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Intimate Partner Violence: Implications For Northern Plains And Upper Midwest American Indian Mother-Daughter Dyads' Attachment Relationships

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INTIMATE PARTNER VIOLENCE: IMPLICATIONS FOR NORTHERN PLAINS
AND UPPER MIDWEST AMERICAN INDIAN MOTHER-DAUGHTER DYADS'
ATTACHMENT RELATIONSHIPS

by

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota
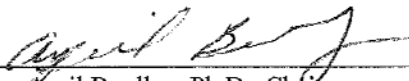
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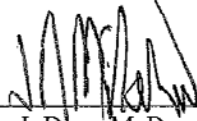
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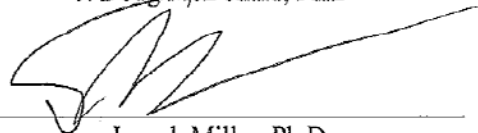
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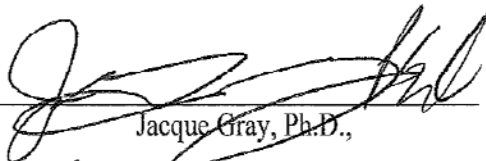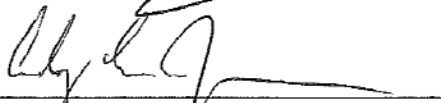
This dissertation, submitted by Julii M. Green in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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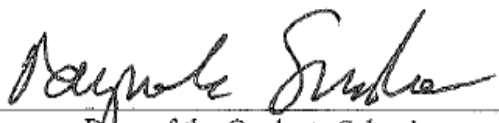
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This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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Dean of the Graduate School

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5-3-17
Date

PERMISSION

Title   Intimate Partner Violence: Implications for Northern Plains and Upper Midwest American Indian Mother-Daughter Dyads' Attachment Relationships

Department   Clinical Psychology

Degree   Doctor of Philosophy

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Julii M. Green

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Dedication

This dissertation is dedicated to my grandmother Edna Rose Starks, my mother Ann Scott, my aunties, my cousins, my nieces, the Native American women and girls in the study, and all survivors of IPV. The countless women who have demonstrated courage and strength while enduring aspects of IPV throughout their lives and who may not have lived to share their stories. I am grateful and honored that these brave women and girls spoke in truth and love to me. That my mentors (community and academic mothers/aunties/uncles) took care of me when I wasn't taking care of myself and that the creator made a way for me in each community I visited (through snow ditches and wayward roads…through whispers and through tears). I am just grateful to be able to be standing here today to bear witness and provide some insight into the lived experiences of the Native American women and girls I met during my dissertation journey.

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As I think about all of the life experiences that have lead me through this academic adventure I must acknowledge the wonderful support system that I have held near and dear to my heart!

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I-we are all grateful for your servant's heart. I am honored to be your partner for life and am forever indebted to you for getting me through this journey. I love you!

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ABSTRACT

An established body of research focused on family violence captures the experiences of women impacted by intimate partner violence (IPV), the implications for child witnesses of IPV, and the predictive risk factors of violence toward women. In an attempt to understand the unique experiences of American Indian women and children this study examined the intersection of American Indian identity, attachment relationships, and traumatic experiences to comprehend the short and long-term impact of IPV.

The current research study included 30 American Indian mother-daughter dyads who had a history of IPV. The findings suggested that participants' substance use during IPV episodes was associated with the relationship between participants' experiences of IPV and mother-daughter attachment relationships. Subsequent findings indicated that participants' who graduated from high school and those participants' whose partners' used substances during IPV episodes were at an increased risk for IPV experiences. Additionally, participants' experiences of IPV were not associated with mother-daughter attachment relationships. Recommendations regarding clinical practice, research and policy are presented. This dissertation is one of the first studies to examine the experiences of Northern Plains and Upper Midwest American Indian mothers' and daughters' attachment relationships and the influence of IPV utilizing the conceptual framework of the medicine wheel and the theoretical framework that

includes IPV, attachment, ptsd symptoms, ethnic/cultural identity and various

contextual variables.

CHAPTER I

Introduction

An established body of research focused on family violence captures the

experiences of women impacted by intimate partner violence (IPV), the implications

for child witnesses of IPV, and the predictive risk factors of violence toward women. In

the U.S. nearly 1.3 million women are physically assaulted by an intimate partner

annually (Tjaden & Thoennes, 2000). Henderson (2000) identified various components

of domestic violence which include physical abuse (e.g., kicking, punching, beating,

and the general exertion of physical power over another person), emotional and verbal

abuse (e.g., public humiliation, name calling, mind games, and manipulation), isolation

(e.g., abuser limits contacts with friends, family and coworkers), and threat or

intimidation (e.g., threats of violence, suicide, or of taking away the children). Sexual

assault and rape—any non-consensual sexual act including penetration—are commonly

identified as an aspect of domestic violence. IPV, family violence or domestic violence

in the current study is defined as conflict between intimate partners including, pushing,

hitting, humiliating, sexually assaulting, arguing and hospitalization for injuries (U.S.

Department of Defense Task Force on Domestic Violence, 2002; Tjaden & Thoennes,

2000).

A review of cross-cultural IPV research demonstrates the magnitude of its

impact on ethnic/racial groups, specifically American Indians (Bohn, 2003; Evans-

Kipp, 2004; Jones, 2008, Robin et al., 1998). American Indian victims of intimate

partner and family violence are more likely than victims of all other races to be injured

and need hospital care. Medical costs related to America Indians' care were more than

$21 million over a four-year period (U.S. Department of Justice, 1999 as cited in North

Dakota Council on Abused Women's Services, 2007). The following are lifetime

prevalence rates of physical assaults across ethnic/racially diverse women: American

Indian/Alaska Native (30.7%), African American (26.3%), White (21.3%),

Latina/Hispanic (21.2%), and Asian Pacific Islander (12.8%) (Trjaden & Thoennes,

2000). It is estimated that 64% (i.e., more than six in ten) American Indian women will

be physically assaulted annually (U.S. Department of Justice, 2007). In fact, nearly

34.1% (i.e., more than one in three) American Indian women will be raped in their

lifetime (U.S. Department of Justice, 2007). Methodological flaws, including small

sample size and ethnic lumping (e.g., failure to recognize variability within ethnic

groups), have made it difficult to draw conclusions about lifetime prevalence rates of

IPV among American Indians (West, 1998 as cited in West, 2005). Therefore it is

important to examine tribal or regional differences in the rates of IPV among American

Indians (West, 2005).

Statement of Problem

  IPV can elicit substantial consequences for battered victims (e.g., psychological

functioning, physical health, financial well-being, etc.), society (e.g., health care, legal

system, communities, labor force, etc.), and the victims' families (e.g., child abuse,

strained relationships, etc.). An exploration of the rates of reported child abuse in the

U.S. imparts additional insight regarding children and adolescents and the impact of

intimate partner violence (IPV). In 2006, an estimated 905,000 children were victims of maltreatment; the rate of abuse was 12.1 per 1,000 children in the population (U.S. Department of Health and Human Services, 2008). It is possible that a large percentage of child victims were also exposed to IPV.

Studies have documented the experiences of children who were exposed to IPV and indicated that these children were at greater risk for being physically abused, neglected, or experiencing other forms of child maltreatment (Fantuzzo et al., 1997; Jouriles et al., 1989; McCloskey et al., 1995; Straus & Smith, 1990; U.S. Department of Health and Human Services, 2008). Adolescent girls with abuse histories might be more susceptible to violence (Bagley, Bolitho, & Bertrand, 1997; Champion & Kelly, 2002) and might be more likely to be in a current relationship with an abusive partner (Champion, Shain, Piper, & Perdue, 2001).

Childhood exposure to continuous intimate partner violence has long-standing implications for their own intimate relationships as adults. Amato and Booth (1991) found that adults who reported high levels of parental conflict tended to identify a disproportionately large number of marital and psychological dilemmas in their own lives. Adults who have witnessed and/or experienced abuse within their home of origin might utilize maladaptive coping strategies within their own relationships. Doucent and Aseltine (2003) evaluated early adult marriages and determined that regardless of parental marital divorce, family conflict was associated with lower future marital support, higher dissatisfaction, and more frequent spousal disagreements. The literature clearly connects childhood witnessing of IPV to later adult experiences of IPV, which might be considered as intergenerational experiences.

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Although the literature reflects the experiences of American women and children, there is limited intimate partner violence (IPV) research that includes the experiences of women and their children from diverse ethnic backgrounds, in general, and American Indians specifically (Indian Child Health Services, 1991; Norton & Manson, 1995; Mitka, 2002). In a representative sample of 16,000 American men and women, American Indian/Alaska Native women were significantly more likely than African American, Caucasian, or mixed-heritage women to report that they were raped (Tjaden & Thoennes, 2000). Additionally, American Indian/Alaska Native women were significantly more likely than African American or Caucasian women to report that they were stalked (Tjaden & Thoennes, 2000). A study utilizing a non-probability sample of 347 Navajo women who accessed a public medical clinic, found that 52% of the sample reported at least one IPV event in their lifetime (Fairchild et al., 1998). Sixteen percent of the women in the study reported being victimized in the last 12 months (Fairchild et al., 1998). In addition to the aforementioned methodological problems that impact accurate prevalence rates of IPV among American Indians, further complications are created by communities that commit to a code of silence regarding IPV (West, 2005). Often members within ethnic/minority communities will suppress information about an abusive partner or IPV episode. Therefore some victims will receive communal pressure to protect their partners and their communities from oppressive societal policies (e.g., abusive partner receiving extensive jail term) and cultural stereotypes (e.g., ethnic/minority group affiliated with higher rates of abuse) (West, 2005).

It appears that high rates of intimate partner violence (IPV) and sexual assault are serious problems within Indian country (Jones, 2008; McEachern et al., 1998; U.S. Department of Justice, 2007). American Indian women experience among the highest rates of violent victimization of any race in the U.S. (Bohn, 2003; Tjaden & Thoennes, 2000). The abovementioned data indicates that IPV might occur more frequently among American Indians than in the general population (U.S. Department of Justice, 1999 as cited in North Dakota Council on Abused Women's Services, 2007; U.S. Department of Justice, 2007). It is also likely that American Indian children and adolescents are being exposed to increased incidents of IPV and/or sexual assault in traditional indigenous communities.

Nearly, 8.8 million children witness IPV annually (Campaign for Funding to End Domestic Violence and Sexual Assault, 2006; Kilpatrick & Saunders, 1997). Empirical evidence suggests that exposure to IPV impacts children's interpersonal relationships, academic standing, and various aspects of their psychological functioning (Armistead, et. al, 1995; Geffner, Igelman, & Zellner, 2003; Graham-Bermann, 2002; Green & King, 2009). Female survivors of intimate partner violence tend to be the primary caretaker of the children within the home. The challenge of caretaking of children while enduring domestic violence might become daunting, resulting in cases of abuse and/or neglect at the hands of the victim of IPV (Domesticviolence.org, 2009). It is estimated that youth who live in households in which a partner is being abused are at greater risks of being victimized than are youth who do not witness IPV in their homes. In fact, forty to sixty percent of males who abuse their current or former partner also abuse their children (American Psychological Association, 1996).

Research studies on child maltreatment and related witnessing IPV in American

Indian communities is limited. Kunitz and associates (Kunitz, Levy, McCloskey, &

Gabriel, 1998) found that 12.7% of Navajo adults identified through Indian Health

Service clinical records had experienced physical abuse before the age of 15. The

prevalence rates of childhood sexual abuse were estimated for this population to be

12.7% among women and 2.4% among men (Kunitz, Gabriel, & Levy, 2000). In

another study that compared rates of childhood maltreatment in two American Indian

communities with the National Comorbidity Survey it was determined that the

prevalence rates within the AI communities were higher than that identified within the

U.S. general population. Ten percent of the Northern Plains and 8% of the Southwest

tribes identified being physically abused before age 16, compared to 3.3% for the U.S.

population (Kessler, Davis, & Kendler, 1997). Studies have connected childhood

adversities (e.g., sexual abuse and physical abuse) with adult drug and alcohol use

concerns and mental health disorders (e.g., depression) in U.S. populations (Brown &

Anderson, 1991; Read, 1998) and American Indian populations (Kunitz et al., 1998;

Libby et al., 2004, 2008). The current study examined aspects of family violence,

substance use, mental health symptoms, and attachment relationships among Native

mothers and daughters.

Conceptual and Theoretical Frameworks

Theory provides an opportunity to shift from the abstract and tentative to a more

focused way of predicting a defined area of interest in our communal society (Newman,

2004). In the field of psychological and social sciences, we are driven to understand the

often complicated phenomena and multi-faceted realities of the person-in-situation

(DiNitto & McNeece, 2008). Theory does not embody an absolute truth but rather provides a lens by which to get one step closer to a greater understanding of our world.

Babbie (1999) suggests that theory has three key components: (1) it assists us with understanding observed instances of behaviors in a way that might suggest other alternatives; (2) it helps us to recognize why events happen, permitting us to predict future events; and (3) it can provide a framework to conduct research. In regards to systematically reducing the prevalence of IPV it is important to understand the causes. In understanding the cause of the problem we are able to comprehend it better and further develop efficient intervention and prevention approaches. Before any attempt is made to establish causality, a theory must be critically evaluated, with special attention paid to the relevance and implications of ethnicity, culture, religious affiliation, and socioeconomic status of the population being studied (Gout, 2010). In the case of the American Indian/Alaska Native population, these steps are even more essential. Because of the complexity of the historical and present-day circumstances of American Indian/Alaska Natives it is warranted not to treat all victims' experiences as the same and to utilize a culturally-informed approach to the conducting research involving this unique population (American Indian/Alaska Native intimate partner violence victims/survivors) (Gout, 2010).

For this reason, the conceptual framework and subsequent theoretical framework identified for this dissertation are reflective of American Indians distinct ethnic/cultural identities and experiences. The conceptual framework addresses the Native American worldview that is based on a system of circles, most notably the medicine wheel. A discussion focused on the interconnected system and aspects of

historical trauma which causes disruptions in family systems as well a loss of cultural connections will be reviewed. The theory allows for a clearer understanding of circumstances and significant changes in position for the American Indian within this country since colonization. The seminal work of Maria Yellow-Horse Brave Heart (1995) introduced the theory; its further application regarding various forms of trauma impacting American Indians/Alaska Natives (e.g., Bigfoot & Schmidt, 2008, 2010) will be addressed. The theoretical framework the present research is based upon includes aspects historical trauma such as IPV, PTSD symptoms, ethnic/cultural identity, substance use, and mother-daughter attachment relationships.

      American Indians: Pan Indianis, Historical Trauma, and Culture. "Pan Indianism" is related to the mistaken belief that American Indians are one cohesive homogeneous group (Evans-Kipp, 2004). McDonald, Morton, and Stewart (1993) define American Indians/Native peoples and Indigenous people, as "(a) any group or individual who can demonstrate blood quantum or ancestral lineage to any federal, state, or locally recognized tribe and/or (b) any person who becomes a member of such a tribe through ceremonial adoption and strives to live in traditional Indian fashion" (pg. 438)". Social service providers and other professionals often generalize the experiences of indigenous people based upon the aforementioned notion of "Pan Indianism". There are more than 560 American Indian tribes and Alaska Native villages identified by the federal government (Bureau of Indian Affairs, 2007). American Indians and Alaska Natives who are recognized by the Federal government are a part of Sovereign nations—with claims to rights and powers (Cornell & Kalt, 1998).

It is common for American Indians to recognize their particular nation or tribe rather than identifying themselves as American Indians (Evans-Kipp, 2004). Additionally, one's membership in a clan or band is likely just as important as one's membership in a nation as the most salient source of one's identity (Evans-Kipp, 2004; Weaver, 1998). It is also possible for an American Indian's ethnic/cultural identity to be tied to a series of traumatic events connected to his or her cultural background or tribal history. Therefore, it is important for research studies to evaluate bicultural identity in traditional indigenous community members in order to better understand family-related experiences (e.g., parent-adolescent attachment and family functioning).

American Indian cultural perspective and the medicine wheel. The American Indian worldview encompasses a holistic perspective to understand a person, family, or tribal community and is often represented by the medicine wheel. The medicine wheel originated from the Lakota tribe (Dapice, 2006 as cited in Muehlenkamp, Marrone, Gray, & Brown, 2009), and its four mutli-dimensional components correspond to the four sacred interconnected parts related to the circle of life. The four sacred parts generally reflect the relationships that are identified as sacred colors (red, yellow, black, and white); the four components of the physical and spiritual world (physical, spiritual, emotional, and mental); the four directions (East, West, North, and South); and the four values of the Lakota (generosity, respect, wisdom, and courage; Roberts et. al., 1998 as cited in Muehlenkamp, Marrone, Gray, & Brown, 2009). BigFoot and Schmidt (2008, 2010) introduced an adapted model of the medicine wheel, "Model of Well-Being", which includes a relational dimension of the

wheel and places the Spiritual/cultural dimension at the core of the wheel (see Figure

1).
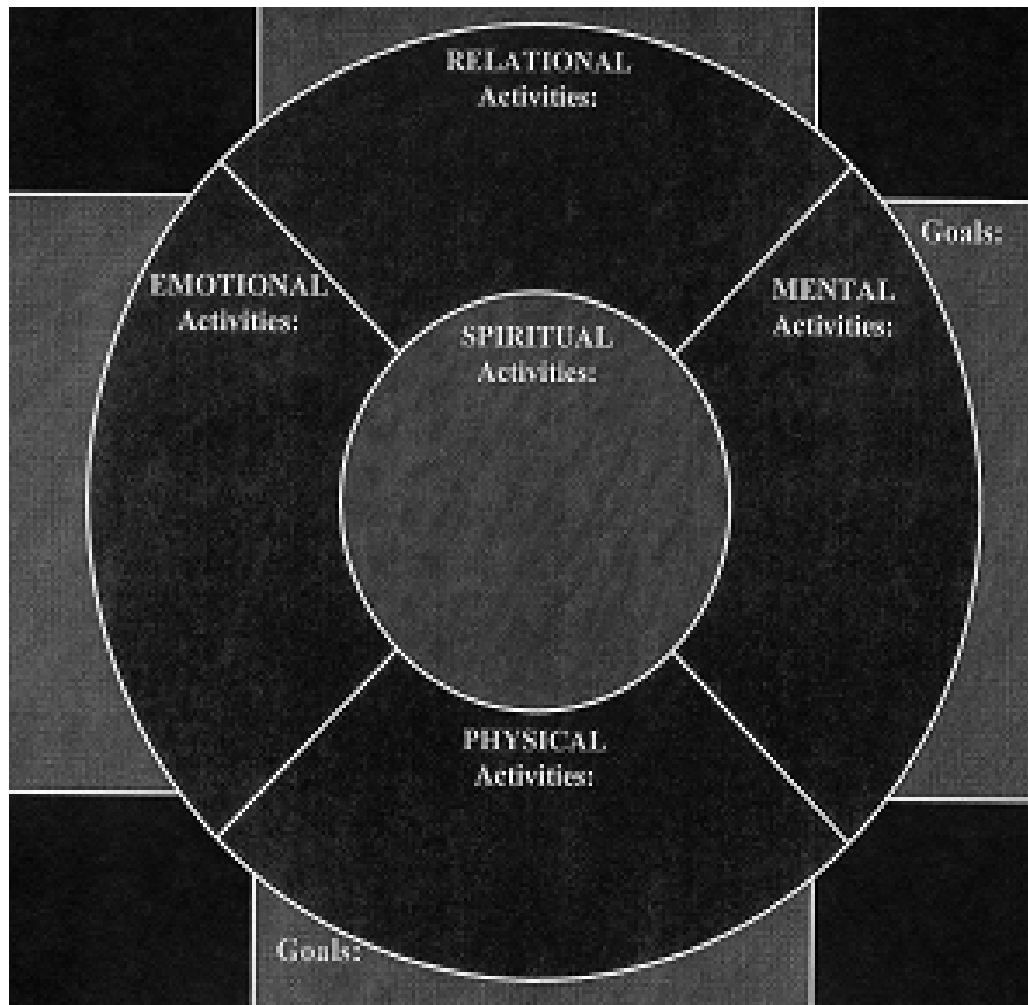
Figure 1

Medicine Wheel Schematic "Mending the Circle" Conceptual Framework. BigFoot &
Schmidt (2008, 2010).

The "Mending the Circle: Model of Well-Being" medicine wheel more

accurately reflects many relationships within American Indian/Alaska Native

communities (e.g., family, community, nature, etc.) as well as a circular world view

where spirituality is the center of one's life. The relational, emotional, physical,

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spiritual, and psychological parts of one's life contribute to personal and tribal community balance. The quadrants are interdependent; if one element is well nurtured, the other elements are likely to be in good order as well (BigFoot & Schmidt, 2008, 2010; Gilgun, 2002). Conversely, disturbance in one element can have repercussions for functioning in other elements. Exposure to trauma might impact a person and generate personal imbalance; imbalance causes disharmony in one or more personal dimensions—spiritual, relational, mental, emotional or physical (BigFoot & Schmidt, 2008, 2010). When some tribal members experience relationship discord it might manifest through interpersonal violence toward a partner, a child, or among tribal community members. When there is conflict (e.g., among family or community members) well-being is affected by personal and community balance, harmony, respect, connectedness, and overall wellness (BigFoot & Schmidt, 2008, 2010). It is important for tribal communities to understand historical trauma and the connections to tribal people's general well-being. BigFoot and Schmidt (2008, 2010) encouraged the incorporation of indigenous practices into established evidenced-based treatments for trauma (e.g., Trauma Focused Cognitive Behavior Therapy, TF-CBT) in an effort to develop the healing processes for American Indian/Alaska Native clients.

Historical trauma is a significant factor to consider when examining the experiences of IPV among American Indian/Alaska Native population. The historical backdrop of the collective trauma experienced by AI/AN people provides a context for understanding changes in the status of American Indian women and their daughters.

Historical Trauma

A review of some of the experiences of Northern Plains and Upper Midwestern American Indians is fundamental in understanding the cultural and historical context of some of the traditional indigenous community members. Northern Plains and Upper Midwest is a region of the United States including but not limited to South Dakota, North Dakota, eastern Montana, and Minnesota. Persons indigenous to tribes within this region are often identified as Northern Plains and Upper Midwestern American Indians (Evans-Kipp, 2004). There are certain life events that American Indians/Alaska Natives have experienced that have affected generations. Cultural trauma focuses on the attack of the foundation of a society in an attempt to damage the community and its members (BigFoot & Schmidt, 2008).

Specific experiences with boarding schools established by the United States government and religious institutions (e.g., Catholic Church) contributed to the degradation of American Indian language, cultural values, and spirituality. Initially, American Indian children were taken from their native land and often had no communication with parental figures or extended family during their time at boarding school (e.g., 1-year minimum) (KAT productions, n.d.). Administrators within the boarding schools would reprimand (e.g., physical punishments) students for attempting to maintain traditional customs (e.g., speaking Native language, participating in ceremonies, etc.). Boarding school faculty would try to facilitate assimilation to European American culture by cutting off students' hair, making students dress in uniforms, and educating students (e.g., labor industry and domestic work) (KAT productions, n.d.). The children within the boarding school often became victims of

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various forms of abuse (e.g., ritualistic sexual abuse, physical abuse, psychological abuse, etc.) at the hands of the boarding school faculty and other children/teens acting out as a result of being victimized themselves (KAT productions, n.d; Brave Heart, 2004; Stone, 2008). The impact of community destruction and the loss of cultural rituals as a result of massacres or warfare and boarding school experiences across generations limited the productivity and functioning of many tribal community members.

Traumatic events that have a lasting effect on individuals or a group of people are known as Historical Trauma (HT) (BigFoot & Schmidt, 2008; Brave Heart, 2004). HT is the collective exposure to traumatic events (warfare, colonization, boarding school experiences, etc.) that impact a person or group of people over a life-time (BigFoot & Schmidt, 2008; Brave Heart, 2004). The history of the Northern Plains American Indians, specifically the experiences of the Lakota (Teton Sioux), include massive destruction through war and colonialism (Brave Heart, 1998) such as: (a) 1890 Wounded Knee Massacre; (b) affiliated war experiences (e.g., prisoners of war and displacement); (c) separation of Native families through the placement of children in boarding schools (e.g., led to the elimination of cultural practices, increase in sexual abuse and other forms of abuse, and affiliated with suicides within communities); and (d) epidemics (e.g., Small pox, tuberculosis, etc.), as when nearly one-third of the Lakota population died between 1936 and 1941 from a tuberculosis epidemic (Brave Heart, 2004; Hoxie, 1989).

The experiences associated with the Holocaust, slavery, colonization and other historical events liken to HT. Communities exposed to continuous violent or traumatic

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events are bound to be vulnerable and influenced by those very events (BigFoot &

Schmidt, 2008, 2010). Similar historical events have occurred throughout Indian

country and depending upon individual differences (e.g., resiliency, coping skills,

complex trauma experiences, etc.), family support, spirituality, or other factors

American Indians' historical trauma response (HTR) will be varied. The impact

historical trauma has on Native communities is identified as HTR and often includes

increased rates of mortality, substance abuse (e.g., alcoholism), suicide, poverty, and

psychological distress (Brave Heart, 1998; 2004).

The aforementioned historical events might have positive and/or negative

intergenerational effects on traditional indigenous communities. Some tribal

community members might experience HTR in a way that decreases family stability

and cohesion. These individuals might be less inclined to relate or support one another

during difficult times. Other tribal community members might be able to foster a

balance within their lives as a result of resilience and connections with other tribal

members. HTR has an important influence on all areas of functioning and should be

considered in the context of research as well as practice within Native communities

Implications of posttraumatic stress disorder for American Indians.

According to the National Center for Post Traumatic Stress Disorder (2007), an anxiety

disorder likely occurs after experiencing a traumatic event. A traumatic event can be

direct (experienced) or indirect (witnessed) and perceived as frightening and horrific.

Individuals often fear that their lives are in danger and uncontrollable fear often follows

the events. Higher levels of PTSD have often been connected to events that were

identified as uncontrollable, involved separation from the family during the horrific

event, and were initiated by other people (Evans-Campbell, 2008). The following represent some of the consequences of PTSD: drug or alcohol problems, shame, despair, feelings of hopelessness, employment problems, relationship problems, physical health problems, divorce and violence.

Much of the American Indian literature documents the effects of PTSD within the population; most notable are those of boarding school survivors. To date there are a number of ways to treat PTSD, including medications, exposure therapy, and cognitive-behavioral therapy (National Center for PTSD, 2007). It is expected that the majority of boarding school victims did not have access to this current information and that most were left untreated and to their own devices. Inability to cope and to access cultural or spiritual supports (as a result of the Indian Religious Freedom Act not being passed by congress until 1978) and the inherent mistrust within mainstream society, increased the likelihood of the transmission of trauma. A number of the consequences of PTSD are remarkable risk factors for IPV: child abuse, chemical and alcohol use/dependency, suicide attempts and/or completions, and depression.

Impact of historical trauma. When considering the aforementioned historical event in addition to forced assimilation, loss of language, loss of culture, and loss of spirituality, there are clear connections with the collapse of Native social structures and family kinship systems (BigFoot & Schmidt, 2008, 2010; Brave Heart, 2004). Increased episodes of interpersonal violence and substance abuse occurred with the destruction of family networks and other cultural supports within many American Indian communities (BigFoot & Schmidt, 2008; 2010; Brave Heart, 2004). Additionally, American Indian women who are sexual abuse or physical abuse

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survivors are at greater risk for substance abuse, major depression, and suicidality (Bohn & Holz, 1996 as cited in Bohn, 2004).

Many women with multiple stressors and limited coping skills are less capable of caring for their families. It is possible that these women might overly focus on the negative aspects of their family's situation, their children's behavior, and life in general. It might be even more difficult for these women to identify their family members' strengths, let alone their personal strengths. The combined effects of family violence are likely exacerbated by a variety of cultural and societal factors. Intimate partner violence (IPV) might impact parenting skills, and long-term consequences could contribute to the development of child psychopathology. IPV might influence American Indian parenting styles in a variety of ways such as: (1) overly critical or lenient parenting; (2) parental inattentiveness; (3) inappropriate parent—child boundaries (e.g., role-reversal where a parent relies on a child to take care of his or her emotional needs rather than providing the child with emotional support); and (4) potential victimization (e.g., child abuse and neglect) (Werner & Kerig, 2006).

The primary dynamics influencing violence in Indian country are potentially linked to Historical Trauma: (a) socioeconomic status; (b) increased rates of alcoholism and substance abuse; (c) increased mortality rates; and (d) psychosocial implications of such factors (e.g., suicide rates, depression, and anxiety amongst Americans Indians) (Brave Heart, 2004; Duran & Duran, 1995). In 2006, a Federal study found that 38,757,253 people were impoverished in the U.S. (U.S. Census Bureau, 2007). American Indians and Alaska Natives had the highest poverty rates (26.6 %) and had a lower median household income ($33,762) compared to the U.S.

average household ($48, 451) (U.S. Census Bureau, 2007). Economic hardships are commonly associated with psychological distress and various health disparities. Financial distress also likely impacts parenting and family cohesion due to the strain of meeting the needs of the family. When people are unable to take care of the basic necessities (e.g., food, clothing, shelter) it can become difficult to provide emotional support and guidance to family members as well. Children in these circumstances often become withdrawn (e.g., internalize) or act out toward others (e.g., externalize) as a means of coping with family difficulties

American Indians' age-adjusted alcohol related deaths were 237% higher, suicide mortality rates were 74% greater, and homicides were 63% greater than for all other races/ethnic groups in the U.S. (IHS, 1999 as cited in Bohn, 2003). There appears to be a dearth of large-scale community studies that include American Indians who access mental health support; limited small-scaled studies demonstrated that mental health service utilization by tribal people is similar to that of the general population. In a review of the literature, Stone (2008) found that 32 % of First Nations people with a mental disorder received services, nearly the same as the U.S. population (Stone, 2008). Although, the examination of historical trauma has been encouraged across various fields there is limited empirical research focusing on HT (Evans-Campbell, 2008; Gout, 2010). In fact, much of the preliminary research has utilized smaller clinical samples making it difficult to establish specific conclusions about the phenomenon (Tehee & Esqueda, 2008). However, it is important to acknowledge the potential combined effects of traumatic experiences (e.g., individual or community related), economic hardships, substance abuse, and psychological distress on American Indian families.

The implications of the aforementioned influences on American Indian familial relationships are unlimited. In some instances families are likely strained, finding it difficult to communicate or address family needs, while other families in Native communities will, in fact, dissolve relationships or separate completely (e.g., move out of the community, end intimate partner relationships, etc.). However, in the midst of such traumatic circumstances many American Indian families are resilient, relying on their spirituality and supportive family networks for survival or perseverance.

American Indian Families: Race/Ethnicity, Culture, and Relational Context

The American Indian culture includes a rich heritage, a variety of traditions, and ceremonies connected with each tribal community (e.g., Pow Wows, sweat lodge, spiritual healers, language, etc.). When considering culture and customs affiliated with American Indians/Alaska Natives it is also important to distinguish race or ethnicity from culture. Race or ethnicity is often determined by a person's physical features (e.g., facial features), genotype (shared genetic characteristics), and the notion of a group of people's collective history (Pinderhuges, 1989), while culture focuses on the shared values, attitudes, norms, and beliefs of a race/ethnic group (Matsumoto, 2000).

Typically people use the terms interchangeably: however, two people from the same race can be very similar (e.g., share same notions of a trickster figure) or very different culturally (e.g., origin/creation story). People born within a certain race/ethnic group might not adopt the cultural stereotype of that race/ethnic group (e.g., an American Indian might adopt a Christian doctrine rather than traditional indigenous spiritual practices). Culture is identified as a learned behavior, while race/ethnicity is not. In an effort to better understand Northern Plains and Upper Midwestern American

Indian families, it will be necessary to describe the types of activities or behaviors that are associated with the culture. Although the current study does not specifically obtain the cultural norms of the American Indian participants in the study, there is an attempt to gather information from narratives as well as examine ethnic/cultural identities of participants. Limited research has examined American Indians' experiences of IPV in the context of ethnic identity; however, major recommendations have called for the inclusion of cultural factors in IPV research (Evans-Kipp, 2005; Robin et. al., 1998; West, 2005). Even fewer studies have identified the experiences of American Indian parent—child relationships (Momper, 2005) in the context of ethnic/cultural identity and attachment.

American Indian family structures differ from typical European American/White families in which the biological parents of a child are the main authority in the family and essentially represent the core of a family (Harry, 1992). Some families, in particular American Indians, identify their extended family as an integral part of the authority structure and the family's identity (Harry, 1992). American Indian parenting research has found that children within the culture traditionally have more freedom than European Americans/Whites and that childcare in some traditional indigenous communities is based on an established sense of community responsibility (Cunningham, Cunningham, & O'Connell, 1986; Everett, Proctor, & Cartmell, 1983; Harry, 1992; Philips, 1983). BigFoot and Schmidt (2008) identified aspects of positive parenting and honoring American Indian children as the caregiver's responsibility to nurture and develop the positive nature of the child. A primary way parents could honor their child might be through the cultural practice of

shunning/ignoring, which is the similar to a time-out procedure (e.g., child stays in separate area and is to refrain from an activity or from communicating with family or others for short period of time). American Indian parents might incorporate cultural practices into the disciplining of a child depending upon one's endorsement of his or her ethnic/cultural identity.

Another aspect of American Indian honoring children through positive parenting might include indirect discipline by have having the child complete an activity to help teach lessons (e.g., planting a garden is often used symbolically to demonstrate the natural course of human development and maturation) (BigFoot & Schmidt, 2008, 2010). The use of extended family members or other tribe members is also quite helpful in honoring or caring for American Indian children. The traditional indigenous community might include: grandparents, aunties, uncles, other extended family members, and neighbors who could potentially make more of an effort to redirect children and/or provide guidance than the biological parents. Many American Indians endorse cultural values that are aligned with harmony in nature, tradition, and humility (Forehand & Kotchick, 1996). In addition, traditional indigenous communities typically uphold respect for elders, cultural customs (e.g., ceremonies), and the sharing of wealth as well as resources (Forehand & Kotchick, 1996). It should be stated with caution that not all American Indians share the aforementioned cultural values; as with any member of a society individual differences are reflected within the group (e.g., varied cultural orientation and/or ethnic identity).

The history of inappropriate research developed within Native communities has established an atmosphere of mistrust with academia and related research communities

(Trimble & Fischer, 2006). Often researchers conducting studies in Indian Country do not have sound partnerships with community stakeholders (e.g., tribal council members, tribe organizations, tribe members, etc.) and community members do not receive lasting benefits from participating in such studies. Potential limitations to the types of research projects, findings or outcomes related to specific tribes, and general interaction with tribal government must be handled with care and concern for information about various tribes. Precedence has therefore been established for researchers to build relationships with Native communities prior to conducting research (e.g., community-based participatory action research) (Noe et al., 2006). Relationship building with elders in the community (e.g., tribal council) and/or a cultural liaison to gain insight about the tribal indigenous community and culture can be mutually beneficial (Noe et al., 2006). The aforementioned steps will likely increase researchers' awareness about the tribal culture as well as the community. The current research incorporates aspects of the community-based participatory action research method in an effort to examine the experiences of American Indian women and their adolescent daughters who are involved in family violence, specifically intimate partner violence (IPV). Although it was recommended to have participants take part in a focus group to briefly process their experiences related to parenting, culture, and coping with personal or family trauma (R. McDonald, personal communication, February 28, 2008), another cultural liaison provided specific insight about building trust among American Indian IPV and sexual assault survivors, which helped facilitate participants' responses to surveys that entail sensitive information (e.g., trauma, IPV, etc.) and contributed to their willingness to access supports after the study ended (L. Thompson, personal

communication, January 5, 2011). Adjustments were made that provided each participant with a secure space to discuss her individual/personal experience with intimate partner violence (experienced and/or exposure to episodes). Additional linkages to advocates, mental health supports, and spiritual healers were provided to each participant as needed.

Ethnic/Cultural Identity

Ethnic/Cultural identity is sometimes measured by an ethnic identity scale, as it in the current study, and it typically is an important factor when considering the mental health well being of racially/ethnically diverse people (Garza & Lipton, 1984; Helms, 1992; Rieckmann, Wadsworth, & Deyle, 2004; Rowe, Behrens, & Leach, 1995). A person's sense of identity provides a feeling of connectedness or belonging to a cultural group, which might accordingly lead to a secure base for personal development (Comas-Diaz & Greene, 1994; Evans-Kipp, 2004). Additionally, political, social, and environmental conditions might influence ethnic/cultural identity. For example, Navajo cultural identity includes the lifestyle choices, values, and beliefs that protect Navajo people throughout their lives (White, 1998 as cited in Lomay & Hinkebein, 2006). Research established that family, spiritual, and environmental components in Navajo cultural identity assisted with people's decision making process and interactions. Limited empirical research has explored the relation between American Indian ethnic/cultural identity and various psychological phenomena (e.g., adolescent behavior, rehabilitation, etc.) (LaFrombiose & Low, 1998; Lomay & Hinkebein, 2006). Even fewer studies have evaluated American Indian parent—child attachment relationships (Sarche et al., 2008) in the context of ethnic/cultural identity.

Additionally, there appears to be only cursory research examining American Indian ethnic/cultural identity and IPV.

In the assessment of American Indian ethnic/cultural identity, two instruments emerged as most helpful for understanding American Indians' experiences. One is the American Indian Cultural Orientation Scale (AICOS; LaFromboise & Rowe, 1995). This scale measures the ethnic/cultural identity categories of traditional, acculturated, marginal, and bicultural and is expected to be relevant across tribal groups. The AICOS demonstrates an essential understanding of the process of acculturation among American Indian people, generally (Carter, 2011). The scale has been critiqued for not representing the intra-group diversity (or within-group differences) across indigenous communities (Carter, 2011).

On the contrary, The Northern Plains Bicultural Inventory (NPBI) by Allen and French (1994) was developed to specifically examine the cultural practices of American Indians affiliated with Northern Plains tribes. The NBPI-R employs Oetting and Beauvais' (1990) cultural identification model's orthogonal plane structure and was adapted from the original NPBI (Allen & French, 1994). The current study utilizes the Northern Plains Bicultural Inventory-Revised (Baker, 2005). This scale utilizes a multilevel format that includes American Indian identity, European American identity, bicultural identity, and marginalized identity.

The theoretical concepts discussed are relevant to better understand American Indian/Alaska Native populations. In this study, I examined of the relationships among the constructs of intimate partner violence, attachment, partner substance use, posttraumatic stress symptoms, ethnic/cultural identity in an American Indian all-

female sample to help us to appreciate the interconnections of the concepts posited

within the research.

CHAPTER II

Literature Review

In this chapter I will review the literature on intimate partner violence (IPV),

attachment, cultural implications of these concepts and their intersections. Each of

these constructs will be discussed with regard to its definitions, construct models, and

existing empirical support.

Intimate Partner Violence

A primary reason for the limited research regarding intimate partner violence

(IPV) in Indian country involves the cultural dynamics as well as social and familial

implications. There are a number of ethical dilemmas and harmful consequences of

IPV, specifically in traditional indigenous communities. The close-knit nature of a

tribal community and its rural setting might increase the chance that members within

the tribal community will know about the family violence that takes place. It is also

likely that the battered individual will not feel safe within the community because he or

she will likely be found if there is an attempt to leave the community. Therefore, a

dilemma exists for victims who chose to remain on the reservation or chose to leave,

limiting their access to familial and cultural support systems. Limited resources

combined with a history of mistrust and inadequate cultural research makes studying

IPV even more difficult with American Indians. It is possible that American Indian

participants are less likely to communicate their experiences with researchers (R.

McDonald, personal communication, February 28, 2008). The current researcher worked with American Indian research assistants in an effort to be more culturally sensitive toward participants' needs. On the other hand, some participants from traditional indigenous communities felt more comfortable sharing their experiences if they were supported by the researcher, regardless of ethnic identity/heritage. Many participants were interviewed by this African American researcher and reported being comfortable with disclosing sensitive information. The fact that I am not from the community could be seen as helpful in that there was less of a chance of knowing relatives involved (L. Thompson, personal communication, January 5, 2011).

Local statistics provide a context for the present research in the Northern Plains and in the Midwest. In 2010, the lifetime prevalence of IPV (e.g., rape, physical abuse, and stalking) for women in the state of North Dakota was 64,000(Black, et al., 2011). Approximately 104,000of the women in the state of South Dakota had lifetime prevalence rates of IPV while 684,000 women in Minnesota had lifetime prevalence rates of IPV. In addition, it is estimated that multiracial (53.6%) and American Indian women (46.4%) respectively, experienced more IPV during their lifetimes than all other ethnic/minority women. American Indian women in the aforementioned areas have limited access to culturally supportive services and likely utilize mainstream services (e.g., crisis centers) that often lack cultural competence. American Indian women faced with this challenge are more likely to experience the inherent institutionalized racism linked with services and maybe apprehensive about reporting violence or accessing assistance (Artichoker & Gullickson, 2003; Wahab & Olson, 2004). IPV prevalence rates in traditional indigenous communities are significantly

underestimated. The general nature of IPV and sexual assault in such communities has been typically viewed as a private rather than a public issue (Artichoker & Gullickson, 2003; Wahab & Olson, 2004). Moreover, American Indian victims of intimate partner and family violence are more likely than victims of all other races to be injured and need hospital care; medical costs for this population were more than $21 million over a four-year period (U.S. Department of Justice, 1999). It is estimated that 64%, more than six in ten, American Indian women will be physically assaulted during their lifetime (U.S. Department of Justice, 2007).

Prevalence rates of sexual assault or rape of American Indian women are also higher compared to sexual assault and rape prevalence rates among women in the general population. In fact, nearly 34.1%, more than one in three, American Indian women will be raped in their lifetime (U.S. Department of Justice, 2007). Accompanying the aforementioned prevalence rates are the increased risk factors for the occurrence of IPV in traditional American Indian communities. Common risk factors include receiving public assistance (Fairchild et al. 1998), use of alcohol (Manson & Norton, 1997; Robin et al. 1998), the victim and perpetrator being under 40 years old (Fairchild et al. 1998), and witnessing parental IPV (Manson & Norton, 1997). A considerable percentage of incidents of IPV in the U.S. involve substances and/or alcohol (Wilsnack, Wilsnack, & Kristjanson, 2008). Research involving individuals convicted of a violent crime against a partner (e.g., wife, girlfriend, etc.) has found that drinking frequently preceded the crime (Greenfield et al., 1998; Slade, Daniel, & Heisler, 1991). In contrast to these findings, some research that has focused on the general population has found lower rates of alcohol use and IPV. The NVAWS

indicated that 6.9% of victims and 33.6% of their partners had been drinking during the time of the violent episode (Thompson & Kingree, 2006). Subsequent studies have found that alcohol use by the male partner at the time of a violent episode was associated with greater severity of violence toward female partners (Fals-Stewart, Leonard, & Birchler, 2005; Kyriacou et al., 1999; Testa, Quigley, & Leonard, 2003) and increased risk of injury (Thompson & Kingree, 2006).

Research has identified specific implications related to alcohol as well as substance use and the development of IPV among American Indians (Lujan et al. 1989; Mitka, 2002). In a study that included 53 neglected and abused American Indian children from the Southwest, alcohol abuse was present in 85% of the neglect cases and 63% of the abuse cases (Lujan et al., 1989). Robin et al. (1998) found that 74% of American Indian women and 62% of American Indian men stated that they were using alcohol during intimate partner violence episodes. Norton and Manson (1997) found that the use of alcohol was associated with more severe abuse episodes; an additional 37% of the women in the study indicated that their victimization made it more likely that they would use substances. Substance use as a coping strategy generally leads to lowered inhibitions, which might increase the potential for victimization. The co-occurrence of substance use and IPV identified in the literature supports the notion of Historical Trauma Response in American Indians living in traditional indigenous communities. Considering the aforementioned prevalence rates and risk factors, there is a specific need for effective and culturally appropriate treatment for intimate partner violence (IPV) in American Indian communities. The sparse research focused on the experiences of American Indian women and their adolescent daughters who have been

impacted by IPV (e.g. victimization, witnessing family violence) calls for more empirical research and effective policies that can influence the effects of IPV in Indian communities. The present research focuses on the implications of Native women's experiences of intimate partner violence and the impact of attachment, partner substance use, trauma experience, and ethnic/cultural identity.

Gorde, Helfrich, and Finlayson (2004) conducted a study to identify trauma symptoms and life skills of 84 IPV victims (primarily women) from three domestic violence programs (i.e., emergency shelters, transitional housing, and a community group). The researchers utilized the Trauma Symptom Inventory (TSI) and Occupational Self Assessment (OSA) to identify the participants' perspectives, while staff members participated in focus groups to identify women's needs. The results of the study identified participants with clinically elevated rates of trauma across settings. Women living in emergency shelters experienced higher rates of distress than women living in transitional housing and in the community. Staff identified mental health needs as important, while women in the study demonstrated defensive avoidance (30.1%) on clinical scales, suggesting likely interference with engagement and working alliance (Gorde et al, 2004). Women in the community scored lower on the defensive avoidance scale than those in transitional housing and emergency shelters, suggesting increased likelihood of accessing mental health services.

In another study, conducted by Skupien (1998), the author investigated the extent to which women were impacted by domestic violence problems on the San Carlos, AZ, Apache reservation. A self-selected, volunteer sample of Apache women (N= 163) reported a yearly injury rate of 31.3% and physical assault rate of 41.7 %,

respectively (Skupien, 1998). Most of the women indicated that the primary cause of

IPV on the reservation was alcohol/drinking. Approximately 57 (35%) women

reported witnessing abuse as a child (Skupien, 1998). The link between these women's

experiences and the witnessing of abuse provides preliminary support for

intergenerational domestic abuse. Additionally, bivariate analysis of abuse risk factors

indicated that women under 46 years old; who had fewer than four bedrooms in the

home; had more people in the home; had an income below $800 per month; and who

were on public assistance were identified as at highest risk of injury and physical abuse

(Skupien, 1998). Additionally, being a woman younger than 46 years old; being a

victim of injury and physical assault abuse; being in a relationship; and financial

decisions about spending habits, were predictors of depression symptoms by the Center

for Epidemiological Studies Depression Scale (CED-S) (Skupien, 1998). Finally, based

upon responses from the women in the sample, experiences of injury and physical

assault abuse; being younger than 46 years old; and having an income of less than $800

per month, were among some of the risk factors for predicting post traumatic stress

disorder symptoms as assessed by the Davidson Trauma Scale-subscales for Frequency

(DTS-F) (Skupien, 1998).

The research provides a cultural context for the Apache women identified in the

study. It further suggested that IPV, depression, and post traumatic stress symptoms

intersect and in fact are influenced by such variables as age, relationship status, and

socioeconomic status. Additionally, participants contributed suggestions about service

providers; they indicated that medical professionals on the reservation needed to

adequately screen for IPV (Skupien, 1998). The participants also wanted more access to

individual and family counseling that had specific domestic violence specializations (Skupien, 1998). Skupien's research is one of the few studies focused on the experiences of American Indian women in traditionally indigenous communities.

The impact of family violence on children. An estimated 3 to 10 million children witness domestic violence each year (Allen et al., 2003; Straus, 1992). In the state of North Dakota at least 4,300 children were directly impacted by such incidents in 2005 (North Dakota Council on Abused Women's Services, 2006). The 1999 report of the National Child Abuse and Neglect Data System (NCANDS) indicated that American Indians families had rates of child victimization that were twice as high as Whites: 20.1 versus 10.6 per 1,000 (US DHHS, 2001). Duran et al. (2004) found that 62.8% of the women in the study experienced physical and/or emotional neglect as children, and 18.8% were severely neglected. Children in this predicament are at high-risk for developing internalizing behaviors (e.g., depression and anxiety), externalizing behaviors (e.g., aggression), low self-esteem, academic problems, and problems with interpersonal relationships (Graham-Bermann, 2002). Childhood adversity, such as exposure to family violence, has a number of risk factors. Children who live in violent homes (e.g., physical abuse between parents) are more susceptible to victimization (e.g., being physically abused) themselves (O'Keefe, 1994; Onyskiw, 2003). Child victims appear to be more vulnerable to future victimization. Battered parents involved in domestic discord are more likely to be depressed as a result of chronic abuse; it is also likely that the battered parent might be unaware of her/his children's distress which might result in an increased risk for neglect or other forms of abuse (Geffner,

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Igelman, & Zellner, 2003; Lieberman & Zeanah, 1995; Lieberman et al., 1997; Wenar & Kerig, 2006).

Studies have estimated that in nearly 60% to 75% of families where a woman is abused, children are also abused (American Psychological Association, 1996; McCloskey, DeVos, & New Berger, 1989; Straus, Gelles, & Steinmetz, 1980). In a national study conducted in homes where IPV occurred, children were physically abused and neglected at a rate 15 times higher than the national average (Senate Hearing 101-939, 1990 as cited in Osofsky, 2004). The aforementioned empirical evidence provides support that links child physical abuse risk factors with IPV.

Childhood exposure to chronic parental conflict seems to have long-standing consequences that might endure across the developmental life-span. Infants and toddlers may have problems in attachment, sensory processing, and sleeping, as well as have difficult temperaments from witnessing continual intimate partner violence (Geffner, Igelman, & Zellner, 2003; Lieberman & Zeanah, 1995; Lieberman et al., 1997). Pre-school age children might potentially develop enuresis, somatic complaints, and school phobias as a result of exposure to intimate partner violence. Additionally, adolescents are more likely to experience academic difficulties and social relationship problems (e.g., trouble maintaining peer relationships) as a result of consistent exposure to family violence (Geffner, Igelman, & Zellner, 2003; Ybarra et al., 2007).

There are additional implications for adults who have been exposed to intimate partner violence as children. The literature suggests that there are intergenerational patterns of IPV (Lieberman, 2007; Lieberman et al., 2005). In fact, witnessing interparental violence is the strongest risk factor of transmitting aggressive behavior

from one generation to the next (Break the Cycle, 2006). Generally, boys who witness intimate partner violence are twice as likely to abuse their own partners and children when they become adults (Strauss et al., 1990). Amato and Booth (1991) found that adults who recalled high levels of conflict between parents while growing up tended to report a disproportionately large number of psychological and marital dilemmas in their own lives (Booth & Edwards, 1990; Kessler & Magee, 1993; Overall, Henry, & Woodward, 1974). Harrist and Ainslie (1998) found that marital discord was significantly associated with child social withdrawal ($d = .24$) and, to a lesser extent, child aggression (p< .07).

Research focused on witnessing IPV has provided insight about specific child behavioral effects (e.g., internalization and externalization). Sternberg et. al. (2006) examined the effects of the type of family violence, age, and gender on children's behavior problems. The researchers utilized a logistic regression of three violence groups compared with a no-violence control group. Children who experienced multiple forms of family violence were at greater risk (externalizing and internalizing behavior problems) than children who experienced only one form of abuse (Sternberg et al., 2006). Children witnesses of inter-personal violence were at similar risk as children victims of violence (e.g., physical abuse) (Sternberg et al., 2006). Regarding outcomes for children 4-6 years old, those who were both abused and witnessed violence (abuse-witness) were at significantly greater risk (1.87 times greater) of experiencing clinical levels of externalizing behaviors than the control (no-violence experience) peer group (Sternberg et. al., 2006).

In addition, among adolescents 10-14 years old, witnesses, victims, and children who were both abused and witnessed IPV were at greater risk (4.90 times, 2.66 times, and 3.14 times; respectively) of experiencing clinical levels of externalizing problems than their no-violence counter parts (Sternberg et. al., 2006). Sternberg et al. (2006) also found that children witnesses of IPV and children who were abused and who witnessed abuse were at significantly greater risk of experiencing clinical levels of internalizing problems than their peers who had no experience with violence. Adolescents 10-14 years old were 1.65 times more likely than 4 -6 year olds to have clinically significant internalizing behavior problems. Thus the research suggested that adolescents were more likely to experience internalizing behavior problems than their younger peers.

A large percentage of children and teens are witnessing and/or experiencing IPV at home, and others may be experiencing it in their own intimate relationships. It has been estimated that one in five female high school students report being sexually and/or physically abused by a dating partner (Silverman et al., 2001). Nearly eight percent of female high school students have been forced to have sex with a boyfriend (Greenfield et al., 1998). Additionally, approximately 40% of teenage girls know a person who has been beaten or hit by a boyfriend (Greenfield et al., 1998). Across the country, in the school year of 1996-1997 it was reported that nearly 4,000 incidents of rape and other forms of sexual assault occurred in public schools. There are a number of special circumstances that increase teens risk of involvement in violent relationships; these include substance use, limited relationship experience, considering that abuse is "normal" in relationships, and thinking that possessiveness is equal to love (WebMD,

2008). Young adults are often very influenced to remain in abusive relationships through examples established by parents, peers, various forms of media, and other role-models (WebMD, 2008). Although the effects experienced by children in homes where IPV happens are also experienced by teenagers subsequent effects might also include increased substance use and abuse (e.g., alcohol and drugs) as well as increased likelihood of running away from home (WebMD, 2008).

Implications of IPV. The impact of IPV can be devastating and long standing. Generally, common physical effects include cuts, bruises, and broken bones (Stop Violence Against Women, 2009), while IPV affects children/teens in the home through direct and indirect circumstances of abuse, as well as removal from the household into foster care. All forms of IPV can be quite demoralizing and harmful to a victim; in fact one of the most destructive forms of violence identified is emotional abuse (Flanagan, 2003). Victims indicate that is more difficult to heal the emotional wounds of IPV than the physical wounds (Flanagan, 2003). Humphreys and Thiara (2003) reported that the research falsely presumes that adult IPV and childhood abuse have the same effect on the victim's mental health. Often the emotional well-being of victims has been overlooked by providers and related services who endorse the medical model.

Humphreys and Thiara (2003) conducted a mixed methods study to discover the mental health concerns of victims of IPV. They also examined the experiences of victims with welfare, legal, and health professionals. Surveys were distributed to 180 women who obtained services from Women's Aid for IPV intervention services. Approximately twenty-five percent of the women were ethnic minorities and twenty women were interviewed by the authors. Themes of emotional distress that

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subsequently coincided with a pattern of posttraumatic stress, self-harm, and depressive symptoms were found in the in-depth interviews. The women in the study connected their emotional distress to the abuse and violence they had experienced in their relationships. The study further revealed that the victims' experiences with service providers suggested that they felt unsupported in that their traumatic experiences had gone unrecognized, they were advised to take medications rather than explore emotional distress, and they often felt blamed for the abuse they experienced.

The psychological and emotional abuse victims experience has long standing effects that often range from depression, and self-injurious behaviors to poor health conditions (Silent Witness Newsletter, 2006). People suffering from severe depression generally have challenges caring for themselves as well as for others (e.g., their children), often resulting in declining health for themselves and contributing to neglect of children. Bonomi (Silent Witness Newsletter, 2006) found that women who had experienced IPV were three times more likely to report symptoms of severe depression. Additionally, the study determined that women who within the last year had experienced sexual or physical abuse in an intimate relationship were three times more likely to report being in poor health than women who had not recently experienced any form of sexual or physical violence (Silent Witness Newsletter, 2006).

Attachment

Attachment and attachment theory are extensively explored topics within the fields of anthropology, sociology, and developmental psychology. Researchers have explored attachment and the structure of the brain (Shore, 2001; van der Hart, Steele, Boon, & Brown, 2001), caregivers response to children's needs (Bowlby, 1988), and

the quality of attachments in specific contexts (e.g., violent families) (Sternberg et al., 2005; Lieberman, A. 2004; Lieberman & Zeanah, 1995; Silverman & Lieberman, 1999). Attachment is often characterized as the bond between a parent figure, usually the mother, and the child. Psychoanalytic and Social Learning theory similarly regard attachment as the child's relationship with his or her mother, which develops as a result of consistent feeding or nurturing (Freud, 1910/1957; Sears, Maccoby, & Levin, 1957 as cited in Cassidy, 1999). According to the initial conceptual frameworks, the child experiences pleasure once hunger drives are satisfied, thus associating the mother with positive events (Freud, 1910/1957; Sears, Maccoby & Levin, 1957 as cited in Cassidy, 1999).

Bowlby (1969; 1982) proposed an alternative model of attachment which was based on evolutionary biology, developmental psychology, ethnology, cognitive science, and control systems theory (Cassidy, 1999). Bowlby appeared to be discontented with traditional theories and drew upon the aforementioned fields to purport that an infant's tie to the mother originally formed as a result of evolution and adaptation (Bowlby, 1969; Cassidy, 1999). He reported that during the time humans were developing, they lived in "the environment of evolutionary adaptedness," where by genetic selection preferred attachment behaviors because they increased the possibility of child--mother proximity, which in turn improved the chance for protection and survival (Bowlby, 1969; Cassidy, 1999). Attachment behavior has the expected outcome of increasing closeness of the infant to the attachment figure (typically the mother) (Cassidy, 1999). Attachment behaviors include those that elicit aversive responses (e.g., crying) that bring the mother to the child to terminate the

behavior (e.g., soothing the child), while other attachment behaviors (e.g., smiling, vocalizing) are signaling behaviors that alert the mother to the child's interests in interaction, and serve to bring her to the child (Cassidy, 1999). These are important behavioral cues for the maintenance of attachment/bonding relationships. According to Bowlby (1969), without the "biological function" of attachment behavior that signals protection from predators, feeding and learning cannot occur. Therefore, in times of distress children are biologically predisposed to seek out their parents in particular (Bowlby, 1969). Attachment is considered a natural characteristic of individuals throughout the lifespan, rather than a sign of infantile behavior that one will likely outgrow.

Attachment in infancy. An established body of empirical work stemmed from Bowlby's theoretical framework. Ainsworth (1969, 1972), among the most pioneering researchers of her time, worked directly with Bowlby in the development of attachment theory. Ainsworth developed a research paradigm to study attachment behavior. The *Stranger Study* included children interacting with their mothers (Ainsworth, 1969; 1972). A stranger comes into the room and talks to the mother, the mother leaves with the stranger, the stranger returns, and finally the mother returns (Ainsworth, 1969, 1972). The infant's behavior is observed at every sequence of the study and typical response styles were identified. As a result of Ainsworth's meticulous studies and Bowlby's prior work in the field, three distinct styles of attachment were identified (Davies, 2004): secure attachment, insecure attachment (ambivalent/resistant), and disorganized (disoriented) attachment (Ainsworth, 1969, 1972; Davies, 2004).

IPV	
PTSD SYMPTOMS	**MOTHER-DAUGHTER ATTACHMENT**
ETHNIC/CULTURAL IDENTITY	
CONTEXTUAL VARIABLES: House hold Income Education Age Partner substance use-IPV Participant substance use-IPV Tribe Region	
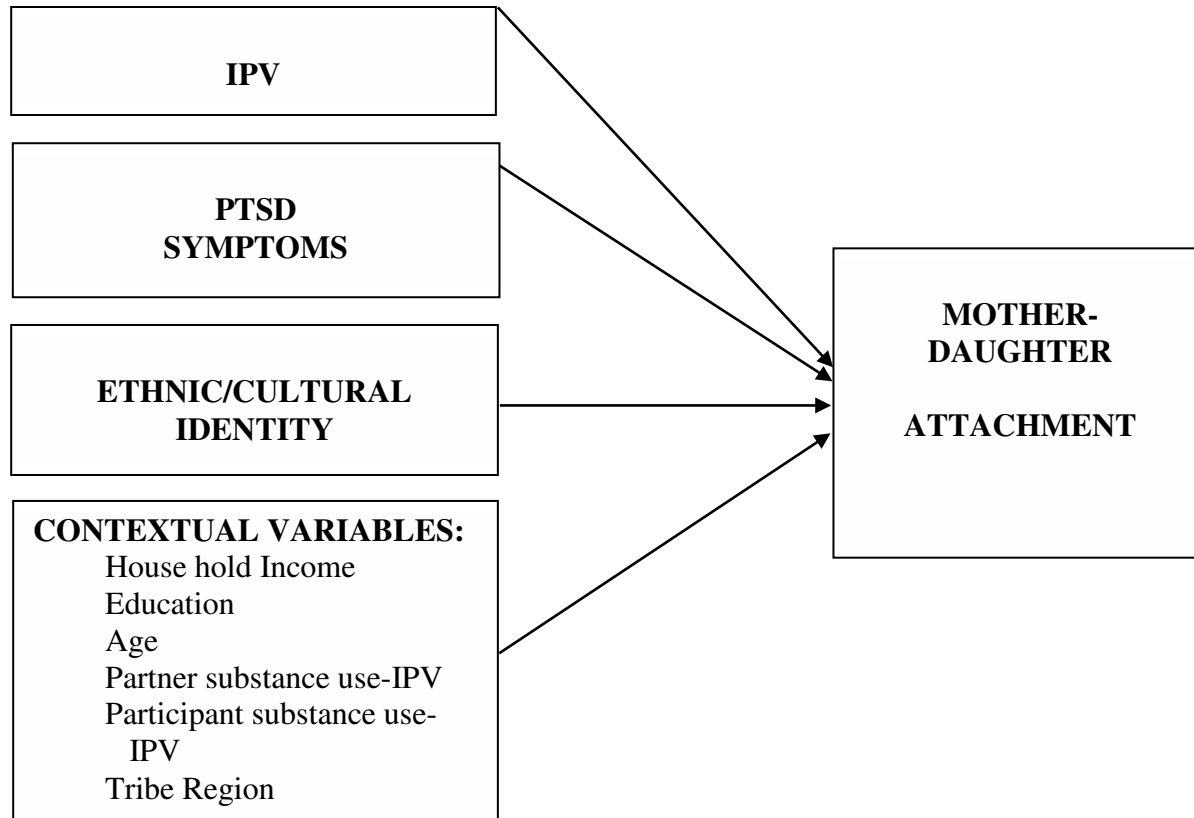
Figure 2
Theoretical Framework

A secure attachment occurred in the event that an infant was confident in the attachment relationship. The infants' responses varied in how distressed they became in response to the separation; however, they were able to self-sooth or explore surroundings when the attachment figure was out of the room (Ainsworth, 1969, 1972; Davies, 2004). Upon the mothers' return, the infants greeted their mothers positively as they appeared relieved and happy (e.g., moving closer to mother). The infants quickly calmed down when the attachment figure returned and were comforted by soothing (Ainsworth, 1972; Davies, 2004). Longitudinal studies found that secure attachment likely has a positive impact on later development of exploring the environment, indicating that these children were also open to learning (Ziv et al., 2004).

Children who exhibit insecure (ambivalent/resistant) attachment styles conveyed an evident need for attachment (e.g., very upset by separation) but lacked the confidence to obtain it (Ainsworth, 1972; Davies, 2004). Ainsworth reported that the children were anxious in the pre-separation episodes, became very upset during separation, and during reunification wanted close bodily contact yet resisted contact and interaction with their mothers (Ainsworth, 1972; Davies, 2004). It was determined that these infants' ambivalent responses and sharp affect reveal their uncertainty about parental response. The potential for future avoidance in developing connections with others is highly likely for infants or children with ambivalent/resistant attachment styles (Bartholomew, 1990). These individuals desire close relationships with others, however, they might avoid establishing appropriate connections with others because of their fear of rejection. It is hypothesized that other individuals with ambivalent/resistant

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attachment styles might generally lack interest in social relationships, similar to individuals with schizoid personality disorders (Bartholomew, 1990).

Ainsworth (1972) further demonstrated that some infants had insecure attachments that were less organized than other infants in the study. The disorganized infants exhibited contradictory behavior when reunited with the mother after separation. The infant greets the mother happily, raises his or her arms to be picked up, then turns away, becomes motionless, and looks dazed (Ainsworth, 1972). It would appear that the infant is under distress in the presence of the parent and that there is likely an internal sense of disorder (Barnett, Ganiban, & Cicchetti, 1999; Davies, 2004). Infants who have experienced a history of unresolved trauma by the parent and maltreatment by the parent generally have similar disorganized responses (Davies, 2004; Lieberman, A. 2004; Lieberman & Zeanah, 1995; Silverman & Lieberman, 1999). Data suggested that disorganized infants and children have lower levels of self-esteem (Cassidy, 1988; Lieberman, A. 2004; Lieberman & Zeanah, 1995; Silverman & Lieberman, 1999) and have difficulty adjusting (Cassidy et al., 1996; Lieberman, A. 2004; Lieberman & Zeanah, 1995; Silverman & Lieberman, 1999; Suess et al., 1992; Wartner, et al., 1994) as compared to securely attached infants and children. In addition, it is possible that children with insecure attachments might be more prone to juvenile delinquency or other aggressive types of behaviors (Bowlby, 1944).

Attachment in adolescents. Attachment theorists and researchers have investigated the concept of attachment well beyond infancy. During the adolescent developmental stage there appears to be an intentional disconnect from the attachment relationship with parents and other parental figures (Allen & Land, 1999). This

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purposive separation likely varies across cultural groups (Allen & Land, 1999). From a developmental perspective, the primary task in adolescence is to develop autonomy such that there is a decrease in the adolescents' reliance on parental support (Allen et al., 1994a; Allen et al., 1994b). Additional research indicates that autonomy can be enhanced when there are established secure relationships.

Allen and Land (1999) suggest that adolescents' development of operational thinking (including logical and abstract reasoning) contributes to the development of cognitive, emotional, and behavioral systems that impact attachment relationships. During this stage it is possible for adolescents to essentially compare relationships with different attachment figures to one another and to idealize their parental figure(s) (Allen & Land, 1999). The ability to objectively examine relationships with attachment figures likely leads adolescents to identify unmet attachment needs (Kobak & Cole, 1994 as cited in Allen & Land, 1999).

Adolescents who tend to have secure attachments often have mature cognitive abilities, as they are able to problem solve with attachment figures, albeit frequently difficult for parents and adolescents (Allen & Land, 1999). Consequently, adolescents who tend to have insecure attachments are more likely to withdraw or actively lash out when under distress (Allen & Land, 1999). These youths typically have great difficulty establishing autonomy in their relationships with parents and have additional difficulty with social development. In general, during adolescence peer relationships begin to become the primary source of attachment. Youth develop appropriate social interactions, become open to criticism from friends, and increase social engagement (Ainsworth, 1989).

Adolescents who utilize friends or peers as attachment figures congruently meet attachment needs and establish autonomy with parents (Steinberg, 2001). Maintaining healthy peer relationships assists in the development of romantic relationships overtime (Ainsworth, 1989). Hazan and Shaver (1994) suggest that prior attachment and current patterns of attachment shape the developing romantic relationships of both young and older adults. Hazan and Ziefman (1999) compared childrens' and adolescents' (age 6-17 years) perspectives on their attachment relationships with parents and peers. They found that children and adolescents were peer-oriented and preferred spending time with friends rather than with their parents. These youth were additionally asked about who they preferred to be comforted by (safe-haven component) and the majority tended to prefer parents as a source of comfort and emotional support. However, there is a shift with adolescents age 8-14 years such that they preferred to obtain support from peers rather than parents. Additionally, adolescents age 15-17 years were fully attached to peers (specifically boyfriends or girlfriends in romantic relationships) (Hazan & Ziefman, 1999).

Adolescents' attachments to their peers and parents have specific implications for their personal relationships (e.g., establishment of secure relationships with partners or decreased connections with partners). Limited studies have examined the impact of parental intimate partner violence (IPV) on adolescents' attachment style. Levendosky et al. (2002) examined parental psychological functioning, parenting, and social support as potential protective and vulnerability factors for adolescent functioning. Findings suggested that adolescents were less affected by violence directed toward their mothers when compared to younger children in similar circumstances. Maternal psychological

functioning was significantly associated with adolescents' development of depression and trauma symptoms. In addition, adolescents who witnessed IPV or experienced child abuse were less likely to have a secure attachment style and subsequently were more likely to have an avoidant attachment style in their personal relationships. It is possible that adolescents within these strained family situations no longer feel a sense of trust in intimate relationships and might be more pessimistic about relationships. Levendosky et al. (2002) reported that the adolescents in the study were more likely to be victimized, lending limited support for intergenerational transmission of violence. Positive parenting served as a protective factor, moderating the impact of the effects of intimate partner violence. Levendonsky et al.'s (2002) sample represented European Americans (67%), African Americans (24%), Hispanics (6%), and other groups (3%); it is unclear what ethnic/racial groups are reflected in the other category. While these are important findings, they are limited in scope and by the nature of the sample. Much more research on IPV, culture, and attachment with American Indians is greatly needed.

Attachment in adulthood. Bowlby (1988) conceptualized attachment as a developmental process that shapes personality organization across the life-span. Pistole (2003) reports that attachment and caregiving are integrated systems. She further acknowledges that attachment produces bonding and maintenance of proximity to a designated or preferred figure (e.g., parent in childhood, friend in adolescence, and romantic partner in adulthood). The preferred individual imparts security through comforting and soothing (safe haven) and guidance (secure base) (Pistole, 2003).

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During adulthood the functional relationship of the attachment figure is activated especially when a person is a) distressed or ill; b) coping with a stressful event; or c) worried about the availability of the attachment figure (Pistole, 2003). Hazan and Ziefman (1999) compared adults in various stages of relationships (e.g., no relationship, in a relationship for less than two years, and in a relationship for more than two years) and examined their attachment relationships with their parents and their peers. They found that adults ages 18-82 were peer-oriented in both proximity seeking (prefer spending time with friends) and safe haven behaviors (prefer being comforted by friends) rather than oriented toward parents or siblings. However, these outcomes varied as a function of adults' relationships; individuals in a relationship for less than two years or in no relationship tended to name the parent as their secure base. Attachment in adulthood appears to have strong ties to patterns of bonding in childhood (Hazan & Ziefman, 1999; Pistole, 2003). There is a need for the further examination of parent and peer attachment relationships with an emphasis on the American Indian cultural group, as the aforementioned literature does not reflect the diverse experiences of American Indians.

Mother-daughter attachment. There are two theoretical camps that attempt to explain why girls become like their mothers, as well as mother-daughter bonding. Psychoanalytic theories generally focus on daughters' unconscious identification with maternal behaviors and values (Boyd, 1989). These approaches also emphasize daughters assigning similar meaning to behaviors and values that their mothers also ascribed. Social learning theorists dispute the idea of unconscious identification and support principles of modeling (Frieze, Parsons, Johnson, Ruble, & Zellman, 1978;

Weitzman, 1984; Boyd, 1989). Social learning posits that girls learn to be maternal, as well as behave similar to their mothers, by persistently and positively being reinforced when they imitate their mothers' actions (Weitzman, 1984; Boyd, 1989). Alternatively, Noddings (1984) suggests that a socialization view, as an explanatory theory, is weak. She further asserts that mothering is replicated through identification, where the meaning of "mothering" and nurturance is internalized, in addition to the modeling of behaviors.

The literature supports that psychoanalytically derived mother-daughter theorists focus on what makes the mother-daughter relationship different from other dyadic relationships (e.g., mother-son, father-daughter, etc.) (Boyd, 1989; Frieze, Parsons, Johnson, Ruble, & Zellman, 1978; Weitzman, 1984). Social/Learning theorists generally explain sex-role behavior in all children, therefore failing to acknowledge the intrinsically unique aspects of mother-daughter relationships, even when compared to father-son relationships (Boyd, 1989; Noddings, 1984; Weitzman, 1984).

Some theorists hold that the mother-daughter relationship or mother-daughter identification is culturally mediated (Chodorow, 1978) and that in Western culture, conflict within mother-daughter dyads is almost inevitable (Bardwick, 1979). Examining two of the first ethnographic international studies on mother-daughter relationships among working class East London and among Mediterranean women it was found that mothers and their daughters were close and caring (Young & Wilmott, 1957; Dubish, 1977). Additional early work of Neisser (1973) was pursued in an effort to explore whether specific cultural patterns facilitate closer mother-daughter relationships. She examined mothers and daughters in six cultural and social groups:

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Hopi Indians of Southwestern United States, the inhabitants of isolated Greek villages, Rajput farmers in Northern India, the Gusii tribes of Kenya, Middle class Japanese, and the women living on Kibbutz in Israel. She reported that mother-daughter relationships seem to be closer under three cultural conditions: 1) when women are methodically excluded from men's leisure activities, 2) when a mother and her daughter live among family members rather than in communal units, and 3) when a mother is responsible for teaching her daughter either ritualistic or practical survival skills (Neisser, 1973; Boyd, 1989).

Furthermore, Neisser's findings did not support associations between mother-daughter attachment and stress levels, mother's work load, matrilineal descent, industrialization, and education. It should be noted that challenges regarding the integrity of Neisser's work have been made, as the documentation of data collection and subsequent analysis were not provided (Boyd, 1989). In addition, it was not clear whether the work was her own or the work of other anthropologists whose work she interpreted (Boyd, 1989).

An overview of the characteristics of mother-daughter relationships indicates that the mother-daughter bond is mutual and interdependent, particularly in adulthood (Bromberg, 1983; Fischer, 1986), rewarding (Baruch, & Barnett, 1983), and close (Boyd, 1989; Bromberg, 1983; Fischer, 1986). The literature demonstrates that mothers and their daughters care for and help one another, even though living distance may influence the type of support given (Horowitz et al., 1983; Lange and Brody, 1983). Conflict reported in the mother-daughter relationship does not appear to detract from it (Boyd, 1949). Finally, mother-daughter relationships are found to be close in several

other cultures and relatively high levels of contact are found within the dyad (Chodorow, 1974; Dubish, 1975; Young & Wilmott, 1957).

Potential Modulating Factors

Children who face multiple stressors appear to be physically, emotionally, and psychologically impacted to differing degrees. There is a growing recognition of a need to look beyond the risk factors and identify the conditions that modulate the effects of developmental adversity on vulnerable children (Cicchetti & Garmenzy, 1993; Garmenzy, 1985). The psychological effects of adverse developmental events (e.g., divorce, early childhood physical abuse, etc.) may be mediated by a host of extenuating factors (e.g., severity of parental discord leading up to divorce or abuse). There are even reports in the literature of abused and neglected children showing apparent resiliency to developmental traumas, with these strengths coming from unknown sources. Resilience in children can be described as (a) managing to circumvent harmful outcomes and achieve favorable outcomes despite being at significant risk for the development of psychopathology; (b) demonstrating persistent capability under stress; and (c) displaying recovery from trauma (Luthar, 1993; Rutter, 1987; Werner, 1995). It should be noted that there is not a standardized definition of resiliency in the literature. Children are considered "vulnerable" if they have been predisposed to psychopathology and show a susceptibility to negative developmental outcomes under high-risk conditions (Rende, 1993; Rothbart & Ahadi, 1994; Thomas, Chess, & Birch, 1968; Marsh & Dozois, 1996).

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Ethnic/Cultural Groups, Attachment, and Violence: Implications for Parenting

Cultural variations in parenting practices may have an impact on parent—child relationships and attachment. For example, research with African Americans conducted by Boykin and Toms (1985) as well as by Harrison (1985) indicates that parents who socialize their children to respond to racism (e.g., identify whether it is safe to confront an individual or follow up another adult for support) within their environments facilitate the development of more autonomous parent—child relationships. A longitudinal study conducted by Quint et al. (1997) found that single mothers who reported utilizing more sources of social support tended to have positive mother—child interactions (e.g., more observed affection) and a decrease in the harshness of disciplinary tactics as measured by lower scores on the Home Observation for Measurement of the Environment-Short Form (HOME-SF). Research with Latinos conducted by Robles and Gamble (2006) demonstrated strong associations between parental monitoring of youth, parent—adolescent attachment, and reduced risks for delinquency. The researchers found that mother—adolescent attachment was significantly related to a reduced risk for delinquency for boys; however, this association was less apparent for girls (Robles & Gamble, 2006). These studies provide evidence that parenting practices must be understood when assessing the parent—child relationship.

There is limited research with American Indians focused on the examination of parent—child relationships and the impact of familial factors (e.g., IPV, divorce, etc.). Sarche et al. (2008) examined maternal correlates, mother—infant relationships, and infant social-emotional development in Northern Plains tribes. These researchers

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found that higher maternal ratings of parent—child dysfunctional interactions were associated with higher reports of children's internalizing (e.g., withdrawal, depression, etc.) and externalizing problems (e.g., impulsivity, aggression, etc.). Further examination of maternal variables indicated that maternal substance abuse was associated with lower infant social-emotional development. The research also indicated that mothers who reported that they accessed more support from friends and families rated their children as having greater social-emotional competence than did mothers who indicated they had less support. These findings are similar to the aforementioned research focused on other ethnic/racial groups, which identified community support as a positive influence on parent—child relationships (Quint et al., 1997). Sarche et al. (2008) also found a significant relationship between maternal self-rated American Indian identity and lower internalizing problems, and a near significant relationship to children's competence. Similar to parents in other ethnic/cultural groups, American Indian parents generally take an active role in socializing their children regarding their ethnicity in the context of the larger society (Harrison et al., 1990 as cited in Glover, 2001). Teaching youth how to respond to a racist environment protects as well as preserves the child's integrity and physical well-being. These findings identify the importance of incorporating ethnic identity in the study of parent—child relationships, as it might be a potential buffer to familial and/or societal adversities (LaFromboise & Low, 1998; Glover, 2001). An estimated 30% of American Indian children were taken from their homes and placed with non-Indian families from the 1920s to 1978. As a result there are significant implications for Native parent—child relationships and Native parenting across indigenous tribal

communities (Jaimes, 1992, p. 326). The Indian Child Welfare Act of 1978 was established to stop the removal of Indian children from reservations by state welfare agencies and state courts (Jaimes, 1992, p.326). American Indian children who were removed from their homes and placed in homes outside of traditional indigenous communities suffered from a decrease of enculturation (e.g., learning aspects of their heritage), and decreased modeling of appropriate parenting, support, and establishment of appropriate attachments (e.g., bonding with parental or familial figures) (Glover, 2001; Stone, 2008). The loss of language, spiritual awareness, and increased rates of substance abuse (e.g., alcohol), as well as poverty potentially leads to a decrease in community cohesion and family connectedness (Stone, 2008). It is possible that more traditional families maintain a strong attachment with their children, as they might be more invested in the child and in preserving community connections. Based upon the experiences of American Indian families there are potential protective and risk factors that are affiliated with their ethnic/cultural identities, attachment domains, and experiences with trauma including intimate partner violence.

Purpose of the Study

Intimate partner violence (IPV) has impacted the natural balance and order implemented by the medicine wheel such that American Indian women, children, and traditional indigenous communities across generations have felt the consequences. The complex association with historical trauma, alcohol and substance use/abuse, socio-economic status, and a host of subsequent variables exacerbates the impact of IPV among tribal communities. The purpose of the current study is to examine the association between IPV and Northern Plains and Upper Midwestern American Indian

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mother—daughter dyads' attachment relationships while exploring the influences of PTSD symptoms, ethnic/cultural identity, partner substance use and participants' substance use (see figure 3). The proposed model asserts that the relationship between participants experienced IPV and mother—adolescent daughter dyads' attachment relationship will be moderated by PTSD symptoms, such that participants' increased trauma symptomology will likely lead to strained attachment relationships (e.g., lower level of overall attachment within the mother--adolescent dyads). The model also posits that participants' ethnic/cultural identities will moderate the relation between experienced IPV and mother—daughter attachment, such that those individuals with bicultural identity or American Indian identity will likely lead to supportive attachment relationships (e.g., stronger overall attachment within the mother—daughter dyads). Those participants with European American identity or marginalized identity will likely have a lower overall attachment within the mother—daughter dyads. A closer examination of some of the abovementioned factors will provide insight into the interconnections of these factors.

It has been well established in the literature that the American Indians experience a disproportionate amount of trauma and related post traumatic stress disorder (PTSD) due to high levels of IPV. We question whether the experience of IPV exposure on adolescents affects mother—daughter attachment relationships through PTSD related symptoms. Limited research has focused on the specific experiences of Northern Plains and Upper Midwestern American Indian mother—adolescent daughter dyads and the relations between the aforementioned variables.

The current study is designed to increase in awareness about IPV in Indian country and increase our understanding of the inter-relationships of a variety of factors such as mother –daughter attachment, ethnic/cultural identity, trauma, and the influence of substance use (e.g., participants and their partners) during IPV episodes. Additionally, the current study assists traditional indigenous communities by identifying available resources (e.g., spiritual healers, culturally appropriate mental health providers, parenting supports, etc.) to address related historical trauma and associated mental health or spiritual needs or concerns linked to traumatic experiences (individual or communal). The results of the study provide traditional indigenous communities with specific information that aids health providers to establish culturally appropriate treatments for battered partners, associated witnesses of IPV, and batterers.

The study's outcomes were provided to specific tribal councils and included recommendations for policies related to IPV. In addition, a summary of the research was provided to local advocacy programs to assist with the potential generation of resources for battered women and their families. In conclusion, American Indian women and their adolescent daughters who participated in the study had an opportunity to gain awareness of their own experiences related to family violence and of available support systems (e.g., community agencies, own resilience, cultural healers, mental health providers, medical providers, etc.). The participants had an opportunity to access spiritual, cultural, and mental health support as these specific needs were identified.

Research Hypotheses

1) Higher rates of participants' reported experiences of intimate partner violence (IPV) will decrease mother-daughter attachment scores.

2) Higher PTSD symptoms will be related to higher experienced IPV and will strain the mother-daughter attachment relationships.

3) Participants who identify with bicultural or American Indian identity will have a stronger mother-daughter attachment bond regardless of experienced IPV. Participants who identify with European American identity or marginalized identity will have a strained attachment bond as IPV increases.

Research Questions

Additional Exploratory Hypothesis/Research Questions

4) How will the participants' household income, education, age, their partners' substance use during IPV, and their substance use during IPV will related to experienced IPV and mother-daughter attachment relationships?

5) Are there tribe region differences in participants' reported experiences of IPV or mother-daughter dyads' attachment relationship?

6) Will there be a strong relationship between daughters' reported observations of IPV and mother-daughter dyads' attachment relationships? It is hypothesized that daughters observed IPV will be associated with lower mother attachment as well as lower daughter attachment.

Qualitative Questions

1) What are the connections between historical trauma and the participants' relationships with one another, their families, and their communities?

2) How will attachment be described and experienced by the participants? Additionally, will participants' narratives identify associations between IPV, trauma, and mother-daughter attachment?

3) How will ethnic/cultural identity be manifested in participants' narratives? Will there be an affiliation with mother-daughter attachment?

4) What types of experiences have the participants had when attempting to access resources and services related to their IPV or family violence episodes.

CHAPTER III

Method

Participants

The present study includes a participant group (N=60) of 30 American Indian mother--adolescent dyads. Twenty-seven participants were from a tribe affiliated with the Northern Plains and 33 participants were from a tribe affiliated with the Upper Midwest. In order to determine the appropriate number of dyads needed to have enough power (i.e., power of at least .80) for the current study, a conventional recommendation (Myers, 1979 as cited in Kenney et al., 2006) indicated that a test of consequential nonindependence should be quite liberal. The suggested number of dyads needed to be able to test for consequential nonindependence is 28. The sample size (30 mother-daughter dyads) was, therefore, adequate for the current study. American Indian adolescent girls and their mothers were recruited from the Northern Plains and Upper Midwestern region of the United States which includes rural cities in North Dakota, South Dakota, and Minnesota. Nonprobability and purposive sampling through crisis centers, rape and abuse centers, local reservations, health clinics, child advocacy centers, and public advertisements (e.g., community newsletters/newspapers, local radio stations, and signs posted in various communities) took place in these areas as the primary researcher received tribal council approval and University Institutional Review Board approval to conduct the research in the identified communities. Collaboration

between the primary research investigator and two tribal communities' domestic violence agencies facilitated the design and conceptualization of the current study. The definition of victim of intimate partner violence for inclusion in the study includes the individual either being hit, kicked, threatened, sexually assaulted, physically, verbally or psychologically abused by a partner, spouse, boyfriend, or lover. The definition of child witness of IPV for inclusion in the study includes being in the room or near violence episodes when mothers were assaulted or victimized.

The descriptive analysis yielded means, frequencies, and percentages for the reported data on age, tribe/region, education, household income, experienced IPV, and witnessed IPV (see Table 1). The mean age for the 30 adult female participants in the study was 40.97, ranging from ages 29 years to 53 years. The mean age for the 30 adolescent female participants in the study was 15.33, ranging from ages 12 years to 18 years. In an effort to honor the participants' confidentiality tribe names were not identified within the sample; however, two main regions of the United States where the tribal council approval and recruitment took place were identified. Nearly 45% of the sample reported being affiliated with a Northern Plains American Indian tribe, and 55% of the participants indicated being affiliated with an Upper Midwestern American Indian tribe. It should be noted that in 3 mother-daughter dyads, the mothers reported being affiliated with an Upper Midwestern American Indian tribe and their daughters reported being affiliated with a Northern Plains American Indian tribe. Additionally, in 5 mother-daughter dyads, the daughter in the dyad was either: 1) a second younger daughter interviewed; 2) a second adopted daughter interviewed; or 3) a second twin

daughter interviewed. For the purpose of the current study all dyads were included in the analyses.

The participants were asked about their sexual orientation and 96.7% reported being heterosexual; while 2 daughters indicated being bisexual. Participants were also asked about their current relationship status and 48.3% indicated being single while 51.7% reported having a partner/boyfriend/girlfriend.

The participants' education was broken down between those who did not graduate high school (26.7%) and those who did graduate high school (73.3%). Twenty-nine (48.3%) of the adult females in the study graduated from high school, while 13 (21.7%) of the adolescent females graduated from high school. One adult female (1.7%) did not graduate from high school and 17 (28.3%) of the adolescent females did not graduate from high school. A summary of participants' demographic characteristics including education, is provided in Table 1. In terms of the household income the majority of the sample reported two of the lowest categories (less than $5,000 and 5k-9,999) representing 30% and 16.7% respectively. The next two categories (10k-14k and 15k-19,999) had 10% and another 10% of the participants. The two subsequent categories (20k-24,999 and 25k-29,999) only had 3.3% and 3.3% respectively. The last two categories (30k-39,999 and 40k and over) held 6.7% and 20% of the sample. As mentioned before, American Indian/Alaska Natives are reported to have lower median household income ($33,762) compared to the U.S. average household ($48, 451) (U.S. Census Bureau, 2007) and this is consistent with those statistics.

Table 1

Descriptive Demographics of Sample Participants

Characteristic	Mothers			Daughters			Dyads		
	N	M	%	N	M	%	N	M	%
Age	30	40.97		30	15.33				
Tribe Region									
Northern Plains	12		20%	15		25%	27		45%
Upper Midwest	18		30%	15		25%	33		55%
Highest Education Completed									
Did not graduate H.S.	1		1.7%	17		28.3%	18		26.7%
Graduated H.S.	29		48.3%	13		21.7%	42		73.3%
Elementary				5		8.3%			8.3%
Middle School	1		1.7%	10		16.7%			18.3%
High School	5		8.3%	13		21.7%			30%
Vocational/tech	4		6.7%						6.7%
Some College	15		25%	2		3.3%			28.3%
Graduated College	4		6.7%						6.7%
Grad. School/Prof.	1		1.7%						1.7%
Household Income									
Less than $5K							18		30%
$5K-$9,999							10		16.7%
$10-14,999							6		10%
$15K-$19,999							6		10%
$20K-$24,999							2		3.3%
$25K-$29,999							2		3.3%
$30K-$39,999							4		6.7%
$40K & Over							12		20%
Types of Abuse									
Witnessed in the home									
Physical Abuse	3		5%	6		10%	9		15%
Sexual Abuse	1		1.7%				1		1.7%

Table 1 (continued)

Characteristic	Mothers			Daughters			Dyads		
	N	M	%	N	M	%	N	M	%
Types of Abuse									
Witnessed in the home									
Emotional/Verbal Abuse	2		3.3%	5		8.3%	7		11.6%
Combination of Abuse	20		33.3%	19		31.7%	39		65%
No Abuse	4		6.7%						
Types of Abuse									
Experienced as Child in home									
Physical Abuse				2		3.3%			
Sexual Abuse	4		6.7%	7		11.7%			
Emotional/Verbal Abuse	1		1.7%	2		3.3%			
Combination of Abuse	19		31.6%	12		20%			
No Abuse	6		10%	7		11.7%			
Types of Experienced IPV									
(Current & Past 2 Relationships)									
Physical Abuse	29		48.3%	8		13.3%		37	61.7%
Emotional Abuse	20		33.3%	10		16.7%		30	50%
Isolation	25		1.7%	10		16.7%		5	58.4%
Threats/Intimidation	26		43.3%	10		16.7%		36	70%
Sexual Abuse/Rape	13		21.7%	4		6.7%		17	28.4%
Attachment Total		3.81(.43)			3.77(.97)			3.79(.50)	
Trauma (T score)		58.57(9.72)			61.23(13.53)			59.90(11.76)	
Ethnic/Cultural Identity									
Bicultural Identity	12		20%	11		18.3%		23	38.3%
European American Identity	8		13.3%	10		16.7%		15	25%
American Indian Identity	3		5%	7		11.7%		13	21.7%
Marginalized Identity	7		11.7%	2		3.3%		9	15%

Note: Frequency of Experienced IPV ranged from 0-3, however, sexual assault/rape range was 0-2.

Approximately, 10% of the adult women in the sample reported witnessing only physical abuse, 3.3% witnessed only sexual abuse/rape, 6.7% witnessed emotional/verbal abuse, and 66.7% witnessed a combination of IPV while growing up in their homes. Only 13.3 % of these women indicated that they had not witnessed IPV while growing up. Witnessing IPV was an inclusion criterion for adolescent female participants within this study. Twenty percent of the adolescent females witnessed only physical abuse, 16.7% witnessed emotional/verbal abuse, and 63.3% witnessed a combination of IPV while growing up in their homes.

A final question asked whether participants had ever experienced abuse (physical, sexual, emotional/verbal, or a combination of these forms) while growing up in their home. No women in the study solely reported being physically abused. About 13.3% of the adult women in the sample reported being sexually abused/raped while growing up and 3.3% of the women in the study reported being emotionally/verbally abused. Nineteen percent of the women stated that they experienced a combination of IPV while growing up in their homes. Approximately 7% of the adult women in the study, while growing up in the home, had not experienced any form of IPV identified within the study. Approximately, 6.7% of the adolescent females in the study reported being physically abused while growing up in the home. Nearly, 23.3% of the adolescent girls reported being sexually abused/raped and about 6.7% of the adolescent girls reported being emotionally/verbally abused while growing up in the home. Forty percent of the adolescent females reported experiencing a combination of abuse while growing up in the home. Only 23.3% of the adolescent girls had not experienced any form of abuse identified while growing up in the home.

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Materials

   All of the 60 participants completed the appropriate version [adolescent or adult form] of the following assessment measures: a) Informed Consent form (see Appendix A), b) Demographic Questionnaire (see Appendix B), c) The Inventory of Parent and Peer Attachment, d) The Revised-Parent Attachment Inventory, e) The Northern Plains Bicultural Inventory-Revised, f) The Trauma Symptom Review for Adolescents, g) The Trauma Symptom Inventory-II, and e) semi-structured interview questions (see Appendix C).

   The demographic/background & IPV questionnaire is a 15-item self-report inventory that asks about a variety of aspects of participants' social history and family structure. The response choice format includes multiple choice as well as dichotomous (i.e., yes/no) format, and free response numeric estimates (e.g., "How many biological children do you have?"). Questions about income and education are provided with multiple-choice response categories. The questionnaire further identifies the type and frequency of relationship violence (e.g., physical abuse, emotional/verbal abuse, isolation, threats/intimidation, and sexual abuse/rape) the participants have experienced (current and past two relationships). Subsequent questions about the individual and her partner's substance use during the relevant episodes were also reported. Additionally, the adolescent females were asked whether they had witnessed the abovementioned forms of IPV in their mothers' current and past two relationships. The author of this study constructed the measure.

Attachment Measures

The Inventory of parent and peer attachment (IPPA; Armsden & Greenberg, 1987) is a measure of adolescents' attachment to parents and peers. In the current study, each adolescent female was asked to complete the IPPA, a self-report inventory that includes 25 items which assessed both positive and negative affective and cognitive dimensions related to attachment. There are three dimensions that are used to measure attachment: (1) communication (C); (2) trust (T); and (3) alienation (A).

The communication dimension is measured with 10 items (e.g., "My mother/father/friends know(s) something is bothering me, he/she asks me"). The trust dimension is measured with nine items (e.g., "My mother/father/friends respect(s) my feelings"). The alienation dimension is measured with six items (e.g., "I don't get much attention from my mother/father/friends"). Adolescent females were asked to complete each set of questions in relation to her mother and her peers. The questions are answered on a 5-point Likert scale (ranging from 1= almost never or never true to 5=almost always or always true). For the purpose of the current study only the responses for attachment to mother were analyzed.

Armsden and Greenberg (1987) used two samples of adolescents, ages ranging from 16 to 20, and found good internal reliability for the IPPA, with Chronbach's alphas .87 for mother attachment, .89 for father attachment and .92 for peer attachment. Test-retest reliability at three-weeks was also good: .93 for parent attachment and .86 for peer attachment (Armsden & Greenberg, 1987). The IPPA also demonstrates good construct validity. It has been found to be associated with such related measures, as the Family Self-Concept ($r = 0.78$ with parent attachment; $r = 0.28$

with peer attachment) and Social Self-Concept ($r = 0.46$ with parent attachment; $r = 0.57$ with peer attachment) subscales of the Tennessee Self-Concept Scale, and to several subscales of the Family Environmental Scale (FES; Armsden & Greenberg, 1987). In particular, parent attachment was positively correlated to Cohesion ($r = 0.56$), Expressiveness ($r = 0.52$), and Organization ($r = 0.38$). Additionally, parent attachment was negatively correlated with Conflict ($r = -0.36$) and Control ($r = -0.20$) (Armsden & Greenberg, 1987). For the purpose of the current study only attachment to parent, specifically mother, data was analyzed. In terms of internal reliability for this sample Cronbach's Alpha for total attachment (to mother) was .82 (N= 30) for 25 items. The Cronbach alphas for the subscales were attachment communication .91 (9 items), attachment trust .93 (10 items), and attachment alienation .79 (6 items) respectively.

Revised-inventory of parent attachment (R-IPA; Johnson, Ketring, & Abshire, 2003). The measure is a revision of the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987) which was originally intended to measure adolescent attachment to parents and their peers. The parent version (R-IPA) allows for the discovery of parents' attachment to their adolescents. The inventory includes seven items for the trust dimension, nine items for the communication dimension, and six items for the alienation dimension (Johnson et al., 2003). Numerous items were modified to allow parents to answer the question based on their relationship with their children. For instance, the original question, "I tell my mother/father/friends about my problems and troubles," was changed to, "I talk to my child about my difficulties." In addition, various items were deleted from the original version, such as, "My

mother/father/friends doesn't understand what I'm going through these days," and additions were included, such as, "I am constantly yelling and fighting with my child." Reliability coefficients are fairly high, ranging from .72 to .95 (Johnson et al., 2003). The revised version of the IPPA (R-IPA) was positively correlated with other measures examining constructs related to attachment, therefore demonstrating convergent validity (Johnson et al., 2003). Internal reliability for this sample is shown by a Cronbach's Alpha of .82 (N= 30) for all 22 items. The Cronbach Alphas for the subscales were attachment communication: .74 for 7 items; attachment trust: .72 for 9 items; and attachment alienation: (-.83) for 6 items.

Scoring each dimension of the IPPA and R-IPA (trust, communication, and alienation) produces a separate score. A number of items within the trust and communication dimensions, in addition to the entire alienation domain, were reverse scored. Responses to questions for each dimension were then added together. In the event that a question was not answered, the mean of the answered questions would be added as the score for the omitted question. However, no participants omitted answers for this measure. All three dimensions were summed to create a total attachment score which was utilized in the analyses.

Posttraumatic Stress Symptom Measures

Trauma Symptom Inventory-II (TSI-2; Briere, 2011) is a revised version of the Trauma Symptom Inventory (TSI; Briere, 1995), a widely used test of psychological trauma. It is a 136-item measure utilized with adults age 18 and above to evaluate trauma-related symptoms and behaviors. The items use a 4-point Likert format (0= never, to 3= almost all of the time). The inventory takes approximately 40-

50 minutes to complete for most adults with a fifth grade reading level (Briere, 2011). There are two validity scales for the TSI-II: Atypical Response (ATR) and Response Level (RL). Additionally, there are 12 clinical scales, 12 subscales, and four factors. The clinical scales include: Anxious Arousal (AA), Depression (D), Anger (ANG), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Somatic Preoccupations (SOM), Sexual Disturbance (SXD), Suicidality (SUI), Insecure Attachment (IA), Impaired Self Reference (ISR), and Tension Reduction Behavior (TRB) (Briere, 2011). The four factors were: Self-Disturbance (SELF), Posttraumatic Stress (TRAUMA), Externalization (EXT), and Somatization (SOMA). For the purpose of the current study, only the TSI-II Posttraumatic Stress factor (TRAUMA; derived from the AA, AI, IE, DA, and DIS subscales) was utilized to measure adult trauma symptoms.

Scores on the TSI-II were measured in terms of a T-scale with a mean set at 50 and standard deviation of 10; scores of 65 and above represent clinical significance or significant psychological distress for the individual (Briere, 2011). The TSI-II demonstrates relatively high reliability with alpha coefficients ranging from .72 to .91, the lowest score (.72) for the ATR validity scale (Briere, 2011). The TSI-II factors demonstrated high internal consistency in the normative sample, with SELF and TRAUMA factor reliabilities at .93 (Briere, 2011). In the present study Cronbach's Alpha was .95 (N= 30) for the 40 items included in the TRAUMA factor.

The Traumatic Symptoms Review for Adolescents (TSRA; Briere, unpublished manuscript) is a self-report inventory of "post-traumatic distress and related psychological symptomology" in male and female youth aged 12– 21

years. The TSRA is a 129- item inventory in with a 5-point Likert format (0= never, to

4= most of the time). The inventory takes approximately 20-25 minutes to complete

for most adolescents. It is useful in the evaluation of children who have experienced

traumatic events, including sexual and physical assault, victimization by peers, major

losses, the witnessing of violence done to others and natural disasters (Briere, 1996).

Scores on the TSRA were derived from a T-scale with a mean set at 50 and standard

deviation of 10; scores of 70 and above represent clinical significance or significant

psychological distress for the individual.

The instrument is suitable for individual or group administration and is based

on the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) as well as the

Trauma Symptom Inventory (TSI; Briere, 1995). In the current study individual

administration was most appropriate as participants met individually with the

researcher. The TSCC yields two validity scales (Under-response and Hyperresponse);

six clinical scales (Anxiety [ANX], Depression [DEP], Anger [ANG], Posttraumatic

Stress [PTS], Dissociation [DIS], and Sexual Concerns [SC]); and eight critical items

(Briere, 1996). Dissociation has two subscales: Overt Dissociation (DIS-O) and

Fantasy (DIS-F). Sexual Concerns also has to subscales: Sexual Preoccupation (SC-P)

and Sexual Distress (SC-D). For the purpose of the current study only the

Posttraumatic Stress (PTS) scale was utilized to analyze adolescent females' traumatic

symptoms.

Reliability analysis of the TSCC scales in the normative sample demonstrated

high internal consistency for five of the six clinical scales (Alpha's range from .82 to

.89) (Briere, 1996). The remaining clinical scale, SC, was moderately reliable

(=.77). The four clinical subscales varied in reliability with DIS-O and SC-P having relatively high internal consistency (.81) and the shorter DIS-F and SC-D scales being somewhat less reliable (.58 and .64 respectively) (Briere, 1996). The two validity scales UND and HYP had coefficients of .85 and .66 respectively. The reliability of the TSCC clinical scales was also generally high in several other samples. However, because the subscales and validity scales were not formalized for the TSRA, reliability coefficients were not determined for these indices (Briere, unpublished). In the present study Cronbach's Alpha was .91 (N= 30) for the 26 items included in the PTS scale.

There is sufficient evidence for convergent and discriminant validity as established by analyses of covariance with other available measures. TSCC scales correlated most with scales of similar content (concurrent validity) and least with scales of less similar content (discriminant validity) (Briere, 1996). Briere and Lanktree (1995) found significant intercorrelations between the TSCC and the Youth and Parent Report versions of the Child Behavior Checklist (CBCL).

Ethnic/Cultural Identity

The Northern Plains Biculturalism Inventory-Revised (NPBI-R; Baker, 2005; NPBI; Allen & French, 1994): The NPBI-R is a twenty-item biculturalism scale composed of factors which are identified as American Indian Cultural Identification (AICI) and European American Cultural Identification (EACI). Mothers and daughters completed the measure. The measure demonstrated high internal consistency: an alpha coefficient of .77 for a revision of the scale (Baker, 2005). Additionally, the Revised NPBI accounted for the same total variance as did the original scale (Baker, 2005).

In scoring the NPBI-R a median split procedure is used. A high score on the AICI scale accompanied by a low score on the EACI scale suggests American Indian Cultural Identification, while a low score on the AICI scale and a high score on the EACI point toward European American Cultural Identification. If scores are above the median on both AICI and EACI, the participant is identified as bicultural. However, if scores are below the median on both AICI and EACI, the participant is identified as marginal. Marginal orientation refers to an individual who is neither acquainted nor involved with either culture.

Internal reliability for this sample on NPBI-R scales of American Indian cultural identity (AICI) and European American cultural identity (EACI) were: AICI with 13 items (N= 60), Alpha= .81; and EACI with 6 items (N= 60), Alpha= .50.

Open-ended Questions

Semi-structured interviews. After completing the questionnaires, American Indian women who had a history of IPV in their relationship and/or who had been sexually assaulted were asked to participate in a semi-structured interview (see Appendix C). In addition, the daughters (12 years-18 years old) of these women who had witnessed IPV were asked to participate in a separate semi-structured interview. The questions were directed toward their experiences related to family bonds (e.g., mother-daughter bond), traumatic encounters associated with IPV, and historical trauma related to their American Indian heritage/family's lived experiences.

Procedures

Upon the participants' response to recruitment efforts, appointments were arranged by the primary research investigator to identify the participants' status on the

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inclusion criteria. The primary research investigator and a research assistant met with participants (mothers and their adolescent daughters separately) at confidential sites within the community (e.g., community center, victim assistance agency, etc.) or within the participants' homes. The participants were informed that at any point they could stop participating in the study and receive a monetary reward for contributing to the research, and were provided with a list of local resources. Following consent of the parent and the adolescent, the participants completed questionnaires in separate areas with access to the primary research investigator or research assistant to ask questions. All participants were given the options of the primary investigator or research assistant reading the questionnaires aloud or completing the questionnaires on their own. All participants chose the reading of the questionnaires aloud. Measures were counterbalanced as to account for potential order effects. The participants completed measures that were related to their background, family dynamics, intimate partner violence (IPV), ethnic/culture identity, traumatic symptoms, and the ways in which they cope.

Participants were offered sage, an herb that has healing and protective properties to ward off evil spirits or negative influences recognized by indigenous communities (L. Thompson, personal communication, Feb. 8, 2011). Sage is often burned in a small bundle similar to incense and has an aromatic scent that facilitates the cleansing or warding off of spirits (L. Thompson, personal communication, Feb. 8, 2011). The participants were also given access to art supplies (e.g., colored pens, paper, play do, games, and stress balls) to help them relax and de-stress throughout the semi-structured interviews. Additionally, participants were offered food and beverages (e.g.,

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snacks, sandwiches, and water) during the course of the study. Finally, the participants were offered other resources to connect them to a community elder/medicine woman/man as well as mental health and/or victims' assistance support as needed. Five participants (five adolescent girls) chose not to participate in the open-ended interview portion of the study. These participants reported having prior engagements and indicated not anticipating the semi-structured interview length of time, although the estimated time was clearly stated on consent forms and recruitment materials. The participants were given the monetary reward for participating as well as a list of local resources to access additional support. Attempts were made to conduct follow-up interviews; however, the primary investigator was unable to reschedule with participants.

After the semi-structured interview and completion of the measures, which took approximately 2 hours, participants were debriefed, provided with local resources for mental health support and traditional healers, and a monetary contribution for their time ($25 gift certificates to Wal-Mart). If a participant had reported being a danger to herself or others (e.g., child abuse, homicidal or suicidal ideation), a more complete assessment of risk would have been conducted and appropriate referrals would have been made by the primary research investigator. If a participant had indicated wanting to harm herself or reported suicidal ideation, a suicide risk assessment would have been conducted. Although a few participants acknowledged having a history of suicide ideation, further assessment did not warrant major concern, as resources and links to local supports were provided. Identification of the participant's intentions or suicide plan, the lethality of the plan, and feasibility of the plan would have been

assessed. Follow up communication with the project supervisor took place for

consultation. Direct connection to a mental health provider (e.g., IHS mental health

clinic) within the community would have taken place if there was a need or major

concern. Disclosure of abuse was assessed for immediate threat in two cases and there

was no need to refer to child protective services as the participants were receiving

social service support. In fact, in the majority of the cases, the agency or service

provider had given the participants the primary research investigator's contact

information in an effort to involve the participant in the research study.

CHAPTER IV

Results

This chapter presents findings of the study, in three major sections. First, the

preliminary analyses are presented that address descriptive information about the

variables under investigation and correlations among variables. In the second section

primary analyses, the testing of six HLM (HLM 6.0) models, are presented. Finally, the

qualitative data are presented in combination with the findings from the quantitative

data analyses.

Preliminary Analyses

Independent Variables: Intimate Partner Violence. Five demographic

questions were asked that attempted to gain information about all participants'

experiences of physical abuse, emotional/verbal abuse, isolation, threats/intimidation,

and sexual assault/rape. The participants were asked whether an abusive episode had

occurred within a current relationship and the past two relationships. Participants'

responses indicated that from 0 to 3.

48.3% of the adult women in the sample had experienced physical abuse, while

33.3% reported being emotionally abused (see Table 1). Nearly 41.7% of the adult

women reported experiencing isolation within their current or past relationships.

Experiencing threats or intimidation in relationships was reported by 43.3% of the adult

women. Approximately 21.7% of the women reported being sexually abused or raped in their current or past relationships.

13.3% of the adolescent girls in the study had experienced physical abuse, while 16.7% reported being emotionally abused in a current relationship or past two relationships (see Table 1). 16.7% of the adolescent girls reported experiencing isolation and another 16.7% of the girls indicated experiencing threats or intimidation in relationships. Approximately 6.7% of the adolescent girls reported being sexually abused or raped in their current or past relationships.

Participants were also asked whether their partner and/or they were using any substances (e.g., alcohol, methamphetamines, combination, etc.) during the IPV episodes identified. 43.3% of the women reported that their partners had used substances during the violent events, while 28.3% of the women indicated that they were under the influence during those times. 3.3% of the adolescent girls reported that their partners were using substances during IPV episodes, while the 3.3% of the girls reported that they had used substances during IPV episodes. These outcomes provide insight into the participants' overall experiences of IPV which allowed for the thorough investigation of mother-daughter dyads. In order to analyze the participants' experienced IPV, separate scores for mothers and daughters were derived.

Forty-five percent of the adolescent female participants reported witnessing their mothers being physically abused, while 46.7% indicated witnessing emotional/verbal abuse of their mothers. Relatively fewer female youth reported having witnessed their mothers' being isolated by their partners or threatened or intimidated by mothers' partners (33.4% and 31.6% respectively). Even fewer participants, only 10%, had

witnessed their mothers' being sexually abused or raped in her current or last

relationship.

An analysis was conducted to determine whether there was a significant bivariate

relationship between daughters' observed IPV and mother-daughter attachment (low vs.

high) scores. There was no correlation between daughters' observed IPV and low or

high mother-daughter attachment ($r = -.131$, $p = .87$). As a result of this outcome, I

determined that further investigation of the participants' experienced IPV would be

would be the focus of the current study.

Posttraumatic stress disorder symptoms. The trauma (posttraumatic stress

symptoms) scores were measured by T scores derived from the TSI-II (TRAUMA)

factor for adult participants and the TSRA (PTS) subscale for adolescent participants.

The adult participants had a mean of 58.57 (SD= 9.72) with a range of 38 to 72.

Approximately 18.3% (n= 11) of the adult sample reported scores that were within the

normal range of psychological functioning, while 31.7% (n= 19) of the adult

participants had problematic, clinically elevated trauma scores.

The adolescent participants had a mean of 61.23 (SD= 13.53) with a range of 41

to 87. Approximately 25% (n= 15) of the adolescents reported scores that were within

the normal range of psychological functioning, while 25% (n= 15) of the participants

had problematic, clinically elevated trauma scores. These outcomes suggest that the

majority of the sample might have undergone one or more major traumas in their lives.

There was an increased likelihood that participants with elevated scores would meet

diagnostic criteria for PTSD. A PTSD diagnosis should not be made or excluded based

solely on the TRAUMA factor or the PTS subscale scores, however. Further exploration of trauma as an independent variable within an HLM model was warranted.

Ethnic/cultural identity. In terms of the NPBI-R (ethnic/cultural identity) scores, 20% (n= 12) of the women and 18.3% (n=11) of adolescent girls in the sample indicated a bicultural identity. The next highest percentage 13.3% (n= 8) of the women and 16.7% (n= 10) of the girls in the study respectively fell into the European American identity category. Nearly 5% (N=3) of the adult women scores and 11.7% (n= 7) of the adolescent girls scores indicated an American Indian identity. Finally, 11.7% (n= 7) of the women and 3.3% (n= 2) of the girls in the study reported having a marginalized identity. Since the largest proportion of participants had a bicultural identity, this group was identified as the reference group with which all other ethnic/cultural groups were compared. An examination of ethnic/cultural identity as a potential protective factor was warranted although there was not complete representation across ethnic/cultural identity groups within the sample (e.g., marginal identity had the fewest number of participants represented).

Dependent variable: attachment. The R-IPA (measure for adults) and IPPA (measure for adolescents) were the primary measures examining attachment in this population. The sample mean for the adult participants total attachment score was 3.81 (SD= .43) with a range of 3.00 to 4.68. The scores on the R-IPA and IPPA range from 1 to 5, and attachment means scores less than 3.45 were considered low, while attachment means that were equal to or were above 3.45 were considered high based on the scoring manuals and previous literature. The majority of the women in the study identified having strong attachment to their daughters. The R-IPA and IPPA have three

subscales; communication, trust, and alienation. The mean for adult participants attachment communication was 3.37 (SD= .67) with a range of 1.71 to 4.57, suggesting a slightly low level of attachment. The mean for adult attachment trust was 3.98 (SD= .50) with a range of 3.00 to 4.80, which suggest that mothers within the study tend to have a high level of trust of their daughters. Additionally, the adult participants' mean for attachment alienation was 1.99 (SD= .63) with a range from 1.00 to 4.00. Scores that were greater than 3.0 were considered high attachment alienation, while attachment means that were less than 3.0 indicate low attachment alienation. The mothers within the current study demonstrated low attachment alienation toward their daughters.

The adolescent participants' attachment total mean was 3.77 (SD= .57) with a range of 1.96 to 4.52, suggesting strong attachment. The mean for adolescent participants' attachment communication was 3.87 (SD= .97) with a range of 1.29 to 5.00, suggesting strong attachment communication toward their mothers. The mean for trust was 3.95 (SD= .63) with a range of 1.60 to 4.60, suggesting that daughters within the study tend to have a high level of trust of their mothers. Additionally, the adolescent participants' mean for attachment alienation was 2.21 (SD= .83) with a range of 1.00 to 4.00, suggesting relatively low levels of attachment alienation toward their mothers These analyses were conducted in order to develop the primary dependent variable of interest: attachment. It was examined as a binomial variable for the hypotheses.

For the purpose of the current study mothers and daughters summed scores were analyzed as 21 mother-daughter dyads (n= 42) reported having high total attachment scores (means greater than 3.45), while 9 mother-daughter dyads (n= 18) reported having discrepancies within their total attachment scores. In 4 dyads (n= 8) mothers and

daughters reported low attachment scores, while in another 4 mother-daughter dyads (n= 8) mothers reported low attachment and daughters reported high attachment. Finally, one dyad included a mother who reported high attachment and a daughter who reported low attachment.

Bivariate results: correlations of contextual, independent, and dependent variables. Separate bivariate correlation matrices of all the variables were generated for mothers and daughters to examine the relationships among the variables. As Table 2 and Table 3 illustrate, analysis indicated that a number of the variables were significantly associated. Specifically, mothers' substance use during IPV-related episodes indicated a moderate negative association with education $r = -.430$ ($p<.01$), a moderate positive association with experienced IPV $r= .440$ ($p< .05$), and a strong positive association with their partners' substance use during IPV-related episodes $r= .637$ ($p< .01$). Mothers who graduated from high school were more likely to experience episodes of IPV and mothers who used substances during IPV were at an increased risk for experiencing IPV. Additionally, women whose partners used substances during IPV-related episodes were at increased risk for experiencing IPV. There was a moderate positive association with mothers' experienced IPV and their PTSD symptoms $r= .394$ ($p< .05$), indicating that mothers who experienced IPV also identified having post traumatic stress disorder symptoms. In order to understand the association between tribe region (Northern Plains vs. Upper Midwest) and ethnic/cultural identity (as measured by NPBI-R) a one-way anova was performed.

There were no statistical differences among the women from the two tribe regions NPBI-R scores $F (3, 26) = 2.32$, p= .10.

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When examining the association between variables for the adolescents within the sample there were a number of significant associations see Table 3. There was strong positive association between the daughters age and education r= .869 (p< .01), and a strong positive association between daughters age and their experienced IPV r= .661 (p< .01). The older the adolescents were the more likely they were to graduate from high school and to experience IPV. Additionally, there were strong positive associations with the adolescent girls' partners' substance use during IPV-related episodes r= .647 (p< .01) and their own substance use during IPV-related episodes r= 1.00 (p< .01). The adolescent girls who used substances during IPV-related episodes and whose partners were using substances during IPV-related episodes were at an increased risk for experiencing IPV.

In order to understand the association between the adolescent girls experienced IPV and ethnic/cultural identity a one-way anova was performed. There were no significant differences between the adolescent participants scores on the NPBI-R and their experiences of IPV $F (3, 26)$ = 1.64, p= .21. A one-way anova was performed to understand the association between adolescent girls PTSD symptoms and their ethnic/cultural identity (NPBI-R scores). There does not appear an association between adolescents PTSD symptoms and ethnic/cultural identity, $F (3, 26)$ = 2.29, p= .10. A final one-way anova was performed to understand whether there was an association between daughters NPBI-R scores and their tribe region. There does not appear to be an association between ethnic/cultural identity and tribe region for adolescent girls within the sample, $F (3, 26)$ = .70, p= .56.

Primary Analyses

Hierarchical linear type models on linear and logistic type regressions were used in the current study. These extensions of the general linear model were used to estimate relationships between IPV and demographic characteristics while accounting for non-independence in the variance of mother-daughter dyads.

Hypothesis 1*:* **model 1 IPV and mother-daughter dyad attachment.** The first step involved building a model to investigate whether participants' experiences of IPV were related to lower mother-daughter attachment relationships as measured by low(= 0) or high (= 1) total attachment scores. The predictor/independent variable (participants' experienced IPV) was entered into the logistic regression model. It should be noted that the independent variable was centered around its grand mean to facilitate interpretation. Participants' experienced IPV was not significant as the coefficient was τ_{00}= -.09, (*SE*=0.09), $t(58)$= -1.03, OR= .91, 95% CI [.77, 1.10], *p*=.31. As participants' experienced IPV increased by 1, the probability of predicting mother-daughter dyads' high attachment scores went down -.09. Essentially there were no significant between dyad differences in IPV represented in the sample. The initial hypothesis was not supported as participants' experienced IPV was not associated with high or low mother-daughter attachment.

Table 2
Intercorrelations for Mothers

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Intercorrelations of Contextual, Independent, & Dependent Variables for Mothers

	Variables	1	2	3	4	5	6	7	8	9	10
1	Age	1.00	.296	.306	-.017	.151	.015	-.293	.116	-.153	-.208
2	Tribe Region		1.00	.227	.306	.220	-.023	-.125	.198	-.384*	-.282
3	Education (no high school vs graduate)			1.00	.189	-.276	-.223	-.430*	-.203	-.259	-.082
4	Household Income				1.00	.080	-.165	-.042	-.289	-.338	-.020
5	IPV Total					1.00	.700**	.440*	.394*	-.113	.112
6	Partners Substance use during IPV						1.00	.637**	.246	.157	.008
7	Participant's Substance use during IPV							1.00	.231	.301	.149
8	PTSD Symptoms								1.00	.224	-.096
9	Ethnc/Cultural Identity									1.00	.063
10	Attachment										1.00

**Correlation is significant at the p<.01 level (2-tailed).
*Correlation is significant at the p<.05 level (2-tailed).

Table 3
Intercorrelations for Daughters

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Intercorrelations of Contextual, Independent, & Dependent Variables for Daughters

	Variables	1	2	3	4	5	6	7	8	9	10
1	Age	1.00	000	.869**	-.021	.661**	.267	.267	.095	-.329	-.087
2	Tribe Region		1.00	.067	-.012	.159	.267	.267	.353	-.114	.102
3	Education (no high school vs graduate)			1.00	-.049	.726**	.306	-.306	.177	-.319	-.114
4	Household Income				1.00	.073	.072	-.072	-.026	.297	.117
5	IPV Total					1.00	.647**	.647**	.163	-.399**	-.213
6	Partners Substance use during IPV						1.00	1.00**	.046	-.138	-.254
7	Participant's Substance use during IPV							1.00	.046	-.138	-.254
8	PTSD Symptoms								1.00	-.398*	.039
9	Ethnc/Cultural Identity									1.00	.086
10	Attachment										1.00

**Correlation is significant at the p<.01 level (2-tailed).
*Correlation is significant at the p<.05 level (2-tailed).

Hypothesis 2: model 2 PTSD as moderator. A second model was tested to address whether higher PTSD symptoms were related to higher experienced IPV and strained mother-daughter dyads' attachment relationships. The model examined the variability of mother-daughter attachment scores and experienced IPV controlling for PTSD symptoms. In model 2, PTSD symptoms (T scores) and participants' experienced IPV were grand-mean centered to facilitate interpretation. The PTSD symptoms slope was 0.026, (*SE*= 0.034)*, t*(56)= 0.76, OR= 1.0, 95%CI [0.95, 1.02] and was not significant (*p*= .45). The correlation between PTSD symptoms and the experienced IPV slope intercept was 0.003, (*SE*= 0.009), *t*(56)= 0.34, OR=1.0, 95%CI [0.98, 1.02] and was not significant (*p*= .73). PTSD symptoms were not associated with the relationship between participants' experienced IPV and mother-daughter dyads' attachment. See table 4 for other statistics (e.g., experienced IPV and mother-daughter attachment) that were entered into model 2 as these results did not vary from model 1. The intraclass correlation coefficient ($\rho = .32$) indicated that about 32% of the variability in mother-daughter dyads' attachment was associated with participants' experienced IPV and PTSD symptoms between groups. The current hypothesis was not supported by the findings.

Hypothesis 3: model 3 ethnic/cultural identity as moderator. The third model tested addressed the question to what extent is the relation between participants reported experiences of IPV and mother-daughter dyads' attachment moderated by participants' ethnic/cultural identities. In model 3, I have included a group of dummy coded variables which reflect the ethnic/cultural identities (as measured by the NPBI-R) in Table 4 and 5: a) bicultural identity (Biculdum); b) American Indian identity

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(AIdum); c) European American identity (EIdum); and d) Marginal identity (MIdum).

Bicultural identity was the reference group representing the majority of the sample

(38.3%). Therefore all other ethnic/cultural identities were compared to it within the

proposed model. Model 3 was tested similarly to model 2; however, each

ethnic/cultural identity dummy code was entered into the model separately and was

respectively multiplied by a slope reflecting the relation between the independent

variable (participants' experienced IPV) and the dependent variable (mother-daughter

dyad attachment). When these variables were entered into the model there were no

significant differences, suggesting that ethnic/cultural identity did not moderate the

relation between participants' experienced IPV and mother-daughter dyads' attachment

scores. The intercept for American Indian identity was 0.32, (SE=0.30), t(52)=1.07,

OR=1.4, 95%CI [0.75, 2.53], p= .29, ns. The finding indicated that when comparing

participants with American Indian identity to those participants with bicultural identity

there was no association between the participants' experienced IPV and mother-

daughter dyads' attachment scores. The intercept for European American identity was

0.02, (SE= 0.25), t(52)= 0.07, OR=1.0, 95%CI [0.62, 1.68], p= .94, ns. The outcome

indicated that when comparing participants with European American Identity to those

participants with bicultural Identity, there were no associations between experienced

IPV and mother-daughter attachment scores. The intercept for marginal identity was

0.41, (SE= 0.33), t(52)= 1.26, OR=1.5, 95%CI [0.78, 2.89], p= .22, ns. The finding

indicated that when comparing participants with marginal identity to participants with

bicultural identity, there was no association between participants' experienced IPV and

mother-daughter attachment scores. The findings also indirectly suggest that there was

no association between bicultural identity, participants' experienced IPV and mother-daughter attachment scores. The intraclass correlation coefficient ($\rho = .48$) indicated that about 48% of the variability in mother-daughter dyads' attachment was associated with participants' experienced IPV and ethnic/cultural identity between groups. The current hypothesis was not supported by the findings.

Hypothesis 4: Model 4 Contextual Variables Mother/Daughter Income, Education, Age, and Partner Substance use During IPV-Related Episodes and Participants' Substance use During IPV-Related Episodes. The fourth model tested addressed the relationship between participants' experienced IPV and mother-daughter attachment and whether it was associated with income, education (did not graduate high school vs. graduated from high school), age, partner substance use during IPV-related episodes, and participants' substance use during IPV-related episodes.

The mother-daughter dyads' attachment total was entered into model 4 as the dependent variable and income, education, age, partner substance use during IPV-related episodes, and participants' substance use during IPV-related episodes were treated as independent variables in the model. Only one of the independent variables had a significant outcome. The participants' substance use during IPV intercept was 0.09, ($SE= 0.03$), $t(53)= 2.78$, $p= .008$. This finding indicated that participants' substance use during IPV-related episodes was significantly associated with the relationship between experienced IPV and mother-daughter attachment scores.

The participants' experienced IPV intercept was 0.02, ($SE= 0.02$), $t(53)= 0.70$, $p= .47$, ns. The participants' income intercept was 0.004, ($SE= 0.02$), $t(53)= 0.19$, $p= .85$, ns. Participants' education intercept was -0.05, ($SE= 0.12$), $t(53)= -0.39$, $p= .70$.

Participants' age intercept was -0.004, (*SE*= 0.00), *t*(53)= -0.90, *p*= .37. Participants' partners' substance use during IPV episodes intercept was -0.06, (*SE*= 0.03), *t*(53)= 1.76, *p*= .08, ns. The intraclass correlation coefficient ($\rho = .58$) indicated that about 58% of the variability in mother-daughter dyads' attachment scores was associated with income, education, age, partner substance use during IPV related episodes, and participants' substance use during IPV episodes. The findings indicated that participants' substance during IPV episodes was significantly associated with the relationship between experienced IPV and mother-daughter attachment relationships.

Exploratory Analyses

  Model 5: tribe region with experienced IPV as independent variable. The fifth model examined whether there were tribe regional differences in participants' experienced IPV as well as mother-daughter attachment relationships. In order to address the first part of the question participants' experienced IPV was entered into an unconditional model and treated as a dependent variable. A subsequent model was tested that included both participants' experienced IPV and participants' identified tribe region, which was treated as an independent variable with two levels (Northern Plains and Upper Midwest). Tribe region coefficient was 1.55, (*SE*= 0.96), *t*(58)= 1.62, *p*= .11. The finding indicated that there were no significant relationships between tribe regions and the participants' experienced IPV. The intraclass correlation coefficient ($\rho = .05$) indicated that about 5% of the variability in participants' experienced IPV was associated with tribe regions.

  In order to determine whether mother-daughter dyads' attachment scores were different among tribe regions a model was tested with mother-daughter attachment

scores as the dependent variable. Tribe regions coefficient in this model was -0.08, (SE= 0.12), t(58)= -0.72, p= .48, ns. The finding indicated that there were no significant differences in mother-daughter dyads' attachment scores in tribe regions. The intraclass correlation coefficient ($\rho = .39$) indicated that about 39% of the variability in mother-daughter dyads' attachment scores was associated with tribe regions, however, as noted above this factor was not a significant contributor in the proposed model (p= .48).

Model 6: contextual variables income, education, age, partner substance use during IPV, and participants' substance use during IPV associated with IPV. The sixth model tested how the participants' experienced IPV was associated with income, education, age, partner substance use during IPV-related episode, and participants' substance use during IPV-related episodes. In order to address the question, participants' experienced IPV was treated as the dependent variable and income, education, age, partner substance use during IPV-related episodes, and participants substance use during IPV-related episodes were treated as independent variables in the model. The participants' income intercept was 0.15, (SE=0.12), t(54)=1.35, p =.20, a non-significant outcome. In the current sample, there was no relation between participants' income and their experiences of IPV. However, participants' education (did not graduate from high school vs. graduated from high school) had an intercept of 2.27, (SE=0.74), t(54)= 3.08, p= .004. This significant finding suggested an association between participants' education and their experienced IPV. Contrary to the literature, in the current sample participants who graduated from high school were more likely to experience episodes of IPV.

Table 4

Regression Results for Mother-Daughter Dyads' Models

	Model 1	Model 2	Model 3	Model 4	Model 5
Mom-Da Dyad-, Intercept Attachment	1.38*** (0.371)	1.44*** (0.392)	1.29 (0.651)	0.82** (0.148)	0.93*** (0.19)
Experienced IPV	-0.09 (0.089)	-0.101 (0.091)	-0.208 (0.164)	0.02 (0.022)	1.93 (1.555)
PTSD Symptoms			0.003 (0.011)		
Ethnic/Cultural ID: BiculDum_IPVslope~					
AIDum _IPVslope			0.32 (0.303)		
EIDum_IPVslope			0.02 (0.251)		
MIDum_IPVslope			0.41 (0.326)		
Contextual Variables: Income				0.004 (0.025)	
Education				-0.05 (0.005)	
Age				-0.007 (0.005)	
Partner Substance Use-during IPV				-0.06 (0.033)	
Participants' Substance Use-during IPV				0.09 (0.032)	
Tribe Region[a]					1.55 (0.955)
Tribe Region[b]					-0.08 (0.117)

Note. Metric coefficients (standard error)

* p< .05 ** p < .01 *** p< .001

[a] Refers to variance component in model with Participants' Experienced IPV as outcome

[b] Refers to variance component in model with Mother-Daughter Dyads' Attachment as outcome

df= 29 (mother-daughter dyads) for majority of models analyzed, however in some cases all participants were included when certain variables (e.g., ethnic/cultural identity, tribe region, etc.) were in models. When that occurred the *df*= 60- no. of total variables included in the specific model.

~Bicultural Identity, is the ethnic/cultural identity reference group all other ethnic/cultural identity variables are compared to it.

Table 5

Odds Ratios for Mother-Daughter Dyads

	Model 1	T-ratio	Model 2	T-ratio	Model 3	T-ratio
Likelihood of High Mom-Daughter Attachment						
Mom-Dau low/high Att Intercept	4.1***	3.71				
Participants' experienced IPV	0.9	-1.03				
Likelihood that PTSD symptoms were associated with Experienced IPV & Mom-Dau Attachment						
Mom-Dau low/high Att Intercept			4.2**	3.66		
Symptoms slope			1.0	0.76		
Participants' experienced IPV			0.9	-1.20		
PTSD PTSD Symptoms_Experienced IPVslope			1.0	0.34		
Likelihood that Ethnic/Cultural identity (Bicultural vs. each ethnic/cultural identity) was associated with Experience IPV						
Mom-Dau low/high Att Intercept					3.6	1.98
Participants' experienced IPV					0.8	-1.27
AI Identity DumCode (AI vs.BI) slope					1.1	0.12
EA Identity DumCode(EA vs BI) slope					2.4	0.80
MI Identity DumCode(MI vs BI) slope					0.9	-0.07
AI Identity X Participants Experience IPV slope					1.4	1.07
EA Identity X Participants Experienced IPV slope					1.0	0.07
MI Identity X Participants Experienced IPV slope					1.5	1.26
Restricted PQL	-3.39		-8.94		-7.44	
Chi-square	35.99		36.23		42.32	
Df	29		29		29	
N	60		60		60	

* p< .05 ** p < .01 *** p< .001
CI= 95%

When age was considered in the model the intercept was 0.03, (SE=0.03), t(54)=.89, p= .38, ns. There does not appear to be an association between participants' age and their experienced IPV. Participants' partners' substance use (during IPV-related episodes) was entered into the model and demonstrated an intercept of 0.69, (SE=0.18), t(54)=3.92, p< .001 indicating a significant relationship. The model indicated that participants' partners' substance use during IPV episodes increased the likelihood of experiencing IPV. Finally, participants' substance use (during IPV-related episodes) demonstrated an intercept of 0.10, (SE=0.20), t(54)=.53, p= .60, ns. There does not appear to be an association between participants' substance use during IPV-related episodes and their experienced IPV. The intraclass correlation coefficient (ρ =.28) indicated that about 28% of the variability in participants' experienced IPV was associated with income, education, age, participants' partners' substance use during IPV-related episodes, and participants' substance use during IPV-related episodes between group differences. The findings indicated that participants' education and their partners' substance use during IPV-related episodes were related to participants' experienced IPV.

Qualitative Data

In the course of conducting this research, multiple kinds of data were collected from each of the study participants. Along with quantitative measures, extensive qualitative data was collected in an effort to explicate the relevant factors and relationships identified in the quantitative analyses reported in the previous section. In order to add qualitative insight to these analyses, this dissertation chapter will illustrate these relationships with content and thematic analysis.

Content/Thematic Analysis

The purpose of using a combination of content and thematic analysis in this study was: (a) to provide information that supports a historical backdrop around trauma within Indian country, (b) to obtain information on American Indian women's perceptions of closeness/attachment within mother-daughter relationships, and (c) to cross-check the validity of the quantitative findings. Since standardized instruments rely on largely closed-ended options, open-ended questions were used to understand more thoroughly how closeness or attachment was experienced by Northern Plains and Upper Midwest American Indian women. For example, several questioned focused upon elements of family relationship changes over time and participants' experiences of trauma in childhood and adulthood.

This study used manifest (surface) content, rather than interpretation, to improve reliability (Babbie, 1989). Validity is ensured by, first, the directness of the open-ended questions. Second, the categories/themes that emerged from the responses matched certain items of the standard measures used elsewhere in the questionnaires.

Historical Context

Historical trauma. Information about historical trauma, a theme that arose within the qualitative data, was derived from the contextual question, "has your family (grandparents, aunties, uncles, mother/father) been impacted by the following federal laws: Termination, Relocation, Child removal (social services—boarding schools….foster care), and Loss of lands-Allotment", asked of each of the participants during the interview. Researchers provided additional explanations of the items mentioned to provide further clarity. Nearly 201 related quotes supported this category

and highlight participants perceptions of historical trauma. The affiliated subthemes

include boarding school experiences, alcohol/drug related experiences, coping with

crisis, and injustice/oppression. Most of the participants indicated that a family

member, they themselves, or someone they knew had some level of experience with at

least one aspect of historical trauma. In order to provide a historical context it is

important that I reflect on a few key responses from participants:

> My mom and my aunties, they all went to a boarding school. (So did the
> participant)…It was fun, but then again, I was far from my family, It was in
> (another state). I really missed my family. I was there for a year and a half.
> Then I went to another school in (city closer to her home). [Participant 1, youth
> female]

> Yeah, my mom and her brothers and sisters. I don't think the government had
> anything to do with it; it's just my grandparent's way to help because they
> didn't have enough money to take care of them…It felt lonesome and sad. My
> grandma and grandpa came and got them when they could... But I don't know
> they had no choice, I guess. They knew they had to be there. And they took care
> of each other… at the boarding school they watched out for each other.
> [Participant 13, adult female]

Participant 13 further described what the state of her reservation and family life

were like and how she believes circumstances might be connected to those early

boarding school experiences.

> It seems like they, sometimes around here are like really pitiful. And I don't
> know what happened there …. But I'm lucky because it seems like my family is
> kind of well off. Like my mom and uncles are well known in the tribe and
> where my mom used to hold a position with the (institution within the
> community). I am working hard and so is my sister; she almost has her two-year
> degree. And then like my uncle's kids, they just drink….I mean they're so
> depressed, that's their way of self-medicating.

Another participant described her awareness of the boarding school experience and how that likely impacted her mother's ability to provide her with adequate love and support.

> Actually yes they did. And I didn't realize that until two years ago the effects of that boarding school, my mother went to a boarding school. And I'm older but my mother, my mother is still alive too. But she was a mom when she was seventeen; she was married when she was sixteen. And she was in boarding school from the time she was four until eleven I think they took her out. And it didn't dawn on me why she had trouble with alcohol or why she was violent and horrifically angry and why she couldn't show compassion or love to her children was because an institution was trying to teach her just how to live. They didn't care about her. Yah, they couldn't. So where does a person learn that if they're not with their family? She had two visits during those years. And where would she learn? [Participant 6, adult female]

> I understand her [her mother's] struggles being an alcoholic for one thing. Ah raising kids on her own, being alone… (the government) Took 'em and I don't know how they passed ICWA law it's called. And they were placed here and there. I think it was because back then the so-called ah social services on the Rez lack of education, lack of services, I think a lot of laziness. They hired these people that don't know a nickel or dime about what they were supposed to be doing about court appearances; those are vital to legal termination. I've seen families never get their kids back. And they were adopted out. They were never given choices trying to get help. Services you know. [Participant 16, adult female]

Participant 16 further reflects on her mother's experiences in a boarding school and her own experiences in an orphanage;

> My grandparents with my mom, she was ah, was at a boarding school. She was beaten, beaten by nuns. Tied to a bed, stuff like that. Myself I've been, been in an orphanage. Oh Catholics ran it. So we're actually right now in a lawsuit with them…(I remember) being maltreated. Child, child molestation happened as well.

> The participants discussed historical events that essentially caused family

systems to be broken and further tormented through alcohol and substance use/abuse.

Subsequent violence (e.g., family violence, intimate partner violence, etc.) were not

common phenomena within reservations and tribal communities prior to the introduction of alcohol as well as other atrocities introduced by colonizers. Participants acknowledged how intertwined injustices as well as oppression were through their narratives. Finally, the participants' powerful narratives provide insight into their lived experiences and the direct effects on their personal relationships with their family members, specifically mother-daughter relationships.

Mother-Daughter Relationships

Attachment. In the current study a second theme, Attachment, developed from the analysis of two questions. First the participants were asked about their thoughts, behaviors, and experiences that helped mothers and their daughters to connect or become closer. The participants answered a subsequent question regarding the barriers to that connection. A majority of participants were able to acknowledge something that facilitated a connection or disconnection to one another. Approximately 215 statements were related to attachment and the subthemes drawn from the analysis include: Quality time, Care taking, Communication, Overprotection, Anger, Arguments, Inability to communicate, Fighting, Lying, Repeating cycle of violence, and Relationship with partner. Participant 3, who prior to the interview reported that she was not close with her mother, recalled having her mother present during a difficult time as being particularly meaningful to her,

> When my son was in the hospital he had [a medical condition] and that brought me really close to my mom because she was the only person I wanted at the time….Umm, I loved having her there. It made me feel like nothing bad was going to happen with her there! [Participant 3, youth female]

Another participant recalled how communication contributes to how close she feels

toward her daughter;

> I guess my daughter, she's the only girl in the home. So we relate really well. She asked me a lot of questions about, "When you were a little girl, what did you do about this?" And I would answer her, how I would handle the situation. So things she's dealing with now she always asks how I handled it. [Participant 4, adult female]

Participants discussed mutual care taking as a supportive part of their attachment

relationship;

> When we went through that crisis, or when we went through decision-making on what was best for our family. We went through a separation and had to move, physically move everything. And I think that we had to walk through that,..Because we had walked through that trauma those experiences helped us feel closer. That we lived with each other and we know we survived all of that and we're still okay. [Participant 6, adult female]

> Oh just cuddling. The cuddling part and sitting down and watching TV together. Or cooking together. Having her help out with the housecleaning stuff. She never you know, my kids never answer back. I said I know that's because of my bringing them up! [Participant 22, adult female]

In coping with trauma, participants also identified aspects of resilience and

perseverance when dealing with remarkable circumstances. One adolescent female,

Participant 17, within the sample discussed her mother's declining health and the way

their relationship was being restored through therapy. The participant and her mother

reported being involved in counseling together and discovering ways to discuss past

traumas (e.g., boarding school experiences and IPV within the home).

> Like her health is dropping. And it's like bringing me closer [to her] because she's finally opening up. And she's finally telling me things like what really happened and why she did this. And not blaming other people. [Participant 17, youth female]

Another participant reflects on aspects of safety and security as a means of connecting with her mother;

> I feel close to my mother…when I feel safe. Umm, being able to call her when I need her makes me feel close to her. [Participant 23, youth female]

Some common thoughts, behaviors, and experiences that impede mother-daughter attachment include re-experiencing traumatic events (e.g., past victimization/abuse).

> Sometimes it feels like she doesn't know what I'm going through. Like I don't know it was when all of that like everything happened. Like going to court and like testifying and getting taken away and all that stuff like she didn't know what was going on. But then I just realized that she does know what happened because she went through it herself. [Participant 21, youth female]

> When I was with my last boyfriend, I kept going back and forth between my Mom's and his house, back and forth, moving back and forth. That was what made me feel distant [from mom]. I knew that they didn't really like him. Well it wasn't him it was more like the way he treated me, they just weren't okay with it. [Participant 19, youth female]

> And I told my daughters…I took enough beatings for all of you kids in my lifetime, I mean to clear you guys of your lifetime of beatings. You know I took'em all you know you guys don't need to be in relationships like that. [Participant 18 adult female]

Although participants identified communication as a strong component of their attachment relationship, some participants had intense reactions;

> I would have to say pretty much everything (contributes to mother and daughter not being close). Well we can't talk. Like I can't just sit down and talk to her. And I can't tell her my problems because it's always my fault. To her everything is my fault. [Participant 3, female youth]

> I feel like, like I don't want to put all my problems on her because her health. Sometimes I'll listen to her but she'll ask me what's wrong. So I'll tell her some but not all of it. [Participant 17, female youth]

When considering the quantitative analyses in conjunction with the qualitative outcomes, the mothers and daughters substance use during IPV-related events was

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associated with experiences of IPV and the mother-daughter attachment bond. One

adult female discusses her difficulty choosing an appropriate mate as her previous

partners have been abusive toward her and her daughters.

I evidently can't pick the right man. But I mean, I don't know if that comes from
how you are raised or what, but there was drinking and violence when I grew up.
[Participant 39, adult female]

Another participant discussed some of the aspects of substance use on her

relationship with her mother.

Me and my mom kind of fell out because we had gotten taken away from her
when we were younger because of abuse in the home. And ah, chemical dependency
problems and stuff like that. [Participant 45, female youth]

I know my grandma was a trouble maker throughout her teenage years. She went
from foster home to foster home cause her mother and grandmother were both
drunks. [Participant 33, female youth]

Furthermore, the mother-daughter dyads in the current sample were more likely

to indicate that they had high rather than low attachment toward one another. As

demonstrated by participants' narratives mothers and daughters provided an array of

ways in which attachment was fortified such as spending quality time with one another,

communication, care taking, and overall support of one another. The participants'

narratives further identified the challenges that impacted their attachment relationships

with one another which often included fighting, re-victimization, and relationship with

partner.

A final theme, IPV/Violence, captured the participants' experiences of IPV and

other related family violence while growing up. The quantitative data regarding the

relation between mothers' and daughters' experiences of IPV and their attachment bond

indicated that there was no association between these variables. An examination of

participants' narratives provided some divergent evidence indicating the potential

negative impact of IPV on the mother-daughter bond. For the purpose of this study,

participants' narratives that encapsulated lessons learned and insights about life were

highlighted. The main category IPV/Violence includes the subthemes Abusive

Behaviors, Sexual Abuse, and Spiritual Abuse. Participant 3 remembered what the

overall impact of intimate partner violence and family substance use had on her

relationship with her mother.

> When I was younger we, my mom and dad were together and they use to drink
> a lot and they would fight a lot. So the cops would come pretty much a lot.
> Finally, social services came and took us all. I have two brothers and three
> sisters. They placed us in different homes. I was the only one with my little
> brother, while everyone else was placed in separate homes. I was one in a half
> two years old. So I was out of the home until I was around 15 when me and my
> younger brother returned home. We [mother and daughter] had a lot of
> conflicts. I didn't know how to be in her home and she didn't know how to be
> our mom. [Participant 3, female youth]

Participant 3 reported mother-daughter conflicts that under normal adolescent

circumstances would be par for the course of natural childhood individuation/separation

stage of development. However, family dynamics and related hardships that surrounded

her and her siblings' removal from their home exacerbated her experience. The

participant's narrative potentially reflects an inability to maintain a substantial mother-

daughter relationship. She identified that she couldn't connect with her mother and that

her mother did not know how to be her mother in turn. This narrative also focused on

aspects of partner substance use that appeared to be a significant predictor within the

quantitative results. The exploratory model 6 demonstrated that the more participants'

partners used substances during IPV episodes the more likely they would experience

IPV. Participants described some of the influences substance use had on members of

their families and communities in general.

> I decided it was one big hurt and that it'd be over someday. But hurt after hurt every time he drank or every time he didn't get his way. [Participant 44, adult female]

> My Mom's family were drunks, druggies and other things. When they, the social security people came and my Grandpa told them to hide and they hid in the bathroom, in the tub and they put a blanket over them. [Participant 37, female youth]

> Alcohol related, drug related they choose to live that kind of life and no responsibilities…don't take care of their kids. Particularly, my brothers,..who have kids all over and they don't take care of them. Instead they party and use drugs. My dad has been an alcoholic all his life and now he is dying from cancer and such…because of bad choices. [Participant 38, adult female]

The complex relationship between substance use and intimate partner violence

has been well established in the literature. The current study revealed strong

associations between partner substance use during IPV-related episodes and increased

IPV experiences. Additionally, there was a linkage between participants' substance use

during IPV-related episodes and the relationship between their experiences of IPV and

mother-daughter attachment. Although the participants' stories did not detail their

direct substance use patterns and specific IPV experiences, the participants did speak

about the implications of substance use broadly in terms of their community as well as

within their families. When exploring the participants' narratives the use of substances

ranged from being a potential coping mechanism to being a staple within some families

or community members' lives was also reported. Another participant reported that

agencies from outside of her community had skewed perceptions of American Indians'

substance use and relationship violence.

They would say well, "All you people do is drink and watch, all you women want to do is drink and sleep with guys…You get what comes. When you sleep with guys and stuff this is what comes. I mean you should handle your own matters, we shouldn't be involved." And, they'd try and put you in this little box that you don't fit in. Because I only drank once in my life and got sick for seven days…I mean, I didn't fit their stereotype. I stayed home and raised my kids, I behaved myself. What they figured I was, I was not. [Participant 39, adult female]

Participant 39's narrative demonstrated the institutional racism that many victims of violence, who are ethnically diverse, contend with while seeking assistance. She was able to recognize that she did not fit the label that many providers likely gave her and she further identified her strengths (e.g., nurturing mother and a responsible individual).

Another participant discussed growing up in an abusive home where she not only witnessed intimate partner violence at the hands of her stepfather but she experienced the abuse as well.

He sexually molested me. Ah and at that time he ended up like getting me pregnant. He ended up getting mad at me [after she disclosed this to her mother and to stepfather] and throwing me down a flight of stairs. And like a week later, I miscarried. [Participant 43, female youth]

Participant 43 reflected on her trauma during her interview and she indicated that it was extremely challenging having to live with what was going on in her home in the past. She further discussed being okay with the removal from her home after trying to reach out to others within the community about her circumstances. The participant reported that it seemed "unbelievable" to even social services that finally intervened.

Well, it really didn't bother me that they were trying to help [social services removed her from the home], but how long   it took them to actually do something about it. I would go to school, tell people, go to powwows and tell people and it was like nobody believed me at first. [Participant 43, female youth]

Many of the participants discussed the implications of remaining in relationships with their partners and figuring out ways to survive. The majority of families endured years

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of torment and trauma. Participant 48, adult, discusses her family's situation in which

her partner's abuse was ritualistic and sadistic.

> For all of us, we just protected each other as much as we could. We were all
> beat up. We were all abused. Even the baby, who is now a teenage boy, he was
> starting to be towards him…We'd, I think we would all try to make him [ex-
> husband] hit, like I would try to make it so he was only mean to me, or the kids
> would try to. Trying to save each other constantly… they knew my ex-husband
> he's a fifth degree black belt in [a form of martial art], so and he, like he can do
> things that you see only Ninjas doing, I mean I'm serious. He can do numb
> chucks, he can do stars, you know he's a lethal weapon within himself. And
> he's crazy. He really is a crazy crazy man!

Participant 50, female youth, was the stepdaughter (Participant 48's biological

daughter) within the abovementioned family and she further identified the ritualistic

abusive behaviors her stepfather demonstrated.

> It wasn't the beatings at first. So we had things like having to balance on a chair.
> Just really weird things. Like if we didn't fold the towels right. I remember one
> night we had to stay up all night with towels on our arms just hanging on our
> arms with our arms out. Just, he was that controlling.

> Many of the participants discussed relying on aspects of their ethnic/cultural

identities and spirituality as means to cope with the horrific experiences they endured.

The women in the study mentioned finding support in traditional, fundamental or

religious institutions, and a combination of traditional Indigenous healing and the

Christian church.

> When I had my breakdown, I never went to church all my life. And then I never
> knew traditional ways. And I ended up going the traditional way and seeing an elder
> and she helped me. And that's how I got better. [Participant 13, adult female]

> I have been encouraged...just basically staying in the word, praying, and seeking
> God's grace. And really looking at some different things in the Bible about healthy
> relationships and what love was and what love isn't. [Participant 4, adult female]

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Sometimes she'll [her mother] bless the house every once in a while. She'll bless us too…Me and my mom, we usually like help serve this dinner at the Powwow to the elders…Which is like really nice. [Participant 37, female youth]

Although quantitative data did not demonstrate an association between ethnic/cultural identity, experienced IPV and mother-daughter attachment relationships some of the ethnic/cultural identity intersections were supported by the participants' narratives. Specifically, participants shared about their ethnic/cultural values, aspects of spirituality and healing.

My family was [traditional indigenous religion], and I guess we were pretty strong in that…And back then they weren't really able to practice traditional ways it could mean persecution and everything else. [Participant 38, adult female]

Yeah we have these ceremonial meetings like every like first of the month..They encourage her [her mother] and most of   our family on my mom's side goes to the ceremonial meetings, they encourage her a lot. [Participant 21, female youth]

We are [traditional indigenous religion],...The culture helped too. Helped us move on and heal. [Participant 32, adult female]

For me deciding to do a documentary [was healing]…Ceremony also really carried me through when my children were   gone too. [Participant 9, adult female]

Another participant discusses her daughter's ethnic/cultural identity development and how she was embracing her Native heritage. The participant further talked about the cultural legacy within her family.

She's very interested in her background because I'm part white and part Indian…My dad is part Norwegian and French and [Northern Plains American Indian tribe]. My mom is [a member of a Northern Plains American Indian tribe]. She [her daughter] is kind of all interested in that because she's amazed by that. And on her father's side..they've got Chief Strong Wind[i]. So she's pretty much in tune with us. She is very respectful regarding her background. [Participant 15, adult female]

A number of women discussed a facet of ethnicity/culture and spirituality that was in fact abusive.

Yes, for the most part it is, but there's a whole, there's another side too. The man that I was married to was supposedly a very traditional man. And he actually used that against us. And tried to tell us that we, if we left him the spirits would tell him where we were and so he kept us there….It's almost as though they want to be your god rather than, you know the real god. [Participant 48 adult female]

Another report of this type of abuse was found in Participant 6 adult female's narrative. She spoke about her and her family's experience with spiritual abuse and indicated that "spiritual and ritual abuse can happen with the misrepresentation of spiritual." She goes on to identify specific modes of transferring misinformation and scare tactics based on spiritual and cultural norms within traditional American Indian communities.

The ceremonies that are happening when somebody misinterprets, or they use that to take power and control over another person. Those things can be used against them. And so the very thing that saved many people can be twisted and turned against them so they are doubly isolated…Well that really happened to me, and to my kids and I really saw that. And even where somebody told me that I was suppose to reproduce with this person, I was to have a child with this person. This was said in the ceremony, 'If you don't do this somebody could die.' I mean those are the things that are said and when you're young and impressionable. If they're [medicine man/woman or /healer] not healthy and balanced, if they're abusive, and they can be. And we do give lots of credit and pay homage and respect to people who carry pipes and have ceremonies and sometime those people are not worthy of that respect and that place we put them. And then we make ourselves vulnerable based on our culture and our belief system.[1]

Participant 6 as well as participant 9 discussed using one's ethnic/culture identity as well as spirituality as buffers to potential negative encounters.

What I taught my kids is when somebody is saying or doing something that makes you uncomfortable and you don't feel like it's safe, that's your spirit talking. Telling you to get away or get out of there. And then when you're hurt there are certain things that you can do. [Participant 6, adult female]

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[1] Pseudonym was used for the identified family member in an effort to keep the participant and her family anonymous.

I believe in traditional ways. I tell my children that it is important to listen to their bodies, it's their spirit talking. 'It's your body's little defense system telling you something is wrong. And that's something you have to listen to.' [Participant 9, adult female]

Finally, participants shared some barriers to accessing support, specifically from

non-Native or mainstream resources.

Well we are connected more so with our culture. And then, mostly because I have trust issues with White religion and White government. We have dysfunction here too but there is just a lot of trust issues regarding White culture. [Participant 38, adult female]

Well I guess the one organization that I worked with a lot was the CVIC. I didn't feel like they did anything really that identified with me as being Native American because when I went to the classes it was in groups. There were was a White person, a Black person, and myself. There wasn't anything specific for ethnicity. [Participant 4, adult female]

A couple of times when it first happened I went through the domestic violence program. But I always ended up going back to him so I just didn't go through with it anymore. I figured you know they were thinking like 'We are helping her again?' [Participant 9, adult female]

It was weird, I didn't like it at first because I wouldn't open up and the staff was getting a little frustrated. I thought I was alone when I really wasn't. When I got to a different facility, I found out that there were other girls like me. There were guys that got abused the same way a woman can. I had no idea. [Participant 17, female youth]

There appear to be a variety of barriers to accessing resources as participants

focused on their experiences of mistrust with majority culture institutions and related

institutional racism they experienced. Participants furthermore identified challenges

associated with the therapeutic process. Many of the participants had difficulty

expressing complicated emotions and discussing traumatic experiences in general;

however, these are common occurrences among most survivors of intimate partner

violence. Although initially participants stated how intimidated they were by the

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subject matter of the research, they were able to share their stories and emerged as empowered. The women and girls often reported feelings of relief as many had not shared certain details of their lived experiences or even thought about their relationships with their mothers and daughters in the context that was presented in the research. Furthermore, when providing the participants with subsequent resources (e.g., mental health, victim's assistance, spiritual healers, etc.) within their communities and outside of their communities the women were encouraged to access and share the information with other families.

CHAPTER V

Discussion

Although there have been significant strides within the field, over the course of

four decades, that have led to IPV being recognized as a public health issue in the

United States, the American Indian/Alaska Native population remains inadequately

represented in the scholarship and research. The purpose of this study was to explore

the impact that IPV had on Northern Plains and Upper Midwest American Indian

mothers' and their daughters' attachment relationships. In this regard, this was the first

study attempting to examine American Indian mother-daughter relationship bonds in

the context of IPV and the further associations with posttraumatic stress symptoms and

ethnic/cultural identity. The study also examined the associations between contextual

variables (e.g., income, education, age, partner and participants' substance use during

IPV-related episodes) and IPV as well as mother-daughter attachment.

The descriptive statistics provide insight into the lived experiences of the

American Indian participants in this study; however, it should be noted that due to the

small sample size cautious interpretations of the outcomes were necessary. The findings

indicate that a majority of the women and girls in the study reported having adverse

childhood experiences (e.g., physical abuse, emotional/verbal abuse, sexual abuse or a

combination of these types of abuse) in addition to later experiences of intimate partner

violence. When considering the unique experiences of American Indians/Alaska

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Natives (AI/AN) and the effects of historical trauma within AI/AN communities as identified in *Chapter 1* there were indications of intergenerational experiences of trauma. The adverse childhood experiences of mothers and daughters within this sample were similar to those found in the literature (American Psychological Association, 1996; McCloskey, DeVos, & New Berger, 1989; Levendosky et al., 2002; Lieberman, 2007; Lieberman et al., 2005; O'Keefe, 1994; Onyskiw, 2003). The patterns identified demonstrate an increased risk of future victimization for the women and girls within the study.

I only recruited participants who reported having a history of intimate partner violence and witnessing intimate partner violence, there were limitations to the generalizability of the sample based on these characteristics. The participants in the current study might have been more willing to volunteer for the study rather than those participants who might be fearful of participating because of their current involvement in violent relationships. Perhaps having a computer based survey that was accessible online could have been made available for Native participants within the communities. Additionally, finding other ways to ensure participants confidentiality in volunteering for the study might have facilitated a broader range of recruitment of victims of IPV. Since this was one of the first studies within the tribe regions included, I made a conservative effort to only focus on limited number victims' experiences rather than potentially cause increased distress within the communities that participated.

Experienced IPV and Mother-Daughter Attachment

The first major finding focused on the participants' reported experiences of IPV and the association with mother-daughter attachment. The hypothesis was not

supported as higher reported experiences of IPV was not associated with higher or lower reported mother-daughter attachment. Although, there wasn't quantitative support of this finding the participants' narratives provide some insight into the mother-daughter attachment bond and the impact of experienced IPV. The participants reported that quality time, care taking, and communication facilitated close relationships among mothers and daughters. The participants' narratives also demonstrated challenges that mothers and daughters experienced which were directly related to IPV. Two key barriers to mothers and daughters attachment bond included repeating the cycle of violence and the relationship with one's partner. Adolescent participants reported having issues with their mothers' current or past abusive partners. Additionally, the girls were able to point out the difference in the quality of their relationships with their mothers when their mothers were not in abusive relationships. Participant 58 reported "I notice we spend more time together when [her mother's partner] is in rehab. We talk more. Even my little sister told my mom it was nice to spend so much time together." Many of the women in the study also discussed the difficulty with supporting their daughters who remained in abusive relationships. Often the adult participants reported wishing their daughters had not repeated the cycle of violence and that they had "taken enough beatings" for their daughters in their own relationships.

According to the conceptual framework of the medicine wheel, there are several imbalances within these Native participants' lives (e.g. relational, emotional, physical, psychological, and spiritual). The participants' experiences of IPV might make it difficult for them to support their immediate family members, extended family, and access community support systems (e.g., tribal police, crisis centers, etc.). Additionally,

adolescent girls impacted by IPV might find it challenging to communicate with their mothers and other supportive family members. Many of the participants in the study attempted to protect one another from knowing about the painful experiences of IPV within their relationships. Mothers and daughters expressed being frustrated with (their mothers' or daughters') choices to not access support from the family or other systems of care, which might have placed some strain on their relationships with one another.

PTSD as a Moderator

Contrary to the literature reviewed in *Chapters 1 and 2*, post traumatic stress disorder symptoms were not associated with the relationship between participants' experienced IPV and the mother-daughter attachment bond. A potential explanation for this outcome is the association between the participants' experienced IPV and the mother-daughter attachment relationship. Research demonstrates that PTSD symptoms are closely associated with IPV and related adverse childhood experiences. Perhaps mother-daughter attachment functioned as a buffer to negative consequences of PTSD symptoms for the participants in the current study. The literature supports the notion that the mother-daughter bond is not associated with stress levels, mother's work related distress, and other factors (Neisser, 1973; Boyd, 1989). The participants' PTSD symptoms were likely circumvented by the high attachment reported by participants.

Ethnic/Cultural Identity as Moderator

Another finding of the current study is the lack of a significant effect of ethnic/cultural identity on the relation between experienced IPV and mother-daughter attachment relationships. The results indicated that ethnic/cultural identity did not function as a buffer between mothers' and daughters' experiences of IPV and their

attachment relationships. The finding was similar to related research attempting to identify an association between American Indian cultural identity and IPV (Gout, 2010). As noted before, the small sample size likely contributed to this outcome as it did not yield sufficient power to find significance. The literature reviewed in *Chapter 2* found support for an association between a maternal self-rated American Indian identity and lower internalizing problems in their children. Findings only approached significance when considering maternal American Indian identity and their children's competence. Additionally, the literature supported the importance of incorporating ethnic identity in the study of parent-child relationships, indicating that it might be a potential buffer to familial and/or societal adversities (LaFromboise & Low, 1998; Glover, 2001). Research further focused on the strengths within ethnic/cultural values that might be imparted from mothers to their daughters through teaching youth how to respond to a racist or hostile environment (Harrison et al., 1990 as cited in Glover, 2001; LaFromboise & Low, 1998; Glover, 2001).

It is possible that the participants in the current study were less reliant on their cultural resources when confronted with experiences of IPV and when managing their attachment relationships with their mothers or daughters. Information from participants' narratives in the current study provided some additional support for ethnic/cultural identity as a safeguard against adverse experiences. Many times ethnic/culture identity and spirituality were interconnected as the women in the study discussed the importance of teaching their daughters to recognize "the spirit" or internal voice related to their culture. Many of the adolescent girls within the study discussed connections to their ethnicity and culture as being essential parts of their overall

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identity development. Mothers and daughters also recounted instances in which traditional cultural ceremonies were a part of their healing from IPV-related experiences. Utilizing a mixed-method approach helped me to better understand ethnic/cultural identity in the context of experienced IPV and mother-daughter attachment.

Contextual variables, experienced IPV, and mother-daughter attachment relationships. When considering contextual variables such as the household income, participants' education, age, their partners' substance use (during episodes of IPV), and their own substance use (during episodes of IPV) in relation to the association between experienced IPV and mother-daughter attachment, there was one major outcome. The participants' substance use during IPV-related events was significantly associated with the relationship between the participants' experiences of IPV and their attachment relationships with one another. One explanation for this finding potentially regards the established attachment styles of the participants. The majority of the mothers and a few daughters in the study experienced IPV; a majority witnessed IPV, and experienced other forms of child maltreatment which might have contributed to an avoidant attachment style. As first discussed in *Chapter 2,* individuals who witness IPV and who have adverse experiences (e.g., relationship violence, child abuse, etc.) are less likely to have secure attachment styles and more likely to maintain avoidant attachment styles over time (Levendosky et al., 2002). Individuals with avoidant attachment styles are more prone to experience increased relationship conflict and might find it difficult to maintain a strong bond. Golder, Gillmore, Spieker et al. (2005) found that women with higher levels of attachment insecurity were more likely

to engage in risky behaviors (e.g., substance use, risky sexual behaviors, etc.) than more securely attached women. From an attachment standpoint the child in an irreconcilable position becomes more than likely to respond with avoidant or disorganized attachment when the parent simultaneously is the source of danger and the source of safety (Hesse & Main, 2006; Lieberman, Van Horn, & Harris, 2005). Additionally, the non-offending parent might not be able to provide security if she herself was victimized or threatened (Dutton, 2000). Mothers who have PTSD tend to be quicker and more impulsive in their reactions toward their children and further misjudge their children's distress (Chemtob & Carlson, 2004). In the participants' narratives some of the barriers to attachment focused on communication, fighting, and relationship with partners. Certain treatment implications should be considered when providing services to clients with similar attachment qualities. Adolescent clients might demonstrate significant resistance toward services and/or the therapist attempting to provide treatment. Additionally, adult women might become defensive and/or overwhelmed in response to the therapeutic process. Trust/rapport building, establishing open communication, and developing realistic expectations around the therapeutic process might help to curtail resistance within the treatment setting. Furthermore, these steps might contribute to the development of skills and qualities associated with secure attachment relationships.

Another explanation for the finding regards the implications entrenched in historical trauma that was reviewed in *Chapter 1*. The historical trauma responses likely contribute to drinking patterns of Native women and girls in ways that might be influenced by the cultural norms and practices of their ethnic and racial group,

biological, and environmental factors (Collins & McNair, 2002). It is possible that adult

females within the study did not have supportive parental and community role models

as a result of the struggles that many Native American families had to endure, which

could have implications for parenting and familial support. The participants' narratives

further support this explanation as many identified inadequate parental figures, violence

as well as substance use within families, impoverished conditions, injustices, and

limited supportive cultural experiences. Some of the mothers within the study might

have found it difficult to fully bond or attach to their daughters; and their daughters

subsequently might not have been able to attach to their mothers. Niyonsenga, Rojas,

Dillon et al. (2010) found that Latino mothers and daughters attachment bond served as

a protective and a risk factor for heavy drinking. The mother might be considered a

powerful enabling social support system that could place the daughter in a high risk

situation for alcohol abuse (Falkin & Strauss, 2003). Corbin et al. (2008) found that

drinking behaviors of same-sex family members may encourage one's drinking

patterns. Galea and colleagues (2004) reported that drinking among social networks

increased the chances of alcohol abuse and dependence. Alternatively, mother's

attachment might function as a protective factor to daughters substance use and

problem behaviors. Essentially, the closeness of a functional and healthy relationship

can reduce their daughters' distress and disengagement (Niyosenga et al., 2010). It

should be noted that a majority of the mothers and daughters in the present study were

four times more likely to be strongly attached to one another which further supports

attachment as somewhat of a buffer to reported experiences of IPV.

Exploratory findings: IPV as independent variable. The following regard the exploratory findings that highlight some of the associations between contextual variables and experienced IPV or mother-daughter attachment. Two notable outcomes were found. Contrary to the literature reviewed in *Chapter 2*, in the current study the participants who graduated from high school were more likely to experience IPV than those participants who had not graduated from high school. A possible explanation for this finding can be found in the cross-cultural research that explored the complex phenomena associated with IPV and female education. Research has demonstrated protection for women at the lowest and highest educational levels (Flake, 2005 Jewkes, 2002). Researchers posit that societies with stronger ideologies of male dominance have more IPV (Flake, 2005; Levinson, 1989). In fact, men who tend to have rather conservative ideologies about the social status of women were more likely to be abusive toward them (Jewkes, Levin, & Penn-Kekana, 2002; Sugarman & Frankel, 1996). Additionally, women who have progressive ideologies, especially regarding gender/sex roles, tended to be at greater risks of IPV (Jewkes, Levin, & Penn-Kekana, 2002; Sugarman & Frankel, 1996). The researchers hypothesized that having some education affirms women enough to challenge certain facets of traditional gender/sex roles; however, such encouragement lends an increased risk of IPV until a high enough level was reached for protective effects to take hold (Flake, 2005). Furthermore, during timeframes of relationship transition women might be at increased risks of IPV (Counts, Brown, & Campbell, 1992; Flake, 2005).

However, an alternative, related explanation for this outcome also reflects a patriarchal perspective: where men were unable to maintain culturally endorsed

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dominance over women, they might resort to IPV to reinstate control (Straus et al., 1980; Flake, 2005). The idea that women with higher statuses than men might become victims of violence at the hands of men might be considered a rather typical occurrence as men more than likely utilize physical aggression to reinforce their dominance (Flake, 2005).

The second important finding in the current research was that partner substance use (during IPV) increased the frequency of participants' experienced IPV, although no specific conclusions can be drawn about the magnitude or intensity of the violence participants endured in the current study. The strong association between partner substance use during IPV-related episodes and increased episodes of IPV was well documented in the literature (see Chapter 1) and similar to the general population findings that increased alcohol use among male partners was associated with increased severity of IPV toward their female partners (Fals-Stewart, Leonard, & Birchler, 2005; Greenfield et al., 1998; Miller, Wilsnack, & Cunradi, 2000; Slade, Daniel, & Heisler, 1991; Thompson & Kingree, 2006). A more culturally representative study involving American Indians revealed that alcohol use was associated with more severe abuse episodes (Norton & Manson, 1997). Robin (1998) also found that 62% of the AI men in the study were using alcohol during IPV episodes. Saylors and Daliparthy (2005) found that Native American women in their study reported being sexually abused by someone who was under the influence of alcohol or drugs in nearly all cases. They also found that half of the Native American women reported that during incidents of IPV they were also using drugs and were at increased risk for contracting HIV. In another study most of the AI women believed the primary cause of IPV on their reservation was

related to alcohol/drinking (Skupien, 1998). Substances used as a coping mechanism for participants and their partners struggling to deal with cultural losses and historical trauma lends even more complexity to understanding the dynamics of IPV within Indian country. As identified in the literature (see Chapter 1), historical injustices, limited power, demoralization, poverty as well as other challenges endured by American Indians/Alaska Natives might contribute to individuals' vulnerabilities and have further implications for alcohol and substance use. It should be noted that specific measures of general substance use were not included in the current research. Limitations regarding the motivation for substance use (e.g., partner forced the substance use, volunteer use of substance, etc.) could provide some insight about the context of the abuse episode. Utilizing substances to cope with experiences of IPV as well as other negative social adversities was commonly found in the literature. Additionally, increased distress within impoverished communities often perpetuates violence within the home, thus contributing to IPV.

The final two outcomes indicated that there were no tribe region differences in either the participants' experienced IPV or in these mothers' and daughters' attachment relationships. The finding suggested that Northern Plains and Upper Midwest American Indians within the current study did not differ in their experiences of IPV or mother-daughter attachment based on their tribe region. The findings might be due to the small sample size, which only captured the experiences of a few members of the identified communities rather than the majority of American Indian women and girls in those areas. The current study might reflect a rather biased sample as only victims and witnesses of IPV were included.

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Alternatively, volunteers for the study might have been different from those individuals who chose not to participate. Perhaps the American Indian women and girls in the current study were more willing to discuss their adverse experiences rather than others in their communities. It should be noted that it was rare for American Indian women and girls within these communities to volunteer for this type of research due to the personal nature of the study (J. Davis, personal communication, September 12, 2011). This important factor adds to the value of this research as the experiences of the Northern Plains and Upper Midwest American Indian women and girls were not overlooked but rather acknowledged and supported. The women's and girls' scores on the measures given did not appear to be extreme scores but rather similar to other ethnic/minority samples' rates of IPV. Additionally, there were some general experiences of victims of violence that resonated within the literature and this study. The adverse experiences that many ethnic/minority women identify with were represented in the current study as evidenced by increased episodes of childhood adversities, linkage between partner as well as participants' substance use and IPV experiences, and historical trauma context providing a broader context of the lived experience of American Indians/Alaska Natives specifically. Some resounding protective factors were also reflected within the research, specifically, the nature of the mother-daughter relationship, ethnic/cultural identity as a valued protective factor, and spirituality as a supportive factor identified by the women's and girls' narratives.

Limitations of Study

There were several limitations to this study. One important limitation was that participants self selected to be in the study based on the inclusion/exclusion criteria.

The participants decided whether they had experienced intimate partner violence (IPV) and/or sexual assault or if they had in fact witnessed IPV and/or sexual assault(s) of their mother. Although the criteria for what constituted intimate partner violence and sexual assault were broad, the criteria could have also included updated forms of IPV such as financial abuse, spiritual abuse, stalking, as well as using the internet (e.g., Facebook, twitter, etc.) or cell phone text messages to follow or harass/discredit the participants. If the aforementioned information had been gathered, a broader understanding of the participants' experiences with IPV could have been captured. Additionally, the magnitude of IPV was not specifically explored within this study. The current study does capture the cumulative effects of IPV, as the literature emphasized the importance of understanding the experiences of IPV as chronic and episodic rather than a narrow view (Smith, Smith, Earp, 1999; Smith et al., 2002). Future research should include specific measures of IPV that reflect the magnitude of victims' experiences such as may be assessed by the use of the Women's Experiences with Battering scale (WEB; Smith, Tessaro, & Earp, 1995).

A second limitation is the small sample size (N= 60, 30 mother-daughter dyads) and norms of the measures. The small size of the sample leads to limited variation in the responses to some of the measures, specifically the post traumatic stress symptom measures and the attachment measures. These measures did not have sufficient Native American/Alaska Native norms to compare with the participants in the current sample. The small sample does not permit generalizability to the population of American Indian women and girls impacted by IPV, although it should be noted that there was considerable similarity between the experiences of the participants in this study and

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those of American Indian/Alaska Native women who were survivors of IPV in similar studies. The sample was purposive, as I only wanted to capture the experiences of American Indian women and their adolescent daughters from the Northern Plains and Upper Midwest regions of the United States. Limited research has been conducted among tribes within these regions; far less attachment research has focused on the experiences of Native women impacted by intimate partner violence in these areas. Although the sample was small as compared to research with majority culture, the impact of the American Indian women and girls who contributed to this study was meaningful. The majority of the collaborative community partners within this study and elders within the communities have indicated the importance of the participants' willingness to share their life stories and lived experiences with an "outsider" in order to bring about awareness and healing (e.g., personal and community). Many of the Native women and girls in the identified communities do not typically volunteer for this type of research that was so personal in nature and potentially re-traumatizing. It should be noted that the process of obtaining tribal council approval to conduct the research, as well as the recruitment of American Indian participants, occurred over a two-year time frame. It was an honor to be a part of the communities' healing process, in some cases, and linking many of the American Indian women and their daughters to local support systems and other resources as needed.

Another limitation within the current study regards the measurement of participants' and their partners' substance use. The current study only assessed discrete time frames for substance use (e.g., during type of IPV) and did not account for patterns of substance use over time, types of substances used, and whether there was coercion

around the substance use. The study could have included the AUDIT and the AUDIT-C to better determine potential substance use problems of the participants. Additionally, the use of a diagnostic interview might have captured specific symptoms of substance abuse/dependency allowing for insight about the participants substance use histories. Specific information obtained could have provided more insight into substance use as a potential coping mechanism for the participants within the study. Additionally, it could have brought about some understanding of the dimensions or scope of substance use or abuse issues within the family in general which is often interconnected with experiences of family violence.

A few additional limitations included the self-report measures as well as the nature and sensitivity of the research involved in this study. The self-report measures used in this research might not have captured the full range of experiences of the participants. Limitations of individual measures trying to tap into various psychological phenomena including trauma, ethnic/cultural identity, and attachment/bonding, might not have fully captured respondents' experiences. It might have been useful to have other reports or measures of the variables of interest to compare in the current study. Additionally, having various reporters (e.g., male partner, other children, other family members within/outside of home, etc.) to corroborate victims' reports might have contributed to the reliability of the participants' responses. However, including the abovementioned potential responders would have been challenging in completing the study in a timely manner and could have potentially caused more harm for the victims within the study. In order to address this limitation only one other witness (participants' daughters) was included within the study to provide some insight into the lived

experience of the victims within the study. Additionally, participants' narratives

provided a wealth of information that offered depth as well as context to the

participants' quantitative responses. I used a mixed-methods approach in the current

study, combining quantitative outcomes with the participants' narratives in an effort to

triangulate the data gathered. The triangulation process was similar to the comparison

of various measures of a particular phenomena and identifying notable patterns that

ultimately contributed to the validity of the study (Jick, 1979; Morrow, 2005).

Initially considering the study focus on IPV in American Indian communities,

when in fact it was often identified as a taboo of sorts, especially with regard to

American Indian/Alaska Natives and other ethnically diverse communities, I was faced

with a number of challenges. The topic was uncomfortable to talk and/or think about;

however, it continues to be pervasive in that it impacts nearly all communities

regardless of race/ethnicity, socio-economic status, class, gender, religion, etc. In the

current study many community partners were interested in the research; however, I

observed some hesitation with regard to referring clients to participate in the study. A

few agencies within the reservations decided not to refer, while others chose to do so.

There was a sense of privacy and keeping one's business to oneself or within the

community, and to that end I respect the boundaries that were established within those

agencies. Additionally, I appreciate the participants who were willing to volunteer their

time and provide some insight into the dynamics of their own homes and life

experiences.

Implications/Recommendations

The results of this study have various implications in the areas of clinical practice, research, and policy.

Clinical implications. One of the primary clinical implications of this study was the need for therapists to be informed about the effects of experiencing as well as witnessing IPV. A therapist must be equipped with the appropriate assessment tools and unique ways to ask personal questions about relationship histories, as well as personal episodes of violence, without making the client suspect of one's inquiry. The therapist must have compassion for clients and the wherewith all to ask more than just one time about relationship violence and/or witnessing family violence. Literature about disclosure of IPV, and witnessing violence, demonstrates that many victims/survivors do not disclose when initially asked about IPV. Additionally, therapists need to have some knowledge about working with American Indian families and their tribal culture. Providing services within AI/AN communities and having some insight about historical trauma and personal experiences that community members' families may have experienced can help facilitate a better context for understanding the communities as well as the women and girls seeking treatment. Furthermore, having some insight about the ethnic/cultural identity of clients can assist with the therapeutic alliance and potential interventions.

Research implications. An established body of research connects adverse childhood experiences (ACEs) (e.g., witnessing family violence, child abuse, partner abuse, parental substance use, parent/family member with mental illness, etc.) to increased health risks in adulthood, higher rates of psychological distress, substance

use/abuse, and an increased likelihood of involvement in relationship violence (Amato & Cheadle, 2005; de Zulueta, 2006; Felitti et al., 1998; Gerke et al., 2006; Menard et al., 2004). Future research focused on some of the intergenerational experiences of American Indians and linkages to ACEs is necessary for the development of culturally appropriate interventions for AI community members. When considering potential protective factors associated with ACEs, attachment and ethnic/cultural identity are most relevant, but the least explored, in public health research. There is evidence that suggests that secure attachment has a positive impact on one's development (Ziv et al, 2004) and is associated with mature cognitive abilities (Allen & Land, 1999), and that securely attached individuals tend to develop healthy friendships as well as romantic relationships (Hazan & Shaver, 1999). A person's sense of identity provides a feeling of connectedness or belonging to a cultural group, which might accordingly lead to a secure base for personal development (Comas-Diaz & Greene, 1994; Evans-Kipp, 2004). Simoni and colleagues (2004) hypothesized that traditional culture influences how AI/AN women experience the effects of childhood sexual abuse, indicating that strong AI/AN identity may be a protective factor. Furthermore, the development of standardized instruments for measuring attachment within the context of American Indian/Alaska Native families might facilitate understanding the unique experiences of these indigenous communities. Previous research suggests that the essential facets of ethnic/cultural identity include attachment to one's culture (e.g., recognizing traditional spiritual practices, speaking their Native language, and engaging in traditional cultural activities); appreciation of their cultural history; and embracing their American Indian/Alaska Native identity (Oetting & Beauvais, 1991; Gout, 2010; Torres-Stone et.

al., 2006; Zimmerman & Ramirez-Valles, 1996; Whitesell et al., 2009). The development of a more robust measure for this construct might facilitate more awareness about the protective elements within the culture and result in the elimination or reduction of IPV-related risk factors. Additionally, qualitative studies and/or ethnographies of traditional indigenous communities can provide cultural and historical context to the experiences of IPV (Gout, 2010).

There is a plethora of research focused on the negative experiences of American Indian/Alaska Natives, which contributes to the demoralization of AI/AN communities. There is a charge for the researchers to focus on the positive aspects of American Indians' experiences. Three well-regarded examples I attempted to follow include a study that conceptualized American Indians' resilience and cultural experiences (Carter, 2011). Another study focused on understanding the interconnections between AI/AN family support and ethnic/cultural identity as protective factors for preventing IPV (Gout, 2010). A final study (Peters, 2011) focused on the Native soul wound, examining aspects of historical trauma among the Waitaha, Maori, and Native Americans. These researchers emphasized the importance of upholding their cultural values within the context of the research they developed. In order to maintain the ethnic/cultural values within American Indian communities it will be important to develop participatory action research that involves tribal members throughout the process of the research. Tehee and Esqueda (2008) provide an excellent example of participatory action research in which they engaged and built trust in an American Indian community as well as obtained adequate information from multiple points of view.

Finally, developing IPV research that includes both partners (including heterosexual, LGBT partners, etc.) in the study might be helpful in obtaining information from both partners' perspectives of the related IPV episodes. Limited research includes couples involved in current IPV. Perhaps research that includes couples who are in treatment or who have had a history of involvement in IPV-related incidents would be appropriate in a therapy-oriented study. Additionally, including other family members (e.g., sons, extended family, elders, etc.) might provide some insight into American Indian/Alaska Natives' attachment relationships among their family and their community, which would provide a broader depiction of attachment. Further examination of attachment within this context would be an excellent contribution to multicultural family psychology research.

Policy implications. The current study provided support for trauma-informed approaches to intervening with AI community members, as a majority of individuals within this study had a history of trauma. Recognizing that individuals with histories of trauma might be more reactive or feel threatened when approached by authority figures (e.g., tribal police, etc.), making sure to respect the boundaries of others is essential. It may be important for law enforcement officers as well as social service providers to incorporate ways to have a more flexible approach when detaining individuals or confronting individuals. In their narratives the participants in the current research identified challenges with tribal communities as well as mainstream social service providers when answering questions about resources. There appears to be a need to develop fair and equitable systems of response to violence. There is a clear need for more support and less judgment around choices made within AI/AN households.

Additionally, linkage to supports (local and off reservations) need to be provided to American Indian victims of violence by all providers who might interact with victims (e.g., law enforcement, medical providers, advocates, therapists, etc.). Many American Indian women and girls within the current study had negative interactions with tribal courts and tribal social services, which facilitated mistrust and limited access to potentially supportive services. If these entities would have been more empathic in their response to victims of IPV, as well as more understanding of their challenges, many participants indicated that they would have been more willing to trust these institutions.

The development of onsite shelters focused on AI women, children, men and the values of AI families as well as communities seems necessary. Many victims of violence within the reservations feel isolated when they leave to access services or support; however, they are willing to endure that because they might feel embarrassed and their safety might be in jeopardy if they remain on the reservation. Incorporating the tribes' values in all that is developed, and evaluating the effectiveness of programming and interactions, will be essential. It will be necessary to hold those in authority accountable for their actions. Injustice was a strong theme identified in the current study, and this was based on participants' overall interactions with authority figures.

Cultural competence and upholding value for all human beings will be essential for community organizations who engage with American Indian victims of violence. Many of the Native women discussed experiences of various levels of victimization with their partners as well as coping with the institutionalized racism inherent in majority culture organizations serving ethnic/minority women. In majority culture

organizations, as well as ethnic/minority-focused agencies, it is necessary to have difficult dialogues about privilege, biases, stereotypes, and acknowledging differences in how ethnic/minority victims are treated versus European American victims who have similar backgrounds or experiences. Education, evaluation of program ideologies, and connecting/collaborating with American Indian IPV organizations might help facilitate aspects of cultural competence within organizations. It is important to be in consultation with Native advocates and organizations so that appropriate cultural brokerage can be facilitated. Assessing the organizations' values and understanding of cultural similarities and differences will be essential.

Conclusion

This study provides some insight into the perspectives of Northern Plains and Upper Midwest American Indian mothers and their daughters who experienced and witnessed IPV. Specific implications of their attachment relationship were explored; however, there is a continued need to examine resiliency, resources and familial supports, using in both science and examination of tribal customs. Future studies should include a component of participatory action research in an effort to understand the diverse cultures and histories inherent in many tribes. Developing a more comprehensive scholarship that is inclusive of American Indian/Alaska Native experiences (e.g., individual, family, and community level responses) will contribute to ending IPV in tribal populations.

Appendices

Appendix A

Informed Consent

TITLE: Intimate Partner Violence and the implication for Northern Plains and Upper Midwest American Indian women and their adolescent daughters' attachment relationships

PRINCIPLE INVESTIGATOR: Julii Green, Doctoral Student
(619)920-3891

DISSERTATION CHAIRPERSONS: J. Doug McDonald, Ph.D.

(701)777-4495

April Bradley, Ph.D.
(701)777-3790

STATEMENT OF THE RESEARCH

This is a research study involving American Indian adult women and adolescents in the northern plains, specifically North and South Dakota and Minnesota. A person who is to participate in the research must give his or her informed consent and assent to such participation. This consent and assent must be based on an understanding of the nature and risks of the research. This document provides information that is important for this understanding. Research projects include only subjects who choose to take part. Please take your time in making your decision as to whether to participate. If you have questions at any time, please ask.

PURPOSE OF THIS STUDY

The purpose of the Intimate Partner Violence and the implications for Native American mother-adolescent dyads' research project is to examine the impact of intimate partner violence on Northern Plains and Upper Midwest Indian mothers' and daughters' relationships. The research focuses on ethnic/cultural identity, attachment (e.g., parental and peer), domestic violence (experience and exposure), and related traumatic experiences.

PARTICIPANTS

Approximately 120 American Indian adult women and their adolescent daughters will take part in this study from tribes in North and South Dakota as well as Minnesota who would like to participate.

LENGTH OF STUDY

Your participation in the study will last until you complete the forms included in the research packet & participate in brief focus group. You will need to complete the forms only one time and time estimated is approximately two hours.

PROCEDURES

If you agree to be in this study, the following will happen:
1. You will be asked to complete several questionnaires. You are free to skip any question you prefer not to answer, but skipped questions do decrease the usefulness of the study.
    A. One questionnaire will ask about some general information (e.g., age, sex, tribe, income, marital status), substances you or your partner are taking, and episodes as well as types of intimate partner violence you have experience and witnessed.
    B. One questionnaire will address how much you identify with Indian or Non-Indian culture.
    C. Two questionnaires will deal with how connected or bonded you are to specific family members and friends.
    D. Two questionnaires will ask about traumatic experiences you either had or have been exposed to during your life (e.g., work, family, health, community)
    E. One questionnaire will ask how you behave and cope with situations.
2. You will also be asked to participate in a face-to-face semi-structured interview where a research assistant will help you complete the set of questionnaires. You will also be asked opened questions and your responses will be audio/video taped. Mothers and daughters will be interviewed separately. We ask (mothers and daughters separately) to discuss their relationships with their (daughters/mothers/families), the influence of their culture and spirituality on their relationships, the impact of domestic violence on their relationships, influence of place of worship on domestic violence in the family, and impact of Native historical events on the family. We will also talk about the kinds of support, if any, that you received and what types of help you need. A member of the research team will help guide the discussion. To protect the privacy of your family member, we will not ask you specific questions about the domestic violence/sexual assault you experienced or witnessed. The semi-structured interview and open ended questions will last about two hours and we will audio or videotape the discussion to make sure that it is recorded accurately. You must agree to be audio/videotaped during the open ended questions, a separate consent is available. The discussion topics will include how relationships between mothers and daughters have been affected by domestic violence, and your thoughts about your culture.
*   Completion of all of these tasks will take about 60-120 minutes. A spiritual healer and a cultural liaison will assist the mental health professional (this researcher) with

follow up support for participants if they request. Additional, resources to help facilitate discussions of family connections and the impact of domestic violence with local mental health supports will be provided.

- The results will be recorded with a code number instead of your name.
- You will receive a list of local and national resources for mental health and a $25 ($50 per dyad) gift card for completing the questionnaires.
- You may withdraw from the study at any time by letting the research assistant that you no longer wish to participate, however, once you turn in the materials there is no way to identify your forms to remove it from the study.

RISKS OF THE STUDY

You may experience frustration that is often experienced when completing surveys. Some questions may be of a sensitive nature, and you may therefore become upset as a result. However, such risks are not viewed as being in excess of "moderate risk."

If, however, you become upset by questions, you may stop participation in the focus group at any time or choose not to answer a question. If you would like to talk to someone about your feelings about this study, you are encouraged to contact, your local IHS Behavioral Health Unit, call 2-1-1 for information and referral in your area, or the mental health crisis line at 1-800-273-8255. For those who are clients of the behavioral health clinics, please feel free to discuss this distress or concern with your counselor. For those who are not clients of behavioral health clinics, we are also including a list of local resources and national hotlines you can access to discuss your concerns. You can also call the researcher and her associates if you need to discuss this distress at 619-920-3891.

BENEFITS OF THIS STUDY

You may benefit from being in this study by becoming aware of how domestic violence and/or sexual assault have impacted you and how you have coped. The implications of the current study will increase awareness about intimate partner violence in Indian country and provide potential links to a variety of factors such as family bond/attachment, socioeconomic status, acculturation/identity, trauma, and adolescents' behavior responses. The current study will assist the reservations by identifying available resources (e.g., community healers, mental health professionals, parenting resources, etc.). The results of the research will likely provide tribal communities with information that will help providers establish culturally appropriate treatment for potential victims of family violence (victims, batters, and witnesses). The outcomes of the current study will be provide to each tribal council and specific recommendations for policies related to intimate partner violence will also be provided. In addition, the outcomes will provide partnerships with local Victims Assistance Programs and Abuse councils with insight about American Indian women's experiences related to intimate partner violence. As a final point, American Indian women and adolescents will have an opportunity to gain awareness of their own experiences related to family violence and available support systems (e.g., community agencies, cultural healers, mental health providers, medical providers, etc.).

COST TO PARTICIPATE IN THIS STUDY

You will not have any direct costs for being in this research study other than the time involved in completing the questionnaires.

PAYMENT FOR PARTICIPATING

You and your adolescent daughter will receive a $25 gift card (total $50 per dyad) for being in this research study. When you complete the questionnaires and answer the open-ended questions, you will receive a gift card from the person who interviewed you. If you interviewed over the phone, the gift cards will be mailed to you or available at the Victims Assistance Program on-site. If you leave before the open-ended questions are answered, you will receive a $12.50 gift card in the mail.

CONFIDENTIALITY

The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. The UND Research Development and Compliance office and the University of North Dakota Institutional Review Board may review your study record.

In addition, your participation in the semi-structured interview indicates that you agree to keep the discussion of the session confidential in an effort to respect the privacy of each participant's experience. We discourage the discussion of others personal experiences without their specific permission.

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of the informed consent with your name will be separated from other coded materials at the clinic site where you complete them. They will be totally separated from any information from your site once received by the researcher or her associates. Informed consent and completed questionnaires will be stored in separate locked cabinets in the Psychology Department at the University of North Dakota. To keep your information safe, the audio or videotape of the open-ended questions will be placed in a locked file cabinet until a written word-for-word copy of the discussion has been created. The researchers will enter study data on a computer that is password-protected. To protect confidentiality, your real name and your family members' name will not be used in the written copy of the discussion. The researchers intend to keep this study data indefinitely, however, audio or videotapes will be erased/destroyed after they are transcribed. If we write a report or article about this study, we will describe the study results in a summarized manner so that you cannot be identified.

VOLUNTARY PARTICIPATION

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which

you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with the University of North Dakota.

If you decide to leave the study before completing the materials, we ask that you inform the person you return the materials to so they can appropriately mark the envelope to not be included in the study.

CONTACTS INFORMATION

The researchers conducting this study are Julii Green, M.S. and her advisors. You may ask any questions you have now. If you later have questions, concerns, or complaints about the research please contact *Julii Green, M.S*. at *619-920-3891, Dr. Doug McDonald* at *701-777-4495,* and *Dr. April Bradley* at *701-777- 3790* during the day.

If you have questions regarding your rights as a research subject, or if you have any concerns or complaints about the research, you may contact the University of North Dakota Institutional Review Board at (701) 777-4279. Please call this number if you cannot reach research staff, or you wish to talk with someone else.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

I have read and understood the research project explained above. Anything that wasn't clear to me was explained so I could understand it. If I have any other questions later, I can have these answered too. I understand that I don't have to help with the project even if my parent(s) or guardian(s) say that it is all right. Even if I decide to do the things I will
be asked to do, I can change my mind later and that will be OK. I have decided I want to help with the project.

Adult Participants Name: _____ _____ _____

                            Print   Signature of Participant   Date

Youth Participants Name: _____ _____ _____

                            Print   Signature of Participant   Date

UNIVERSITY OF NORTH DAKOTA IRB
AUDIO/VIDEOTAPE ADDENDUM TO CONSENT FORM

You have already agreed to participate in a research study entitled: Intimate partner violence and the implications for Northern Plains American Indian mother—daughter dyads' attachment relationships conducted by Julii Green, M.S. (principal investigator), faculty advisors Drs. J. Doug Mc Donald and April Bradley, and a research assistant (undergraduate working toward a B.S./B.A.). I am asking for your permission to allow us to both audio and/or videotape as part of the open-ended questions portion of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

In addition, your participation in answering the open-ended questions indicates that you agree to keep the discussion focused on the questions. All information recorded will be held in confidence in an effort to respect the privacy of each participant's experience.

The recording(s) will be used for analysis by the research team. The recording(s) will include your first name as an initial identifier for this investigator. The videotape recordings will include full facial pictures.

The recording will be stored in a locked file cabinet, linked with a code to your identity, and will be destroyed (erased) or a videotape will be demagnetized following transcription. No identifying information will be included in the transcription.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participants Name: _____ _____ _____

                      Print   Signature of Participant   Date

Participants Name: _____ _____ _____

                      Print   Signature of Participant   Date

Appendix B

Demographic Questionnaire (Adult & Adolescent)

Demographic/Background Questions (ADULT)

1) What is your date of birth (month/day/year)?
   Age_____

2) What is your Culture/Ethnicity/Race?
   1) American Indian _____   1a) Tribal Affiliation_____

   2) Latino/Hispanic_____   3) Asian/Pacific Island___

   4) African American_____   5) White/Caucasian_____

   6) Multiracial/Biracial_____

3) What is your Gender/Sex?

4) What is your current relationship status?
   Single_____   Separated/Divorced_____
   Partner/Boyfriend/Girlfriend_____ Widowed_____
   Married_____   Living with partner_____

5) What is the highest grade in school you have completed?
   55= Kindergarten
   01= Elementary school (1st-5th grade)_____
   02= Middle school (6th-8th grade)_____
   03= High School (9th-12th grade)_____
   04= Vocational/ technical
   05= Some college
   06= Graduated College
   07= Graduate School/Professional

6) Please complete the following table:

Identify the child/children participating in the box with (*) and then add information about any additional children you have or who are living in the home.

Child's Birthday & (Mo/date/year) Age	Child's relationship 1)Natural child 2)Adopted child 3)Step child 4)Other (e.g., Foster, describe)	Child's Gender 1) Female 2) Male	What is your child's Culture/Ethnicity/Race 1)American Indian 1a)List Tribal Affiliation 2)Latino/Hispanic 3)Asian/Pacific Island 4)African American 5)White/Caucasian 6)Multiracial/Biracial
*Child 1 D.O.B.: AGE:	1__ 3__ 2__ 4__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
*Child 2 D.O.B.: AGE:	1__ 3__ 2__ 4__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
*Child 3 D.O.B.: AGE:	1__ 3__ 2__ 4__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Child 4 D.O.B.: AGE:	1__ 3__ 2__ 4__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Child 5 D.O.B.: AGE:	1__ 3__ 2__ 4__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Child 5 D.O.B.: AGE:	1__ 3__ 2__ 4__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___

7) Who were you primarily raised by?

8) What was the total household income before deductions for past year?
  1. Less than $5,000
  2. $5,000-$9,999
  3. $10,000-$14,000
  4. $15,000- $19,999
  5. $20,000-$24,999
  6. $25,000-$29,999
  7. $30,000-$39,999
  8. $40,000 and over

9) Have you ever witnessed physical/sexual/emotional/verbal abuse
         while growing up in your home?

         Yes_____   No_____

10) Where you ever a victim of physical/sexual/emotional/verbal abuse
             while growing up in your home?

         Yes_____   No_____

The following questions are about dishonoring women in relationships through domestic violence. When answering think about your relationship with your current t partner/husband/boyfriend. Also answer the question considering your past two partners/husbands/boyfriends as identified below.

In your current relationship have you ever experienced….

11) Physical abuse (kicking, punching, beating, physically overpowered)
     by a partner/husband?   # of times during
                                                   relationship
         Yes _____   No _____   _____

         Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

         11a) In your last relationship did this occur?
                                           # of times during
                                           during relationship
         Yes _____   No _____   _____

         Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

         How many (# of years)_____ and/or (#of months)_____ were in the
                                                            relationship?

11b) In your relationship before that one did physical abuse occur?

                                                  # of times during
                                                  during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the
                                                                   relationship?

12) Emotional & Verbal abuse (public humiliation, name calling, mind games, and manipulation) by a partner?

                                                  # of times during
                                                  during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

12a) In your last relationship did this occur?

                                                  # of times during
                                                  during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the
                                                                    relationship?

12b) In your relationship before that one did emotional& verbal abuse occur?

                                                  # of times during
                                                  during relationship

Yes _____   No _____   _____
Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

13) Isolation (partner limits contacts with friends, family, community, and coworkers) by a partner?

                                          # of times during
                                          during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

13a) In your last relationship did this occur?

                                          # of times during
                                          during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the relationship?

13b) In your relationship before that one did isolation occur?

                                          # of times during
                                          during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the relationship?

14) Threat or Intimidation (Threats of violence, suicide, or taking away the children) by a partner?

                                          # of times during
                                          during relationship

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

14a) In your last relationship did this occur?

                                    # of times during
                                    during relationship

 Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the relationship?

14b) In your relationship before that one did threat or intimidation occur?

                                      # of times during
                                    during relationship

 Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

15) Sexual assault or Rape (unwanted or forced sexual acts/intercourse) by a partner?

                                      # of times during
                                    during relationship

 Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

15a) In your last relationship did this occur?

                                      # of times during
                                    during relationship

 Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the relationship?

15b) In your relationship before that one did sexual assault or rape occur?

<div align="right"># of times during
during relationship</div>

Yes _____   No _____   _____

Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

How many (# of years)_____ and/or (#of months)_____ were in the relationship?

Demographic/Background Questions
(DAUGHTERS/ADOLESCENTS)

1) What is your date of birth (month/day/year)?
   Age_____

2) What is your Culture/Ethnicity/Race?
   1) American Indian _____   1a) Tribal Affiliation_____

   2) Latino/Hispanic_____   3) Asian/Pacific Island___

   4) African American_____   5) White/Caucasian_____

   6) Multiracial/Biracial_____

3) What is your Gender/Sex?

4) What is your current relationship status?
   Single____   Partner/Boyfriend/Girlfriend_____
   Married_____   Living with partner_____

5) What is the highest grade in school you have completed?
   55= Kindergarten
   01= Elementary school (1st -5th grade)_____
   02= Middle school (6th-8th grade)_____
   03= High School (9th-12th grade)_____
   04= Vocational/ technical
   05= Some college
   06= Graduated College
   07= Graduate School/Professional

6. Please complete the following table: Identify who lives in your home.

Person's Age	Relationship 1)Mother 2)Father 3)Sister 4)Brother 5)Other (e.g. grandma/pa, your child.. describe)	Person's Gender 1) Female 2) Male	What is the person's Culture/Ethnicity/Race 1)American Indian 1a)List Tribal Affiliation 2)Latino/Hispanic 3)Asian/Pacific Island 4)African American 5)White/Caucasian 6)Multiracial/Biracial
Person 1 : AGE:	1__ 4__ 2__ 5__ 3__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Person 2: AGE:	1__ 4__ 2__ 5__ 3___	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Person 3 : AGE:	1__ 3__ 2__ 4__ 3__	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Person 4 : AGE:	1__ 4__ 2__ 5__ 3___	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Person 5 : AGE:	1__ 4__ 2__ 5__ 3___	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___
Person 6 : AGE:	1__ 4__ 2__ 5__ 3___	1__ 2__	1__ 1a_____ 2__ 3__ 4__ 5___ 6___

7) Who were you primarily raised by?

8) Have you ever witnessed physical/sexual/emotional/verbal abuse
while growing up in your home?

Yes_____   No_____

9) Where you ever a victim of physical/sexual/emotional/verbal abuse
while growing up in your home?
Yes_____ No_____

The following questions are about dishonoring women and girls in relationships through domestic violence. When answering think about your relationship with your current partner/boyfriend. Also answer the questions considering your

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mother's relationships (current and past two partners/husbands/boyfriends as identified below).

In your current relationship have you ever experienced….

10) Physical abuse (kicking, punching, beating, physically overpowered) by a partner/boyfriend/other?   # of times during
                                                                                                during relationship & years in
                                                                                                relationship

Yes _____   No _____   _____

    10(a1) Were (you/your) partner… using any substances (e.g., alcohol, marijuana, methamphetamine during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

    10 (a2) In your last relationship did physical abuse occur?
                                                                                # of times during
                                                                                 during relationship & years in
                                                                                 relationship
Yes _____   No _____   _____

    10 (a3) In your relationship before that one did physical abuse occur?
                                                                                # of times during
                                                                                during relationship & years in
                                                                                relationship
Yes _____   No _____   _____

    10 (b1) In your mother's current relationship have you witnessed this?
                                                                                # of times during
                                                                                during relationship
Yes _____   No _____   _____

10(b2) In your mother's last relationship did you witness this?
                                                                                # of times during
                                                                                during relationship
Yes _____   No _____   _____

11) Emotional & Verbal abuse (public humiliation, name calling, mind games, and manipulation) by a partner/other?
                                                                                # of times during
                                                                                during relationship
Yes _____   No _____   _____

11(a1)Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

11(a2) In your last relationship did this occur?

                                                            # of times during

          Yes _____   No _____

11(a3) In your relationship before that one did emotional& verbal abuse occur?

                                                            # of times during
                                                            relationship & years in
                                                            relationship
          Yes _____   No _____   _____

11(b1) In your mother's current relationship have you witnessed this?
                                                            # of times during
                                                            during relationship
          Yes _____   No _____   _____

 11(b2) In your mother's last relationship did you witness this?
                                                            # of times during
                                                            during relationship
          Yes _____   No _____   _____

12) Isolation (partner limits contacts with friends, family, community, and coworkers) by a partner?
                                                            # of times during
                                                            during relationship
          Yes _____   No _____   _____

12(a1)Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

12(a2) In your last relationship did this occur?
                                                            # of times during
                                                            during relationship & years in
                                                            relationship
          Yes _____   No _____   _____

12(a3) In your relationship before that one did isolation occur?

                                    # of times during
                                    during relationship & years in
                                    relationship

     Yes _____   No _____   _____

12(b1) In your mother's current relationship have you witnessed this?

                                    # of times during
                                    during relationship

     Yes _____   No _____   _____

12(b2) In your mother's last relationship did you witness this?

                                    # of times during
                                    during relationship

     Yes _____   No _____   _____

13) Threat or Intimidation (Threats of violence, suicide, or taking away the children) by a partner?

                                    # of times during
                                    during relationship

   Yes _____   No _____   _____

13 (a1)Were (you/your) partner using any substances (e.g., alcohol, marijuana, methamphetamine, etc.) during any occurrences? Estimate the number of times that you _____ & your _____ partner were using.

13(a2) In your last relationship did this occur?

                                    # of times during
                                    during relationship & years in
                                    relationship

     Yes _____   No _____   _____

13(a2) In your relationship before that one did threat or intimidation occur?

                                    # of times during
                                    during relationship & years in
                                    relationship

     Yes _____   No _____   _____

13(b1) In your mother's current relationship did you witness this?

                                    # of times during
                                    during relationship

     Yes _____   No _____   _____

13(b3) In your mother's last relationship did you witness this?

                                       # of times during
                                         during relationship

Yes _____   No _____   _____

14) Sexual assault or Rape (unwanted or forced sexual acts/intercourse)
     by a partner?

                                         # of times during
                                         during relationship

Yes _____   No _____   _____

14(a1)Were (you/your) partner using any substances (e.g., alcohol,
marijuana, methamphetamine, etc.) during any occurrences? Estimate
the number of times that you _____ & your _____ partner were
using.

14(a2) In your last relationship/past did this occur?

                                       # of times during
                                       during relationship & years in
                                       relationship

Yes _____   No _____   _____

14(a3) In your relationship before that one did sexual assault or rape
      occur?

                                         # of times during
                                         during relationship & years in
                                         relationship

Yes _____   No _____   _____

14(b1) In your mother's current relationship have you witnessed this?

                                         # of times during
                                         during relationship

Yes _____   No _____   _____

14(b2) In your mother's last relationship did you witness this?

                                         # of times during
                                         during relationship

Yes _____   No _____   _____

Appendix C

Interview Questions

- How was your experience responding to questions about your relationship with your (child/mother)?

- What is a life lesson you learned from your (e.g., child/mother)?

- What types of experiences help you feel closer to your (child/mother/family)?

- What thoughts/behaviors make you feel distant from your (child/mother/family)?

- Is your (child/mother) active in the church (e.g., Catholic, or fill in_____)/place of worship's community and teachings (e.g., practice in the home)?

- What role has the church or place of worship played in your family's response(s) to family violence (e.g., encourage you to stay, provided resources, etc.)?

- How do your family members respond to family violence?

- Have you accessed local social services, victim's assistance programs, tribal police, etc. in response to the family violence?

- Has your family (grandparents, aunties, mother/father) been impacted by the following federal laws: Termination, Relocation, Child removal (social services—boarding schools….foster care), and Loss of lands-Allotment

Appenix D

Qualitative Codes

Codes derived from interviews

Main Category/Theme	Subtheme
1) Historical Trauma	1.a) Boarding school experiences
	1.b) Alcohol/Substance related experiences
	1.c) Coping with Crisis
	1.d) Injustice/Oppression
2) Attachment	2.a) Quality time
	2.b) Care taking
	2.c) Communication
2a) Barriers to Attachment	2.d) Overprotection
	2.e) Anger
	2.f) Arguments
	2.g) Inability to communicate
	2.h) Fighting
	2.i) Lying
	2.j) Repeating cycle of violence
	2.k) Relationship with partner
3) Violence/Abuse	3.a) Abusive Behavior
	3.b) Spiritual Abuse
	3.c) Self Harm/Suicide Ideation (In context of Abuse/IPV)
4) Spiritual/Religious Support	4.a) Traditional Indigenous Practices
	4.b) Formal Church/Religion
	4.c) Combination of Traditional and Formal Church
	4.d) No Affiliation
	4.e) Struggling with spiritual belief
5) Resources-Response to IPV	5.a) Advocate/Victims Assistance
	5.b) Counseling/Therapy
	5.c) State/Federal Government
	5.d) Traditional Medicine/Traditional Healer
	5.e) Tribal Council/Government
	5.f) Tribal Police
	5.g) Tribal Social Services
	5.h) Others
	5.i) No Assistance /Help

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Codes derived from interviews (Cont.)

Main Category/Theme	Subtheme
6) Self/Family Response to IPV	6.a) Supportive
	6.b) Adapting & Living In Two Worlds
	6.c) Scared
	6.e) Mad/Upset
	6.f) Sad
	6.g) Encouraged to Stay
	6.h) Emptiness
\	6.i) Kept Emotions Inside/To Self
	6.j.)Fight
	6.k) Nothing
	6.l) Not Aware of IPV
	6.m) Life on the Reservation

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