are at in their healing journey rather than dictating where they believe the client should be.

In Janelle and Winston's quest for change, they encountered some major difficulties which included physical and emotional challenges in their lives. Physically, they had challenges with housing, food, and finances. A number of authors (Gracey & King, 2009; King et al., 2009; PHAC, 2010; Van Uchelen et al., 1997) have indicated that marginalized people and those living with HIV are often concerned with everyday necessities such as food and safe housing. Janelle

and Winston were no exception. In their stories, they recounted their lack of money and the requests of others for them to sell drugs. A large part of their transformation was finding the ability to say no to these temptations. It would have been easier for them to agree to selling drugs, thus solving their financial difficulties in illegal but familiar ways. However, in their stories, they spoke of supporting each other on a regular basis to avoid the temptation to use drugs and return to their old lifestyles. In one story, Janelle shared how good it felt when Winston told her that he was not going to let them use intravenous drugs. She felt he was being strong for her, and she shared that, at times, she was the one who stayed strong for Winston. They relied on each other.

Both Winston and Janelle had a number of motivations for self-transformation. Winston's most important motivation for staying out of prison was to maintain contact with Janelle and especially his son. He recognized how much time he had wasted in prison and knew that it was taking him away time from his family. His son was a strong motivation for his change. I remember how proud he was to share pictures of his son and related stories of his desire to have his son back in his life. I found Winston's story about the hopes and dreams he had for his son to be a powerful example of how far he had come with self-transformation. When I posed a scenario about how his son should handle a bully, Winston said his son should deal with the situation differently than he himself would have in the past. This involved seeking help from others, such as teachers, rather than using violence and anger. Being aware of Winston's history of violence, his story about his son surprised me and spoke to Winston's own personal transformation. Janelle's motivations for change were also her children, but her stories

recounted the difficulties of drug addiction in light of knowing what harms and difficulties her children had to face.

Hearing Janelle and Winston's stories of self-transformation impressed upon me the challenges they faced but, at the same time, highlighted their resiliency. Both of them displayed resiliency as they survived on the streets battling their addictions in the face of violence and potential violence. They displayed extreme resilience considering their history of physical, sexual, and emotional abuse. Society provided them with very little support, especially in their childhood years. Finally, as a health care worker, it saddens me to consider how callous it is to speak to individuals about changing their lives without fully understanding who they are and what life experiences they have gone through. With these thoughts, I consider how loss and grief have impacted Winston and Janelle's lives.

Loss and grief.

Both Janelle and Winston experienced loss and grief throughout their lives. Wanganeen (2010) speaks about loss and grief from two points of view. He argues that loss and grief are both recognized and unrecognized. Loss and grief continually occur and, if they are recognized, then they can be dealt with in a healthy fashion. However, if individuals fail to recognize the loss and grief they have experienced, it may lead to unhealthy and potentially catastrophic results. For Janelle and Winston, I only introduce these topics and will further expand on these in the final chapters.

In Janelle and Winston's stories, there is grief for the innocence they have lost. Janelle spoke about the sexual abuse she experienced and her loss of innocence when she was molested

by a stepbrother and a stepfather at the age of 13. Janelle mentioned that unfortunately other children in her community also were victims of abuse from adults. This highlights the importance of focusing not only on an individual, but also on their family and community. Her sexual abuse was not dealt with and treated; the lack of recognition of her loss of innocence contributed to her turning to drugs and alcohol as a way to handle her problems. Dayton (2000) argues that trauma may trigger people to engage in substance abuse, and, with Janelle's history, this was a plausible scenario. Janelle also mentioned in her stories that her drug use enabled her to forget about the problems in her life, albeit for a short period of time.

For Winston, loss and grief in his life were related to his positive HIV status. He spoke about the potential loss of time with his son if he died of AIDS. He also stated that he wanted to be like other fathers and sons he had observed at his workplace. He wanted to one day be able to work together with his son like the other father and son couples at his place of employment, but he recognized that most likely that would never happen. Instead, it was his wish to one day talk to his boss about hiring his son. This would help his son have a chance to find stability and happiness. Being diagnosed with HIV took away Winston's hope of living a long life, but it also gave him a chance to reflect on how best to spend the rest of his life with his son and wife. Winston recognized the potential loss in his life and considered a positive way to be able to handle his loss.

In the following chapter, the participants' lives will be considered on a deeper and more analytic level.

Chapter Seven: Overarching Analytical Interpretations

The four participants shared their stories and their experiences of living with HIV and previous incarceration in the context of their lives as Aboriginal people. I have organized this chapter into three major sections which are the overarching analytical interpretations based on the four participants' stories. In these sections, I weave together the participants' narrative threads and provide interpretations of their experiences with traumatization, stigma, and transformation. I start the discussion with the experience of traumatization.

Traumatization

All four participants experienced the world from the vantage point of trauma. The participants' experiences of living with HIV were woven within a lived experience of trauma that started early in their lives and has contributed to their development as adults. I utilize Briere and Scott's (2006) definition of trauma which suggests that trauma refers to major events that are psychologically overwhelming for the individual. This is an appropriate perspective as it encompasses the vast physical, emotional, and spiritual damage that impacted participants' lives. In this section, I discuss intergenerational trauma and the trauma related to street life, living an addicted life, living with HIV, and incarceration. I also explore trauma related to loss and grief.

Intergenerational trauma.

The first pattern observed regarding the participants' experiences with trauma was that there was an intergenerational link between the trauma experienced by the participants and their parents. Intergenerational trauma has been discussed extensively by a number of authors (Bombay, Matheson, & Anisman, 2009; Braveheart-Jordan & De Bruyn, 1995; Craib et al.,

2009; Lederman, 1999; Menzies, 1999; Pearce et al., 2008; Phillips, 1999; Waldram, 1997), and these authors have noted that residential schools and colonialism are forms of intergenerational trauma that have impacted First Nations cultures. A key factor has been the removal of children from the care of their parents and grandparents. The lack of emphasis on cultural knowledge in foster care or in adoptive families was apparent in all of the participants' stories. I was reminded of this when Lauren recounted a story of how she and her brother were asked by their father to start a fire, and, when they went to start the fire with a gallon of gasoline, they realized how far removed they were from their roots.

In traditional First Nations cultures, knowledge is passed orally between generations and sacred cultural stories are interwoven with history. Important life lessons are shared as a guide for people to know how to live and, these lessons are passed between one generation to the next (Laliberte et al., 2000). As a result of residential schools, First Nations children and youth were separated from their families and communities, and many traditional teachings were lost or compromised. The loss of teachings through familial connections was experienced not only as a form of trauma by individuals, but also to the communities where the participants lived. In addition to lost teachings, the existence of residential schools also played a role in the multiple traumas experienced by individuals due to physical, emotional, and sexual abuse (Adams, 2000; Chrisjohn & Young, 2006; Miller, 2000).

As I reflected on the participants' narratives, I wondered if their parents were residential school survivors. I also wondered if their parents ever discussed their experiences with their children. Bombay and colleagues (2007) found that residential school survivors tended not to

speak with their children about their time in residential schools. As a result of trauma, there is often an emotional distance between parents and their children. In one of her stories, Janelle recalled that she had observed Winston trying to show emotion to his mother by giving her hugs; however, his efforts were not reciprocated.

The only mention of residential schools in the participants' narratives was a story Janelle shared during which she mentioned a person she knew who had received residential school money. This 'silence' is interesting because it may indicate that some individuals did not have first-hand experiences with residential schools or, alternatively, they were not fully aware of the ripple effect on their own lives of the residential school traumas suffered by family members. Another thought that I considered was based on the writings of Neumann (1998). She speaks about the challenge of writing her father's Holocaust experiences in Auschwitz. She recognized that her father would speak of certain experiences, yet she also acknowledged that there was duality in his life experiences that did not allow him to speak of other experiences and limited others from fully understanding his experiences:

> The survivor living in today, living in the world that emerged after the Holocaust, often in direct opposition to it, experiences a duality, a "double vision," a double knowing of sorts that infiltrates every corner of his life – the meaning from before Auschwitz, paralleling somewhat the meaning of life today, held up starkly against the meaning of the camp. And while the survivor can speak and hear and understand in the post-Holocaust (and pre-Holocaust) language, knowing that what he is saying to others is being taken in a certain way, he is also always aware of the second meaning, the deeper hidden meaning,

> inscribed in the Holocaust world. But this second meaning cannot be repeated today, and in fact it cannot be heard or discerned outside of that place, that is, in a world that is post-Holocaust – in a world that exists beyond the camps. It cannot be shared with, nor can it be re-created in any way for, those who never experienced what Auschwitz was. For those who claim to try to understand what it was like, but without having experienced, in themselves, the horror of what it must have meant to survive, that world is beyond conception, beyond utterance, beyond comprehension. It cannot be recalled. (Neumann, 1998, p. 430)

Through Neumann's (1998) writings, I considered how the participants seemed open to sharing their experiences with me, yet the silences and pauses present in our conversations left me wondering what was being left out in their stories and why aspects of their experiences were silent. Based on Neumann's writings about her father, I wondered how much of those silences spoke to the participants' realization that their words would be insufficient to express the trauma that they experienced in their lives. In one of our conversations I asked Mary about the importance of people "walking in her shoes" so that they could understand what she lived through. She replied that she did not want anyone to walk in her shoes because of the abuse she had experienced. She acknowledged that her world was one that she did not want others to dwell in. I wondered if this was why she chose not to or could not elaborate on all of the difficult life events that occurred in her life.

Certain authors acknowledge that trauma can carry on throughout several generations (Atkinson, 2002; Atkinson et al., 2010; Roberston, 2006) and can manifest itself through

ongoing abuse, undiagnosed post-traumatic syndrome disorders, and depression. The participants' shared stories that had a common theme of their parents living through different traumas. The traumas experienced by their parents and other relatives appeared to have an effect on their children. Perhaps because of the abuse the parents were experiencing, they became less attentive to the traumas experienced by their children, or they were unable to interrupt this trauma. The participants may have also become desensitized to their own children's trauma, but, as we talked, some participants recognized their children's challenges. For example, Janelle shared a story about how her son got caught up in violence and was given a knife to defend himself from possible attackers. Lauren wanted her son to live a different life, but she recognized the difficulties and challenges he had had to face when she was incarcerated and away from her family. Mary had not been in contact with her children for many years and struggled between wanting what was best for them and her addiction to drugs. For Winston, his dreams for his son impressed me; he recognized that his son needed to approach life in a much less violent way than he did. For Winston, this meant that his son needed to make changes early in his school life by avoiding violence and seeking help from teachers.

Street life trauma.

The participants were also traumatized by the experiences they had observed and been involved in on the streets. At the same time, living on the streets sometimes served an important purpose in their lives. For example, at times it gave the participants a way to meet their needs, whether those needs were food or access to substances. At other times, the participants met their needs through abusive, violent, and illegal practices. For example, Winston spoke about his

experiences with bikers and gang life which highlighted the violence in his life. Janelle and Mary also shared their experiences of street violence, particularly related to the dangers of prostitution and drug use. Lauren shared stories of fighting on the street and the violence she witnessed, including her brother being beaten in front of her. These street traumas, and the participants' risk behaviors related to these traumas, were their realities. Their behaviors can be viewed as strictly negative; however, they can also be viewed through a different lens.

I read the work of several authors (Linton, Singh, Turbow, & Legg, 2009; Mill, 1997; Mill & Anarfi, 2002; Shannon, Bright, Gibson, & Tyndall, 2007) who have challenged or described the concept of risk behaviors. For instance, Mill (1997) argued that HIV risk behaviors are survival techniques for Canadian Aboriginal women to escape challenging home environments. Women often ran away from foster homes and institutions following physical and sexual abuse. The risk behaviours of participants in the current study were also survival techniques to escape the abuses and challenges in their lives. For example, Lauren spoke about the stress of losing her child and the many broken relationships she experienced. Lauren turned to drug use as a way to ease the immense pain she felt in her life. She understood that drugs complicated her life and were a source of many of her problems, yet she turned to them to find comfort to her pain. Unfortunately, that relief was only short term and, in the end, only caused more complications such as turning to prostitution to support her drug habit.

Despite the street being a source of trauma, it also acted as a support for the participants. They spoke about a community formed by people on the street. Mary considered people living on the street as part of her supportive community because they would all help each other.

However, not all spoke highly about the street community. Winston, for example, spoke negatively about street life and his desire to get away from it. Similarly, Lauren had experienced violence on the streets. Even with this negativity, the street alleviated some loneliness, and, for some participants, it was also a source of support.

Trauma as a result of living an addicted life.

Another form of trauma revolved around the participants' addicted lives. Being exposed to an environment filled with drugs and alcohol can have a negative effect on how a person views themselves and others (Csiernik, 2002; Dayton, 2000). In all of the participants' stories, drugs and addiction to substances were a common narrative thread. Addiction and trauma were linked closely together for the participants. The participants believed that traumas were often a trigger for wanting to use drugs and alcohol. In turn, substance use led to an increased susceptibility of the participants to participate in high risk behaviors. A prime example is that some participants turned to sex work to obtain money for drugs, but, this behavior, in turn, increased their risk of being assaulted and traumatized.

Living with substance use also meant living with the challenges of recovering from addiction. The participants had good days and bad days, ups and downs. They shared stories of attending programs to help them quit their substance use. However, what became evident was that maintaining a drug-free life was often like taking two steps forward and one step back. Participants could be doing well with their substance use for a period of time and then encounter an event or situation that led them to consider using substances. Mary summed up her substance use experiences when she shared that *once a drug addict always a drug addict* or, in other words,

the lure of drugs is always present. Interestingly, Mary's statement reflects the most common treatment modality in Canada, Alcoholics Anonymous or Narcotics Anonymous, which see sobriety as a lifelong process.

The trauma of living with HIV.

The experience of being diagnosed with and living with HIV was also a source of trauma for participants. The way participants were treated when they were given their diagnosis affected how comfortable they were with accessing the health care system following diagnosis. Winston found out about his HIV status in prison. To help him make sense of his status, he found the use of an informal peer support group effective. Lauren also received her diagnosis in prison; however, the physician who diagnosed her was judgmental, and, as a result, she avoided accessing health care for many months after her diagnosis.

HIV is now considered a long term condition rather than an acute illness and people are living longer with it (Deeks, Lewin, & Havlir, 2013; Gifford & Groessl, 2002). However, there was still a belief by all of the participants that their lives were going to be shorter as a result of their positive status. Winston, in particular, had developed AIDS and realized that he might not lead a full life. For example, he mentioned that he would miss spending time with his son and grieved the anticipated loss of time. All of the other participants indicated they were aware that their lives would be shorter than if they had not been infected with the virus. The participants' realities were that they felt their lives would be shortened by the virus in spite of improvements to treatments.

HIV diagnosis has been a turning point in many individuals' lives (Kremer, Ironson, & Kaplan, 2009; Lewis, 1999; Tewksbury & McGaughey, 1998). Kremer and colleagues (2009) described individuals hitting rock bottom and utilizing their spirituality to help them deal with their HIV and to make changes in their lives. Despite the trauma of an HIV positive diagnosis, there were positive things that occurred as a result of the participants finding out their status. For example, participants seemed more reflective about their lives and considered making positive and healthy changes. They chose to deal with their substance use by going into rehabilitation facilities or joining a methadone program. These programs are offered to those living with or without HIV, but the participants seemed to take their treatment plans more seriously after they were diagnosed with HIV. Another positive impact was that being diagnosed with HIV holds the potential to prevent the spread of HIV. When the participants found out they were HIV positive, they did not want to pass the virus on to others. Winston shared his HIV status with the people with whom he shared drugs. Mary stated that she quit her involvement in sex work and even spoke to other sex workers about the importance of being honest about their HIV status to themselves and to others in order to prevent transmission of the virus. If participants had not been aware of their HIV status, they inadvertently may have placed others at risk because of their high risk behaviors. These precautions were far different from the comments I have heard made by the public and by correctional workers who suggest that HIV positive people want to maliciously spread their HIV virus to intentionally hurt others.

Incarceration trauma.

Trauma was also experienced by the participants during incarceration. Winston felt jail was not a good place to be because it created "better" criminals. People in jail learned negative behaviors from each other such as using violence to achieve certain goals. Comack (2008) states that, "prison only encourages and reaffirms aggression, dominance, and the exercise of brute power and force as legitimate social practices (p. 145)". The stories shared by Comack's participants are similar to Winston and Lauren's narratives regarding their experience with violence in both prison and in the community. All of the participants in the current study shared similar backgrounds to those in Comack's study; they lived through the child welfare system and had to survive through a life of crime.

Being incarcerated is a difficult experience and it changes people. Lauren, for example, spoke about her transition from a fish to a shark. A fish is eaten and taken advantage of by larger predators in the water. Lauren was initially a fish that others took advantage of, but there was a point in her incarceration experience when she became the shark. She became the individual taking advantage of others, and this involved the use of intimidation and physical violence to assert her control over others. Lauren also experienced physical violence when she was thrown into a jail cell by other inmates and then was physically assaulted. However, what was just as traumatic was the mental trauma and anguish of not knowing when this attack would occur.

A common experience that all participants shared was the feeling of separation from their loved ones while incarcerated; this was especially difficult. This was another form of mental and

emotional trauma. Participants understood that they had committed crimes that placed them in prison, but the reality of being separated from their family was at times unbearable.

In federal corrections, there are Aboriginal Healing Lodges that incorporate Aboriginal values, traditions, and beliefs in the design of their programs (Correctional Service of Canada, 2013). All offenders attending these programs are required to follow Aboriginal programming and spirituality. Hayman (2006) critiques the intentions of corrections. She states that Healing Lodges in prisons are "not places of healing: they are sites of coercion, repression, and pain" (p. 257). According to Hayman (2006), the priority of prisons is still heavily focused on punitive actions instead of rehabilitation. Instead of more control being given to Aboriginal staff and promoting Aboriginal governance, Correctional Services Canada maintained control of the Healing Lodge by promoting non-Aboriginal people to leadership positions. This compromised the initial healing philosophy of the lodge. Despite this, some of the participants found prison to be a place where they could heal. Lauren utilized the skills and experience of elders to help her heal while she was incarcerated. She also discovered that staff were able to positively influence her by asking her to consider why she would engage in certain actions. Winston, on the other hand, could not connect with elders, but he did connect with some of the health care workers.

Both Lauren and Winston had experienced federal and provincial corrections. They believed that there were major differences between the two institutions and reported receiving much more support in federal corrections. They had more access to methadone treatment, HIV health care services, and support from elders in federal institutions than they did in provincial ones. Overall, they felt there was more understanding by staff in federal corrections. Their

stories strongly suggest a need to more closely examine the differences in the correctional systems but, more importantly, to determine what role corrections could play in meaningful healing.

Trauma as a result of loss and grief.

In regard to trauma, all of the participants expressed a sense of loss and grief from a variety of experiences in their lives. The participants also felt the loss of opportunities. They talked about losing the opportunity to be a child, and, as a result, their youthful innocence was taken away. They were forced to grow up too quickly and had to deal with meeting basic necessities of life such as finding a safe environment in which to live. The participants also mentioned the loss of the opportunity to shift their life in different directions. Winston shared his dreams of being a dentist while Janelle wanted to be a nurse. Because of how their childhood had unfolded, the participants believed that their dreams had been taken away from them. Their childhood was something that they were not able to control. Lauren had contemplated leaving foster care to be with her family in order to follow a more positive path in her life. The participants recognized that their lives were different because of their HIV positive status. Even with the improvements in HIV drug therapy, they always had questions and thoughts about the loss of years with their family and friends.

Many of the participants shared their journey as they discovered their spirituality. Discovering one's spirituality, especially Aboriginal spirituality, is complex and is bound in culture and ways of living (Fleming & Ledogar, 2008; Waldram, 1994). Spirituality provided participants with grounding in their lives because it offered something larger to believe in and

also provided a sense of belonging. When Lauren connected with her native spirituality, particularly from elders working in prison, she embraced it and was able to garner strength from it. For example, she learned ceremonies that enabled her to respect her brother after he died. Mary not only believed in native spirituality, but she also believed in Christianity. In her stories, she spoke about helping others and God's desire for her to share her stories with others. Janelle also believed in both native spirituality and Christianity, but she was afraid of the power of native spirituality because of her family's experiences. Her family had witnessed supernatural things that had happened to a girl; they blamed this event on native spirituality. Janelle's family felt that native spirituality could harm people if it was not taken seriously. This let Janelle focus more on the beliefs of Christianity. For the participants, spirituality was an important aspect of their lives because it helped them make sense of their losses and helped them grieve. Understanding spirituality was important because it was an influential element for each of the participants and who they were as individuals.

Loss meant a number of different things for the participants. For some participants, loss, such as the loss of a loved one, was something tangible. For others, loss was recognized as an important and integral part of an individual and included loss of innocence or trust in others. The healing process following loss was complicated, and the participants' experiences provided a glimpse of their losses, how they grieved, and how they dealt with their loss.

Relevance of trauma.

Over the course of the research, I have reflected on the participants' stories of trauma and the relevance of trauma to their lives. When I first started this research, I was not sure what I

was going to hear from the participants. I had notions that I might hear stories about environments riddled with abuses; in fact, I did hear stories from participants about these childhood traumas. However, I also realized that trauma was an everyday occurrence in the participants' lives. This was highlighted in the first participant meeting with Lauren. She spoke to me through a broken jaw that had been smashed by her boyfriend. The effects of trauma were ubiquitous in her life. I could visually see the effects of trauma on her face, but the most serious traumas were those that I could not see.

There were many unseen traumas, and these traumas were often revealed through the participants' scars, including their tattoos and their own writings. All tattoos have meaning in peoples' lives and are often connected to previously lived traumas (Sarnecki, 2001; Trachtenberg, 1998). For example, Mary had the name of her son tattooed on her body to remind her not only of her son but also of the pain she experienced when she injected drugs. Lauren did not speak about tattoos, but she did share her writings and projects with me from her time in federal corrections. The collages she made in prison about her past abuses were extremely powerful as she revisited them. The importance of these childhood traumas and experiences was a reminder to me as a nurse and researcher that the participants' lives were much more than I initially perceived them to be. Their lives were more than what could be answered on a questionnaire, filled out on an intake assessment sheet, or shared during a conversation. Their traumas of the past and the traumas they faced on a daily basis shaped who they were and how they related to their world.

The trauma the participants experienced was also significant because it was much more than one event; each trauma built upon another. The trauma originated before the participants were born in the form of intergenerational trauma experienced by their parents and relatives, and then it was transferred directly onto the participants. As the participants tried to make sense of this intergenerational trauma, they were drawn into a life that involved the street world, the world of addiction, and the world of incarceration. In each of these areas, the participants experienced further trauma adding to the complexity of issues they needed to deal with.

HIV trauma was significant because it introduced a very visible illness into their lives which required the addition of more health care services. Participants became more visible in both corrections and in the community because they had special appointments to attend, different medications to take, and were viewed as different because of their illness. They also had more attention focused on them because their HIV status.

Participants' traumas were also significant because they influenced how they viewed their spirituality and the resources they could potentially access. Janelle and her family were most likely affected by intergenerational trauma and a loss of culture. This resulted in the family's wariness with Aboriginality spirituality and eliminated some resources that could have provided Janelle with important support in both corrections and in the community. All of these traumas contributed to individuals having complex needs that health care and correctional institutions were ill equipped to work with.

Stigma

In this section, I explore and discuss stigma experienced by the participants. Stigma is present in all cultures. Foundational work on the topic of stigma was conducted by Goffman (1986). Goffman (1986) viewed stigma as a process whereby an individual was marked as different and reduced from being a whole person to one who was substandard and, therefore, easier to discriminate against. I examine the three most prevalent types of stigmas that were experienced by the participants which include HIV stigma, addiction stigma, and incarceration stigma.

HIV stigma.

The participants experienced HIV stigma on two levels. The first level was related to the experiences of participants at the individual level while the second level refers to stigma at the societal level. Individuals are discriminated at the individual level because HIV is viewed as a disease that harms and kills (CATIE, 2011). Lauren discussed hearing inmates speak about people living with HIV as being a "walking disease." People living with HIV are also stigmatized because individuals believe HIV is easily transferable to others through household and food contact. In the current study, this lack of knowledge made others hypersensitive when they were in contact with the participants. This was the case with Janelle's mother who became disturbed when she realized that Winston had prepared the food that she was eating. This is a reminder that HIV education must remain a priority in addressing HIV transmission, not only for individuals who are at risk of contracting HIV, but also for the families and friends of those who are living with HIV.

Another stigma related to being HIV positive was that society assumed that the participants had acquired HIV through intravenous drug use or unprotected heterosexual sex. While this was in fact true for the participants in the current study, these labels act as a barrier to understanding and contributes to discrimination. When Lauren was diagnosed with HIV while in corrections, the physician callously reminded her that he had previously warned her about her risky behaviors. He labeled and judged her and made no further attempts to understand her life situation. Lauren felt shamed by him and following this, she avoided accessing health care. The physician missed an opportunity to get to know Lauren as an individual and plan her care accordingly.

HIV stigma has the effect of silencing individuals (De Santis & Barroso, 2011; Duffy, 2005; Fielden, Chapman, & Cadell, 2011; Mill et al., 2010). De Santis and Barroso (2011) cited instances of HIV stigma causing individuals to pull away from social supports and, at times, spiritual supports. Mill and colleagues (2010) argued that stigmatization is a social control mechanism that marginalizes people living with HIV and AIDS. Mary believed that some of the sex workers she knew kept silent because they felt that disclosing their HIV positive status would increase the likelihood of them being shunned by others, thereby making it impossible to continue working in the sex work industry. Their silence placed others such as the 'johns' at risk for contracting HIV. Winston shared that he was not always open about his HIV status; he believed he had lost a job because his employer found out about his positive status.

Individuals were also silenced when they heard others speak negatively about people living with HIV. Mary, for instance, heard others use the term "plague" to identify them. Being

considered unclean or having the "plague" resulted in individuals being shunned. Lauren felt shunned by her ex-boyfriend because he could not come to terms with her HIV status. He did not bring up any of these issues when she was in prison, but, after her release, he treated her poorly and ended their relationship. Unfortunately, other participants also shared Lauren's loneliness but were often unable to find others with whom to develop relationships. Mary considered herself lucky to find a boyfriend who accepted her despite her HIV status. Janelle felt good that she could support Winston and help him deal with his HIV. In addition, when she found out she was positive, having Winston in her life made her feel less alone. Lauren struggled with not having a partner who accepted her HIV status; however, she did find support from her son and other family members who understood her challenges.

To more deeply understand HIV stigma, I also considered HIV stigma from a broader societal level. A number of authors have written about HIV stigma and discrimination, particularly the relationship between HIV stigma and society (Goldin, 1995; Mill et al., 2010; Parker & Aggleton, 2002). Goldin (1995) provides a number of reasons why society discriminates against people living with HIV. For example, he argues that society stigmatizes and discriminates based on theologically based blame. He commented that "since AIDS is the result of morally reprehensible behavior and represents divine retribution, ostracism and blame are appropriate responses" (p. 1364). This attitude is an unfortunate example of how HIV stigma is propagated in mainstream society and behaviors are justified, often erroneously. Other authors (Mawar, Saha, Pandit, & Mahajan, 2005; Mill, 2003) suggest that HIV has been viewed as a potential threat to society because of its contagiousness which has been associated with the

sexual spread of HIV (Mwinituo & Mill, 2006). Recognition that HIV rates is higher among marginalized individuals (Mawar et al., 2005; Mill et al., 2009) also makes it easier for individuals in mainstream society to distance themselves further from PHAs. Lauren spoke about feeling "invisible" to people driving past her on the streets. From her perspective, she felt that, when people did this, they did not see her for who she was; she related this to her lack of self-esteem. Lauren's experience highlights the lack of self-esteem that occurs not only from living with HIV but also from the multiple and layered stigmas that the participants dealt with throughout their lives.

Multi-layered or multiple stigmas have been discussed by a number of authors (Daftary, 2012; Mill et al., 2009; Parker & Aggleton, 2002). Multi-layered stigma is associated with belonging to a particular culture (i.e., Aboriginal), gender, sexual orientation (i.e., gay or transgendered), social class (i.e., poverty), or having additional illnesses (i.e., a mental health condition) (Mill et al., 2009). All four participants experienced multi-layered stigma. The participants were injection drug users, were involved in commercial sex work, were Aboriginal, came from a low socio-economic class, and suffered from other illnesses which included depression and post-traumatic stress disorder. Winston, for example, talked about the difficulties he faced when he looked for work because he was previously incarcerated, which made him automatically less trustworthy. Being HIV positive added to the layer of stigma. He avoided sharing his status with others. Winston also talked about avoiding being identified as a substance user because he felt he might lose his construction job. He was not able to talk to others about the emotional and physical suffering he was experiencing from withdrawal and avoided asking

for any assistance from his co-workers. Another example of layered stigma was described by Lauren. Lauren shared the story of her rape and the reaction of the police officers. She felt they did not pursue the matter because of who she was: a substance user, a sex worker, and an Aboriginal woman. Each layer of stigma resulted in the participants either feeling the effects of the stigma directly from others through their attitudes or experiencing a sense of avoidance by others. As mentioned, Winston avoided asking for help for his withdrawal symptoms as he did not want to be judged and looked down upon. In addition, in one of Mary's stories, she shared how street workers living with HIV avoided being stigmatized and shunned because of their positive HIV status. Multi-layered stigma increased the complexity of individuals' lives and also made it very difficult to provide assistance to the person living with HIV.

Addiction stigma.

The participants experienced stigma due to their substance use which resulted in negative experiences. These experiences ranged from overt confrontation to subtle discriminatory practices. Addiction stigma is based on judgments by individuals who do not understand addiction as an illness. For example, Winston shared that nurses in the provincial correctional center did not work with him and his physician to ensure he received additional narcotics to help him cope with his drug withdrawal. The nurses did not understand how difficult it was for Winston to go through withdrawal when his body was significantly weakened by HIV. The nurses wanted to maintain the same treatment practices they were used to instead of being open to other treatment options.

A number of authors (Beyer, Malinowska-Sempruch, Kamarulzaman, & Strathdee, 2010; Monks, Topping, & Newell, 2013; Natan, Beyil, & Neta, 2009) have reported that nurses often have multiple discriminatory beliefs about people who use substances. They view addicts as being unhygienic, violent, dangerous, harboring contagious diseases, unwilling to change, and non-compliant. In addition, Earnshaw and colleagues (2013) found that addiction stigma was not only prevalent among health care workers but also that it was widespread in family members and friends. Some of Mary's narratives about substance use support these findings. Mary felt that people who use substances were always going to use substances, even after they recovered or went through treatment. Her statement indicates that, even among people who use substances, there is a belief that previous substance use may lead to future substance use.

Another manifestation of addiction stigma is the belief that people who use substances are assumed to be dangerous individuals. In a study by Corrigan, Kuwabara, and O'Shaghnessy (2009), individuals who used drugs were often seen as more dangerous and blameworthy when compared to people with other mental illnesses. There is an assumption that, because engaging in illicit substance use is an illegal behavior, those participating in such behaviors are dangerous individuals, criminals, and "junkies" (Templaski, Friedman, Keem, Cooper, & Friedman, 2007). There is also a belief that substance use is controllable, and some individuals fail to control their substance use because they are weak or lazy (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013; Earnshaw et al., 2013). The onus of change is placed on the individual, and their personal shortcomings are emphasized if they are unable to quit.

Current research challenges the paradigm that substance use is, for the most part, the fault of the person using substances. Addiction is now recognized as a neurobiological condition (Leshner, 2001; Volkow, 2007); this research has been helpful in staving off the argument that substance use is solely the fault of the individual and their lack of will power to quit. Hammer and colleagues (2013) cite individuals in their study who indicated that, when substance use is viewed as a disease, some of the blame is diminished when they seek treatment. However, Hammer and colleagues (2013) also discuss the dangers of viewing substance use as a "brain disease." They caution that substance use is much more than just a neurological process; rather, it is a complex condition that involves multiple factors, including social, psychological, and biological ones.

An example of the complexity associated with substance use is the experience that Winston shared regarding his methadone experience and work. Winston shared the troubles he had securing his methadone when his job required him to move to a different city to work on a project. Winston did not tell his employers about his methadone treatment, perhaps because he worried about how individuals would view him if they were aware of his addiction issues. Unfortunately, Winston was unable to have his methadone transferred to the town where he was working, and this resulted in Winston experiencing severe withdrawal symptoms. He also experienced social isolation and mental anguish as he avoided his co-workers and suffered alone through his withdrawal.

Incarceration stigma.

The participants also experienced stigma related to their history of incarceration. Lauren experienced stigma from guards in prison when she was transferred to the federal penitentiary. She came to the penitentiary with a history of being violent and causing trouble within the provincial jail system. The guards monitored her closely. Lauren felt that the guards were waiting for her to make a mistake, such as becoming involved in a violent altercation, so that they could send her into segregation or isolation. Lauren was labeled as a tough offender in provincial corrections and this label, and the stigma attached, followed her into federal corrections.

In prison, Lauren's reputation for being tough garnered her both respect and fear from the other inmates. In a study by Anderson (2000), certain neighborhoods where incarceration was common actually accepted individuals who came from prison as having "street" credibility because they had spent time in prison. This reinforces how important it is to understand that what is considered negative in one context is not necessarily so in another context.

For the most part, however, incarceration is viewed by most of society as negative, and the stigma faced by those incarcerated often continues after they are released from prison (Schnittker & John, 2007). For example, the participants found it difficult to secure employment after being released from prison. Haney (2003) suggests that it is common for inmates to become discouraged when looking for work because of their lack of skills. Pager (2003) also contributes that many employers view individuals with a history of incarceration as being unreliable. This was the experience of participants in the current study. Unfortunately, being

unable to find employment from legitimate sources of work made it more tempting for participants to consider selling drugs or become involved in other illegal activities to help them meet their needs. Winston and Janelle shared the tensions and temptations of trying to build a life free of criminal activity while at the same time resisting opportunities to engage in criminal behaviors. Another consequence of incarceration stigma is a diminished social status (Braman, 2004). In Braman's writings, individuals with a history of incarceration often lacked power in their lives, and, when they found jobs, they felt they needed to prove their worth.

Relevance of stigma.

The participants experienced multi-layered stigma related to being incarcerated, living with HIV, and living with addictions. In addition to these forms of stigma, being Aboriginal and living with mental illness were additional reasons for the participants being stigmatized and discriminated against. The participants discussed these last two attributes in relation to stigma in less depth. The Canadian health care system does not have a strong focus on mental health, particularly as it relates to Aboriginal people (Kirmayer, Simpson, & Cargo, 2003; Kirmayer & Valaskakis, 2009). This lack of attention to mental health issues is perhaps one of the reasons why mental health was not discussed much by the participants.

There is also the issue of racism that has much relevance in the participants' lives. Health Canada (2012) reports that, due to widespread racism and stereotyping, many Aboriginal people do not seek health care. In addition, Browne and colleagues (2005) mention that racism plays a definite role in the experience of Aboriginal people living with HIV. Having grown up in Prince Albert, I was always aware of racist attitudes that individuals had regarding Aboriginal

people. Sadly, I ponder whether the constant exposure to racism in the community has become so normalized that the participants did not use the term racism even though it is still very prevalent in their environment. The complexity of understanding how these stigmas relate to one another is challenging, but what is common is how isolated, silenced, and discriminated the participants felt. This is not uncommon and has been discussed by a number of other authors (De Santis & Barroso, 2011; Fielden, Chapman, & Cadell, 2011; Mill et al., 2010). I still recall noticing how sad Lauren was when describing how she was unable to get the police to take her seriously after she was sexually assaulted. She felt her status as a sex worker caused her pleas for action against the perpetrator to be taken less seriously; however, I also wonder if her status as an Aboriginal women also played a role in the police's inattention.

Stigma affected the health of participants. They described the negative treatment they received from individuals in their lives and health care workers that resulted in them avoiding health care. One individual with discriminatory behaviour may cause others to avoid health care services but, on the flip side, individual health care workers and those working with PHAs also have the ability to promote and champion appropriate health care for PHAs. As an example, Lauren shared that a support health care worker stood up for her when a methadone worker treated her poorly. Acknowledging and being aware that stigma is still present reminds individuals working with PHAs that their actions can positively affect their clients' health. In a study by Fielden and colleagues (2011), health care providers were recognized as important intermediary partners for youth living with HIV.

Stigma contributed to participants feeling alone and invisible with their personal struggles and resulted in them being labeled. They felt that their voices and life experiences were not understood and valued. Unfortunately, this is not uncommon (De Santis & Barroso, 2011; Duffy, 2005). The negative result was that some participants felt disempowered when reaching out to health care workers and accessing public services. As a consequence, they may have turned to familiar behaviors such as substance use and criminal activities.

The effects of stigma resulted in barriers for participants to develop stable lives. Stigma created negative messages and reinforced to participants that they were different from the rest of society (Carr & Gramling, 2004; Fielden et al., 2011; Mill et al., 2010). Individuals that the PHAs casually encountered and the people closest to them, including family members, friends, and health care workers, communicated these messages. The participants internalized these negative messages and the negative labels they received. As a result, stigma degraded and destroyed their self-esteem resulting in hopelessness. With hope taken away, some participants encountered issues of depression and anxiety adding further life challenges. Despite these challenges, participants were still able to create meaningful change in their lives. It is this change that I focus on in the following section.

Transformation

The participants experienced stigma and trauma, which impacted their lives and acted as a catalyst for personal transformation. Transform is defined as to "make a thorough or dramatic change in the form, appearance, character, etc." (Thompson, 1993, p. 970). The participants' transformation was a testament to their resiliency and strength. Transformation for the

participants occurred in the areas of cultural identity, family, healing, and community. In addition, through limiting the harm, transformation occurred. I begin with cultural identity.

Cultural identity.

Some participants described a renewed awakening of their cultural identity following their HIV diagnosis. This had a transformative influence in their lives. For example, both Lauren and Mary had opportunities to access cultural services in and out of corrections. After they were diagnosed with HIV, they took the opportunities to find out about their cultural identities through ceremonies and engaged in discussions with elders more seriously. As described earlier, there is a loss of Aboriginal culture and identity as a result of residential schools and institutionalization (Adelson, 2000; Barlow, 2009; Comack, 2008; King et al., 2009; Laliberte et al., 2000; Truth and Reconciliation Commission of Canada, 2015). Adelson (2000) argues that if colonialism and neocolonialism has resulted in disenfranchisement and attempts to eradicate cultural history, then "reconstitution and reaffirmation of identity" (p. 30) may be what is needed to counteract those trends. In addition, the Truth and Reconciliation Commission of Canada (2015) offers a detailed document that provides not only a history of the effects of colonialism in Canada, but also a call for action to address the assimilation attempts made by churches and governments on Canadian Aboriginal people. All of the participants grew up with Aboriginal family members and friends around them. However, Mary was the only participant who followed traditional Aboriginal beliefs and customs from an early age. The other participants were exposed to Aboriginal teachings later in their lives but did not embrace the teachings as readily as Mary, whose father was an elder.

Lauren found strength from discovering her Aboriginal culture. She was initially exposed to her culture by her father at the age of 12 and found out more about her ancestors through an assignment in prison. She was asked to prepare a family tree and, by doing so, she discovered stories about relatives that she could relate to. Lauren was proud to discover that she had an ancestor who had fought with Louis Riel. She was also proud to hear about her family's resiliency and strength during difficult times from the past. McDonald (2013) also shared a personal story about his experiences in discovering more about himself through his Aboriginal roots. He had felt disconnected from others and, as a result, experienced depression and low self-esteem. Through his work with individuals who understood his culture, which was similar to Lauren's and Mary's experiences, he was able to find strength and stability. Mary was fortunate that her father was an elder and that she was able to learn about her culture from him. Winston and Janelle had opportunities to learn about Aboriginal culture in prison but did not fully embrace what they were exposed to.

Even though some of the participants had not fully accepted all of the tenants of Aboriginal culture, they still had a common identity. This identity was a mix of urban street culture and Aboriginal cultural beliefs. In regard to urban street culture, participants talked about their lives on the street and shared commonalities such as substance abuse, street violence, and identification as *street people* by the general public. Their lives were often transient: one day they would be living in the city, the next on a reserve, and the following couch surfing or sleeping at different homes.

All of the participants shared a visible Aboriginal identity. Seeing the participants, it would be easy to assume, as I did, that they shared similar beliefs regarding Aboriginal traditions and practices. When I first started working in corrections in the late 1990s, I was not aware of the diversity among Aboriginal people. I assumed that those coming from a First Nations community most likely followed a traditional lifestyle, but, the more I spoke with Aboriginal offenders and through my work at First Nations University, I began to appreciate the diversity. This diversity was not only from one community to another but also within a community. For example, Lauren spoke about living in her home reserve where she did not engage in traditional spiritual practices; however, she spoke about other community members who followed traditional practices closely. The participants could be placed on a continuum to describe how closely they actively and openly practiced traditional Aboriginal beliefs. On one end of the continuum was Mary. She had been influenced early in her life by Aboriginal traditions and practices and grew up in a home with her father who was an elder. Lauren was in a different place. She did not share Mary's experiences of learning about her Aboriginal culture from her immediate family, but she still identified with her Aboriginal roots. Lauren searched for who she was and, with the help of elders from corrections, she came to appreciate that she wanted to further understand her Aboriginal identity. This identity helped her to better understand herself as an individual coming to terms with the abuses she had faced, and it gave her the strength to deal with difficult issues in her life, including the death of her brother. Janelle lived on a reserve, but this did not mean she wanted to follow Aboriginal teachings and traditions. In fact, Janelle feared the power of Aboriginal practice. She shared a story about a young girl prematurely aging

because she did not take Aboriginal spirituality seriously. After this event, she and her family were wary of Aboriginal spirituality. Winston did not have Aboriginal teachings passed onto him. He had opportunities to learn about his culture in corrections but hesitated to do so because he felt unable to trust the elders who provided the teachings. Winston and Janelle acknowledged Aboriginal practices; however, they had not engaged in them as readily as Mary and Lauren. All four participants provided examples of the diversity of individuals' practices of and relationships with traditional Aboriginal beliefs. The Truth and Reconciliation Commission of Canada (2015) also recognizes the diversity in Aboriginal beliefs as well as the importance of the inclusion of traditional supports such as elders:

> We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. (p. 211)

This is a reminder that projects created for and with Aboriginal people must consider the diversity of Aboriginal individuals and communities. Not all Aboriginal people engage in or accept Aboriginal belief systems. Hayman (2006), based on the policies of the Correctional Service of Canada, reminds us of this situation. Correctional Service of Canada requires individuals attending Healing Lodges to be fully engaged in traditional Aboriginal practices. The result of this policy is that individuals who may be interested in exploring, and perhaps understanding, their culture are not always permitted to attend Healing Lodges unless they want to be fully engaged in their culture.

Family.

Children were a primary motivation for participants to change their lives. They said their children made them consider how they lived their lives. Lauren mentioned that her son brought out the best in her. She had reason to hate many things in her life because of her experience with trauma and stigmatization; however, when Lauren spoke to her son about using the word "hate," she also shared with him that *hate* had held her back in life. Her son was a reminder to her that she had someone who relied on her and who valued her words as a source of wisdom.

Winston's attitude was also transformed by his son. He shared his desire that his son's life would be much different than the life he lived, which was full of violence. He wanted his son to live a peaceful life and to seek out teachers if he got into trouble with others in school. This was a major transformation for Winston because, when we had talked in prison, well before this research occurred, he spoke negatively about individuals who told on others. This change in Winston's attitude represented a significant shift in his thinking that was influenced by his hopes and dreams for his son.

Having children often made participants want to change their lifestyles. Mary spoke of the need for her to quit drugs because this behavior had previously resulted in her children being apprehended by Child Welfare. She recognized the hurt she had caused her children. Mary said she hoped to one day be healthy and stable enough to care for her children again. Winston and Janelle understood the dangers of substance use and wanted to stop this behavior because their children had been taken away from them as a result of it.

Finally, children and family represented hope. Having children created reasons for the participants to live. Mary spoke about always having her children in her mind and heart even though they were no longer living with her. Her children gave her hope that they would perhaps be together again. For the other participants, they shared that, although living with HIV would most likely shorten their lives, they wanted to be on treatment in order to live as long a life as possible and to see their children get older and flourish. The children symbolized new hope for the participants and fostered the belief that they could create something positive with their children.

Healing.

With hope present in the participants' lives, there was also a capacity for healing. A number of authors have written about the role of hope in cancer patients and families (Duggleby, Bally, Cooper, Doell, & Thomas, 2012; Duggleby, Ghosh, Cooper, & Dwernychuk, 2013; Mehl-Madrona, 2008). In addition, work in the area of hope has also been discussed in a nursing context and brought together in a meta-synthesis by Hammer and colleagues (2009). However, little has been written about hope and healing within a population similar to that of the research participants. A narrative conceptualization of hope is just beginning to emerge.

Nunn (2005) introduced a narrative construction of hope as being a reflective multi-dimensional practice that considers the various past narratives in a person's life and forms a hopeful narrative for one's future. Li and colleagues (2008) applied this narrative construction of hope in an educational setting as they kept hope alive while teaching in a cross-cultural context. They shared their experiences of teaching in various classrooms and university settings

with others in order to allow others to relate and reflect on their experiences. In this way hope is linked across time, place, and social contexts.

Healing encompassed many aspects of the participants' lives. Authors Iwasaki and colleagues (2005) and Barton (2004) conducted research with Aboriginal people living with diabetes. In their research, they demonstrate that healing must be a holistic process that incorporates the mind, body, and spirit. Physical healing is only one area to focus on. As described in the participants' stories, areas of healing also included the mental, social, and spiritual aspects of their lives. In addition, the Truth and Reconciliation Commission of Canada (2015) also adds that healing for Aboriginal people should also have a connection with the earth. This could include activities such as healing camps that allow individuals to experience healing from the natural world.

Participants shared their experiences with depression and post-traumatic stress. Janelle spoke about her difficulties getting out of bed in the morning while Lauren spoke directly, and with emotion, about her depression. Being unable to function because of depression and low energy affected the ability of participants to work on other areas of their lives such as finding employment or adhering to medical treatment plans. As described by Winston, it was a strain on his relationship with Janelle to watch her stay in bed all day. Winston found it difficult to understand.

Participants described having mental health issues such as anxiety, depression, and posttraumatic distress. I recall participants speaking about their mental health issues with a sense of resignation. As they described their issues, there was a sense of powerlessness to change their

situations. They had to succumb to a health care system that often told them what they needed to do rather than working alongside them to improve their situations. Like others, they too might have encountered a health care system that was racist (Barlow et al., 2008; Health Council of Canada, 2012). The mental health services described by the participants were few and these meager resources, including the limited availability of counselors and mental health professionals, affected their health. Kirmayer, Brass, and Tait (2000) argued that poor quality mental health services have placed individuals at risk for poorer health. The lack of mental health and holistic services needs to be improved. The inclusion of Aboriginal elders in supporting individuals will create opportunities for individuals to find balance in their lives. Hunter and colleagues (2006) stressed the importance of urban-based Aboriginal people finding balance and healing from shared interactions between Aboriginal traditions and non-Aboriginal health professionals. Lauren described the strength she gained from her culture which contributed to improvements in both her mental and spiritual health.

Another important component of the mental health of participants was the issue of trust. It was important for participants to be able to place their trust in others. Several authors (De Santis & Borroso, 2011; Grant, Prachakul, Pryor, Keltner, & Raper, 2009) have highlighted the importance of trust and psychosocial support for people living with HIV. Grant and colleagues (2009) spoke about the importance of having adequate psychosocial support, and they recommend that health care professionals should empower family and friends to provide social support to the PHAs in their lives. However, developing trust has its challenges. Lauren had opened up to an aunt about her abuse and then immediately found herself placed in a foster

home. This was a direct violation of the trust between herself and her aunt who had promised not to tell anyone about what she had shared. However, her aunt had an obligation to act upon the information because Lauren was a minor and any abuse disclosed needed to be reported to the authorities even if this broke Lauren's trust in her aunt. I can see the challenges and tensions in this situation and wonder if this could have been dealt with in ways that continued to support the relationship between Lauren and her aunt. Janelle had openly discussed her trauma and history with a counsellor who, later in their meetings, made sexual advances toward her. She felt exploited. As a way to survive and to avoid feeling taken advantage of, participants chose to closely guard what information they shared with others. The danger of jeopardizing their trust was that it prevented family, friends, and health care professionals from maintaining meaningful relationships with them.

Even with these challenges, participants made changes in their lives a reality. In the participants' stories, there was a sense of hope. What was common for all four participants was the hope that their children would be returned to them if they could find stability in their lives. Mary did not mention hope in her narratives but she did mention "love." Love is very similar to hope, and, according to Mary, love was about a better way to look at things. For the participants, hope and love translated into changes which included staying away from substance use, finding stability in their lives, and living healthier lives. At the same time, participants received negative feedback from the people closest to them that they were failures in life. Mary was treated harshly by her stepmother, and Winston had arguments about his substance use and HIV status with people who did not even know him. Participants found it helpful to seek forgiveness from

others and themselves. In prison, Lauren was required to apologize to the person she had robbed and take responsibility for her crime. She came to realize how her crimes affected others and recognized the importance of receiving forgiveness from others and forgiving herself, in order for her to continue the healing process.

Community.

Participant transformation was tied to their community and surroundings. As a health care worker, it is easy to solely focus on the individual without appreciating the influence that community has on the participant's ability to change. When I first considered the participants and their communities, I utilized the Canadian Institute of Health Research (2007) definition that considered community for Aboriginal individuals as their First Nations community. Based on my work in corrections, my thoughts on Aboriginal community evolved to encompass affiliations beyond a First Nations community. I was interested in how the participants defined their community. Some participants expressed that, for them, community was indeed their First Nations community while others indicated that their community was elsewhere such as the downtown core neighborhood.

An article by Van Uchelen and colleagues (1997) poses a different concept of community. They defined their participants' community as the street. The street provided participants with a connection, interdependence, and a sense of community. Individuals were able to participate in activities and socialize with one another while on the street. The importance of having a street community, as described by Van Uchelen and colleagues, was that a street community had strengths. Some of the participants in the current study also viewed their

downtown core neighborhood as positive. Mary included women who were in the sex trade in her downtown community. Living near other people who shared similar experiences provided a sense of support. In Mary's community, people were known to share their homes with others who needed a place to sleep.

The street community was not always positive because of the barriers to transformation it posed for some participants. Winston and Lauren both reported having difficulty changing their lives because the people they had associated with in the past had not changed as a result of their prison experience. Some of their old acquaintances and family members expected Winston and Lauren to become involved in their previous activities of drugs and violence. This made it difficult for them to make meaningful changes in their lives.

Participants were directly affected by their communities; however, the experiences they shared demonstrated that the personal changes they made in their lives also affected their communities. The participants were perhaps unaware of the effect they had on others in their communities, but there was a positive influence. Mary spoke candidly about the need for sex workers to change their practices to limit the spread of HIV and about the responsibilities of both 'johns' and sex workers. Lauren had taught her son and his friend, indirectly, about the importance of volunteering at community soup kitchens. Winston and Janelle's efforts to remain drug free provided positive role models to others in the community. These examples provide positive examples of individuals who had been involved with crime but had been able to find some stability in their lives. Change that was attempted and achieved by participants spilled into the community, and the participants started to create new stories of hope and success for others.

Tousignant and Sioui (2009) discuss resiliency and healing in Aboriginal communities. They point out that community change comes from individuals who have gone through deep change and who can also envision that change for their community. The participants were going through change, and their stories were a reminder to others that individuals and communities can in fact change.

Identifying communities and their abilities to adapt is also important for health care providers. Recognizing the relationship between communities and individuals reinforces the importance of not only providing holistic care for the individual, but also points to the importance of considering community as the unit of care. Tousignant and Sioui (2009) speak about resilience in Aboriginal communities. They recognize that individuals in communities have experienced multiple traumas and loss of culture from colonialism and suggest that these communities need to heal. The authors also highlight the importance of cultural identity as central to resilience. Some of the participants found strength from their cultural identity but others had not.

Limiting the harm.

Living with HIV appeared to transform the participants. The initial diagnosis of HIV was a very difficult experience. Participants expected an earlier than normal death and grieved the time that would be lost with loved ones. Participants also dealt with the news of their newly diagnosed status in maladaptive ways such as through substance use. However, over time, their stories reflected resilience and a change in how they handled their HIV status. They became more knowledgeable about the disease and tried to take care of themselves by adhering to

medication treatments and seeking treatment for their addictions. At the time of the conversations, all of the participants were on methadone maintenance therapy (MMT). MMT is a recognized treatment strategy to handle opioid addiction, and, in fact, the use of methadone treatment and concurrent use of antiretroviral medication is a supported combination medication duo (Batkis, Treisman, & Angelina, 2010; Palepu, Tyndall, Joy, et al., 2006).

Being HIV positive made participants seriously consider their health, their lifestyle practices, and the effects of their high risk activities. As mentioned earlier, participants considered harm reduction techniques such as avoiding drug cravings through the use of MMT and considering the high risk activities they had engaged in. Harm reduction is not a new concept and has been discussed by a number of authors (Hilton, Thompson, Moore-Dempsey, & Janzen, 2000; Shoveller, DeBeck, & Montaner, 2010; Small, Kain, Laliberte, Schechter, O'Shaughnessy, & Spittal, 2005). Avoiding drug and alcohol use was another form of harm reduction attempted by the participants because they realized that their drug and alcohol use was tied directly to other high risk activities, such as unprotected sex and intravenous drug use that placed them at increased risk. However, even when participants were not able to resist intravenous drug use, they reported notifying others of their HIV positive status and tried to make sure that their substance use equipment was not shared.

Another change shared by participants was that they wanted to give back to others. They wanted to be a stimulus for change by speaking about their high risk behaviors and sharing their life stories with at-risk youth. Winston and Lauren, in particular, asked me how they could share their stories in presentations to help people understand their lives. They wanted to help others

avoid their own past negative experiences. Participants were transformed from focusing solely on themselves and their addictions to wanting to share their experiences with others. Their desire to share their stories with others, in light of the significant trauma they had experienced, reaffirmed the generosity of their human spirits.

In the following chapter I present key insights and recommendations based on the participants experiences.

Chapter Eight: Key Insights and Recommendations

The overarching analytic interpretations of trauma, stigma, and transformation have been discussed in the last chapter. In this final chapter I discuss four key insights from this research as well as provide recommendations for nursing, corrections, and future research.

Key Insights

In this study, the participants' voices were heard in regard to a number of areas; however, four key threads have surfaced. These key insights build upon the analytical interpretations from the preceding chapter and highlight the new knowledge identified in this study. The first insight is that *Aboriginal participants experienced a world characterized by traumatization which is vastly different from the world most health care providers come from.* The second insight is that *children acted as motivators for the participants who helped them move beyond the stigma and discrimination that they had experienced*. The third insight is that *the use of power by institutions and organizations and the historical misuse of power with generations of Aboriginal people have resulted in participants feeling powerless to change their life situations.* The final key insight is that *Aboriginal culture, when embraced through an evolutionary process of transformation, has the potential to heal Aboriginal participants holistically.*

From different worlds.

Aboriginal participants experienced a world characterized by traumatization which is vastly different from the world most health care providers come from. When I first embarked on this research, I quickly realized that I was no longer positioned in the world of HIV that I was accustomed to. I had carried out most of my HIV practice in federal corrections. In that

environment, I could readily recruit clients from within the institution into the anonymous HIV testing program that I was involved in. In prison, offenders still had an opportunity to decline a meeting with the nurse, but, for the most part, they complied with my requests to meet with them. In the community, the participants had more control over their lives. They were no longer required to follow the rules of a correctional facility and were free to choose whatever activities they wanted to participate in. Their activities were varied and included attending medical appointments, looking after their children, and trying to achieve a sense of stability in their lives. Their lives also included criminal elements that linked them to substance use and violence.

As my world and the participants' worlds collided, I saw how different our worlds were. The world I was most familiar with was based on my upbringing and education. My parents raised me as a Filipino Canadian. They brought me to Canada as a little boy, and I worked hard at trying to understand what mainstream Canadian culture was like in order to fit in. I recall learning much of my English from the television shows, *Mr. Dress Up* and *Sesame Street*. I also remember family discussions around the kitchen table about the pronunciation of words. My father was concerned that, if the English words he learned in the Philippines were said improperly, it could lead to misunderstandings with others. As a child, it felt good to be able to help my parents learn the subtleties of the English language.

My education at school was a combination of what I learned in the classroom and what I learned from the other students. The students I was exposed to in elementary school made me feel like I was always trying to catch up to them as they spoke about sports like hockey and the awards professional hockey players could win. I randomly picked a hockey team to cheer for

just so that I could join in their conversations. The classroom curricula were primarily Western based without any significant mention of Aboriginal people in Canada. My formal education did not prepare me to understand my participants' world. Their world was complex and alien to me and revolved around a backdrop of trauma, institutionalization (correctional and family services), and the stories shared in this dissertation. Their world was often physically located in the downtown core of Prince Albert, their Aboriginal communities and the larger urban centres like Edmonton and Saskatoon. They shared stories of the substance use and violence they had encountered in their world, and, for the most part, they knew how to negotiate their world well. Mary shared that she was not afraid to walk around in the downtown area in the middle of the night to speak with people who were homeless. This was a world so foreign to me.

Another difference in the participants' world was how they accessed the health care system. The participants engaged with the health care system primarily in emergency situations. Winston described using the health care system after he broke his leg as a result of a physical altercation with others involved in drugs. Mary described accessing the hospital because of a drug overdose. For the most part, participants did not utilize the health care system for preventive services unless they already knew they were at risk for contracting a disease. Janelle recognized that having unprotected sex with Winston placed her at high risk for acquiring HIV, and she made sure to be tested routinely for HIV. Correctional facilities have an opportunity to address health care issues. Participants recalled that, on admission to corrections, there were opportunities to address some of their health care needs that were often forgotten when they were out of prison. This perhaps is an area where additional research is required.

It is important for health care workers to acknowledge and understand how vulnerable and fragile individuals can be when they access the health care system (Gracey & King, 2009; King et al., 2009; Van Uchelen et al., 1997). Understanding how the health care system is utilized creates opportunities to provide more efficient care and to improve client experiences. Lauren felt that the methadone coordinator who did not understand why she was late for an appointment treated her poorly. She was ashamed because she did not understand the procedure to access her methadone since this was the first time she attended the clinic. Subsequently, she shared her negative experience with a support worker who became an advocate for her and reported to others how Lauren had been treated. Lauren's support worker knew the importance of genuinely listening to Lauren's experiences, and she reacted appropriately. The result was improvements to the system, particularly once it was discovered that the methadone coordinator had treated others the same way she had treated Lauren. The health care worker also reinforced the effectiveness of an ally to stimulate change. This was particularly relevant to Lauren as she could not always trust health care workers.

Lauren's support worker demonstrated that there were positive steps being taken within the health care system, especially on an individual level. It is important to accentuate the positives as well as describe the challenges of the system in order to avoid creating a sense of despair in the system that makes any efforts appear futile. The positive stories reaffirmed that positive change was occurring in the various institutions and systems. For instance, the participants shared that they had found a sense of hope in the correctional system. Janelle found the elders and staff in the women's penitentiary to be insightful and sensitive to her past

experiences of trauma and survival. Winston also shared his positive experiences in federal corrections which were a contrast to his provincial correctional experiences. He found the nurses and staff to be supportive of his medical needs. Janelle and Mary both pointed to positive resources within the community where programs were being developed and opportunities to access respectful health care through local clinics were growing. It was important to create space for positive stories in the participants' lives.

As I consider spaces, I am reminded of Ermine's (2007) work on the ethical space of engagement. He argues that researchers must examine the influence of Western perspectives on our understanding of the world. In addition, he discusses the importance of respecting different worldviews. This is a common message that I encountered from a number of other authors (Bhabha, 1994; Clandinin, 2013; Lugones, 1987; Thomas, 2003). Ermine (2007) discusses building ethical spaces to understand each other's points of view. This entails recognizing that a person has their own ethical space which contains their beliefs and backgrounds. For instance, I am influenced by Western thinking, my culture, and my professional background as a nurse. My influences contribute to how I view the world and others. The participants shared their words and worlds during our conversations. Their stories became a catalyst that brought together the worldviews of health care professionals and individuals who may have shared narratives similar to those of the participants. By bringing together the positives and negatives of their worlds and perspectives, new understandings were possible. The participants' stories, both positive and negative, also had the power to stimulate thought and discussion by creating new spaces for people to discuss their narratives.

One of the areas that this dissertation opens up for discussion is the effect of post-colonialism on the past and future of Aboriginal people. Earlier in the dissertation, post-colonial literature was discussed. For example, Laliberte and colleagues (2000) and Miller (1996) described and analyzed the effects of residential schools, the 60s scoop, and the reserve system on Aboriginal people. This has resulted in many Aboriginal people losing their culture and connection with the past (Battiste, 2000; Carpenter, 1999; Kirmayer, Simpson, & Cargo, 2003). A disconnect with culture and past traditional practices and supports from elders and their community had detrimental effects on Aboriginal people which may have also contributed to the overrepresentation of Aboriginal people in prisons (Johnson, 2005; PHAC, 2010b).

Another area that this dissertation highlights is the issue of racism. The participants did not discuss racism directly, but racism is a topic that is relevant in their lives. Authors Browne and colleagues (2005) and a Health Canada (2012) report point to the prevalence of racism within the lives of Aboriginal people. The participants also speak around the issue of racism, but it would be important in future studies to explore the issue of racism directly.

Health care workers and research participants may come from different worlds, but, by learning to understand each other's worlds, they can develop a better understanding of how best to work together. A potential way to do this can be conceptualized through Lugones (1987) work. Lugones (1987) describes women of color, with different backgrounds, traveling to each other's world to genuinely try to understand the other person's experiences, rather than judging them. As health care workers, it is also important to prioritize understanding others rather than judging individuals based on pre-conceived ideas. A model that seems to be effective is the one

practiced by Vancouver Native Health Society. This agency provides integrated HIV care for both native and non-native individuals in the downtown core neighborhood in Vancouver (Benoit, Carroll, & Chaudhry, 2003). With this model, individuals have access to integrated care which includes a focus on nutrition, counseling, pharmacology, dentistry, nursing, and medical care in one location. In a study by Benoit and colleagues (2003), Aboriginal women found it beneficial to have a place where they could shape and influence the care they received in the community. In the participants' worlds, having integrated health care services also benefitted their health. For example, *Access Place* is a clinic in the downtown core area in Prince Albert run by the health region that provides HIV and sexual health testing and counseling by nurses. There are a number of integrated services at the clinic that benefit people living on the street. These services include: a nurse practitioner who can diagnose and treat clients for a number of chronic conditions and illnesses; visiting physicians; a housing placement coordinator; condom and intravenous needle distribution; and nursing support for HIV and hepatitis treatment. Having a clinic based on a "one stop" service model provides people living on the street with the opportunity to access health care services at one location and also provides access to health care workers who routinely work with individuals experiencing homelessness, poverty, and addictions issues. These issues are known to be prevalent in Indigenous populations worldwide (Gracey & King, 2009; King et al., 2009). The "one-stop" ancillary service model was also shown to be effective in retaining youth in HIV care in the United States (Naar-King, Green, Wright, Outlaw, Wang, & Liu, 2007). Having an integrated clinic is an important initiative but

what is also noteworthy is the ability of the participants to influence and make meaningful changes in their care by having their voices heard in the organizations they were involved in.

Children as motivators.

Children acted as motivators for the participants who helped them move beyond the stigma and discrimination that they experienced. This insight is a result of my observations regarding my participants' physical reactions as they talked about their children during our conversations together. I wanted to understand the relationship between the participants and the people they cared for the most, which were usually their children. I recalled the happiness the participants showed when they spoke about their children who reminded them that they had someone who relied on them.

The participants lived unstable lives because of their substance use, and the periods of incarceration made it difficult to create a stable home for their children. This resulted in other family members having to care for their children. In cases of abuse or neglect, their children were often apprehended by Child and Family Services and placed in foster homes. Regardless of whether the child was in the care of other family members or in a foster home, it resulted in a physical distance between the participants and their children. Despite the distance, the participants shared stories of their efforts to be with their children. For example, Lauren hitchhiked home for Christmas during inclement weather to see her son. She closed the physical distance between them. Lauren wanted to maintain the family tradition of being with her son at Christmas.

As Lauren's son got older, she wanted to maintain a relationship with him, but this required her to create a safe physical environment for him. During our conversations, she moved to a new home because she was worried that her enemies knew where she lived; they had threatened to not only harm her but also her son. By moving to a new home, she hoped that it would be a safer environment. Her stories reminded me of the lengths that parents will go to be with their children and to keep them safe.

Janelle and Winston also demonstrated their love for their son. Their son was in foster care and, in order for them to get him back into their care, they needed to demonstrate that they had a stable life. This entailed going to addiction treatment and having a permanent residence. Their son was the motivation for them to change their lives.

Mary's children also motivated her to change her life. Her primary motivation was not to get her children back. Rather, what motivated her was the fact that she had hurt her children because of her addictions. She injected drugs into a tattoo with her son's name to remind her of the pain she had caused him due to her substance use. She, too, worked hard to overcome her addiction but was quick to remind me that an addiction relapse was only one drink or drug exposure away. She wanted to have her children back in her life but was wary that she might not be ready to have them back until she felt more in control of her life. She gave up being with them because she felt they were in a better environment than what she could provide. Mary's actions reflected caring and love that was focused more on the best interests of her children than her own interests. Children motivated the participants to find stability in their lives and were a reminder for their parents to strive for a better life.

My discussions with elders and many Aboriginal people have revealed that Aboriginal people hold a common view that children are a gift from the creator or God. Children come into this world because they are meant to be here. As I reflect on Winston and Janelle's narratives, they both practiced protected sex initially, but, as their relationship developed into something more serious and committed, they stopped having protected sex with the hopes that Janelle might become pregnant. She did and she gave birth to a healthy son. Winston and Janelle's situation highlights the importance of relevant education for all people living with HIV and those considering conception. Loufty and colleagues (2012) have provided Canadian HIV pregnancy planning guidelines for HIV positive individuals to decrease the chance of children being born with HIV. These guidelines are important. However, another consideration is to address the guilt and the feeling of being judged when couples consider having children. The ability to have these discussions between a health care provider and PHA is required and underscores the importance of developing trusting relationships with health care providers who understand the world their clients come from.

Power and powerlessness.

The third key insight is that *the use of power by institutions and organizations and the historical misuse of power with generations of Aboriginal people have resulted in participants feeling powerless to change their life situations.* The participants' narratives were a window through which I was able to better understand how power influenced and molded their lives. To accomplish this, I used Foucault's (1977, 1995) writings on power. As a PhD student, I gravitated toward Foucault because I found value in his analysis of the relationships between

institutions and society (Foucault, 1977, 1995). I found his work on the development of health care and prison structures to be especially enlightening (Foucault, 1977, 1995). His work has also been used by others to critique health policy discourses (Coyte & Holmes, 2006; Holmes & Gastaldo, 2002) and discourses on power and societal structures (Garland, 1990; Gutting, 2005; Rabinow & Ross, 2003). Foucault's discourse on power emphasizes the importance of viewing the many visible and invisible influences associated with power. To illustrate this, in his book *Discipline and Punish* (Foucault, 1977/1995), the individuals who were most visible were insane criminals. There was a process to becoming visible. The criminally insane were categorized through the creation of categories that defined and classified them as being deviant (Foucault, 1977/1995; Gutting, 2005). Once defined as deviant, it allowed authorities to rationalize their use of power to imprison and punish these individuals. By defining deviancy, it drew a line in the sand between what behaviors were normal and acceptable and what were deviant and looked down upon. It also made it easier to convince others in society that the use of power was required to deal with these *deviants*.

Foucault's perspective on power is complex. Power is present through physical means, such as through physical punishment, and through structures, such as prisons and hospitals. In addition, it is pervasive in all areas of society. Power influences how society convinces others to conform to a set of expectations. It is through this set of expectations that physical power is exercised and legitimatized. For example, the creation of residential schools essentially speaks to the value placed on assimilating Western thinking and culture on others. Aboriginal children were forcefully removed from their communities, their families, and their culture by the

Canadian government. Power was exercised by physically removing the children from their communities. There was another level of societal power that allowed these actions to take place. The location of this power is not so easily pinpointed.

The use of visible power is often easy to recognize. It takes shape in the physical world and is present in institutions. Visible power is exerted on individuals by others. Examples of this power are the use of violence to control others in prison and on the street (Barlow, 2009; Comack, 2008). Lauren shared stories of being sent to segregation, also known as isolation, if she did not conform to the rules of prison. In addition, Winston shared stories of biker gangs controlling others through the threat and use of violence to make others do their criminal bidding.

Participants were also viewed as having power. For example, by virtue of being in prison, the participants were viewed as having street and criminal credentials. The people who were in their circles looked up to them or feared them. Comack (2008) conducted interviews in prison, and his male participants shared that their physicality and reputation were important factors to earn respect from others in and out of jail. Winston and Lauren shared that people knew their reputations as violent individuals; this made people wary of them. Janelle shared that being associated with her family had both negative and positive connotations. For example, individuals who knew her family knew that they were a tight knit unit. However, people did not want to cross her family because it meant there might be retaliation. In addition, the police associated her family members as being part of a gang.

The participants were viewed as being powerful and dangerous because of their history with prisons, street life, violence, and high risk behaviors such as drug use. The result was that they became defined as such. They were viewed by society as prostitutes, drug dealers, and criminals. In addition, because they were living with HIV, some people viewed them as diseased. Lauren spoke about working as a sex trade worker and feeling like no one even noticed her. She became invisible to society and felt like she did not count. This was also reinforced in her story about being sexually assaulted and her struggle to be taken seriously by the police. She felt the authorities did not care about her claims of being abused because she was a sex trade worker. Lauren felt frustrated by her treatment, and this widened the gap in trust between her and the authorities. Lauren felt she was not noticed by society, yet, when she was noticed, it was for all the wrong reasons. Society saw her as a sex trade worker but failed to see her as a struggling mother, a lost daughter, a person living with trauma, and a human being.

Foucault (Foucault, 1977, 1995; Gutting, 2005) also wrote about invisible power. In his analysis of prisons, the deviants were identified as such by others. The deviants were visible, but there was an invisible element. The invisible element was the people reviewing the deviants' dossiers and charts. These individuals made the decisions about who would be released from the institution and who required further incarceration or treatment. In the participants' lives, the health and front line workers also judged and exercised their use of power. They reviewed the charts of the inmates and had access to the inmates' history, their drug practices, and the diseases they lived with. They could make decisions on who would be able to access certain medications and treatment. In the community, decisions were made for the participants about whether they

were able to receive methadone treatment or if they met the criteria to get their children back from Child and Family Services. In prison, participants shared that correctional officers had the power to isolate them from others if they did not conform to the rules of the institution. In addition, racist practices are also prevalent in the correctional system as evidenced through the overrepresentation of Aboriginal people in the prison system (Johnson, 2005; PHAC 2007a; Trocme et al., 2004).

The participants experienced powerlessness because they were also affected by the power used not only in their lives but also in the lives of their family members. The degradation of the participants' culture through the history of colonialism, residential schools, 60s scoop, and the child welfare system played a large role in the participants' lives. This has been previously discussed, but there were also effects from the institutionalization that had been a large part of the participants' lives in the form of foster care, young offender programs, and corrections. Institutionalization is defined as "the adverse psychological effects on individuals residing in institutions, especially of long stays in large-scale institutions, such as mental hospitals and prisons. Most frequently mentioned effects, whose precise causes are debated, are dependency, passivity, and lethargy" (Scott & Marshall, 2005, p. 313). Lauren shared her experiences of feeling dependent on the correctional system. She felt she would always return to prison and that she deserved no better than prison; she felt powerless to change. She was defined as a deviant because she engaged in illegal activities. After many years of institutionalization, she was told she was not a good person. It was not until she met supportive correctional staff and elders that she felt empowered to expect better things. She could control her actions and make decisions

that had the power to transform her life into something more. What helped Lauren were the elders and staff who had the courage to confront Lauren with behaviors they observed, such as acting out violently against others, that held her back in prison. Having elders who understood her background and could relate to her life made a difference to her healing. The elder support was important for Lauren. Braken and colleagues (2009) also discovered the importance of elder support with the Canadian Aboriginal offenders' population they worked with.

Lauren's experiences are a reminder that being in corrections is a form of institutionalization that has the potential to address healing and health; however, the focus is still on incarceration and punishment. Several authors (Hayman, 2006; Holmes, 2003; Martel & Brassard, 2008) have even challenged the concept of healing in prisons. As mentioned earlier, Hayman (2006) has argued that, in prison, regardless of the programs available, punishment is the overriding role that prisons can play. Despite this, Lauren believed that prisons had the ability to support individuals with their healing journey, and she was able to take her opportunities with elders to learn about her culture and learn about more positive ways to approach her life.

Healing and culture.

The final insight is that *Aboriginal culture, when embraced through an evolutionary process of transformation, has the potential to heal Aboriginal participants holistically.* Aboriginal people come from diverse cultural backgrounds. In Canada, there are 615 First Nations communities and 10 distinct First Nations language families (Statistics Canada, 2008). Adding to this diversity are the settings that Aboriginal people live in, particularly the different

urban and community settings (Peters, 2007). One of the common messages mentioned by the participants in Peters' (2007) study was the ability of individuals to thrive in both urban and community settings because of the important foundation provided by their First Nations and Métis cultures. Other authors have also identified the importance of First Nations cultures in providing support for Aboriginal people to heal. Fleming and Ledogar (2008) described the importance of Aboriginal spirituality and culture in protecting against alcohol use, suicide ideations, and suicide attempts. In addition, other authors (Berry, 1999; Brave Heart, 1998) have highlighted the effectiveness of First Nations culture in dealing with the legacy of historical trauma related to colonialism and residential schools. Lauren spoke about how beneficial it was for her to learn about her culture from elders in corrections. Her culture gave her the strength to deal with difficulties in her life, such as the death of her brother. Lauren credited the counseling she received from the elders and the ceremonies she participated in with providing her with this inner strength. In addition, those same elders also helped her believe that she deserved more from life than just going in and out of prison.

There were differences, however, between how individuals understood and integrated culture into their lives. Mary shared that her father was an elder, and, as a result, she was exposed to Aboriginal culture. She stated she understood her culture; however, understanding culture is different than actively integrating it into one's life. Mary discussed knowing about her culture, but she did not talk about her active participation. I wonder now if this was her choice, or if perhaps there were few opportunities for her to practice. In our conversations, she often referenced Christianity and God; her spiritual beliefs were a blend of both her Aboriginal beliefs

and Christianity. Winston and Janelle also acknowledged being Aboriginal, but they did not embrace their culture in the ways Lauren did.

There was a range in how the participants identified with their Aboriginal ancestry. In a study by Martel and Brassard (2008), individuals in prison situated themselves as Aboriginal in four configurations. The first configuration was "adopting hegemonic Aboriginality" (p. 348). In this configuration, individuals accepted cultural and traditional Aboriginal symbols endorsed by prison and reinforced pre-existing Aboriginal self-identification. The second configuration was "refusing identify" (p. 348). In this perspective, individuals refused to disclose that they were Aboriginal because of traumatic experiences in the past or because of previous imprisonment. The third configuration was "stereotyping identity." In this configuration, individuals "enact[ed] clichés of the 'Indian' to acquire privileges from staff or secure better treatment from prisoners" (p. 348). The fourth configuration was "claims-making." This occurred when an inmate "requests modification to prison conditions using politically charged claims of Aboriginality" (p. 348).

As I consider Martel and Brassard's (2008) work, I draw similarities with the participants. Lauren identified with and accepted cultural and traditional Aboriginal symbols as endorsed by the prison. The correctional facilities chose which elders and First Nations cultures were represented in prison. Following the teachings and philosophies of the elders was beneficial to Lauren. She could relate to and had a natural respect for them. I wonder what would have happened had there not been this natural respect by Lauren.

From my discussions with inmates in federal corrections, it is apparent they are concerned about potential problems when elders come from only the local area. One such problem is that inmates housed in Federal corrections come from across Canada. Inmates who are not familiar with elder traditions and their cultural practices may not want to access the cultural programs in prison. Martel and Brassard's (2008) work is also relevant to Janelle and Winston. Both participants did not follow Aboriginal cultural practices, but they accepted and recognized their Aboriginality because it allowed them to access certain benefits such as subsidized housing on reserve. Their claims to being Aboriginal were different than Mary and Lauren's claims.

The differences between how Aboriginal cultures are embraced by the participants were most likely due to their exposure to Aboriginal cultures early in their lives. Winston and Janelle did not have positive early exposure to their Aboriginal cultures. In fact, Janelle and her family were wary about the power of Aboriginal spirituality after they witnessed how it had affected a young girl who did not take Aboriginal spirituality seriously. On the other hand, both Mary and Lauren were exposed to Aboriginal culture early in their lives. Lauren described how her father exposed and taught her about Aboriginal spirituality and smudging. This early exposure to Aboriginal culture made it easier for both Mary and Lauren to trust more readily the elders and their teachings. They were able to garner this additional support, but, for Janelle and Winston, this support was largely missing.

Each participant's identification with being Aboriginal was charged with personal meaning. Lauren, for example, demonstrated that there is a positive journey that can be

undertaken by allowing oneself to understand and embrace who one is as an Aboriginal person. By learning and embracing her Aboriginal culture, she was able to transform into someone stronger. Lauren always knew she was of Aboriginal descent, but she did not appreciate what this meant until later in her life. The Aboriginal role models she saw growing up were not healthy and positive. These role models were involved with drugs, alcohol, and violence. As Lauren got older, many of the other Aboriginal people she encountered also had issues with drugs and violence. As a result of her environment and the choices she made, she ended up becoming involved in negative behaviors and practices in order to achieve a sense of belonging. It was also a way to survive. Lauren understood she was packaging and moving drugs for her father, but she did so because she loved him and wanted his approval.

Even with all of these experiences, Lauren was able to find a sense of self through her culture. She became more interested in Aboriginal culture as a result of self-reflection during programs she attended in corrections and in the community. These programs, which were focused on healing and Aboriginal cultures, became catalysts for her to question who she was as an individual. Elders in corrections ran these programs, and they blended their knowledge of culture to address the pain that people like Lauren were feeling. The counseling that Lauren received from the elders challenged the negative perception she had about herself and her outlook on others. However, the change in Lauren required a readiness to change. This readiness came from understanding and appreciating the many losses in her life because of drugs, violence, and the choices she made. Her children were taken away from her; however,

she had to come to terms with the crimes she committed and the hurt these crimes had caused others. Her readiness to accept healing was reflected in the stories she shared.

As I reflect on the participants, they have all healed and progressed along different continuums in their lives by sharing their stories. Tafoya (2000) argues that all people have been influenced by the power of stories. However, Tafoya emphasizes the importance of First Nations stories as a metaphor. In his writings, he shares a story of the monster, Dashkayah, also known as Bigfoot or a Sasquatch, and a boy who is cunning enough to help others and himself escape from this monster. In this story, the boy and the other children who were captured by Dashkayah, escaped and pushed Dashkayah into the fire. Dashkayah's burning body was transformed into mosquitoes which, according to legend, are why mosquitoes live off the blood of young children today. These stories are metaphors for real life. For example, the monster can represent HIV, gang violence, or addiction. Tafoya (2000) states that, if we focus on the structure of the stories, it makes it easier for health care providers and educators to understand the metaphoric value of the story and what Aboriginal stories are saying. Tafoya (2000) further explains that this story is similar to Hansel and Gretel. In both stories, the witch in Hansel and Gretel and Dashkayah wanted to eat the children, and they were both defeated. However, there are differences to the two stories (Tafoya, 2000, p. 58):

> In European culture there is an idea that evil can be identified and then destroyed. Indeed, there seems to be an obligation to do so. . . . There is always a witch to burn or a dragon to slay. But Dashkayah does not die, she is transformed. As in many American Indian stories, there is the theme of transformation and restoration to harmony, rather than a

> European approach of attempting to dominate nature by deleting an undesirable (by human standards) aspect of it.

According to Tafoya (2000), we can deal with incurable diseases such as AIDS by transforming them into something manageable.

Considering the Past and Thoughts on the Future

In this section, I reflect on the effect that the stories had on me and the participants. I also discuss the future considerations and implications for nursing care and research. Using narrative inquiry (Clandinin, 2013; Clandinin & Connelly, 2000), I was privileged to be able to form relationships with Lauren, Mary, Winston, and Janelle. Forming these relationships reminded me of how close I was to the participants because of the hours we spent talking together. However, I remind myself that, despite all of the time together, I was only able to come to know a small part of their experiences. In no way do the stories I have presented speak to all of the participants' lives, but rather only moments of their lives.

The stories elicited an emotional response from all of the participants because it reminded them of their past—a past filled with happy memories but also with sadness due to their previous traumas. Mary shared how difficult it was to read about the things that had occurred in her past, but when she talked to others about how she felt, she realized how important it was to recognize what she had dealt with. She needed to come to terms with those experiences in order to move on. Her story is a reminder of how the past has formed and influenced the participants but also how it has affected who they are today, and who they are becoming.

As I consider the past, present, and future, I realize how fast time marches on and how lives constantly change. The initial conversations I had with the participants occurred well over a year and a half ago. Since then, all of the participants have chosen to become parents again, and all have had healthy babies who are HIV negative. They have experienced the joy of having more children, but they have also experienced heartache. I was devastated to hear that Winston and Janelle had a baby boy who died in the care of Child and Family Services. This sent Winston into the familiar world of substance use as he tried to cope with what happened. However, even in his grief, he was able to find time to meet with me. Our contact together reaffirmed that narrative inquiry is built on relationships. He shared with me his time and his stories; I demonstrated to him that, as a researcher, I truly cared about him and his current life situation, and I tried to be supportive. Winston and Janelle's loss of their child reminded me of their ongoing relationship with Child and Family Services.

I too have been affected by this research. I have conducted quantitative research in both the community and in my previous graduate program. I felt removed from the people that my past research was supposed to provide guidance for. I never really knew the participants. They were numbers that I tried to understand using statistical tests. In another study, the participants were individuals whom I took blood samples from and counselled briefly during one or two visits. However, I never really had an opportunity to get to know them and, in turn, they never had a chance to really know what I was trying to accomplish through my research. This disconnect between myself and the research participants served a particular purpose, but it was

geared towards what I, as a quantitative researcher, believed was important to be measured and subsequently attempted to measure.

As I engaged with my dissertation research, my shift from quantitative to qualitative research was significant. I felt privileged and valued the personal knowledge of the participants gained through narrative inquiry because I wanted to hear the voices of the participants. This approach changed me. Their stories introduced me to a world of trauma that I had read about but was not intimately aware of until I saw their faces, heard their stories, and felt the heartache in their voices. Their stories changed me and made me aware of what I took for granted in life such as my own children and economic stability. As a nurse, I now view the clients I work with in a different light. I am more aware of potential traumas and the silences that hide those traumas. I also try to assume less about the clients I work with. The research has opened my eyes to different worlds, and I look for opportunities to find ways to advocate for clients in order to help them transform their lives in a more meaningful direction.

Recommendations for nursing practice.

The participants' stories have highlighted a number of recommendations for nurses. Nurses in clinical practice must consider their own personal belief systems and assumptions when working with individuals similar to the participants in the current study. They must deepen their understanding about how history and personal traumas shape lives and the kind of care people are willing to engage with. In addition, nurses must engage with clients by looking past the labels of incarceration and HIV and recognize that these are individuals who have their own unique and complex life experiences. This entails understanding that the labels and diagnosis of

HIV are only parts of a person's life. The labels do not provide a clear story of the traumas and struggles that previously incarcerated individuals living with HIV are still working through. As a nurse, I have often been busy with a hectic and heavy workload and I am reminded how important it is for me to understand who my clients are and subsequently tailor care to their needs. This requires considering not only the physical aspects of an individual's care but also the other aspects of their being (mental, emotional, spiritual). Understanding the world through Indigenous ways of knowing would help to introduce nurses to Aboriginal knowledge systems and help them better understand the worldviews of Aboriginal people. The medicine wheel (Lane, Bopp, Bopp & Brown, 2012) is one example of an Indigenous knowledge symbol that can be used to help understand this worldview and to reinforce that multiple approaches and considerations are required.

Nurses are asked to consider all aspects of client care, including the physical, the spiritual, the emotional, and the social aspects of the individual. Caring for HIV positive individuals obviously entails physical care, but this research also highlights that the emotional, spiritual, and social aspects of the client are critical to the provision of holistic care. This research highlights the need to incorporate a focus on mental health disorders, substance use issues, and issues of powerlessness. Nurses are in a prime position to effect change; however, trust needs to be built between nurses and their patients.

I have witnessed health care professionals judging individuals and commenting that they are 'non-compliant' with care. This is similar to the experiences of the study participants. Health care professionals believe that these individuals do not to want to participate in their care when,

in fact, some people have difficulty trusting because of their past experiences. When clients engage with health care professionals, but then express some hesitation with their care, health care professionals should not view this as negative but rather as an opportunity to build a therapeutic foundation.

Nurses must recognize that some clients are survivors and that they are resilient. There is often a feeling among nurses that we need to 'fix' people. However, we delude ourselves by making this assumption. Clients will shy away from our attempts to assist them if they feel their wishes and needs are not being considered. The challenge for nurses is to figure out how to build the rapport needed to meaningfully engage individuals and to work in a collaborative manner.

Health professionals can improve how they work and care for clients through education and advocacy. For example, the CANAC (2013) has identified that there has been little nursing education focused on HIV care. When participants were asked what health care providers could do to improve their working relationship with them, the clear message was that there needed to be respect, understanding, and a commitment to working together in a partnership rather than "fixing" the participants. This message is a reminder that health care organizations need to integrate the GIPA principle (UNAIDS, 2007). GIPA stands for greater involvement of people living with AIDS. GIPA "is not a project or programme. It is a principle that aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives" (UNAIDS, 2007, p. 1). A call to revisit these principles in the environment of HIV and community practice is critical for

all health organizations. Government officials and politicians need to understand the complexity of care required for these individuals and the reality that more resources are needed. This involves addressing the health care needs in and out of corrections and the improved coordination of these health care services in the community. For example, more resources are required in the community to address the limited mental health counselling and addiction services.

The participants in the current study are really a subset of PHAs. The current literature on the needs and issues of PHAs needs to be critically and carefully evaluated. Are the current participants represented in the literature or are other groups of PHAs the focus of research? Nurses also need to pay attention to who is setting the discussion topics and steering the research agenda. In this research, I allowed the discussions to be led by both myself and the participants. If the participants wanted the conversation topic to be about their personal issues and problems, I allowed the discussion to go in that direction because he or she felt it was important that I know about how they were feeling and what was happening in their lives.

Recommendation for corrections.

The participants all had a history of incarceration. This research demonstrated that there are opportunities for corrections to play a role in the rehabilitation of offenders. Participants who had been incarcerated in both the federal and provincial correctional systems reported feeling much more supported in federal corrections because of the number of services available such as access to elders and better overall support. I recommend that provincial corrections review and compare their counseling and health care services with those offered in federal corrections to

determine which services they may be able to adopt. This would entail the following: looking at the supports individuals receive while on the methadone program; HIV testing and support services; and Aboriginal culture and elder support. Lauren and Winston were both incarcerated in federal and provincial corrections. Winston found the support he received from federal health care to be positive while Lauren shared her positive experiences with federal health care, staff, and elder support. Lauren also appreciated having access to more counseling support and programs that allowed her to talk about what she had experienced in the past.

Another recommendation for corrections is the need for sensitivity in disclosing an HIV diagnosis to individuals. Are physicians and nurses who work closely with offenders adequately aware of how offenders feel while in their care? Lauren felt suicidal for 3 days after her diagnosis with HIV and the health care staff did not note her feelings. This example raises the importance of mental health services in corrections and the need to evaluate the supports and services currently available. Research highlighted from this dissertation is beneficial to demonstrate to correctional staff the influence that their actions and approaches have on the current and future health of an offender.

Healing is not a primary initiative in corrections (Hayman, 2006), but the correctional system is an environment where there are opportunities for individuals to access HIV support and perhaps find opportunities to learn more about Aboriginal culture and healing. As indicated in this research, Aboriginal culture may facilitate the participants' cultural, spiritual, mental, and emotional healing. The participants' narratives point to the need to further explore the culture

and supports available through corrections and also to critically examine what factors in corrections contribute to individuals feeling powerless to change their lives.

Aspects of this research need to be shared with offenders and staff in prison. The participants' stories are powerful because they allow other people with similar life experiences to see that there is hope after a positive HIV diagnosis. The participants demonstrated that they were able to form meaningful relationships with others and were able to cope with their HIV positive status. For corrections staff, it is important to know that they have a very significant impact on the health and positive transformation of the people they are responsible for.

Recommendations for education.

Findings from this research would be useful in teaching graduate and undergraduate nursing and health science students. The narratives shared by the participants provide useful insights about the lives of clients who are often marginalized and can provide a platform for students to challenge their own thoughts and assumptions about working with these population groups. This research values the perspectives of the participants and demonstrates that, by privileging their stories and personal knowledge, we can identify the gaps in health care that limit our understanding about how to improve the health care system. Working at First Nations University of Canada, I am fortunate to see Indigenous Health Studies courses offered to nursing and health students which address a number of salient issues such as colonialism, residential schools, and White privilege. However, research such as this will add additional voices and experiences from the participants.

Recommendations for research.

As I reflect on the current study, there is definitely more research that needs to be done. As mentioned earlier, research conducted within corrections can be beneficial to explore the salient issues that offenders experience while in correctional facilities. The narratives shared have pointed to a number of issues that can be further explored. One direction in research is identifying the attitudes of nurses and health care providers who work with this population group. What are these attitudes and what types of education and future initiatives may be beneficial in creating meaningful change? Another direction for research is investigating the extent to which people living with HIV are being meaningfully included in decision making and planning initiatives in health care settings, especially in rural and smaller city settings.

This research is also a reminder that participant voices and perspectives need to be heard in research. Just recently, I had the opportunity to listen to a physician speak about the state of HIV in northern Saskatchewan. In his presentation, a key focus was the need to have more physicians trained to address HIV. As I observed those in the room, nurses were agreeing with him and with the statistics he presented. He focused on treatment as a priority. However, what frustrated me was that the voices of the clients were missing. With client voices missing, the dominant voices around the discussion table were those of the health care providers. I would be interested in conducting community-based research that focuses more on initiatives centered on participants and the needs of the community.

Conclusion

As I conclude this dissertation, I am thankful for the privilege of getting to know each of the participants. They have shared their lives with me, and, for that, I will be forever changed. I will be changed as a researcher, a nurse, and a father. As a researcher, I appreciate the importance of focusing on the individual participants and their narratives. Their narratives provide a much fuller understanding of their lives and illuminate gaps in their care. As a nurse, my views about what nursing needs to do to address this group of individuals has been influenced and challenged. I am reminded that culture and spirituality play significant roles in the lives of people. I need to understand these issues from my clients' perspectives and from their life events rather than just from my own personal point of view. As a father, their stories impress upon me how I take for granted the simple blessing of being with my children and remind me how influential I am in all stages of their lives.

Although this research is formally completed, I still meet the participants on the streets where we take advantage of the opportunity to catch up on each other's lives and plan for the occasional cup of coffee or lunch date. The participants have a sense of pride in their stories and are pleased that they are valued and will be shared with others. Their stories provide us with a brief glimpse into their lives. What we see is that their lives have been shaped by their childhood experiences and by the way they have negotiated into adulthood. The participants have experienced a world surrounded by trauma and the after effects of that trauma. The trauma is not only limited to them but to the trauma their families and other Aboriginal people in Canada have experienced. Many of their stories are about their struggles, but other narratives revolve around

hope and resilience centered on the love they have for their children and family. With this hope and resilience, they continually strive to improve their lives.

The participants' stories have also made me consider the power relations and societal structures that influence their lives and health. One such structure is the correctional system that does not adequately address the HIV and mental health needs of inmates. The correctional system has been a large part of the participants' lives for many years, and they have identified areas where it can be improved to better serve them and others in similar situations. The role of corrections as a place for healing has been questioned and perhaps future research will help clarify this role.

As I consider my own field of nursing and health care, the participants' narratives have pointed to a number of gaps. I recognize that nurses need to appreciate and understand the world that patients dwell in and how they view the world of health care. It is also important for nurses to understand that colonization continues to have a lingering and prominent effect on many Aboriginal clients' health and social issues. The nurses' and clients' worlds differ, yet nurses share the same fundamental goal and desire to address and improve client health.

Finally, the research highlights the importance of culture. Culture has been identified by both Lauren and Mary as a very important resource in their lives. Culture provided them with a sense of identity about who they are as individuals and has given them support through elders and traditional ceremonies. Further research is required to explore the important links between Aboriginal culture and healing.

References

Adams, H. (2000). Challenging Eurocentric history. In Laliberte, R. F., Settee, P., Waldram, J. B., Innes, R., Macdougall, B., McBain, L., et al. (Eds.), *Expressions in Canadian Native Studies* (pp. 40–53). Saskatoon, SK, Canada: University Extension Press.

Adelson, N. (2000). Re-imagining Aboriginality: An Indigenous peoples' response to social suffering. *Transcutural Psychiatry, 37*(1), 11–34.

Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence, 88*, 188–196. doi:10.1016/j.drugalcdep.2006.10.014.

Aidsinfo. (2007). *HIV and pregnancy*. Retrieved from http://aidsinfo.nih.gov/ContentFiles/HIVandPregnancy_FS_en.pdf

Alonzo, A. A., & Reynolds, N. R. (1995). Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Social Science & Medicine, 41*(3), 303–315. doi:10.1016/0277-9536(94)00384-6

Alvesson, M., & Skoldberg, K. (2007). *Reflexive methodology: New vistas for qualitative research.* Los Angeles, CA: Sage.

Aroni, R., Goeman, D., Stewart, K., Sawyer, S., Abramson, M., & Thein, F. (1999). *Concepts of rigour: When methodological, clinical and ethical issues intersect*, Vol. 2000. AQR. Retrieved from http://www.aqr.org.au/local/offer/papers/RAroni.htm

Anderson, E. (2000). *Code of the street: Decency, violence, and the moral life of the inner city.* New York, NY: W.W. Norton & Company.

Andrews, M. (2007). Exploring cross-cultural boundaries. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 489–511). Thousand Oaks, CA: Sage.

Bamberg, M. G. W. (1997). Positioning between structure and performance. *Journal of Narrative and Life History, 7*(1–4), 335–342.

Bamberg, M. (2011). Who am I? Narration and its contribution to self and identity. *Theory Psychology, 21*(3), 3-24.

Bartlett, J. G. (2003). Conceptions and dimensions of health and well-being for Métis women in Manitoba. *Circumpolar Health 2003,* 107–113.

Bartlett, R., Brown, L., Shattell, M., Wright, T., & Lewallen, L. (2013). Harm reduction: Compassionate care of persons with addictions. *MedSurg Nursing, 22*(6), 349–358.

Barlow, J. K. (2009). *Residential schools, prisons, and HIV/AIDS among Aboriginal people in Canada: Exploring the connections.* Ottawa, ON, Canada: Aboriginal Healing Foundation.

Barlow, J. K., Reading, C., & Akan, M. (2008). Aboriginal people living with HIV/AIDS (final report 2008). Vancouver: Canadian Aboriginal AIDS Network.

Barton, S. S. (2004). Narrative inquiry: locating Aboriginal epistemology in a relational methodology. *Journal of Advanced Nursing, 45*(5), 519–26.

Barton, S. S. (2008). Using narrative inquiry to elicit diabetes self-care experience in an Aboriginal population. *Canadian Journal of Nursing Research, 40*(3), 16–36.

Bateson, M. C. (1994). Peripheral visions: Learning along the way. New York: HarperCollins.

Batkis, M. F., Treisman, G. J., & Angelino, A. F. (2010). Integrated opioid use disorder and HIV treatment: Rationale, clinical guidelines for addiction treatment, and review of interactions of antiretroviral agents and opioid agonist therapies. *AIDS Patient Care, 24*(1), 15–22.

Battiste, M. (2000). *Reclaiming Indigenous Voice and Vision.* Vancouver: University of British Columbia Press.

Berry, J. W. (1999). Aboriginal cultural identity. *The Canadian Journal of Native Studies, 1,* 1–36.

Beyrer, C., Malinowska-Sempruch, K., Kamarulzaman, A., & Strathdee, S. A. (2010). 12 myths about HIV/AIDS and people who use drugs. *The Lancet, 376*, 208–211. doi:10.1016/S0140-6736(10)61005-7.

Bhabha, H. K. (1994). *The location of culture*. London & New York, NY: Routledge.

Blackstock, C., Trocme, N., & Bennett, M. (2004). Domestic violence and child welfare: Child maltreatment investigations among Aboriginal and non-Aboriginal families in Canada, *Violence Against Women, 10*(8), 901–916.

Bramadat, I. J., & Saydak, M. I. (1993). Nursing on the Canadian prairies, 1900–1930, effects of immigration. *Nursing History Review, 1*(1), 105–117.

Browne, A. J., & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing aboriginal women. *Nurse Researcher, 9*(3), 28–41.

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health, Nov 2009,* 6–47.

Boulos, D., Yan, P., Schanzer, D., Remis, R. S., & Archibald, C. Estimates of HIV prevalence and incidence in Canada, 2005. *Canada Communicable Disease Report 2006*, *32*(15), 165–174.

Braken, D. C., Deane, L., & Morrissette, L. (2009). Desistance and social marginalization: The case of Canadian aboriginal offenders. *Theoretical Criminology, 13*(1), 61–78.

Braman, D. (2004). *Doing time on the outside: Incarceration and family life in urban America.* Ann Arbor: University of Michigan Press.

Brave Heart, M. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work, 68*(3), 287–305.

Braveheart-Jordan, M., &. DeBruyn, L. (1995). So she may walk in balance: Integrating the impact of historical trauma in the treatment of Native American Indian women. In J. Adleman & G. M. Enguidanos (Eds.), *Racism in the lives of women: Testimony, theory and guides to antiracist practice* (pp. 345–368). New York, NY: Haworth Press.

Briere, J. N., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.

Browne, A. J., Smye, V. L., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *Canadian Journal of Nursing Research, 37*(4), 16-37.

Bunting, S. M. (1996). Sources of stigma associated with women with HIV. *Advances in Nursing Science, 19*(2), 64–73.

CAAN. (2015). *CAAN Mission, Philosophy, Goals and Vision.* Retrieved from http://www.caan.ca/about/mission/

CAAN. (2011). *International strategic plan on HIV & AIDS for Indigenous Peoples &*

Cain, R., Collins, E., Bereket, T., George, C., Jackson, R., Li, A., Prentice, T. & Travers, R. (2014). Challenges to the involvement of people living with HIV in community-based HIV/AIDS organizations in Ontario, Canada. *AIDS Care, 26*(2), 263-266.

Cain, R., Jackson, R., Prentice, T., Collins, E., Mill, J., Barlow, K. (2013). The experience of HIV diagnosis among Aboriginal people living with HIV/AIDS and depression. *Qualitative Health Research, 23*(6), 815-824.

Caine, V. (2002). *Storied moments: A visual narrative inquiry of aboriginal women living with HIV*. (Unpublished master's thesis). University of Alberta, Edmonton.

Caine, V. (2010). Narrative beginnings: travelling to and within unfamiliar landscapes. *Qualitative Health Research, 20*(9), 1304–1311.

Canadian Aids Society. (2002). *Position statement: Drug laws and HIV/AIDS*. Retrieved from http://www.cdnaids.ca/web/setup.nsf/(ActiveFiles)/PS_Drug_Laws_and_HIV/$file/Drug_Laws_and_HIV_En_Red.pdf

Canadian Association of Nurses in AIDS Care (CANAC). (2013). *Core competencies for HIV/AIDS nursing education at the undergraduate level*. Retrieved August 15, 2014 from http://www.canac.org/Resources/CANAC_core_comp_e.pdf

Canadian Blood Services. (2009). *HIV and AIDS*. Retrieved from http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/page/E_HIV+and+AIDS?OpenDocument

Canadian HIV/AIDS Legal Network [CHALN]. (2010). *HIV and hepatitis C crisis in Federal Prisons, according to new CSC report*. Retrieved from http://www.aidslaw.ca/publications/interfaces/downloadDocumentFile.php?ref=1036

Canadian Institutes of Health Research [CIHR]. (2007). *CIHR guidelines for health research involving Aboriginal people.* Ottawa, ON, Canada: Canadian Institutes of Health Research.

Canadian Nurses Association. (2002). *Hepatitis C: A nursing guide*. Ottawa, ON, Canada: Hepatitis C Division, Health Canada.

Canadian Institutes of Health Research [CIHR]. (2007). *CIHR Guidelines for health research involving Aboriginal people.* Ottawa, ON, Canada: Canadian Institutes of Health Research.

Canadian AIDS Treatment Information Exchange [CATIE]. (n.d). *HIV in Canada: Trends and issues for advancing prevention, care, treatment and support through knowledge exchange – An environmental scan.* Retrieved from http://www.catie.ca/pdf/canada/HIV-in-Canada_ES.pdf

Carpenter, J. (1999). The elders have waited for young people to ask such thing. In P. Kulchyski, D. McCaskill, D. Newhouse (Eds.), *In The Words of Elders: Aboriginal Cultures in Transition* (pp. 217-254). Toronto: University of Toronto Press.

Carr, R. L., & Gramling, L. F. (2004). Stigma: A health barrier for women with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care, 15*(5), 30–39.

Carter, C. I., & Macpherson, D. (2013). *Getting to tomorrow: A report on Canadian drug policy*. Vancouver, BC, Canada: Special Screencraft Printers.

CATIE. (2011). *A practical guide to HIV drug treatment for people living with HIV*. Retrieved from http://www.catie.ca/en/practical-guides/hiv-drug-treatment

Chrisjohn, R. & Young, S. (2006). *The circle game: Shadows and substance in the Indian residential school experience in Canada* (revised ed.). Penticton, BC, Canada: Theytus.

Clandinin, D. J. (2007). *Handbook of narrative inquiry: Mapping a methodology*. Thousand Oaks, CA: Sage.

Clandinin, D. J., & Caine, V. (2013). Narrative inquiry. In A. A. Trainor & E. Graue (Eds.), *Reviewing Qualitative Research in the Social Sciences.* New York, NY: Routledge.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco, CA: Jossey-Bass.

Clandinin, D. J. (2013). *Engaging in Narrative Inquiry.* Walnut Creek, CA: Left Coast Press.

Clandinin, D. J., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 35–75). Thousand Oaks, CA: Sage.

Cohen, S. (1985). *Visions of social control.* Cambridge: Polity Press.

Coles, R. (1989). *The call of stories: Teaching and the moral imagination.* Boston: Houghton Mifflin.

Comack, E. (2008). *Out there in here: Masculinity, violence, and prisoning.* Halifax, NS & Winnipeg, MB, Canada: Fernwood.

Correctional Service of Canada. (2013). *Correctional Service of Canada healing lodges.* Retrieved from http://www.csc-scc.gc.ca/aboriginal/002003-2000-eng.shtml

Correctional Service of Canada Review Panel. (2007). *A roadmap to strengthening Public Safety: Report of the Correctional Service of Canada Review Panel.* Ottawa, ON, Canada: Minister of Public Works and Government Services.

Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction. *Journal of Social Work, 9*(2), 139–147. doi: 10.1177/1468017308101818.

Coyte, P. C., & Holmes, D. (2006). Beyond the art of governmentality: Unmasking the distributional consequences of health policies. *Nursing Inquiry, 13*(2), 154–160.

Craib, K. J. P., Spittal, P. M., Patel, S. H., Christian, W. M., Moniruzzaman, A., Pearce, M., Demerais, L., et al. (2009). Prevalence and incidence of hepatitis C virus infection among Aboriginal young people who use drugs: Results from the Cedar Project. *Open Medicine, 3*(4). Retrieved from http://www.openmedicine.ca/article/view/249/287

Csiernik, R. (2002). Counselling for the family: The neglected aspect of addiction treatment in Canada. *Journal of Social Work Practice in the Addictions, 2*(1), 79–92.

Daftary, A. (2012). HIV and tuberculosis: The construction and management of double stigma. *Social Science and Medicine, 74*(10), 1512–1519.

Dayton, T. (2000). *Trauma and addiction.* Deerfield Beach, FL: Health Communications.

Dawley, K. (2001). Ideology and self-interest, nursing, medicine, and the elimination of the midwife. *Nursing History Review, 5,* 99–126.

Dewey, J. (1938). *Experience and education*. New York, NY: Collier Books, Macmillan.

Dewey, J. (1981). *The later works, 1925-1953: Vol. 10. Art as experience* (J. A. Boydston, Ed.). Carbondale: Southern Illinois University Press.

Deeks, S. G., Lewin, S. R., & Havlir, D. V. (2013). The end of AIDS: HIV infection as a chronic disease. *Lancet, 382,* 1525–1533.

De Santis, J. P., & Barroso, S. (2011). Living in silence: A grounded theory study of vulnerability in the context of HIV infection. *Issues in Mental Health Nursing, 32,* 345–354.

Des Jarlais, D. C., Galea, S., Tracy, M., Tross, S., & Vlahov, D. (2006). Stigmatization of newly emerging infectious diseases: AIDS and SARS. *American Journal of Public Health, 96*(3), 561–567.

Downey, C. A., & Clandinin, D. J. (2010). Narrative inquiry as reflective practice: Tensions and possibilities. In N. Lyons (Ed.), *The handbook of reflective inquiry.* Dordrecht, Netherlands: Springer.

Duffy, L. (2005). Suffering, shame, and silence: The stigma of HIV/AIDS. *Journal of the Association of Nurses in AIDS Care, 16*(1), 13–20.

Duggleby, W., Bally, J., Cooper, D., Doell, H., & Thomas, R. (2012) Engaging hope: The experiences of male spouses of women with breast cancer. *Oncology Nursing Forum, 39*(4), 400–406.

Duggleby, W., Ghosh, S., Cooper, D., & Dwernychuk, L. (2013). Hope in newly diagnosed cancer patients. *Journal of Pain and Symptom Management, 46*(5), 661–670.

Duncan, K. C., Reading, C., Borwein, A. M., Murray, M. C. M., Palmer, A., Michelow, W., Samji, H., Lima, V. D., Montaner, J. S. G., & Hogg, R. S. (2010). HIV incidence and prevalence among Aboriginal peoples in Canada. *AIDS Behavior*, published online 27 August 2010 [EPub ahead of print].

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. New York, NY: State University of New York Press.

Ermine, W. (2007). The ethical space of engagement. *Indigenous Law Journal, 6*(1), 193–203.

Emden, C., & Sandelowski, M. (1999). The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research. *International Journal of Nursing Practice, 5,* 2–7.

First Nations Centre. (2007). *OCAP: Ownership, control, access and possession.* Sanctioned by the First Nations Information Governance Committee, Assembly of First Nations. Ottawa, ON, Canada: National Aboriginal Health Organization.

Farlex. (2014). *The free dictionary by Farlex*. Retrieved from http://www.thefreedictionary.com/transformation

Fielden, S. J., Chapman, G. E., & Cadell, S. (2011). Managing stigma in adolescent HIV: Silence, secrets and sanctioned spaces. *Culture, Health & Sexuality, 13*(3), 267–281.

Fleming, J., & Ledogar, R. J. (2008). Resilience, an evolving concept: A review of literature relevant to aboriginal research. *Pimatisiwin, 6*(2), 7–23.

Foucault, M. (1977). The birth of social medicine. In P. Rabinow & N. Rose (Eds.), *The essential Foucault: Selections from The Essential Works of Foucault 1954-1984* (pp. 319–337). New York, NY: The New Press.

Foucault, M. (1995). *Discipline & punish: The birth of the prison*. Toronto, ON, Canada & New York, NY: Second Vintage Books. (Original work published 1977)

Fournier, S., & Crey, E. (1997). *Stolen from our embrace: The abduction of First Nations children and the restoration of Aboriginal communities.* Vancouver, BC & Toronto, ON, Canada: Douglas & McIntyre.

Gagnon, M., & Holmes, D. (2008). Governing masses: Routine HIV testing as a counteroffensive in the war against HIV-AIDS. *Policy, Politics, & Nursing Practice, 9*(4), 264–273.

Garland, D. (1990). *Punishment and modern society: A study in social theory.* Chicago, IL: The University of Chicago Press.

Geertz, C. (1988). *Works and lives: The anthropologist as author.* Stanford: Stanford University Press.

Geertz, C. (1995). *After the fact: Two countries, four decades, one anthropologist.* Cambridge, Mass.: Harvard University Press.

Goffman, E. (1986). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simons & Schuster, Inc.

Goldin, C. S. (1994). Stigmatization and AIDS: Critical issues in public health. *Social Science and Medicine, 39*(9), 1359–1366.

Goin, L., & Mill, J. (2013). Resilience: A health promoting strategy for Aboriginal following family suicide. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 11*(3)*,* 485–499.

Goulet, L. M. & Goulet, K. N. (2014). *Teaching each other: Nehinuw concepts and Indigenous pedagogies.* Vancouver: UBC Press.

Gracey, M., & King, M. (2009). Indigenous health part 1: Determinants and disease patterns. *Lancet, 374*(4), 65–75.

Grant, J. S., Prachakul, W., Pryor, E. R., Keltner, N. L., & Raper, J. L. (2009). Sources of functional social support provided to people with HIV. *Journal of Nursing & Healthcare of Chronic Illnesses*, *1*(4), 331–338.

Grekul, J., & LaBoucane-Benson, P. (2008). Aboriginal gangs and their (dis)placement: Contextualizing recruitment, membership, and status. *Canadian Journal of Criminology and Criminal Justice, 50*(1), 59–82.

Grifford, A. L., & Groessl, E. J. (2002). Chronic disease self-management and adherence to HIV medications. *Journal of Acquired Immune Deficiency Syndromes, 31,* S163–166.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Thousand Oaks, CA: Sage.

Gutting, G. (2005). *Foucault: A very short introduction.* Toronto, ON, Canada: Oxford.

Hall, S., Held, D., Hubert, D., & Thompson, K. (Eds.). (1995). *Modernity: An introduction to modern societies.* Oxford: The Open University.

Haney, C. (2003). The psychological impact of incarceration: Implications for post prison adjustment. In J. Travis & M. Waul (Eds.), *Prisoners once removed: The impact of incarceration and reentry on children, families, and communities* (pp. 33–66). Washington, DC: The Urban Institute.

Harrington, A. (2005). *Modern social theory: An introduction.* Oxford: Oxford University Press.

Harrowing, J., Mill, J. & Birse, E. (2009). Management of patients with HIV infection and AIDS. In R. Day, P. Paul, & B. Williams (Eds.), *Brunner & Suddarth's Textbook of Canadian Medical-Surgical Nursing* (2nd ed.) (pp. 1715–1752). Philadelphia, PA: Lippincott, Williams, & Wilkins.

Hawkins, T. (2006). Appearance related side effects of HIV-1 treatment. *AIDS Patient Care & STDS, 20*(1), 6–18. doi:10.1089/apc.2006.20.6

Hawkins, K., Reading, C., & Barlow, K. (2009). Search for safe spaces: A qualitative study of the role of sexual violence in the lives of Aboriginal women living with HIV/AIDS. Vancouver: Canadian Aboriginal AIDS Network.

Hayman, S. (2006). *Imprisoning our sisters: The new Federal women's prisons in Canada.* Montreal, Kingston, London, Ithaca: McGill-Queen's University Press.

Health Canada. (2003). *HIV/AIDS epi update*. Minister of Public Works and Government Services Canada: Ottawa.

Herdt, G. (2001). Stigma and the ethnographic study of HIV: Problems and prospects. *AIDS and Behavior, 5*(2), 141–149.

Holmes, D., & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing, 38*(6), 557–565.

Hudson, B. A. (2008). *Understanding justice: An introduction to ideas, perspectives and controversies in modern penal theory*. Maidenhead, Berkshire, UK: Open University Press.

Iwaskaki, Y., Bartlett, J., & O'Neil, J. (2005). Coping with stress among Aboriginal women and men with diabetes in Winnipeg, Canada. *Social Science & Medicine, 60,* 977–988.

Johnson, S. (2005). Returning to correctional services after release: A profile of Aboriginal and non-Aboriginal adults involved in Saskatchewan corrections from 1999/00 to 2003/04. *Juristat: Canadian Centre for Justice Statistics, 25*(2), 1–25.

Jürgens, R. (1996). *HIV/AIDS in prisons: Final report*. Retrieved from http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=585

King, T. (2003). *The truth about stories: A Native narrative.* Toronto, ON. Canada: Anansi.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *Lancet, 374,* 76–85.

Kirmayer, L. J., Brass, G. M., & Tait, C. (2000). The mental health of Aboriginal peoples: Transformations of identity and community. *The Canadian Journal of Psychiatry, 45*(7), 607–616.

Kirmayer, L. J. & Valaskakis, G. G. (2009). *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada.* Vancouver, BC. Canada: UBC Press.

Kowalewski, M. R. (1988). Double stigma and boundary maintenance: How gay men deal with AIDS. *Journal of Contemporary Ethnography, 17*, 211–228.

Laliberte, R. F., Settee, P., Waldram, J. B., Innes, R., Macdougall, B., McBain, L., et al. (Eds.). (2000). *Expressions in Canadian Native studies.* Saskatoon, SK, Canada: University Extension Press.

Larkin, J. Flicker, S., Koleszar-Green, R., Mintz, S. Dagnino, M., & Mitchell, C. (2007). HIV risk, systemic inequalities, and aboriginal youth. *Canadian Journal of Public Health, 98*(3), 179–182.

Lederman, J. (1999). Trauma and healing in Aboriginal families and communities. *Native Social Work Journal, 2*(1), 59–90.

Leshner, A. I. (2001). Addiction is a brain disease. *Issues in Science and Technology Online, 17*(3). Retrieved from http://www.addictionrecoveryguide.org/articles/

Lessard, S. M. (2014). *Red worn runners: A narrative inquiry into the stories of Aboriginal youth and families in urban settings* (Unpublished doctoral dissertation). University of Alberta, Edmonton, AB.

Lessard, S., Caine, V., & Clandinin, D. J. (2015). A narrative inquiry into familial and school curriculum making: attending to multiple worlds of Aboriginal youth and families. *Journal of Youth Studies, 18*(2), 197-214.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 163–187). Thousands Oaks, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. In Y. S. Lincoln & E. G. Guba, *Naturalistic Inquiry* (pp. 289–331). Newbury Park, CA: Sage.

Lines, R. (2002). *Action on HIV/AIDS in prisons: Too little, too late – A report card*. Montreal, QC, Canada: Canadian HIV/AIDS Legal Network.

Link, B. G. & Phelan, J. C. Conceptualizing stigma. *Annual Review of Sociologoy, 27*, 363-385.

Linton, A. B., Singh, M. D., Turbow, D., & Legg, T. J. (2009). Street youth in Toronto, Canada: An investigation of demographic predictors of HIV status among street youth who access preventive health and social services. *Journal of HIV/AIDS & Social Services, 8*, 375–396.

Living conditions for First Nations 'unacceptable': Fontaine. (2007). Retrieved from http://www.cbc.ca/news/canada/living-conditions-for-first-nations-unacceptable-fontaine-1.680540

Lugones, M. (1987). Playfulness, "world"-traveling, and loving perception, *Hypatia, 2*(2), 3–37.

Lux, M. K. (2001). *Disease, medicine, and Canadian plains native people, 1880–1940.* Toronto, ON, Canada; Buffalo, NY; London: University of Toronto Press.

Martel, J., & Brassard, R. (2008). Painting the prison 'red': Constructing and experiencing Aboriginal identities in prison. *British Journal of Social Work, 38*, 340–361.

Martin, F. E. (1998). Tales of transition: Self-narrative and direct scribing in exploring care-leaving. *Child and Family Social Work, 3*(1), 1–12.

Mashing, R. (2009). *Aboriginal strategy on HIV/AIDS in Canada II: For First Nations, Inuit and Metis Peoples from 2009 to 2014.* Canadian Aboriginal AIDS Network.

Matiation, S. (1999b). *Discrimination, HIV/AIDS and the Aboriginal people*. Ottawa, ON, Canada: Canadian HIV/AIDS Legal Network and the Canadian Aboriginal AIDS Network.

Mawar, N., Saha, S., Pandit, A., & Mahajan, U. (2005). The third phase of HIV pandemic: Social consequences of HIV/AIDS stigma & discrimination & future needs. *Indian Journal of Medical Research, 122*, 471–484.

May, K. A. (1991). Interviewing techniques in qualitative research: Concerns and challenges. In J. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 188–201). Newbury Park, London, New Delhi: Sage.

McDonald, J. (2013). An Aboriginal experience of transformation. *Satir Journal of Counselling and Family Therapy, 1,* 103–106.

McNiff, J. (2007). My story is my living educational theory. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 489–511). Thousand Oaks, CA: Sage.

Meleis, A. I. (1996). Culturally competent scholarship: Substance and rigor . . . based on a keynote speech given at the 11th research conference "Toward Culturally Competent Health Care, "Rutgers State University. *Advances in Nursing Science, 19*(2), 1–16.

Menzies, P. (2009). Homeless Aboriginal men: Effects of intergenerational trauma. In J. D. Hulchanski, P. Campsie, S. Chau, S. Hwang, & E. Paradis (Eds.), *Finding home: Policy options for addressing homelessness in Canada* (pp. 601–625). Toronto, ON, Canada: Cities Centre, University of Toronto.

Menzies, P. (2010). Intergenerational trauma from a mental health perspective. *Native Social Work Journal, 7,* 63–85.

Michalowski, M., & Verma, R. B. P. (2005). Projections of the Aboriginal populations, Canada, provinces and territories: 2001 to 2017. Retrieved from http://www5.statcan.gc.ca/access_acces/alternative_alternatif.action?loc=http://www.statcan.gc.ca/pub/91-547-x/91-547-x2005001-eng.pdf&l=eng&teng=ARCHIVED+Projections+of+the+Aboriginal+Populations%2C+Canada%2C+Provinces+and+Territories%2C+2001+to+2017&tfra=Projections+des+populations+autochtones%2C+Canada%2C+provinces+et+territoires%2C+2001+%C3%A0+2017

Mill, J. E. (1997). HIV risk behaviors become survival techniques for Aboriginal women. *Western Journal of Nursing Research, 19*(4), 466–489.

Mill, J. E., Allen, M. N., & Morrow, R. A. (2001). Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research, 33*(2), 109–127.

Mill, J. E., & Anarfi, J. K. (2002). HIV risk environment for Ghanaian women: Challenges to prevention. *Social Science & Medicine, 54*, 325–337.

Mill, J., Austin, W., Chaw-Kant, J., Dumont-Smith, C., Edwards, N., & Groft, J. (2007). *The influence of stigma on access to health services by persons with HIV illness: Stigma project*. Retrieved from http://www.caan.ca/wp-content/uploads/2012/05/The-Influence-of-Stigma-on-Access-to-Health-Services-by-Persons-with-HIV-Illness.pdf

Mill, J. E., Edwards, N., Jackson, R. C., MacLean, L., & Chaw-Kant, J. (2010). Stigmatization as a social control mechanism for persons living with HIV and AIDS. *Quality Health Research, 20*(11), 1469–1483.

Mill, J., Edwards, N., Jackson, R., Austin, W., MacLean, L., & Reintjes, F. (2009). Accessing health services while living with HIV: Intersections of stigma. *Canadian Journal of Nursing Research, 41*(3), 168–185.

Mill, J., Harrowing, J., Rae, T., Richter, S., Minnie, K., Scovia, M., et al. (2013). Stigma in AIDS nursing care in sub-Saharan Africa and the Carribean. *Qualitative Health Research, 23*(8), 1066–1078.

Miller, J. R. (1996). *Shingwauk's vision: A history of Native residential schools*. Toronto, ON, Canada; Buffalo, NY; London: University of Toronto Press.

Miller, J. R. (2000). *Skyscrapers hide the heavens: A history of Indian-White relations in Canada* (3rd ed.). Toronto, ON, Canada; Buffalo, NY; London: University of Toronto.

Munhall, P. L. (2004). "Unknowing": Toward another pattern of knowing in nursing. In P. G. Reed, N. C. Shearer, & L. H. Nicoll (Eds.), *Perspectives on nursing theory* (pp. 239–246). Philadelphia, PA: Lippincott Williams & Wilkins.

Morrow, R. A. (2005). *An invitation to rethinking the classical sociological imagination: From the Enlightenment to the early 20th century crisis of modernity.* Unpublished manuscript, University of Alberta.

Monks, R., Topping, A., & Newell, R. (2013). The dissonant care management of illicit drug users in medical wards, the views of nurses and patients: A grounded theory study. *Journal of Advanced Nursing*, *69*(4), 935–946. doi:10.1111/j.1365-2648.

Mwinituo, P. P., & Mill, J. E. (2006). Stigma associated with Ghanaian caregivers of AIDS patients. *Western Journal of Nursing Research, 28*(4), 383–391.

Natan, M. B., Beyil, V., & Neta, O. (2009). Nurses' perception of the quality of care they provide to hospitalized drug addicts: Testing the theory of reasoned action. *International Journal of Nursing Practice, 15*, 566–573. doi:10.1111/j.1440-172X.2009.01799.x.

Nduati, R., Richardson, B. A., John, G., Mbori-Ngacha, D., Mwatha, A., Ndinya-Achola, J., et al. (2001). Effect of breastfeeding on mortality among HIV-1 infected women: A randomized trial. *Lancet, 357*, 1651–1655.

Neumann, A. (1998). On experience, memory, and knowing : A post-holcaust (Auto) Biography. *Curriculum Inquiry, 28*(4), 425-442.

Nunn, B.V. (2005). Getting clear what hope is. In J. Eliott (Ed.), Interdisciplinary perspectives on hope (pp. 63-77). New York: Nova Science.

Palepu, A., Tyndall, M. W., Joy, R., et al. (2006). Antiretroviral adherence and HIV treatment outcomes among HIV/HCV co-infected injection drug users: The role of methadone maintenance therapy. *Drug and Alcohol Dependence, 84,* 188–194.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine, 57*, 13–24.

Patterson, M., Jackson, R., & Edwards, N. (2006).Ethics in Aboriginal research: Comments on paradigms, process and two worlds. *Canadian Journal of Aboriginal Community-based HIV/AIDS Research, 1*, 48–61.

Patton, M. Q. (Ed.). (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pearce, M. E., Christian, W. M., Patterson, K., Norris, K., Moniruzzaman, A., Craib, K. J. P., et al. (2008). The Cedar Project: Historical trauma, sexual abuse and HIV risk among young Aboriginal people who use injection and non-injection drugs in two Canadian cities. *Social Science and Medicine*; *66*(11), 2185–2194.

Peters, E. J. (2007). First Nations and Metis People and diversity in Canadian cities. In K. Banting, T. J. Courchene, & F. L. Seidle (Eds.), *Belonging diversity, recognition and shared citizenship in Canada* (pp. 207–247). Montreal, QC, Canada: The Institute for Research and Public Policy.

Phillips, G. (1999, November). *How we heal* [Online]. National Stolen Retrieved from http://www.freewebs.com/indigenous_sobriety/Aboriginal%20Australia/How%20We%20Heal%20from%20Adidictions%20and%20Trauma.pdf

Pinnegar, S., & Daynes, J. G. (2007). Locating narrative inquiry historically: Thematics in the turn to narrative. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 3–34). Thousand Oaks, CA: Sage.

Polkinghorne, D. E. *Narrative knowing and the human sciences.* Albany: State University of New York Press.

Public Health Agency of Canada [PHAC]. (2007a). *A comparative analysis: Strengthening ties – strengthening communities and leading together: Canada takes action on HIV/AIDS 2005–2010*. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/nacha/ca0-eng.php

Public Health Agency of Canada [PHAC]. (2007b). *HIV/AIDS: Epi updates*. Ottawa, ON, Canada: Author.

Public Health Agency of Canada [PHAC]. (2012). *People in Prison.* Retrieved from http://infobase.aspc-phac.gc.ca/aids-sida/pr/sec4-eng.php#footnote3

Public Health Agency of Canada [PHAC]. (2008a). *Summary: Estimates of HIV prevalence and incidence in Canada, 2008 info sheet.* Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/estimat08-eng.pdf

Public Health Agency of Canada [PHAC]. (2008b). *HIV and AIDS in Canada: Surveillance report to December 31, 2008*. Public Health Agency of Canada (Cat. No. HP37-2/2008-1-2E-PDF)

Public Health Agency of Canada [PHAC]. (2010a). *HIV/AIDS among Aboriginal people in Canada. HIV/AIDS: Epi update*. Public Health Agency of Canada (Cat. No. HP40-56/9-2010E-PDF).

Public Health Agency of Canada [PHAC]. (2010b). *Population-specific HIV/AIDS status Report: Aboriginal peoples*. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/aboriginal-autochtones/chapter-chapitre-3-eng.php

Public Health Agency of Canada [PHAC]. (2012). *Fact sheet: People in prison*. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/pr/sec4-eng.php

Public Health Agency of Canada [PHAC]. (2014). *HIV/AIDS EPI updates: Chapter 1: National HIV prevalence and incidence estimates for 2011*. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/pdf/EN_Chapter1_Web.pdf

Rabinow, P., & Rose, N. (2003). *The essential Foucault: Selections from The Essential Works of Foucault 1954–1984*. New York, NY: The New Press.

Richardson, B. A., John-Stewart, G. C., Hughes, J. P., Nduati, R., Mbori-Ngacha, D., Overbaugh, J., et al. (2003). Breast-milk infectivity in human immunodeficiency virus type 1-infected mothers. *The Journal of Infectious Diseases, 187*(1), 726–740.

Riessman, C. K., & Speedy, J. (2007). Narrative inquiry in the psychotherapy profession. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 426–456). Thousand Oaks, CA: Sage.

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research . *Journal of Advanced Nursing, 53*(3), 304–310.

Rothman, D. J. (1971). *The discovery of the asylum: Social order and disorder in the new republic.* Boston, MA & Toronto, ON, Canada: Little, Brown, & Company.

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research, 13*(7)*,* 905–923.

Sarnecki, J. H. (2001). Trauma and tattoo. *Anthropology of Consciousness, 12*(2), 35–42.

Schlosser, J. A. (2008). Issues in interviewing inmates: Navigating the methodological landmines of prison research. *Qualitative Inquiry, 14*(8)*,* 1500–1525.

Schnittker, J. & John, A. (2007). Enduring stigma: The long-term effects of incarceration on health. *Journal of Health and Social Behavior, 48*(2), 115-130.

Shannon, K., Bright, V., Gibson, K., & Tyndall, M. W. (2007). Sexual and drug-related vulnerabilities for HIV infection among women engaged in survival sex work in Vancouver, Canada. *Canadian Journal of Public Health, 98*(6), 465–469.

Smillie-Adjarkw, C., Larkin, J., Flicker, S., Restoule, J., Koleszar-Green, R., Barlow, K., Mitchell, C., & Mashing, R. (2013). HIV/AIDS, Colonialism and Aboriginal Youth in Canada: Implications for HIV prevention work. *Canadian Journal of Aboriginal Community-based HIV/AIDS Research, 5*(Winter 2013), 95-113.

Smith, D., Edwards, N., Peterson, W., Jaglarz, M., Laplante, D., & Estable, A. (2010). Rethinking nursing best practices with Aboriginal communities: Informing dialogue and action. *Nursing Leadership, 22*(4), 24–39.

Smith, L. T. (2006). *Decolonizing methodologies: Research and indigenous people*. London & New York, NY: Zed Books Ltd.

Spittal, P. M., Craib, K. J. P., Teegee, M., Baylis, C., Christian, W. M., Moniruzzaman, A., & Schechter, M. T. (2007). The cedar project: prevalence and correlates of HIV infection among young Aboriginal people who use drugs in two Canadian cities. *International Journal of Circumpolar Health, 66*(3), 226–240.

Sproule-Jones, M. (1996). Crusading the forgotten: Dr. Peter Bryce, public health, and prairie native residential schools. *Canadian bulletin of medical history, 13(2)*, 199–224.

Statistics Canada. (2005). *Canada's Aboriginal population in 2017*. Retrieved from http://www.statcan.gc.ca/daily-quotidien/050628/dq050628d-eng.htm

Statistics Canada. (2008). *Aboriginal peoples in Canada in 2006: Inuit, Metis, and First Nations, 2006 Census*. Retrieved from http://www.statcan.gc.ca/daily-quotidien/080115/dq080115a-eng.htm

Statistics Canada. (2013). *Aboriginal peoples in Canada: First Nations People, Metis and Inuit: National Household Survey, 2011.* Retrieved from http://www5.statcan.gc.ca/access_acces/alternative_alternatif.action?t=99-011-XWE2011001&l=eng&loc=http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.pdf

Tafoya, T. (2000). Unmasking Dashkayah: Storytelling and HIV prevention. *American Indian and Alaska Native Mental Health Research, 9*(2), 53–65.

Tait, H. (2008). *Aboriginal people survey, 2006: Inuit Health and Social Conditions* (Cat no. 89-637-X no. 001). Retrieved from http://www.cwlc.ca/files/file/Aboriginal%20Peoples%20Survey%202006%20(Inuit%20health%20and%20social%20conditions).pdf

Tang, S. Y. & Browne, A. J. (2008). 'Race' matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity and Health, 13*(2), 109-127.

Tempalski, B., Friedman, R., Keem, M., Cooper, H., & Friedman, S. R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States. *Geoforum, 38*, 1250–1263. doi:10.1016/j.geoforum.2007.03.012.

Tewksbury, R., & McGaughey, D. (1998). Identities and identity transformation among persons with HIV disease. *Journal of Gay, Lesbian, and Bisexual Identity, 3*(3), 213–232.

Thompson, D. (1993). *The Oxford dictionary of current English*. Toronto, ON, Canada: Oxford Press.

Thunderbird, S. *Medicine wheel teachings*. Retrieved from http://www.medicinewheel.com/

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388–396.

Tousignant, M., & Sioui, N. (2009). Resilience and Aboriginal communities in crisis: Theory and interventions. *Journal of Aboriginal Health, 5*(1), 43–61.

Trachtenberg, P. (1998). *7 Tattoos: A memoir in the flesh*. New York, NY: Penguin.

Trocme, N., Knoke, D., & Blackstock, C. (2004). Pathways to the overrepresentation of aboriginal children Canada's child welfare system. *Social Service Review, 78*(4), 577–600.

Truth and Reconciliation Commission of Canada. (2015). *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada.* Retrieved from http://www.trc.ca/websites/trcinstitution/File/2015/Exec_Summary_2015_06_25_web_o.pdf

UNAIDS/WHO. (2005). *HIV-related stigma, discrimination and human rights violations: Case studies of successful programmes. UNAIDS best practice collection*. Geneva: Joint United Nations Programme on HIV/AIDS and World Health Organization.

UNAIDS. (2007). *Policy brief: Greater involvement with people living with HIV (GIPA)*. Retrieved from http://data.**unaids**.org/.../2007/jc1299_policy_brief_**gipa**.pdf

UNAIDS. (2013). *Global report: UNAIDS report on the global AIDS epidemic 2013*. Report on the Global AIDS Epidemic. Retrieved from http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf

Van Uchelen, C. P., Davidson, S. F., Quressette, S. V. A., Brasfield, C. R., & Demerais, L. H. (1997). What makes us strong: Urban Aboriginal perspectives on wellness and strength. *Canadian Journal of Community Mental Health, 16*(2), 37–50.

Volkow, N. D. (2007). Drugs, brains, and behavior: The science of addiction. *NIH Medicine Plus, 2*(2), 14–17. Available at http://www.nlm.nih.gov/medlineplus/magazine/issues/spring07/articles/spring07pg14-17.html

Waldram, J. B. (1994). Aboriginal spirituality in corrections: A Canadian case study in religion and therapy. *American Indian Quarterly, 18*(2), 197–214.

Waldram, J. B. (1997). *The way of the pipe: Aboriginal spirituality and symbolic healing in Canadian prisons.* Peterborough, ON, Canada: Broadview Press.

Waldram, J. B., Herring, D. A., & Young, T. K. (2004). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto, ON, Canada; Buffalo, NY, & London: University of Toronto Press.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods.* Halifax, NS & Winnipeg, MB, Canada: Fernwood.

Wood, E., Montaner, J. S. G, Li, K., Zhang, R., Barney, L., Strathdee, A., Tyndall, M. W., & Kerr, T. (2008). Burden of HIV infection among Aboriginal injection drug users in Vancouver, British Columbia. *American Journal of Public Health, 98,* 515–519.

Worthington, C., Jackson, R., Mill, J., Prentice, T., Myers, T., & Sommerfeldt, S. (2010). HIV testing experiences of Aboriginal youth in Canada: Service implications. *AIDS Care,* 22(10), 1269-1276.

Young, R. J. C. (2001). *Postcolonialism: An historical introduction.* Oxford: Blackwell.

Zaccole, A, Ristoch, J, Barlow, K., & Seto, J. (N.D.). *Addressing homophobia in relation to HIV/AIDS: Final Report of the environmental scan 2004-2005. Ottawa, ON: Canadian AIDS Advocacy Network.*

Zakaria, D., Thompson, J. M., Jarvis, A., & Borgatta, F. (2010). *Summary of emerging findings from the 2007 National inmate infectious diseases and risk-behavior survey*. Retrieved from http://www.csc-scc.gc.ca/text/rsrch/reports/r211/r211-eng.shtml

Appendix A: Participant and Researcher Agreement

Research is a process between the researcher and the participant where we work together. As a participant you are allowed to ask questions and ask how the research and the research process can benefit or help you. As the researcher I will be open to talking with you about any of your concerns or questions in a respectful manner before and during the research process.

As a participant please write down or have me write down for you how you feel this research can benefit you and I will write my comments and a summary of our talk on this document. If we need more room we can use a separate page.

Participant's issues, concerns, goals, and/or expectation from the research	Summary of the discussion between the researcher and the participant

After going over this document with the researcher I _____ (participant's name) agree to participate in the research project entitled: A Narrative Inquiry into the Experiences of Previously Incarcerated Aboriginal Persons Living with HIV and AIDS. Anytime during the research process this agreement can be reviewed and changed.

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

Appendix B: Referral Groups

Elders

Elder Vicki Wilson
Elder Lorne Waditika

Health and Social Services

601 North Outreach Centre – HIV/AIDS support organization
Iskwew/Women Helping Women – provides support groups, counseling, and referrals for victims of abuse
Métis Addiction Council of Saskatchewan Inc. – alcohol and drug outpatient services, detoxification program, inpatient 28-day treatment program
Prince Albert Parkland Health Region Sexual Health Clinic – needle exchange program; HIV, hepatitis, and sexual transmitted infection counseling and testing; & outreach programs
Prince Albert Safe Shelter for Women – emergency housing for women and children who are the victims of domestic violence
Sexual Assault Services – sexual assault counselor and mobile crisis

Mental Health Services

Prince Albert Mental Health Centre – inpatient and outpatient services
Catholic Family Services – counseling for individuals, families and groups

Appendix C: Consent Form

Project Title: A Narrative Inquiry into the Experiences of Aboriginal People Living with HIV and Previous Incarceration

Principal Investigator: Anthony de Padua, doctoral candidate
Faculty of Nursing, University of Alberta
email: ********@********** Mobile: ***-***-****

Supervisor: Dr. Judy Mill, Faculty of Nursing, University of Alberta
email: ********@********* Phone: ***-***-****

Please read the questions below and answer the question by placing your initials in either the "yes" or "no" column on the right:	**Yes**	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached Information Sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity or chance to ask questions and discuss this study?		
Do you understand that you are free to leave the study at any time, without having to give a reason?		
Has the issue of confidentiality been explained to you?		
Do you understand who will be able to see or access the information?		

This study was explained to me by: _____.

I agree to take part in this study: ***Yes*** ___ ***No*** ___

_____ _____
Signature of Research Participant Date

_____
Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Principal Researcher
Date

The information sheet must be attached to this consent form and a copy given to the research participant.

Appendix D: Research Information Sheet

Title of Research Study:

"A Narrative Inquiry into the Experiences of Aboriginal People Living with HIV and Previous Incarceration"

Principal Investigator: Anthony V. de Padua, doctoral candidate
Faculty of Nursing, University of Alberta
Edmonton, Canada

Supervisor: Dr. Judy Mill, Faculty of Nursing, University of Alberta

Purpose: I am conducting this research study for my thesis work as a doctoral student in the Faculty of Nursing at the University of Alberta. The purpose of this study is to explore the healthcare experiences of previously incarcerated Aboriginal men and women who are living with HIV or AIDS. By listening to your stories I would like to be able to better understand your experiences with the healthcare system. Through your stories I will learn more about what you think is important about your own experiences with HIV and how you see the health care system. You do not have to join this study. Taking part is entirely voluntary or up to you. If you decide to participate and then change your mind, you are free to leave the study at any time. You may also refuse to answer any questions asked by me.

Procedures: Taking part will involve a number of conversations (at least 5 to 6), each lasting up to 90 minutes and this will occur over 2-4 weeks. We will discuss your history and your experiences with the healthcare system. With your permission, I will audio-tape our talks, but the tape recorder can be shut off at any time you like. I will also take notes at times about the things that I am seeing, hearing, and feeling. The conversations will take place at the Sexual Health Clinic or at another place that we agree on.

Confidentiality: Any information that is collected from you will remain confidential. Confidential means that I will not list or use the names of any people interviewed in any research reports. All information will be held confidential or private, except in the unexpected circumstance when professional codes of ethics or legislation (or the law) require reporting. In addition, if traditional First Nations knowledge is shared, people on my research committee will read over the information before I share it with anyone else.

In Canada, study information is required to be kept for 5 years. The information will be kept in a secure and safe area (i.e. a locked filing cabinet) in my office at First Nations University of Canada, Prince Albert. Even if you withdraw from the study, the medical information which

obtained from you for study purposes will not be destroyed. You have the right to check your records and request changes if your personal information is incorrect. Your name or any other identifying information will not be attached to the information you give. Your name will never be used in any presentations or publications of the study results. As the researcher I may write academic articles based on this study. Your name will be changed to protect your privacy. If you would like to be recognized in any future papers or presentations this can be discussed. The information from this study may be used again in the future to help us answer other study questions. Before we use the information for any other study questions an ethics board will first review the new study to ensure the information is used ethically or in a responsible way.

Possible Benefits: You can help health care professionals, like nurses, improve their work with previously incarcerated Aboriginal people living with HIV. The research may also help you reflect and better understand different areas in your own life.

Possible Risks: There should be no risks to you from your participation in this research. If you feel stressed out as a result of our discussions, I will offer to send you to a counselor or an Elder in Prince Albert.

Voluntary Participation: You are free to leave this research study at any time. With your permission, I will audio-tape our talks, but you may ask that the tape recorder be shut off at any time.

Reimbursement of Expenses: You will be reimbursed $20 for each visit, to cover incidental expenses such as transportation or babysitting.

If you have concerns about your rights as a study participant, you may contact the Research Ethics Office at (780) 492-2615. This office is not connected with the study investigators.

Sincerely,

Anthony de Padua

Anthony de Padua, RN, MSc, PhD (c) Doctoral Student Faculty of Nursing University of Alberta Phone: ***-***-**** Email: *********@********	Dr. Judy Mill (supervisor) Faculty of Nursing University of Alberta Phone: ***-***- **** Email: ********@********