Chapter 9

Taking the Medicine Wheel to the Street

Counselling Aboriginal Street Youth about HIV/AIDS and Educating Those Who Help Them

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It is difficult to credit that which we perceive as overwhelming with any sense of immediacy—it's easier to say 'why bother?'

—Ken Garnhum, from 'Beuys Buoys Boys', in R. Wallace, ed., *Making Out—Plays by Gay Men* (Toronto: Coach House Press, 1993), 85–7.

INTRODUCTION

Anyone who has become HIV-positive quickly learns that it is not simply a physical problem being experienced—there are always mental, emotional, and spiritual aspects influencing the quality and direction of daily life with HIV. So often it is not AIDS itself that is the problem (i.e., its medical definition), but rather what AIDS *means* inside the mind, feelings, and spirit that will affect the path of each person's journey while living with the virus.

Frequently, only the medical aspects of treatment or prevention are given attention, as if maintaining the body's physical health is the patient's sole responsibility, while far too often there is much less preparation for encountering, understanding, or coping with the numerous psychosocial issues that may also arise. The consequences of living daily with HIV and its resulting limitations not directly connected to medical problems, such as poverty or homelessness, are sometimes harder to deal with due to their more subtle and socially isolating nature. This is especially true for individuals without a strong emotional support system of family or friends.

Many youth have grown up with AIDS already being part of their reality during adolescence—it has been an unavoidable and integral part of their life rather than something new invading the emotional security of youth. For any young person, this could easily lead to feeling defeated before ever having had a chance to get started in life. Apathy and resigned acceptance are understandable responses to feeling powerless in the face of danger. Youth, who already assume a talisman of invincibility against death, seem to be facing the threat of HIV with an increasing attitude of inevitability.

For the several hundred youth in each major Canadian city who have left home environments too abusive or emotionally toxic to stay, or who have not managed to adapt to foster homes, living on the street is their only real alternative. Surviving by any means necessary within this desperate poverty and alienation becomes their total focus:

> If you're on the street, your primary needs are getting food and a safe dry place to sleep or you have to walk around all night. You need a place to live where you can rest without fear of being attacked or having your stuff stolen. Things like a bus pass and medical insurance help, too, as does money, but simply staying alive comes first.
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> Being HIV-positive is not so concrete a thing as eating and surviving; it can wait, unless you're sick. But when you're sick, it's hard to know if it's from eating out of dumpsters, drugs, street abuse, or what. So the idea that there's this slow-growing virus is no big thing—you'll deal with it later when the problem gets bigger. In the meantime, you just lock it away in a closet in your mind and keep focusing on more urgent things like getting food or a place to sleep for that night.
>
> My life's already been screwed by HIV anyway, so why should I worry about infecting a trick? He's using me; why should I care about him? Nobody ever did anything nice for me, except my brothers on the street—why should I have to look out for somebody else? If they demand a condom, fine; if they don't and I can get more money that way, why not? (R.S., 1997)

In the case of street youth, and particularly First Nations street youth (most of whom initially thought themselves invulnerable because rumour had it that only White men got AIDS), HIV is often considered just one more of many personal crises to be dealt with alone and outside the usual social support systems available to those less marginalized and more societally integrated. 'Aboriginals account for up to 70 per cent of the street youth population in many Canadian cities. Overt racism . . . makes already harsh living conditions worse for Aboriginal youth. It also makes it harder for them to escape the vicious cycle of disconnection from family, home, history, and culture' (Gilchrist, 1995, as quoted in Ker, 1995: 1).

Street youth are often involved in prostitution or selling drugs in trade for food or shelter, and substance abuse becomes a way to numb oneself against daily horrors or loneliness. Aboriginal youth are no exception:

> I remember watching my Mom go out the door and wondering when I'd be eating again, because there'd been no food in the house for a few days already. My Dad had just beat up on her, and when she left he started punching me. Me and my sisters ran into the bush and hid out until it was dark. I woke up hungry and wet, and decided right then to just keep away, and just kept going.
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> I came to the city with my friend and he taught me how to work the street. At least now I have a hotel room and can buy food and drugs. I don't do lots of drugs, just enough to keep me from being so afraid of the johns. (E.F., 1997)

This is a subculture with a value system quite different from those of young people securely tucked away in suburban homes with families who love them and schools that understand their needs. They are often the children of parents raised in the residential school system, whose cultural values were eroded by 'misplaced fixing'. Alienated by force from traditional ways, their only reality was marginalization and internalized racism—they were left little else of themselves and their life's purpose (Chrisjohn and Young, 1996). Self-esteem is usually close to being non-existent in most of the Aboriginal street youth I have encountered, as is even the concept of there being something called a 'self' in the first place, never mind one that has the right to be treated decently. As one such youth explained it:

> There was 'Indian', and there was 'White'—and an entire universe between them. I only knew what I'd lived, and that was, at least on my reserve, that 'Native' was real second-class, full of despair, danger, and no future.
>
> If you'd told me a few years ago that some day I'd come to a point where I'd feel some pride in my culture, I'd have laughed you off the street. No way! If I could have turned my skin white I would have, immediately. Now I'm beginning to meet guys like me who are succeeding and get respect, even though their skin is dark like mine—what a new concept! (N.S., 1997)

Who to trust and whose advice to believe are issues nearly insurmountable, and dependable role models who can bridge the gap between youth and social services, or medical personnel able to provide help, are even rarer for the Aboriginal street youth community (which in age actually ranges far wider than ages typically considered 'adolescence'—street 'youth' I have worked with have ranged from under 10 years old to sometimes past the late twenties). And it *is* a true community, family of affiliation and similarity supplanting birth family ties and replacing relatives' traditional influence. The individual's sense of obligation is to peers with whom he/she shares more in common.

> It's really frustrating because it always comes down to those things that happen: the alcoholism and sexual abuse that nobody wants to talk about. That's why we're running away. That's why we don't want to be at home. That's why we're going out and getting high so we can't feel anything, so we don't have to think about those things. That's why we're not where we're supposed to be.
>
> Because of that little piece of hell that we carry around inside that we don't want to talk about because nobody else knows how we're feeling. Yet everybody feels the same way. (Larkin, 1997)

Although Aboriginal street youth may report to non-Native medical staff for HIV-testing and treatment when there is an immediate medical crisis, large gaps still exist between current forms of delivery of treatment/prevention information and the ability of most Aboriginal street youth to understand and make use of those facts. When not in the doctor's office, most of these youth find HIV less of a priority than the basics of daily survival. When medical decline begins, they have less knowledge of how to access treatment, less successful experience doing so, and less awareness of the importance of early intervention and active partnerships with doctors.

Although, ideally, 'it is important to establish an environment of trust in which information is shared and decisions are made jointly' (Peterkin, 1996: 27), for most urban Aboriginal street youth, approaching their own health care proactively and trusting medical professionals are simply not activities they are familiar with, and so they most often deal with HIV by denial, procrastination, self-sabotaging behaviours such as substance abuse to numb or distract, and/or unabated despair:

> Teens aged fifteen to twenty-four . . . have a suicide rate three times higher than the rest of the adolescent population. . . . The role of self-esteem in the practice of safer IV drug use, alcohol abuse, and sexual behaviour is critical. . . . Abused children . . . who run away to urban centres are at a high risk for prostitution and IV drug use; such individuals have very little concern for their own safety, as they have never experienced it in the past, and have no perception that they are of any value worth protecting. (Pow, 1997: 5–6)

Peers may provide some relief but are rarely factually informed enough to provide practical help. And many simple basic facts, such as the possibility of long-term survival or that some bothersome ailments are curable along the way, are rarely available (or believed) on the street.

An HIV-positive diagnosis is an emotional rape, a violation of a person's innocence, of his/her guarantee of a future and the right to health. Once diagnosed, HIV becomes part of everything else the person does and plans and thinks about, always there, even if not always in the foreground. People with the virus become eternally vigilant for even the slightest sign of poor health, and *nothing* can replace that loss of innocence and turn their lives back to what they were like before. Feelings of helplessness and seemingly intolerable levels of anxiety become part of daily life; feelings of shame, of 'feeling dirty' or unworthy of the caring offered by friends or family, can complicate sharing the stresses even further. One youth explained it as HIV always being there, riding along on his left shoulder, whispering in his ear.

Helping these youth is difficult, but not impossible. It has become obvious to those trying to provide psychosocial or medical support that, to help most street youth change HIV-related behaviours or take more responsibility for better self-care of their health as they try to survive AIDS, methods different from those used in treating mainstream, middle-class, well-educated youth need to be found.

More precisely, an environment needs to be created that will permit these youth to initiate a desire for learning more about preventing or living with HIV, where their feelings and fears can be expressed safely and received with respect and lack of judgement by both peers and counsellors, and where need for changing behaviours or self-perceptions can be perceived as being self-initiated and done from a position of strength rather than from shame or weakness.

Very simply, they need a 'home base' where they can learn that they are not alone, where role models successful at dealing with HIV can be found *from within their own culture,* a group of people like themselves who can be trusted to help each other out and not divulge confidences shared. This need is no different from anyone else living with HIV—but it has been my experience that Aboriginal street youth do not usually initiate the founding of formal support groups. Some of them are so estranged from their communities and families that they may not even be aware of resources for counselling, visiting, or traditional healing available to them as part of their rights as band members (Peterkin, 1996: 35). Others who are non-status or Métis have no idea how to avoid being trapped in between the various support systems and need help with discovering resources they have a right to access.

Long before modern technology and scientific advancements resulted in Western medicine's current emphasis on treating specific isolated parts of the body without equal attention to its inseparable wholeness, many indigenous cultures have a long history of not making any distinction between physical healing and spiritual healing, and this is certainly true for most First Nations world-views. Many doctors and scientists are now beginning to return to focusing on these less tangible kinds of mind-body connections, as demonstrated by the growing interest in fields such as psycho-neuroimmunology. Attention is finally being paid to the evident effects of people's emotions, thoughts, and attitudes on their state of physical health and the ability of their immune systems to mobilize healing.

However, most Aboriginal people never believed otherwise, and although urban street youth may be geographically far removed from their home communities, their roots are still deeply there, even if only in rebellion to traditional ways. Because of this, some of the teachings their families have long used can still be put to effective use in the city and on the street, as long as they are presented in a non-preaching, non-judgemental, and non-coercive manner.

More specifically, two aspects of traditional Native healing practices have been used directly or indirectly for the past few years with Aboriginal street youth in Vancouver and other cities by counsellors doing group and/or one-to-one work with them (although not often in the usual kind of office or agency setting): (1) *the Medicine Wheel,* the traditional model adapted as a framework for teaching information about AIDS prevention, treatment, and self-care,[1] as well as a focus for discussion and counselling about related life issues; and (2) *the Healing Circle,* a regular (usually weekly) drop-in opportunity to share, to be listened to with respect and without judgement, to learn factual information as a serendipitous by-product of the process, to encounter healthy Aboriginal HIV-infected or affected role models, and probably most importantly, to find peers and counsellors who can be trusted and counted on for help outside the Circle event itself.

As well, both of these have been used conceptually as teaching models in various programs to train and sensitize counsellors, youth workers, and others about the different subtleties HIV/AIDS might present in the lives of their future Aboriginal clients. Of course, implications also exist for the counsellors' own self-care, especially if they are Aboriginal themselves.

Although the examples in this chapter arise from my personal experiences in counselling and teaching, this is not meant to suggest that Vancouver is the first or only place that such models have ever been used. Medicine Wheels and Healing Circles have been part of traditional teachings for centuries prior to any cities' existence in Canada, and numerous agencies across Canada (such as Healing Our Spirit BC First Nations AIDS Society in Vancouver, Manitoba Aboriginal AIDS Task Force in Winnipeg, Feather of Hope in Edmonton, Atlantic First Nations AIDS Task Force in Halifax, and others) have used these and other traditional teachings, such as the Teaching Turtle (McLeod et al., 1996), as models for successful interventions with Aboriginal street youth for many years prior to my having started my specific work with them.

I wish to be clear that the cultural information summarized below did not originate with me, but rather is my best attempt at distilling and sharing learnings from a variety of teachers, such as Leonard Johnston and Frederick Haineault, who were the first to use the Wheel for HIV/AIDS education when they began Healing Our Spirit in 1991, and Dolan Badger (a recent educator for that organization, who clarified many of its details for me), and also from the many clients and friends whose teachings through informal encounters provided me the best opportunities to learn through personal experience.

It is extremely important to note that there is a big difference between my becoming sensitized to the cultural information that helps me to better help my clients (and myself) and my assumption that this awareness now gives me an inherent right or role to present this information as if I now 'own' it. I am the student here, and I am not Aboriginal, nor do I wish to pretend that I am. However, this is the community in which I feel most at home and prefer to be. I help any time that I am asked or invited to, but this is far different from assuming that help is needed before it is asked for, or that I have a right or obligation to inflict my ideas just because I might be well intentioned.

It is with deep respect that I offer reflections on what I have learned so far, in the hope that this may help others—but I am not suggesting that people like me should take on any active sole-leadership roles in activities like the Circle described below. Sometimes the best kind of help that can be offered is supportive silence and background 'invisible' helping. Most Aboriginal people I know are tired of Euro-Canadians assuming Native People are not educated in the first place just because they have been educated differently.

> It is not suggested that non-Natives presume to teach Aboriginal youth about their world, but rather that non-Natives need to become more sensitized not only to the reasons that such awareness is so vitally necessary, but also to the reasons that it really won't work for them to be doing this activation from their inalterably outside position. (Fife, 1997)

THE MEDICINE WHEEL

Explaining the Medicine Wheel as 'a traditional conceptual model for teaching numerous understandings about life' is a *vast* understatement of the fullness and

richness of its meaning to the many First Nations people whose cultures use it as a rich source of knowledge about the cycles, rhythms, and meaning of life itself. Its significance lies not only in the concepts its framework maps, but also in their interrelatedness and further connections to other levels of living and being.

The Wheel, also known as the 'Circle of Life' or 'Cycle of Life', represents time and seasons of nature and humans, demonstrating their connection to Mother Earth and to the lives of all inhabiting and being nurtured by her. It also describes the parts of a person that exist within the reciprocity of other parts, as well as their goal of harmony and relationship—and thus also shows the path towards healing by striving to better balance all the aspects to the greater good of the whole-beyond-its-parts.

The model is an unbroken circle, ever cycling in life's eternal revolutions; the goal is not to drive out disharmonious or potentially destructive parts, but rather to encompass them as natural contrasting components coexisting within the larger, flexibly adjusting balance. ' "Evil" cannot be eradicated, but turned into something that is more in balance with the universe, and indeed, the universe would not be in balance without the "Evil".... Evil doesn't disappear ... it takes on more manageable form that a person can live with on a daily basis' (Tafoya, 1997: 2).

Along with the traditionally important symbol of a wheel, a circle, a full wholeness of cycles, the number 'four' assumes a powerful place in most Aboriginal cultures, playing an important role in every aspect of being. The Medicine Wheel encompasses many interrelated levels of the four aspects of things; for example, the four directions (East, South, West, North), each representing cycles of seasons and stages of life, each with its own animal symbols and spirit colours connecting to the natural aspect it relates to, or as another example, the four races (red, yellow, black, and white). Over time, occasional variations have evolved between different descriptions of the Wheel, depending on each Native nation's tradition of application, so the following examples (from Cree teachings) may not match other models exactly, but all Wheels have a similar overall structure and content. The details may vary from nation to nation; what is most important is that the concept of the Wheel and the way it is used is known to all.

At the right is East, which begins the quadrant of yellow (daybreak), turning next to South. From South to West is white (high noon when the sun is at its hottest), moving to West. From West is red (the colour of the setting sun), and the final turning is to North (black for night).[2] These are also seasonally representative from the new yellow-green young growth of spring, the dry high sun of summer, the autumnal colours of leaves, and the dark long nights of winter and nature's resting.[3]

The Wheel also describes the four stages of human life (child, youth, adult, and elder) as well as the four aspects of life itself (physical, emotional, mental, and spiritual). These four aspects are part of every individual, whether or not the person actually accesses them or is consciously aware of their internal existence.

East to South is child/physical (children being very active, touching and experiencing all things as directly as possible). From South to West is youth/emotional (adolescence being well known as a time of turbulence with strong body/emotional changes). West to North is adult/mental (a time for more rational, cognitive experiencing through thinking), and North back again to East is elder/spiritual (like winter, time for endings and rebirth, as Mother Earth prepares once again for separating, and then rejoining, spirit and matter).

Each stage and each aspect of human life is necessary for the formation of a fully healthy person; to neglect or diminish the worth of any of them throws health and/or life itself out of balance. To be whole, each aspect needs specialized attention for growth and healing, and each needs to be focused on every day of one's life. 'There is not just one fixed "correct" traditional Medicine Wheel—it's a learning tool where different peoples have adapted it to fit their own particular culture. . . . It's not each exact detail that's so important as the recognition of the whole, that the Wheel is universal . . . that we are all on that Wheel together, and the transitions are not fixed passages' (McLeod, 1997).

Most First Nations also have some tradition of using smoke from burning special plants as a means of cleansing, purification, grounding 'negative energy', keeping away harmful spirits and welcoming in good ones. This smoke-covering/bathing ritual, often called 'smudging' (also sometimes called 'brushing' or 'wiping', since an eagle feather is usually used to rhythmically move the smoke around), is used to clear and harmonize the physical environment (including one's body), and is also often done to prepare a room, or the people in it, for special events, ceremonies, or discussions to occur.

The substances used in smudging (the 'medicines') differ among various Native nations, particularly those geographically separated, but there are traditionally also four of these medicines, each representing one of the four directions (though, again, each nation will have evolved its own unique variations over time): sweetgrass from the East, sage from the South, cedar or tobacco from the West, and from the North, a fungus that grows on the north side of weeping willows.[4]

People of many (but not all) Aboriginal nations will be accustomed to smudging themselves and/or brushing their environments with different medicines, depending on each nation's cultural traditions. Those nations whose traditions do include smudging will usually begin ceremonies (including Healing and other kinds of Circles) with each person being offered the opportunity to take part by smudging themselves either as they enter the door or in turn around the Circle as they stand at its beginning. Even if a particular medicine is not available in a specific territory, or if people of a particular nation do not smudge at all, most are still aware of what others have traditionally used, even if not done that way in their own territory. Again, it is the process and overall concept that matters more than any particular details.

The Medicine Wheel also must be conceived of as an integrated whole that is so much more than the sum of its individual parts. All four aspects and the quadrant areas connecting them have a place on the Wheel and are deeply interconnected. Every part is needed to complete the whole, yet each is different. Each provides context for the others but all are not the same. They connect through the middle, as well as through each other, since even the centre is made

up of all parts without them losing their distinct identities even while blended. The full model must be conceptualized in a minimum of four dimensions.

Thus, each aspect of life is an integral part of life itself, which cannot continue without all of them doing their parts to keep the entire wholeness alive, healthy, balanced, nurturing, and supportive of life itself. People are their own agents of healing, and the goal is to attain balance not only among all the parts but also in their relationships with others. 'A person is a mental, emotional, physical, and spiritual being who grows and changes through the existence of vision and will. All these relationships affect each other' (Young and Paul, 1995: 100). And when HIV/AIDS is perceived through the Medicine Wheel's framework, implicit in the middle where all these connect in wholeness and balance can be found the immune system, functioning as a natural fusion of mental, emotional, and spiritual with physical.[5]

Similarly, in the circle of individuals, families, and communities, everyone is a part of the Medicine Wheel of life. Each is somehow different, yet equal, and each is needed to form the whole, like individual links in a chain joined together even though no two are exactly alike. In terms of using this model in HIV/AIDS treatment and education, this message also carries the signal that even though people's HIV status might make them 'different', all persons living with the virus are nevertheless part of the circle and should not be excluded. This also subtly signals that discriminating against some people, cutting their links with others based on their differences, will break the chain and leave the Wheel no longer whole.

Although not all Aboriginal cultures use the Medicine Wheel, they certainly incorporate aspects of its underlying concepts and teachings in their daily lives. Therefore, even though Aboriginal youth may come from nations where the Wheel was not part of their upbringing, they nevertheless will understand what it is about, even if only at the deeper level of collective unconscious. And using it is a way to join together street youth from east of the mountains with those with whom they might not initially think they would share much in common. Finding these deeper connections can be a beginning towards reunification with cultural traditions and the family ties bridging them.

Aboriginal people's traditional sources (and definitions) of help usually involved relationships with nature, spirituality, tradition, and culture (which, in their world-view, were much the same anyway). 'In western culture, children are shaped with values to help that individual strive for individualism. The Aboriginal prepare and mould their children through a process of collective consciousness, within a world where they can see their relationships to all life: human, animal, and plant' (Young and Paul, 1995: 107). Healing was traditionally more collectively oriented and focused more on reconnections with others, rather than on individual ego-accomplishments, and even today people seem to be returning to nature, spirituality, and family to heal and find balance in their lives (McCormick, 1995).

Non-Natives need to realize that Aboriginal thought process, philosophy, and world-view are intrinsically opposite to most Western/European/non-Native values and ways of thinking: 'We are non-linear in our thinking, which is directly

opposite to the way that most social workers are educated. Furthermore, to us, *relationship* is central, not our accomplishments or the material world' (Fife, 1997).

THE MEDICINE WHEEL AS A MODEL FOR AIDS EDUCATION

The Medicine Wheel has proven to be a useful model for teaching about HIV and its progression, as well as a method of explaining why prevention and treatment efforts must be aimed at the whole person (and at all four races!), not just at their medical symptoms. As Leonard Johnston explained it, the four stages of the medical model commonly used to explain the progression of the virus once it enters a person's body can be seen to fit quite well into the parts of the Medicine Wheel.

Window period. Starting in the East, where there are new beginnings and new experiences, the virus gets into our bodies and, like a little child, it wants to touch everything and get into everything, exploring everywhere it can find. Like a small child, the virus is very physical, but with its effects reaching not much farther into the world than its own personal sphere of influence. At this stage, a time of innocence, most people do not even realize they might have been infected and may, in fact, be unknowingly infecting others through high-risk behaviour (or, they are so angry or desperate that they don't care who they infect).

Asymptomatic stage. From the direction of the South comes involvement with the here-and-now, like a youth exploring everything in the immediate world around them, but not yet aware of larger influences of the complex world surrounding it. It is at this stage that the person finds out that they are HIV-positive, and it becomes a very emotional time as one confronts one's own mortality (often for the first time). A wide range of feelings erupt, such as anger, fear, loss, hatred, self-hatred, apathy, isolation, shame, denial, sadness, anxiety, and many others. Like a youth who is dealing with the pressures of growing up, the infected person experiences these numerous complex emotions and becomes similarly self-absorbed. It is at this stage that an HIV-positive person may appear fine and feel healthy, but nevertheless, the immune system is slowly being broken down.

Symptomatic stage. From the direction of the West comes reflection and contemplation. The virus has slowly broken down the immune system, and it is getting harder and harder to fight off common infections. Signs of sickness may have begun to appear, and the person usually wants to learn more about what is happening to their body. For some people previously unaware they had been infected, the appearance of various HIV-related illnesses may be the first time they even realize the virus is inside them.

This is the stage where mental processes start to become more active, where people often try to educate themselves and those around them about the effects of the virus, and where they try to mentally adapt to internal emotional and physical changes. They try to deal with it rationally, but this is usually not enough by itself.

This is the adult stage, often accompanied by increased responsibilities and commitment to struggle to assist and educate others as well as self. People begin to take stock of their lives, to deal with unfinished business and relationship dif-

ficulties, to mend broken ties or unmet obligations, as a means of 'preparing the way' and beginning to try to understand their particular life's journey.

AIDS stage. From the direction of the North comes understanding, wisdom, and often, acceptance of inevitable decline. The virus has broken down the immune system so much that the body develops various life-threatening opportunistic infections. Treatment drugs may help for a while, but for many people these do not succeed forever, and so death approaches closer, faster. Much like elders realizing the end is drawing near, people dying from AIDS-related causes often gain in wisdom as they begin to look inside and contemplate the larger aspects of life. It is not uncommon for earlier anger, fear, denial, or bitterness to give way to more peaceful resolution and readiness for whatever will come after physical death.

In this stage, people who are HIV-positive begin to review their life's path and reflect upon what they have accomplished, who they are, and how they have affected others, as well as what might still be necessary for completing the final steps towards resolution and closure. It can be a time of understanding what one's value has been and for discarding less meaningful things or feelings.

Death may not be 'the end', but it is a termination of this particular journey, and this can give much reason to examine its meaning. It is at this time that spirituality frequently increases in importance, along with a return to more traditional roots and ceremonies. Contemplating one's death is rarely easy, particularly for youth who may still carry the blush of invulnerability. But all elders are not necessarily aged, and some youth become quite wise as they approach the end of their current life path.

Going through the stages. Just like the maturing of a human being, this path/progression is not a smooth linear one but one of frequent backsliding, of reaching one stage while perhaps still feeling part of an earlier or later one, or even sometimes of being in two stages at the same time. Growing older is not a simple step-by-step progression, and sometimes the journey pauses a long time before getting moving again. Everyone travels the wheel at their own individual pace; so, too, life with HIV!

Viewing AIDS from a Western/European medical model, we appear to see a linear decline downward towards death—which is usually viewed primarily negatively, as if a disappointing failure or defeat. One message of viewing life alternatively as a continually turning circle is that things can be seen as not inevitably proceeding down some straight-line path to a finishing point (after which there is nothing), but rather a model whereby death can be seen as being an integral part of life still ongoing. Ending is also beginning, and the spirit continues onward even though we have no explanation for this from within the limits of our human knowledge. It is all a cycle: the body goes back to Mother Earth and new things grow from it, while the spirit and the circle continue onward.

HEALING CIRCLES

The Healing Circle is a way for a group of people to meet together for support and problem-solving in a manner in which each participant is on equal footing

with the others. It is a 'Circle' because all people are seated in a big circle,[6] so that there is less power imbalance among all participants and all can learn from each other. Someone may initiate calling the Circle together, but it is a true circle with no teacher-student foreground/background prioritization.

All listen to whoever is speaking, without interrupting. Each person speaks only for themselves alone, owning their feelings and making 'I' statements rather than trying to speak for other people. The speaking travels around the Circle clockwise as many times as needed, with no time limit set, but although one has the right not to speak, no one can be interrupted once they have started talking.

> There is no set time length for sharing circles; you stay however long it takes. This is part of the discipline. So you need to be aware of the time factor about sharing circles, that they can take as long as they want, that they *are* a natural rhythm, and that silence is still participation too. Silence is a way of communicating—even if people are not talking, they are still an active part of all that is happening. (McLeod, 1997)

To symbolize visually each person's right to speak in turn, some iconic object is usually passed from speaker to speaker, such as an eagle feather, special stone, or talking stick—whoever holds this may speak uninterrupted until deciding to pass it to the next speaker. Talking, Sharing, or Healing Circles in any Aboriginal tradition may differ slightly as to specific patterns or rules (such as how many 'rounds' occur); however, similar to Medicine Wheels, their concept is still used in most First Nations communities.

> A Circle is a universal way of celebration, a way for us to look at ourselves as an entity. We call the attention of the Creator through drum and song and prayer. We are presenting ourselves to the Creator in this way, so it doesn't matter who you are. We are celebrating that we exist; it's a celebration of all on the physical plane, that all that has been created is good and there should be no shame. Reality is what is there—it is not to be judged; all is sacred. In any Circle, there is no preconceived idea of what will come from it. If the elements are there, then when they come together there *will* be answers in the Circle. So you must come without expectations. You're there to receive whatever will come. (McLeod, 1997)

HEALING CIRCLES FOR ABORIGINAL STREET YOUTH IN VANCOUVER

For many months, I was involved with a weekly Circle (support group) for Aboriginal street youth in Vancouver, which can serve as a good illustration of applying the above concepts to real-life situations.

This group began its meetings initially as a result of the AIDS-related deaths of several youth within a three-week period and the resulting effects on their friends. Their formal memorial services had been well attended; several youth had spoken caring messages at the services and expressed some of their feelings. But once these

were over, there still seemed to be a need to grapple with the despair and emptiness felt on the street by both street kids and various youth counsellors—there was a general feeling that something else was needed to honour the deceased in a way that marked their passing in a meaningful and more positive way.

Since two Aboriginal street youth workers, Dolan Badger and Greg Scofield, had just begun a group for HIV-positive Aboriginal street youth, they decided to try the approach of calling an evening Healing Circle for the HIV-affected street community, including counsellors and other workers, as a way to help everyone process what had been happening. 'It was better when they opened the circle wider; there was more of a family feeling that way' (Eagles-Claw, 1997).

For most street youth, there is no family other than themselves with whom to grieve a death and share the turbulent feelings of being left behind by those who have passed on, while they must still try to survive a daily life that is often quite brutal. Yet it is often at times like this that they search their memories to grasp traditions long ago rejected, in some awkward attempt to 'do the right thing' ritually, even if unclear on its actual details or reasons. Doing something is preferable to doing nothing, and anything that feels at all right can provide some amount of comfort:

> Group ritual provides a structure for powerful open expression of emotion in a way that is not uncontrollable and overwhelming to those involved. It also provides a community-sanctioned role for the participants . . . [and it] moves us from stranded individual confrontation with unknown forces to community participation in their harnessing and adaptation. (McKusick and Tafoya, 1992: 5)

Although each youth attending was not necessarily familiar with various components of a traditional Healing Circle, such as smudging, opening prayer, singing songs, passing the eagle feather to each speaker, and so forth, every one of them had memories of having seen such things before, or at least of hearing about them from their elders, even if many years earlier.

The Circle provided a way for these youth to connect with each other on common ground, even though they might come from different backgrounds individually. And the informal environment certainly felt more like home than the fluorescent-lit funeral parlours from earlier in the month or the agency offices of counsellors trying to help each individual client in isolation from their circle of friends. Non-Native people were also welcome to attend, as long as traditional ways were followed. Some of these were other youth, while others were their counsellors—but all were equal in the group since all were attending for personal rather than professional reasons, and this had its own benefits in keeping things Aboriginal-focused.

Although the Circle was initially conceived of as a one-time event, those attending requested to meet again on a regular basis, and so a weekly Circle for HIV-infected or -affected First Nations street youth was born. The group continued for many months under the leadership of Dolan Badger and with the background involvement of myself, a non-Native psychologist and art therapist who has been counselling HIV-positive, gay and two-spirited First Nations people (most of whom are street-involved) for the past eight years.

I attended the weekly group but stayed less active than the Aboriginal leader(s), often just listening intently unless I had something personal to share (a Circle is *not* a therapy group needing any 'outside expert' guidance!). Instead, I was connected through being permitted to hear the experiences, thoughts, and feelings shared by youth, who then would frequently seek me out for more private individual counselling regarding how to handle what personally/emotionally arose during their Circle sharing. The weekly gatherings varied in group size, usually containing about a dozen 'regulars' and a random dozen or so more who dropped in for most but not all of the evenings.

For street youth, this type of attendance record can be considered a success, especially when this became obvious from seeing them together outside the group in mutually supportive situations, such as going together to funerals or AIDS information evenings, which previously they would not have considered risking attending alone. They finally had an environment where it was all right to talk about HIV—and acceptable to discuss, or even show, their feelings. The Circle became a safe place, a family whose members were now traditionally related and 'raised', not unlike traditional family training or upbringing:

> Throughout the years that Aboriginal youth become street-involved, there are wide gaps that separate each majority group. It all differs depending upon which category and first friends you knew and hung around with (such as drag queens, trannies, fems, straight or gay, butch, s & m, lesbian, alcohol and/or drug addicts, *and most importantly, street-involved or not*).
>
> Each person would recognize one another by gestures, but interaction was non-existent. Each category deeply expressed their family values, taking on family roles such as mothers, daughters, sons, aunties, and so on, and we would adopt any newcomer to the scene and take them under our wing.
>
> As violence accelerated in the streets, each family branch slowly combined together to make a more larger support system, which, with the healing circles, gave the opportunity for them to educate and experience themselves in the various needs, lifestyles, and family network that each group possessed.
>
> Healing circles were an ideal place for them to grasp and take in the knowledge that each group possessed in a non-judgemental, open-minded, and safe environment outside the street and bar establishment. (Eagles-Claw, 1997)

Without the Aboriginal 'activators' the Circle could not have happened, but neither they nor I presented (or even considered) ourselves as its 'leaders'—each week the group found its own topic evolving and its own goals being planned naturally. We found that our presence in the Circle or in more private encounters with the youth individually was not solely in the role of counsellors, but also, since we were members of the Circle ourselves, we were 'practically family'. In speaking just as human beings instead of facilitators, our own stories taught and our ears learned from lessons taught by the stories related by the youth around

us—it turned out that it was not just the youth who learned more about the effects of HIV on daily life and found some much-needed healing!

In seeing their role models express feelings and demonstrate skills needed for self-care and processing personal grief, the youth learned more about how their own feelings and problems were connected and new ways to process AIDS-related losses in a context of understanding and support. These are good skills to have learned, and are especially effective because the learning happened as a natural process instead of a planned lesson. In the fullness of the Circle everyone, including facilitators, gave as well as received, helped as well as learned, and formed bonds for surviving when solitude was not able to provide answers. It was another lesson on the journey to self-esteem and self-trust that these youth needed in order to be confident enough to request information, seek treatment, and trust medical professionals if only they were willing to risk trying.

USING THE MEDICINE WHEEL FOR REACHING STREET YOUTH

We found the Medicine Wheel model useful not only as an underlying conceptual model for AIDS-related helping and teaching, but also actively helpful as a visible reference for stimulating discussion or self-reflection in both private individual counselling sessions and in the Circle/group.

I believe that the success of this group demonstrated that adapting traditional rituals and practices, such as the Medicine Wheel, Healing Circles, smudging, and so forth, to both street culture and current issues of HIV awareness and self-care, can result in clients' increased sensitivity to HIV-related medical, emotional, and spiritual needs, as well as better self-respect, self-empowerment, awareness of cultural and spiritual roots, and thus healthier lifestyles. Not insignificantly, their willingness to use existing medical services and help peers do the same increased as a result of these traditional practices and ceremonies.

Various other workers have also confirmed that the youth in the group, in addition to regularly attending the weekly Circle, began not only to improve their record of keeping medical and counselling appointments, but also to take a more active role in these sessions, demonstrating more sophisticated knowledge and greater interest in maintaining better health care for themselves and their peers. More than a few times we were pleasantly surprised to find one of 'our' youths being already aware of an upcoming AIDS information session or conference event we wanted to alert them to, or spontaneously offering to go along to speak 'from the heart' when we mentioned teaching various workshops to AIDS counsellors-in-training.

And although these youth could not be expected to become medical experts or prevention specialists overnight, we were pleased to note the increasing occurrence of the occasional medically correct statement or clean-needle lecture being spontaneously delivered by one or another of these youths to peers outside our Circle. All of these may be small measures of success, perhaps, but they are still important steps on the path to taking care of oneself and not harming others.

It is important to recognize that our group was not unique. All across Canada for many years different AIDS agencies and organizations have been using different approaches to try to reach youth, and some of these approaches will work with any young people seeking survival and family on the street. Many Aboriginal AIDS organizations have had similar groups ongoing for years, and I encourage readers to contact those listed at the end of this chapter for their stories and advice. 'It is important for social workers to educate themselves about existing Native organizations, and their various approaches, in order to refer clients appropriately. Not knowing about them is no excuse; "not knowing" is far too often a matter of simply "not caring enough to find out" ' (Fife, 1997).

USING THE MEDICINE WHEEL TO TEACH YOUTH COUNSELLORS ABOUT HIV/AIDS

As explained previously, the Medicine Wheel can be an excellent model for teaching many things about life and has been used successfully by many Aboriginal AIDS organizations as a foundation for integrating AIDS-related information into a culturally appropriate context and providing a less threatening educational framework for getting these urgently needed facts into a community usually resistant to such attempts. And I have just discussed above how well these concepts succeed when applied to working with Aboriginal street youth.

So when I received a request from the Native Youth Worker Training Program (of the Urban Native Youth Association) for Dolan Badger and myself to share our HIV-related knowledge, counselling experiences, and intervention methods in a six-day course for counsellors-in-training, I knew that much more needed to be taught than just the usual 'AIDS-101' medical facts or prevention information. To teach only the physical/medical aspects of AIDS would have provided a good start, but this by itself would not have been sufficient, in that doing this would neglect the complex psychosocial, emotional, and even spiritual issues involved in understanding how HIV affects the whole person. Counsellors hoping to help those living with HIV must be taught how these other factors directly influence the way the virus is experienced physically, especially when considering AIDS in Aboriginal communities, even urban ones.

The Medicine Wheel model was an obvious vehicle for teaching the subject matter. As well, its concepts were important at a meta-level as the foundation for planning the course layout as an integration of such applications. Balancing the components of the Wheel in scheduling the topics and experiential components each day of the course would automatically produce a comprehensive training package that would include all aspects necessary for understanding the numerous interrelated complexities involved. The students would encounter learning in all four quadrants and have personal experiences from each part, which would help them integrate cognitive learning with their own individual discoveries about feelings, beliefs, and attitudes. And they would better understand, viscerally, the interrelationships involved in people's resulting behaviours and consequences.

The course was taught to 25 students ranging in age from late teens to mid-forties, and from almost as many different Native nations, who were midway through their 10-month training to become Aboriginal youth workers. Some were deeply spiritual; others culturally urban and not practising any of the traditional ways. Their diversity reflected the complex mixture of youth they would later be encountering as clients.

The model of delivering information during this course was conversational rather than formal lecturing, and was done in a Circle format where the two of us sat among them (and usually not next to each other). Although there were six full teaching days, these were scheduled across several weeks, so that there was time to absorb the information without being overwhelmed and so that questions could emerge naturally. Each day began with a smudge and a checking-in around the Circle to see how people were and what they wanted from the day. The first day this was done more formally, with people introducing themselves and where they were from (both familially and geographically), and sharing what they chose to about any HIV-related personal experiences. They were told that all their questions would be answered by the end of the course, but that the first day was for focusing on the other-than-medical aspects because these were needed first in order to make use of the factual parts taught later, and that this schedule reflected the way things usually happen naturally—emotionally before medically.

I co-ordinated the first day, which was oriented totally to psychosocial issues (such as the feelings at testing or diagnosis, family concerns, partners and children, what happens after death, and so forth). Students learned about these cognitively in the morning and experienced many of them during the afternoon, when they not only viewed and discussed videotapes of Aboriginal people living with HIV talking about their life experiences, but also had some private time with their inner thoughts and feelings during an 'art-therapy' kind of assignment for which they were asked to draw what HIV/AIDS means to them. After drawing, they could volunteer to discuss why they drew what they did, what it meant to them, and how they felt. At the end of the day, they discussed in the Circle how there were more mental, emotional, and spiritual elements to HIV knowledge and treatment than they had realized, and how this might affect not only their work, but their own personal lives.

The second and third days were given over to basic AIDS information and were taught by Badger, based on his past work as an Aboriginal AIDS educator. The Medicine Wheel was used throughout, not only for explaining the stages of AIDS but also as a model for integrating the physical with the other components.

Throughout this course, we collaborated in presenting the information, with an easy conversational tone, and deferring to each other when not knowing an answer. On days one of us co-ordinated, the other still took active part. In this way, our major cultural differences were openly acknowledged, yet treated respectfully. Thus, our comfortable interchanges served as a clear message that cultural differences can coexist and be noted when they make a significant difference, but also that there is benefit from using the best of both worlds without this difference devaluing or threatening either one of them.

On the fourth day, we returned to more personal integration of fact with feeling. The morning consisted of guest speakers from various Aboriginal AIDS organizations and agencies: an educator and client counsellor from Healing Our Spirit; an educator from the BC Native AIDS Awareness Program; the Native social worker from St Paul's Hospital; an educator from the Transgendered/Transsexual High Risk Project; and two speakers from the YouthCO (Positive Youth Counselling and Outreach) Project. All these people were invited so that the class could meet those they were most likely to be networking with regarding their future clients, once they began actively working with street youth.

In the afternoon, Aboriginal youth and adults who are themselves living with HIV came to speak directly with the class and tell their stories. This was a very powerful session, as one young woman (with her child) and four young men spoke from their hearts, giving real-life pictures of what it is like to live with HIV as Aboriginal persons who had 'come from the streets' (or, in the case of two speakers, were actually still there). The questions the class asked afterwards clearly indicated not only that they had heard about future clients' situations, but also that they had very quickly internalized the message about how HIV might eventually affect them personally and the risks they might need to be aware of in their own personal non-work-related lives.

That day ended with the usual closing Circle, but the class was so moved that two members spontaneously asked people to wait while a drum was brought so that an Honour Song could be sung for the guests and teachers. It was a moving ending to a deeply emotional, mental, and spiritual day.

On the fifth day the class went to the building where most HIV-positive people in Vancouver eventually go for services because it houses the Persons With AIDS Society, AIDS Vancouver, Positive Women's Network, Wings Housing Society, the food bank, and library. Representatives from these groups spoke to the class and gave informal tours (often accompanied, at our request, by Aboriginal workers or volunteers associated with these organizations). Additional site visits were done at a nearby street-oriented community health centre and the office of the Street Youth Services organization. By the end of that day, the class had been to most places their clients might go and had seen first-hand the human faces inside what might have previously been perceived of as doors too overwhelming to walk through.

On the final day, the invited speaker was a mother from a village in northern British Columbia, accompanied by her daughter and granddaughter, who spoke about the death of her son from AIDS-related causes and how this affected not only his immediate family but also the entire community. They spoke about stigma, shame, healing, and breaking the silence surrounding it all—and the class learned a lot more about the personal face of HIV and its 'psychosocial ramifications'. These guests also explained their involvement in contributing a panel about him to the Canadian AIDS Memorial Quilt, and how it was used at his Stone Feast a year later as well as in a Display of Quilts for Aboriginals at the Friendship Centre in Vancouver several months later. After that introduction to the Quilt's prevention/awareness educational possibilities, in addition to its

grieving and memorializing functions, the class was shown a real piece of the AIDS Quilt, along with short videos relating to it. Finally, the class participated in another art-therapy exercise for closure, showing what HIV/AIDS means to them now that they have completed the course.

Course evaluations demonstrated students' enthusiastic response to this more encompassing way of learning about HIV that integrated the psychosocial and medical aspects by addressing all four components of the Medicine Wheel. Many emphasized that they had heard the warnings and facts before, but never before understood the complexity behind them or the feelings involved. As well, they had not previously recognized their own personal risks. This kind of feedback, combined with our own experiences during the course, suggests that teaching the Aboriginal counsellors of Aboriginal street youth using a model based on the Medicine Wheel, Healing Circles, and other First Nations traditions can greatly benefit the healing work done with Aboriginal street youth.

CONCLUSION

Aboriginal street youth live in both street and First Nations cultures simultaneously and are at extreme risk of HIV infection. They need culturally sensitive and non-judgemental counselling, education, and treatment—but first must come their internal desire to seek these (and their willingness to actually experience the accompanying feelings). These youth will trust most those who are most familiar with their underlying culture and its traditional value system, regardless of how long ago *they* think they left such things behind. Aboriginal spirituality is so much more than just religion—it is an entire way of life, with involvement all day long every day, not simply once a week inside a building—and this is as true for street youth as it is for their elders.

Many traditional healing models and spiritual considerations still have an important place in HIV work with today's Aboriginal street youth. In addition, they provide a foundation for teaching others how to do this work. Medicine Wheel teachings and Healing Circles can serve as an excellent means of beginning the connecting and reconnecting necessary for these youths' survival. 'Fear attacks us physically, trying to kidnap our spirits, our souls. But two against one—you and the spirit within—have better odds to challenge fear' (Ward, 1997: 14).

Even if not actively pursued as interventions, deeper meanings flowing within the Wheel and the concepts rooted in the Circle approach can help Aboriginal youth improve their self-understanding and their connections with friends, families, and traditions, as well as with a network of counsellors and other workers who are better sensitized and therefore offering deeper understanding of the complex net their lives are caught up in. In the best of all possible worlds, these services would be offered by Aboriginal helpers; however, in the meantime, the information in this chapter may hopefully suggest ways that non-Natives can also help, and still do so in appropriate ways.

> It is important to understand that learning all these techniques in these pages is a goal for respectful awareness, not a certificate qualifying non-Native readers to now go out and start up Healing Circles for Native youth. Rather, such learnings teach sensitivity to the ways such things are done, and thus can help, and that there are certain ways to begin them, such as contacting local elders who can then decide what should or should not be started, by whom, and how. It may turn out that the more non-Native social workers truly understand, the more they will realize how much of a back seat they should take.
>
> Ceremony is so very private, and is best done by those traditionally trained and entrusted to do it. Sometimes it may be better to help assist the formation of Healing Circles from a background position, and actually not participate in them at all. *This is a difficult understanding for people who truly care, and truly want to help: that sometimes the best 'helping' they can do is to not be seen to be helping.* By doing this, historical paternalistic attitudes can be confronted and Native people can be in control of our own empowerment. (Fife, 1997; emphasis added)

Acknowledgements

I want to acknowledge with grateful appreciation and deep respect the consultative advice from the following colleagues, who helped review this chapter for publication: Alan Mousseau (Ojibway), Speaker, Healing Our Spirit BC First Nations AIDS Society; Connie Fife (Cree), Counsellor, Urban Native Youth Association; Nikki A. Williams (Shushwap), Speaker, Healing Our Spirit BC First Nations AIDS Society; Tia Eagles-Claw (Okanagan), Street Youth Peer Counsellor; Albert McLeod (Cree and Scottish), Director, Manitoba Aboriginal AIDS Task Force; Bert Isaac (Kwakiutl and Coast Salish), Counsellor, Urban Native Youth Association; Kecia Larkin (Kwakwaka'wakw), Educator; Curtis Yellow Fly (Blackfoot Siksika), Research Worker, Aboriginal Community Health Project; Vince Smith (Cree), Street Youth Peer Counsellor; Robert Abraham (Tatla Lake), Speaker and Peer Counsellor; Nadine Caplette (Métis), Program Manager, BC Native AIDS Awareness Program; Ken Ward (Enoch Cree), Educator and Peer Counsellor; and especially Dolan Badger (Cree), Counsellor, Urban Native Youth Association Safe House, with whom an earlier version of this chapter was originally presented as a poster session at the International AIDS Conference in Vancouver, July 1996.

I also want to thank my friends Robert Cross (Oglala Lakota and Northern Cheyenne), William Belgarde (Cree), Connie Fife (Cree), and Evan Adams (Coast Salish), whose supportive understanding of my intentions in writing this helped me greatly in clarifying my personal responsibilities in creating it.

I would also like to acknowledge the pioneering work of my friend and mentor, Frederick Haineault, co-founder of Healing Our Spirit BC First Nations AIDS Society, from whom I first learned about the AIDS Medicine Wheel (and many other things as well). Though he has passed on from illness related to AIDS, his gifts of teaching and friendship are still greatly appreciated.

NOTES

1. As first conceptualized by Leonard Johnston, after going to the elders for healing and then relating their teachings about the Wheel to his personal journey with AIDS (McLeod, 1997).
2. Different Aboriginal nations may conceptualize parts or all of this differently; for example, North can represent elder and/or winter, as in resting-to-begin-again, and so its colour may be white instead of black.
3. Another version might have the four major elements rather than seasons, for example; so blue (for water) might replace black. What is most important is the overall concept and its application, even though specific details might vary.
4. Or, as another version of the model arranges it: East—tobacco (yellow), South—sage (red), West—cedar (black/blue), and North—sweetgrass (white) (Young and Paul, 1995: 40).
5. As noted in a lecture by Dr Brian Woodfall, the first doctor I am aware of who has acknowledged this understanding in public lecture.
6. There are a few exceptions, such as 'people experiencing uncontrollable outbursts, . . . like bursts of anger which might lead to physical danger or physically sick from illness or alcohol or drugs, or women in their high moon [menstruation]. They can participate and speak but not sit with others in the first circle. Such people are not considered to be dangerous or unwanted, but who possess high power and energy that could interrupt or deflect the healing process of the Circle. Both kinds go through a body cleansing period that releases high energy. They are welcome to speak from the outer circle, which surrounds the original circle. It's always preferred to have 48 hours of cleanliness [drug-free] before attending a circle; we ask people to be honest—if they're not 48-hours clean, please sit in the back' (Eagles-Claw, 1997).

AGENCIES AND ORGANIZATIONS INVOLVED IN HIV/AIDS EDUCATION AND COUNSELLING IN ABORIGINAL COMMUNITIES

AIDS Yellowknife
Box 864, Yellowknife, NWT, X1A 2N6.
Phone: (403) 873–2626; *Fax*: (403) 873–2626

AIDS Yukon Alliance
7221 7th Avenue, Whitehorse, Yukon, Y1A 1R8
Phone: (403) 633–2437; *Fax*: (403) 633–2447

All Aboriginals Against AIDS
P.O. Box 145, Lennox Island, PEI, C0B 1P0
Phone: (902) 831–2779; *Fax*: (902) 831–3153

All Nations Hope AIDS Network
1852 Angus Street, Regina, Sask., S4P 3A2
Phone: (306) 924–8424; *Fax*: (306) 525–0904

Atlantic First Nations AIDS Task Force
P.O. Box 47049, Halifax, NS, B3K 2B0
Phone: (902) 492–4255; *Fax*: (902) 492–0500

Feather of Hope Aboriginal AIDS Prevention Society
#201-11456 Jasper Avenue, Edmonton, Alta, T5K 0M1
Phone: (403) 488–5773; *Fax*: (403) 488–3735

Healing Our Spirit BC First Nations AIDS Society
415–B West Esplanade, North Vancouver, BC, V7M 1A6
Phone: (604) 983–8774; *Fax*: (604) 983–2667

Manitoba Aboriginal AIDS Task Force
555 Broadway Avenue, 3rd Floor, Winnipeg, Man., R3C 0W4
Phone: (204) 772–6800; *Fax*: (204) 772–2784

Two-Spirited People of First Nations
Suite 201–A, 45 Charles Street East, Toronto, Ont., M4Y 1S2
Phone: (416) 944–9300; *Fax*: (416) 944–8381

Urban Aboriginal AIDS Awareness
2001 St-Laurent Boulevard, Montreal, Que., H2X 2T3
Phone: (514) 499–1854; *Fax*: (514) 499–9436

Note:
Although not a formal agency, the **Canadian Aboriginal AIDS Network** should be noted here as another very important organization to contact: 1-800-597-3809.

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Social Work and HIV

The Canadian Experience

Edited by
William Rowe and Bill Ryan

OXFORD
UNIVERSITY PRESS