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They tell us “we don’t belong in the world and we shouldn’t take up a place”: HIV discourse within two-spirit communities

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Abstract

Objectives: We investigated how HIV discourse is negotiated and given meaning in the lives of young, male two-spirit leaders, when considering their communities’ and their own health and wellness. These men are also unique in that they have always lived under the specter and dominant discourse of HIV, that is, they are part of a second generation since the time of HIV/AIDS.

Methods: We conducted a Discourse Analysis of six qualitative interviews from the HONOR Project, a multi-site, mixed-methods study of the two-spirit community across the United States, foregrounding the relationships amongst trauma, coping, and health.

Results: HIV functions discursively in four ways, as a: shadow presence, professionalized identity, health sub-/priority, and vehicle for belonging and (re)claiming.

Conclusions: This study is important to social work as well as HIV prevention and care as it affords voice to two-spirit men, a highly marginalized community and one often silenced in scientific discourse. And, it centralizes language and context, complicating social epidemiological characterizations of HIV/AIDS, risk, and historically traumatized populations.

Keywords

HIV/AIDS; two-spirit; American Indian / Alaska Native; Discourse Analysis

INTRODUCTION

HIV/AIDS is simultaneously a physiological condition and psychosocial phenomenon, being a prominent part of the contemporary social and scientific landscape for many communities across the United States (U.S.). In particular, American Indians and Alaska Natives (AIAN) comprise approximately 1.7% of the population in the U.S., or 5.2 million people (CDC, 2015a, 2015b), and have experienced health disparities for over five centuries, which more recently includes HIV (Jones, 2006). As of 2010, AIAN persons accounted for approximately 1% of all new HIV infections, or 210 of 47,500 (CDC, 2015a); by 2013, this rate follows those of African Americans, Latinos, Native Hawaiians / Pacific Islanders, and

multi-racial people(CDC, 2015b). Overall, racial/ethnic minorities account for one-quarter of the U.S. population, but 58% of HIV/AIDS cases(Vernon, 2007). At face value, these rates may appear less alarming for AIAN people; however, these rates obscure the enduring fourth world status of AIAN people today. This fourth world status of AIAN people is one characterized by little empirical research, intergenerational poverty, historical trauma, and concomitant socio-health disparities including increased rates of STI's, drug use, poor access to healthcare, underreported and low HIV testing, and disproportionate morbidity once diagnosed with HIV (CDC, 2015b; Chae& Walters, 2009; NASTAD, 2013; Rhoades, 2003; Simoni, Walters, Balsam, & Meyers, 2006).

Compounding this are the even more unequal health disparities for two-spirit and lesbian, gay, bisexual, transgender, and queer (LGBTQ) AIAN people. The term *two-spirit* is often looked at as a Native variant of mainstream, binarized, and Western conceptions and expressions of gender or sexuality. Yet, in 1990, Native activists claimed a term of their own – *two-spirit* (Anguksuar, 1997) – to counter historical and contemporary colonizing language around indigenous expressions of gender and sexuality (e.g., *berdache*, *third gender*). While not utilized by all AIAN communities, this identification originates from the Northern Algonquin word *niizhmanitoag*, meaning *two spirits*, and signifies an inclusion of masculine and feminine elements within one person (Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006). More critically, this term often functions multi-dimensionally as a chosen identity to transcend binarized sexualities and genders – as well as a decolonizing and re-/indigenizing standpoint and an active critique of White supremacy and heteropatriarchal structures from outside and within Native communities (Balestrery, 2012; Driskill, 2010; Garrett & Barrett, 2003; Walters, 1997; Wilson, 1996). In that way, an appreciation of this identity must also include an analysis of the lived experience and social roles of two-spirit people in their relationships, including those with other non-Native LGBTQ people, wherein they actively and continually must negotiate their identities, which may be contested by these relationships (Blackwood, 1997).

Within the HIV epidemic, 76% of those AIAN infected were men, and three-quarters occurred via male-to-male sexual behavior (or, men-who-have-sex-with-men, [MSM]), which is 18 times more than Whites(CDC, 2015a). Moreover, AIAN MSM and those MSM with a history of injection drug use constitute 73% of all AIAN people living with HIV(NASTAD, 2013). Added to this, two-spirit people face an increased number of public health problems including intersectional discrimination and stigma, histories of sexual and other victimization, substance use, and adversely affected mental health (Chae& Walters, 2009; NASTAD, 2013; Balsam, Huang, Fieland, Simoni, & Walters, 2004; Fieland, Walters, & Simoni, 2007; Nelson, Simoni, Pearson, and Walters, 2011). These factors are increasingly associated with the sexual risk taking of both MSM and two-spirit persons (Simoni, Walters, Balsam, & Meyers, 2006; Nelson, Simoni, Pearson, & Walters, 2011; Walters, Simoni, & Harris, 2000).

From a social epidemiology perspective, HIV is necessarily an important health issue for AIAN and two-spirit communities today, albeit poorly understood. Still, this top down perspective does little to expose what HIV means in the situated context of the lived experiences of two-spirit people, this is to say, what HIV means amidst the felt experiences

when negotiating a fourth world location replete with historical trauma, “compounded risk”, and an invisibilizing of health status (Balestrery, 2012; Fieland, Walters, & Simoni, 2007). While this marginalized and colonized social location fosters risk and health disparities, it also offers conditions of resistance and resilience; important to that process are multiple factors including identity and enculturation (Walters, Simoni, & Evans-Campbell, 2002).

Thus, working against the tendency to reduce two-spirit identity to one static demographic in the pathway of HIV transmission, this study sought to center attention on two-spirit persons themselves and their process of identification in the face of HIV. Even more, attention was paid to participants from a younger cohort. Soon into the third decade of the epidemic, attention was given to the behaviors and barriers of younger people and specifically men-who-have-sex-with-men *vis-à-vis* continued HIV infections despite best practice efforts in prevention and care. A public discourse mounted about this problematic “second wave” in the U.S. HIV epidemic (*cf.* Gross, 2003). Compounding the multiple oppressive forces and health disparities for two-spirit men, and in particular those who are younger, is now another one around HIV/AIDS. To that end, through attention to their narrated experiences, an understanding of the discourse of HIV was sought in the lives of these younger men who have always lived under the presence of HIV, that is, men who have always known a time when HIV existed and has been communicated in the public sphere. Such an attention to this group of men disrupts the presumed concordance between being exposed to HIV in the public sphere and therefore a certainty about prevention practices and HIV status. Moreover, this approach sought to problematize the assumption that we are all speaking the same language in HIV care and prevention when discussing HIV in the lives of two-spirit people: does HIV mean the same thing in each situation for everyone. From this vantage point, young two-spirit people are afforded voice, on one level, about the public health problem of HIV, risk, contagion, as well as about survival, resistance, and cultural continuance (Driskill, 2010). In so doing, this work speaks back to and complements social epidemiological efforts (Nelson, Simoni, Pearson, & Walters, 2011) by illustrating what noted determinants and disparities mean in context, how two-spirit people negotiate them, and how HIV operates in everyday life. To be clear, such a stance requires an ethic of “speaking nearby” (*cf.* Chen & Trinh, 1994) rather than presuming to or summarily speaking for two-spirit men.

METHODS

To achieve this aim, a secondary qualitative analysis was conducted on data from the HONOR Project, a mixed-methods, Native-run, and multi-site study of two-spirit AIANs across the United States, which aimed to test an “indigenist” stress-coping model, investigating the relationships amongst trauma, coping, and health. The study procedures have been detailed elsewhere (Cassels, Pearson, Walters, Simoni, & Morris, 2010; Chae & Walters, 2009; Lehavot, Walters, & Simoni, 2009). The HONOR Project began with 5 focus groups and over 60 individual, in-depth interviews or *testimonios*, identifying stressors and coping strategies specific to two-spirit leaders (Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006). This informed the second phase, from 2005 to 2007, of 448 semi-structured interviews of two-spirit people in seven geographic areas (i.e., Seattle-Tacoma, San Francisco-Oakland, Los Angeles, Denver, Tulsa-Oklahoma City, Minneapolis- St. Paul, and New York). Given its combination of targeted, partial network, and respondent-driven

sampling, the HONOR Project could maximize heterogeneity in the sample while reducing selection bias (Nelson, Simoni, Pearson, & Walters, 2011).

For this specific study, a theoretical and purposive sample was drawn of 6self-identified two-spirit men, regardless of sero-status (i.e., HIV positive, negative, unknown),who hold social influence for future generations for the fact that they were recruited in as leaders in their respective communities, and who uttered “HIV” or “AIDS” in their HONOR Project *testimonio*. They also were a maximum of 35 years old at the time of their interview, that is, they representthis “second wave”within the U.S. HIV epidemic, one which has always lived with HIV/AIDS in the public sphere. All interviews and surveys were conducted in English. Further demographics for these selected participants were not available due to HONOR Project study protocol and procedures. The original HONOR Project study was approved with the Institutional Review Board (IRB) of the University of Washington; this secondary analysis was exempt from review per the IRB at the California State University, Sacramento, and was approved by the Indigenous Wellness Research Institute (IWRI; see www.iwri.org), which conducted the HONOR Project.

To achieve the secondary analysis, a Discourse Analysis (DA; Gee, 2014a, 2014b) was conducted. DA is an empirically-driven, interpretive methodology based in psycho- and socio-linguistics – paying attention explicitly todiscourse, or “language-in-use”relative to social, political, and cultural formations (Jaworski&Coupland, 1999; Cameron, 2001). DA is most concerned with the functional qualities of language and communicative practices, beginning with two premises: 1. discourse is a major institution in our modern world; and, 2. language only has meaning in-and-through social practices. Discourse is language that indexes social order *and also* actively shapes social order and individuals’ interaction with society. Accordingly, discourse can *do* many things: it allows for identities to exist, governs the ways to talk meaningfully about social topics, regulates social conduct, and it can maintain systems of inequality and privilege, among other things. DA as epistemological approach and methodology investigates texts-in-context, providing insights into social life to better apprehend how language and society reciprocally reflect one another. As such, it is the very premise that language *does* certain things that moves beyond perceived (or imposed) distance between social actors and language systems, and it provides for an analysis that can explain, “the nature of the language system, since the system itself reflects the functions that it has evolved to serve” (Halliday, 1997, p. 36).At-large, DA encompasses many traditions from various fields, and the objects of analysis can be institutional communicative practices (e.g., public policy, news media, marketing) as well as interpersonal communication (e.g., conversations, community organizing).Given its attention to deconstruct social relationships, appreciate the production of identities through language, and bring to light interfaces of knowledge and power, DA was selected as an appropriate tool to analyze these *testimonies* and have a small window into how HIV functions in the lives of these two-spirit men.

This variant of DA (Gee, 2014a, 2014b) provided a first cycle closed-coding schema (Creswell, 2013; Miles, Huberman, &Saldaña, 2014; Saldaña, 2013)based onthe seven “building tasks” of language, or the “things” that language does to reciprocally construct the social world: significance, activities, identities, relationships, politics, connections, and sign systems. These building tasks allowed for aprovisional interrogation of the incidents

ofspoken “HIV/AIDS” throughout the interviews. A second coding cycle manifested over several re-readings, advancing an interpretive framework to understand HIV’s situated meaning *within* these participants’ lived two-spirit narratives, that is, how two-spirit leaders embody HIV discourse and incorporate it into their identity. Additionally, to increase trustworthiness and rigor (Padgett, 2008; Tracy, 2010), the researchers engaged in cultural consultation and self-reflexive journaling.

RESULTS

Figure 1 illustrates the four discursive themes that constituted “HIV” within these narratives: HIV as shadow presence, as professionalized identity, as a health sub-/priority, and as a vehicle for belonging / (re)claiming.

Shadow Presence

Discrete, spoken incidents of both *HIV* and *AIDS* are largely absent within these narratives. When they do appear, the young two-spirit leaders do not ruminate about the virus or the epidemic. And while HIV is silent *per se* and silenced, its presence is felt and implied nonetheless. One participant, a pre-med major and employee of an AIDS Service Organization, mentioned HIV in terms of being a given identity, rather than medico-social problem:

But I think you know asking how important for you to find out (your status) – because some people don’t want to know if they’re HIV positive. They don’t want to go get tested because they don’t want to face the truth.... I think that’s important because I think those tough questions like that are good because it makes people start thinking.

(Frank)

The virus functions as a “truth” from which to hide, or not face, symbolizing stigmatized activities. Those activities one does or confesses to doing, and upon facing them directly they have to face HIV (positivity) and think one’s self in that light. Another participant furthers this in speaking to the omnipresence of HIV. The epidemic is a constant worry and an endemic part of enacting a gay lifestyle so much so that it apparently does not even need to be named or be discussed:

You know, my first boyfriend was a doctor and he said, you know, it may be controversial but as long you wear a condom when you have you know when you fuck or get fucked like you really have not a...you chance it but you don’t have a lot to worry about....

(Ed)

The virus is simultaneously ubiquitous and silenced into a vector of behavior and risk. To embody a gay sexuality is to communicate HIV, notionally and physically, centralized onto or *into* the male body. The male rectum, which is the privileged object that “you fuck or get fucked”, stows HIV and the discomfort or anxiety of risk away, from other health discourses and from one’s mind. This nature of embodiment appears to be associated with a history of obscuring health promotion in Native country, for at least one participant:

Well STD prevention, of sexual health, substance abuse, getting you know yearly exams, dental, like I mean all those things don't ever come into play, 'cause there's no messages I think. Well there is now, certainly HIV and AIDS but, I don't know, maybe I just didn't see it or maybe I was blind to it, but I never saw that growing up....

(Mike)

Whereas now there may be messaging about sexual health apparent to this participant living in urban areas, there was not during childhood on the reservation, or in Native-centric places. Still, an assumption inheres that a causal relationship exists between macro-level health communication and behavior change, or that people are going to uptake and adhere to prevention prescriptions. This experience of lacking HIV messaging, or access to such knowledge, can be attributed to the fourth world status of AIAN people in modern times. The lack of attention, resources, and capacity building contributes to a silencing of both HIV and the epidemic within Indian life, as well as has negative impacts on other mental / health conditions. This silencing about HIV contributes to a *shadow presence* across generations, within and outside Native communities:

I'd be really curious to see if there are differences, if there are sort of differences in the results that you, in the research that you, if there are difference between generations. [researcher: The younger, sort of gay men now versus older gay men?] Right. [researcher: in terms of their experiences around like?] Health issu-....I mean I'd be interested in hearing about, obviously this isn't a question but I know that there were a couple times when I had like, sort of like uh, when I have sort of STD scares...

(Tony)

Even in attempting to now express impactful life events, a language is non-existent to recount phases, generations, and evolutions throughout the epidemic. At the same time, the "scare" or psychic stress of HIV seems universal, or some fact of common sense knowledge. This lack of a shared language works to disconnect two-spirit persons in two ways, concurrently. In the first case, the two-spirit men are connected to other non-Native gay men for the fact of their sexual and social relationships, yet at the same time and in those same intimate moments of socializing and/or having sex, they are detached from one another through the fact that something so prolific as HIV does not carry a common language to discuss its continued stress and effects. All the while, the two-spirit men contend with disconnections within their own Native communities due to a double stigmatization regarding HIV and their sexuality, which induces fear and distance from other AIAN people.

Professionalized Identity

In the second discursive theme, every participant incited HIV as a way to connect with a professional world. In one sense, HIV offers a viable entryway into adulthood, building professional and financial capital. To do such work offers these leaders a sense of pride, purpose, and societal worth – as, primarily, a gay-identified person. One participant explains:

I'm kind of a key stake holder I guess in the community and I never really thought of myself that way, but I'm developing a project here and I work with AIDS Project

[city] on a new, you know, an initial developing project called the [name] which is an HIV/AIDS prevention for Native American two-spirit, Native American gay men....I mean you know not to boast myself or anything but, you know, but it is just my connections with people.

(Joe)

To embody HIV as a professional is to serve one's community as much as to have to choose which community to serve. Being an HIV professional focuses attention on the LGBT community at-large – that is, *non*-Native community, which becomes an identitarian-based initiative of sorts for the agency. From that vantage point, HIV could be viewed as not a central concern for AIAN people, or something less well understood or –addressed, and therefore being an HIV professional offers footing from which to take action. Joe and another participant continue this line of thought:

...and your jobs and what you're doing happen for a reason...I feel that my current job with HIV prevention here is that...I did the Native, helping Native communities with tribal court development. But then I also need to look at myself as being gay and help that community....

(Joe)

I mean, I used to do work in the HIV community and I remember that you know CDC or whoever was always sort of looking, was sort of giving money, well they weren't always giving money but you know they always sort of wanted to look for these like, two-spirited Natives....

(Tony)

An identifiable constituency or market now personifies HIV, a contingent of whom are two-spirit people. In commodifying this population for professional practice and scientific concern by public health and medicine, AIAN people and a larger "Native-ness" are synonymized with non-normative sexuality, that is, another cohort of people outside the (hetero-)norm and therefore in need of attention and intervention. They become another letter to add to the evolving LGBTQ+ community acronym. This works to bring primary attention to their sexuality and gender, which has the potential effect of eclipsing the larger fourth world status that compounds their lived health disparities and the marginalizing conditions in which they live within their tribes as well as in the non-Native world, off the reservation. Also, this way of targeting and essentializing AIAN people for public health practice works to elide a fuller, more accurate framing and contextualization of health disparities, including HIV, and its risk. As Joe aptly articulates above, that to focus his work on HIV prevention required him to step away from a larger Native community framework and practice.

Mental / Health Sub- / Priority

In the third discursive theme, each of the participants gave voice to alcohol being a primary mental / health problem as well as instigator for such problems for both AIAN and (non-Native) gay persons. However, for AIAN people, alcohol is less attributable to a behavior or performed identity; rather, it is *genetic* factor, an immutable characteristic. Conversely, HIV

is aligned with a gay identity and health concern, fostering another discursive bifurcation between “Native” and “gay”. Two participants articulate this phenomenon:

I’m HIV negative um, and the Natives that I know are negative but I do know that it’s a concern for reservation Indians. I just, I don’t know enough about it or the issue. Physical concerns, I would just say like I said the alcoholism. Whatever it is about Indians and Indian genes...I just think Indians shouldn’t drink period... there’s a lot of parallels I think between the mental health of gay and mental health of Natives – it’s like you know of society’s telling us that we’re, “we don’t belong in the world”...

(Ed)

...I think the substance abuse, especially, well, just in the gay community... has a high prevalence.... And that can cause just even more mental health disparities in an individual. You know, um, their acceptance, their socializings, um, their issues, their HIV risk.

(John)

The bifurcation begins to appear wherein *health* is either a Native issue or a gay issue. The tie that binds, though, is alcohol. “HIV” is discussed in universalizing medical language, that is, as HIV risk or some-*thing* socially understood. Again, HIV is positioned as a problematic for sexualized interaction and cultural affiliation. That sort of cordoning of the issue works to deemphasize risk, sexuality, and gender in AIAN mental / health narratives. The reasons for such an elision are various, yet one participant offers a poignant insight:

I think the primary one (health concern) is you know HIV and AIDS and I think it’s because of the stigma around it, everybody thinks, or people think it’s a gay disease. Growing up on the reservation, when I first heard of it was a city-, actually I heard of it because of Magic Johnson, but you know it was like a city disease, it’s those people over there. And when I was moving out here people were like, ‘Well, stay away from San Francisco you’re going to end up with AIDS’....

(Frank)

HIV discourse works to divide within one’s self and in one’s relationships to a Native-ness versus other identities. As in this narrative, HIV functions nimbly as a metaphor for leaving the reservation, indulging in urbanized life, being a part of mainstream (i.e., Non-Native) culture, for death (i.e., HIV synonymized with AIDS), and for a built space (e.g., San Francisco equals gay neighborhoods). In these senses, HIV subjugates(gay) sexuality and pathologizes a gay community. This is juxtaposed to a privileging of reservation life and Indians, who may or may not experience HIV as a problem in their everyday lives. Resultantly, two-spiritpeople’s health concerns are multiply impacted yet left ricocheting between identities that are not allowed to intersect.

Belonging, (Re)Claiming

Finally, in the fourth discursive theme, HIV functions as a discursive mechanism to connect with and re-/claim community and culture, but moreover to belong. The stakes and

negotiations involved in such belonging are experienced differentially depending on the culture and community. As one participant illustrates:

I see other gay people back on the reservation that are stuck and it's because their families are too afraid for them to come to the city, whether it's because they're going to catch HIV and AIDS or you know just lose who they are, they're going to become washichu you know which is white...

(Frank)

Here HIV functions as a connection to White culture, or a separation from indigenous ways and reservation life. To move closer to HIV signals a decreased authenticity as AIAN, that is, a loss of traditional ways. Parallel to this, HIV and its intersections with a professional identity facilitated a more expansive connection to a network of other AIAN, specifically two-spirit, people:

...my last job (in HIV prevention) opened my eyes to other Nations and other tribal communities and other people....I ended up doing a lot of traveling and so in that process I made good friends over the country, who are two-spirited....Like without them I'm nothing, is how I see it.

(Mike)

In this other sense, HIV can bridge AIAN people. Not only does it provide a way to participate professional practices but, moreover, it imbues a meaningful sense of belonging to two-spirit AIAN people, rather than Native culture and people generally. As such, the embodiment of HIV discourse centralizes the problematic of HIV into a marginalized social location. In this way, the professionalization around HIV across the United States helped facilitate, or was co-extensive with, the first modern, culturally legitimate mobilization of two-spirit people, diverse sexualities, and related health concerns more broadly. As HIV and two-spirit people have gained more voice, per se, the discourses of the epidemic has potentially run the risk of subsuming two-spirit people.

Furthering this perspective, another participant speaks to yet more stakes involved:

...I think for me I would probably want to go see a gay man for any type of services (medical). Any health, HIV, any of that type of stuff. I would probably feel comfortable going directly to a gay man just because he understands it one hundred percent.

(Frank)

HIV facilitates a belonging to a claimed two-spirit and broader (non-Native) LGBT community. This viral bridge extends into knowing and communing with other gay men at least in the realm of health / -care, or that it consolidates HIV into gay socialization and understanding one's self as Gay. Another young participant speaks to this:

I was up for um, being like 'cause I do modeling as well so I was up for like the crystal meth boy and they were gonna do a thing on like... [researcher: poster boy.] Yeah, you know 'cause I'd done crystal meth and I'd been sober like a couple years so I was gonna be a poster boy (for an HIV and meth social marketing campaign)...

(Ed)

The connection to the gay community through HIV similarly requires a separation from other parts of oneself, in this case from a foregrounded indigeneity. The participant is accepted into the gay world through being an addicted man, and is connected insofar as he performs this pathologized and stigmatized identity in the public sphere. But this pride in belonging to a gay community and cultivating a social cachet as an “HIV poster boy” places demands on the participant to sideline his Native-ness. This same participant continues to describe the tensions within this discourse:

But, I find out later he (participant's father) was like, 'Fucking faggot, this fucking kid's going to die of AIDS,' and just all the really mean nasty things the he could say about me he said, and just you know it sucked. And, that's how I came out to him and slowly he, my mom went to the PFLAG meetings and he just realized you know I was like the family favorite.

(Ed)

In foregrounding and claiming a sexualized identity, an implicit rupture is thrust onto the participant, alleging a distancing from Native culture. Simultaneously, in giving voice to one's sexuality, there is an incitement to the critical history of AIDS, bringing forward imminent death and plague. Also, this reenergizing of the (AIDS) past allows for a contemporary distancing from HIV in Native communities by aligning “AIDS” with gayness, non-Native-ness, and harmful behaviors.

DISCUSSION

This study is not without limitations. This work is inherently qualitative and did not have positivist aspirations or intentions towards sample-to-population generalizability or predictability (Jaworski&Coupland, 1999); it did not seek to be representative of all two-spirit people nor the diversity amongst all tribes and two-spirit definitions. Certainly, a larger sample size would have increased depth, specificity, and complexity. Still, both the unique social location of the selected participants and the related paucity of empirical data about two-spirit men (or people in general) provides an often unheard, marginalized, and critical voice for social science and public health moving forward in the epidemic. At-large, Discourse Analysis can speak to the *normalization* of processes not distributions therein (Fairclough, 2003). On a practical level, DA is often compelled to justify the selection of materials for analyses, and DA argues for more context relatedness, more contingency, and more tolerance of ambiguity (Fairclough, 2003). And, unlike more dominant forms of research, DA does not claim the dominance in its analysis or results. Instead, this methodology is an appropriate way to provide clarity on *how* communication in all its forms permeates social life. And, a great strength of DA is that it brings to light the “social voices” (Lemke, 1995) within communities, not simply displaying individuals' subjective experience; DA elucidates the inter-subjectivity of meaning in socially-situated contexts. Importantly, DA brings to bear what the stakes are for individuals and communities within discourses and social life, especially in the vein of investigating who and what are included and excluded from the communication we have about important topics. From this perspective, this qualitative study and its findings hold potential to contribute to the transferability (Polit&

Beck, 2010), or case-to-case translation, in understanding how HIV functions beyond mainstream (LGBTQ) lives and instead in the lives of two-spirit and possibly other Native peoples too often positioned in the margins of social life.

Specifically to that point, then, these *testimonios* recast dominant notions about HIV. For professionals, these narratives can contribute to a more contextualized framing around identity, HIV, stigma, and resiliency in order to establish more culturally humble and responsive interventions with highly marginalized populations, starting with attention to two-spirit men and women. When set in lived context, “HIV” becomes complicated by the competing demands of daily living on and off the reservation, as well as hierarchized within felt experiences of coping with health disparities for themselves and their communities, both Native and non-Native. One illustration of this is the findings herein, that is, parallel to its virologic existence and physical effects, HIV in a discursive or psychosocial frame is a shadow presence, professionalized identity, sub-/priority in health, and a mode of belonging / (re)claiming.

In some respects, these findings do reinforce existing recommendations for HIV care and prevention specifically with AIAN communities (Burks, Robbins, & Durtschi, 2011; NASTAD, 2013), which include relying on data-driven knowledge, increasing culturally responsive services, and comprehending the differential impacts of HIV within two-spirit communities. The narratives here of young two-spirit leaders make this point even more salient as their words call for an ethic of fluidity in appreciating and navigating multiply oppressive forces in highly marginalized social positions. They suggest that our planning and service delivery systems may make good use out of a concentration on racism in more gay-centric contexts and heterosexism in more Native-centric ones. Specifically, this analysis echoes findings from the same qualitative and quantitative dataset of the HONOR Project when considering the experiences two-spirit men with homelessness, such that identity and its active negotiation *vis-à-vis* operant culture and oppressive forces were important factors in surviving, coping, and living (Walters, Chae, Perry, Stately, Old Person, Simoni, 2007). As well, more generally, this work echoes recent findings that there is “diversity within diversity” when we listen closely to the narratives of multiply socially-located and oppressed persons, who talk about their health and wellbeing (Hudson, 2015).

Likewise, innovative prevention may emerge by renegotiating deeply held beliefs of cause-and-effect within HIV/AIDS, or that the physiologic transmission of HIV is inseparable from the discourses under which many affected persons live and resist. To that end, as we hear the stories of these leaders, we find a salient continual renegotiation of their identities, that is, *two-spirits* less well understood as simply anti-normative or some racialized alternative – but rather an active bridging of multiple worlds (Driskill, 2010). The more that prevention and care can support a positive trajectory of identity development and self-actualization in themselves as AIAN and two-spirit people (Chae & Walters, 2009), the more they are protected and supported in increasing wellness and effectively navigating their multiple social locations. These narratives suggest an attention to the identity of HIV and its multiple social meanings, existing throughout this second generation, would be an important factor to consider and further research. In that vein, these discourses could be further unpacked through innovative community-based projects that harness the power of language

within Native communities and digital storytelling technologies to decolonize and promote healing from intergenerational trauma; see, for example, the participatory based research of Beltrán & Begun (2014), or the community based prevention efforts of the Red Circle Project (www.redcircleproject.org) of AIDS Project Los Angeles.

CONCLUSION

Ultimately, the attention here to discursive aspects of the epidemic brings to bear the essential importance of the national standards for Culturally and Linguistically Appropriate Services, or the CLAS Standards, as recently established by the U.S. Department of Health and Human Service, Office of Minority Health (2013). The Standards point to the fact that services necessarily must be congruent with an individual's cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs. Quite importantly, the fact that CLAS Standards exist expose the reality that professional practices are produced by professionals themselves and the discourses they build and sustain. Our practices and discourses in which we participate may be helpful or may work against the communities and concerns that motivate us. Among many effects, the CLAS Standards can work to be one of the ways to reduce health disparities and to improve the quality of services; in effect, they are a "blueprint" for communities and health care organizations to best serve increasingly diverse populations.

With respect to two-spirit people, a deepersensitivity and a grounded understanding of the languages we use, as practitioners and healthcare consumers, can buffer against stigmatizing assumptions, such as positioning two-spirit people unassumingly as yet just another vector of risk. Instead, we can be present with the cultural production and active identity negotiation amidst this time of HIV and its co-constitutive oppressive forces (Delor & Hubert, 2000; Epstein, 2003). Through appreciating how "HIV" has functioned sitting *within* the larger lived experiences of contemporary AIAN and two-spirit people, this work speaks to the need for language to be a necessary component of the social and health justice of AIAN people. In a wider frame, rhetorical sovereignty (Driskill, 2010) is part and parcel to the empowerment, wellness, self-determination, and belonging of those who have been *inadequately* afforded a place within our society, indeed for AIAN peoples. Even more specifically in this aim to understand the meanings of HIV for AIAN people, language is a central component of the world-making project of two-spirit people, replete with becoming and wellbeing.

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Figure 1:
HIV discourse within two-spirit communities.