VIOLENCE AGAINST NATIVE WOMEN IN SUBSTANCE ABUSE TREATMENT

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Abstract: Many mental health problems among substance abusing populations are directly linked to high rates of abuse and trauma. There is increasing evidence of associations between childhood physical and sexual abuse to adult substance use and HIV- risk behavior. The relationship of abuse, mental health problems, substance abuse, and high-risk sexual behavior has rarely been studied in the female Native American population. Significant relationships were found among childhood abuse, trauma, substance abuse, and high-risk sexual behavior among urban Native women.

Violence is a critical public health issue in the United States, particularly due to its devastating impact on the health and well being of women and children. Recent research on specific types of violence against women have been increasingly persuasive in underlining the association among childhood abuse and neglect, subsequent adult victimization and abuse, trauma experiences, and substance abuse and mental health disorders, especially depression and post-traumatic stress disorder (Kendler et al., 2000; Campbell, 2002). One study revealed that 38% of people who had been sexually abused and 33% who had been physically abused as children experienced PTSD during their lifetime (Widom, 1999). In examining the effects of historic and cumulative lifetime violence on women's health, research has shown that 32 to 68% of women in nonpsychiatric samples report some lifetime experience of physical or sexual assault, with one in five to one in two women reporting multiple abuse experiences (Bohn, 2002). In addition, up to 60% of murders of women in North America are committed by intimate partners (Brock & Stenzel, 1999). Clearly the mental health consequences

of physical or sexual abuse are often severe. Trauma has been associated not only with psychological distress, but also with risky behavior and social role impairment. Traumatized women engaging in substance abuse and unsafe sex are at high risk for contracting HIV/AIDS (Walters & Simoni, 2002; Simoni, Sehgal, & Walters, 2004).

Native Women and Violence

An important gap in the literature is a lack of information on minority women's experience with violence and its consequences. The above studies are all derived from general population-based samples; when an American Indian/Alaska Native (AI/AN) specific sample is examined, the rates of abuse and associated mental health and substance abuse disorders are significantly higher. Department of Justice statistics reveal that AI/AN women experience two to three times more violent victimizations, including aggravated assault, simple assault, and rape, than women of any other ethnic group in the U.S. (Greenfield & Smith, 1999). The National Center on Child Abuse and Neglect (1999) revealed that 79.8% of American Indian girls had experienced sexual abuse. In a study of the prevalence of child maltreatment and mental disorder outcomes among American Indian women in a primary care setting, Duran et al. (2004) found that 77% of respondents reported some type of childhood abuse or neglect. Neglect was the most commonly reported form of maltreatment, with 63% of respondents having experienced physical or emotional neglect as children. Significantly, nearly 90% of neglected women were also abused; 81% of emotionally abused women were also physically or sexually abused. The lifetime prevalence of mental disorders was highest among women who were both sexually and physically abused as children (Duran et al., 2004). In another study of urban Americans Indians/Alaska Natives in a primary care setting, rates of physical abuse among AI/ANs have been reported to be as high as 46%. Here, victimized individuals had significantly more alcohol use, current depression, history of depression/suicide attempts, and health problems (Buchwald et al., 2000). In one community-based sample, Hobfoll et al. (2005) examined AI women's childhood physical/emotional and sexual abuse and the relationship with later psychological disorders and risky sexual behavior. The study found that child physical/emotional abuse has a greater impact on later psychological distress than does child sexual abuse. In a large community-based study of two tribes, one Southwest and one Northern Plains, for females, the effect of childhood physical abuse on a subsequent PTSD diagnosis was nearly double that of males

(Libby et al., 2005). The historical trauma experienced by Native people, often exacerbated by severe sexual abuse, seems to increase the co-occurrence of substance abuse and mental health issues among Native women (Bohn, 2003).

Many women entering substance abuse treatment programs have experienced childhood trauma and alcohol-related violence. Independent of race/ethnicity, women seeking treatment for substance abuse disorders report high rates of violent assault (Noether et al., 2005; Kilpatrick, Resnick, Saunders, & Best, 1998). Between 55 and 99% of women with substance use disorders report being victimized at some point in their life (Najavits, Weiss, & Shaw, 1997). The National Institute on Drug Abuse (NIDA) reports that as many as two-thirds of all people in treatment for drug abuse were physically, sexually, or emotionally abused during childhood (Swan, 1998). The combination of traumatic victimization, mental health issues and substance use leads to a complex clinical dynamic, and although women facing all three of these issues may have more severe troubles and may have more service need, there is limited screening for trauma in most substance abuse programs and a lack of available trauma services (Domino, Morrissey, Chung, Larson, & Russell, 2005).

Though Native women have received little research attention, studies indicate that American Indian/Alaska Native women have an especially high prevalence of all forms of abuse. In an urban San Francisco Bay Area study of AI/AN women receiving substance abuse treatment, 86% of women reported having been physically abused and 69% reported having been sexually abuse during their lifetime (Saylors & Daliparthy, 2004; Saylors, 2003). Very few studies have focused on the relationship between trauma, alcohol and other drugs, and HIV risk in urban American Indian women, though Walters and Simoni (1999) found that substance use mediated the relationship between nonpartner sexual trauma and sexual risk behavior. As well, urban Indian drug users are at greater risk for HIV infection than reservation Indians, because they more frequently trade sex for money or drugs and practice unsafe sex while using drugs (Stevens, Estrada, & Estrada, 2000).

Loss of cultural identity can erode family structure and cultural traditions that discouraged substance use. For American Indians, acculturation stress can become cumulative within communities, and its effects can be experienced over time as "intergenerational grief" (Brave Heart, 2003; Brave Heart & DeBruyn, 1998; Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998). One way of coping with stress and emotional loss, especially for many younger Native men and women, is

to turn to alcohol, and as a consequence, alcohol-related violence has become quite common. Native women often bear the brunt of violence in drinking situations, which may also place them and their children at extremely high risk for sexual abuse. Many AI/AN women in substance abuse treatment reflect on finding themselves in adult relationships that mirror the abuse they experienced as children or adolescents.

Many American Indian/Alaska Native women use alcohol for escape or relief, however temporary, from anguish linked to past or current experiences of sexual and/or physical violations. For many, cultural identity conflicts have created behavioral, health and lifestyle problems. For urban Natives, the government's Voluntary Relocation Program of the 1950s and 60s uprooted American Indians from their tribal lands and traditions, moving them to West Coast cities where they had to adjust to racism and discrimination in housing and employment, create a new social environment, and rebuild communities. Rapid acculturation changes have contributed to a loss of Native cultural traditions and practices for many urban AIs/ANs (Brave Heart & DeBruyn, 1998; Saylors, 2003).

The question thus arises as to whether substance abuse treatment programs are sufficiently responsive to the emotional, social and cultural needs of Native women. Although research has attempted to identify barriers to treatment among women and to learn about what factors predict treatment outcome, little is known about the treatment needs of minority women, especially AI/AN women. Although there has been an increase in programs specifically for women, treatment models are based largely on traditional male programs and may not be responsive to women's needs, especially women from minority groups. Since many addicted women have experienced childhood physical and sexual abuse, exacerbating their powerlessness with models that use aggressive, confrontational or punitive methods can be alienating and often promotes premature dropout. Residential programs that favor a more family-centered, cooperative, and comprehensive approach are more effective for women (Brown, Sanchez, Zweben, & Aly, 1996). Progress has been made in the development of residential treatment programs for female substance abusers and their children, particularly in response to the evidence that the lack of childcare and residence options are major barriers to women entering treatment. Advances have also been achieved in recognizing that women's needs differ from men with respect to patterns of drug use, drug effects, family relationships, victimization histories, and access to treatment. As Prochaska and colleagues' (1992) stages of change model has been clinically adapted

to fit women's "levels of immediacy" needs in addressing certain issues over other less prioritized ones, especially in working with women with co-occurring disorders, patterns of recovery suggest that stabilization of substance abuse behaviors may be necessary before gains can be made in reducing mental health and trauma symptoms. (Brown, Melchior, & Panter, 2000; Noether et al., 2005).

Method

Study Design and Sample

This study reports information about experiences and effects of alcohol-related violence among American Indian/Alaska Native women entering substance abuse "healing" programs in an urban Native environment. Its chief purpose is to convey information about the nature and extent of such violence, particularly presenting data showing the relationship between childhood victimization, subsequent adult victimization, and substance abuse. Despite increasing recognition of the relationship between victimization experiences and substance abuse among women, there nevertheless remain broad gaps in information about this phenomenon concerning Native women. These findings will have implications pertaining to how treatment programs can best respond to the needs of victimized women.

Subjects

This study examines the findings among American Indian/Alaska Native women in both residential and outpatient substance abuse treatment settings in urban Oakland and San Francisco, California. Longitudinal outcome data were collected at the California sites over a period of 3 years. From September 1999-October 2002, the Native American Health Center (NAHC) in Oakland and San Francisco provided outpatient substance abuse and mental health services to AI/AN women through a CSAT grant (#TI12205): the Women's Circle. NAHC worked in close collaboration with the Friendship House Association of American Indians, which includes a 30-bed residential substance abuse treatment facility in San Francisco and a 5-bed women and children facility in Oakland. The sample includes Native women who received residential and outpatient services under the Women's Circle project. Of the 334 women admitted at intake, 283 or 84.7% were AI/AN. The unduplicated sample for this study is 334.

Data Collection and Assessments

At intake, staff reviewed our local informed consent procedure with clients, explaining that participation in project evaluation is voluntary and that the data collection procedure is confidential, other than mandated reporting requirements when abuse or threat to harm is mentioned. Once clients understood their human subject protection and signed the informed consent form, a case manager interviewed female participants using the Government Performance Results Act (GPRA) data collection instrument developed by CSAT, along with a supplemental HIV risk assessment and AI/AN supplement which examines potentially relevant sociocultural factors. Through a structured interview, clients were asked to report their usage of alcohol and drugs within the past 30 days; lifetime alcohol and drug use; demographic/background information; history of abuse; health status; legal status; and risk factors for HIV. The client was also asked about cultural and traditional practices that she engages in.

The women who participated in the project were asked to agree to be interviewed at two later dates, 6 and 12 months after intake, using the same data collection instrument. The baseline data was compared to the follow-up data at 6 and 12 months. This allows us to examine trends in outcomes over time, looking for changes in behavior as influenced by substance abuse and mental health treatment, as well as noting important factors in the social and cultural context in urban Native women in the Bay Area.

Results

Univariate analyses were conducted to provide descriptive information about Native women's experiences with violence, abuse and substance use, with the aim of understanding behavioral relationships between women's experiences of abuse and their subsequent or concurrent substance abuse. Chi-square analyses were used to assess whether the relationships between the experience of previous or current violence or abuse and substance abuse are significant. Correlation between these experiences is substantiated through the data. P values less than 0.05 were considered to be statistically significant, and analyses utilized 95% confidence intervals.

Selective Non-Response

Although little has been written about the effects of response bias and selective non-response around sensitive issues like alcohol and drug use, sexual behavior, and physical, emotional or sexual abuse, our data raise questions about the effect of response bias. Research indicates that selective non-response regarding usage of alcohol and drugs leads to lower, biased estimates of drinking, heavy drinking, and drug use, as well as to lower, biased estimates about the prevalence of problems due to the use of alcohol and drugs. Both of these factors result in biased estimates of the prevalence of alcohol and drug abuse dependence (Caetano, 2001). Along these lines, we attribute some underreporting around the sensitive subjects of illicit drug use, alcohol use, and sexual, emotional and physical abuse, to response bias. Another limitation in the data analysis pertains to the fact that it is often difficult to re-contact clients at follow-up, so there is some variance in the sample size at 6 and 12-month follow-up intervals. Our overall follow-up rate for the project was 73% at 6 months and 54% at 12 months.

Prevalence of Violence-Related Experiences

Female clients were asked about personal violence and related experiences, specifically focusing on whether they had experienced emotional, physical or sexual violence. The data suggests that the majority of the female clients were emotionally abused in their lifetime. Of those interviewed during intake into the Family & Child Guidance Clinic of the Native American Health Center, 89% (n=179) of AI/AN women reported having been emotionally abused during their lifetime. Consistently, this came through in their clinical presentation and was addressed as a treatment issue.

Although our instrument did not capture details regarding intimate partner violence, clients reported a substantial amount of physical violence during their lifetime. Of the sample of Native women served by the program, 84% said they had been physically abused. There is growing evidence of association between family violence (during childhood and adulthood) and women's health. As well, our data suggests that there is a strong association between physical abuse and sexual abuse. A low significance value (0.00 for Pearson chi square, likelihood ratio and linear by linear ratio) indicates that there is strong relationship between the 2 variables of physical and sexual abuse. Of the Native women served by the NAHC program, 67% reported experiencing

sexual abuse in their lifetime. Of those same women, 39% responded affirmatively when asked, "Have you ever been forced to have sexual contact when you didn't want to?" indicating they had experienced coercive sex.

Furthermore, we see high correlations between various types of abuse that women report experiencing. As noted in Table 1, any women who were sexually abused were also physically abused. Specifically, 96.7% of the women in the sample who were sexually abused were also physically abused. Only 78.4% women who reported being physically abused admitted to being sexually abused. Emotional abuse is a constant in all types of reported abuse. For example, of those women who reported being physically abused, 94.7% said they were also emotionally abused, and of those who reported sexual abuse, 95.8% said they were emotionally abused.

Table 1
Correlation Between Various Types of Abuse

	Physical Abuse*			Emotional Abuse*			Sexual Abuse*		
	%	X2	p value	%	X2	p value	%	X2	p value
Physical Abuse	x	x	x	94.7	27.217	0.000	78.4	50.945	0.000
Emotional Abuse	88.6	27.217	0.000	x	x	x	72.6	20.392	0.000
Sexual Abuse	96.7	51.579	0.000	95.8	20.941	0.000	x	x	x

*94.7% of the Physically abused women were also Emotionally abused with a X^2 value of 27.217 and p value of 0.000

78.4% of the Physically abused women were also Sexually abused with a X^2 value of 50.945 and p value of 0.000

88.6% of the Emotionally abused women were also Physically abused with a X^2 value of 27.217 and p value of 0.000

72.6% of the Emotionally abused women were also Sexually abused with a X^2 value of 20.392 and p value of 0.000

96.7% of the Sexually abused women were also Physically abused with a X^2 value of 51.579 and p value of 0.000

95.8% of the Sexually abused women were also Emotionally Abused with a X^2 value of 20.941 and p value of 0.000

Numerous studies have documented a correlation between intimate partner violence and sexual risk behavior for HIV (Raj, Silverman, & Amaro, 2004; Walters, Simoni, & Harris, 2000). In cases where there is a history of intimate partner violence, much of the literature points to a woman's increased vulnerability to HIV risk factors. Such risks arise when a woman's partner controls sex and condom use, and she does not advocate for herself in safe sex practices for fear of the partner's

violent response to safe sex negotiations. In such a case where domestic violence is present, the woman's health may be compromised by her male partner's risk for HIV, such as history of injection drug use, sexually transmitted infections, infidelity in the current relationship, or not getting tested for HIV. What remains unclear is whether a woman's exposure to emotional, physical, or sexual violence makes her more prone to engage in high-risk behavior, whether that be sexually risky behavior or dangerous substance abuse. Although our data collection instrument for the Women's Circle project (1999-2002) did not contain questions about client's trauma experience, PTSD symptoms or intimate partner violence, we have since recognized the need to better understand these dynamics and have added some additional questions into the intake questionnaire, which is part of the Bay Area Red Road (BARR), a local shared database between the Native American Health Center and the Friendship House Association of American Indians that we have built as part of a Strengthening Minority Communities CSAT project (TI13326). At the onset of our current Native Women's project (TI15707) in October 2003, we pilot tested the trauma questions and in 2004 began collecting these data in order to more comprehensively understand and address trauma within our target population. Although the data is preliminary and the sample is small (n=57), it is part of our efforts to focus on the traumatic experiences of our women clients (Saylors & Daliparthy, 2005).

Childhood Violence

Information on the prevalence of child abuse is provided in Table 2. Of the 63% of clients who reported being physically abused as a child, 22% said that alcohol or drugs were involved in the situation when the violence occurred. In examining the age that abuse first occurred, most often abuse occurred when children were between the ages of 6-10 years old (43%). Of grave concern is the rate of sexual abuse among Native women: This abuse starts early. When we asked female clients whether "as a child someone ever exposed themselves to you or touched you inappropriately," 55.6% said yes. Of those, 37% had this experience between the ages of 1-5 years, and 37% between 6-10 years of age.

Table 2

Child Abuse

	Number	Percent
Yes	36	63.2
No	21	36.8
Total	57	100.0%

Adult Violence Experiences

When clients were asked about whether they have been hit or beaten up as adults, 75% answered affirmatively. Of those who experienced physical violence as adults, 67% said that it was perpetrated either by a current or ex boyfriend, husband, or partner. Of those who had experienced physical violence as adults, 74% of the incidents involved alcohol or drugs. Although the BARR data is preliminary, some important findings emerge from the data. Of the women who reported forced sexual intercourse, 77% said that it had happened more than once. 71% of respondents stated that the person who had forced them to have sex was under the influence of alcohol or drugs. 27% of the women reported that during the incident(s), they were also using alcohol or drugs.

The complex relationships among trauma, substance abuse, and mental health issues raise concerns about the best approach for sustaining recovery. In a qualitative study of female trauma survivors with co-occurring disorders, Harris and colleagues (2005) identified themes around elements that women said helped them in supporting their recovery (connection, self-awareness, a sense of purpose and meaning, and spirituality). The team concluded that women and clinicians must place a high priority on the development of boundary management and other relationship skills, as well as attend to negative feelings and depression to help women develop a strong sense of identity and find meaningful activities to invest in.

Abuse History and Service Use

In our research, there is a high correlation between a woman's history of any type of abuse during her lifetime and her propensity to seek mental health or substance abuse services, as seen in Table 3. For example, of women who reported being sexually abused, 84% came to the Family & Child Guidance Clinic seeking mental health services, 56%

seeking substance abuse services. Generally, of women who report any type of abuse, 40% have been dually diagnosed with both mental health and substance abuse diagnoses.

Table 3

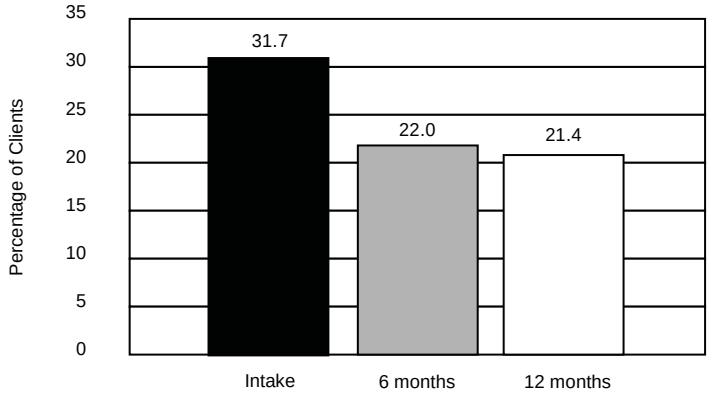
Co-Morbid Disorders: Relationship Between Lifetime Abuse and Women seeking Mental Health or Substance Abuse Services

If Abused:	Mental Health	Substance Abuse	Dual
Sexually	83.8	56.3	40
Emotionally	85.3	56	40.4
Physically	84	57	40

Substance abuse

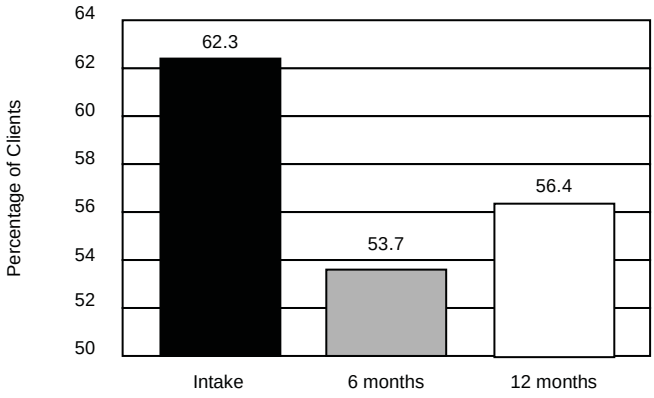
At intake, clients were asked about past 30-day alcohol use. 31.7% of the clients (n=106) said that they had "used alcohol during the past 30 days." The mean number of days of alcohol use was 8.39 days (CI 6.7-10.1 with SD of 8.8). By 6 month follow-up, the percentage of clients who reported using alcohol during the past 30 days was reduced to 22%, with a mean of 7.26 days of alcohol usage in the past month (CI 5.1-9.4 and SD of 7.9). Subsequently by 12-month follow-up, the percentage of clients who used alcohol during the past month reduced to 21.4% with a mean usage of 7.56 days (CI 4.9-10.2 and SD of 8.2). Overall, there was a 10.3% reduction in the number of clients who reported using alcohol during the past month (prior to the interviews at intake, 6 month follow-up and 12 month follow-ups), as seen in Figure 1.

Figure 1
Past 30 Days of Use of Alcohol



Significantly, many of the women served reported drinking alcohol to intoxication, which means drinking five drinks or more in one episode. As noted in Figure 2, of the total clients who reported using alcohol during the past 30 days, 62.3% of them used alcohol to intoxication, with a mean usage of 7.23 days (CI 5.5-9.0 and SD of 7.2). Subsequently, by 6-month follow-up, 53.7% of those who used alcohol in the past 30 days reported that they used alcohol to intoxication. By 12-month follow-up, 56.4% of those who used alcohol in the past 30 days reported using alcohol to intoxication, with a mean usage of 5.4 days (CI 2.5-8.2 and SD of 6.4). Of those clients who drank alcohol in the past 30 days, the percentage of those who drank to intoxication (5+ drinks), was 62% at intake, a significantly high rate of intensive alcohol use.

Figure 2
Past 30 Days Use of Alcohol to Intoxication
(Among Users of Alcohol)



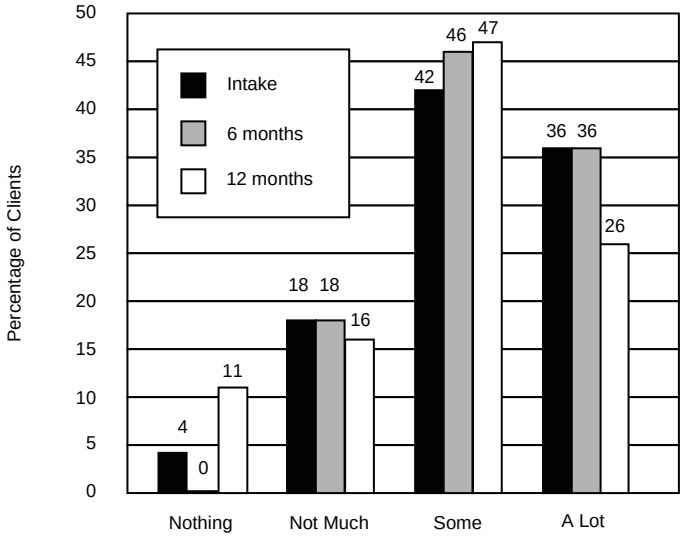
When the women served by NAHC were asked about their drinking history over the course of their lifetime, 88.3% of users of alcohol drank alcohol to intoxication. Women reported a mean of 10 years of alcohol usage (CI 7.9-12.1 and SD of 7.7), with the range of drinking years being between 1 and 35 years.

Positive effect of culture

Cultural beliefs and Native traditional practices integrated into treatment serve as powerful resiliency factors for clients. Clients were asked questions at intake to get a sense of their cultural

orientation, acculturation, and traditional religious practices. The questions help shape the intake case manager's recommendations at case conference, as NAHC employs mostly Native clinicians who integrate clinical psychotherapeutic and traditional practice, as well as inform our understanding of cultural resiliency as a treatment outcome. When clients were asked "How much do you know about your culture?" they responded in the ways noted in Figure 3.

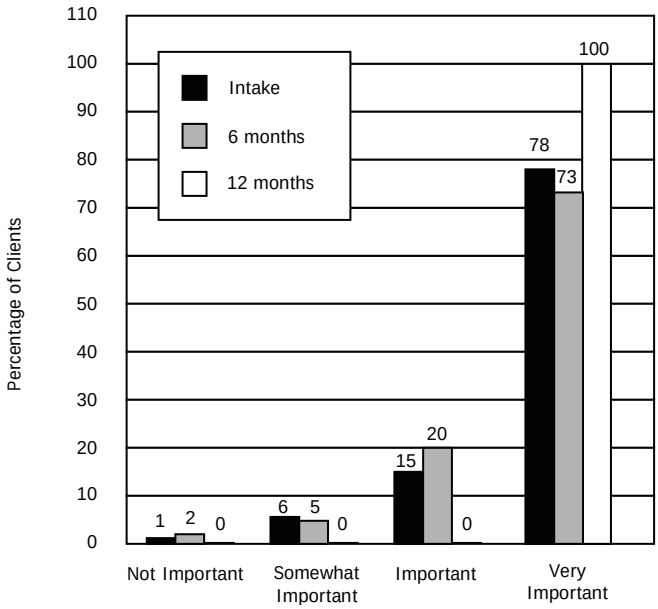
Figure 3
How Much Do You Know About Your Culture?



Significantly, a majority of our clients indicated that they know some or a lot about their culture coming into the program. However, those who reported having a lot of knowledge about their culture reduced their assessment of their knowledge after 12 months. Upon closer examination of the data, this seems to be a consequence of a smaller sample size at 12-month follow-up. In analyzing these responses regarding culture, we separated Native and non-Native clients and found no statistically significant differences in the data.

Clients were also asked "How important it is to you to be Native?" Their responses are noted in Figure 4. Native identity is important for the majority of the clients at NAHC and increases substantially after being involved in the program.

Figure 4
How Important is Being Native to You?



Conclusion

A significant correlation between violent trauma experiences and mental health issues, specifically PTSD, is underlined by our findings in working with Native women in the urban San Francisco Bay Area. We find consistent reporting that victims of abuse, especially childhood sexual and physical abuse, experience long-lasting psychological trauma. Robin, Chester, Rasmussen, Jaranson, & Goldman (1997) found that both women and men with a history of childhood sexual abuse were significantly more likely to receive diagnoses of three or more psychiatric disorders, compared to subjects with no such history. Further, people who experience PTSD often experience other psychiatric conditions such as depression, other anxiety disorders, and intermittent explosive disorders. Abuse-related PTSD may also increase alcohol and drug use, which is often used as a coping mechanism.

The co-occurrence of traumatic experiences, mental health and substance abuse disorders make for a complex clinical dynamic and

current services delivery systems are often inadequate in treating women with these experiences. "Limited screening for trauma, a lack of available trauma services, extremely fragmented or siloed services that fail to comprehensively address these issues, and a lack of cross-training among services for violence and mental health and substance use disorders are significant barriers to women's recovery" (Domino et al., 2005).

This study posits the close association between experiences of violence, associated trauma in the form of PTSD and other mental health disorders, and drinking, and looks at cultural identity as a mitigating factor for dealing with these trauma experiences. The work done at the Bay Area sites is community based and the data that were collected came from mixed samples of Native women receiving mental health and substance abuse treatment services in both outpatient and residential settings. These data address childhood abuse and the subsequent substance abuse and mental health disorders that appear for these Native women in adulthood. In analyzing the data, we found that client non-response presents a significant limitation to our findings. The effects of selective non-response need to be further investigated and the association between the experience of abuse, substance abuse, and mental health issues needs to be further researched, in particular in Native communities. This study provided a number of observations that we hope will be useful in structuring interventions for women with profound trauma histories. As Villanueva (2003) points out, we may be better able to engender change in clients' substance use and PTSD if we understand American Indian epistemology regarding personal change and combine AI/AN constructs of reconnection and healing with Western clinical treatment paradigms that use psychologically based, empirically validated interventions. The clinical model at the Native American Health Center has aimed at cultural congruence, integrating cultural healing and clinical care, to draw together the strengths of traditional healing approaches (such as Talking Circles or sweat lodge ceremonies), clinical psychotherapy, and evidence-based substance abuse treatment models such as cognitive behavior therapy, motivational enhancement therapy, and family interventions (Saylors & Daliparthy, 2005; Nebelkopf & Penagos, 2005; Bien, 2005). A growing body of literature indicates positive results from approaches that integrate treatment in dealing with the constellation of mental health and substance abuse disorders and a trauma history (Morrissey et al., 2005; Zlotnick, Najavits, & Rohsenow, 2003; Judd, Thomas, Schwartz, Outcalt, & Hough, 2003; Barrowclough, Haddock, & Tarrier, 2001; Ouimette, Moos, & Finney, 2000). When providing substance abuse treatment in Native communities, it is crucial

to create an environment where trust building can occur and which aims to build community and peer support. In order to provide our clients with strength-based, culturally dynamic care, we must understand the nature and repercussions of abuse histories among Native women and how these factors play out in mental health and substance abuse services.

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References

Barrowclough, C., Haddock, G., & Tarrier, N. (2001). Randomized controlled trial of motivational interviewing, cognitive behavioral therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry, 158,* 1706-1713.

Bien, M. (2005). Art therapy as emotional and spiritual medicine for Native Americans living with HIV/AIDS. *Journal of Psychoactive Drugs, 37*(3), 281-292.

Bohn, D. (2003). Lifetime physical and sexual abuse, substance abuse, depression, and suicide attempts among Native American women. *Issues in Mental Health Nursing, 24*, 333-352.

Brave Heart, M. Y. H. (2003). The Historical Trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, *35*(1), 7-14.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2), 60-82.

Brock, K., & Stenzel, A. (1999). *When men murder women: An analysis of 1997 homicide data—females murdered by males in single victim/single offender incidents*. Washington DC: Violence Policy Center.

Brown, V. B., Melchior, L. A., & Panter, A. T. (2000). Women's steps of change and entry into drug abuse treatment: A multidimensional stages of change model. *Journal of Substance Abuse Treatment, 18*, 231-240.

Brown, V. B., Sanchez, S., Zweben, J. E., & Aly, T. (1996). Challenges in moving from a traditional therapeutic community to a women and children's TC model. *Journal of Psychoactive Drugs, 28*(1), 39-46.

Buchwald, D., Tomita, S., Hartman, S., Furman, R., Dudden, M. & Manson, S. M. (2000). Physical abuse of urban Native Americans. *Journal of General Internal Medicine, 15*, 562-564.

Caetano, R. (2001). Non-response in alcohol and drug surveys: A research topic in need of further attention. *Addiction*, *96*, 1541-1545.

Campbell, J. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336.

Domino, M. E., Morrissey, J. P., Chung, S., Larson, M. J., & Russell, L. A. (2005). Service use and costs for women with co-occurring mental and substance use disorders and a history of violence. *Psychiatric Services, 56*(10), 1223-1232.

Duran, E., Duran, B., Brave Heart, M. Y. H., & Yellow Horse-Davis, S. (1998). Healing the American Indian soul wound. In Danieli, Y. (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341-354). New York: Plenum Press.

Duran B., Malcoe L.H., Sanders M., Waitzkin H., Skipper, B., & Yager, J. (2004). Child maltreatment prevalence and mental disorders outcomes among American Indian women in primary care. *Child Abuse & Neglect, 28*(2), 131-45.

Greenfield, L. N., & Smith, S. K. (1999). *American Indians and crime*. Washington, D.C.: U.S. Department of Justice, Office of Justice Statistics.

Harris, M., Fallot, R. D., & Berley, R. W. (2005). Qualitative interviews on substance abuse relapse and prevention among female trauma survivors. *Psychiatric Services, 56*(10), 1292-1296.

Hobfoll, S. E., Bansal, A., Schurg, R., Young, S., Pierce, C. A., Hobfoll, I., et al. (2002). The impact of perceived child physical and sexual abuse history on Native American women's psychological well-being and AIDS risk. *Journal of Consulting and Clinical Psychology, 70*(1), 252-257.

Judd, P. H., Thomas, N., Schwartz, T., Outcalt, A., & Hough, R. (2003). A dual diagnosis demonstration project: Treatment outcomes and cost analysis. *Journal of Psychoactive Drugs, 35*(1): 181-192.

Kendler, K., Bulik, C. M., Silberg, J., Hettema, J. M., Myers, J., & Prescott, C. A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and cotwin control analysis. *Archives of General Psychiatry, 57,* 953-959.

Kilpatrick, D. G., Resnick, H. S., Saunders, B. E., & Best, C. L. (1998). Victimization, posttraumatic stress disorder, and substance abuse among women. In C. L. Wetherington & A. B. Roman (Eds.), *Drug addiction research and the health of women* (pp. 285-307). Rockville, MD: National Institute on Drug Abuse.

Libby, A. M., Orton, H. D., Novins, D. K., Beals, J., Manson, S. M., & the AI-SUPERPFP Team. (2005). Childhood physical and sexual abuse and subsequent depressive and anxiety disorders for two American Indian tribes. *Psychological Medicine, 35,* 329-340.

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56*(10), 1213-1222.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and post-traumatic stress disorder in women: A research review. *American Journal on Addictions, 6,* 273-283.

National Center on Child Abuse and Neglect. (1999). *Annual report: National incidence and prevalence of child abuse and neglect*, *1998*. Washington DC: U.S. Department of Health and Human Services.

Nebelkopf, E. & Penagos, M. (2005). Holistic Native Network: Integrating HIV/AIDS, substance abuse, and mental health services for Native Americans in San Francisco. *Journal of Psychoactive Drugs, 37*(3), 257-264.

Noether, M. A., Finkelstein, N., VanDeMark, N. R., Savage, A., Reed, B. G., & Moses, D. .J. (2005). Design strengths and issues of SAMHSA's Women, Co-occurring Disorders, and Violence study. *Psychiatric Services, 56*(10), 1233-1236.

Ouimette, P. C., Moos, R., & Finney, J. (2000). Two-year mental health service use and course of remission in patients with substance use and posttraumatic stress disorders. *Journal of Studies on Alcohol, 61,* 247-253.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Application to addictive behaviors. *American Psychologist, 47,* 1102-1114.

Raj, A., Silverman, J., & Amaro, H. (2004). Abused women report greater male partner risk and gender-based risk for HIV: Findings from a community-based study with Hispanic women. *AIDS Care, 16*(4), 519-529.

Robin, R. W., Chester, B., Rasmussen, J. K., Jaranson, J. M., & Goldman, D. (1997). Factors influencing utilization of mental health and substance abuse services by American Indian men and women. *Psychiatric Services, 48*, 826-832.

Saylors, K. (2003). The Women's Circle comes full circle. *Journal of Psychoactive Drugs, 35*(1), 59-62.

Saylors, K. & Daliparthy, N. (2004). Aiming to balance: Native women healing in an urban behavioral health care clinic. In E. Nebelkopf & M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 169-178). Walnut Creek, CA: AltaMira Press.

Saylors, K. & Daliparthy, N. (2005). Native women, violence, substance abuse and HIV risk. *Journal of Psychoactive Drugs, 37*(3), 273-280.

Simoni, J.M., Sehgal, S., & Walters, K. (2004). Triangle of risk: Urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS and Behavior, 8*(1), 33-45.

Stevens, S. J., Estrada, A. L., & Estrada, B. D. (2000). HIV drug and sex risk behaviors among American Indian and Alaska Native drug users: Gender and site differences. *American Indian Alaska Native Mental Health Research, 9*(1), 33-46.

Swan, N. (1998). Exploring the role of child abuse in later drug abuse. *NIDA Notes: Child Abuse and Drug Abuse, 13*(2), 1-4.

Villanueva, M. (2003). Posttraumatic stress disorder, alcohol, and tribes: Obstacles to research. *Alcoholism: Clinical & Experimental Research, 27*(8), 1374-1380.

Walters, K. L., & Simoni, J. M. (1999). Trauma, substance use, and HIV risk among urban American Indian women. *Cultural Diversity and Ethnic Minority Psychology, 5,* 236-248.

Walters, K. L., & Simoni, J. M. (2002). Reconceptualizing Native women's health: An 'indigenist' stress-coping model. *American Journal of Public Health, 92*(4), 520-524.

Walters, K. L., Simoni, J. M., & Harris, C. (2000). Patterns and predicators of HIV risk among urban American Indians. *American Indian and Alaska Native Mental Health Research, 9*(2), 1-21.

Widom, C. S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Psychiatry, 156*(8), 1223-1229.

Zlotnick, C., Najavits, L., Rohsenow, D., & Johnson, D. M. (2003). A cognitive-behavioral treatment for incarcerated women with substance use disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25,* 99-105.