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Learning from the Past: young Indigenous people's accounts of blood-borne viral and sexually transmitted infections in Australia

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Abstract

The Indigenous Resilience Project is an Australian community-based participatory research project using qualitative methods to explore young Aboriginal and Torres Strait Islander people's views of blood borne viral and sexually transmitted infections (BBV/STI) affecting their communities. In this paper we present an analysis of narratives from young people who had a previous BBV/STI diagnosis to explore how they actively negotiate the experience of BBV/STI infection to construct a classic resilience narrative. We examine two overarching themes: first, the context of infection and diagnosis, including ignorance of STI/BBV prior to infection/diagnosis; and second, turning points and transformation in the form of insights, behaviours, roles and agency. Responding to critical writing on resilience theory, we argue that providing situated accounts of adversity from the perspectives of young Indigenous people prioritises their subjective understandings and challenges normative definitions of resilience.

Keywords: resilience; sexual health; young people; Indigenous people; Australia.

Introduction

The Indigenous Resilience Project (IRP) is a community-based participatory research (CBPR) project exploring young Aboriginal and Torres Strait Islander people's views of blood-borne viral and sexually transmitted infections (BBV/STI) affecting their peers and communities. Over the course of three years, a collaboration of researchers at the National Centre in HIV Epidemiology and Clinical Research, University of New South Wales and health care staff at three Aboriginal Community Controlled Health Services (ACCHS) worked together with young Indigenous people to develop and conduct qualitative research projects. This paper concentrates on the IRP-CBPR conducted with the Townsville Aboriginal and Islander Health Service (TAIHS).

Townsville is a large regional city on the north-east coast of Australia. The population at the time the project was conducted was 175,542; 5.9% identified as Indigenous (compared to 2.3% nationally) and almost a fifth of the population was aged 14 to 24 years (Australian Bureau of Statistics 2010). Townsville is the regional administrative centre for government services, has a large university, army base, industrial port, and extensive healthcare facilities servicing communities across northern Queensland. It is an important regional hub for Aboriginal and Torres Strait Islander people from across North Queensland, particularly Palm Island (an Aboriginal community 65 km to the north-west) and Mount Isa (a regional town 900km to the west). Community and clinical surveys provide snapshots of STI prevalence among Indigenous people in the region. A study of 1500 people participating in a population screening program in eight Indigenous communities around a large city close to Townsville found that 10% screened positive for chlamydia or gonorrhoea (Fagan 2001). A subsequent study of women attending an Indigenous Mums and Babies programme between 2000 and 2003 found a fifth screened positive for a STI; one third of women aged less than 20 years screened positive for chlamydia (Panaretto *et al.* 2006). Recent research on the efficacy of outreach chlamydia screening found the prevalence of chlamydia among young Indigenous people at a local Townsville high school and a youth service to be 15% and 17% respectively (Buhrer-Skinner *et al.* 2009). These findings suggest that young Indigenous people living in and around Townsville are at risk of STI infection, a point underscored by the participants in our study, a quarter of whom spontaneously reported a previous BBV/STI diagnosis (Mooney-Somers *et al.* 2009b).

At the heart of the IRP-CBPR is a commitment to strengths inquiry. According to Brough *et al.* (2004), health promotion has largely failed Indigenous communities by focusing on narrowly-defined behaviour change with little attention to upstream factors. This they argue has left the door open for a moral sub-text in which Indigenous people are seen to lack the capacity to exercise self-discipline. Practices that put young people at risk of BBV/STI are only part of the lived experience of BBV/STIs in Indigenous communities, thus this project aims to identify, assess and enhance the more nuanced BBV/STI indicators of resilience among young Aboriginal and Torres Strait Islander people.

The term resilience has been employed across a range of disciplines to refer to concepts such as the character of invulnerability (Olsson *et al.* 2003), positive adaptation despite adversity (Luthar *et al.* 2000), and relative resilience to psychosocial risk experiences (Rutter 1999). These definitions are not entirely compatible, for example a static trait of invulnerability versus the process of responding to adversity, but they do share common the underlying notion of a positive adaptation to a stressor.

The long history of resilience research tends to be seen in terms of two (sometimes three) waves (see for example (Richardson, 2002)). The first wave shifted the focus of psychological research with young people facing persistent disadvantage from problems and pathologies to strengths and survival. It sought to understand how children in poor and disadvantaged communities, particularly in the USA and UK, reached normal developmental outcomes (for example, Rutter 1981; Werner and Smith 1992). This foundational work focused on identifying qualities of resilient people and demonstrated that resilience is not a 'reflection of extraordinary coping abilities' (Mancini and Bonanno 2006, 976) but relatively common. However, it did little to explain how individuals came to display resilience (Harvey and Delfabbro 2004) and questions arose about whether identifying protective factors was sufficient (Fleming and Ledogar 2008). Thus, a second wave of resilience research focused on the underlying processes of resilience, how protective and risk factors interact to protect and strengthen people (Luthar *et al.* 2000). A plethora of protective factors at the level of the individual, their family and their society have been identified (Fleming and Ledogar 2008; Garmezy 1991; Masten 2006; Werner 1995). Here resilience is seen as the process of coping with adversity in such a way as to produce positive outcomes (Richardson 2002). A third wave, which overlaps the second wave of contemporary resilience research, is

concerned with intervention and the possibilities for strengthening protective factors and moderating risk factors to facilitate resilience (Masten 2006). Consistencies across these differences includes the broad consensus that resilience is a dynamic process that changes or modifies the likely negative outcome if an individual is exposed to a particular risk, stressor, or adverse event (Luthar *et al.* 2000; Olsson *et al.* 2003; Rutter 1987). Resilience is neither universal nor absolute, individuals can exhibit resilience in some areas of their lives and not others; it may wax and wane as new challenges emerge across the lifespan or life circumstances change (Fergus and Zimmerman 2005; Luthar *et al.* 2000).

Three explanatory models have been developed to explain interactions between protective/promotive and risk factors. *Compensatory models* frame protective factors as directly counteracting or operating in the opposite direction to a risk factor (Fergus and Zimmerman 2005). In an example from research with Canadian Indigenous communities, alcohol moderation is directly associated with a lower risk of youth suicide (Fleming and Ledogar 2008). In comparison, the *protective models* posit that resources, such as self esteem, supportive family or engagement in traditional cultural activities, moderate or reduce the risk of a negative outcome or enhance a protective factor (Fergus and Zimmerman 2005). In Canadian Indigenous communities, for example, being drug free has been associated with lower alcohol use. Thus, being drug free is protective in the sense that it enhances the effect of low alcohol use on lowering suicide risk (Fleming and Ledogar 2008). Finally, *challenge models*, such as Richardson's notion of 'resilient reintegration' (2002), propose that the association between a risk factor and an outcome is curvilinear. Exposure to low levels and high levels of a risk factor are associated with negative outcomes; however, a moderate level of a risk factor confronts an individual with enough to learn how to overcome it but not so much that they are overwhelmed. A significant feature of the challenge model is that risk and protective factors are one in the same, thus the model is concerned with degree of exposure (Fergus and Zimmerman 2005).

A persistent critique levelled at conventional resilience research is of cultural hegemony (Ungar 2004). Concerns that resilience models rely on culturally specific criteria of normal functioning arose relatively early in the development of resilience research (Bottrell 2009), and speak directly to attempts to generalise specific competencies across populations and contexts (Harvey and Delfabbro 2004; Ungar 2004). Evidence to support these concerns comes from research demonstrating that resilience is both content and context specific; factors that are protective in one context may not be in another, and indeed may become risk factors (Fergus and Zimmerman 2005). Differences in factors contributing to resilience have been demonstrated across gender, socioeconomic status, ethnicity, immigration status and age, resulting in a growing awareness that social and economic contexts are important to understanding resilience (Fleming and Ledogar 2008). Some theorists have gone further, problematising the normative definition of resilience, whereby the very 'criteria for assessment of positive and mal-adaptation is embedded in socio-cultural assumptions and historically specific societal expectations' (Bottrell 2009, 324; Harvey and Delfabbro 2004). Outcomes used to determine resilience may not necessarily be valued by the individual or their community and evidence from cross-cultural studies show significant and meaningful cultural variations in responses to adversity (see Harvey and Delfabbro 2004). Moreover, adverse events may not be experienced by individuals in similar ways, raising significant implications for understanding individual responses. One reaction to the universalising tendency of contemporary notions of resilience is a call to attend to individuals' perceptions of resilience (Bottrell 2007; Fergus and Zimmerman 2005) such that the 'definition of resilience itself should be based less upon so-called objective cut-off scores, but also upon culturally and socially relevant rating of success [...] whether or not a person has proved to be successful and is well adjusted is very much an issue of individual determination' (Harvey and Delfabbro 2004, 11).

Reflecting a commitment to respecting Indigenous familial and community values, the working definition of resilience we employed throughout this project was the means by which young people make use of individual and community strengths to protect themselves against adverse health outcomes and enhance their health and wellbeing. In this paper we explore how young Indigenous people actively negotiated the experience of BBV/STI infection to construct a narrative of resilience embodying personal, familial and community strengths. By providing situated accounts of adversity from the perspective of young Indigenous people we prioritise their subjective understandings and challenge normative definitions of resilience (Bottrell 2009; Ungar 2004).

Data collection and analysis

An extensive consultation process with community stakeholders identified young people experiencing or facing homelessness as a priority population for the local community and health services. Eight young Indigenous people from this population and seven Indigenous health care providers (including WE & RS) attended a three-day research training and development workshop run by the university researchers (JMS & LM), and worked collaboratively to develop questions, recruitment strategies and culturally safe ways of conducting our research (described in detail in Mooney-Somers and Maher 2009a). As the research is concerned with intimate and often stigmatised behaviours, considerable time was given to discussing how best to research these topics in a sensitive and culturally appropriate way.

Data was collected by five young Indigenous people (peer researchers) and WE while spending time meeting and getting to know people in the community (potential participants and others). Field interviews conducted with participants were opportunistic; taking place during fieldwork at malls, parks, homeless hostels and drop-in centres across Townsville at the time that recruitment occurred. Interviews often began with an important cultural protocol of introducing yourself and your family; the amount of time spent on this varied considerably, especially if there was a shared family connection. Constructed much like a conversation, the interviews were documented by hand on a pro-forma that had been developed by the peer researchers and the authors during research training. The hand written notes were typed up by the peer researchers or the site coordinator (WE). The pro-forma consisted of specific demographic and informational questions and broader questions designed to elicit stories about experiences of using health services, accessing condoms, and discussing BBV/STI with sexual partners. In addition to verbatim interview notes, the pro-forma included space for the researchers to record their impressions of the interview and participant, and indicate if they had referred the participant to any services or given them information or BBV/STI resources (for a discussion of 'no research without service' see Mooney-Somers & Maher, 2009a).

Our study sample consists of 45 people, 17 men and 28 women, aged between 17 and 26 years, all of whom self-identified as Aboriginal or Torres Strait Islander (the study inclusion criteria). Reflecting the priority population that emerged during consultation, we aimed to recruit young people who had experience of or were at risk of homelessness. A quarter of our participants spontaneously reported a previous BBV/STI diagnosis: chlamydia (N4), gonorrhoea (N2), infectious syphilis (N1), trichomoniasis (N1), hepatitis B (N1), hepatitis C (N1) and cervical cancer (N1). This sub-sample, the subject of the analysis presented in this paper, consists of 7 women and 4 men, average age 24 years. Six young women had children; two reported their children had been removed by child safety services, a third that her children were living with extended family. Three participants lived in homeless hostels, four described themselves as temporarily boarding with friends or relatives, and the remaining four were in rental accommodation. None of these participants described themselves

as currently working, two were undertaking formal study, and several reported leaving school between the ages of 14 and 16 years.

A thematic analysis was undertaken by the university researchers JMS and LM. Following the processes outlined by Braun and Clarke (2006), field interview notes were read and re-read to identify recurrent patterns, or themes, related to the project questions: what keeps young people healthy and protected against BBV/STI, and how can we help young people be stronger so they can better prevent BBV/STI and obtain appropriate care and treatment. Accounts of BBV/STI infection revealed reflexive narratives about adversity and strength and the accounts from these 11 individuals were subject to detailed thematic analysis. Common features included descriptions of context of infection and diagnosis, ignorance of STI/BBV prior to infection/diagnosis, lessons learnt or turning points, changes in behaviour linked to diagnosis, and additional outcomes linked to the experience of infection. We present these as two overarching themes: (1) context of infection and diagnosis; and (2) turning points and transformation in the form of insights, behaviours, roles and agency. Following Braun and Clarke (2006), extracts from the field interviews are provided to illustrate each theme. Interview quotes are de-identified and pseudonyms used throughout.

Results

We begin by discussing the first theme, context of infection and diagnosis, throughout which young people's descriptions set the scene for the subsequent theme of turning points and transformation.

Context of infection and diagnosis

During the field interviews, 11 young people spontaneously disclosed a previous BBV/STI diagnosis. Most recounted the way they believed they had contracted their infection. It was common to attribute blame to a specific individual.

I think he passed the STI to me. He was sleeping with my friends (Samantha, age unknown, moves between Townsville and Palm Island).

However, a few attributed their infection to their own risky behaviours,

Like before I never have one partner and never use a condom and I had that thing [chlamydia] (Ester, 26, living with family).

Most young people described what prompted BBV/STT screening. For some, a test was prompted by the appearance of signs that caused the young person some concern.

I felt funny at night, did not know about this disease [...] I went to the doctor and told him how I was feeling. I was naive, they did blood test and found out that I had chlamydia (Lanie, 23, living with partner's family).

It was also common for health checks to be sought at the suggestion of others.

His [sibling] came round to me and told me to get myself checked out (Lindy, 17, living with family).

Very few young people described their experience of diagnosis. It is striking that both of the negative experiences reported were related to a diagnosis of viral hepatitis.

The doctor at the emergency clinic at [location] just blurted out that I have hepatitis C, 'have a nice day, see ya later', and did not explain anything to me. I was upset, shocked, this doctor should have told, explained something to me. The blood test showed hepatitis C positive. That was it (Edwina, 24, living in hostel).

After setting the scene of their diagnosis, many young people mentioned their ignorance of BBV/STI at the time of infection.

I was shocked when I found out. I did not know anything about STI [...] I didn't know anything and thought I might die (Lindy, 17, living with family).

It was common for participants to identify people in their lives, particularly parents, who they felt should have educated them about infection prevention. They indicated that they had missed out on information about prevention and the skills to put prevention strategies into action.

My mum never talk to me about pregnancy and all that, she is very strict and protective [...] I could never feel comfortable talking to her. I suggest that parents these days need to be more open minded and teach their kids about these infections so that children are much more prepared and feel confident enough to stand up for themselves (Lanie, 23, living with partner's family).

Complaints about the failure of responsible adults to educate them can be read as an attempt to absolve young people of blame for their infection. An alternative and not necessarily contradictory reading is that these stories provide a means to make sense of an illness experience. Other authors have identified several, often coexisting, narrative structures within the accounts of people experiencing illness (Thomas-MacLean 2004). For example, restitution narratives describe illness and the return to normal life; chaos narratives involve people's struggle to make sense of their experiences; while quest narratives demonstrate how illness is useful (Frank 1995). Accounts of BBV/STI infection and diagnosis in our study overwhelmingly correspond to the quest narrative, where ignorance acts as a precursor to enlightenment and transformation. This reading is supported by young people who, unlike their contemporaries above, attributed their ignorance not to a failure by others, but to their own lack of attention when information was provided.

I'm not educated, I finish at [2nd year of high school]. I never really listen to my gran, she use to growl me all the time, my gran is now gone, passed away in [year] and now I look back I should have listened to her. I now is sorry I never listen to them (Samantha, age unknown, moves between Townsville and Palm Island).

Turning points and transformations

Richardson (2002) argues that some level of distress or disruption to our normal view of the world is required for learning to occur following an adverse event; learning is not an inevitable outcome of adversity. The narratives from young people in our study consistently contained moments of disruption; these turning points or crisis points provide insight into their subsequent transformation. For some, like the young man in the next extract, the disruption was prompted by the physical experience of infection.

I feel like I learned a lesson from this. I was scared because when I had that pus I couldn't walk properly. It was sore. I went to the doctors and they told me that I have to use condoms, and they gave me these tablets, those big ones and they poke a long cord down my penis. They were trying to make all these pus to come out and that was sore. They have to give me a needle to make me numb, it was sore. I can't hardly walk but I tell you, I will never want to be in that place again (Mark, 26, living with family).

One young woman spoke of her shock at diagnosis and the shame and stigma she felt at being infected.

Makes me think twice about the stupid things I did, never heard about trichomoniasis before [...] it was a hard lesson for me, a big shock for me after I learned I had picked up trichomoniasis after having unsafe sex! Yuck! I felt dirty and not wanted (Nina, 26, living temporarily with friend).

Finally, some young people described their diagnosis as facilitating a realisation that they had got away lightly given the much greater threat of HIV/AIDS.

Now have had it I can see that guy could have anything like AIDS. You can get treatment for some stuff but some you can't (Lindy, 17, living with family).

The extracts above feature several insights into participants' reflections on their vulnerability to, and the consequences of, infection. We read these accounts as narrative structures depicting an experience of illness as ignorance leading to infection, which in turn allowed for enlightenment and transformation. It is important to note that a turning point in these accounts was not the fact of having had an infection. It was a disruption to the young person's world view that facilitated something often characterised as recovery (Shepherd, Reynolds, & Moran, 2010), but which the young people in our study spoke about as transformative, often using a metaphor of learning.

Learnt my lesson at the time (Fred, 19, living with family)

The experience I had made me more wiser (James, 25, living in hostel).

Transformations took the form of gaining knowledge and understanding such as the insights into the importance of preventing BBV/STI discussed above. Young people also linked their infection to a subsequent change in their prevention practice, that is, the 'lesson' was that their practices had made them vulnerable to infection. Specifically, they reported that they *now* used condoms, had BBV/STI health checks, requested new partners have BBV/STI checks, spoke to their partners about preventing BBV/STI, and took time to build a trusting relationship with new sexual partners. For example,

When I meet someone new I would say to him to go first for a sexual health check before I sleep with him [...] I feel like I learn a lesson from past experience, you know, trust nobody until you know them (Samantha, age unknown, moves between Townsville and Palm Island).

I don't hold back with using condoms. I need protection because I had an infection before like pus coming out of my thing from all sorts of girls in [place], that is why I realise I have to use the condom (Mark, 26, living with family).

Behaviour change is not simply a matter of intention and young people described barriers that made following through on intentions difficult. In the extract below, Fred describes how the experience of infection created a desire to use condoms that was not always easy to act on.

Learnt my lesson that time, I was told by this doctor that next time I have to use protection, so I like to use condoms when I can get them. I know TAIHS give out free condoms but it is hard to find some or to buy some when you need them [...] Not always easy to get condoms. Protection is a very easy word but is hard to do. I have to always think to myself what next (Fred, 19, living with family).

Ester raises two further barriers to consistent preventative behaviours which are commonly referred to in the literature: intoxication with alcohol or drugs and a male partner's reluctance to use condoms (De Bro *et al.* 1994; Holland *et al.* 1990).

With alcohol and drugs it would be easier not to use protection during sex and being under the influence of drugs and alcohol and go with the flow and the fella may not want to use the protection. I would probably go along willingly being intoxicated or sober myself to bother with protection. But still I have to think about the end result and then would have to go for a sexual health check later on. It is a lot easier aye! You know just go with the flow and then before you know it oooops! You end up with something (Ester, 26, living with family).

According to Frank, the problem with quest narratives 'is that they may show movement through illness as too clean and the transformation too complete, and they implicitly deprecate those who fail to rise out of their own ashes' (1995, 135). This resonates with young people in our

study who raised the possibility of becoming infected again; some did suggest that this would be a disappointment to them.

I would not go back there again once I catch it. Silly person not to learn (Eric, 26, living temporarily with family).

I don't want to make the same mistake like before (Nina, 26, living temporarily with friend).

However, in Ester and Eric's extracts above we can see that their experiences have not produced fixed notions of learning and behaviour change, but rather flexibility and persistence that are productive *in their lived experience*. Ester's new awareness prompts a health check up, while Eric tries to anticipate when he might need condoms.

The quest narratives that we see in young people's accounts are also pervasive in the resilience literature, particularly in relation to the challenge model of resilience. Mancini and Bonanno note that the loss of a significant other or a life-threatening event 'may promote a changed and expanded understanding of the possibilities of self [...] They may seek to broaden their behavioural repertoire and redefine their beliefs, trying out new roles and new relationships, engaging in new activities' (2006, 980). Transformations of the self, the third type of transformation, were described by a significant proportion of young people in our study. There was a remarkable and persistent theme present in young women's accounts where they depict a new self who is an educator and responsible carer, sharing their new awareness and skills with peers, challenging the dominant discourse of stigma and shame, vouching for specific health services, and supporting friends should they need to seek medical assistance. Young women often indicated that this was motivated by a hope that others could be spared learning the hard way – that is, through direct personal experience of an infection.

I would anticipate going out to speak to children in school as a role model, the church has helped me a lot to be aware and not to be ashamed of where and what I did in the past (Nina, 26, living temporarily with friend).

Don't be shy to talk to someone; I know the people at sexual health listen to you. They did to me. They want me to come in to clinic for a check up or follow up I always go [...] I can even take the person to the clinic myself [...] I learned the hard way, now it is my turn to tell these young people not to be shy to get help (Samantha, age unknown, moves between Townsville and Palm Island).

Slightly different were changes in young people's sense of self, which they described as a new-found personal strength to carry on and look to the future. We interpret these narratives about growth as young people's new sense of agency. Reflecting on their experiences, many participants now felt responsible for and able to look after their own health.

I use to feel dirty when I was told I had trichomoniasis, but now I have got over it and [I'm] now aware to be taking precautions and to feel good about myself for keeping myself free from these troubles (Nina, 26, living temporarily with friend).

We also see agency in extracts such as those from Ester and Eric, in which young people go beyond condom use to actively draw on a variety of preventative strategies. Specifically, for many of the young people in our study having a trusting relationship with one partner was their preferred strategy (Mooney-Somers *et al.* 2009b). Previous research has highlighted the association between condoms and casual partners or condoms and new partners (East *et al.* 2007) where continued use in longer-term partnerships or relationships where familiarity and trust has been built becomes problematic. Condom free sex signifies trust and abandoning condoms in a relationship becomes a symbolic marker of love and commitment (Hillier *et al.* 1999; Kirkman *et al.* 1998). Prioritising trust or love means that young people in our study who contracted an infection are resisting a strategy (condoms) that would likely have prevented their earlier infection and any future infection. Instead young people employ a preferred strategy that allows their relationship to be prioritised. We can see this in the following extract where Davina describes how unprotected sex made her vulnerable to infection, yet she still does not use a condom.

I'm sexually active at the moment and I don't use protection because I know him [...] I also want to go now and get my HPV vaccination from the doctors [...] I trust my partner that is why I do not use protection [...] I was scared back then especially after I was told I had cervical cancer. I did not understand that cervical cancer can be caused by not having protected sex. I still do not use protection now but at least I know what will happen to my health if I do not look after myself (Davina, 26, living in hostel).

The experience of infection and diagnosis has not changed Davina's condom use but it has educated her and provided a motivation to seek HPV vaccination. In some narratives then, self transformation comes from *now* having the ability to make informed decisions and choose strategies that work for young people in the sociocultural context in which they negotiate sexual relationships. That is, their understanding of prevention and resilience to ill health is not simply measured by commitment to condom use, but meaningful interpersonal experiences of sex, trust and love. This contextualisation of resilience in the sexual lives of young people asks us to take seriously the calls for resilience to be understood in terms of local meanings (Bottrell 2009; Ungar 2001; 2004). Our findings highlight the need to understand how young people exercise agency in applying new knowledge in ways that are 'legitimate and functional adaptations to contextual demands' (Burack *et al.* 2007, 20-21).

Conclusion

Resilience is not simply a matter of evading or avoiding risk, or of returning to equilibrium after exposure to an adverse experience (Garmezy 1991; Olsson *et al.* 2003; Rutter 1987). Nor is it an inevitable outcome of adversity. The few accounts of repeat diagnoses in our study suggest that the transformations outlined above did not occur *just* because young people contracted an infection. According to Richardson (2002), individuals who do not learn from a stressful life event and attempt to return to life as it was before the stressor – 'homeostatic reintegration' – are likely to re-experience it. Richardson also describes unproductive responses to stressful life events that demonstrate that the positive and productive responses to BBV/STI described by young people in our study need to be seen as more than just learning lessons and changing behaviour. Although they revealed some shame, embarrassment and anguish associated with diagnosis, our young

participants did not appear to become overwhelmed. They built on their experience to increase their confidence in dealing with sex and relationships in a more skilled manner. Confronting their experience in this manner young people evoke 'resilient reintegration', whereby an individual responding to a stressful life event 'puts his/her life back together in a way that leaves him/her with more protective factors and skills to effectively reintegrate in the face of future life events' (Richardson *et al.* 1990, 37). That is, their engagement with adversity in the form of an STI experience has given them insights and skills allowing them to be better prepared to deal with subsequent life events and stressors (Bell 2001; Fleming and Ledogar 2008). For many, there was an additional level of transformation beyond simply gaining skills. They described to us a new resolve around their health, a strengthened sense of agency, and a sense of connection to and care for others.

It is worth reiterating that we did not seek resilience narratives about STI/BBV infection; the fact that they emerged through the field interviews suggests these young people understand their experiences of infection as an important part of their biography and journey of enlightenment and transformation (Frank 1995). Narrating their experience as useful or productive clearly fostered a positive sense of self. Embedding this narrative detail into theories of resilience we have explored specific turning points where young people reflect on life trajectories that could have been quite different. Beyond theory, we would like to suggest that our exploration of resilience narratives also provides insights into potential sources of intervention to reduce infection transmission among young people. One such opportunity may be to respond to young women's desire to share their experiences of diagnosis and the resulting knowledge about prevention with other young people by facilitating formal peer mentoring or support. This has the dual advantage of also allowing them to take on valuable and self-esteem enhancing leadership roles in their community. We would also like to suggest that these narratives highlight opportunities to support young people by leveraging the reflective space created by their response to infection and diagnosis. For example by using the adverse event of BBV/STI diagnosis to support a trajectory that involves growth (resilience) rather than the homeostatic, maladaptive or dysfunctional reintegration foreshadowed by Richardson (2002). We note that the young people in our study appear to have undertaken this work on their own and caution against over formalising, or institutionalising, this process. Again, peer support may be a promising alternative.

Our study has four limitations of note. We did not ask young people if they had ever been diagnosed with BBV/STI, thus, the narratives we have presented here are a self-selected sample that may under-represent those diagnosed with BBV/STI and/or over-represent people who have gained some insight through their experience. Thus, we do not claim to present the variety of ways in which young Indigenous people in Townsville give meaning to the experience of BBV/STI infection. Secondly, young men are under-represented in our sample. The need to respect cultural protocols around gender is important in health care and promotion. Most of the data was collected by women and they were not always comfortable approaching men to participate in the study. Thirdly, our project is explicitly local, and we make no claims to the generalisability of our findings to other young people, Indigenous or non-Indigenous. However, the insights provided by our analysis of young Indigenous people's responses to infection may prove to be valuable at a time when the rate of infection of many STIs, notably chlamydia, is rising among all young people in Australia (National Centre in HIV Epidemiology and Clinical Research 2009).

Finally, the flexibility of a qualitative approach, especially our documenting of conversations with note taking rather than recording, meant that field interviews could be held when an opportunity arose, easily started, paused and resumed creating a less formal and intrusive research experience for our participants. Interviews took place in public spaces and noise, interruptions and unforeseen disruptions were common. In this context, digital recording of these casual, extended

encounters would have been labour and cost intensive and the openness of the participants may have been jeopardised. However, notes from field interviews are an imperfect record of a conversation. In addition, while the peer interviewers bring personal depth to the data collection, their novice interviewing skills means that the field notes do not contain the same detail and breadth that may have been produced by experienced interviewers.

Eliciting subjective accounts of young people's perspectives on BBV/STI provided narratives of BBV/STI experience, which in turn made explicit the dynamic process of responding to and making sense of an adverse event. This process of resilience had important implications for identity, and for many of the young people in our study produced a stronger sense of self. We acknowledge that it is possible to read narratives of past mistakes and lessons learnt as attempts to provide a positive ending to a shameful time in young people's lives (Newman *et al.* 2007) or to demonstrate to the interviewer how they have redeemed or bettered themselves. However, we read them as exemplars of the challenge model of resilience, where young people's engagement with BBV/STI infection has 'result[ed] in the identification, fortification and enrichment of resilient qualities or protective factors' (Richardson 2002, 308). The young people in our study clearly articulated that the experience of infection has created new competencies in terms of negotiating safe and healthy relationships and preventing BBV/STI and accessing health services, as well as new insights into the value of protecting health for their self and family. More broadly, the positive self concept that many young people describe, the sense of pride in valuing their health and looking after themselves, the sense of connection to family and community, may contribute to generalised competence across a range of domains leaving these young people better prepared for a range of future adversities. Our findings not only reinforce the principles of a strengths-based approach, but show how a public health response to BBV/STIs can move beyond narrowly defined behaviour change - use condoms, get tested - to include broader issues such as identity, autonomy and community.

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