INTIMATE PARTNER VIOLENCE IN AMERICAN INDIAN AND/OR ALASKA NATIVE COMMUNITIES: A SOCIAL ECOLOGICAL FRAMEWORK OF DETERMINANTS AND INTERVENTIONS

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Abstract: This essay synthesizes the research on intimate partner violence (IPV) in American Indian and/or Alaska Native communities using a social ecological framework. The review of literature demonstrates that American Indian and/or Alaska Native women are at an elevated risk for IPV compared to non-American Indian women and thus this essay describes multi-level interventions that are culturally appropriate for American Indian and/or Alaska Native communities. The interventions address a variety of determinants including gender, age, socioeconomic status, alcohol, European colonization, and infrastructure.

The annual economic victim-related costs of intimate partner violence (IPV) in the U.S. have been estimated at $67 billion (Miller, Cohen, & Wiersema, 1996). These costs are associated with the severe and negative health and social consequences of violence to victims of IPV. These consequences include lower physical health (Brokaw et al., 2002; Hathaway et al., 2000; McNutt, Carlson, Persaud, & Postmus, 2002; Silverman, Raj, Mucci, & Hathaway, 2001), lower mental health (Hien & Bukszpan, 1999; Roberts, Williams, Lawrence, & Raphael, 1998; Woods, 2000), and lower employment status (Browne, Salomon, & Bassuk, 1999; Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999). Additionally, there are significant effects on child witnesses to IPV (Carlson, 2000).

Although still understudied, an increasing number of studies about IPV in American Indian and/or Alaska Native (AI/AN) communities have appeared in the literature in recent years (e.g., Fairchild, Fairchild, & Stoner, 1998; Norton & Manson, 1995). These studies indicate that IPV is more prevalent in AI/ANs than other ethnic groups and that effectively addressing

IPV involves unique cultural aspects. However, this literature has not been integrated at this time (see Williams, 2002 for a compendium of literature on related topics). Further, the literature often fails to recognize the multidimensional nature of the determinants of IPV. Thus, the purpose of this essay is to complete a narrative literature review for research on the prevalence, determinants, and interventions for IPV in AI/AN communities. After reviewing the prevalence of IPV, the determinants and risks will be organized using the social ecological framework. The essay concludes with a discussion of how to integrate the various dimensions of the ecological model to better address IPV in AI/AN communities.

Prevalence of IPV

Prevalence estimates of IPV are affected by several factors that are important for comparison across studies: Did the study include emotional as well as physical abuse? Did IPV occur in the past year or lifetime (i.e., the time frame)? Did the study include a clinical, shelter, or representative sample? (Carlson, 2000). Carlson explained that prevalence is elevated in studies that included emotional and physical abuse, referenced lifetime violence, and occurred in clinical or shelter settings. The review presents a variety of studies that illustrate prevalence and make relevant comparisons between non-American Indian and AI/ANs given the above factors.

Several studies report data from clinical/hospital samples and allow for a comparison of non-AI to AI/ANs. Bauer, Rodriguez, and Perez-Stable (2000) surveyed 734 primary care patients (31% White, 31% African American, and 36% Latina) in the San Francisco area about physical, sexual, and psychological abuse. They found that 15% of the women had experienced abuse in the past 12 months and 51% had experienced abuse in their lifetime. These findings are consistent with Wilt and Olson's (1996) review of a number of studies examining IPV in emergency rooms. In these studies, they found that IPV ranged from 4 to 30% of women seen in emergency rooms (ERs) for current IPV (i.e., for the current visit to the ER) and 11 to 54% for lifetime IPV. In comparison, Fairchild et al. (1998) surveyed 341 women at an Indian Health Service hospital on the Navajo Reservation about physical, sexual, and psychological violence. They found that 16.4% reported violence in the past 12 months, while 52.5% reported any type of violence in their lifetime (40.5% reported verbal, 41.9% reported physical, and 12.1% reported sexual).

Given that IPV rates are higher in clinical and emergency room settings (Carlson, 2000), it is also important to examine rates in population-based surveys. Wilt and Olson (1996) included a review of population-based studies for severe and lifetime domestic violence. They found a range of 0.3 to 5% of women experienced severe violence in the past year, while 8 to 22% of women experience any type of violence in the past year. Over their lifetime, 9 to 13% of women experienced severe abuse and 7 to 30% experienced any type of violence.

There are four studies of AI/AN women in the community. Lee, Sanders Thompson, and Mechanic (2002) displayed data from the National Violence Against Women Survey (Tjaden & Thoennes, 2000) and found that 61.4% of AI/AN women reported physical assault in their lifetime compared to 51.8% of women overall. Additionally, 34.1% of AI/AN women reported rape and 17.0% reported stalking compared to 18.2 and 8.2% of women overall respectively. However, the sample of AI/AN women was very small relative to the overall sample. Second, Norton and Manson (1995) surveyed 198 AI women from a reservation in the Rocky Mountain region. They found that 46% of the women experienced physical assault in their lifetime. Third, a study of a Southwestern AI community found that 31% of women reported any type of intimate violence in the past year, while 91% reported any type of intimate violence in their lifetime (Robin, Chester, & Rasmussen, 1998). Finally, a study of AIs living on or near seven Montana reservations found that 3% of women experienced physical violence and 18% experienced emotional abuse in the past year (Harwell, Moore, & Spence, 2003). The variation in these four studies can partially be accounted for by the nature of the questions asking about IPV. For example, Harwell et al. only utilized two broad questions about IPV, while Robin et al. used a modified version of the Conflict Tactics Scale (Straus, 1979) to capture a wide range of violent behaviors including emotional, physical, and indirect (e.g., witness of violence).

Finally, it is also important to compare the rates of homicide due to IPV in non- AI and AI/AN women. Arbuckle et al. (1996) completed a retrospective analysis of female homicides in New Mexico from 1990 to 1993. They found an overall homicide rate of 4.3 per 100,000 with 46% of those victims being killed by a male intimate partner. The rate of female homicide among American Indians (4.9 homicides per 100,000 people) was significantly higher than that of Hispanics (1.7) and Whites (1.8).

In summary, AI/AN women are at greater risk for violence than are non-AI women. AI/AN women are almost three times more likely to be killed by an intimate partner than Hispanics and Whites and have twice the prevalence rate of rape. Further, in population-based surveys the lifetime prevalence of any type of IPV for AI/ANs ranges from 46 to 91% compared to a range of 7 to 51% for non-Native women (see Table 1 for a summary of any type of violence in clinical and population-based samples). The range in estimates of prevalence is attributed partially to the instrument used. The majority of studies utilize the Conflict Tactics Scale (Strauss, 1979), but certain studies with low and high estimates utilize instruments that capture a limited (Harwell et al., 2003) or wide (Robin et al., 1998) range of behaviors indicative of intimate partner violence respectively. Finally, the estimates for AI/ANs are based on limited research and thus it is important for future research to provide baseline information on the prevalence of physical and emotional abuse.

Table 1
Range of Prevalence of Any Type of IPV in Population-based and Clinical Samples

Setting	AI/AN		Non-AI/AN	
	Past year	Lifetime	Past Year	Lifetime
Clinical	16.4%	52.5%	4-30%	11-51%
Population-Based	18-31%	46-91%	8-22%	7-51%

Note: Percentages illustrate ranges found in previous studies. Single percentage indicates only one study.

Social Ecological Framework

This review draws on the social ecologic framework as a way to organize the literature. From a public health perspective, the *social ecological framework* provides guidance to factors at multiple analytic levels that may influence IPV vulnerability and coping (Bogard, 1999). The social ecological framework identifies proximal and distal factors related to IPV victimization at five levels (Bogard, 1999; Heise, 1998; Little & Kaufman Kantor, 2002). The first level, *intrapersonal or individual*, refers to the most immediate determinants of victimization. The second level, *interpersonal*, refers to the interactions between couples, families and other small groups. The third level, *institutional or organizational*, refers to factors having to do with the culture or practices of specific institutions such as local hospitals, clinics, and multi-national corporations. The fourth level, *community*, focuses on the current and historical relationships of members of a specific physical or psychological community. The final level, *policy*, emphasizes the governmental laws and statutes (federal, state, and tribal) about violence.

A foundational principle of the social ecological framework is that IPV causes and outcomes reflect interplay of factors at multiple levels. While an individual's vulnerability to IPV may be easily traced to causes at the individual and interpersonal levels, these more immediate causes may in turn be traced to factors operating at the higher levels of institutions, communities, and social policy. Hence, the contemporary IPV prevention field is rich with targets for change that include not only individual criminal justice and psychotherapeutic activities but also advocacy, organizational change efforts, policy development, economic supports, environmental change and multi-method programs (Bogard, 1999; Heise, 1998; Little & Kaufman Kantor, 2002). Within this framework, these five levels are used to organize the following two sections on the determinants and interventions of IPV in AI/AN communities.

Determinants of IPV

Individual Level

At the individual level, five determinants are associated with IPV: biological sex, age, social economic status (SES), substance use, and cultural identity. Biological sex is the primary risk factor for IPV in AI/ANs (and all ethnic groups). Women are 5 to 8 times more likely to experience IPV than men (Rennison, 2001; Rennison & Welchans, 2000; Schafer, Caetano, & Clark, 1998). Rennison and Welchans (2000) found that women were the victims of IPV at a rate of 7.7/1,000 women in 1997. In contrast, there were 1.5 male victims per 1,000 for the same year. Eighty-five percent of all IPV victims were women in 1997. Finally, male-to-female violence has more serious consequences in that it is more often repeated and is more likely to result in injury or death then female-to-male violence (Schafer et al., 1998).

Studies for women in the U.S. in general demonstrate that the age range at the highest risk is 16-24 (Rennison, 2001). Two studies on AI/AN women found similar results, but did not break down the age range as much as did national studies because of smaller sample sizes. Kunitz, Levy, McCloskey, and Gabriel (1998) found that AI/AN men and women who were below 50 were more likely to strike or have been struck by a partner than men and women aged 50 or above. Fairchild et al. (1998) found that AI women aged 40 or less were 5.6 times more likely to experience IPV than women aged more than 40.

SES as measured by employment, education, and income has found to be determinants of IPV. The general literature on IPV illustrates that being unemployed is a risk factor for sexual and physical abuse for women, while less education is also a risk factor for physical abuse (Black, Heyman, & Slep, 2001; Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001). Additionally, lower income and education are risk factors for being a perpetrator of IPV. For AI women, Fairchild et al. (1998) found that women receiving government assistance were 2.3 times more likely to be a victim of IPV than women not receiving assistance. Lower income also reduces a woman's access to victim services for IPV, especially in rural areas where transportation and phones can be limited resources (McEachern, Van Winkle, & Steiner, 1998).

Alcohol is often used by either perpetrators or victims in cases of IPV. Chester, Robin, Koss, Lopez, and Goldman (1994) argued that the pattern of alcohol use in Indian Country has accompanied a sharp increase in IPV. Kunitz et al. (1998) found that alcohol dependence is an independent risk factor for both being a perpetrator and victim of IPV. Finally, Norton and Manson (1995) found that 94% of cases of women who entered treatment for IPV involved alcohol (husband, wife, or both). Further, in a community sample of AI women, Norton and Manson found that a significantly greater percentage of victims of IPV (64.8%) involved alcohol problems compared to AI women who did not experience IPV (39.2%).

In addition to these risk factors, individual protective factors have been postulated. Walters and Simoni (2002) identified cultural buffers as protective factors of negative health and social outcomes resulting from trauma including IPV. Specifically, they posited that cultural practices serve as coping mechanisms to mediate the impact of IPV on negative health and social outcomes such as those noted earlier in this essay. The cultural buffers include having a strong ethnic identity, enculturation (process of identifying with one's minority culture), spiritual coping, and immersion in traditional health practices (e.g., sweat lodge ceremonies and traditional healers). Walters and Simoni argued that women who maintain a traditional cultural identity and engage in traditional practices are better able to handle traumatic events.

Interpersonal/Family Level

Two risk factors at the interpersonal level include gender roles and family bonds. Gender roles refer to the social constructs of men's and women's social roles that are historically shaped, culturally contextualized, and class specific (Hamby, 2000). Gender roles involves looking at how women's social roles and social situations differ from men's, how women are treated publicly and privately, how IPV affects women's lives in different ways from men, and how IPV affects the relationship between men and women. Gender roles is usually taken to be synonymous with women in part because women continue to be subordinate in all spheres of economic, social, political and family life globally (Saltzman, Green, Marks, & Thacker, 2000). Hamby (2000) explained that the primary cause of IPV in AI/AN women (and for all women) is the gendered nature of power and control. Specifically, the goal of male batterers is to maintain male dominance, which is reproduced through gender socialization. Further, Hamby (2000) argued that SES is not a direct factor for AI/AN women, but lower SES creates stress that can result in IPV if gender domination is also present. However, Anderson (1997) found support for both sociodemographic factors and gender domination in her analysis of data from the National Survey of Families and Households.

The strength and nature of family bonds is an additional interpersonal factor. Stephens (1999) identified a key barrier for battered mothers leaving abusers is that they feel they should stay for the sake of the children. Further, children often bond with an abuser, which makes it even more difficult for women to leave. As Little and Kaufman Kantor (2002) explained, "Many battered women, if faced with a choice between the current family situation and an unknown future, including questions of where she will live, how she will support herself, or how she will cope with her children, will choose not to leave the relationship" (p. 136).

Organizational Level

At the organizational level two-factors contribute to the continued experience of IPV: lack of routine screening in health care settings and lack of infrastructure for addressing IPV. Lack of routine screening for IPV in health care settings results in an unintended consequence of continued IPV. Because of the confidentiality inherent in medical care, victims may feel more comfortable reporting their IPV experience than in other settings. Unfortunately, there is a breakdown in transmission of assistance (Little & Kaufman Kantor, 2002). Many health care providers are uncomfortable addressing IPV and do not feel that health care settings, including emergency rooms, are appropriate for such intervention (Ramsay, Richardson, Carter, Davidson, & Feder, 2002). However, Rosenberg and Fenley (1991) found that 43 to 85% of women (especially those who are IPV victims) believe that screening in health care settings is appropriate. Further, primary care identification and intervention efforts could reduce IPV incidence by 75% (Rosenberg & Fenley, 1991).

Many AI/AN communities are located in rural areas, which do not have adequate victim or legal services for victims of IPV. If the services are available, transportation is an issue. McEarchern et al. (1998) described the conditions of three Navajo women experiencing IPV in the western part of the Navajo reservation. These women lived far away from any of the victim services and did not own a phone or a working car. Thus, they were isolated from all other people. There were also only five police officers patrolling 4,100 square miles of land and thus they could not rely on legal system support. The rural and isolated nature of many AI/AN women places unique constraints in responding to IPV and thus the absence of infrastructure likely results in repeated violence for victims.

Community Level

A key community or societal risk factor, and one that is unique to AI/ANs, is colonization. While a few researchers argued that IPV existed in AI/AN communities before the arrival of European colonizers (e.g., Durst, 1991), most authors noted that IPV is a relatively new phenomenon (Chester et al., 1994; E. Duran, Duran, Woodis, & Woodis, 1998; McEachern et al., 1998). Hamby (2000) illustrated that even if IPV existed prior to colonization, it has escalated in the last 150 years. European colonizers introduced Western patriarchy, rapid transition from hunting/farming to cash-based economy, removal of children to boarding schools and foster homes at rates 5-20 times the national average, and relocations to less desirable areas (Chester et al., 1994; McEachern et al., 1998). These factors produced cataclysmic changes in spiritual, social, and economic structure and drastically changed traditional lifestyles, thus creating historical trauma (B. Duran, Duran, & Brave Heart, 1998; E. Duran et al., 1998). Historical trauma is "unresolved trauma and grief that continues to adversely affect the lives of survivors of such trauma" (E. Duran et al., 1998, p. 99). Historical trauma is passed from one

generation to the next such that events that happened many years ago still impact people today.

These changes and the resulting historical trauma altered the way that AI/AN men and women related (Brave Heart & DeBruyn, 1998; E. Duran et al., 1998). E. Duran et al. (1998) argued that these influences created antagonistic relationships between AI/AN men and women. For example, traditionally within Navajo culture, men and women shared equal rights and status. Navajo common law emphasizes reciprocal relationships between a husband and wife (McEachern et al., 1998). Further, the influences of European colonization robbed most AI/AN men of their traditional roles and they lost status and honor (E. Duran et al., 1998). To regain honor and control of their lives, some AI/AN men mirrored the European model of control and power over their intimate partners. Thus, women's subordination or gender inequality among AI/ANs is largely a consequence of European contact and colonialism (Chester et al., 1994; E. Duran et al., 1998; Hamby, 2000; McEachern et al., 1998).

Policy Level

At the policy level, there is limited research identifying the direct relationships between laws and the occurrence of IPV. Rather, most of the determinants at this level are offered as the result of anecdotal evidence or speculation. Specifically, the consequence for perpetrating IPV is relatively minor and thus protection for victims is minimal. The monitoring of defendants (i.e., perpetrators) is minimal and in some cases violating protection orders results in a misdemeanor rather than a felony (Newmark, Rempel, Diffily, Kane, 2001). For example, two reports by the New Mexico Intimate Partner Death Team Review (Crandall, Worthington, & Wilson, 1999; Olson & Crandall, 1998) found that 19% of 73 women killed by intimate partners from 1993-1998 had an order of protection. Further, in 42% of these cases, the order of protection had been violated.

Intervention Strategies

Mainstream interventions are an important part of the response system for AI/ANs. Groginsky and Freeman (1995) noted that AI/AN women have many of the same needs and should have the same referral for services that women from other ethnic groups receive. Further, Groginsky and Freeman argued one cannot assume an AI/AN woman will want traditional cultural services or AI/AN advocates just because she is AI/AN. However, it is important to note that the economic resources for many AI/AN women are limited and thus they cannot rely completely on mainstream services (Hamby, 2000). Furthermore, mainstream interventions were not uniquely designed for AI/ANs and thus they are not necessarily consistent with their cultural values. In this section, we focus on culturally specific interventions for addressing IPV.

Individual Level

E. Duran et al. (1998) discussed the importance of repairing antagonistic relationships between AI/AN men and women with culturally sensitive therapy. They argued that traditional psychotherapy has the potential to reinforce antagonistic relationships and thus create epistemic violence. Epistemic violence occurs when the "production of meaning and knowledge fails to capture the truth of Native and tribal lives" (E. Duran et al., 1998, p. 97). For example, epistemic violence might occur when a well-meaning therapist only addresses individual-level factors for violence in a relationship, especially encouraging mainstream behaviors to address the problem. Epistemic violence is overcome when a therapist can (a) help a Native patient connect to the role history and colonization has contributed to the current social problems, (b) help re-connect the patient to traditional indigenous healing methods, and (c) help the patient reach out and see the commonality of his/her problems with others in the community and contribute to community through narratives of both wounding and healing.

E. Duran et al. (1998) advocated an approach called hybrid therapy. Staff is trained in Western and AI/AN treatment systems and Western-trained AI/AN and other psychotherapists work alongside traditional AI/AN healers. Non-native practitioners should be provided a network of traditional healers, but they can make their own networks by contacting traditional healers and/or tribal programs on their own to form hybrid teams. The bicultural approach is designed to acknowledge historical roots of trauma, moves the patient towards culturally-appropriate sanctions, and allows individuals to redefine themselves in culturally appropriate ways. Hybrid therapy is theoretically and culturally grounded in the historical relationships and experiences of AI/ANs, particularly related to historical trauma from colonization. There are three steps in the protocol: (a) assessment about overall mental health functioning, level of acculturation, spiritual functioning, and general health; (b) implementation of psychotherapy and traditional ceremonies as appropriate; and (c) evaluation and further recommendation for ongoing therapy and/or participation in traditional ceremonies as warranted (B. Duran et al., 1998; E. Duran et al., 1998). E. Duran et al. (1998) and B. Duran et al. (1998) described why hybrid therapy should work, but no direct empirical evidence is available. Thus, future research will need to investigate the benefits of hybrid therapy and whether it is more beneficial than mainstream psychotherapy.

Interpersonal Level

Interventions at the interpersonal level include counseling both the victim and the perpetrator together (and possibly other family members). While there are examples of this intervention in mainstream psychotherapy (e.g., Dunford, 2000; O'Farrell, Van Hutton, & Murphy, 1999), there are no studies that focus specifically on AI/AN couples. One study reported the benefit of a traditional aboriginal healing ceremony, called the Healing Circle,

in a cognitive therapy group of three Ojibway and two non-aboriginal survivors of sexual abuse (Heilbron & Guttman, 2000). The ceremony contributed positively to the healing process. However, the benefit of family-level interventions for AI/AN couples is unknown.

Organizational Level

Intervention at the organizational level includes two settings: domestic violence shelters/programs and traditional health care centers. Norton and Manson (1997) described a successful domestic violence program for urban AI women. The program had trouble with AI women stopping therapy after a few initial office visits. The program set up a more flexible program that included home visits to build trust in a familiar environment (and also alleviate transportation problems). After the success of home visits, the program began a weekly domestic violence group in an informal setting (a potluck dinner). Outcome data from this program was not available, but the anecdotal evidence of maintaining scheduled appointments and building trust provides a promising strategy for other domestic violence programs serving urban AI women.

Health care intervention is usually confined to the identification of IPV victims. Unfortunately, the identification rate of IPV in patients is poor in mainstream populations. For example, Martins, Holzapfel, and Baker (1992) found that physicians' files documented only 1% of possible cases in a population with an IPV prevalence of 30% (including physical and emotional violence). Ideally, health care providers would have a policy of routine screening to detect cases of IPV. Clark (2001) examined the screening rates of Indian Health Service facilities and found that facilities with policies and procedures for domestic violence were more likely to screen than facilities without policies. Additionally, having a domestic violence committee increased the likelihood of screening. These findings suggest the importance of having policies for screening for IPV and services to treat IPV in a culturally appropriate manner. Additionally, health care providers need training on how to screen and talk about IPV with patients since, from the patient perspective, shame, fear of criminal justice involvement, and fear of more violence also may prevent honest disclosure (Chester et al., 1994; B. Duran et al., 1998).

Community Level

A critical first step for AI/AN communities is to have the infrastructure to address IPV. It is important that communities have mental health services (e.g., therapy and shelters) integrated into the health-care system (Chester et al., 1994; Groginsky & Freeman, 1995). These services especially need to emphasize confidentiality because many AI/AN communities tend to be small and "everyone knows everyone else."

However, the infrastructure is not sufficient in and of itself because infrastructure does not address historical trauma caused by colonization.

Researchers (B. Duran et al., 1998; Durst, 1991; McEarchern et al., 1998) argued that the services provided to address IPV need to emphasize community-level responsibility and not simply individual responsibility. They argued that the community-level is most appropriate in AI/AN communities to not only respond to IPV, but also to prevent it from occurring in the first place. Durst (1991) studied two Alaska Native communities and their responses to IPV. He found that both communities increased active response toward IPV, but that active response included both privatization and communitarian. Privatization is the approach found in most social work approaches such as having a professional therapist privately and separately counsel the perpetrator and victim. Communitarian responses involved the larger community, for example, by involving the tribal leaders to go to the family and "counsel" them in the manner of an elder. Durst found that social work interventions that focused on the community at large have a positive impact on changing attitudes about IPV and thus encourage community-based action. Steps need to be taken to protect confidentiality of the family in order for the communitarian approach to be effective. For example, the tribal leaders would need to maintain privacy of the specific couple, but can involve the larger community in discussions about violence and how to prevent future violence.

McEachern et al. (1998) advocated a similar approach to addressing IPV. They argued for a Freirian approach to overcoming the oppression faced by AI/ANs as a result of colonization. Freire (1970) illustrated the importance of critical awareness and reflection through dialogue or "liberating education" for allowing people to escape the bounds of oppression. McEachern et al. argued that dialogue groups could help women come together and explore their lives. They were careful to note that we must trust women to have the answers to improve their situation. They also noted that men can be helped to understand how various forms of oppression have contributed to their place in life and help them move beyond violence in the household. McEarchern et al. explained that the use of dialogue is appropriate because of its fit with cultural values (Navajo in particular), but also because it does not require outsiders to come in and try to "fix" the problem.

A third community-level approach involves the use of healing rituals for addressing historical trauma in general, which helps to prevent IPV (Brave Heart, 1999; B. Duran et al., 1998). B. Duran et al. (1998) described an approach used in the Lakota community that they feel have some application to other AI/AN communities. The Lakota intervention model included a memorial for the massacre at Wounded Knee and "catharsis, abreaction, group sharing, testimony, opportunities for expression of traditional culture and language, ritual, and communal mourning." (p. 72). The purpose of the model was to help the community members facilitate mourning, tolerate effects that accompany the trauma, and validate/normalize the traumatic response. The authors also noted that all participants felt better about themselves after the intervention with 75% expressing high agreement that

the intervention helped them overcome feelings of cultural shame. However, direct evidence about the effect on violence is needed with future research.

A fourth community approach is the *Kanuhkwene* project (Hagen & House, 1995). The project was developed by Oneida women to address critical social issues including domestic violence. The women created an organization of women based on Oneida values of community and connection with the social and natural world. The project integrates mainstream and traditional social services and has restored some of the balance in gender roles. Although the evidence is anecdotal, the *Kanuhkwene* project demonstrates the possibilities for women creating a network of support for themselves to address important social issues in a culturally appropriate manner.

These four approaches are all culturally appropriate responses for responding to and preventing IPV. However, while all four may be appropriate for AI/ANs in general, each is contextually bound to a particular AI/AN community. Hamby (2000) argued that interventions for IPV have to be created specifically for each AI/AN community because each community has different gender roles resulting from patriarchy/matriarchy, matrilineal (line of descent or clan membership is passed through the mother), or matrilocal (living and social arrangements focused on the women's family of origin) relations. These three factors result in different authority, restrictiveness, and disparagement of women (Hamby, 2000). Thus, while there are some common features for AI/AN communities (e.g., colonization and historical trauma), it is important to not overgeneralize any intervention and to make sure it is appropriate for a given community before implementation.

Policy Level

There are three types of legal measures that are designed to prevent further IPV: civil legal sanctions (i.e., protection orders), arrests, and domestic violence courts. These measures have mixed success in mainstream settings. For example, protection orders serve as a deterrent for some male perpetrators, but half reabuse and a few even kill their intimate partners (Fagan, 1996). Additionally, arresting perpetrators of IPV has the following results: (a) arrest is associated with less repeat offending; (b) the reduction in repeat offending associated with arrest is modest compared to other factors (e.g., batterers age and prior criminal record); (c) regardless of whether the batter was arrested, less than half of the suspects committed a subsequent offense; and (d) a minority of suspects continued to perpetrate IPV regardless of whether they were arrested (Maxwell, Garner, & Fagan, 2001). However, these findings have not been established specifically in AI/AN communities.

Conclusions: Integrating Levels of the Social Ecological Model

The impact of mainstream interventions at any given level is small to moderate. The likely reason for this limited impact of any given intervention

is that it does not address determinants at multiple levels. For example, therapy for perpetrators appears to reduce IPV and may address some individual and perhaps couple-level determinants (e.g., substance abuse and control issues). However, the therapy likely does not adequately address historical trauma associated with colonization, or policies that have limited consequences for perpetrators. Additionally, providing adequate infrastructure for victim services does not address legal concerns if these agencies are not coordinated. Multi-level interventions for IPV have rarely been addressed in the literature, especially for AI/AN communities. In closing, we discuss one model of multi-level interventions for IPV in mainstream communities, and then summarize culturally appropriate and multi-level interventions for AI/AN communities.

The Services-Training-Officers-Prosecutors (STOP) Violence against Women Formula Grants program provides funding to stimulate the growth of programs serving women victims of violence. Federal funding for the STOP program between 1995 and 2000 totaled $672.2 million and supported over 9,000 subgrants (Zweig & Burt, 2003). Zweig and Burt recently completed an evaluation of the STOP program and how it influenced women's services. The authors included both a community sample (1,509 women in 26 communities) and a victim service sample (500 women from nonprofit victim services and 390 from legal system agencies) to assess women's attitudes and behavior regarding IPV interventions. In general, they found that women reported benefiting from the services especially when victim services agencies worked in collaboration with the legal system and other relevant services. Women reported that coordinated agencies were more helpful and were more satisfied with the legal system. Further, arrests and convictions occurred more frequently when community agencies worked together. Thus, the STOP evaluation helps to illustrate that the multi-level interventions are more effective than interventions at any single level.

The STOP evaluation did not target AI/AN communities in particular and thus we are left to speculate what an effective multi-level intervention would look like for these communities. These interventions will need to be culturally appropriate and focus on universal as well as selected and indicated prevention. Universal prevention is broad efforts to educate, inform, and address the public in order to encourage non-violent behavior. Selected prevention involves intervening with the perpetrator before violence becomes an entrenched pattern, while indicated prevention focuses on interventions after violence occurs. The common thread in selected and indicated prevention is that IPV has already occurred. Unfortunately, most resources have been targeted to indicated prevention to the exclusion of universal prevention (Gundersen, 2002). We suggest that a multi-level intervention can address both universal and selected/indicated prevention.

Table 2 illustrates a social ecological approach to interventions to address IPV in AI/AN communities. We reiterate that specific interventions need to be tailored to each particular tribe in order to be culturally appropriate

Table 2
Social Ecological Framework for Prevention of IPV

Level	Primary	Secondary/Tertiary
Individual		
Hybrid Therapy		X
Interpersonal/Family		
Communication Skills Training for Families	X	
Hybrid Family Therapy		X
Organizational		
Screening by Health Care Providers		X
Coordination of Agencies		X
Community		
Healing Rituals	X	X
Community Dialogues	X	
Policy		
Encourage policy makers to provide resources for infrastructure		X
Encourage policy changes regarding economic development	X	X

(Hamby, 2000). One way to approach tribal specificity is to engage in Community Based Participatory Research (CBPR) that ensures that local tribal members and their representatives will have a prominent voice in the research and intervention process (Chavez, Duran, Baker, Avila, & Wallerstein, 2003). At the individual level, prevention efforts focus on hybrid therapy and are predominantly selected/indicated (B. Duran et al., 1998; E. Duran et al., 1998). The therapy applies primarily to perpetrators, but also could be applied to victims of violence. The advantage of hybrid therapy is that it combines both mainstream and traditional approaches to address violence. This approach is inclusive rather than assuming all AI/ANs want to be treated with only mainstream or traditional healings.

At the interpersonal/family level, universal prevention can be addressed with communication skill training. One aspect that contributes to IPV is the lack of communication skills to address conflict when it arises. This intervention can focus on culturally appropriate conflict management skills for intimate partners. The type of training may also be appropriate as selected prevention if victims and perpetrators decide to remain in their relationship. The skill training should include a focus on communicating

emotions. Umberson, Anderson, Williams, and Chen (2003) found that violent men are less emotionally reactive (i.e., repressed emotions) to stress and relationship dynamics than nonviolent men. This skill training would likely be accessed at the organizational level via agencies such as shelters and community centers. Selected/indicated prevention can be addressed through family therapy that addresses complex factors associated with violence such as attachment, complicated bereavement, and multigenerational family issues. The family therapy will need to include culturally appropriate values and likely hybrid therapy can be applied at this level.

Selected/indicated prevention is the main focus at the organizational level. Assessments by health care providers are a critical component at this level. Indian Health Service, tribal, and private health care providers will need to have training in cultural competence in order to obtain accurate and complete information in interactions as well as develop useful screening instruments. After diagnosing IPV, health care providers will need to coordinate with victim service agencies to provide adequate treatment. Finally, victim services will need to integrate their efforts with the legal system to provide protection for victims.

At the community level, healing rituals provide the opportunity for universal and selected/indicated prevention. Healing rituals (Brave Heart, 1999, 2003; B. Duran et al., 1998) provide an opportunity to address historical trauma. While historical trauma can be addressed on an individual level, the public health benefit is greater at the community level. Additionally, community dialogues provide an opportunity for universal prevention (Durst, 1991; McEachern et al., 1998). These dialogues provide a proactive approach from the community members themselves to address their own problems.

Finally, at the policy-level great focus needs to be placed on increasing resources to address IPV. The coordination of agencies and provision of services is only possible if the tribe has adequate resources. On a more global level, policy changes are needed to stimulate economic development. Increasing employment opportunities will help reduce the stress in families that can be a determinant at the individual level (Little & Kaufman Kantor, 2002).

In conclusion, AI/AN women have a greater prevalence of IPV than do non-AI women. In order to adequately assess this health disparity, it will be necessary to utilize culturally appropriate multi-level interventions that adequately address determinants that occur at individual, interpersonal, organizational, community, and policy levels. While the social ecological framework makes intuitive sense, there are few multi-level interventions to address IPV and none in AI/AN communities. Further research is needed to better understand how interventions at different levels work together to reduce IPV (both universal and selected/indicated prevention). If we are to reduce IPV in AI/AN communities, we will have to overcome several barriers including the lack of funding for AI/AN communities and the lack of practitioners of Western psychotherapy and traditional AI/AN practices.

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