



Research article

Abuse of power in relationships and sexual health



Dionne Gesink^{a,*}, Lana Whiskeyjack^b, Terri Suntjens^{b,1}, Alanna Mihic^c, Priscilla McGilvery^{d,2}

^a Dalla Lana School of Public Health, University of Toronto, 155 College St., 6th Floor, Toronto, Ontario M5T 3M7, Canada

^b Blue Quills First Nations College, Box 279, St. Paul, Alberta T0A 3A0, Canada

^c University of Toronto, 155 College St., Toronto, Ontario M5T 3M7, Canada

^d Saddle Lake Health Center, P.O. Box 160, Saddle Lake, Alberta T0A 3T0, Canada

ARTICLE INFO

Article history:

Received 23 January 2016

Received in revised form 31 May 2016

Accepted 2 June 2016

Keywords:

Abuse of power

Sexually transmitted infections

Sexual abuse

Sexual health

Trauma

Suicide

Indigenous

ABSTRACT

STI rates are high for First Nations in Canada and the United States. Our objective was to understand the context, issues, and beliefs around high STI rates from a *nêhiyaw* (Cree) perspective. Twenty-two in-depth interviews were conducted with 25 community participants between March 1, 2011 and May 15, 2011. Interviews were conducted by community researchers and grounded in the Cree values of relationship, sharing, personal agency and relational accountability. A diverse purposive snowball sample of community members were asked why they thought STI rates were high for the community. The remainder of the interview was unstructured, and supported by the interviewer through probes and sharing in a conversational style. Modified grounded theory was used to analyze the narratives and develop a theory. The main finding from the interviews was that abuse of power in relationships causes physical, mental, emotional and spiritual wounds that disrupt the medicine wheel. Wounded individuals seek medicine to stop suffering and find healing. Many numb suffering by accessing temporary medicines (sex, drugs and alcohol) or permanent medicines (suicide). These medicines increase the risk of STIs. Some seek healing by participating in ceremony and restoring relationships with self, others, Spirit/religion, traditional knowledge and traditional teachings. These medicines decrease the risk of STIs. Younger female participants explained how casual relationships are safer than committed monogamous relationships. Resolving abuse of power in relationships should lead to improvements in STI rates and sexual health.

© 2016 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

1. Introduction

Many Indigenous nations share a holistic Indigenous knowledge tradition, which supports sophisticated social, cultural, spiritual, political, and economic mechanisms and processes to sustain healthy human, natural, and spiritual relations (i.e. relations with beings in the physical and spiritual realms). In the last several generations, these processes have been interrupted by enforced legislative and social change (Bombay, Matheson, & Anisman, 2014; Canada, 1996, 2012; Ross, 2014).

* Corresponding author. Tel.: +1 416 978 5869.

E-mail addresses: dionne.gesink@utoronto.ca (D. Gesink), lanawhiskeyjack@gmail.com (L. Whiskeyjack), terricardinal@hotmail.com (T. Suntjens), alanna.mihic@gmail.com (A. Mihic), priscillamcgilvery@yahoo.com (P. McGilvery).

¹ Current address: Kehewin Health Services, Box 220, Kehewin, Alberta T0A 1C0, Canada.

² Current address: Blue Quills First Nations College, Box 279, St. Paul, Alberta T0A 3A0, Canada.

In that same period, Indigenous nations have experienced disparities in many social and health indicators (Adelson, 2005), including disproportionately high rates of human immunodeficiency virus (HIV) (Newman, Woodford, & Logie, 2012; Shea et al., 2011) and other sexually transmitted infections (STIs) (de Ravello, Everett Jones, Tulloch, Taylor, & Doshi, 2014; Eitle, Greene, & Eitle, 2015; Kaufman et al., 2007; Minichiello, Rahman, & Hussain, 2013; Winscott, Taylor, & Kenney, 2010).

HIV rates reported for Indigenous peoples in Canada are higher than those reported for Indigenous peoples in Australia and New Zealand (Shea et al., 2011). Within Canada, HIV rates reported for First Nations are higher than those reported for the general population (Archibald, Sutherland, Geduld, Sutherland, & Yan, 2003; Duncan et al., 2011; Spittal et al., 2007). The majority of reported HIV cases among First Nations are women (Cedar Project, Mehrabadi, et al., 2008; Shea et al., 2011), while the majority of reported HIV cases among the general population are men. These gender differences reflect differences in the HIV epidemic, which predominantly affects heterosexual and intravenous drug user subpopulations (Duncan et al., 2011) for First Nations and men-who-have-sex-with-men for the general population. The differences in affected populations suggest that gender and culture specific interventions are needed to prevent the HIV epidemic from widening (Shea et al., 2011).

Little was known about the HIV situation for the Saddle Lake Cree Nation, an Indigenous community in Alberta, Canada, with high rates of STIs, teen pregnancy, drug use, and gang activity; factors indicating vulnerability to rapid spread of HIV. In 2009, the Health Director for Saddle Lake formed our research team. Our objective was to understand the context, issues, and beliefs around high STI rates from a *nēhiyaw* (meaning Cree, in Cree) perspective. We used Indigenous methodology (Kovach, 2009; Wilson, 2008) grounded in *nēhiyaw* epistemology (Kovach, 2009) that everyone and everything is related. Our intention was to use the results to inform community-based HIV prevention interventions centered around restoring balance to sexual health.

2. Methods

2.1. Design

This qualitative study used in-depth interviews to explore why STI rates were high in the community.

2.2. Theoretical framework

We used grounded theory (Charmaz, 2014) informed by one of the core principles of *nēhiyaw* Natural Law – *wahkohtowin*. *wahkohtowin* means everything – flying beings, swimming being, standing beings, still beings, four-leggeds and two-leggeds – is related (BearPaw Legal Education and Resource Centre, 2004). *nēhiyaw* believe individuals, communities and societies, ecologies and environments are all interrelated, interdependent and connected and therefore healthier following the teachings of *wahkohtowin*. The medicine wheel (Dapice, 2006) is a pan-First Nations model of *wahkohtowin* and provides direction on how to live a healthy life (Fig. 1). The medicine wheel represents how an individual has four aspects of self that are developed while passing through four stages of life. Physical and spiritual are opposite along the same axis as are mental and emotional as these aspects balance each other. These aspects touch each other at the center of the circle to show that all aspects come together to one. Clockwise movement around the wheel, starting in the east, shows: (1) the flow through the various stages of life from child to elder, (2) the flow of relationships, responsibility, and knowledge between people for each stage of life, and (3) the aspects and values being most actively developed at a given stage of life. It is believed that if a stage is missed or skipped in the sequence, the individual must go back later in life and live through that developmental stage.

The research team used the teachings of *wahkohtowin* and the medicine wheel as reminders that: everything is related; sexual health should be considered from physical, mental, emotional and spiritual perspectives; sexual health means taking care of one's body, mind, and spirit and being wise about with whom we share ourselves intimately; sexual relations is about the people we have sex with and those power dynamics; STIs are but one indicator of the health of our sexual relations and our sexual selves; and finally, understanding, restoring and maintaining sexual health requires a holistic life-course approach. In these ways, *wahkohtowin* and the medicine wheel were used to inform participant recruitment, interview conversation and probes, data analysis and interpretation of the results.

2.3. Setting

onihcikiskowapowin, meaning “shadow on the lake”, is also known as the Saddle Lake Cree Nation, and is located in Treaty 6 region in Alberta. Saddle Lake is one of the larger First Nations communities in Canada with 9474 registered band members in July 2011 and 6026 members living on reserve (Indian and Northern Affairs Canada). The original language is Plains Cree, Y dialect. Data collected for this project are owned by the Saddle Lake community and stewarded by the University of Toronto in accordance with principles of Indigenous community ownership, control, access and possession (OCAP; <http://fnigc.ca/ocap.html> accessed May 31, 2016). Ethical review was conducted and maintained with both Blue Quills First Nations College and the University of Toronto.

A band council resolution was passed in 2009 approving collaboration between Saddle Lake Cree Nation and the University of Toronto. Our research team comprised Cree community members (also referred to as community partners), some of whom worked at the health center on-reserve or the local First Nations College or were otherwise employed in/around the

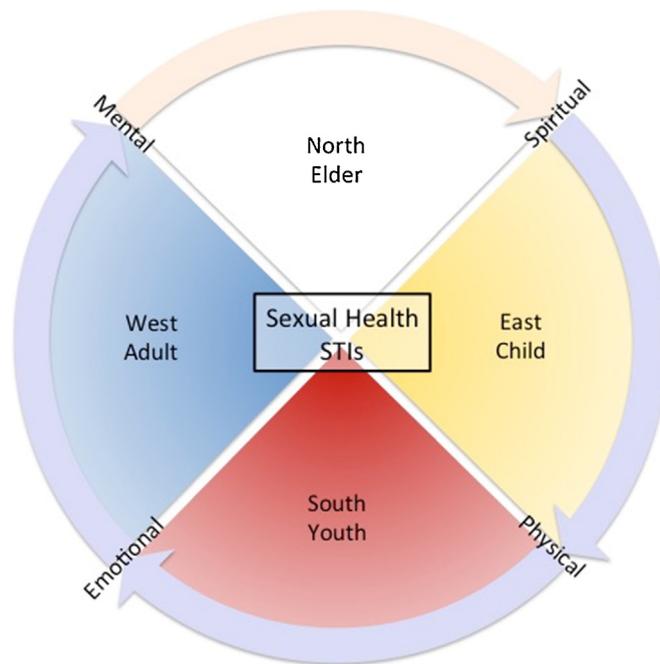


Fig. 1. The medicine wheel as a model for health and development.

community, or unemployed, as well as two non-Cree western researchers from the University of Toronto. There was some turn-over in community partners over the six-year life of this project; however, two community partners and two non-Cree partners remained constant. The research team was advised by elders, the community health board and ad hoc advisory groups as needed. Cree and non-Cree partners co-led the research as part of the decolonizing and indigenizing research agenda. Community-identified research questions and methods were given priority. The research process was grounded in ceremony and followed Cree protocols as dictated by the culture, elders and Chief and Council. Specific protocols are described when relevant to the methods.

2.4. Recruitment and participants

Cree research protocol and ethics (Blue Quills First Nations, 2009) dictates that a knowledge seeker (researcher) work on their relationship with a knowledge keeper (community participant) before asking for knowledge (Kovach, 2009; Wilson, 2008). Therefore, our community interviewers led recruitment. First, they thought of all the people in the community that they knew were knowledgeable about sexual health and STIs (Fig. 2). Next, from this group, they thought about who would be comfortable talking with them about sexual health and STIs. From this subgroup, they identified those community members with whom they were comfortable talking about sexual health and STIs. Interviewers invited a diverse sample of those knowledgeable community members (hereafter called community participants) to participate in our study as our seed sample (Fig. 2). Community participants were welcome to bring anyone else they thought should attend the conversation and were asked at the end of the interview if there was anyone else who should be interviewed. Inclusion criteria were: being 18 years old or older, an active member of the Saddle Lake community and comfortable talking about sexual health and STIs – topics otherwise considered taboo in the community, especially, sexual health.

2.5. Data collection

In-depth interview methods were developed as a collaboration between Cree interviewers and non-Cree research partners. In-depth interview methods were grounded in the Cree values of relationship, sharing, personal agency and relational accountability (Kovach, 2009; Wilson, 2008). Cree interviewers showed and explained STI statistics to community participants and then asked why the participant(s) thought STI rates were high for the community. The remainder of the interview was unstructured, where discussion was supported by the Cree interviewer through probes and sharing in a conversational style. This method is consistent with a narrative approach in health behavior and health psychology (Chadwick, Cooper, & Harries, 2014; Murray, 1997, 2000; Riessman, 2008) and Indigenous methodology, which honors sharing stories as a means of knowing, and values conversation as a method of gathering knowledge (Kovach, 2009). A narrative approach to data collection was also used to allow *nêhiyaw* perceptions, beliefs, observations and experiences to be in the foreground.

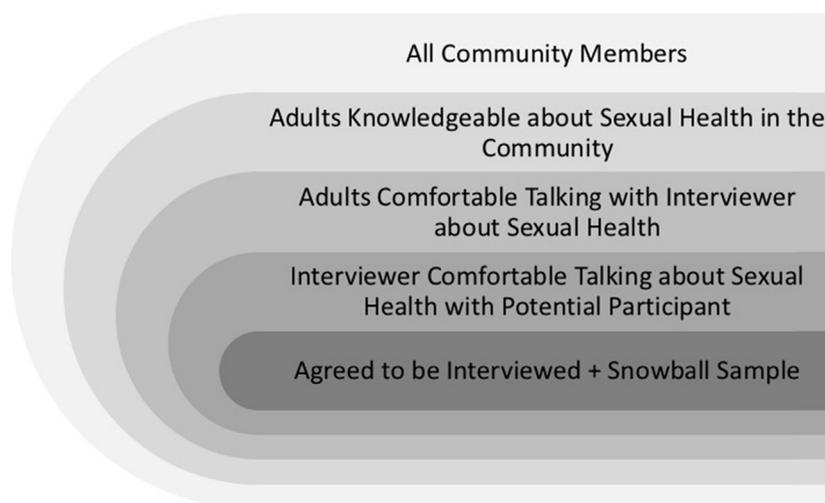


Fig. 2. Participant recruitment and selection strategy to build diverse purposive sample.

Interviews took place at a safe location selected by the participant(s) and agreed upon by the Cree interviewer. Following Cree protocols, all participants were offered tobacco during the consent process. One Cree interviewer tied prayer ribbons around her voice recorder to show her connection to ceremony and truth-telling, and to signal her commitment to safety, honesty, and confidentiality. Interviews ranged in duration from one to five hours, depending on the accompanying activity (e.g. visiting vs running errands) and the time needed for the participant(s) to fully develop and share their story, perceptions and observations (Green & Thorogood, 2009).

Interviews were conducted in English primarily, though some Cree speakers used Cree intermittently during the interview. Our community interviewers were capable when speaking Cree, though not fluent, and could either follow or ask for clarification as needed. Interviews were voice recorded and transcribed by each Cree interviewer. Cree language was translated into English during transcription. Interviews were conducted until theoretical saturation was reached, meaning no new information emerged during subsequent interviews and our theory was well developed. Theoretical saturation was identified using an iterative and constant comparative approach (Creswell, 2013; Glaser & Strauss, 1967). Participants were acknowledged for their time and contribution with a financial honorarium.

2.6. Data analysis

We conducted an inductive thematic analysis with a focus on the content of the Cree participant interviews. We also looked beyond the literal content to the meaning underlying the words used, ideas and interpretations that participants themselves may not have noticed or been aware of to build a theory describing why STI rates might be high in the community (Charmaz, 2014; Corbin & Strauss, 1990).

Four research team members (two Cree interviewers and two non-Cree researchers) read, re-read and open coded transcripts to identify semantic codes that could be grouped later into concepts or themes. All four team members met for 3 days to review codes and identify priority themes. Subsequently, one non-Cree researcher continued the analysis searching for, reviewing and defining subthemes, themes, and an overarching narrative and theory. HyperRESEARCH version 7.3.2 (ResearchWare Inc., Randolph, MA, 2015) was used to manage and analyze transcripts and codes.

Reliability was increased by sharing the initial coding among four team members, cross-checking and reconciling coding differences during analysis (Creswell, 2013). We supported our theory by providing thick description in the form of illustrative passages quoted verbatim from transcripts and contextualized so they are meaningful to outsiders. Indigenous methodology expects that knowledge be shared in the context and way it was shared with the knowledge seeker; therefore, our passages are lengthy in efforts to keep the knowledge intact. Passages are presented anonymously to protect the identity of the speaker given the small size of the community.

Validity was increased by involving both Cree and non-Cree partners in the analysis, spending prolonged time in the community, seeking negative or discrepant information during analysis that might challenge interpretations, and listening to community feedback for agreement with, or reinterpretation of, study findings after returning results to the community (Creswell, 2013).

3. Results

Twenty-two in-depth interviews were conducted with 25 community participants between March 1, 2011 and May 15, 2011. Community participants were a balance of men and women, ranging in age from 18 to 65 years, living on-reserve and off-reserve, employed and unemployed, and working in health or other fields or retired.

Two storylines dominated participant narratives when community members were asked why STI rates were high: one about abuse of power in relationships and the other about addiction. This manuscript will focus on abuse of power in relationships. Participants also provided ideas about how to restore balance to sexual health, which are integrated as they relate to abuse of power in relationships and STIs.

All community participants responded to the question “Why are STI rates high for Saddle Lake?” with first-hand accounts of abuse, violence, and trauma, including personal experience with childhood sexual abuse, physical abuse, or forced sex as an adolescent or adult, or witnessing physical, sexual, gang, or lateral abuse or violence. All participants had experienced some form of cultural violence. Several participants recounted detailed traumatic memories, especially around personal violation and violence, though none disclosed currently being in an abusive relationship. Some relived past traumas during their narrative, reflecting their healing process. Community members did not look for new ways, but rather traditional ways to reduce STIs and restore sexual health. They also shared visions of a healthier future.

Our theory is a narrative that abuse of power in relationships is occurring at the dyad, kinship, intergenerational, communal, societal and system levels. Abuse and violence not only cause physical wounds, but also mental, emotional and spiritual wounds (Fig. 3). These wounds disrupt movement around the medicine wheel (Fig. 1), thereby inhibiting living a good life and being healthy. People who are wounded seek medicine (Fig. 3). In Cree ways of knowing, there are helpful medicines and harmful medicines, and most medicines can both heal and harm depending on how they are administered or used. Wounded people who focus on ending pain and suffering most easily find medicine in the form of sex, drugs, and alcohol. These medicines temporarily relieve pain and suffering but can cause harm and increase the risk of STIs. In extreme cases, some individuals will end their abuse, pain and suffering permanently by ending their life (suicide). Wounded people who focus on true healing focus on the medicine provided by ceremony, traditional ways, and *wahkohtowin* – restoring relationships, which are believed to decrease the risk of STIs (Fig. 3). Each element of this theory is detailed below.

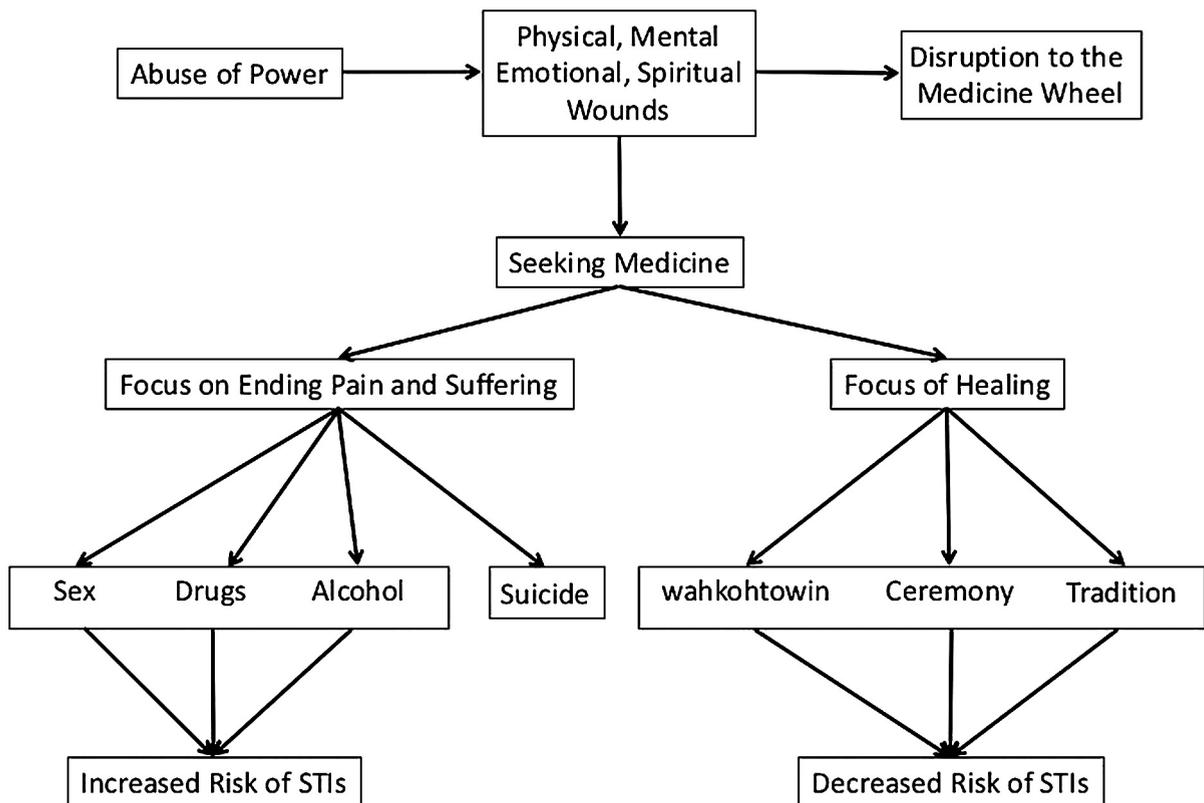


Fig. 3. Model describing the theorized relationship between abuse of power in relationships and STI rates based on in-depth interviews with Cree community members from Saddle Lake, Alberta, 2011.

3.1. Abuse of power in relationships

The cultural violence of colonization, including assimilation laws, policies and practices around the reservation system, and residential schools, severed many generations of First Nations from their natural parenting experience, traditional teachings around *wahkohtowin*, language, ceremonies and rites of passage (Bombay et al., 2014; Brave Heart & DeBruyn, 1998; Canada, 1996, 2012; Carr, Martins, Stingel, Lemgruber, & Juruena, 2013; Evans-Campbell, 2008; Robertson, 2006):

“I keep going back to the whole residential school era and I keep saying that because I think a lot of that, a lot of what is happening in our communities stems from that whole colonial process of not just being locked away, away from your family in a residential school but in our community, communities were locked away in reserve systems where they had to get permission to go.” (Int 22)

One of the cycles of abuse of power in relationships most relevant to sexual health is sexual abuse and forced sex. The residential school era affected several generations of families when clergy (both priests and nuns) sexually abused residential school children (Fogler, Shipherd, Clarke, Jensen, & Rowe, 2008; Pargament, Murray-Swank, & Mahoney, 2008), resulting in multiple generations of family members being physically, emotionally, psychologically and sexually abused (Pearce et al., 2015; Ross, 2014). Participants shared accounts of historic and current childhood sexual abuse, suggesting that in some cases, what might have started as external sexual abuse by clergy, may have transferred internally and become sexual abuse within families, perpetuated inter-generationally thereafter (Robertson, 2006):

“People have also normalized sexual abuse because it’s been happening for so many generations. Kids don’t see this as wrong because it’s what they been growing up seeing.” (Int 16)

Participants also recounted stories of individual and gang-rapes perpetrated by men against women in the community, more evidence of abuse of power in relationships between the genders.

Residential school survivors said sex was taboo and sexual abuse was “hush-hush”:

“The way I think about it was the hush-hush was lot of young girls and a lot of young men were sexually assaulted by their families especially the ones at the boarding school. I felt that carried on from there. . .” (Int 7.1)

We hypothesize the taboo likely originated from hiding sexual and other forms of abuse that occurred within schools and families. The punishments in residential schools were humiliating and severe making them highly effective at silencing children (Robertson, 2006; Ross, 2014; Wesley-Esquimaux & Smolewski, 2004). As one residential school survivor explained while being interviewed at her childhood residential school: “. . .you don’t see or if you see, you don’t say anything. And that’s really been controlled from here [the residential school]; you see something, you don’t talk about it.” (Int 7.1).

Participants recounted incidents of children being forced to have sex and how with this loss of choice is the loss of ability to protect oneself from STIs and pregnancy: “Even if the girls know, or the boy, but mostly girls for us, even if they know they should be using something [referring to condoms] you don’t expect that when you are raped.” (Int 3).

Participants recounted incidents where adults used their power, position and access to perpetrate incest by preying on children in their families. Some shared stories of men in the community threatening violence to intimidate and silence anyone trying to stop their abuse:

“I remember my mom. . .she approached a father and she told him that she was aware and that his girls were talking and that it wasn’t right. It wasn’t right to be abusing his girls like that. He told her ‘Don’t you ever come in my house and don’t you ever come and tell me what to do in my house, because this is my house. And don’t dare anybody - social services – anybody, come to my door!’ or he was going to get violent and he was going to take a gun at them. And that was how he hushed it up. And from that family I see, and I remember that family so clearly, I seen that ripple into the daughters and their kids now and the uncles still after their nieces and nephews.” (Int 22)

Lack of consequences has further emboldened community sexual abuse perpetrators, some of whom escalate to child exploitation and prostitution:

“I get afraid too when these men sexually assault little girls. The girls can get that disease too, or little boys. It’s not just little girls too it’s boy that get raped. As long as somebody has a hole in their body I guess. (Int 7.1)

“So that’s a form of prostitution that nobody is really talking about.” (Int 7.2)

This latter statement by Interviewee 7.2 alludes to children being prostituted by caregivers and so abused not by one adult, but many adults. These are not older children who have been pushed into commercial sex or exchanging sex for resources by poverty and addiction environments, but rather young children being treated as commodities and prostituted out to other adults by their caregivers and experiencing forced sex.

Several stories of failed attempts to report and stop child sexual abuse were recounted; not a single successful case was told. We identified four reasons why disclosing sexual abuse may not have been successful to date (Table 1):

1. There is no clear reporting system or infrastructure to support local handling of cases.

Table 1
Obstacles to ending sexual abuse.

Obstacle	Illustrative passage
Abuse of position to dead-end investigations involving family members	I am aware of some situations where kids have talked about it and it's hushed, hushed like shut down either at, maybe they talk about it in school, get into the social services area where things are supposed to be dealt with and because of family relationships, it seems to be political at times, it stops. (Int 22) "I think sexual abuse plays a part in the spread of STI's. I know of a young girl who was 16 and she had a baby from her stepfather and when she went for her initial checkups, they did find Chlamydia and gonorrhoea. She did disclose to us it was her stepfather that had gotten her pregnant. Her mom was only with this guy for a couple months and the abuse started right away. We had to treat this case sensitively and asked her if she wanted to go to the police but she didn't want to at that time because of fear of being kicked out. We set her up with a psychologist and we tried to get her into a safe house but couldn't find one in the area. In 2 weeks she ended up moving away. She refused to press charges and we contacted child welfare to take the case, I know there was an investigation but child welfare couldn't give me any information so I don't know what happened with this case. . . . This family normalized it and the mom knew about it and it was seen as okay. We had no authority to press charges. From my understanding only police can lay charges and there needs to be a disclosure to them personally. This girl would not disclose to the police and she refused to go the talk to the police. She was scared her mom would freak out. She was scared her mom would abandon her and also that her mom would deny it even though she knew what was going on." (Int 19)
Lack of resources	
No clear reporting system	
Duty to report on Child	
Fear of abandonment Fear of family disruption	So much sexual abuse is not being taken to the police and charges are not being laid. People fear it. These men are our fathers, our uncles, and our cousin. They don't press charges because they fear family breakdown and having to see these people in their life every day. They fear how it will make other people feel. They think about others and not how it is affecting them. If someone is raped by someone unknown, they are more likely to charge or open up about it than if it was someone in their family. (Int 19)
Fear of complacency	I don't understand why there is community knowledge that a person is sexually abusing their grandchild and people talk about it but are doing nothing. Kids won't speak out when they see that nothing is being done, or nothing will be done to protect them. So they become silenced. And sex offenders are not punished so therefore they continue abusing with no fear. (Int 13)

2. Some administrators in the duty to report chain abused the power of their position to dead-end investigations involving family members.
3. The Royal Canadian Mounted Police (RCMP) require first hand reporting of sexual abuse by the victim/child, and children are reluctant to report first hand because of fear of the RCMP due in part to strained relationships between the RCMP and the community.
4. Children being terrified to report their abuse because of fear of abandonment, fear of family disruption, fear of ending up in a worse situation and fear of complacency of those who are supposed to help them.

Finally, young women described the potential for physical, mental, and emotional harm making committed monogamous relationships too risky and dangerous to be desirable:

"That's when relationships can get really domestic [referring to domestic violence] and some relationships are really harmful in stages. Like you don't really know that you don't really know that it's happening until it happens. Some people get really hurt over long term relationships." (Int 12.3)

The high co-occurrence of violence, infidelity and STI transmission within committed relationships described in other interviews (Pedersen, Malcoe, & Pulkingham, 2013) both validates the concerns of these young women and exposes the rationality behind casual sexual relationships being less risky than committed relationships because it is much easier to negotiate condoms and other forms of safety.

3.2. Physical, mental, emotional and spiritual wounds and disruption of the medicine wheel

Participants described how abuse of power in relationships caused physical, mental, emotional and spiritual wounds in the individual: "I really believe that when kids are abused, raped, their spirit is taken; their soul is gone. So it leaves them a void . . ." (Int 22). Considering the evidence that early life emotional trauma is a known risk factor for attachment

Table 2
Seeking medicine.

Medicine	Illustrative passage
Sex, drugs, alcohol	“There is such a void, when you come out of that place, there is such a void. There such a cloud of emptiness and you need to fill it and for me I filled it with food and work. It just never was satisfying because it just kept going. For some women its booze, it’s drugs, it’s relationships and sex, other things. It’s addictions that drive that whole thing. That whole emptiness that whole need, your spirit being removed . . .” (Int 22)
Suicide	I remember after that training noticing behaviors in a young girl in my class, age 9, who seemed to show signs of sexual abuse. She seeked attention from boys, by what some would say “slutty”. She also dressed inappropriately for her age. I couldn’t say for sure though, but it’s sad to say that a year later she committed suicide at the age of 10 years old. People did say she was probably sexually abused and I’m not sure what happened with that whole situation. I’m not sure if there was an investigation or what. Nothing is being done, gossip stays gossip, and community knowledge about abusers remains community knowledge. There is a fear to speak out . . . (Int 16)
Relationships	[My sister] is the one that started it all with that one little question, ‘why are you doing this? I don’t like seeing you like this.’ That’s powerful stuff. That’s my little sister. . . I have a connection with her. She got through to me - so grateful for her. If it wasn’t for her I probably would be still trapped in that lifestyle (drugs). That’s was who changed me, it was her question. (Int 8)
Traditional teachings	We need to build self-esteem for these young people and teach them to respect one another and themselves. I believe that a curriculum needs to be developed in the community that will address the needs of the community and focus on incorporating our cultural traditions and ceremonies. (Int 13)
Traditional medicine	“Remember what your Mosom told you, ‘you respect your body’, ‘respect yourself.’” And respecting your body means a lot of things too. It’s not just about sex. It’s about like a eating and exercising and. . . <Interviewer: and the way [kokum] explained it to me was that was my medicine (vagina). That was my very powerful medicine down there.> It is actually. It really is because you can feel like that’s your soul. (Int 4)
Ceremony	Rites of passages for pre teens needs to be done more. We need to teach these teenagers about respecting themselves and the changes in their bodies and welcome that beauty. Getting your period should be a beautiful thing not a degrading dirty thing. Why is getting your period a dirty thing. (Int 16)

disorders (Rincon-Cortes & Sullivan, 2014), post-traumatic stress disorder (Nadew, 2012; Pratchett & Yehuda, 2011), adult anxiety disorder (Fernandes & Osorio, 2015) and a variety of other psychiatric problems (Dvir, Ford, Hill, & Frazier, 2014; Sigurdardottir, Halldorsdottir, & Bender, 2014), it becomes clear how physical, mental, emotional and spiritual wounds affect various aspects of the self and could disrupt development and flow around the medicine wheel. One participant explained how disruption of the medicine wheel is visible in the youth:

“ . . . when we talk about the medicine wheel, these young kids when looking at them, for example, if there is a medicine wheel here. Ask them to draw their own [referring to personal medicine wheel] and draw how much each one of the colours cover the area: emotionally, physically, spiritually, and that with their body. You will find out that most of it would be red with emotions, lack in spirituality. . .” (Int 10)

3.3. Seeking medicine

Two participants explained how wounded individuals seek medicine to alleviate their suffering and find physical, mental, emotional and spiritual healing (Fig. 1). Unfortunately, the medicines most easily accessed – sex, drugs, and alcohol – are effective at temporarily ending suffering by numbing pain, the physical manifestation of mental, emotional and spiritual wounds (Table 2); however, they do not heal:

“When you are wounded you always look for some kind of a medicine that’s going to help you recover your wounds or cover them. The sad part about this is this medicine they’re seeking is not the right one. It’s not a good medicine, it’s a medicine that’s eventually going to hurt them more and more in the future although it will temporarily work for them. . .” (Int 10)

In fact, these three medicines, sex, drugs and alcohol, can contribute to co-creating high-risk sexual environments, situations and states that can lead to more trauma, suffering, and increased STI transmission (Devries, Free, Morison, & Saewyc, 2009).

Six participants described an association between suicide and sexual abuse (Table 2). It was suggested that suicide, while possibly one of the most difficult choices to make, requiring both despair and courage, is one of the more easily accessed permanent options to end suffering for many in the community. We hypothesize that for those who have taken their own life, suicide was the only fail-safe option to end their abuse given the obstacles to ending sexual abuse in the community.

When community members talked about healing wounds, especially around sexual health, they spoke of the importance of individuals having healthy positive relationships with themselves, their Indigenous identity, their spirituality, their culture, their community, and all their relations (*wahkohtowin*) – elders, grandparents, aunties and uncles, siblings, all the generations, the ecology and the environment (Table 2).

Ceremony, traditional teachings (Table 2) and remembering what is sacred were also seen as powerful medicines for healing and development:

“This one old lady told me, she said, ‘. . . this part of your body [gesturing to the pelvic region], your private area is like a sacred place. Why it’s a sacred place is because a baby grows there. That’s the sacredness of it.’ That’s why you don’t just let everyone come into your body. That’s where a baby grows. . . . It’s like a temple for us to give birth to these children.” (Int 7.1)

Healing the mental, emotional, spiritual and physical self through ceremony, traditional teachings and healthy relationships is likely to decrease the risk of STIs.

Community members shared visions of love and spiritual connection for the future of intimate and sexual relationships:

“That’s sharing yourself! That’s sharing your soul, like you’re opening up yourself to that person. To share something so joyous and special. . . .” (Int 11)

4. Discussion

Our focus was on STIs; however, abuse of power, especially in terms of sexual abuse, emerged as a dominant root cause of elevated STIs through an indirect pathway. We learned that abuse of power in relationships is causing physical, mental, emotional and spiritual wounds that are disrupting the medicine wheel. Wounded individuals are seeking medicine to stop their suffering and find healing. Similar to other studies, many are accessing temporary (sex, drugs and alcohol) or permanent medicines (suicide) that relieve suffering but that do not heal (Cedar Project, Pearce, et al., 2008; de Ravello et al., 2014; Eitle et al., 2015; Hadland et al., 2012, 2015; Hoertel et al., 2015; Ramisetty-Mikler & Ebama, 2011; Walters et al., 2002). Others seek healing by participating in ceremony and restoring relationships (*wahkohtowin*) with self, spirit/religion, others, traditional knowledge and traditional teachings. Medicines that focus on suffering could increase STIs, while medicines that focus on healing could decrease STIs (Fig. 3). The connections between abuse of power in relationships, wounding, disruption to the medicine wheel, seeking medicine, types of medicines, and relationship to STIs have not been described before (Fig. 3). The next step is to address the questions, “What needs to be done to decrease levels of abuse?” and “How can we improve the situation for vulnerable young persons?”

Another unique contribution is our finding that some young women find casual sexual relationships safer than committed monogamous relationships. Closer inspection reveals the rationality of this statement. Many of the committed monogamous relationships witnessed and modeled at home and in the community threatened domestic violence, infidelity, economic insecurity, inability to negotiate condoms, abandonment and physical, mental, emotional and sexual abuse. Casual relationships did not. Sex was perceived as, and may in fact be, safer because of two underlying assumptions and accompanying behaviors associated with casual relationships: (1) sex is a privilege, which gives sexual partners choice, including the ability to say no and negotiate sexual activities, and (2) sex is occurring outside the relationship, and therefore condoms are used without having to be negotiated.

The role of gender was apparent throughout the interviews with participants describing both boys and girls being at risk for childhood sexual abuse, boys having a harder time disclosing abuse than girls, girls and very young women being preyed upon by much older men, intoxicated or drugged girls being gang raped at parties, and women feeling scared, dirty, blamed, shamed and stigmatized about STIs.

Our interviews suggest a desperate gap in community infrastructure for effectively handling sexual abuse and sexual violence (Table 1), as observed in other settings (Collin-Vezina, De La Sablonniere-Griffin, Palmer, & Milne, 2015). Currently, there does not appear to be a safe legal or cultural way for sexual abuse survivors to end their abuse or seek justice (Ross, 2014). The current system has not validated those who have come forward with allegations, which has a ripple effect in communities because children see what happens when other children speak up and nothing is done or things get worse. The obstacles we identified (Table 1) can be classified using the categories presented by Collin-Verzina et al.: barriers from within, barriers in relation to others, and barriers in relation to the social world (Collin-Vezina et al., 2015). Our findings also underscore their conclusion that, “the burden is on the larger community to create a climate of safety and transparency that makes the telling of CSA [childhood sexual abuse] possible” (Collin-Vezina et al., 2015).

According to Finkelhor’s precondition model (Finkelhor, 1984), sexual abuse is perpetrated when four preconditions are met: motivation to commit sexual abuse is achieved (i.e. sexual arousal, emotional congruence, or sexual satisfaction); internal inhibitions are overcome (e.g. overcome taboos through cognitive distortion); external inhibitions are overcome (i.e. creating an opportunity for abuse because the victim is alone/vulnerable and they are unlikely to be seen or caught); and finally, the victim’s resistance is overcome (i.e. grooming or forced sex). Societal complacency, even tacit acceptance, of sexual abuse through silence erodes healthy social constructs of sexual abuse as impermissible, thereby eroding one of the barriers to perpetration and facilitating the first precondition of motivation.

The participants shared stories of how residential school imposed and engrained silence in the children, creating a culture of silence in the community, which has persisted. Silence contributes to normalization and normalization helps satisfy the second precondition of sexual abuse by overcoming internal inhibitions because sexual abuse is normal. Silence also facilitates the third condition for sexual abuse by overcoming the external inhibition of being caught.

Overcoming external inhibitions is further supported when perpetrators have no consequences for their abuse (Table 1). Disclosure of sexual abuse will be perceived as risky to survival and therefore highly imprudent, even impossible, if community normalization of sexual abuse requires survivors to choose between social, kinship and economic security (i.e. silence)

and physical, mental, emotional and spiritual health (i.e. disclosure). Silence and ineffective or non-existent processes for restoring sexual safety further contribute to normalizing sexual abuse.

The fourth precondition, overcoming victim resistance, is easily achieved when adults, who are physically, mentally, and emotionally more developed than children, abuse their power over children (Table 1).

4.1. Reflexivity

Cree research team members approached the research from a relational paradigm (Kovach, 2009; Wilson, 2008), meaning grounded in spirituality (involvement of and connection to the spiritual realm) and reciprocity (“honouring our relationships with other life”, for example, other people, plants, animals; (Hart, 2010). Non-Cree research team members approached the research from a pragmatic paradigm, taking a community based participatory research approach (Israel et al., 1998), which values local knowledge as equally expert and integrates local (in this case Cree) and global (in this case non-Cree) knowledge and thinking to shape research questions, methods, analysis, interpretation and communication. These two paradigms dovetailed to facilitate the research such that the perspective of each group was integrated with the other allowing seemingly disparate ideologies to come together and work collaboratively and synergistically.

The two Cree interviewers were both women from the Saddle Lake community, had extensive extended family connections and large social networks in the community, lived in the community with their families and actively participated in the life of the community (e.g. social events, baseball leagues and ceremonies). One Cree interviewer, in her late 20s, was a college student in a Health Sciences program. The other Cree interviewer, in her mid 30s, was an art and sociology instructor at a local college. Both women had deep and long-standing community connections and knowledge and were highly respected by community members, which strengthened the interview methods, rapport and support building for participants, and provided additional insider insight during data analysis and interpretation. The one weakness of this intimate community connection and knowledge is that participants may not have fully verbalized existing knowledge already shared between the participant and Cree interviewer during the interview.

The two non-Cree researchers were both white women living in downtown Toronto. One was a professor in her late 30s/early 40s, the other was a doctoral student in her late 20s. Both spent extensive time building relationships with community members and being experientially trained by community members in Cree culture, protocols, ceremony and ways of knowing and doing. The non-Cree researchers were involved in discussions around how to conduct interviews and development of the interview guide; however, did not participate in the interviews themselves in efforts to support and foster Cree independence and to mitigate the possibility that community members may simply tell white researchers what they think the researchers want to know. One non-Cree researcher led the analysis of the transcripts. One limitation of this study is that no men were part of the research team; therefore, we are missing the data a man would evoke from participants during data collection, as well as the male perspective on the identification and interpretation of themes.

Our use of Cree ways of knowing and doing created an open, safe and supportive environment for the research, interviewers and community participants, as well as for storytelling and disclosure. This approach and environment ultimately led to richer, more reliable accounts of sexual health in the community.

4.2. Restoration activities

The Saddle Lake community has responded to these findings with complex community-led restoration activities (interventions) that bring together Cree knowledge and ways of knowing and doing with evidence-based research as it relates to HIV/STIs and sexual health. Specifically, we are developing, delivering and evaluating community-led sexual health restoration activities focused on addressing abuse of power in relationships via the healing pathway (Fig. 3): restoring relationships (*wahkohtowin*), ceremony, and tradition. Based on our theory, resolving abuse of power in relationships through the healing pathway should lead to decreased STI rates and improved sexual health of individuals and the community.

Acknowledgements

We thank Sherri Chisan, Alsen White, James Makokis, CB, White Buffalo Woman, Keyano Whiskeyjack, VW, Adeline Wood, George Brertton Giant, Leslie Cardinal, Carley Cardinal, all community participants, Blue Quills First Nations College, the Saddle Lake Health Board, Saddle Lake Chief and Council and the Saddle Lake Cree Nation. This work was supported by First Nations Inuit Health Alberta Region and the Canadian Institutes of Health Research funding reference number 492948.

References

- Adelson, N. (2005). *The embodiment of inequity: Health disparities in aboriginal Canada*. *Canadian Journal of Public Health*, 96(Suppl. 2), S45–S61.
- Archibald, C. P., Sutherland, J., Geduld, J., Sutherland, D., & Yan, P. (2003). *Combining data sources to monitor the HIV epidemic in Canada*. *Journal of Acquired Immune Deficiency Syndromes*, 32(Suppl. 1), S24–S32.
- BearPaw Legal Education and Resource Centre. (2004). *Wahkohtowin – Cree Natural Law: The Canadian legal system and Cree Natural Law*. Edmonton, Alberta.
- Blue Quills First Nations College Research Ethics Policy (2009).
- Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 51(3), 320–338. <http://dx.doi.org/10.1177/1363461513503380>

- Brave Heart, M. Y. H., & DeBruyn, L. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research (Online)*, 60–82.
- Canada. (1996). *Royal commission report on aboriginal peoples*. Ottawa: Government of Canada.
- Canada. (2012). *They came for the children: Canada, aboriginal peoples and residential schools*. Winnipeg.
- Carr, C. P., Martins, C. M., Stingel, A. M., Lemgruber, V. B., & Juruena, M. F. (2013). The role of early life stress in adult psychiatric disorders: A systematic review according to childhood trauma subtypes. *Journal of Nervous and Mental Disease*, 201(12), 1007–1020. <http://dx.doi.org/10.1097/NMD.0000000000000049>
- Cedar Project, P., Mehrabadi, A., Paterson, K., Pearce, M., Patel, S., Craib, K. J., et al. (2008). Gender differences in HIV and hepatitis C related vulnerabilities among aboriginal young people who use street drugs in two Canadian cities. *Women and Health*, 48(3), 235–260. <http://dx.doi.org/10.1080/03630240802463186>
- Cedar Project, P., Pearce, M. E., Christian, W. M., Patterson, K., Norris, K., Moniruzzaman, A., 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. <http://dx.doi.org/10.1016/j.socscimed.2008.03.034>. S0277-9536(08)00178-0
- Chadwick, R. J., Cooper, D., & Harries, J. (2014). Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery*, 30(7), 862–868. <http://dx.doi.org/10.1016/j.midw.2013.12.014>
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Collin-Vezina, D., De La Sablonniere-Griffin, M., Palmer, A. M., & Milne, L. (2015). A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse and Neglect*, <http://dx.doi.org/10.1016/j.chiabu.2015.03.010>
- Corbin, J., & Strauss, A. L. (1990). *Grounded theory research: Procedures, canons, and evaluative criteria*. *Qualitative Sociology*, 13(1), 3–21.
- Creswell, J. S. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). California: Sage Publications.
- Dapice, A. N. (2006). The medicine wheel. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society/Transcultural Nursing Society*, 17(3), 251–260. <http://dx.doi.org/10.1177/1043659606288383>
- de Ravello, L., Everett Jones, S., Tulloch, S., Taylor, M., & Doshi, S. (2014). Substance use and sexual risk behaviors among American Indian and Alaska Native high school students. *Journal of School Health*, 84(1), 25–32. <http://dx.doi.org/10.1111/josh.12114>
- Devries, K. M., Free, C. J., Morison, L., & Saewyc, E. (2009). Factors associated with pregnancy and STI among Aboriginal students in British Columbia. *Canadian Journal of Public Health*, 100(3), 226–230.
- Duncan, K. C., Reading, C., Borwein, A. M., Murray, M. C., Palmer, A., Michelow, W., et al. (2011). HIV incidence and prevalence among aboriginal peoples in Canada. *AIDS and Behavior*, 15(1), 214–227. <http://dx.doi.org/10.1007/s10461-010-9792-y>
- Dvir, Y., Ford, J. D., Hill, M., & Frazier, J. A. (2014). Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities. *Harvard Review of Psychiatry*, 22(3), 149–161. <http://dx.doi.org/10.1097/HRP.0000000000000014>
- Eitle, D., Greene, K., & Eitle, T. M. (2015). American Indians, substance use, and sexual behavior: Do predictors of sexually transmitted infections explain the race gap among young adults? *Sexually Transmitted Diseases*, 42(2), 64–67. <http://dx.doi.org/10.1097/OLQ.0000000000000230>
- Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, 23(3), 316–338. <http://dx.doi.org/10.1177/0886260507312290>
- Fernandes, V., & Osorio, F. L. (2015). Are there associations between early emotional trauma and anxiety disorders? Evidence from a systematic literature review and meta-analysis. *European Psychiatry*, <http://dx.doi.org/10.1016/j.eurpsy.2015.06.004>
- Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.
- Fogler, J. M., Shipherd, J. C., Clarke, S., Jensen, J., & Rowe, E. (2008). The impact of clergy-perpetrated sexual abuse: The role of gender, development, and posttraumatic stress. *Journal of Child Sexual Abuse*, 17(3–4), 329–358. <http://dx.doi.org/10.1080/10538710802329940>
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.
- Green, J., & Thorogood, N. (2009). *Qualitative methods for health research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Hadland, S. E., Werb, D., Kerr, T., Fu, E., Wang, H., Montaner, J. S., et al. (2012). Childhood sexual abuse and risk for initiating injection drug use: A prospective cohort study. *Preventive Medicine*, 55(5), 500–504. <http://dx.doi.org/10.1016/j.ypmed.2012.08.015>
- Hadland, S. E., Wood, E., Dong, H., Marshall, B. D., Kerr, T., Montaner, J. S., et al. (2015). Suicide attempts and childhood maltreatment among street youth: A prospective cohort study. *Pediatrics*, <http://dx.doi.org/10.1542/peds.2015-1108>
- Hart, M. A. (2010). Indigenous worldviews, knowledge, and research: The development of an indigenous research paradigm. *Journal of Indigenous Voices in Social Work*, 1(1), 1–16.
- Hoertel, N., Franco, S., Wall, M. M., Oquendo, M. A., Wang, S., Limosin, F., et al. (2015). Childhood maltreatment and risk of suicide attempt: A nationally representative study. *Journal of Clinical Psychiatry*, 76(7), 916–923. <http://dx.doi.org/10.4088/JCP.14m09420>
- Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173–202. <http://dx.doi.org/10.1146/annurev.publhealth.19.1.173>
- Kaufman, C. E., Shelby, L., Masure, D. J., Marrazzo, J., Wong, D., de Ravello, L., et al. (2007). Within the hidden epidemic: Sexually transmitted diseases and HIV/AIDS among American Indians and Alaska Natives. *Sexually Transmitted Diseases*, 34(10), 767–777. <http://dx.doi.org/10.1097/01.olq.0000260915.64098.cb>
- Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts*. Toronto: University of Toronto Press.
- Minichiello, V., Rahman, S., & Hussain, R. (2013). Epidemiology of sexually transmitted infections in global indigenous populations: Data availability and gaps. *International Journal of STD and AIDS*, 24(10), 759–768. <http://dx.doi.org/10.1177/0959646213481526>
- Murray, M. (1997). A narrative approach to health psychology: Background and potential. *Journal of Health Psychology*, 2(1), 9–20. <http://dx.doi.org/10.1177/135910539700200102>
- Murray, M. (2000). Levels of narrative analysis in health psychology. *Journal of Health Psychology*, 5(3), 337–347. <http://dx.doi.org/10.1177/135910530000500305>
- Nadew, G. T. (2012). Exposure to traumatic events, prevalence of posttraumatic stress disorder and alcohol abuse in Aboriginal communities. *Rural Remote Health*, 12(4), 1667.
- Newman, P. A., Woodford, M. R., & Logie, C. (2012). HIV vaccine acceptability and culturally appropriate dissemination among sexually diverse Aboriginal peoples in Canada. *Global Public Health*, 7(1), 87–100. <http://dx.doi.org/10.1080/17441692.2010.549139>
- Pargament, K. I., Murray-Swank, N. A., & Mahoney, A. (2008). Problem and solution: The spiritual dimension of clergy sexual abuse and its impact on survivors. *Journal of Child Sexual Abuse*, 17(3–4), 397–420. <http://dx.doi.org/10.1080/10538710802330187>
- Pearce, M. E., Blair, A. H., Teegee, M., Pan, S. W., Thomas, V., Zhang, H., et al. (2015). The Cedar Project*: Historical trauma and vulnerability to sexual assault among young aboriginal women who use illicit drugs in two Canadian cities. *Violence Against Women*, 21(3), 313–329. <http://dx.doi.org/10.1177/1077801214568356>
- Pedersen, J. S., Malcoe, L. H., & Pulkingham, J. (2013). Explaining aboriginal/non-aboriginal inequalities in postseparation violence against Canadian women: Application of a structural violence approach. *Violence Against Women*, 19(8), 1034–1058. <http://dx.doi.org/10.1177/1077801213499245>
- Pratchett, L. C., & Yehuda, R. (2011). Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Development and Psychopathology*, 23(2), 477–491. <http://dx.doi.org/10.1017/S0954579411000186>
- Ramisetty-Mikler, S., & Ebama, M. S. (2011). Alcohol/drug exposure, HIV-related sexual risk among urban American Indian and Alaska Native Youth: Evidence from a national survey. *Journal of School Health*, 81(11), 671–679. <http://dx.doi.org/10.1111/j.1746-1561.2011.00643.x>
- Riessman, C. K. (2008). *Narrative methods for the human sciences*. California: Sage Publications, Inc.
- Rincon-Cortes, M., & Sullivan, R. M. (2014). Early life trauma and attachment: Immediate and enduring effects on neurobehavioral and stress axis development. *Frontiers in Endocrinology (Lausanne)*, 5, 33. <http://dx.doi.org/10.3389/fendo.2014.00033>

- Robertson, L. H. (2006). The residential school experience: Syndrome or historic trauma. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 4(1), 1–28.
- Ross, R. (2014). *Indigenous healing: Exploring traditional paths*. Toronto: Penguin Canada.
- Shea, B., Aspin, C., Ward, J., Archibald, C., Dickson, N., McDonald, A., et al. (2011). HIV diagnoses in indigenous peoples: Comparison of Australia, Canada and New Zealand. *International Health*, 3(3), 193–198. <http://dx.doi.org/10.1016/j.inhe.2011.03.010>
- Sigurdardottir, S., Halldorsdottir, S., & Bender, S. S. (2014). Consequences of childhood sexual abuse for health and well-being: Gender similarities and differences. *Scandinavian Journal of Public Health*, 42(3), 278–286. <http://dx.doi.org/10.1177/1403494813514645>
- Spittal, P. M., Craib, K. J., Teegee, M., Baylis, C., Christian, W. M., Moniruzzaman, A. K., et al. (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.
- Walters, K. L., Simoni, J. M., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska natives: Incorporating culture in an “indigenist” stress-coping paradigm. *Public Health Reports*, 117(Suppl. 1), S104–S117.
- Wesley-Esquimaux, C., & Smolewski, M. (2004). *Historic trauma and aboriginal healing*. Retrieved from Ottawa.
- Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Winnipeg: Fernwood Publishing.
- Winscott, M., Taylor, M., & Kenney, K. (2010). Sexually transmitted diseases among American Indians in Arizona: An important public health disparity. *Public Health Reports*, 125(Suppl. 4), 51–60.