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Intimate Partner Violence in the Lives of Urban Wisconsin American Indian Women- a Continuation of Colonial Injustice

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DOCTORAL DISSERTATION:

INTIMATE PARTNER VIOLENCE IN THE LIVES OF URBAN WISCONSIN AMERICAN INDIAN WOMEN- A CONTINUATION OF COLONIAL INJUSTICE

by

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ABSTRACT

INTIMATE PARTNER VIOLENCE AGAINST WISCONSIN AMERICAN INDIAN WOMEN: A CONTINUATION OF COLONIAL INJUSTICE

by

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American Indian women experience intimate partner violence (IPV) at a disproportionately higher rate than any other population, including during the pregnancy period (Bohn, 2002; Burnette, 2016; Kvinge et al., 1998; Robin, et al., 1998). IPV is associated with a range of trauma-related health and mental health impacts. Existing literature largely focuses upon the experiences of violence in the lives of American Indian women living on reservations or in rural areas, even though 70 percent of AI women live in urban areas in the United States. To address this gap, this qualitative study was conducted to deepen our understanding of urban American Indian women's individual lived experiences with IPV; to better understand their unique health needs after experiences of IPV; and to determine the impacts of IPV on their health and wellbeing.

In this critical ethnographic study data from semi-structured individual interviews were collected with 34 AI women survivors living in urban areas in Wisconsin. These data were analyzed using thematic analysis. The study was informed by postcolonial and Indigenous feminist theories to frame our understanding of the contexts in which American Indian women experience IPV. Findings from this study revealed how IPV uniquely manifests in the lives of urban AI women, including during the pregnancy period. Additionally, the COVID-19

pandemic served to exacerbate barriers American Indian women face to help seeking after experiences with IPV. These findings contribute to a critical analysis of the intersecting complexities that impact help-seeking for urban American Indian women. From a postcolonial and Indigenous feminist perspective, the structural barriers that inhibit help seeking for women are deeply rooted in a history of colonization and the intersection of racism, sexism and poverty. This analysis not only fills a gap in the literature but can also contribute to the development of context specific interventions that are urgently needed to ensure that American Indian women obtain the necessary services following experiences of IPV in order to reduce its devastating impacts.

TABLE OF CONTENTS

LIST OF FIGURES

This dissertation is dedicated to the memory of Kozee Medicinetop Decorah and to the strong, amazing, and resilient women who entrusted me with their powerful stories of survival. Your voices matter in helping to make meaningful changes to break the cycle of violence.

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CHAPTER I: INTRODUCTION

Statement of Problem

Violence against women is a widespread social, public health, and human rights issue. The right to live free from violence is one of the most fundamental rights of a human being, a right that is a key component in internationally recognized documents such as the Universal Declaration of Human Rights. This right is not always true for American Indian women (LeMay, 2018). Violence, particularly intimate partner violence (IPV), against American Indian women is one of the most serious public health issues occurring in American Indian communities today. Although all types of violence against women is an international concern, this dissertation focuses upon IPV that is victimized against American Indian women in the United States.

The incidence of IPV against women is greatest among American Indians than any other racially defined group (Finfgeld-Connett, 2015). The 2010 National Intimate Partner and Sexual Violence Survey (NISVS) report conducted by the National Institute of Justice, reveals that more than 4 in 5 (84.3%) American Indian women have experienced violence in their lifetime (Rosay, 2016). More than half (55.5%) of the women reported physical violence by an intimate partner. Additionally, 66.4% of American Indian women reported being psychologically or emotionally abused by an intimate partner. The study also found that more than one in three (39.8%) American Indian women experienced violence within the past year (Rosay, 2016). American Indian women also experience one of the highest rates of homicide in the US. Nearly half, or 46.6% of American Indian women who were murdered were victims of violence, often at the hand of an intimate partner (Petrosky, Blair, Betz, Fowler, Jack, & Lyons, 2017). Although statistics and data may define the scale of the problem of IPV against American Indian women, the numbers do not convey the highly personal experiences of this crisis. The dire statistics only

tell a part of the story, but then fails to account for the devastating and lasting impacts that IPV has on survivors and American Indian families and communities, whether in urban areas or on reservations.

IPV is defined as any act or behavior within an intimate relationship that results in physical, psychological, or sexual harm to those within the relationship (World Health Organization, 2013). IPV is a form of systematic violence that a perpetrator uses as a means to obtain or maintain a sense of power and control over a victim (Overstreet & Quinn, 2013). IPV involves the subjection of a partner to types of abuse such as physical abuse, psychological abuse, sexual violence, and sexual abuse or reproductive coercion. Physical abuse includes the throwing of objects, pushing, kicking, biting, slapping, strangling, hitting, beating, threatening with any form of weapon, or actually using a weapon. Mental or psychological abuse includes things such as harassment; verbal abuse such as name calling, degradation, and blaming; threats, and stalking (World Health Organization, 2013).

Emotional abuse may include isolating the woman from family and friends and/or depriving her of food, money, transportation, and access to health care. Sexual violence includes a continuum of sexual activity that covers unwanted kissing, touching, or fondling; sexual coercion; and rape. Reproductive coercion involves behavior used to maintain power and control in a relationship related to reproductive health and can occur in the absence of physical or sexual violence. A partner may sabotage efforts at contraception, refuse to practice safe sex, intentionally expose a partner to a sexually transmitted infection (STI) such as human immunodeficiency virus (HIV), control the outcome of a pregnancy (by forcing the woman to continue the pregnancy or to have an abortion or to injure her in a way to cause a miscarriage), forced sterilization, or control access to other reproductive health services (World Health Organization, 2013).

American Indian women are at increased risk for IPV during pregnancy. Violence during pregnancy may negatively impact birth outcomes such as miscarriage, delayed prenatal care, premature labor or birth, fetal injury, small for gestational age infants, or stillbirth (Center for Disease Control, 2016). Contrary to common belief, pregnancy does not prevent the occurrence of intimate partner violence. According to a 2010 World Health Organization (WHO) multi-country study on women's health and violence against women, the majority of women who reported physical abuse during pregnancy had also been abused prior to pregnancy. Even more concerning was that about half of the respondents stated that they were abused for the first time during a pregnancy (García-Moreno, et. al., 2015).

American Indian women experience violence by both Indian and Non-Indian men; however, IPV is perpetuated mostly by non-Indian men. Specifically, the NISVS study found that 78% of IPV against American Indian women was committed by Non-Indian men (Rosay, 2016). This highlights the fact that IPV is not an intraracial problem amongst American Indians, but rather reinforces that this is a symptom of the larger issue of colonization and violation of American Indian women by men of other ethnicities.

IPV against women is associated with a range of trauma-related health and mental health effects. IPV against women disrupts and impacts the environment in which she lives, causing a woman to feel unsafe, ungrounded, and fearful within her mental or physical environment. Additionally, women who have been victims of IPV may experience adverse physical and mental health effects. There is clear and consistent evidence within the literature that supports the relationship between women that experience IPV and the existence of chronic health conditions (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Stockman, Hitomi, & Campbell, 2014).

Ongoing or repeated instances of IPV against women has been associated with depression, anxiety, and post-traumatic stress disorder (Evans-Campbell, Lindhorst, Huang, &

Walters, 2006; Childress, 2013; Stockman, Hitomi, & Campbell, 2014). In addition to depression, anxiety, and PTSD, evidence strongly suggests that experiencing IPV increases the risk of other mental health conditions, including self-harming behavior, suicidal ideation, eating disorders, and other anxiety and mood disorders, substance abuse, and sleep disturbances (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Childress, 2013). Without intervention, repeat acts of violence may also lead to serious injury or even loss of life (Burnette, 2015a). Women may also experience decreased production and quality of life as a result of violence, which could impact other areas of life such as employment, education, and self-care (Stockman, Hitomi, & Campbell, 2014).

The disproportionate rates of violence against American Indian women has gained more national attention in the past few years (Amnesty International, 2007; Committee on Indian Affairs, 2007; United Nations, 2013; Urban Indian Health Institute, 2018; CDC, 2018). A common thread within the explanations for the disproportionate rate of IPV and other types of violence against American Indian women is the impact of colonization on the contemporary realities of American Indian women. Amnesty International (2007) states "Indigenous peoples in the USA face deeply entrenched marginalization- the result of a long history of systematic and pervasive abuse and persecution" (p. 13). As the original inhabitants of this land, now called the United States, American Indians are the most impacted by colonization. This dissertation will discuss these root causes, colonial history, and intersections of historical trauma, structural violence, and sociopolitical factors driving the high rates of IPV against American Indian women. The postcolonial and Indigenous feminist perspective that guides the methodological approach of this dissertation situates inequities and IPV against American Indian in the historical, legal, social, political, and economic contexts in which they arise. This activist approach to research will help to unmask the ways in which current research and healthcare

discourses may continue to constrain, rather than improve access and care to medical and support services for American Indian victims of IPV (Browne, A., & Smye, V., 2002). Context is key in providing meaningful and humanistic care to those most vulnerable. Without considering the contexts in which IPV occurs, nurses and allied health professionals run the risk of making assumptions or judgements against their patients that can cause harm by perpetuating negative and oppressive stereotypes.

Purpose of the Study

The purpose of this qualitative dissertation study is to explore the perceptions of IPV among American Indian women living in Wisconsin to better understand the individual lived experience and the impacts of IPV on health, wellbeing, and pregnancy outcomes. This study will address gaps in the literature surrounding the phenomenon of IPV against American Indian women, specifically American Indian women residing in urban areas in Wisconsin. To date, there are currently no studies published about the incidence or prevalence of violence, nor the individual lived experience of IPV against American Indian women in Wisconsin.

Capturing the lived experience of IPV against American Indian women is necessary to understand their experiences as victims of IPV in the local context as well as rooted in contemporary realities. This is essential because gender-based violence such as IPV, is shaped by one's social position within historical and current intersecting systems of oppression (Connell & Messerschmidt, 2005). This study will also address the impacts and limitations of the Violence Against Women Act (VAWA). Findings of this study can be used to assist tribes to establish functional tribal courts in order to prosecute perpetrators. Exploring and understanding the root causes of IPV against American Indian women can also be used to inform policy, and the creation of best practice recommendations, and culturally safe screening and interventions for healthcare practitioners who work with American Indian victims and survivors of IPV.

Positionality

My justification for this study is both personal and professional. My personal justification stems from my positionality as an enrolled member of the Bad River Ojibwe tribe, as a nurse researcher, as well as my experience as an IPV survivor. Conducting this study is also important to me, because as stated previously, the incidence of IPV is higher against American Indian women than any other racial group in North America. A dissertation study that explores the stories and experiences of American Indian IPV victims will help to enhance the understanding of individual lived experiences of violence in the local context.

Research Aims

Specific aims of this study include: 1. To deepen our understanding of the individual lived experience of IPV in the lives of American Indian women in urban areas, 2. To better understand the unique needs of American Indian women living in urban areas (Milwaukee and Fox Cities). 3. To determine the impacts of IPV on the health and wellbeing of American Indian women. 4. To determine the impacts of violence against American Indian women on the health and well-being of urban American Indian communities.

Research Questions

The research questions that will guide this dissertation study are as follows:

1. What is the lived experience of IPV in the lives of American Indian women living in urban areas, 2. What are the health needs of American Indian women residing in urban areas after an experience with IPV. 3. What are the impacts of IPV on the health and wellbeing of American Indian women. 4. What are the impacts of IPV against American Indian women on the health and well-being urban and American Indian communities.

Importance of the Study to Knowledge Development, Nursing Practice, and Policy

The use of postcolonial and Indigenous feminist frameworks in guiding this study offers

new insights into the highly complex barriers that AI women living in urban areas face when seeking help after experiencing IPV. Postcolonial and Indigenous feminist frameworks center voices AI survivors who have lived IPV experience within the sociopolitical contexts of IPV. AI survivors who have experienced IPV are the experts on what they need in terms of interventions, therefore, it is crucial for their voices to be heard.

Findings from this qualitative study can be used for the promotion and development of culturally safe interventions to reduce the burden of IPV and prevent injury and death due to IPV for American Indian women. Consistent and effective assessment and screening of IPV and early intervention is essential in preventing unintended injury or death, as well increasing the quality of life in American Indian women.

Additionally, findings from this study will help inform practice and policy recommendations grounded in the lived experiences of victims which can then be used by nurses and advocates, as well tribal communities who are already working alongside IPV victims. Findings from this study can further nurture academic community partnerships to foster a holistic approach in addressing gender-based violence that considers the social, cultural, and economic contexts that inform American Indian women's experiences of IPV.

This study also addresses the imperative need for nursing scholars to give voice to this important issue. Overall, much of the literature about the phenomenon of IPV against American Indian women is written primarily by social work, psychology, anthropology, law, and public health scholars, and by very American Indian scholars. Additionally, very little of the literature surrounding IPV against American Indian women is written from a nursing perspective. This highlights the need for nursing scholars as well as women of color to contribute to the body of research surrounding issues of IPV against American Indian women.

This study is timely considering the growing crisis of violence against American Indian women and the tragic numbers of American Indian women that are currently missing or have been murdered. Findings from this study have the potential implication for creating meaningful change in our ability to better care for AI victims of IPV and reduce barriers to care for AI women. Additionally, studies that critically analyze the experiences of vulnerable populations, such as AI women, when navigating care for IPV related needs, are essential to uncovering how nurses and allied care providers can create spaces where AI women feel safe and respected within the healthcare setting.

Organization of Dissertation

This introductory chapter describes the phenomenon of IPV in the lives of American Indian women, and the impacts that experience. In addition, this chapter also outlines statement of problem, purpose of the study, research questions, and research aims of this study. The second chapter will provide a literature review on the prevalence of IPV, impacts on health and wellbeing, health needs, health outcomes and health care seeking experiences of American Indian women. Historical and contemporary contexts, including sociopolitical contexts that drive the high rates of IPV against AI women is discussed, as well as policies aimed to combat this crisis. The third chapter highlights the study methodology including a discussion on theoretical framework provided through manuscript 1, which focuses upon the utility of a postcolonial and Indigenous feminist framework in framing the understanding of IPV in the lives of AI women and ends with the details of the study methodology. Chapter four outlines findings from the study which will be analyzed and discussed through two manuscripts. The first manuscript reports on findings on the barriers experienced when seeking help after an experience of IPV for urban American Indian women. The second manuscript describes the impacts of IPV, particularly during the pregnancy period, and how this can inform the work of nurses and allied

health professionals with insight into the lived realities of AI women in urban areas. The content of the three manuscripts are detailed in Table 1.

Lastly, chapter five will synthesize the two findings manuscripts and highlight the implications of the research findings for policy, practice and research.

Table 1. Manuscripts and Target Journals

Manuscript	Title	Aim	Target Journal
1	The Utility of Postcolonial and Indigenous Feminist Frameworks in Guiding Research About Intimate Partner Violence in the Lives of American Indian Women	Analyze the utility of postcolonial and Indigenous feminist frameworks in informing nursing research and practice specific to addressing intimate partner violence in the lives of Indigenous women	Journal of Transcultural Nursing
2	The Value of the Local Context in Understanding Intimate Partner Violence during Pregnancy in American Indian Women	Inform the work of nurses and allied health professionals with insight into the lived realities of AI women in urban areas, and how IPV manifests in the lives of AI women during the pregnancy period	Nursing Outlook
3	Barriers Faced by Urban Wisconsin American Indian Women Following and Experience with Intimate Partner Violence	Analysis of the barriers faced by urban AI women in Wisconsin when seeking help by after an experience with IPV in the local context	Violence Against Women

CHAPTER 2: REVIEW OF THE LITERATURE

In exploring what is currently known about the crisis of IPV against American Indian women, it was necessary to first conduct a thorough literature review. The following chapter outlines the existing literature that explores the incidence and prevalence of violence against American Indian women within certain tribes in the US; risk factors of IPV; impacts of IPV; policy and historical perspectives; and contemporary perspectives.

Overview of Intimate Partner Violence

Intimate partner violence (IPV) is a complex and pervasive public health problem experienced by millions globally. IPV involves various types of trauma such as physical violence, sexual violence, and psychological aggression by a current or former intimate partner (Black et al., 2011). IPV is defined as any behavior within an intimate relationship that results in physical, psychological, or sexual harm to those within the relationship (World Health Organization, 2013). IPV is a form of systematic violence that a perpetrator uses as a means to obtain or maintain a sense of power and control over a victim (Overstreet & Quinn, 2013). IPV involves the subjection of a partner to types of abuse such as physical abuse, psychological abuse, sexual violence, and sexual abuse or reproductive coercion. IPV that is perpetrated against victims can be very traumatic, resulting in long-lasting negative physical and mental health consequences (Black et al., 2011). IPV is associated with a range of trauma-related health and mental health effects. Victims of IPV are at risk for developing depression, PTSD, substance abuse, and suicidality as well as a range of chronic health conditions (Howell, Thurston, Schwartz, Jamison, & Hasselle, 2018).

Violence Against Women of Color

IPV is a global problem that affects women of all ages, ethnicities, socioeconomic and cultural backgrounds, in both rural and urban settings (World Health Organization, 2013b). IPV

is the most common type of violence against women, affecting 30% of women globally (World Health Organization, 2013b). The WHO conducted a large multi-country study to determine prevalence of intimate partner violence globally. Findings confirmed that IPV against women was widespread in all countries (World Health Organization, 2013b). Study results revealed that 13-61% reported physical violence by a partner, 4-49% reported severe physical violence by a partner, 6-59% of women reported sexual violence by a partner at some point in their life, and 20-75% of women reported emotional or mental abuse.

Although any woman may become a victim of IPV, women of color are disproportionately impacted by IPV. According to the 2010 National Intimate Partner and Sexual Violence Survey (NISVS), 44% percent African American women have been subjected to lifetime IPV, compared to non-Hispanic white women (27%). (Black et al., 2011). Latina women also experience lifetime IPV (37%). Women who identify with more than one race are also at increased risk at 54% for lifetime violence. The 2010 NISVS also found that women of color are more likely than non-Hispanic White women to be raped by a current or former intimate partner.

There are many contextual factors that increase the risk for IPV for women of color including racism, class, language barriers, distrust of law enforcement or social services, skepticism or distrust of domestic violence shelters or services, cultural factors, and fear of deportation for undocumented women, all increase their difficulty in accessing help and support services (CDC, 2016; Howell, Thurston, Schwartz, Jamison, Hasselle, 2018; Lee, Thompson, & Mechanic, 2002).

Intimate Partner Violence Against Indigenous Women

Many studies have reported disproportionately high rates of violence for indigenous and other minority groups, compared with White or European ethnic groups. Indigenous peoples,

also known as First Nations people, Aboriginal peoples, or Native peoples, are ethnic groups who are the first inhabitants of a country or geographical region at a time when other groups settled, occupied, or colonized that country or geographical region. It is estimated that there are more than 370 million indigenous people spread across 70 countries worldwide (United Nations, 2017). Violence against Indigenous women, particularly in Canada, Australia, and New Zealand, are just as staggering as rates of violence against American Indian women in the U.S. (Field & Caetano, 2004; Malcoe, Duran, & Montgomery, 2004; Wahab & Olson, 2004).

After reviewing the literature base for IPV against American Indian women in the U.S. and Indigenous women in other parts of the world such as Canada, Australia, and New Zealand, it is evident that despite the fact that the countries are located in different geographic areas, with Australia and New Zealand in entirely geographic regions from North America, there are commonalities of remnants of colonization. For example, the literature points to themes of oppression, historical trauma, loss of land, poverty, health disparities, land degradation, colonial rape, and alarming rates of IPV, all similar to American Indian populations in the U.S. For the sake of clarity in this dissertation, indigenous women include women from tribes in Canada, Australia, and New Zealand. Some of the literature refers to indigenous women in Canada as both "First Nations" and "Aboriginal", and some articles referred to women from tribes in both Australia and New Zealand as "Aboriginal," while also referring to indigenous women in New Zealand as "Maori".

Rates of IPV in the lives of Indigenous women in Canada, Australia, and New Zealand are staggering and reflect similar rates of IPV against American Indian women in the U.S. There have been news sources that have stated that violence against women in New Zealand are among the highest in the world (Ainge Roy, 2018), but there are few scholarly sources to substantiate this. A report called In Pursuit of Justice from the United Nations Entity for Gender Equality and

the Empowerment of Women reports that IPV against Indigenous women in New Zealand is the highest among any other country in the developed world with rates as high as 87% for lifetime violence (United Nations Women, 2011). Similarly, The Guardian recently published an article stating that "New Zealand has the highest rates of domestic violence in the developed world, with police responding to a family violence incident every four minutes" (Ainge Roy, 2018). Scholarly sources have reported rates of violence against Indigenous women in New Zealand to range between 57- 65% (Fanslow, Robsinson, Crengle & Pearse, 2010; Hoeata, Nikora, Li, Young-Hauser, & Robertson, 2011; Meyer, 2012). Several articles identified the contextual factors that perpetuate violence against women such as colonization, historical trauma, oppression, poverty, racism, unemployment, and substance abuse (Fanslow, Robsinson, Crengle & Pearse, 2010; Hoeata, Nikora, Li, Young-Hauser, & Robertson, 2011; Meyer, 2012).

Rates of IPV against Indigenous women in Australia are also high. Some articles combined data from both Australia and New Zealand as "Aboriginal women", which may have skewed data. Rates of IPV against Indigenous women in Australia ranged from 21-45% for lifetime violence. Several articles also identified the contextual factors that perpetuate violence against women such as colonization, historical trauma, oppression, poverty, racism, unemployment, and substance abuse. It was also noted that Indigenous women who reside in rural or remote areas are at higher risk for violence (Chappell, L., & Curtin, J., 2013; Ghafournia, N., 2011; Murray, S., & Powell, A., 2009; Phillips, R., 2006; Taft, A. J., Watson, L. F., & Lee, C., 2004; Taylor, N., Putt, J., & Makkai, T., 2007).

In Canada, rates of IPV against Indigenous women is higher than rates for other ethnicities. Rates in Canada varied between 28-40%, which are lower than rates for Indigenous women in other parts of the world. It has been speculated that the number is probably much higher, and that there have been flaws in data collection. Several articles also discussed the

contextual factors that perpetuate violence against women such as colonization, historical trauma, oppression, poverty, racism, unemployment, and substance abuse (Bopp, J., Bopp, M., & Lane, 2003; Brownridge, 2003; Brownridge, 2008; Brennan, 2011; Barrett & Pierre, 2011; Cameron, 2006; Daoud, Smylie, Urquia, Allen, & O'Campo, 2013; Jiwani & Young, 2006).

Similar to American Indian women in the U.S., Indigenous women around the world are often targets of IPV and sexual assault. Many indigenous communities are located in rural areas, with few resources and little help from the government or non-governmental agencies. Similar to American Indian women in the US, indigenous women in other parts of the world often have strained relationships with law enforcement, making prosecution difficult. Many indigenous societies also find themselves the focus of land dispossession and disputes between tribes/nations and non-indigenous groups, often resulting in these communities enduring the impact of national and ethnic conflict (Field & Caetano, 2004; Malcoe, Duran, & Montgomery, 2004; Wahab & Olson, 2004).

Violence against American Indian Women in the U.S.

There were several themes identified from the literature that explored the phenomenon of IPV against American Indian women. Themes include the historical and social context of IPV including historical trauma, incidence and prevalence of IPV against American Indian women within certain tribes in the US, the interpersonal context and individual lived experiences with IPV, risk and resilience factors, stigma and barriers to care, and the use of critical and feminist theoretical frameworks. Several of the studies also focused on the impacts of IPV on physical and mental health, as well as substance abuse. There is also an emphasis in the literature on the health disparities that exist today among American Indians.

Incidence and prevalence of IPV against American Indian Women

The National Intimate Partner and Sexual Violence Survey (NISVS) indicated that more

than 84% of American Indian women had reported lifetime IPV (Rosay, 2016). The specific types of abuse include a 56.1% report of sexual violence, 55.5 % physical violence by an intimate partner, 48.8 % report of being stalked, and 66.4 % report of psychological or emotional abuse by an intimate partner (Rosay, 2016). American Indian women experience violence by both Indian and Non-Indian men; however, the incidence of IPV is perpetuated mostly by non-Indian men. Specifically, the NISVS study found that 97% IPV against American Indian women was committed by Non-Indian men (Rosay, 2016).

A recently published survey Urban Indian Health Institute called Our Bodies, Our Stories reveals an alarming trend of sexual violence in the lives of American Indian women living in Seattle. The original survey of 148 American Indian women residing in Seattle was conducted in 2010 by the CDC and the Urban Indian Health Institute (Echo Hawk, 2018). Results reveal that nearly all of the respondents (94%) had reported victimization of sexual violence. Roughly 40% of the respondents had also attempted suicide after the assault. Nearly half of the respondents reported abusing alcohol at least once a month. More than 50% reported a lack of permanent housing. For 70% of respondents, their first sexual encounter in life was rape or sexual assault. For 82% the assault occurred prior to 18 years of age. It took eight years for the survey results to be published because leaders at the Urban Indian Health Institute believed the information would only lead to negative characterizations of the American Indian community.

Earlier literature revealed varying rates of IPV and were conducted in various areas of the U.S. Prior to 1980, there were only a few national studies of IPV in the U.S., and the studies used survey methods that were criticized and questioned due to the approaches used to recruit and interview participants (Lee, Sanders-Thompson, & Mechanic, 2002). For example, during the 1980s, the number of journal articles about IPV increased, however, many studies used small or convenience samples of women who either were residents of domestic violence shelters or

attended public prenatal clinics. These studies primarily focused on women of color, or women living in poverty, which may have inadvertently reinforced stereotypes about IPV.

A book titled Battered Wives written by Del Martin, originally published in 1976 and revised in 1981, is one of earliest published work surrounding IPV. Martin discusses that the foundation of "wife battering" exists within the institution of marriage itself and not the interaction between man and wife. Specifically, violence occurs because of the historical attitudes of men toward women, the economy, and inadequacies in legal and social service systems (Martin, 1981). Research on IPV specifically in the lives of American Indian women emerged in the early 1990's. Early studies also referred to IPV of American Indian women by men as "wife abuse", "wife battering" and "battered woman syndrome" and often focused upon detection and treatment as opposed to identifying the causes of violence.

The earliest literature specific to IPV in the lives of American Indian women acknowledged concepts such as historical trauma and structural violence as a phenomenon related to IPV. Bohn (1993) conducted research with American Indian women who accessed the Minneapolis Indian Health Care Center for their health care. Her findings indicated that 90% of participants (27 out of 30 participants) had experienced IPV. Bohn (1993) concluded that historical trauma and oppression has led to the erosion of American Indian women's self-esteem and traditional values that are manifested in high rates of violence, suicide, and IPV.

Norton & Manson (1995) used qualitative interviews to determine the relationship between mental health concerns and alcohol use among American Indian women IPV victims. Results revealed that all of the women (N=198) felt depressed within the past year after an incident of IPV. 88% of the respondents reported misusing alcohol in the year after the IPV incident.

Walters & Simoni (1999) surveyed 68 American Indian women residing in New York

city to assess for rates of IPV and HIV risk. 44% of women reported lifetime IPV and 27% sexual assault. This study utilized a postcolonial framework to guide the study.

Several quantitative studies reported results reflecting the incidence and prevalence of IPV as well as the co-occurrence of adverse health outcomes of IPV in the lives of American Indian women from various tribes, regions, or urban settings. Evans-Campbell, Lindhorst, Huang & Walters (2006), for example, used quantitative questionnaires to determine the prevalence of IPV among American Indian women residing on reservations in the southwest. Both studies confirmed that American Indian women experienced IPV at rates higher than other racial groups.

Malcoe & Duran (2004) utilized mixed methods during different phases of the study, including surveys to produce both quantitative and qualitative results about the relationship between IPV and socioeconomic status. The study revealed that a significant number of American Indian women study participants experienced lifetime IPV (82%), and that a large number of that same sample were also at or below the federal poverty line (48.9%).

Duran, Oetzel, Parker, Malcoe, Lucero, & Jiang (2009) examined the relationship between the severity of IPV and mental health disorders in American Indian women such as anxiety, PTSD, substance abuse, or any mood disorder. Results indicate that the prevalence of severe physical, or sexual abuse was significant for any mental health disorder and women with history of IPV were five times more likely to experience PTSD than women without a history of IPV.

Malcoe & Duran, B, & Montgomery (2004) conducted a study to determine the incidence of IPV and the relationship between socioeconomic status and IPV. Based on their findings concluded that low-income American Indian women experienced IPV at exceptionally high rates (42% of women surveyed).

Thompson, Saltzman, & Johnson (2003) used results from the National Violence Against Women Survey (NVAWS) and Canadian Violence Against Women Survey (CVAWS) to determine the risk factors that predicted injury occurrence in IPV victims. Results revealed that victim history of IPV, women who witnessed violence as children, alcohol consumption by perpetrator, feared injury or death, and emotional abuse are the highest predicted risk factors of IPV.

Tehee & Esqueda (2008) used surveys to determine if American Indian and European American's definitions of perceived causes of intimate partner violence differed. Results revealed that more American Indian women perceived only physical acts of violence as the definition of IPV whereas European American women tended to define IPV as emotional, verbal, or physical abuse.

Klevens, et al., (2012), used a randomized control trial (RTC) in their study design, to determine the effect of screening for IPV on a woman's quality of life. There were three groups in the study, with two intervention groups and one control group. The first control group was screened for IPV and given a resource list; the second group was not screened for IPV and was just given a resource list. The control group was not screened and was not given a resource list. The results revealed that there was not a significant difference between the screened plus resource groups and the screen only or control groups.

Several of the studies were conducted with rigorous statistical methods appropriate for the research question (Evans-Campbell, Lindhorst, Huang & Walters, 2006; Duran, Oetzel, Parker, Malcoe, Lucero, & Jiang, 2009; Klevens, Kee, Trick et al., 2012; Malcoe, Duran, Montgomery, 2004; Tehee & Esqueda, 2008; Thompson, Saltzman, & Johnson, 2003). For example, these six studies sought to explore the relationship between variables representing complex social concepts such as the relationship between poverty and the incidence of IPV, or

the adverse health effects of IPV against American Indian women. To simplify the models and provide relational data, the researchers used factor analysis methods (Tehee & Esqueda, 2008; Thompson, Saltzman, L. & Johnson, 2003).

Historical and Social Context of IPV

One of the major themes identified from the literature is that IPV against American Indian women is situated within a given historical and sociopolitical context. The historical origins of settler colonialism and European patriarchal systems that still exist today are discussed in the literature to situate the historical context of IPV against American Indian women. Over the past five hundred years, American Indians have experienced colonization, war, conquest, rape, and genocide, all of which has alienated them from their land and their own bodies. In this section, we briefly review some of the historical contexts that inform women's experiences of violence in American Indian communities today.

Pre-contact

To fully understand how violence against American Indian women has occurred over time, it is necessary to briefly discuss the history of settler colonialism and European patriarchal systems that still exist today. IPV and gender discrimination against American Indian women specifically by colonizers (most notably White men) has been present for hundreds of years. When the Europeans first arrived to the Americas, they not only believed they were entitled to the land, but they also believed they were entitled to the bodies of the American Indian women who inhabited the land (Burnette, 2016; Casselman, 2016; Deer, 2015; LeMay, 2018).

Women focused societies provided organization and cultural synthesis within American Indian way of life. Indigenous knowledge suggests that there was not ever a need for "feminism" prior to colonization because of the egalitarian nature and the balance of power between American Indian women and men. In most, if not all Indigenous languages, there is no word that

exists for “feminism” (Tohe, 2000). Andrea Smith (2008) explains that in traditional tribal societies, women hold a place of authority in her home. Many American Indian and indigenous societies were matrilineal, with lines of descent passing along the mother’s line. Women were often the center of economic, social, and cultural activities (Casselman, 2016; Deer, 2015; Smith, 2008). While American Indian women prepared meals, cared for children and the sick, some were also medicine healers (Deer, 2015) and many also engaged in political affairs and councils where they helped determine the outcome for violators of crime. Some American Indian women fought alongside men during combat (Casselman, 2016; Deer, 2015). The matrilineal cultural values and norms that naturally protected American Indian women were contested and reversed by the patriarchal norms typical of European society through the process of colonial subjugation (Burnette 2015; Casselman, 2016; Deer, 2015; Smith, L.T.,1999).

Respect is considered to be a foundational value among American Indian and Indigenous nations, and spiritual beliefs made it possible for indigenous communities to live in harmony without formal government or sanctioning organizations. Because women were considered sacred, they were naturally protected and IPV, for example, was inconsistent with these spiritual values (Smith, L.T., 1999; Casselman, 2016; Deer, 2015). Violence against American Indian women was therefore, likely a very uncommon occurrence. According to oral tradition, prior to European colonization, any kind of violence against American Indian women was virtually unheard of (Casselman, 2016; Deer, 2015; Weaver, 2009). In the rare instances in which it did occur, American Indian communities used their own functional tribal justice systems to quickly address it and restore balance within the community (Casselman, 2016; Deer, 2015; Weaver, 2009). Harsh sanctions such as banishment from the tribe, public humiliation, or relinquishing the perpetrators’ important tribal status and responsibility, made violence an infrequent practice (Casselman, 2016; Deer, 2015; Weaver, 2009).

European men were confused and offended by the idea of matrilineal societies and women centered economics because European settlers coming from a patriarchal society were accustomed to dealing with men. They therefore often refused to trade and conduct business with American Indian women (Amnesty International, 2007; Deer et al., 2008). European Americans in fact considered these unfamiliar matrilineal ways to be foreign and "un Christian" (Deer, 2008). Historical written documents of early contact between American Indian nations have detailed the impressions and attitudes that European men had about the relations between Indian men and women. Deer (2015) explains that "Europeans found the role of Native women perplexing, often describing it as uncivilized". The rights of Indian women within their own nations were not recognized and in some cases were determined to be illegal according to European and United States law (Deer, 2015). American Indian were subsequently perceived by European men to be "uncivilized and subsequently became targets of the federal efforts to civilize the Indian populations" (Deer, 2015, pg. 8). Therefore, the erosion of the rights of American Indian women put them at even higher risk for violence perpetrated by European men because their tribes could do little to nothing to protect them as a result of their stripped sovereignty (Deer, 2015).

In the same way that domination and control were paramount in patriarchal European households, contributing to the oppression of White women, domination and control was also paramount during colonialism, adversely affecting American Indian women (Casselman, 2016; Deer, 2015). The raping of American Indian women became a means of colonial conquest. The social construction of American Indian women by European men as exotic and sexually promiscuous led to the idea that American Indian women were available and free for sexual violation (Casselman, 2016; Deer et al., 2008; Deer, 2015; Weaver, 2009). In other words, Native American Indian's bodies were free for the taking, just as the land was.

Alcohol and substance misuse

Prior to European colonization, American Indians were relatively unaware of the effects of alcohol. Some tribes produced weak fermented beverages, but these were typically used only for ceremonial purposes (Beauvais, 1998; Frank, Moore, & Ames, 2000; Johnson, W., 1911; Young, 1996). When various European colonists suddenly made large amounts of potent distilled spirits and wine available to American Indians the tribes had little time to develop social, legal, or moral guidelines to regulate alcohol use. Early traders quickly established a demand for alcohol by introducing it as a source of trade, often using it in exchange for highly desired animal skins and other valuable resources (Beauvais, 1998; Frank, Moore, & Ames, 2000; Whitbeck, Chen, Hoyt, & Adams, 2003; Young, 1996). European traders also found that furnishing free alcohol during trading sessions gave them a distinct advantage in their negotiations. Historical records suggest that hundreds of distinct peoples across this large continent were suddenly exposed to alcohol after limited or no previous exposure (Johnson, W., 1911; Young, 1996). For Native Americans on the east coast, this exposure would have occurred in the 16th century, whereas for some midwestern and western tribes, it could have been as late as the mid-19th century (Beauvais, 1998; Frank, Moore, & Ames, 2000; Whitbeck, Chen, Hoyt, & Adams, 2003; Young, 1996).

Within the century, after contact, the majority of American Indians were likely to have developed significant risks for socially and physically harmful alcohol use, which have largely persisted despite extraordinary efforts to control them ever since (Beauvais, 1998; Frank, Moore, & Ames, 2000; Whitbeck, Chen, Hoyt, & Adams, 2003; Young, 1996). Despite representing only 1.5-2% of the U.S. population, American Indians experience higher rates of alcohol misuse compared to other ethnic groups. Negative stereotypes often depict American

Indians as “drunks” or binge drinkers and exacerbate the stigma associated with these statistics (Chartier & Caetana, 2015; Whitbeck, Chen, Hoyt, & Adams, 2003).

Colonization and Historical Trauma

Colonization occurs when a dominant group deliberately sets forth to alter or eliminate the laws, customs, and belief systems of a community (Burnette, 2015b). Colonization of American Indians specifically began after the arrival of European Americans. Colonization manifested in the forcible removal of American Indians from their homeland and their children being taken from their families and forced to attend boarding schools in an effort to assimilate them to European ways. Their hair was cut off and they were not allowed to speak their Native languages. They were also not allowed to practice their traditional customs or religions. European Americans also exposed the Native Americans to viruses and bacteria they did not have natural immunity to, which ultimately led to a great number of fatalities. Additionally, American Indians were decimated by warfare and were enslaved which greatly reduced their numbers. Eventually, after many treaty violations American Indians were placed onto reservations, having lost their original home territories and land, with very little resources on which to live. These injustices are cumulative and have resulted in generational oppression and trauma (Burnette, 2016).

The historical atrocities that were inflicted against American Indians by Europeans over hundreds of years caused a great deal of trauma that has left deep scars. The trauma against American Indians is referred to as historical trauma. Historical trauma is described as the intergenerational, cumulative, emotional and psychological wounding, extending over an individual lifespan and across generations (Brave Heart, Chase, Elkins, & Altschul, 2011; Burnette, 2015b). The theoretical framework of historical trauma has been used to explain the seeming repetitive cycle of trauma and despair specifically within American Indian and

Aboriginal or First Nations people. Essentially, the framework of historical trauma describes the unresolved trauma of genocide, loss of culture, loss of language, kinship systems, and forcible removal from family and communities (Kirmayer, Gone, & Moses, 2014). A serious manifestation of this historical trauma is the increased victimization of IPV in the lives of American Indian women (Gone, 2009). The cyclical and generational nature of historical trauma results in American Indians normalizing the oppression, racism, deprivation, and subsequent violence that occurs across generations in the form of IPV (Burnette, 2015b).

Initially, historical trauma was a term developed in the late 1990's to describe the psychological impact of the trauma of colonial policies experienced specifically by Indigenous populations (Brave Heart, Chase, Elkins, & Altschul, 2011; Czyzewski, 2011). Historical trauma has since evolved over the last few decades to also speak to the experiences of minority groups and communities other than American Indians in an effort to explain the relationship between present day health disparities and historical traumatic events as well as ongoing structural violence (Brockie, Heinzelmann, & Gill, 2013).

Legal Historical Context

The phenomenon of IPV against American Indian women is a highly complex issue with deep roots in historical trauma, structural violence, cultural issues, and also issues of jurisdiction and sovereignty. The foundation of the gendered violence experienced by American Indian women can be tied to legal and political structures in the United States. The astounding levels of IPV against American Indian women is indeed inextricably linked to the way that the United States created and sustained a legal system that has systematically stripped the inherent sovereign authority of tribal nations. The social system, including the law, federal policy, monetary resources, and other systemic factors profoundly affect American Indian women who are victims of violence, particularly women residing on reservations (Casselman, 2016; Deer,

2015). In order to understand this foundation of colonial injustice, a few key historical policies must be briefly discussed.

First, the Major Crimes Act is a law passed in 1885 that places certain crimes under the federal government's jurisdiction if they are committed by a American Indian on tribal land including rape, murder, manslaughter, kidnapping, maiming, incest, assault, arson, burglary, robbery, or felony child abuse or neglect (Bachman et al., 2008). Prior to the passage of the Major Crimes Act, tribes had the authority to police and prosecute major offenses that occurred their sovereign tribal lands. With the passage of the Major Crimes Act, the federal government had authority over these crimes, and tribes could exercise concurrent, or simultaneous, jurisdiction over these particular crimes. Despite this ability, concurrent jurisdiction might lead to neither government taking full responsibility to prosecute crimes of IPV against American Indian women (Bachman et al., 2008). A study conducted in 2010, revealed that the federal authorities declined to prosecute 67% of sexual abuse and similar occurrences occurring on tribal lands (National Congress of American Indians, 2013).

Another major injustice to tribes which further eroded sovereignty was the supreme court Oliphant *v*. Suquamish (1978) court ruling. This ruling was considered to be the nail in the coffin in terms of eroding tribes of their inherent right to self-govern and protect their tribal members. Specifically, the Oliphant v. Suquamish is a 1978 supreme court ruling in that Native nations to not have the legal right to arrest and prosecute non-Native offenders for crimes that occur on tribal lands. In other words, this decision severely limited the sovereignty of Tribes, rendering them powerless to protect American Indian women from acts of IPV and sexual violence committed by non-Indian men. This ruling ultimately created a void wherein American Indian women became targets for sexual offenders and predators who were aware of the limitations or outright lack of prosecution by federal authorities for the past 35-40 years (Casselman, 2016).

The Violence Against Women Act (VAWA), originally passed in 1994, The VAWA is a group of individually conceived legislative pieces that were joined to create a package of Federal laws and grant programs that address IPV, sexual assault, and stalking. The 2013 reauthorization of the VAWA was a turning point for addressing the alarming rates of violence against Native American women. Unlike the previous authorizations that did not offer much protection for Native women. In an attempt to increase rates of prosecution of violent acts against Native American women, the Special Domestic Violence Criminal Jurisdiction Statute (Title IX) was added to the 2013 reauthorization of the VAWA. Title IX recognizes and affirms the inherent sovereign authority on Indian tribal governments, but to a limited extent. Title IX includes a statute that grants tribes jurisdiction to prosecute non-Natives in certain instances such as domestic violence, dating violence or violations of protection orders occurring on tribal lands (Casselman, 2016).

While the VAWA 2013 revision was an attempt to protect Native women from IPV on reservations, the stipulation for tribal authority for prosecution is that the assailant must be a person that the victim knows, such as a husband, boyfriend, or domestic partner, not a total stranger. The non-Native perpetrator must also work or live on the reservation. It requires the victim to know her assailant, beyond first encounter, and a tribal prosecutor must be able to prove this beyond a reasonable doubt. In addition, tribal judges must have the proper credentials and due to lack of resources and funds some reservations struggle to staff qualified judges. For some reservations, this could be an added expense which they are not compensated for by VAWA and it may take years before they can implement proper credentials for tribal judges (Casselman, 2016; Childress; Chekuru; Hudetz).

According to the National Congress of American Indians (2017), during the first two years that the statute went into effect, only 13 of the 562 federally recognized tribes in the U.S.

were voluntarily compliant with the regulations of the act. This can be attributed in part to regulations that tribes do not have the monetary resources to carry out due process and that there are tribes that do not yet have a tribal court system in which to prosecute a perpetrator (Casselman, 2016).

The 2018 reauthorization of the VAWA addresses some of the gaps in the 2013 reauthorization. In July 2018, Representative Sheila Jackson Lee, D-Texas, introduced the reauthorization of VAWA 2018 (HR 6545). Within this proposal, there are much needed improvements that address the loopholes of justice for Native American women. Under Title IX "Safety for Indian Women," the bill builds on the progress made in 2013 VAWA and closes some of the remaining jurisdictional loopholes such as expanding tribal jurisdiction to include sexual assault, stalking and trafficking, expands tribal jurisdiction to cover child abuse and other attendant crimes such as children being concurrently abused or as witnesses, improving data collection and response to missing and murdered Indigenous women, and creating federal punishments for violating tribal exclusion orders (Nagle, 2018).

Unfortunately, as of March 2019, it has not passed the House and Senate or been signed into law. The 2018 reauthorization also does not apply to Alaskan Native women or American Indian women who reside on reservations in Maine due to the complex history of what constitutes Indian Country (reservation boundaries or tribal lands), in that state.

Barriers to Help Seeking

There are different types of barriers that can hinder help seeking when involved in a violent relationship. Contextual barriers to help seeking include economic abuse (e.g., control over monetary resources), inadequate structural responses (e.g., lack of enforcement of restraining or protective orders), and lack of or inaccessibility to professional and community resources, as well as IPV stigmatization (Overstreet & Quinn, 2013).

The individual lived experiences of IPV may be different for women of who live in various geographic locations whether it is reservation based or in an urban area. Accessibility of services, such as IPV support services, which can include shelter, food, group therapy, legal assistance, and advocacy can be inaccessible to minority women due to reasons compounding potential geographic distance (Hawkins, et al., 2017; Klevens, et al.,2010). Hawkins et al., argues that providers serving IPV survivors have to be actively nondiscriminatory as it can negatively impact service access and utilization (2017). This relates to understanding the lived experiences of American Indian women as situation by structural violence theory. Barriers in accessing healthcare occur due to various factors including economic and geographic. Access to care in tribal health centers is largely impacted by geographic location and tribal affiliation (Raglan, Lannon, Jones, & Schulkin, 2016). The number of American Indian women who live in urban and metropolitan areas is increasing. Overall, the relocation of American Indians from rural reservations to urban areas has resulted in the loss of access to tribally affiliated health care services (Raglan, Lannon, Jones, & Schulkin, 2016). American Indian women residing on reservations and in rural areas may also have difficulty accessing transportation, receive less than adequate care, and may have difficulty accessing specialist care (Raglan, Lannon, Jones, & Schulkin, 2016).

There are disparities in screening for IPV survivors among healthcare providers based on socioeconomic status and race/ethnicity (Bohn, Tebben, & Campbell., 2004). Healthcare provider support and assistance is crucial because, individuals "literally biologically embody exposures arising from our societal and ecological context." (Kreiger, 2012). Yet, nurses and other healthcare providers need to be better trained as many do not feel they have received adequate training to screen for IPV (Sprague, 2012). Hawkins et al., note that "the robustness of the training should reflect the seriousness and high prevalence of the problem and should thus be

an integral part of medical training" (2019). Furthermore, as part of this training, nurses and other healthcare providers should learn about the history of the medical establishment with minorities, especially American Indian women, and how it may affect trust and IPV disclosure.

Additionally, because of past experiences and resultant mistrust in an inadequate legal system, most women do not report abuse to authorities (Amnesty International, 2007; Bachman et al., 2008). Other reasons for non-reporting include breaches in confidentiality, fear of retaliation from families or the community, and harmful historical relations with government agencies.

There are many legitimate reasons why American Indian women may distrust healthcare providers or have a fear of accessing the healthcare system. These include their experiences with racism and dehumanizing treatment. Federal Indian Health Care Centers exist to provide quality healthcare to American Indians. However, in 1976, the Government Accounting Office (GAO) released the results of an investigation into "incidental" tubal ligations or hysterectomies that had been performed during other routine procedures, and without the consent of the patient, or consented under coercion. Records verified that the Indian Health Service (IHS) in four areas (Albuquerque, Aberdeen, Oklahoma, and Phoenix areas) had performed 3,406 sterilizations between 1973 and 1976 (Rutecki, 2010). Independent research suggests that the IHS underestimated this figure because many of the procedures were contracted out to non-IHS physicians. Further estimations support that 25-50% of American Indian women were sterilized during this time (Rutecki, 2010). The GAO also admitting during the investigation that "contract" physicians were not required to comply with any federal regulations, including informed consent (Rutecki, 2010). During this same period of time, there was an increase in abortions at IHS clinics. For example, between 1972 and 1978, there was a 130% increase in abortions on one Navajo reservation alone (Rutecki, 2010). IHS healthcare professionals used

coercive tactics to obtain consent by threatening to withdraw future healthcare provisions or threatening to take custody of their children.

Significance of Historical Context to Nursing Practice

It is essential that nurses must recognize and acknowledge the role that historical trauma plays in reproducing inequities that manifest as poor health outcomes, increases in rates of victimization of IPV against American Indian women, barriers and reluctance of victims to seek help services. Additionally, having a deep understanding the colonial history and historical trauma against American Indians can inform nurses' ability to support and advocate for IPV victims.

Many American Indian women who have the desire to leave a violent situation have limited access to IPV related services, due to the fact that most are located in large cities and towns, which may be far from reservations or rural areas (Klingspohn, 2018). Additionally, many programs or services were originally designed by and for non-Native populations. American Indian women who manage to access these programs and services often find staff with limited cultural awareness and program supports that have little cultural safety or relevance for them (Klingspohn, 2018). Therefore, women who do not anticipate feeling safe when seeking resources tend to avoid doing so.

Women of color, including American Indian women, are less likely to be seen as being victims of IPV and other types of violence. Instead, they are often seen as deserving of harm or not taken seriously if harmed. Because American Indians, and particularly women, have historically been dehumanized and left with little legal recourse, they become easier targets for abuse and are more reluctant to come forward. Crenshaw (1991) explains further that race and culture are factors that feed into the suppression of help seeking behaviors surrounding instances of IPV, stating that "women of color reluctant to report abuse or call police because of a "general

unwillingness among people of color to subject their private lives to the scrutiny and control of a police force that is frequently hostile" (Crenshaw, 1991, p. 1257).

Klingspohn (2018) discusses how a "trauma informed care and practice embraces a recovery focused, strengths-based approach, with an understanding and response to the impacts of trauma, where psychological, physical and emotional safety are paramount for providers and service users and provides opportunities for control, empowerment and recovery" (p 4). Given the colonial history of intergenerational and historical trauma experienced by American Indian women, all nurses and providers delivering services to address IPV must have a clear understanding of the traumatic effects of colonization and the impacts on American Indian women as well as develop competency in the types of culturally safe and trauma informed care that will be effective (Klingspohn, 2018).

Globalization, contemporary contexts and structural violence

Contemporary, ongoing forms of structural violence and oppression perpetuate the cumulative effects of trauma. For example, modern day American Indian reservations and even urban American Indians and other minority communities continue to experience structural violence including disparate poverty, unemployment, lack of educational opportunities, lack of safe housing, alcohol and drug abuse, lack of access to healthcare, discrimination, and the breakdown of family units (Brockie, Heinzelmann, & Gill, 2013).

There is an epidemic of IPV, and sexual violence being perpetrated against American Indian women in various parts of the United States including the Great Lakes region, driven by globalization, land degradation, and extraction. This is particularly true near the Bakken oil fields in North Dakota and the Tar Sands of Alberta, Canada. Whether through fracking, tar sands mining, or mountaintop removal, the violation of the earth through extraction runs parallel to the violation of the human rights of American Indian and First Nations people (Lucchesi, A. &

Echo-Hawk, A. 2019).

The construction of the pipelines, damming, and other mining projects often brings an influx of male workers to rural areas near small towns and reservations, where they live in laborers' camps, or temporary housing. This temporary housing has been referred to as "man camps" by locals and are often typically disconnected from the surrounding local community. For example, since the 2005 Bakken oil boom, there have been over 100,000 men from outside the state of North Dakota that have moved into the laborer camps near the Bakken Region over the past decade or so. The Bakken shale region is an area rich in shale oil supplies which surrounds the area near the Fort Berthold Reservation, which is home to the Three Affiliated Tribes of the Mandan, Hidatsa, and Arikara Nations.

Consequently, there has been a surge in rates of violent crimes, particularly against American Indian women with this influx of temporary workers. For example, in 2012, the Fort Berthold tribal police department reported more murders, sexual assaults, instances of domestic violence, and human trafficking cases than in any year before. The surrounding counties offer similar reports (Crane-Murdoch, 2013).

The CDC (2016) reports that homicide was the third leading cause of death for American Indian women and girls age 10-24 in 2016 in the United States. Yet few United States government resources have been extended to combat this reality. Meanwhile, fossil fuel companies continue to swell as their profits skyrocket (Lucchesi, A. & Echo-Hawk, A., 2019).

As mentioned previously, globalization has led to increases in rates of IPV, sexual violence, and homicide in other postcolonial nations where Indigenous communities have been impacted by fossil fuel extraction. A recent government report from the Lake Babine and Nak'azdli nations of British Columbia, Canada, found that the influx in temporary workers in the areas are associated with increased rates of IPV against indigenous women (Amnesty

International, 2016). While indigenous women made up less than 5% of the total female population in Canada in 2015, they comprised one quarter of all murdered women in the country that same year (Amnesty International, 2016).

When American Indian women often go missing in life, they also go missing in the media, and in the efforts to find them. The federal, state, and local authorities, as well as the media are less likely to spend time or effort searching for a missing American Indian woman (Smith, 2005). For example, when a young blonde woman named Dru Sjojin went missing near the North Dakota/ Minnesota border in 2003, it sparked a media outcry and more than 150 National Guard members, and almost 1,000 volunteers searched for her. The search costs exceeded more than $150,000, which included costs for manpower, fuel, and food (Smith, 2005). When American Indian women have gone missing in that very same area, or any area for that matter, there rarely, if ever has any media attention, or the same effort in search and rescue efforts (Smith, 2005; Echo Hawk, 2018). For example, since that time, it is estimated that there are hundreds American Indian women that are still missing, or have been murdered in North Dakota, but the exact number is unknown (Lucchesi & Echo-Hawk, 2019). The lack of data or inaccuracy of data is largely due to reporting inconsistencies and jurisdictional confusion and conflicts between tribal, federal, state, and local authorities (Buckley, 2014; LaDuke, 2019; Lucchesi & Echo-Hawk, 2019; Vibes, 2017).

The process of economic globalization in particular has been associated with an influx of racialized and sexual violence, such as human trafficking due to the resulting economic inequalities that occur in vulnerable communities and populations (Kukkanen, 2008). Globalization includes the expansion of markets, trade liberalization and cheap labor (Kukkanen, 2008). Human trafficking is a part of modern-day globalization and is eerily similar to how the trans-Atlantic slave trade of centuries ago was spurred economic globalization. Indigenous

women are among the hardest hit by the ill effects of economic globalization. Indigenous people, including American Indians are often subjected to displacement due to land exploitation for natural resources, whether it is mining, logging, agribusiness, or oil exploration, causing further marginalization. It is important to discuss human trafficking within the context of both historical and contemporary issues because there is much overlap between human trafficking experienced by American Indian women.

The United Nation defines human trafficking as "the recruitment, transportation, transfer, harboring, or receipt of persons by improper means (such as force, abduction, fraud, or coercion) for an improper purpose including forced labor or sexual exploitation" (United Nations Convention against Transnational Organized Crime resolution, 2011). There are other multiple legal definitions at the federal, state, and tribal levels and varying degrees of understanding of the phenomenon, but the underlying commonality is that trafficking can be understood as a form of prostitution that involves the control by third party and exploitation of the victim (Farley, Matthews, Deer, Lopez, Stark, & Hudon, 2011).

Farley, Matthews, Deer, Lopez, Startk, & Hudon (2011) published a report titled *Garden of Truth* that discusses the findings of their study surrounding issues of prostitution and human trafficking of American Indian women residing in Minnesota. The authors interviewed 105 American Indian women and found that 92% of the participants had been raped in their lifetime, and 79% of the women had been sexually abused as children by an average of 4 perpetrators. About half of the women (48%) reported being trafficked for sex and used by more than 200 buyers during their lifetime. 84% had reported being physically assaulted during a prostitution act, including 74% that suffered a head injury. Almost all of the women interviewed (98%) reported being currently or previously homeless. The report also revealed that much of the trafficking took place on the ships or near ship ports in Duluth, Minnesota or being trafficked

from reservations to urban areas such as Minneapolis (Farley, Matthews, Deer, Lopez, Startk, & Hudon, 2011).

Stigma and Politization of IPV and other Violence

Stigmatization of intimate partner violence can be a major barrier to help seeking. Stigma is defined as a feeling of disapproval or devaluation that a group or a society has about something (Overstreet & Quinn, 2013). Goffman's (1963) work suggests that a stigmatized identity denotes the mark of failure or shame. Goffman viewed stigma as a process based on the social construction of identity. Persons, who have become associated with a stigmatized condition, transition from a normal status in society to that of a discredited social status (Goffman, 1963).

It is important to recognize that stigmatization can be a deterrent to help-seeking behaviors on several levels. The Overstreet & Quinn IPV stigmatization model considers stigma on the individual, interpersonal, and sociocultural levels. Self-stigma is an internalized stigma on an individual level, which addresses how internalized negative beliefs about intimate partner violence can impact health seeking. Anticipated stigma is a concern about what will happen once others know about the partner abuse such as rejection or disapproval and can affect the decision to disclose the violence and seek help (Overstreet & Quinn, 2013). Cultural stigma refers to the imbedded negative cultural beliefs about intimate partner violence victims that may delegitimize women's experiences of the violence. An example of cultural stigma is the belief that intimate partner violence victims provoke or falsify their own victimization (Overstreet & Quinn, 2013).

Interpersonal Context of IPV and Themes of Lived Experiences

Other recurring themes identified from the review of qualitative studies include: the effects of violence, the cyclical nature of violence, normalizing and tolerating violence, the strength and resilience of victims, barriers to help-seeking, and the role of substance use in IPV.

Murphy, Risley-Curtiss, & Gerdes (2004) utilized hermeneutic phenomenology as a methodology to explore the experiences of American Indian IPV survivors and to uncover implicit and explicit meanings imbedded in those experiences. This study enhanced and expanded understanding of victimization and survivorhood through in-depth phenomological interviews of thirteen American IPV survivors. A pattern of themes was identified through the victims' stories including: breaking down, breaking out, and breaking through. These three themes created the image of a spiral as the visual representation of victimization and survivorhood. Murphy, Lemire & Waisman (2009) reported a case study from one American Indian woman named Annie. Annie's story was explicated using hermeneutic phenomenological interviews and critically analyzed to explore the complex link between victimization and her becoming an abuser herself. Themes identified included getting out of hand (escalating abuse), they're in my footsteps all the way now (her children repeating the cycle of abuse), and what's a Miranda right? The American Indian woman interviewed, Annie, was ultimately arrested for murdering her abuser in self-defense.

Several articles discussed the importance of situating American Indian women's experience with IPV in historical and social contexts. The historical impacts of colonization, and forced assimilation are viewed as the primary social determinant of health that has led to intergenerational trauma and current day struggles such as discrimination, racism, poverty, stigma, isolation, and substance abuse (Brownridge, 2008; Burnette, 2011; Chmielowska & Fuhr, 2017; Klingspohn, 2018; Montesanti, 2015; Kuokkanen, 2008; Wirihana & Smith, 2014).

Several of the qualitative studies focused on the individual lived experiences of American Indian women who are IPV survivors. For example, Burnette (2015a) conducted qualitative interviews of 49 American Indian women from a southeastern tribe to better understand the relationship between historical oppression and incidence of IPV. Healthcare providers who deliver care to American Indian women within that tribe were interviewed as well, and these data were critically analyzed.

Childress (2013) conducted a meta-summary of qualitative findings of nine studies. The extraction of relevant statement of findings and reduction of statements were performed to confirm recurring themes in primary studies that illustrate American Indian women's experiences with IPV. Jones (2007) conducted qualitative interviews with American Indian IPV victims as well as focus group interviews with healthcare providers to identify needs and barriers to service delivery of American Indian IPV victims.

A limitation noted across several of the studies is that there were small sample sizes used in many of the studies for both qualitative and quantitative studies. The studies were also limited to certain geographic areas, tribes, or reservations in the United States and Canada. This is a limitation because the findings may not be transferrable to victims in different tribes or geographic locations. American Indian reservations and urban communities within the United States spread from coast to coast and culture, language, and customs may differ from tribe to tribe. Results or findings of one study may thus not necessarily be relevant to another tribe or helpful to all American Indian IPV victims (Burnette, 2014).

A major gap in the literature that focuses on incidence and prevalence of IPV against American Indian women is the ethnicity of the perpetrator. This is a key element to being able to discern whether IPV among American Indian women is an intraracial issue versus an interracial issue. It was not until the 2010 NISVS was published that the ethnicity of the perpetrator was

specifically identified in the literature. The data and revealed that 97% of IPV against American Indian women is perpetrated by non-Indian men (Rosay, 2016). The ethnicity of the perpetrator is crucial to note because this highlights the fact that IPV is not an intraracial problem amongst American Indians, but rather reinforces that this is a symptom of the larger issue of colonization and violation of American Indian women by men of other ethnicities, mostly notably Caucasian men.

Impacts of IPV

IPV is associated with a range of trauma-related health and mental health effects. IPV against women disrupts and impacts the environment in which women live, causing a woman to feel unsafe, ungrounded, and fearful within her mental or physical environment. Additionally, women who have been victims of violence may experience adverse physical and mental health effects. There is clear and consistent evidence within the literature that supports the relationship between women that experience IPV and the existence of chronic health conditions (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Stockman, Hitomi, & Campbell, 2014).

Ongoing or repeated instances of violence against women has been associated with depression, anxiety, and post-traumatic stress disorder (Antai, D., 2011; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Childress, 2013; Stockman, Hitomi, & Campbell, 2014). In addition to depression, anxiety, and PTSD, evidence strongly suggests that experiencing IPV increases the risk of other mental health conditions, including self-harming behavior, suicidal ideation, eating disorders, and other anxiety and mood disorders, substance abuse, and sleep disturbances (Bonomi, Anderson, Rivara, & Thompson, 2007; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Childress, 2013). Without intervention, repeat acts of violence may also lead to serious injury or even loss of life (Bonomi, Anderson, Rivara, & Thompson, 2007; Burnette, 2016). Women may also experience decreased production and quality of life as a

result of violence, which could impact other areas of life such as employment, education, and self-care (Stockman, Hitomi, & Campbell, 2014).

Ongoing or repeated IPV against women has been associated with depression, anxiety, and post-traumatic stress disorder (Duran et al., 2009). In addition to depression, anxiety, and PTSD, evidence strongly suggests that experiencing IPV increases the risk of other mental health conditions.

Women exposed to IPV are at risk for engaging in deliberate self-harm than non-abused women (Evans-Campbell, Lindhorst, Huang & Walters, 2006). IPV is associated with increased suicidal ideation and suicide attempts. The World Health Organization multi-country study on women's health and IPV against women, found that women who reported partner violence at least once in their lifetime are nearly 3 times as likely to have suicidal thoughts and nearly 4 times as likely to attempt suicide, compared to women who have not been abused by a partner (García-Moreno, Jansen, Ellsberg, Heise &Watts, 2005). The results of a systematic review suggest a relationship between experiencing IPV and having a diagnosis of an eating disorder. Compared to those without such a diagnosis, women and men with an eating disorder are significantly more likely to have experienced lifetime IPV (Centers for Disease Control, 2016). There is also evidence for increased risk of other anxiety and mood disorders such as bipolar disorder or borderline personality disorder among intimate partner violence survivors (Evans-Campbell, Lindhorst, Huang & Walters, 2006). Victimization of IPV is also associated with increased risk for substance abuse such as binge drinking alcohol or abuse of prescription medication or illegal drugs (Duran, et al., 2009). Women who experience acts of IPV frequently experience poor or decreased sleep quality, nightmares reliving the trauma, and sleep disorders (Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S., 2007; Evans-Campbell, Lindhorst, Huang & Walters, 2006).

IPV During the Pregnancy Period

IPV during pregnancy is of great concern due to the potential for negative consequences to both the mother and her unborn child (McFarlane, Parker, & Soeken, 1995; Taillieu & Brownridge, 2010), with the most tragic consequence of IPV being the death of the mother and/or child. AI women are considered to be especially vulnerable to IPV victimization during the perinatal period (Burnette, 2015). Burnette (2015) found that "over half of women (52%) described pregnancy as a time of increasing vulnerability to IPV." (p. 11) in her qualitative study with AI women living on a reservation in the southwest. According to a 2010 World Health Organization (WHO) multi-country study on women's health and violence against women, the majority of women who reported physical abuse during pregnancy had also been abused prior to pregnancy. Even more concerning was that about half of the respondents stated that they were abused for the first time during a pregnancy (García-Moreno, et. al., 2015).

Some earlier studies discuss the prevalence of IPV during a pregnancy (Bohn 2002; Kantor & Jasinksi, 1998; Kvinge et al., 1998; Robin et al., 1998) with estimates ranging from 9% among AI women with past year pregnancies (Malcoe et al. 2004) to 38% among teenaged AI mothers (Mylant & Mann 2008). One study revealed that 6% of AI women who were pregnant at the time of the interview reported that their partner had threatened their life or the life of their baby (Bohn, 2002).

Racial Disparities

It is important to first note that significant racial disparities exist in the rates of maternal and infant mortality of women of color, particularly for AI women and Black women. The high rates of racial disparities and the high rates of IPV place women of color, especially AI women, at especially high risk for adverse health outcomes (Stockman, Hyashi, & Campbell, 2015).

According to the CDC (2019), AI women and Black women are two to three times more

likely to die from pregnancy-related causes than white women. Complex factors exist that contribute to the disparities in maternal and infant mortality such as racism. For example, the structural racism that exists within the health care system, social service system, and law enforcement that manifests in poorer quality care for women of color than for White women (Taylor, Novoa, Hamm, & Phadke, 2019). The cumulative stress and experience of structural violence, racism, and sexism manifests in racial disparities including adverse pregnancy and infant outcomes such as preterm birth and high infant mortality rates (Taylor, Novoa, Hamm, & Phadke, 2019).

There are significant racial disparities for ethnic minorities beginning early in their lives. In the state of Wisconsin, babies born to non-Hispanic black mothers suffer the highest infant mortality rate in the nation. From 2013-2015, there were 14.3 deaths per 1,000 births, with the national average of this same group was 11.1 deaths per 1,000 births (Wisconsin Department of Health Services, 2018). Nationally, the infant mortality rate for AI babies is 9.21 deaths per 1,000 live births as compared to 4.67 deaths per 1,000 births for white non-Hispanic babies (Ely & Driscoll, 2019). In the city of Milwaukee, one of the most segregated cities in the United States, the infant mortality rate is staggering at 15.4 deaths per 1,000 births for non-Hispanic black babies. This rate is three times higher than that of non-Hispanic white babies at 5.1 deaths per 1,000 births from 2015-2017. (City of Milwaukee Health Department, 2018). The City of Milwaukee did not report the infant mortality rate for AI babies in their community health assessment report. A query the Wisconsin Interactive Statistics of Health (WISH) database for AI infant mortality rate for the city of Milwaukee yielded a result of 13.0 deaths per 1,000 births from 2010-2018 for AI babies.

Women of color, including AI and Black women in Milwaukee experience significant impacts from increased levels of segregation, poverty, and housing insecurity. The poverty rate

for Blacks in the city of Milwaukee is 33.4%, which is five times greater than whites and among the highest poverty rates in the US of largest urban areas (Levine, 2020). In the book Evicted, Matthew Desmond argues that women of color experience challenges with accessing and maintaining stable housing in urban environments with evictions occurring at rates three times as high as White women (Desmond, 2016). Additionally, African American women, particularly with lower incomes, are evicted at significantly higher rates than women of other racial groups for reasons such as having children, poverty, and landlord-tenant gender dynamics (Desmond, 2016).

Other racial disparities include the high rates of incarceration for American Indians in the state of Wisconsin. For example, in 2013, Wisconsin saw an increase of 42% of American Indians in county and city jails between 1999 and 2013, had the highest incarceration rate for American Indians in the U.S. in 2013 (U.S. Department of Justice, 2017).

IPV and Maternal Health Disparities and Outcomes

IPV experienced during pregnancy is associated with negative maternal outcomes, particularly for women of color, regardless of their insurance status or access to medical care (Sharps, Laughon, & Giangrande, 2007). Aside from physical injuries sustained as a result of IPV, women may also experience negative outcomes such as hypertension, edema, vaginal bleeding, placental problems, severe nausea and vomiting, dehydration, urinary tract infections, and premature rupture of membranes (Sharps, Laughon, & Giangrande, 2007).

In addition to physical health impacts, IPV during pregnancy has been associated with poor mental health outcomes (Sharps, Laughon, & Giangrande, 2007). AI women who experience IPV whether pregnant or not were found to have a substantial increase in risk for a mood or anxiety disorders and were more likely to be hospitalized for mental health related problems (Raglan, Lannon, Jones, & Schulkin, 2016). Experiencing poor mental health during

pregnancy may adversely impact birth outcomes. For example, IPV during pregnancy places AI women at risk of depression and posttraumatic stress disorder (PTSD) with stress in pregnancy associated with both preterm birth and low birth weight (Raglan, Lannon, Jones, & Schulkin, 2016).

Women of color, including AI women, are more likely to experience barriers to accessing prenatal care or late entry into prenatal care or no prenatal care at all. (Clark, et. al., 2002; Sharps, Laughon, & Giangrande, 2007). The intersecting factors that lead to marginalization, and the context of their lives that place them at risk for disparities include high rates of poverty, lower levels of formal education, limited access to transportation, racism, and other stressors (Sharps, Laughon, & Giangrande, 2007).

IPV experienced during pregnancy is also associated with adverse fetal or infant outcomes such as miscarriage, fetal injury, small for gestational age, low birth weight, preterm birth, and stillbirth (Bailey, 2010; Sharps, Laughon, & Giangrande, 2007). Infants born preterm are at an even higher risk of lifelong health complications. The risk for infant mortality is also higher for infants born preterm (Raglan, Lannon, Jones, & Schulkin, 2016).

Maternal Psychosocial and Behavioral Risk Factors

In addition to direct physical and health effects, IPV during pregnancy has been associated with many mental health factors. Women who experience IPV either during or outside of pregnancy were found to have a substantial increase in risk for a mood or anxiety disorder, and more likely to be hospitalized for mental health related problems (Raglan, Lannon, Jones, & Schulkin, 2016). Experiencing mental health issues during pregnancy may adversely impact birth outcomes. Depression is the most common mental health consequence of IPV and has been linked to both preterm birth and low birth weight (Raglan, Lannon, Jones, & Schulkin, 2016). Pregnant IPV victims are also at risk of experiencing posttraumatic stress disorder

(PTSD) with stress in pregnancy associated with both preterm birth and low birth weight (Raglan, Lannon, Jones, & Schulkin, 2016).

Depression and other mental health conditions have also been linked to preterm birth. Native American women experience higher rates of depression and other mental health disorders compared to women of other racial and ethnic groups (Raglan, Lannon, Jones, & Schulkin, 2016). Rates of suicide among American Indians have remained higher than rates for other racial and ethnic groups for the past 25 years (Raglan, Lannon, Jones, & Schulkin, 2016). It has been hypothesized that American Indian women experience higher rates of depression and other mental health disorders because of historical trauma and ongoing structural violence in their communities (Burnette, 2016).

Tobacco, alcohol or other drug use during pregnancy are modifiable risk factors for spontaneous preterm labor. American Indian women are at significantly greater risk for tobacco and alcohol use during pregnancy compared to non-Hispanic white women (Raglan, Lannon, Jones, & Schulkin, 2016). According to the Indian Health Service (2016), American Indian women living in urban areas are more likely to smoke cigarettes or consume alcohol compared to women living on reservations (IHS, 2016).

Risk and Resilience Factors

The literature points to certain risk factors that increase the incidence of IPV for victims and perpetrators. However, those risk factors that contribute to IPV may not be direct causes. A woman who is identified as "at risk" does not necessarily become a victim of IPV. Some risk factors for intimate partner victimization and perpetration are the same, while others are associated with one another. For example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization. A combination of individual, relational, community or societal factors may increase the risk of becoming a perpetrator or victim

(Overstreet, N., & Quinn, D., 2014; Yakubovich, Stöckl, Murray, Melendez-Torres, Steinert, Glavin, & Humphreys, 2018).

The literature also points to resiliency among American Indian IPV survivors. Personal strength and growth can lead to positive outcomes including resilience and adaptation. Studies of women who have been successful in overcoming the difficulties of IPV have revolved around the concept of resilience. Resiliency can be defined as an individual's ability in the face of overwhelming adversity to 1) adapt and restore equilibrium to her life and 2) avoid the potentially harmful effects of stress (Humphreys, 2003). Social and community support, character resources, and spirituality and religion are coping mechanisms that have been attributed to developing resilience in women experiencing IPV (Anderson, 2017; Asay, S. M., Defrain, J., Metzger, M., & Moyer, B., 2016; Burnette, C., 2015a).

CHAPTER III: METHODOLOGY

Chapter 3 begins with manuscript 1 which focuses upon the theoretical frameworks that guide this study. The remainder of the chapter discusses the methodology used to carry out this study.

Manuscript 1: The Utility of Postcolonial and Indigenous Feminist Frameworks in Guiding Nursing Research and Practice About Intimate Partner Violence in the Lives of American Indian Women

This first manuscript discusses the utility of postcolonial and Indigenous feminist theoretical frameworks in researching IPV in the lives of Indigenous women. This manuscript places emphasis on how postcolonial and Indigenous feminist frameworks consider the complex history and the sociopolitical contexts in which IPV occurs that ultimately shape health experiences and outcomes for Indigenous women.

It is formatted based on the journal guidelines for *Journal of Transcultural Nursing.* This version contains all revisions requested by the reviewers in order to be considered for publication.

The Utility of Postcolonial and Indigenous Feminist Frameworks in Guiding Nursing Research and Practice About Intimate Partner Violence in the Lives of American Indian Women

Abstract

The purpose of this theoretical paper is to analyze the utility of postcolonial and Indigenous feminist frameworks in informing nursing research and practice specific to addressing intimate partner violence (IPV) in the lives of Indigenous[1] women. Prevailing feminist narratives of the 20th century focused overwhelmingly on patriarchy as the sole source of oppression against women and root cause of IPV. These narratives failed to consider complex historical ways in which patriarchy intersected with colonialism and racism to produce violence, impacting the contemporary realities of Indigenous women. In contrast, postcolonial and Indigenous feminist frameworks consider the colonial history that has disempowered Indigenous women and their nations over centuries of settler occupation. Situating IPV within historical, legal, social, and political contexts can unmask how current research and healthcare discourses may continue to constrain, rather than improve access, care, and services for Indigenous victims of IPV (Browne & Smye, 2002).

Keywords: intimate partner violence, Indigenous women, American Indian women, postcolonial feminism, indigenous feminist frameworks

[1] In this paper, the authors use the term Indigenous to include American Indian and Alaskan Native to refer to Indigenous groups in the US. The term Indigenous is used in reference to Native groups in Canada who are sometimes also referred to as First Nations, and more generally to Indigenous peoples in scholarly discourse.

Positionality

"Who does the telling" is essential (Janack, 1999, p. 326). Researchers' individual identities, and their position even as feminist scholars, impact the research process (Bourke, 2014). Mkandawire-Valhmu (2018) wrote, "we are all biased, which necessitates the articulation of…social location" (p. 7). This paper was written by feminist scholars who identify as women of color, including, Indigenous (enrolled member of Bad River Band of Lake Superior Chippewa, and Southern Cheyenne descendent), African, Latinx, Hapa, as well as White, from a space of unified sisterhood. The unified sisterhood exemplified in the writing of this manuscript is not born of the epistemological ignorance that informed earlier feminist theorizing. This sisterhood is based on the painful recognition and understanding that the privilege embodied by some of the co-authors has contributed to the marginalization of others.

This sisterhood also recognizes the importance of creating a space where these tensions can be explored further by nurses and allied researchers searching to understand and address the problem of violence in the lives of Indigenous women. The goal, through this collaborative feminist theorizing, is to inform research and, ultimately, health interventions that would lead to better health outcomes for Indigenous women and women of color more broadly.

Background

IPV in the lives of women is a widespread social, public health, and human rights issue. The right to live life free from violence is one of the most fundamental rights of a human being, a right that is a critical component in internationally recognized documents such as the Universal Declaration of Human Rights. This violation of human rights has occurred for Indigenous women since the earliest days of colonization (LeMay, 2018). The United Nations (2013) described violence against Indigenous women as "endemic" (p. 22). Violence against Indigenous

women is systemic, unjust, avoidable, and results in a massive physical, psychological, and generational burden to Indigenous women and their families.

It is imperative to recognize that the alarming rates of IPV against Indigenous women today reflect the cumulative consequences of a colonial agenda filled with historical, legal, social, and administrative policies designed to oppress and disempower Indigenous populations over the past few centuries (Casselman, 2016). IPV against Indigenous women is deeply rooted in historical trauma, structural violence, and the intersection of race, class and gender bias, as well as issues of jurisdiction, and sovereignty. The use of postcolonial and Indigenous feminist frameworks in research and practice thus facilitates a deeper understanding of why IPV occurs in the lives of Indigenous women at such high rates today.

This manuscript begins by defining violence and providing the reader with an overview of the incidence and prevalence of IPV in the lives of Indigenous women; followed by how Indigenous communities, before colonization, were structured to value and protect women, and a discussion of colonization as the impetus for the oppression of Indigenous communities past and present. The article concludes with recommendations for utilizing postcolonial and indigenous frameworks in research and practice to support and promote feminist activism and decolonization efforts in academic and community settings.

Intimate Partner Violence against Indigenous Women

IPV is defined as any act or behavior within an intimate relationship, threatened or actual, which results in physical, psychological, or sexual harm to those within the relationship (World Health Organization, 2013). IPV is a form of systematic violence that a perpetrator uses as a means to obtain or maintain a sense of power and control over a victim (Overstreet & Quinn, 2013). An expansive discussion of different forms of IPV is beyond the scope of this article;

however, the World Health Organization (2012) is an excellent resource for in-depth information.

The rates of IPV are higher among Indigenous women than any other racially defined group in the United States (Burnette, 2016; Finfgeld-Connett, 2015). According to a report conducted by the National Institute of Justice in 2010, more than 4 in 5 (84.3%) Indigenous women experienced violence in their lifetime (Rosay, 2016). IPV victimization is associated with a wide range of acute and chronic physical and mental health impacts, severe injury, and even death (CDC, 2016).

Feminist Frameworks

For Indigenous women's the detrimental health impacts of IPV must be understood within the historical and sociopolitical contexts as well as women's experiences with Western healthcare systems to better understand the complexities of IPV in the lives of Indigenous women. While Western feminist theories are useful in that they examine the detrimental impacts of patriarchy on women, many fall short by not accounting for or analyzing how racism and racial or ethnic identity affects ethnic minority and Indigenous women's experiences (Ortega, 2009)., Patriarchy is not merely about the examination of power dynamics and relationships between men and women. It also encompasses the social systems organized around principles of power, control, and domination (Johnson, 2005), all key factors that impact the manifestation of IPV among Indigenous women. It is important to note here that feminist thought has been informed by Indigenous influences, which are explicated in the sections below.

Indigenous Influences on Feminism

In her book, *Sisters in Spirit*, Sally Roesch Wagner (2001) discussed how Haudenosaunee (Iroquois) women were an inspiration to suffrage leaders and early feminists in the mid-1800s. Suffrage leaders such as Elizabeth Gage and Susan B. Anthony observed and wrote about the

differences between the treatment of Indigenous women in their home communities versus settler women (Wagner, 2001). Early suffrage leaders envied the Haudenosaunee matriarchal societies, observing how allied tribes recognized how powerful and important these Indigenous women were in their communities (Wagner, 2001).

In her article, "Who is Your Mother: Red Roots of White Feminism," Paula Gunn Allen (1984) built upon the notion that contemporary forms of feminism are rooted in Indigenous ways of knowing, noting "yet feminists too often believe that no one has ever experienced the kind of society that empowered women and made that empowerment the basis of its rules of civilization," (p. 39) referring to the influence of early Indigenous matriarchal societies on American feminist thought.

Historically, Indigenous women were highly respected, considered sacred, and therefore naturally protected from violence. These protections stemmed from highly functional kinship systems, clans, and well-formed governments, to "maintain a balance of spirituality between men and women" (Wagner, 2001, pg. 29). The cultural values and norms that contributed to the protection of Indigenous women were not contested or reversed until patriarchal norms typical of European society were imposed in the Americas through the process of colonial subjugation (Burnette 2015; Casselman, 2016; Deer, 2015; Tuhiwai Smith, 1999).

Before colonization, violence against Indigenous women was an uncommon occurrence. Indigenous scholar Lisa Poupart explained, "according to the oral traditions within our tribal communities; it is understood that prior to mass Euro-American invasion and influence, violence against Indigenous women was virtually nonexistent in traditional Indigenous families and communities" (p. 91). In the rare instances when violence did occur, Indigenous communities used their own functional tribal justice systems to quickly address issues of violence and restore balance within the community (Casselman, 2016; Deer, 2015; Weaver, 2009).

Indigenous Feminism

Indigenous feminism is an intersectional theory and practice that focuses on the promotion of decolonization and Indigenous sovereignty. Indigenous feminism aims to challenge patriarchy, White supremacy, colonialism, and imperialism, though there are also Indigenous feminists who instead seek to move beyond these systems of oppression and rebuild and rearticulate sovereignty as Indigenous women and nations outside settler-colonial societies.

An Indigenous feminist approach to nursing research and practice promotes human dignity by acknowledging the centuries of oppression and injustice experienced by Indigenous peoples, as well as promoting their inherent right to self-determination and self-governance. Indigenous feminist analysis and activism also serve to promote social justice and praxis across race, class, and gender lines for all Indigenous people, including the right of sovereign nations to self-govern and to protect the wellbeing and safety of its citizens (Casselman, 2016; Deer, 2015; Suzack, Huhndorf & Perreault, 2010).

Although there are many Indigenous women who are concerned with issues of gender-based violence, the misconceptions and pervasive stigmas related to feminism have kept some from identifying as feminists (Shanley, 1984). Some Indigenous women believe that the more significant issues of colonization and oppression of all Indigenous peoples, as well as the quest to restore full tribal sovereignty, are ignored if the focus is solely upon issues of gender (Suzack, Huhndorf & Perreault, 2010).

Conversely, some Indigenous scholars believe that their communities are not impacted by patriarchy; therefore, there is no need to be involved in "women's movements" or to use feminist frameworks for addressing issues such as gender-based violence. AI scholar Bea Medicine (1978) described this in her book, *The Native American Woman: A Perspective*, explaining that many of her Indigenous female acquaintances felt no need to be a part of any women's

movements because they were “already liberated!” (p.3). In Laura Tohe’s article, “There is No Word for Feminism in My Language,” she discussed how Navajo women have not been marginalized or impacted by issues of patriarchy because of their stable matrilineal structures. While it may be true that some Indigenous women are still living under protective matrilineal systems, most Indigenous women do not live with those same inherent protections. It could also be argued that no society affected by colonialism has been left untouched by the patriarchy inherent to the European settler mentality.

Postcolonial feminism

A postcolonial feminist framework provides an analytical lens to better understand the complexities within sociopolitical and historical locations of vulnerable populations (Mkandawire-Valhmu, 2018). Postcolonial feminism emerged from postcolonial and feminist theories as a response and intervention to colonialism and imperialism (Mohanty, 2003). A postcolonial feminist approach seeks to deconstruct and disrupt the dominant discourses of Western feminisms and Western hegemony, and also focuses on the human consequences of the exploitation of colonized populations due to globalization, including exploitation of their lands (Jaggar, 2001; Scholz, 2008). Thus, a postcolonial feminist framework can play an important role in furthering our understanding of IPV within Indigenous women’s lives.

The term ‘postcolonial’ is often mistaken as a reference to the time after colonization. Yet, it does not mean that colonization efforts have ended (Racine, 2011). The expansive period of colonization has had a lasting impact on the political, economic, and cultural spheres of postcolonial states and societies reaching to the present time. Indigenous lands and communities, whether rural or urban, are still presently impacted by the influence of settler colonization. The postcolonial period, therefore, includes both the period after colonization to the present day; one cannot be separated from the other.

Postcolonial feminism is, therefore, both a response and an intervention to the imposition of colonialism, imperialism, and the dominant discourse of Euro-American feminisms about communities of color, including Indigenous populations. Similar to Indigenous feminism, postcolonial feminism aims to understand and undo the legacies of colonialism within feminist activism (Racine, 2011; Wallaschek, 2016).

A postcolonial feminist epistemological approach not only focuses on patriarchy as a source of oppression, but also examines how social inequalities are etched within historical, political, social, cultural, and economic contexts that influence health and healthcare delivery (Racine, 2011; Mkandawire-Valhmu, 2018). Postcolonial feminist thought helps us move from the idea of women as a homogenous group defined solely by their gender, to consider other identities under which women fall that also impact their health and wellbeing. This underlines why issues of race and class, as well as gender, are essential to explore in health and nursing research (Racine, 2011).

Nursing Research and Practice

Indigenous and postcolonial feminist frameworks strengthen nursing research and practice by providing an analytic lens to better understand the complex historical and contemporary factors that shape the health and wellbeing of Indigenous women. This is especially valuable given the consequences when Western feminisms do not consider these complexities as they relate to healthcare practice. As discussed earlier, Western feminist theorizing often did not understand or take into account the intersections of historical, sociopolitical, and economic factors that shaped the experiences of violence in the lives of women of color generally, and Indigenous women specifically. Therefore, there is a critical need for analysis of the intersection of patriarchy, colonialism, and racism, and the resulting impact on Indigenous women's experiences of IPV.

The use of postcolonial and Indigenous feminist frameworks in research and practice prevent the perpetration of oppression and racism when engaging with Indigenous women in research as well as in healthcare settings. Bringing history to light is crucial. Without recognizing the historical and contemporary systems of oppression beyond gender, and the role that researchers and healthcare professionals might play, recommendations for interventions may be inadequate or even cause harm. Nurses and allied health professionals must possess a deeper understanding of the structural and contextual factors that increase the risk of IPV for various populations of women. Failing to understand the context of historical and contemporary oppression impacting women's lived experiences of IPV only serves to uphold White supremacist ideologies that blame women for their realities.

Key to avoiding the replication of oppression and racism is reflexivity, which involves recognizing where we as researchers and healthcare professionals are situated in relation to the individuals and communities we engage with when it comes to power and privilege (Racine, 2002; Ritchie et al., 2014). Recognizing potential areas of biases and how these biases impact our professional role and how we relate with those we interact with, is critical (Ritchie et al., 2014). Inability to acknowledge and address our biases through reflexivity not only leads to the replication of oppression, it can also serve to uphold hegemonic ideologies that perceive Indigenous peoples as responsible for the health disparities they experience, for instance, the IPV that Indigenous women disproportionately experience. When women's experiences are not contextualized historically and socio-politically, there is a danger of interpreting their experiences as innate rather than as resulting from centuries of systematic oppression.

To better understand how cycles of violence against Indigenous women have persisted over time, the history of settler colonialism and European patriarchal influences that continue to impact Indigenous communities to this day must be examined. Colonization occurs when a

power-yielding group deliberately sets forth to alter or eliminate the laws, customs, and belief systems of a community (Burnette, 2015). Colonization of Indigenous populations specifically began after the arrival of Europeans.

Historical Contexts of IPV against Indigenous Women

European colonists established a racialized system wherein white men occupied the top tier of the social and economic hierarchy. Settler colonization is a distinct theoretical framework that highlights the permanency of land occupation. This occupation is arrived at through the extermination of Indigenous peoples, including American Indians, privatization of the land, and exploitation of labor for the purposes of wealth accumulation (Bonds & Inwood, 2016).

The historical atrocities that were inflicted against Indigenous populations by Europeans over hundreds of years caused a great deal of trauma that has left deep scars, which is referred to as historical trauma. Historical trauma is described as the cumulative, emotional, and psychological wounding, extending over an individual lifespan and across generations (Brave Heart, Chase, Elkins & Altschul, 2011). Mainly, the framework of historical trauma describes the unresolved trauma of genocide, loss of culture, loss of language, kinship systems, and forcible removal from family and communities (Kirmayer, Gone, & Moses, 2014).

Racial Stereotypes and Prejudice

From their first arrival in what is now the US, Europeans believed they were entitled to the land, as well as to the bodies of the Indigenous women who inhabited the land (Burnette, 2016; Casselman, 2016; Deer, 2015; LeMay, 2018). Violence against Indigenous women became a means of colonial conquest by European settlers. The social construction of Indigenous women by European men as exotic and sexually promiscuous led to the idea that Indigenous women were available and free for sexual violation (Casselman, 2016; Deer, 2015; Weaver, 2009). These stereotypes are still pervasive in contemporary representations of Indigenous

women in all aspects of society. For example, the word ‘squaw’ still commonly appears in city and park names and media representations (Merskin, 2010). This dehumanizing and disenfranchising term, which stems from an Indigenous word for vagina, has been used pejoratively against Indigenous women and underscores the continued pervasive representations of Indigenous women (Merskin, 2010).

Indigenous women also experience prejudice through invisibility, which is driven by a lack of media coverage. There are often nationwide manhunts, alerts, and round-the-clock news coverage when an affluent, white woman goes missing. However, news coverage can be minimal to nonexistent when an AI woman or girl goes missing. For example, when Jayme Closs, a white teenage girl, went missing in Wisconsin, her disappearance was continually covered by every major news outlet in the nation (SBI, 2019). However, the disappearance of young Indigenous women like Ashley Heavyrunner Loring received minimal news coverage, and her family received minimal assistance from federal authorities in determining what might have happened (SBI, 2019). Many missing and murdered Indigenous women today remain unnamed and their disappearances unknown or unheard of.

Jurisdictional Confusion and Lack of Justice

In addition to historically rooted prejudice, the perpetuation of violence against Indigenous women is linked to oppressive policies that have slowly eroded the inherent right of tribes to self-govern. In the US., Supreme Court decisions in the late 1800s and early 1900s not only assaulted tribal sovereignty, but also created much jurisdictional confusion. These decisions transferred jurisdiction from tribal authorities to federal authorities (Major Crimes Act) and to some state authorities (Public Law 280) for certain severe crimes committed on tribal lands by Indigenous persons or committed by non-Indigenous persons (Oliphant v. Suquamish). The Oliphant vs. Suquamish ruling was particularly detrimental taking into account that much of the

violence against Indigenous women is perpetuated predominantly by non-Indigenous men (Rosay, 2016).

Indigenous women have therefore become targets for violence by sex offenders and predators who are aware of these jurisdictional loopholes. Federal authorities have also failed Indigenous women by declining to prosecute 67% of sexual and other assaults occurring on tribal lands from 2005-2009 (National Congress of American Indians, 2013). The 2013 Reauthorization of the Violence against Women Act (VAWA) restored some of the lost jurisdictional authority to tribes for the arrest of non-Indigenous perpetrators; however, prosecutions have been minimal due to a variety of reasons, such as lack of ability to carry out due process or lack of tribal resources (Casselman, 2016).

Contemporary Contexts of IPV and Indigenous Women

Indigenous women often face a myriad of barriers when seeking help after experiences of IPV, as a result of racial prejudice, lack of trust in healthcare providers and authority figures, as well as geographic barriers (Burnette, 2016; Casselman, 2016; Satyen, Rogic, & Supol, 2018). The individual lived experiences of IPV may also differ for Indigenous women in various geographic locations in the US. IPV support services, which can include shelter, food, group therapy, legal assistance, and advocacy (Hawkins, et al., 2017), can be inaccessible to women due to factors compounded by potential geographic and economic distance.

Access to care in tribal health centers or shelters, for example, is primarily impacted by geographic location and tribal affiliation (Raglan, Lannon, Jones, & Schulkin, 2016). Indigenous women residing on reservations and in rural areas may have difficulty accessing transportation and specialist care, and receive less than adequate care (Raglan, Lannon, Jones, & Schulkin, 2016). While the number of Indigenous women who live in urban areas is increasing, the relocation of Indigenous populations from rural reservations to urban areas has resulted in the

loss of access to tribally affiliated health care services (Raglan, Lannon, Jones, & Schulkin, 2016).

Issues of Trust

There are legitimate reasons why Indigenous women may distrust healthcare providers or have a fear of accessing the healthcare system. These include experiences with racism and dehumanizing treatment over many years. For example, the Indian Health Service (IHS) was complicit in modern forms of genocide through forced or coerced sterilizations and abortions. In 1976, the Government Accounting Office uncovered the practice of "incidental" tubal ligations or hysterectomies performed during unrelated routine procedures, without consent, or consented under coercion. Records verified that IHS practitioners performed 3,406 sterilizations between 1973 and 1976 (Rutecki, 2010).

During this same period, increase in abortions occurred in IHS clinics. Between 1972 and 1978, a reported increase of 130% in abortions occurred on one Navajo reservation alone (Rutecki, 2010). It is crucial to highlight that the increased abortion rates, tubal ligation, and hysterectomy procedures were not from Indigenous women exercising their reproductive freedom. Instead, it was IHS healthcare professionals who terminated reproductive rights as a means of attempting to control the Indigenous population (Rutecki, 2010).

Unfortunately, this practice continues among some Indigenous communities that span the US-Canadian border. For example, in Canada in 2018, sixty Indigenous women filed a class-action lawsuit against the Royal University Hospital in Saskatoon for sterilizations that took place without informed consent between 1995 and 2017 (Moran, 2018). Indigenous women reported that while they were actively in labor, they would be "approached, harassed, and coerced into signing the consent forms" and "could not see their baby until they agreed to a tubal ligation" (Moran, 2018). While the authors are speaking from a positionality within the US, the

authors recognize that many of these experiences are shared experiences by Indigenous peoples that traverse geographic borders and have relevance in not only Canada but even in New Zealand and Australia where there is also a similar history of settler colonialism.

Nurses are indeed in a unique position to provide reassurance to victims of IPV, that they are in a safe and supportive environment, without judgement. For some Indigenous victims of IPV, the nurse may be the first and only person that she has encountered who can offer the opportunity to effectively screen for IPV, provide support, and the necessary resources to her. Nurses must, therefore, be prepared with a deep understanding of the realities and needs of women who have experienced IPV, and the contexts in which it occurs.

A postcolonial and Indigenous feminist framework in research can also contribute to the development of culturally informed and effective approaches to IPV research. This framework considers the history of oppressive practices in the provision of healthcare to ethnic minorities, including Indigenous women, and how it affects trust, IPV disclosure and even healthcare access or help seeking. Research that centers the voices and experiences of Indigenous victims and survivors of IPV can contribute to practice through the development of interventions that are victim and survivor led and thus more practical and effective.

Lastly, the use of postcolonial and Indigenous feminist frameworks in research support an anti-oppressive research approach, particularly when used in conjunction with methodologies that seek to privilege the voices of vulnerable populations. Vulnerable populations are especially at risk of experiencing health inequities resulting in poor health outcomes, including from objectification through oppressive research practices (Tuhiwai Smith, 2012. Methodologies that are anti-oppressive address the power differential between researcher and participant or communities, thereby lessening any potential negative impacts, and promoting meaningful change (Coughlin & Brydon-Miller, 2014).

Discussion

Utilizing postcolonial and Indigenous feminist frameworks as an approach to nursing research focused on IPV in the lives of Indigenous women contributes to a deeper understanding of the relationship between colonization, historical oppression, and the ongoing structural violence that still exists in Indigenous communities today. These frameworks facilitate a deeper understanding of the contexts in which Indigenous women experience IPV and ensures that interventions developed are tailored to women's unique sociocultural needs. Additionally, exploring and understanding the contextual and root causes of violence in the lives of Indigenous women empowers nurses to inform policy, and promote the development of health interventions that are culturally safe and rooted in Indigenous women's contemporary realities that are historically situated.

There has never been a greater need than now for nurses to develop a consciousness about the reality of violence experienced by women and Indigenous women in particular. Nurses have a unique opportunity to help stop the cycle of abuse through an increased understanding and awareness of the injustices experienced by Indigenous. Breaking the cycle of violence can be accomplished through consistent IPV screening, providing validation and support to victims, and through advocacy efforts such as identifying community resources available to women so they may be referred appropriately

There are opportunities for the synergy of nursing interventions and care, research and scholarship, and social action to address IPV in the lives of Indigenous women as a public health crisis and a social justice issue. Indigenous women who experience IPV deserve and need a tribal-centric response to their unique and individual experiences (Deer, 2015). This involves a nursing response that centers a contemporary Indigenous woman in her own place and time,

empowering her to access the collective strength and wisdom that have enabled Indigenous peoples to survive (Deer, 2015).

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Purpose of the Study

The purpose of this qualitative dissertation study was to better understand the lived experiences of and impacts of intimate partner violence (IPV) among American Indian women in the local context. This study address gaps in the literature surrounding the phenomenon of violence against American Indian women, specifically American Indian women residing in urban areas in Wisconsin. To my knowledge, there are currently no studies published about the incidence or prevalence of violence of IPV against American Indians women in Wisconsin, or about their individual lived experiences with IPV.

A qualitative study was necessary in order to accomplish the research aims of gaining a deeper understanding of the individual lived experiences of IPV, as well as to understand how historical, social, and political processes exacerbate IPV rates against American Indian women centered in their contemporary realities. The understanding of complex issues can only be gained through data that is obtained through in-depth individual interviews with American Indian women.

My justification for this study was both personal and professional. My personal justification stems from my positionality as an enrolled member of the Bad River Ojibwe tribe, as a nurse researcher, as well as my experience as an IPV survivor. Conducting this study was also important to me, because as stated previously, the incidence of IPV is higher against American Indian women than any other racial group in North America. A dissertation study that explores the stories and experiences of American Indian IPV victims will help inform the work of nurses and allied health professionals with insights gained of the lived realities of AI women in urban areas.

Methods

Research Aims and Questions

The purpose of this qualitative dissertation study is to explore the perceptions of IPV among American Indian women to better understand the individual lived experience of, and the impacts of IPV.

Specific aims of this study include: 1. To deepen our understanding of the individual lived experience of IPV in the lives of American Indian women living in urban areas, 2. To better understand the needs and health outcomes of American Indian women after an IPV experience living in urban areas. 3. To determine the impacts of IPV on the health and wellbeing of American Indian women. 4. To determine the impacts of violence against American Indian women on the health and well-being of American Indian communities.

To accomplish these research aims, the following research questions are proposed:

1. What is the lived experience of violence in the lives of American Indian women urban areas, 2. What are the health needs of American Indian women residing in urban areas (Milwaukee) after an experience of IPV 3. What are the impacts of IPV on the health and wellbeing for urban American Indian women 4. What are the impacts of IPV against American Indian women on the health and well-being of American Indian communities?

Research Design

Kincheloe, McLaren, Steinberg, & Monzo (2018) propose that mainstream research practices contribute to the reproduction of the status quo in term of race, gender and class. Several research methodologies have been historically interlinked with colonialism as early researchers objectified Native communities and appropriated knowledge and information about the "savages" to colonizers for their colonial expansion (Tuhiwai Smith, 2012). Because of past exploitation and objectification, many indigenous peoples view research with suspicion and consider it a "dirty" word (Tuhiwai Smith, 2012).

It is, therefore, important that critical scholars are committed to working in solidarity

with people who are oppressed (Freire, 2008). However, working in solidarity with those who experience oppression may be difficult for researchers who are socialized within mainstream or Eurocentric society. Researchers must prioritize the meaning that research participants make of their situation as opposed to imposing meaning onto participants (Suzack, 2010). It is also imperative for researchers to be reflexive in the research process, by being aware of their own power, privilege, and values (Tuhiwai Smith, 2012; Mkandawire-Valhmu, 2018; Denzin & Lincoln, 2018). This study was conducted using a critical ethnography methodology.

Critical Ethnography

Critical ethnography was chosen for this study because it calls for an examination of the patterns of power and domination in social and political interactions, as well as addresses the processes of injustice or unfairness (Madison, 2012). Critical ethnography is a type of ethnography which embodies critical theory as its organizing framework. This method brings forth a critical investigation of culture, power, and structural relations with an overarching goal of freeing people from domination, injustice, and oppression (Anderson, 1989). The central aims of critical ethnography are to explain events, enhance understanding, and generate insights about social phenomena (Anderson, 1989). A study utilizing critical ethnography begins with the ethical responsibility of the researcher to disrupt the dominant narrative and move from "what is" to "what could be", (Madison, 2012). Researchers who use critical ethnography have an ethical obligation to make a contribution toward changing conditions that lead toward greater freedom, equity, and justice (Madison, 2012; Denzin, 2018).

Critical ethnography aligns with the fundamentals of critical indigenous pedagogical practice. Exploring issues of race, gender, inequality, injustice, and oppression deepens our understanding of the context of Wisconsin American Indian women residing in urban areas after an experience of IPV. It has been argued that traditional research practices contribute to the

reproduction of oppression based on race, gender and class (Burnette, 2015; Denzin, 2012; Madison, 2012). Ethnography, in particular, has been interlinked with colonialism, due to early ethnographers gathering knowledge and information about the "savages" and then providing this knowledge to colonizers for their colonial agenda and expansion (Jordan & Yeomans, 1995; Smith, L.T., 1999).

Using a critical inquiry in research can help clarify the ways historical dynamics are manifested in cultural behaviors including gendered violence against women. The perpetuation of inequality and injustice is unveiled when the dynamics of privilege and oppression are understood (Quantz, 1992). Critical ethnographers detail participants' human agency and resistance to oppressive domination and subjugation. Quantz (1992) added that culture is the result of enduring political and social struggle of groups with differing levels of power to understand their experiences.

Description of Research Sample

This study included participants who were purposively selected. Inclusion criteria for the participants included (a) adult female (b) having experienced lifetime IPV including physical, emotional, psychological, and/or sexual abuse (c) self-identify as being Indigenous or American Indian (d) currently reside in urban areas of Wisconsin (e) not currently at risk for harm or violence.

Recruitment

In collaboration with the AI communities in two large urban areas, AI survivors were recruited for the study by responding to flyers, which were distributed at the following health facilities and social service agencies primarily serving American Indians: Gerald Ignace Indian Health Care Center, Sojourner Family Peace Center, HIR Wellness Institute, other local community agencies, community recreation centers, mental health service providers, criminal

justice and law enforcement agencies, other local domestic violence centers, local pow wows when they occur, and Indian Community School. Referrals from several local domestic violence shelters such as Sojourner Family Peace Center, Hope House, Fresh Start Learning, Impact, Wounded Wings, and any other local victim services for those who have experienced IPV, and referrals from social workers or staff from Indian Community School were accepted. To recruit American Indian women in the Fox Cities urban area including cities such as Green Bay, Appleton, Oshkosh, and Neenah, fliers were distributed by Reach Counseling Services and Wise Women Gathering who provide IPV services to American Indian women in their clinics located in Neenah and Oshkosh, WI. The flyer provided a brief overview of the study and study objectives, and inclusion criteria.

Additionally, snowball sampling, which relies on existing study participants to recruit future participants from among their family, acquaintances, or other community members, was used as an effective recruitment strategy for this study. (Ritchie, Lewis, & Elam, 2003). Approximately 1/2 of the survivors were referred by another participant who had participated in the study. This method is especially crucial for communities that are challenging to gain trust and entry into, such as AI communities. This method is also useful for difficult to reach and vulnerable populations, especially due to the highly sensitive nature of the research topic of IPV. (Appendix H).

Demographics

Interviews took place with 34 AI survivors[2] of IPV that resided in urban areas of Wisconsin as their primary residence, although several of the survivors frequently travel back to

[2] For this study, we refer to participants as "survivors" to honor women and their capacities in spite of the trauma they have endured from IPV

their reservations in rural areas of the state. Survivors ranged in age from 20-53, with an average age of 38 years. All 34 of the survivors in the study experienced at least one form of IPV by one or more intimate partners. All of the survivors were enrolled members of a federally recognized tribe, with some of the survivors being of more than one tribe. All survivors reported having one or more pregnancies in their lifetime. Most of the survivors (85%) had one or more children, ranging between 1-7 children with an average of 2.7 children. Their children ranged in age from 1 month to 34 years. Two survivors were pregnant at the time of the interview with one being in the first trimester, and the other in the third trimester. Regarding marital status, .05% of survivors were married, 29% were divorced, 32% were separated, 53% were single, and .02% widowed.

Regarding education, .05% of survivors completed some high school, .05% held a GED, 21% had a high school diploma, 26% had some college, .05% had an associate degree, 29% had a bachelor's degree, and 12% had a master's degree. Several survivors (26%) worked as professionals (e.g., mental health, social services, child care, and victims services), 21% of survivors worked in the service industry (e.g., bartending, waitressing, or gaming), 18% of women were not employed, disabled, or performed volunteer work without pay, and 35% of the survivors were currently unemployed due to COVID-19 whether through temporary furlough or permanent lay off. The salary range for survivors was from $0-$75,000 per year with an average salary of $29,487 per year.

There were two survivors who volunteered for interviews that were excluded for safety concerns. Both survivors were previously working prior to the COVID-19 pandemic, but both were impacted when the stay at home order was declared. Both survivors were sheltering at home with their abuser and were not able to safely participate in a phone or Skype interview. Both survivors were provided with information on available resources in the area in which they

lived. There were two survivors who volunteered for interviews that were excluded for safety concerns. Both survivors were previously working prior to the COVID-19 pandemic, but both were impacted when the stay at home order was declared. Both survivors were sheltering at home with their abuser and were not able to safely participate in a phone or Skype interview. Both survivors were provided with information on available resources in the area in which they lived. (Appendix E).

Setting

Ten interviews were conducted face-to-face at HIR Wellness Institute in Milwaukee, and three conducted via home visits, and twenty-one interviews were conducted via Skype or over the phone due to the social distancing mandates related to COVID-19.

Methods of Data Collection

Procedure

A semi-structured interview guide was reviewed with tribal key informants and revised, as needed, to ensure cultural sensitivity prior to conducting interviews with participants. Data were collected through individual interviews with survivors from February to May of 2020. Thirteen interviews were conducted face-to-face and twenty-one interviews were conducted via Skype or over the phone due to the social distancing mandates related to COVID-19. Demographic data were collected to contextualize the lives of the AI survivors (Table 1). All participants were given a $50 gift card for their time and participation in the study.

The interviews were audio recorded and professionally transcribed. Interpretive analysis was achieved by listening to the recorded interviews and reading the transcribed interviews several times in order to gain a deeper understanding of the data. The data from the transcribed interviews was then analyzed into initial codes and then grouped into themes using thematic analysis.

Prior to the interview questions, the researcher provided an introduction of the interview, reviewed the purpose of the study, reviewed the content of the consent form, and use of the recording device was explained. Demographic and background information was collected at that time as well. An introduction and instruction included a statement similar to:

"Thank you for agreeing to talk about your experience with intimate partner violence with me. I am interested in your experiences with intimate partners that have involved violence during your life. Feel free to ask me questions. You do not have to answer any question that you do not feel comfortable answering. If you need time to think about any of the questions, feel free to let me know and we can come back to it".

The interview was audio recorded to ensure accuracy of the data. The recordings were professionally transcribed immediately following each interview. Each audio file was stored on an iPad issued by UWM. The original transcript was destroyed after transcription was complete. The consent form was be reviewed with each participant and written consent for the study was obtained.

To encourage more involvement in the study, the participants were reminded that their data and stories would be de-identified to protect their confidentiality. The researcher will not use participant names in oral or written reports, link the data, or publicly identify the subjects as participants in the study.

Interview Questions

Semi-structured interview questions were informed by postcolonial and Indigenous feminist frameworks are outlined in Appendix D.

Ethical Considerations

Cultural Safety and Reflexivity

Oppression is the subjugation of a group through social, economic, political and/or

cultural dominance that results in negative consequences or impacts. Anti-oppression involves recognizing, acknowledging and acting to equalize the power imbalances that exist in our communities. Anti-oppression is a stance that guides practice, particularly when working with oppressed individuals and communities. Anti-oppression involves recognizing differing types of oppression that marginalize individuals based on their gender, sexual orientation, race, religion, age, ability, and colonization (Coughlin & Brydon-Miller, 2014).

Anti-oppression researchers ensure that they practice self-reflection, are reflexive, recognize oppression, and they shed light on power and privilege (Coughlin & Brydon-Miller, 2014). Their research agenda also promotes action, resistance and reciprocity. Researchers can avoid replicating oppression by avoiding research that may promote further oppression of a community. Anti-oppression researchers do not just focus on their own individual research, but rather focus on making systemic change within institutions in order for future research to be done in anti-oppressive ways (Coughlin & Brydon-Miller, 2014). Self-reflection encourages us as researchers to become more reflexive in our thinking and explores ways of mitigating the oppression experienced by the research participants (Coughlin & Brydon-Miller, 2014).

Vulnerable populations are especially at risk of experiencing health inequalities, resulting in poor health outcomes, including from research. Therefore, research that is beneficial to marginalized populations is crucial to addressing disparities. Researchers are morally and ethically obligated to deliberately use methods and to engage in processes in their conduct of research, that are culturally safe. Mkandawire-Valhmu (2018) argues that an essential element of cultural safety is the "need to uphold the human rights, self-worth, and dignity of all people, regardless of race, ethnicity, sexual orientation, class, or social location" (p. 27).

Protection of Human Subjects

American Indian women who have been victims of abuse are considered to be especially

vulnerable. Because of the complex history of research with American Indian communities, special ethical precautions for this study will be taken. Potential risks were minimized in the following ways: (a) All participation was voluntary and the researcher reminded participants throughout the interview of their right to stop participation at any time and to not respond to any of the questions asked if they are not comfortable responding, (b) Any women who self-identified as being currently at a safety risk was excluded from this study due to potential for retaliation by their partner, and (c) To ensure they had most privacy along with psychological and physical comfort, participants were control of the time, place, and the interview if they consented to participation. Participants were given options about where the interviews could be held including locations such as HIR Wellness Institute or their private home, and either phone or Skype once social distancing mandates were put in force. Participants were able to take as much time as they needed to decide on whether to participate in the study.

If women experienced any psychological discomfort during the interview, the researcher, a master's prepared nurse with experience in mental health and trauma informed care was prepared to take steps for appropriate referrals. Participants were probed to assess their psychological well-being throughout and at the end of interviews. As an additional precaution, a resource guide with a list of relevant IPV, mental health, or AODA resources was given to all participants.

IRB approval was obtained from both UW-Milwaukee and the Ho-Chunk Nation IRB. Per the Indian Health Service national IRB board, it was not necessary to have IRB approval from each respective tribe that the women residing in Milwaukee may belong to because Milwaukee is an urban area and not located on any particular tribal reservation boundaries. Each participant volunteered to be interviewed and written informed consent was obtained by the researcher. The participants were allowed to refuse to be interviewed at any time.

Intellectually challenged women, and women experiencing extreme PTSD or other mental health manifestations of abuse were not eligible to be interviewed. Patient confidentiality was upheld at all times. Consent documents were created at a 4th grade reading level and checked for culturally appropriate language and other cultural considerations.

Data Analysis

Data from this study was analyzed using the principles of thematic analysis. Thematic analysis is a method used in qualitative research for the identification, analyzation and interpretation themes, or patterns of meaning, within data (Braun & Clark, 2015). Thematic analysis is useful through the emphasis of a flexible and organic approach to the generation of codes and themes from qualitative research data (Braun & Clark, 2015). The flexibility with this method is that it is not tied to a particular epistemological or theoretical perspective, unlike many qualitative methodologies. Braun & Clarke (2006) provide a six-phase framework for conducting thematic analysis. 1.) Become familiar with the data 2.) generate initial codes 3) identification of themes 4.) review of identified themes 5.) defining and naming themes 6.) write up.

The interviews were audio recorded and professionally transcribed. Interpretive analysis was achieved by listening to the recorded interviews and reading the transcribed interviews several times in order to gain a deeper understanding of the data. The data from the transcribed interviews was then analyzed into initial codes and then grouped into themes using thematic analysis.

The thematic diagrams below illustrate the themes identified from the interviews conducted with AI survivors.

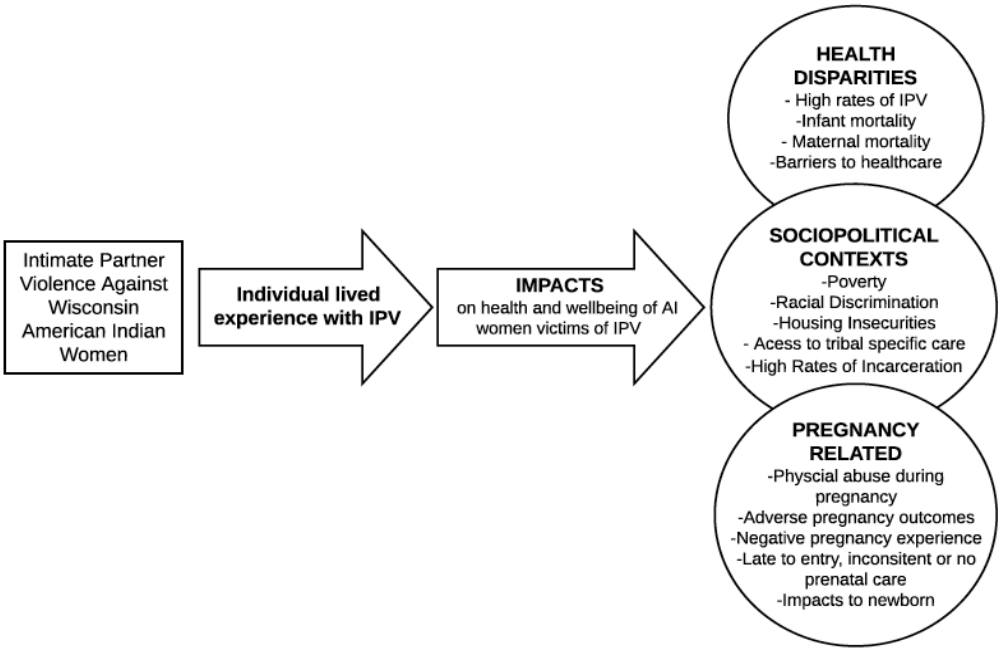

Figure 1. Thematic diagram summarizing AI women's experiences with IPV during pregnancy

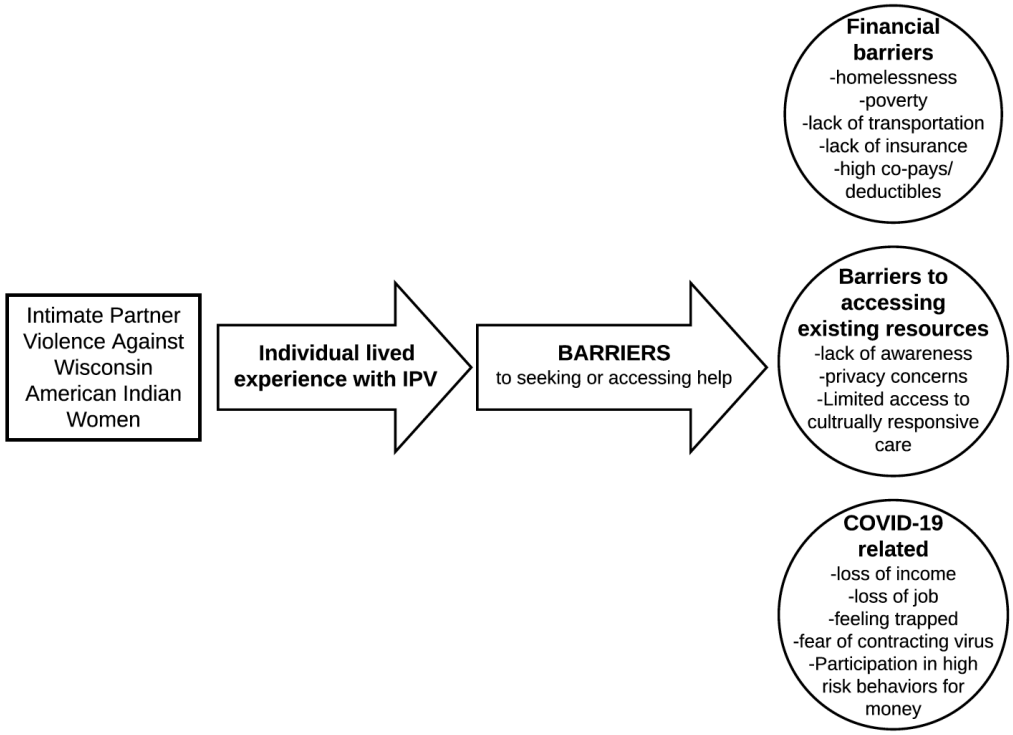

Figure 2. Thematic diagram summarizing AI women's experiences with barriers to help-seeking after experiences of IPV

Rigor and Trustworthiness

When conducting qualitative research, there is a need to clarify that the research findings are representative of the realities of the situations and of the persons that have been interviewed (Bloomberg & Volpe, 2008).

Credibility

Credibility is a method in research to establish trustworthiness by examining accuracy of the data, data analysis, and conclusions. For qualitative researchers, credibility specifically means that there is a match between the researcher's portrayal of participants and the participant's perceptions. Bloomberg & Volpe (2012) discuss the following methods that qualitative researchers can use to enhance credibility in qualitative studies including self-

reflection, prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy, and member checking. Credibility was established in this study through member checking. All survivors interviewed were offered the opportunity to participate in member checks post-interview. Five of the 34 survivors participated in this process. All survivors validated the accuracy of the written transcript of their interview, to ensure that they were consistent with their experiences with IPV, as well as verification of the themes of interpretations of data of five randomly selected de-identified transcripts. Credibility was also established through peer-debriefing with research mentor throughout the research process. Confirmability was enhanced through continuous, in-depth and reflective journaling throughout the research process.

Self-Reflection

Self-reflection of the researcher helps to clarify any biases that could be introduced into the study. Prolonged engagement with the intended research community allows for the learning of traditions and customs of the participants and helps to build trust with participants. Persistent observation is used to enhance credibility by allowing for in-depth exploration of what the researchers are examining and investigating in detail. This ensures that the researcher's interpretation of processes and interactions in the setting are trustworthy.

Peer Debriefing

Peer debriefing is used to ensure that none of the researchers inadvertently incorporate their biases into their analyses (Ritchie, Lewis, & Elam, 2003). This method consists of researchers asking a colleague or another person to review the study to determine if the results align with the data. The PI's major professor will perform an audit of the interviews to confirm the analysis of the qualitative interviews. Negative case analysis is used to identify and determine discrepancies in data. Referential adequacy is a method used to store raw data in

records to examine later and to compare to other future studies to demonstrate the credibility of data (Ritchie, Lewis, & Elam, 2003).

Dependability

Dependability is the ability to track the processes or procedures used to collect and interpret the data findings. This is done by providing a thorough and detailed explanation of how data was collected in the study, how it was analyzed, and providing an "audit trail" during this process. Dependability is also established by involving other researchers or colleagues to code some of the transcribed interviews. This also helps to minimize potential bias of the principal investigator (Bloomberg & Volpe, 2008). Dependability was established through an audit trail and co-authors' verification of identified themes. Two AI community members (Ho-Chunk Nation and Bad River Band) also served as cultural guides as well as provided ongoing spiritual and emotional support to the researcher during the study.

Confirmability

Confirmability refers to the extent that a result can be confirmed by others. There is an underlying assumption in research that every researcher approaches the study with personal perspective informed by their individual lived experiences and worldview (Morrow, 2005). Therefore, exercising continuous reflexivity is a critical component of maintaining confirmability in qualitative research in order to minimize researcher bias and increase trustworthiness (Maxwell, 2012). Confirmability was enhanced in this study through daily and as needed, in-depth journaling throughout the research process to practice frequent self-reflection.

Transferability

Transferability is another method used by qualitative researchers to establish trustworthiness. In qualitative studies, transferability means the ability for the data analysis and study findings to be applied to similar contexts and settings. Qualitative researchers use this

method by providing a detailed and rich description of the study site, participants, and to explicate the study demographics and findings in such a way that other researchers can assess how the findings are applicable to their own research contexts (Bloomberg & Volpe, 2008). Transferability was enhanced in this study by providing detailed and rich descriptions of the contexts and process of the study, my role as a researcher, the participants and as well as the assumptions undergirding my study.

Limitations

This qualitative study is not without limitations. The study relied on self-reports from participants. IPV is a highly sensitive topic and AI survivors may have felt unable to disclose anything that could be considered unlawful. In this regard, there may be important additional information that was not obtained through the interviews. The use of telephone and skype interviews for some of the interviews was not ideal. I would have preferred to interview all of the survivors in person to allow for a closer analysis of non-verbal communication on the part of women participating. However, due to the social distancing mandates related to the COVID-19 pandemic, it was not possible to interview all of the survivors in person. Nevertheless, the analysis demonstrated consistency between the narratives of the women who were interviewed in person and those of women interviewed using other channels.

Chapter IV

This chapter provides an analysis and synthesis of the findings reported in the two findings manuscripts. Manuscripts 1 and 2 primarily focus on the findings from interviews with survivors. The last section of this chapter provides a brief summary of themes identified from interviews that were not discussed in the prepared manuscripts. Consistent with a postcolonial feminist perspective, my intention is to focus on the women's narrative.

Manuscript 2: Barriers Faced by American Indian Women in Urban Wisconsin in Barriers Faced in Seeking Help Following an Experience of Intimate Partner Violence

The first manuscript reports on the barriers that AI women may face when help seeking after an IPV experience. It is formatted based on the author's guidelines for *Violence Against Women*, which is the target journal for this publication. The manuscript provides a summary of pertinent literature on contextual and structural barriers that women of color, and particularly American Indian women face, postcolonial and Indigenous feminist methodology, the data collection, narratives of the survivors, and data analysis process followed by a description of the findings based on the voices of the survivors. The results were analyzed, and policy and practice recommendations are discussed.

Barriers Faced by American Indian Women in Urban Wisconsin in Barriers Faced in Seeking Help Following an Experience of Intimate Partner Violence

Abstract

Background: American Indian[3] (AI) women face the highest prevalence rates of intimate partner violence (IPV) (Finfgeld-Connett, 2015). AI women also face many barriers to help seeking after experiencing IPV.

Purpose: The purpose of this study was to better understand the barriers to seeking help by urban AI women after an experience with IPV.

Method: This critical ethnography study used data from semi-structured qualitative interviews with 34 AI survivors living in urban areas in Wisconsin. The study was informed by postcolonial and Indigenous feminist frameworks to frame our understanding of the context in which IPV occurs.

Findings: Findings show that urban Wisconsin AI survivors experience IPV within the context of racism and poverty, which intersect to impact help seeking and ultimately, women's health outcomes. The COVID-19 pandemic served to exacerbate barriers to help seeking.

Discussion: Context specific interventions are necessary to address barriers that urban AI women face in order to reduce the devastating impacts caused by IPV especially taking into account the ongoing Covid-19 pandemic.

Keywords: Intimate partner violence, domestic violence, barriers, help-seeking

[3] The Bureau of Indian Affairs (BIA) defines American Indian (or Native American) as an individual who is a 'member' of an Indian tribe, band, or community 'recognized' by the federal government; who lives on 'or near' a reservation; who is of 1/4 or more Indian ancestry. This includes American Indians, Alaskan Natives and Pacific Islanders.

Background

Nurses have a critical role to play in the support, treatment, and prevention of intimate partner violence (IPV) in the lives of women, especially for populations that are at greatest risk for violence. IPV in the lives of AI women is one of the most serious public health and human rights issues occurring in AI communities today. AI women experience violence at a higher rate than any other ethnic minority group in the United States (Casselman, 2016; Finfgeld-Connett, 2015). The United Nations (2013) has also described violence against AI women as "endemic" (p. 22). According to the 2010 National Intimate Partner and Sexual Violence Survey (NISVS) report conducted by the National Institute of Justice, up to 84.3% of AI women have experienced violence in their lifetime (Rosay, 2016). This includes 55.5% of AI women who have experienced physical abuse by an intimate partner, and 42.2% experiencing severe physical abuse by an intimate partner (Rosay, 2016).

Barriers to Help Seeking

Despite the severe negative impacts of IPV many women do not seek help after experiencing IPV (Satyen, Rogic, & Supol, 2018). This is especially the case for ethnic minority women (Women of Color Network, 2006). Understanding the reasons why AI women choose to not seek help and the barriers they experience when seeking help after an experience of IPV is critical. Without help, ongoing or repeated instances of IPV against women has been associated with depression, anxiety, and post-traumatic stress disorder (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Childress, 2013; Stockman, Hitomi, & Campbell, 2014). Additionally, evidence strongly suggests that experiencing ongoing IPV increases the risk of other mental health conditions, including self-harming behavior, suicidal ideation, eating disorders, and other anxiety and mood disorders, substance abuse, and sleep disturbances (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Childress, 2013). Without intervention, repeated acts of

IPV may lead to serious physical injury or even loss of life (Burnette, 2015). Women may also experience a reduced quality of life as a result of IPV, which impacts not only self-care, but also education, employment and women's overall wellbeing and contribution to society (Stockman, Hitomi, & Campbell, 2014).

The individual lived experiences of IPV and the barriers to help seeking are unique to each survivor and are impacted by a variety of factors. Help seeking behavior is any type of behavior or activity that involves an external source of help such as advice, information, treatment, or general support in response to the problem being experienced (Satyen, Rogic, & Supol, 2018). In the case of IPV, of greatest interest to nurses is help seeking that involves the healthcare system as this is the context in which nurses are most capable of minimizing barriers to help seeking for women.

Much of the literature surrounding help seeking behaviors and barriers to accessing help after an experience of IPV is specific to AI women residing on reservation or rural areas. The individual lived experiences of IPV may, however, differ for AI women based on their geographic location. It is therefore critical to gain a localized understanding of urban AI women's experiences and the barriers that they face after an IPV incident.

There are different types of barriers that can hinder help seeking when women are involved in an abusive or violent relationship. The patterns of help seeking behaviors or barriers experienced are not identical across cultural groups, but rather they are contextual and vary upon a variety of factors including geographic location and cultural norms (Satyen, Rogic, & Supol, 2018). Other types of barriers include inadequate structural responses (e.g., lack of enforcement of restraining or protective orders), barriers to healthcare access and lack of or inaccessibility to professional and community resources, as well as IPV related stigma (Overstreet & Quinn, 2013).

There are unique circumstances that exist within the context of communities of color that may account for the underreporting of IPV or barriers to seeking help or care after experiencing IPV (Nnawulezi & Sullivan, 2013). Accessibility of services, such as IPV support services, which can include shelter, food, group therapy, legal assistance, and advocacy are especially inaccessible to ethnic minority women (Hawkins, et al., 2017; Klevens, et al.,2010).

For AI women, access to care in tribal health centers is also largely impacted by geographic location and tribal affiliation (Raglan, Lannon, Jones, & Schulkin, 2016). Overall, approximately 70% of American Indians live in urban areas today due to federal relocation policies, resulting in the loss of access to tribally affiliated health care services (Casselman, 2016). AI women tend to not seek help from mainstream healthcare facilities because of lack of trust of healthcare providers and healthcare facilities where services are often not culturally relevant (Deer, 2015; Hamby, 2004).

COVID-19

During data collection for this study, which occurred over a period of four months, we began experiencing a global crisis due to the Covid-19 pandemic. Disasters and pandemics can create further complexity in terms of how IPV is experienced (Parkinson, 2017). This particular urban metropolitan area was already seeing an uptick in homicides prior to the pandemic with twice as many homicides seen in 2020 as were seen the same time the previous year, and two of every five of these homicides being related to domestic violence (Lutheran, 2020). Consistent with global trends, IPV and sexual assault advocates in Wisconsin began to report an increase in self and police referrals to their agencies by women experiencing IPV after the pandemic began (Lutheran, 2020). AI women experiencing IPV are particularly at increased risk for harm as a result of the "stay at home" measures put in place to combat Covid-19 because home is not necessarily the safest place for them. The constant messages by health officials and the media of

"Safer at Home" can inadvertently send the wrong message by ignoring the violence that may be occurring behind closed doors in the home. These messages also do not convey how emotionally challenging it can be for survivors, who are traumatized as a result of being trapped at home with their abuser, and how increased isolation minimizes women's ability to seek help. Fear of seeking shelter or services may also be exacerbated by fear of contracting and becoming ill with Covid-19 (Lutheran, 2020).

Ethnic minority populations are at greater risk for contracting Covid-19, or experiencing severe COVID related illnesses (CDC, 2020). According to the CDC's report on COVID-19 in the Racial and Ethnic Minority Groups, hospitalization rates for COVID-19 related illness are highest among American Indians and Black persons, followed by Hispanic or Latino persons (CDC, June 2020). In Wisconsin, African Americans make up only make up about 7% percent of the statewide population, yet they account for 22% of the state's COVID-19 cases and 29% of COVID related deaths (Wisconsin Department of Health Services, 2020).

In other parts of the country, American Indians are also disproportionately affected. At the writing of this manuscript, infections on the Navajo nation have surpassed infections in New York city, which was the previous epicenter of the pandemic. Since Covid-19 was first reported on the Navajo Nation in mid-March, infection rates per capita have soared to the highest in the country compared with any individual state (Cheetham, 2020). The COVID-19 pandemic thus only exacerbates the challenges that ethnic minority communities already face, particularly AI women, who already experience high rates of IPV.

It is imperative that researchers pursue the development of new knowledge aimed at identifying the unique needs of AI women who have experienced IPV in the local context. Specifically, there is a gap in the literature surrounding the phenomenon of IPV against AI women living in urban and metropolitan areas. To date, there are currently no studies published

about the incidence or prevalence of violence, nor the individual lived experience of IPV in the lives of AI women in Wisconsin. This study was thus conducted to gain an understanding of the needs and barriers to help seeking of AI women living in urban areas of Wisconsin. In this study, we seek to not only address a major gap in the literature, but we also seek to center the voices of AI women through research led by a nurse researcher who is AI (enrolled member of Bad River Band) and an IPV survivor.

Methodology

Our qualitative study was conducted using a critical ethnographic approach. Interviews with 34 AI women took place in urban cities in Wisconsin during the spring of 2020. Critical ethnography was chosen for this study because it calls for an examination of the patterns of power and domination in social and political interactions, as well as addresses the processes of injustice or unfairness (Madison, 2012). In our qualitative study, we used postcolonial and indigenous feminist epistemologies to inform our analysis of the contexts in which IPV occurs. A critical feminist approach is valuable to advancing nursing science because it allows for a comprehensive analysis of the barriers impacting AI women's access to services taking into account sociopolitical structures and historical processes.

Use of a postcolonial feminist framework in research allows for an understanding and unraveling of the legacies of colonialism through feminist activism (Racine, 2011; Wallaschek, 2015). A postcolonial feminist approach also underscores the need to examine how disparities and inequalities are etched within historical and sociopolitical contexts that ultimately influence healthcare delivery and health outcomes (Racine, 2011; Mkandawire-Valhmu, 2018). Mkandawire-Valhmu emphasizes that a postcolonial feminist perspective encourages us to not only recognize the adverse health outcomes experienced within communities, but also enables us to acknowledge and appreciate the "strengths and capacities they possess on which we can build

to address problems affecting human health" (p. 3).

Indigenous feminism focuses on the gender struggles that engage cultural identity and decolonization specific to Indigenous contexts (Huhndorf & Suzack, 2010). Indigenous feminist activism and analysis promotes the understanding of the complexities and specificities of Indigenous women in their own time and place (Huhndorf & Suzack, 2010). Most importantly, an Indigenous feminist framework in research promotes social justice across race, class, sexuality, and gender lines for all Indigenous people. Additionally, Indigenous feminism creates a space for the promotion of human dignity by supporting and advocating for American Indian's inherent right to self-govern in order to protect the safety and wellbeing of their own citizens (Huhndorf & Suzack, 2010).

Sample and Setting

University and local tribal human subjects' approvals were both obtained prior to data collection. This study included participants who were purposively selected. Inclusion criteria for the participants included (a) adult female (b) having experienced lifetime IPV including physical, emotional, psychological, and/or sexual abuse (c) self-identify as being Indigenous or American Indian (d) currently reside in urban areas of Wisconsin (e) not currently at risk for harm or violence. Interviews took place with 34 AI survivors[4] of IPV that resided in urban areas of Wisconsin as their primary residence, although several of the survivors frequently travel back to their reservations in rural areas of the state. Survivors ranged in age from 20-53, with an average age of 38 years. All 34 of the survivors in the study experienced at least one form of IPV by one or more intimate partners. All of the survivors were enrolled members of a federally recognized

[4] For this study, we refer to participants as "survivors" to honor women and their capacities in spite of the trauma they have endured from IPV

tribe, with some of the survivors being of more than one tribe. All survivors reported having one or more pregnancies in their lifetime. Most of the survivors (85%) had one or more children, ranging between 1-7 children with an average of 2.7 children. Their children ranged in age from 1 month to 34 years. Two survivors were pregnant at the time of the interview with one being in the first trimester, and the other in the third trimester. Regarding marital status, .05% of survivors were married, 29% were divorced, 32% were separated, 53% were single, and .02% widowed.

Regarding education, .05% of survivors completed some high school, .05% held a GED, 21% had a high school diploma, 26% had some college, .05% had an associate degree, 29% had a bachelor's degree, and 12% had a master's degree. Several survivors (26%) worked as professionals (e.g., mental health, social services, child care, and victims services), 21% of survivors worked in the service industry (e.g., bartending, waitressing, or gaming), 18% of women were not employed, disabled, or performed volunteer work without pay, and 35% of the survivors were currently unemployed due to COVID-19 whether through temporary furlough or permanent lay off. The salary range for survivors was from $0-$75,000 per year with an average salary of $29,487 per year.

There were two survivors who volunteered for interviews that were excluded for safety concerns. Both survivors were previously working prior to the COVID-19 pandemic, but both were impacted when the stay at home order was declared. Both survivors were sheltering at home with their abuser and were not able to safely participate in a phone or Skype interview. Both survivors were provided with information on available resources in the area in which they lived.

Recruitment

In collaboration with the AI communities in two large urban areas, AI survivors were

recruited for the study by responding to flyers, which were distributed at health facilities and social service agencies primarily serving American Indians. The flyer provided a brief overview of the study and study objectives, and inclusion criteria. Additionally, snowball sampling, which relies on existing study participants to recruit future participants from among their family, acquaintances, or other community members, was used as an effective recruitment strategy for this study. (Ritchie, Lewis, & Elam, 2003). Approximately 1/2 of the survivors were referred by another participant who had participated in the study. This method is especially crucial for communities that are challenging to gain trust and entry into, such as AI communities. This method is also useful for difficult to reach and vulnerable populations, especially due to the highly sensitive nature of the research topic of IPV.

Data Collection and Analysis

A semi-structured interview guide was reviewed with tribal key informants and revised, as needed, to ensure cultural sensitivity prior to conducting interviews with participants. Data were collected through individual interviews with survivors from February to May of 2020. Thirteen interviews were conducted face-to-face and twenty-one interviews were conducted via Skype or over the phone due to the social distancing mandates related to COVID-19. Demographic data were collected to contextualize the lives of the AI survivors (Table 1). All participants were given a $50 gift card for their time and participation in the study.

The interviews were audio recorded and professionally transcribed. Interpretive analysis was achieved by listening to the recorded interviews and reading the transcribed interviews several times in order to gain a deeper understanding of the data. The data from the transcribed interviews was then analyzed into initial codes and then grouped into themes using thematic analysis.

Guba and Lincoln (1989) recommend the use of strategies for establishing rigor in

qualitative research such as credibility, dependability, confirmability and transferability of the research data. Dependability was established through an audit trail and co-authors' verification of identified themes. Two AI community members (Ho-Chunk Nation and Bad River Band) also served as cultural guides as well as provided ongoing spiritual and emotional support to the researcher during the study. Credibility was established through member checking. All survivors interviewed were offered the opportunity to participate in member checks post-interview. Five of the 34 survivors participated in this process. All survivors validated the accuracy of the written transcript of their audio interview, as well as verification of the themes of interpretations of data to ensure that they were consistent with their experiences with IPV. Credibility was also established through peer-debriefing with research mentor throughout the research process. Confirmability was enhanced through continuous, in-depth and reflective journaling throughout the research process.

Results

Our findings center on the major theme of barriers that urban Wisconsin AI survivors face when seeking help following an experience of IPV. This major theme reveals the complexity of the women's experiences and the complex intersecting factors that make help seeking difficult after experiencing IPV. Each of the survivors experienced individual circumstances and contextual or structural barriers for why they were unable to access or refused help after a particularly dangerous situation. Under this major theme, we identified two minor themes from our data related to the perceptions of barriers to help seeking- *financial related barriers* and *barriers to accessing existing resources*. Sub-themes that fell under the theme of financial barriers include: 1. *I Didn't Have Anywhere to Go and No Way to get to Help*, which speaks to survivors' concerns about finances, housing, homelessness, and transportation, including COVID-19 related concerns; 2. *I Don't Have any Insurance,* which speaks to

survivors' reluctance or refusal to seek medical or other care due to insurance concerns. Sub-themes that fell under the barriers to accessing existing resources include: 1. *I Wasn't Aware of the Resources,* which speaks to the lack of awareness of resources that are available; 2. *The Native Community is So Small*, which speaks to the privacy concerns that survivors had that prevented them from seeking or accessing help; 3. *I Feel Invisible*, which speaks to survivors' inability to access help because they weren't believed, listened to, or the IPV taken seriously, as well as survivors' struggles with needs that were greater than the resources were able to provide for them. Personal barriers such as fear of retaliation or fear of increased violence are beyond the scope of this manuscript and will be discussed in a future publication.

Of the 34 survivors interviewed, 68% refused or were unable to seek medical attention or other types of care after an IPV experience(s) even if they sustained an injury, and 24% of survivors received medical care only because the IPV was witnessed and a call to 911 was placed on their behalf. Some of the survivors interviewed (17%) sought other types of help such as a domestic violence shelter, counseling, or a call to the police.

Financial Related Barriers

Survivors spoke about their struggles with homelessness, housing related challenges, poverty, and lack of transportation to access help after experiences with IPV in their relationships. Of the 68% of survivors who did not seek care or help after an experience of IPV, 30% of survivors specifically cited fear of homelessness or housing challenges as their primary barrier to leaving an abusive relationship or dangerous situation. The remaining 29% of survivors cited financial barriers, lack of insurance, or transportation as the reason for not seeking help. The COVID-19 pandemic only served to heighten survivors' limitations in seeking help, compounded by the trauma or stress of being quarantined with an abuser. During the study period, 12 of the 34 women interviewed had recently lost their employment due to the COVID-

19 pandemic and mandates for social distancing. Many of the survivors worked in service industry jobs such as gaming, food service, or bartending and had either been laid off or furloughed.

I Didn't Have Anywhere to Go and No Way to get to Help

Lack of housing impacts AI survivors' ability to leave a potentially dangerous situation. Housing is an immediate and basic need for survivors of IPV. The additional barriers and complexities that AI survivors face such as poverty, homelessness, lack of transportation, and limited resources may compound the trauma experienced and hinder them from seeking and obtaining help. Not accessing the help that they need puts survivor's at risk for severe injury and even death.

Olive[5], the mother of a 1½ year old, describes how she returned to an abusive relationship to avoid homelessness, because she felt that she had no other options. She explained, "I tried to get help when it (IPV) first started… I was homeless and scared…. which is why I always went back. My parents didn't care about me and my friends were sick of the drama". Olive's experience was typical for many of the other survivors who had limited family support.

Danica, a divorced mother of a 4-year-old child, explained how she was forced to stay in her home with her abuser because she was in school full-time and relied on his income. She also did not have the support of family or friends which compounded the trauma that she was experiencing. "I put up with the abuse too many times to count. I told my parents about it at first and my Dad actually asked me what I did to upset him enough to hit me. I asked if I could move back home, even though it meant leaving the city. I was told that I 'made my bed and needed to sleep in it'. I knew right then that I didn't have anyone. I didn't want to be homeless,

[5] All names have been changed to pseudonyms to protect the identity of the survivors

so I stayed, but then it got worse". The abuse continued until an incident that required medical attention. Danica's abuser was finally arrested, but she ended up losing the home because she could not afford to pay for it on her own.

Amelia, a single Mom of 3 children, described how she experienced homelessness after a particularly dangerous instance of IPV. She began living with her now ex-partner when she first discovered that she was pregnant with her first child because she felt that she "didn't have a choice but to live with him" due to the fact that she was very young and didn't have a job at the time. She explained, "I had to live with him because I had nowhere else to go. And living in that house for five years was like living in absolute hell". After years of living with her abuser, Amelia experienced severe physical abuse that happened in a public area where a witness contacted 911, and she was taken to the hospital for treatment. Once she recovered from her injuries, she was taken to a domestic violence shelter for a short while, and then eventually moved in with a family member who cared for her children while she recovered.

Landlords are primarily interested in protecting their financial interests and may refuse to allow women out of a lease with an abuser after an experience with IPV. As a result, survivors stayed in abusive relationships because they needed housing, or they ended up homeless. Jessica described how she ended up homeless as a result of IPV, resulting in her having to live in her car for several months because she could not get out of a lease with her abuser. She explained: "after the abuse…I ended up pretty much just living out of my car because I couldn't afford a place of my own. I was living in my car for about six months before the lease that I had signed with him had ended and I could enter into a new lease and actually live somewhere." Jessica's situation exemplifies how survivors must navigate complex legal issues including leases with landlords in order to obtain safe housing while experiencing IPV.

Nora, a mother with two young children, shared how she remained in an abusive

relationship for fear of being homeless. She moved to a large city from a smaller reservation-based town to be with her boyfriend, who ended up abusing her. She explained, "right now, I did go back to him… but I really did try to leave and was told that there are no shelters available. And it's pretty scary being homeless here, it's huge and I've probably seen a tiny part of it, so that's part of it too".

Mallory, a survivor without children, stayed with her ex-abusive partner for several years because of homelessness and felt obligated to accept the abuse because she had nowhere else to live. She explained, "I'd just started dating my boyfriend at the time, so I went to his house, I had nowhere else to go, and I said 'I'm homeless, and I don't know where to go'…"so I felt loyal to him from that point forward because he rescued me. He got me off the streets. I had nowhere else to go. That's how I got trapped… and took the abuse".

Chelsea, a survivor without children, described how she stayed in more than one abusive relationship because she did not have anywhere else to live. "It was years that I stayed in relationships, cause it was between 1-2 years that I literally had no way out and no resources".

Tina, a divorced mother of 2 children, was trying to seek help from an organization after her abuser was arrested for assaulting her, but the organization required that she testify against her perpetrator in order to receive housing and furniture from them. She explained "because of domestic violence, I became homeless, so I needed the services, so I had to talk…to put him to jail." Tina struggled to do this because of her fears of his reaction. She explained, "I couldn't face him. I just couldn't. I didn't want to face what happened… I just wanted the whole thing to go away". Tina and her children continued to struggle with homelessness after the incident for "a long time". Tina's story, like so many others, demonstrates how a lack of housing impact survivor's ability to leave dangerous situations, and puts them at risk for reconciling with abusers in order to obtain shelter or other resources.

Nova, a single mother with three children under the age of 8, found it challenging to find housing or employment because of her criminal record, which highlights the complex barriers that survivors face when trying to leave an abusive relationship. She explains, "we need more homeless shelters. A shelter would have been awesome. That's why I stayed as long as I did. It's so hard to find housing, especially when you're a drug felon. It's hard, even if you're not, but it's 10x harder if you are. Having a record has really messed up my life. I guess that's why I feel like not trying anymore because I already have such a bad record that I'm never going to be able to get a good job or a place to live". Nova's story reiterates how the lack of housing or shelter can be dangerous for survivors because they often feel that they have no other option but to stay.

Several survivors expressed their concerns about how the COVID-19 pandemic has impacted the ability to seek help by adding layers of stress, uncertainty, and complexity to an already complicated reality. Mia, a single mother of two children ages 5 and under and also pregnant, moved from her reservation to a city to put distance between her and her abuser. She discussed her unfamiliarity with domestic violence resources since moving to a city, as well as her concerns about the COVID-19 pandemic and how that would impact the services available to her and other survivors. "Back home, that's really all I know, but not here. There's a shelter there, but it's so small. And I feel with the epidemic, like what's going on now, and with domestic violence, there's a lot of cases. There is a need for more housing, maybe just a lot of help with getting homes because I know a lot of women, they either live with their abuser and then sometimes when you wanna get away it's hard to get away if you share a home together. Like right now, with everyone stuck at home together because of the virus".

Mila, a single mother with four children, discussed how her concerns not only for herself, but for others in AI communities about the struggles that survivors face during the COVD-19

pandemic due to the shelter orders in place. She stated, "we're being quarantined in our houses… a lot of discussion in tribal communities is, what about the people that are home with their abuser in there"?

Some of the women interviewed did not have access to personal transportation. Of the 12 participants that were interviewed face-to-face, 4 did not have transportation to the interview. Two of the women took the city bus to the interview site from a different part of the city and it took them 1-1.5 hours to take the bus each way to the interview depending upon which direction they were coming from. This was discovered after the participants arrived at the interview and demographic data was collected. One of the participants was given a ride home after the interview and the other participant chose to take the bus back home. After learning of transportation challenges, remaining participants were asked if they had transportation to the interview site. Two participants requested a home interview because they did not have transportation available to get to the interview. Prior to the interview starting, the participants without transportation expressed how stressful it was to not have transportation, especially with children in the home.

Tina, a divorced mother of two children, described how she did not have a vehicle when she experienced IPV, which resulted in her having to flee from her abuser late at night on foot. She explained, "I opened the door and I went running downstairs barefoot outside, and I asked the neighbor if I could use her phone and she wouldn't let me because I probably looked like a crazy woman". She ended up finding a phone and called her sister who lived in another city. "I called my sister in California and she called an Uber for me to take to my friend's house".

Anna, a single mother with two children under the age of 5, also described the challenges of leaving the abuse because of a lack of transportation. She described how she stayed with her abusive partner for several years because she did not have transportation to leave or anywhere to

go. She explained how after a particularly violent episode of physical abuse, she wanted to call the police, but he took her cell phone from her and broke it. She then had to run down the street to a neighbor's house and they called the police for her. She explained that she told the police, "I don't have anywhere to go. I don't have a vehicle… all I have was his family, but it's his family, not mine".

Some of the survivors expressed their concerns specifically about finances related to the COVID-19 pandemic. The added stress of the manifestations of the pandemic such as loss of jobs, income, or social isolation, serves to compound the difficulties that AI survivors may face when trying to leave an unsafe situation.

Anna expressed concerns about her recent job loss and how it impacted her ability to keep her housing. She explained, "I'm still waiting for unemployment… I've had troubles applying because my claim was rejected, and it is being investigated. They don't think that I'll be called back to work until late summer, so I don't know what we're going to do".

I don't have any insurance

Some survivors refused or reluctantly accepted medical care after sustaining IPV injuries because they did not have medical insurance. The financial concerns related to not having insurance or the ability to pay for services prevented some survivors from seeking help which exacerbated the traumatic experience of an IPV-related assault.

Cheyenne, a single mother of a 7-year-old child, refused medical care after she sustained significant IPV related injuries because she did not have medical insurance. She explained, "I refused to go to the emergency room after he hit me even though I should have gotten stitches because I didn't have any insurance and I didn't want a bunch of bills…I think a lot of people assume that because I'm Native that it's going to be free, but that's not true".

One survivor who reluctantly accepted care faced a large medical bill that caused her

stress after an IPV related experience. Nora was significantly injured by her current partner, which resulted in her being taken to the hospital via ambulance. She did not have medical insurance and was unemployed. Resultantly, she was unable to pay the bill. She explained, "one night he punched me in the face and blood came gushing out and someone called the police because I was running around yelling and screaming outside. The ambulance took me to the hospital even though I didn't want to go because I don't have any insurance... and the total bill is $15,000 and they keep calling me and I have no way to pay it. And if I would have known that, I wouldn't have done it because they said it ended up not showing anything".

Barriers to Existing Resources

Survivors shared their challenges in help seeking or accessing services that met their needs due to contextual and structural barriers including concerns for privacy, ability to access culturally sensitive care, distrust of law enforcement and/or medical professionals, and being unaware of available resources in the community.

The Native Community is So Small

Some survivors refused or were reluctant to seek help from services that were specifically for American Indian women due to privacy concerns.

Chelsea explained that she avoided care at any agencies specifically for American Indian women because she was concerned for her privacy. She stated, "there really aren't many resources here for Native women…because this Native community is so much smaller. People are constantly gossiping. They know where the health center is and know when the group times are, or if they don't know, they know somebody that they can call and find out".

Ashley, a single mom of 5 children, experienced severe physical abuse by her ex-partner. She explained how she chose to not participate in any counseling or support groups after her IPV attack. "In the Native community… I didn't want everybody to know my business. And I'm a

private person…I know it was known what happened to me, but sometimes you don't want to get around other individuals that have had it (IPV) happen to them because they might know who you are".

I Feel Invisible

The feeling of invisibility, or not being heard, or believed was a concern by several of the survivors who were interviewed related to inadequate structural responses. Additionally, when some survivors did seek care, they spoke openly about their experiences with racism or dehumanized treatment, which resulted in their needs not being met. This impacted survivors' ability to receive needed help or services and deterred them from seeking help in the future. One survivor, Chelsea, had experienced abuse by her partner on more than one occasion, and felt that her concerns were not taken seriously. The last time that she experienced abuse by her now ex-partner, she explained that the only way to get an emergency response to IPV was to "say that we had a gun, because of the repeat behaviors and the calls… they take longer to respond. They have said to me in the past 'oh yeah, they're just fighting, whatever, they'll just pass out or something', so there was a risk of a false report just to get help…. They notice you're Native American, and they just want the quick fix… It feels like I'm invisible…so what's the point in even calling for help".

Zoe described how she felt invisible after she experienced abuse from her partner, and her neighbor overheard the situation going on in her apartment and called the police. She explained how her concerns were not taken seriously by the police because "he was a white man and I was a Native American woman living in a white community". She remained in the home, in fear, because the perpetrator was not arrested for the assault.

Ava, who experienced IPV from her ex-husband and was divorced, explains that she refused medical care after an incident of physical IPV because she felt that no one was going to

help her or that no one would take her concerns seriously. She explained "I didn't seek, I refused medical treatment and stuff… nobody's going to help me, so just let me go home and I'll be okay".

Hailey, a single mother of two children, described how she attempted to seek counseling after she experienced IPV by her ex-partner, but she did not receive the help that she was needing because of a lack of cultural understanding. She explained, "I didn't like it…she just had no cultural understanding and really struggled with the way that I had relationships in my life…no understandings around kinship and relationships and family…she had a very individualistic sense of what was right, and it did not fit very well and made me feel ashamed. So, I never went back to counseling there, or anywhere again".

Some survivors felt invisible because they attempted to seek help after an experience with IPV, but their story was not believed, and even resulting in their arrest. By being wrongly arrested, survivors experienced injustice by the very system that was supposed to protect them. Not only did this exacerbate distrust, but it also placed women at higher risk of severe injury or even death because they become even more reluctant to seek help particularly in a crisis situation.

Chelsea explained that she called the police for help when the abuse with her ex-boyfriend began, but then stopped reaching out for help when the perpetrator was never held accountable for his actions. She explained, "I did call the police a few times after abuse, a lot of it was when I was intoxicated. They didn't take my injuries or anything seriously. They would make me leave for the night and cool down and let my abuser stay and they never arrested him because I would fight back, or they didn't believe me".

Mila experienced a similar situation in which she was arrested after being physically assaulted by her ex-partner because she was on probation. She explained, "he came home drunk

one night and started hitting me and we were fighting… and 'cause we lived in an apartment, somebody must have heard the screaming and they called the cops and I'm the one who went to jail. 'Cause I was on probation. I wasn't even doing nothing. He didn't go to jail and he's the one who hit me."

Danica, a divorced mother of a 4-year-old, shared her story of how she too, was wrongly arrested after being physically assaulted by her ex-husband. She explained that she called the police after her ex-husband violently hit her several times, but when the police arrived, she was the one who was arrested because she fought back and became upset. She stated, "he was playing like he was the victim and put on quite a performance… and I was still angry, and he pretended to be 'scared for his life', so they arrested me, handcuffed me and took me to jail. They were just so clueless. I never called the police again after that situation, even when I was afraid for my life".

Some participants attempted to seek help after an experience of IPV but felt that their needs were not met through the resources that they accessed, or that their needs were greater than the resources available to them. Additionally, the COVID-19 pandemic greatly impacted women's ability to seek help, particularly because of the social distancing mandates.

For example, Anna expressed frustration when she tried to seek help after experiencing IPV by her ex-partner but was not able to get the help that she needed. She explained, "I try to build a relationship with someone like, they would just give me an hour of their time, and I think, Oh, we are going to get everything done, and then they drop the ball and I fall through the cracks". she continued to explain that it had become even more challenging to access help due to the COVID-19 pandemic. She explained, "I'm still seeking help right now, but with all of the coronavirus stuff, everything is at a standstill, so it's really kind of hard…I'll have to wait and hopefully go once things kind of start to return back to normal".

Mila expressed her concerns about the COVID-19 pandemic and the impact that it has had on tribal communities. She explained, "I had noticed a lot... I've been reading a lot in the news like domestic violence, and a lot of it is... now with this quarantine... we're being quarantined in our houses. A lot of discussion in tribal communities is, what about people that are home with their abuser in there? I know that there are women struggling out there".

Luna, who was married with 2 children, expressed her concern about the cancellation of face to face support groups due to the social distancing mandates. She expressed how women who relied on support groups and talking circles, such as herself, would get support during the pandemic. She stated, "we were doing support groups for women. But now it's all cancelled because of the Coronavirus. So, there's no support now".

I Didn't Know Where to Go for Help

Some survivors experienced barriers to help seeking because they were not aware of available resources. For example, Chelsea utilized the emergency room after experiences of IPV from her ex-partner before she was aware of any other services available. She explained, "the ER isn't helpful. If it's not life and death, then 'okay go away'…but that (the ER) was my way out, that was my go-to that night, I didn't know where else to go (for help), I didn't have anything else".

Lilly was also unaware of services available to her, so she did not seek care after she experienced physical abuse from her ex-partner. She explained, "I wasn't aware of any resources… I felt very isolated and alone. I didn't get any real help".

One survivor, Zoe, knew that there were services available in her county, but was not aware that she could utilize resources in other counties. She explained, "at the time of the abuse, I was living in Waukesha county, and on three different occasions I did call a shelter program in Waukesha. And every time they were like, 'Well, we don't have room for you.' And they

basically told me that I was out of luck. I didn't know that you could cross county lines, or anything like that. I thought it was a county program where you had to be living in your county to benefit it".

One survivor avoided seeking care because she assumed that she was not eligible because she did not have children. She explained, "I didn't try to get help during the abuse. I just assumed that only women with kids or women that were beaten so badly that they had to go to the hospital could stay in a shelter or get help. I just didn't know what to do. I didn't know my choices; I didn't know that I could just talk to somebody about it".

Discussion

Our findings center on the unique needs Wisconsin AI survivors and the barriers they are confronted with when deciding how and whether to seek help after an IPV experience. Aligning with existing research, participants reported IPV to be prevalent in urban AI communities. We demonstrate through our findings, the complexities of help-seeking for AI women in urban environments. The barriers to seeking help after an experience of IPV are directly tied to structural barriers resulting from colonization and the intersection of racism, sexism, poverty. Women's experiences of IPV and the barriers to help seeking were exacerbated by the ongoing Covid-19 pandemic.

The use of postcolonial and Indigenous feminist frameworks guiding our analysis offers new insights into the highly complex barriers that AI survivors living in urban areas face when seeking help after experiencing IPV. Postcolonial and Indigenous feminist frameworks center Indigenous ways of knowing and the voices AI survivors who have lived IPV experience. AI survivors who have experienced IPV are the experts on what they need in terms of interventions.

Each of the survivors experienced individual contextual and structural barriers that impacted their ability to access help after some particularly dangerous situations. Our findings

demonstrate that the Indian Health Service model makes it difficult for low income and uninsured American Indians living in certain urban areas to seek healthcare. Contrary to the common stereotype that American Indians reside on reservations or in rural areas, approximately 70% of American Indians currently live in urban settings (Casselman, 2016). Since the late 1950's, American Indians have experienced rapid urbanization, due in large part to federal policies that disempowered tribes such as the Indian Relocation Act of 1956. Despite the high rates of urbanization, the Indian Health Service, which provides the majority of health care to American Indians and Alaska Natives, has allocated only 1% of its funding to urban areas (Evans-Campbell, Lindhorst, Huang, & Walters, 2006).

Resultantly, many urban based AI survivors who have the desire to leave a violent situation have limited access to tribally specific IPV related services, particularly after-hours emergency care and sexual assault nurse examiner (SANE) services. This was evident from our findings as several survivors outright refused or reluctantly accepted medical care after injuries because they did not have medical insurance. Financial concerns coupled with not having insurance can exacerbate the traumatic experience of an IPV assault. The impact is that survivors are not provided services to mitigate consequences of the violence and to begin healing and repairing their lives.

In addition to challenges with access to medical and other services, there are many reasons why AI survivors may distrust healthcare workers or be afraid of accessing the healthcare system. These include survivors' experiences with racism and dehumanizing treatment. Non-AI individuals, including law enforcement or other helping professionals, may hold a negative implicit bias fed from negative racist stereotypes (Beniuk, 2012). The historical disrespect and mistreatment of American Indians by healthcare providers is responsible for much of the inherent distrust that survivors have of the system. This dejected history includes the

nonconsensual sterilization of AI women by Indian Health Services from 1970-76, during which an estimated 25 to 50 percent of AI women were sterilized (Rutecki, 2010). This is underscored by current practices that often lead to survivors feeing dehumanized and disrespected. (Beniuk, 2012).

Additionally, many programs or services were originally designed by and for non-AI populations. AI women who manage to access these programs and services often find staff with limited cultural awareness and program supports that have little cultural safety or relevance for them (Klingspohn, 2018). Therefore, women who do not anticipate feeling safe when seeking resources tend to avoid doing so. Nurses and other healthcare providers need to learn about the history of the medical establishment with minorities, in this case AI survivors, and how it may affect trust and women's ability to feel safe enough to make an IPV disclosure and to seek help.

Our findings highlight the need for safe and affordable housing as a crucial concern for AI survivors of IPV in urban areas, as well as for the advocates and services that provide support and help to them. Our findings also reveal that some AI survivors are reluctant to leave abusive relationships for fear of homelessness, which puts them at greater risk for injury or even death. The literature shows that IPV and sexual assault are the leading causes of homelessness and housing insecurity for women, particularly for women of color (Safe Housing Partnerships, 2019). Desmond (2016) discussed how women of color experience challenges with accessing and maintaining stable housing in urban environments where African American women are evicted at rates three times as high as White women (Desmond, 2016). African American women, particularly with lower incomes are evicted at much higher rates than women of other racial groups for reasons such as having children, poverty, and landlord-tenant gender dynamics (Desmond, 2016).

Our findings demonstrate that the COVID-19 pandemic had a major impact on the lives

of survivors such as job loss or layoffs, loss of income, exacerbation of housing insecurity, being quarantined with an abusive partner and loss of or restrictions of available resources. These additional stressors and barriers impacted survivors' ability to leave potentially dangerous situations. Our findings demonstrate the urgency of informing scholars and healthcare and social service providers about the impact that the pandemic has had on barriers to seeking help for urban based AI survivors especially taking into account the continued uncertainties associated with the trajectory of this particular pandemic.

Our study also shows that there are fears of contacting law enforcement due to distrust. Much of the literature has focused on the distrust between reservation-based AI survivors and law enforcement related to issues of tribal sovereignty and jurisdictional confusion. Our study indicates that the same applies to urban AI women experiencing IPV. Our findings also align with the literature in that many AI survivors do not report IPV to authorities. Many women of color are reluctant to report IPV to the authorities for fear of subjecting themselves or loved ones to a system they perceive as culturally, racially, or sexually biased (Women of Color Network, 2006). The reluctance to call police or seek emergency care after a particularly dangerous experience puts survivors at risk for the escalation of harm or death. Women of color, including AI women, are also less likely to be seen as being victims of IPV and other types of violence and deserving of justice. Instead, they are often seen as deserving of harm or not taken seriously if harmed. This is because American Indians, and particularly AI women, have historically been dehumanized and left with little legal recourse (Casselman, 2016). Crenshaw (1991) explains further that race and culture are factors that feed into the suppression of help seeking behaviors surrounding instances of IPV, stating that "women of color are reluctant to report abuse or call police because of a general unwillingness among people of color to subject their private lives to the scrutiny and control of a police force that is frequently hostile" (Crenshaw,

1991, p. 1257).

Although many of the survivors either refused care or help or experienced barriers in seeking help, there were survivors who did seek and receive help. Of the 32% of survivors who did seek and receive help, they felt most comfortable accessing care by agencies that provide care specifically to AI community members, or they travelled back to their reservations to seek help. This highlights the need for additional resources for urban based AI women that is culturally specific, safe, and accessible, especially during times outside of typical "business hours".

Our study also reveals that not all AI survivors are aware of the resources that are available to them. This may be due to a variety of reasons such as recently moving to a city from a reservation or rural areas, or moving from one urban area to another, or just being aware of the resources existent in the community in which they are living especially if IPV is a new experience for them. This highlights the need for social services, healthcare, and advocacy agencies to collaborate to ensure that all women are aware of the resources available in their communities. This can be creatively done through social media campaigns, outreach and collaboration with community-based agencies where women frequent or access services including grocery stores and gas stations. Outreach to AI community leaders and having information readily available at pow wows and at other AI community events is another way of communicating available resources.

Limitations

This qualitative study is not without limitations. Our study relied on self-reports from participants. IPV is a highly sensitive topic and AI survivors may have felt unable to provide their true perceptions or felt afraid to disclose anything that could be considered unlawful. The use of telephone and skype interviews for some of the interviews was not ideal. We would have

preferred to interview all of the survivors in person to allow for a closer analysis of non-verbal communication on the part of women participating. However, due to the social distancing mandates related to the COVID-19 pandemic, it was not possible to interview all of the survivors in person. Nevertheless, our analysis demonstrated consistency between the narratives of the women who were interviewed in person and those of women interviewed using other channels.

Conclusion and Implications

To date, there are no studies focused on the unique needs of AI women in the state of Wisconsin who experience IPV. Through this study, we provide a localized understanding of IPV through an analysis of women's individual lived experiences. The narratives that inform our analysis were made possible through the creation of a safe space for survivors to tell their stories and to engage in meaningful change for their communities.

Through our study, we also address the imperative need for nursing scholars and providers of healthcare and social services to give voice to this important issue., Much of the literature about the phenomenon of IPV in the lives of AI women is written primarily by social workers, psychologists, anthropologists, lawyers, and public health scholars, and very few, by AI scholars. There is a dearth of literature on IPV in the lives of AI women written from a nursing perspective. This highlights the critical need for nursing scholars to contribute to the body of research surrounding issues of IPV against AI women as well as women of color more broadly.

Our study also demonstrates the critical need for healthcare and allied professionals to reestablish and to build trusting relationships with AI communities in order to better serve the needs of AI survivors of violence. Specifically, this study demonstrates the critical need to increase funding allocation for urban IHS facilities to ensure the provision of services for AI survivors that is safe, culturally relevant, and affordable.

Women who have experienced IPV seek healthcare not only for their injuries but also for

preventative care such as prenatal care, which can offer opportunities for nurses to effectively screen for IPV as well as provide support. As the largest body of healthcare professionals, nurses are often the first ones to interact with women who have experienced IPV. Nurses must, therefore, be prepared with a deep understanding of the realities and needs of women who have experienced IPV. Nurses can use the knowledge gained through this study to develop a critical consciousness about the relationship between the intersection of IPV and other structural barriers to help seeking by victims.

Finally, this study demonstrates how the use of postcolonial and Indigenous feminist frameworks in research helps provide an analytic lens to look at the impact of barriers to care, which can shape the experiences of AI survivors who have experienced IPV. This study also demonstrates the value of research guided by critical feminist frameworks as a vehicle of social activism and change.

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This manuscript is dedicated to the memory of Kozee Medicinetop Decorah of the Ho-Chunk Nation. Kozee was a mother to 3 young children whose life was violently cut short by her partner during the study period.

Figure 1. Thematic diagram to illustrate the barriers face for AI women in help seeking after an IPV experience

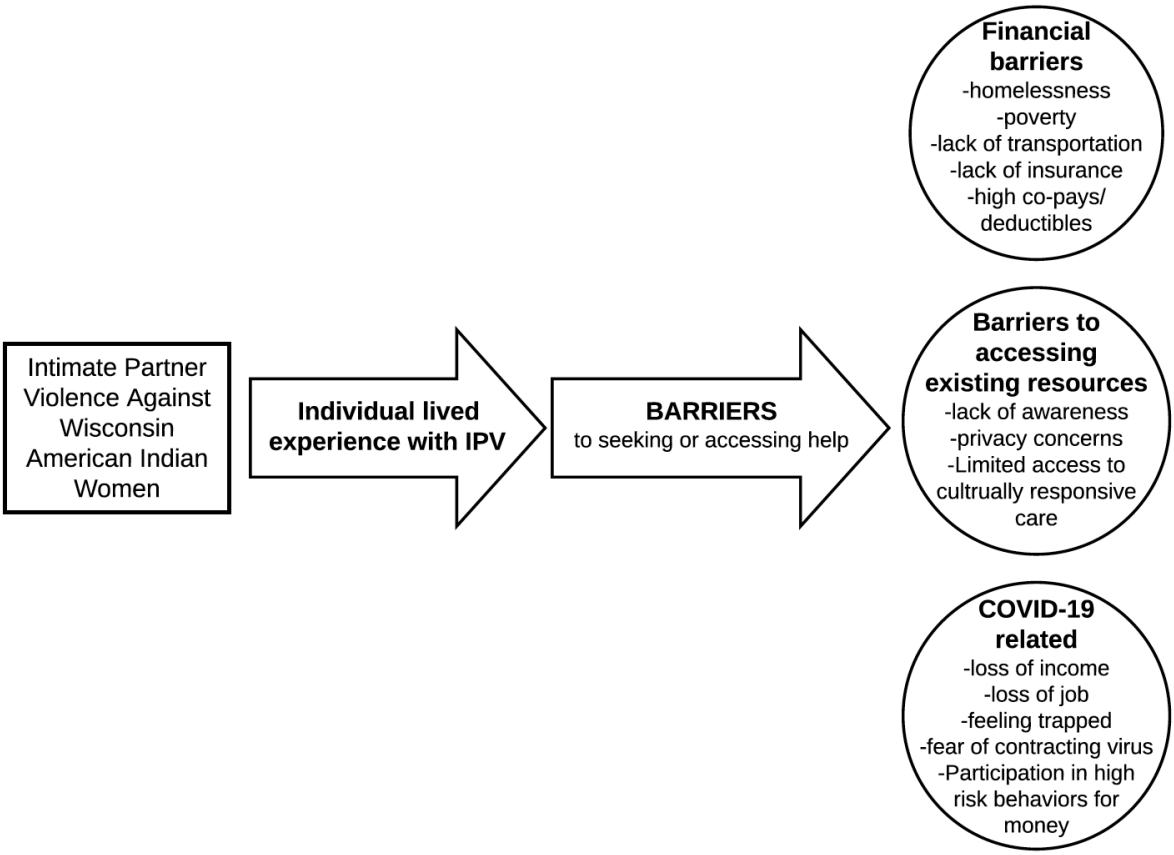

Table 1. Demographic data for women interviewed (n=34)

Participant Age:	
18-25	6
26-35	9
36-45	10
46-55	9
Current Marital Status:	
Single	18
Married	3
Divorced	10
Separated	2
Widowed	1
Enrolled in federally recognized tribe:	34
Yes	0
No	
Children:	
Yes	29
No	5
Average number of children	2.7
Currently pregnant:	
Yes	2
No	32
Education Level:	
Some HS	2
GED	2
HS graduate	7
Some college	9
Associates degree	2
Bachelor's degree	8
Graduate degree	4
Current employment Status:	
Full time (40 hours/wk)	9
Part-time (<40 hours/ wk)	7
Volunteer work	1
Not employed	2
Disabled	3
Unemployed r/t COVID	12
Annual Household Income:	
Less than $10,000	7
$10,000-$19,999	4
$20,000 to $29,999	5

$30,000-$39,999	10
$40,000-$49,000	2
$50,000 or more	6

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Manuscript 3: The Value of Local Context in Understanding the Impacts of Intimate Partner Violence During Pregnancy in Urban American Indian Women

The second manuscript reports on the impact of IPV on pregnancy experience and outcomes for urban Wisconsin American Indian women. It is formatted based on the author's guidelines for Nursing Outlook, which is the target journal for this publication. The manuscript provides a summary of pertinent literature on the prevalence of IPV against American Indian women during the pregnancy period, as well as the impacts of IPV to mother and baby, postcolonial and Indigenous feminist methodology, the data collection, narratives of the survivors, and data analysis process followed by a description of the findings based on the voices of the survivors. The results were analyzed, and policy and practice recommendations are discussed.

The Value of Local Context in Understanding the Impacts of Intimate Partner Violence During Pregnancy in Urban American Indian Women

Abstract

Background: American Indian[6] (AI) women experience intimate partner violence (IPV) at a disproportionately high rate with a high risk for IPV during pregnancy (Burnette, 2015; Sharps, et. al., 2016). Purpose: The aim of this study is to inform the work of nurses and allied health professionals with insight into the lived realities of AI women in urban areas, and how IPV manifests in the lives of AI women. Methods: Through this critical ethnographic study, we analyzed data from semi-structured interviews with 34 AI women in urban Wisconsin. Postcolonial and Indigenous feminist frameworks informed our study to contextualize how IPV occurs in urban AI women's lives. The COVID-19 pandemic served to exacerbate the stressors in AI women's lives placing them at risk for IPV. Findings: Our findings highlight the impacts of IPV the lives of urban AI women in the local context. Discussion: Knowledge gained from this study will be used to inform the development of effective interventions to minimize barriers to accessing prenatal care and help seeking when experiencing IPV that in order to reduce the devastating consequences to AI women and children.

[6] The Bureau of Indian Affairs (BIA) defines American Indian (or Native American or Indigenous) as an individual who is a 'member' of an Indian tribe, band, or community 'recognized' by the federal government; who lives on 'or near' a reservation; who is of 1/4 or more Indian ancestry. This includes American Indians, Alaskan Natives and Pacific Islanders.

Introduction

Intimate Partner Violence (IPV) is a significant public health concern that disproportionately impacts ethnic minority women, with the highest prevalence rates against American Indian (AI) women (Burnette, 2015; Rosay, 2016). IPV during pregnancy is of great concern due to the potential for negative consequences to both the mother and her unborn child (McFarlane, Parker, & Soeken, 1995; Taillieu & Brownridge, 2010), with the most tragic consequence of IPV being maternal and/or infant mortality. AI women are considered to be especially vulnerable to IPV victimization during the perinatal period (Burnette, 2015). Burnette (2015), in her qualitative study with AI women living on a reservation in the southwest, found that "over half of women (52%) described pregnancy as a time of increasing vulnerability to IPV" (p. 11). According to a 2010 World Health Organization (WHO) multi-country study on women's health and violence against women, the majority of women who reported physical abuse during pregnancy had also been abused prior to pregnancy. Even more concerning was that about half of the respondents stated that they were abused for the first time during a pregnancy (García-Moreno, et. al., 2015).

Earlier studies also support the notion that AI women experience increased vulnerability to IPV during a pregnancy (Bohn 2002; Kantor & Jasinksi, 1998; Kvinge et al. 1998; Robin et al. 1998;) with estimates ranging from 9% among AI women with past year pregnancies (Malcoe et al. 2004) to 38% among teenage AI mothers (Mylant & Mann 2008). One study revealed that 6% of AI women who were pregnant at the time of the interview reported that their partner had threatened their life or the life of their baby (Bohn 2002).

Racial Disparities

It is important to first note that significant racial disparities exist in the rates of maternal

and infant mortality of women of color, particularly for AI women and Black women. The high rates of racial disparities and the high rates of IPV place women of color, especially AI women, at exceptionally high risk for adverse health outcomes (Stockman, Hyashi, & Campbell, 2015).

According to the CDC (2019), AI women and Black women are two to three times more likely to die from pregnancy-related causes than white women. Complex factors exist that contribute to the disparities in maternal and infant mortality such as racism. For example, the structural racism that exists within the health care system, social service system, and law enforcement manifests in poorer quality care for women of color than for White women (Taylor, Novoa, Hamm, & Phadke, 2019). The cumulative stress and experience of structural violence, racism, and sexism manifests in racial disparities including adverse pregnancy and infant outcomes such as preterm birth and high infant mortality rates (Taylor, Novoa, Hamm, & Phadke, 2019).

There are significant racial disparities for ethnic minorities beginning early in their lives. In the state of Wisconsin, babies born to non-Hispanic black mothers suffer the highest infant mortality rate in the nation. From 2013-2015, there were 14.3 deaths per 1,000 births, with the national average of this same group at 11.1 deaths per 1,000 births (Wisconsin Department of Health Services, 2018). Nationally, the infant mortality rate for AI babies is 9.21 deaths per 1,000 live births compared to 4.67 deaths per 1,000 births for white non-Hispanic babies (Ely & Driscoll, 2019). In the city of Milwaukee, one of the most segregated cities in the United States, the infant mortality rate is staggering, at 15.4 deaths per 1,000 births for non-Hispanic black babies. This rate is three times higher than that of non-Hispanic white babies at 5.1 deaths per 1,000 births from 2015-2017. (City of Milwaukee Health Department, 2018). The City of Milwaukee did not report the infant mortality rate for AI babies in their community health assessment report. A query of the Wisconsin Interactive Statistics of Health (WISH) database

for AI infant mortality rate for the city of Milwaukee yielded a result of 13.0 deaths per 1,000 births from 2010-2018 for AI babies.

Women of color, including AI and Black women in Milwaukee experience significant impacts from increased levels of segregation, poverty, and housing insecurity. The poverty rate for Blacks in the city of Milwaukee is 33.4%, which is five times greater than that of whites; is among one of the highest poverty rates in the US of largest urban areas (Levine, 2020). In his book Evicted, Matthew Desmond argues that women of color experience challenges with accessing and maintaining stable housing in urban environments with evictions occurring at rates three times as high as White women (Desmond, 2016). Additionally, African American women, particularly with lower incomes, are evicted at significantly higher rates than women of other racial groups for reasons such as having children, poverty, and landlord-tenant gender dynamics (Desmond, 2016).

Other racial disparities include high rates of incarceration for ethnic minority populations including American Indians as well as African Americans in the state of Wisconsin. For example, in 2013, Wisconsin saw an increase of 42% of American Indians in county and city jails between 1999 and 2013, had the highest incarceration rate for American Indians in the U.S. in 2013 (U.S. Department of Justice, 2017).

IPV and Maternal Health Disparities and Outcomes

IPV experienced during pregnancy is associated with negative maternal outcomes, particularly for women of color, regardless of their insurance status or access to medical care (Sharps, Laughon, & Giangrande, 2007). Aside from physical injuries sustained as a result of IPV, women may also experience negative outcomes such as hypertension, edema, vaginal bleeding, placental problems, severe nausea and vomiting, dehydration, urinary tract infections, and premature rupture of membranes (Sharps, Laughon, & Giangrande, 2007).

In addition to physical health impacts, IPV during pregnancy has been associated with poor mental health outcomes (Sharps, Laughon, & Giangrande, 2007). AI women who experience IPV whether pregnant or not were found to have a substantial increase in risk for a mood or anxiety disorders and were more likely to be hospitalized for mental health related problems (Raglan, Lannon, Jones, & Schulkin, 2016). Experiencing poor mental health during pregnancy may adversely impact birth outcomes. For example, IPV during pregnancy places AI women at risk of depression and posttraumatic stress disorder (PTSD) with stress in pregnancy associated with both preterm birth and low birth weight (Raglan, Lannon, Jones, & Schulkin, 2016).

Women of color, including AI women, are more likely to experience barriers to accessing prenatal care or late entry into prenatal care or no prenatal care at all. (Clark, et. al., 2002; Sharps, Laughon, & Giangrande, 2007). The intersecting factors that lead to marginalization, and the context of their lives that place them at risk for disparities include high rates of poverty, lower levels of formal education, limited access to transportation, racism, and other stressors (Sharps, Laughon, & Giangrande, 2007).

IPV experienced during pregnancy is also associated with adverse fetal or infant outcomes such as miscarriage, fetal injury, small for gestational age, low birth weight, preterm birth, and stillbirth (Bailey, 2010; Sharps, Laughon, & Giangrande, 2007). Infants born preterm are at an even higher risk of lifelong health complications. The risk for infant mortality is also higher for infants born preterm (Raglan, Lannon, Jones, & Schulkin, 2016).

There is a critical need for researchers to gain a deeper understanding of the experiences of, challenges faced by, and impacts of IPV following an experience of IPV for urban AI women, particularly in the local context. To date, there are currently no studies published about IPV in the lives of AI women in Wisconsin. The purpose of this study was to gain a deeper

understanding of the impacts of IPV in the lives of AI women taking into account the local context of urban areas of Wisconsin. In this study, we use feminist epistemologies to guide our study in order to highlight the voices of AI women through their stories of survival following IPV experiences. We also address a gap in the literature through this research which is led by an AI nurse researcher (enrolled member of Bad River Band) who is also an IPV survivor.

Theoretical Framework

In order to fully capture the complex realities of AI women's experiences with IPV, our qualitative study was informed by postcolonial and Indigenous feminist frameworks. The use of feminist epistemologies in our research was beneficial in framing our understanding of the context in which IPV occurs specifically for urban Wisconsin AI women. The use of a feminist approach in research contributes to the advancement of nursing science through a deeper analysis of the individual lived experiences of AI women following experiences of IPV, leading to effective, survivor led interventions.

A postcolonial feminist framework in research aims to understand and address women's experiences while disentangling the legacies of colonialism within feminist activism (Racine, 2011; Wallaschek, 2015). A postcolonial feminist framework uncovers the disparities and inequalities that are etched within historical and sociopolitical contexts that impact the delivery of healthcare delivery and health outcomes (Racine, 2011; Mkandawire-Valhmu, 2018). Postcolonial feminist scholars use counter-hegemonic research methods that both recognize the adverse health outcomes experienced within communities as well as the "strengths and capacities they possess on which we can build to address problems affecting human health" (p. 3).

An Indigenous feminist approach to research emphasizes the consideration of the historical and contemporary contexts specific to Indigenous women in their own time and place (Huhndorf & Suzack, 2010). Utilizing an Indigenous feminist framework in research places

emphasis on issues surrounding gender struggles through the promotion of social justice across race, class, sexuality, as well as gender lines for all Indigenous people (Huhndorf & Suzack, 2010). Finally, an Indigenous feminist framework in research supports the promotion human dignity by supporting American Indian tribes' inherent right to self-govern, which grants tribal communities with the ability to protect the safety and wellbeing of their own citizens (Huhndorf & Suzack, 2010).

Methods

Our qualitative study was conducted using a critical ethnography methodology. Study participants were purposively selected in collaboration with AI communities in two large urban areas. Participants volunteered for the study by responding to flyers distributed at health facilities and social service agencies primarily serving AI women and their families. The recruitment flyer provided a brief overview of the study and study objectives, and inclusion criteria. In the study, snowball sampling was particularly useful for recruiting participants. Snowball sampling is a useful recruitment strategy in research that relies on existing study participants to recruit future participants from their personal circle. (Ritchie, Lewis, & Elam, 2003). Approximately half of the survivors interviewed in this study were referred by another survivor who had been interviewed. Snowball recruitment is especially useful in order to gain trust and entry into communities that are difficult to reach due to issues of trust, such as AI communities.

Inclusion criteria for this study includes self-identification as American Indian; between ages of 18-55; female; history of a pregnancy within the past 10 years; current or history of victimization of IPV; currently reside in urban areas of Wisconsin; not currently at risk for harm or violence. Individual, in-depth interviews were conducted with participants using semi-structured interview questions by the Principal Investigator. Guided by postcolonial and

Indigenous feminist frameworks, interview questions were formulated to gain a deeper understanding of the individual lived experiences and impacts of IPV on health, wellbeing, and pregnancy outcomes. Interview questions were reviewed by two tribal community leaders and revised, as needed, to ensure cultural appropriateness. If the study prior to survivor interviews. Probing questions were used to clarify any responses that were unclear or to gain further understanding as needed. Interviews with a total of 34 AI women took place in a large urban city in Wisconsin during the spring of 2020. Thirteen interviews were conducted in person and twenty-one interviews were conducted via phone or video chat due to the COVID-19 pandemic social distancing mandates. Demographic data were obtained from all participants, and all interviews were audio recorded. Interviews lasted from 1-3 hours. All participants received a $50 store gift card as a token of our appreciation for their participation and time.

Ethical Consideration

Approval for this study was granted by the University of Wisconsin-Milwaukee Institutional Review Boards and the Ho-Chunk Nation prior to data collection. Prior to the start of the interview, the study purpose and risks were reviewed with all participants. All participants were informed that they could stop the interview at any time or withdrawal from the study at any time. Written consent was obtained from each participant prior to the start of the interview. To protect the anonymity of the participants, names were replaced with a pseudonym created by the researcher for the purposes of data reporting.

Sample

Thirty-four AI women were interviewed for the study (Table 1). Their ages ranged from 20-53, with an average age of 38 years. All survivors self-reported being AI with current or a history of IPV by one or more intimate partners. All survivors reported having one or more pregnancies in their lifetime. Twenty-three of the survivors had between 1-7 children with an

average of 2.7 children, ranging in age from 1 month to 34 years. Two survivors were currently pregnant in the first and third trimesters at the time of the interview. Most of the participants were single, divorced, or separated (N=30), and three participants were married, and one was widowed.

Regarding education, fourteen of the participants had at least some college, ranging from associate degree to a master's degree. Nine survivors (26%) worked as professionals such as mental health, social services, childcare, and victims' services, the remaining survivors worked in the service industry and were involved in bartending, waitressing, or gaming), or were not employed, disabled, or performed volunteer work without pay. Twelve of the survivors were furloughed or laid off from their jobs due to COVID-19. Annual earnings for survivors ranged from $0-$75,000, with average earnings of $29,487 per year.

Data Analysis

Data collection and analysis was guided by a feminist lens to address the power dynamics that can occur between researcher and participants. The interviews with survivors were audio recorded and then immediately professionally transcribed. Interpretive analysis was attained by both reading the transcribed interviews and listening to the recorded interviews several times and in order to gain a deeper and more intimate understanding of the data. The data were first analyzed into initial codes and then grouped into several themes using the principles of thematic analysis.

Trustworthiness

Trustworthiness is essential to enhancing integrity and rigor in qualitative inquiry. Several strategies were employed to establish the trustworthiness of this study. Dependability was established through an audit trail and co-authors verification of identified themes. In an effort to provide ongoing cultural guidance and support to the researcher during the study, two

AI elder community members (Ho-Chunk Nation and Bad River Band) also served as cultural guides. Five of the 34 participants took part in the process of member checking to enhance credibility of the study. Of the survivors that consented, five survivors were randomly chosen to participate in member checks to validate the accuracy of a random sample of five written transcripts based on the audio interview. All survivors provided verification of the themes identified through data analysis to confirm consistency with their IPV experience. Continuous peer-debriefing with a research mentor throughout the research process enhanced the confirmability of the study. In-depth, reflective, and continuous journaling throughout the research process enhanced confirmability of the study.

Findings

Our findings reveal that IPV during the pregnancy period was reported to be common among the survivors interviewed, with 68.8% (N=22) reporting physical and/ or emotional IPV during the pregnancy period, and some women experiencing IPV with more than one of their pregnancies (N=16). Our findings were classified under one major theme "experiences of IPV during pregnancy". There were two identified sub-themes of "impacts of IPV on pregnancy experience" and "adverse outcomes due to physical IPV during the pregnancy period".

Impacts of IPV on pregnancy experience

Survivors reported that their pregnancies tended to amplify relationship stress and pregnancy was perceived as a trigger for IPV, often fueled by their partners' jealousy, insecurity, or a means of controlling the relationship. Chelsea[7] for example, explained how she experienced pregnancy loss with more than one partner due to physical IPV. She became engaged in a relationship that "developed at a very fast pace", and her partner became abusive right away,

[7] All names have been replaced with pseudonyms to protect the identities of the participants

even during pregnancy. She explained, “immediately I had to move in with him… I got pregnant immediately within a month or two. And it was just jealousy…he didn't want me loving somebody more than him. He then beat me up…he beat me to make sure that I miscarried. Then I got into other relationships, and again I was physically assaulted while pregnant, twice…and the way stuff was going I miscarried myself twice by just excessive drugs and alcohol and just made myself miscarry”.

Several survivors experienced layers of stress and limited support during their pregnancy that negatively impacted their pregnancy experiences. Survivors reported that they received little or no prenatal care during pregnancy due to their experiences of physical and emotional IPV. Hailey, a single mother of two school age children, experienced emotional abuse and extreme controlling behavior by her ex-partner. Because of his need to control her whereabouts, she had to miss prenatal appointments and was not able to participate in classes to prepare for labor and delivery. She explained “when I was pregnant… I would not say that I had great prenatal care because it became very restrictive in my house. It was like I couldn't really go anywhere unless he was gonna come with me. Because of his job, if he couldn't make it to a prenatal appointment then he didn't want me to go. So, we never did the birth classes. I went to like a small handful of my prenatal appointments”.

Nova, a young single mother of three children under the age of 8, explained that she did not cope well with the IPV and as a result did not receive any prenatal care and ended up giving birth to her son while incarcerated. She explained, “my last pregnancy was bad, because it was right after my mom passed away…and the fights- it got real bad… he threw me down a flight of stairs. I ended up not going to any pregnancy appointments... me and him ended up going to jail 'cause we were doing drugs really bad. And that was hard for me. I had my son while I was in jail on my mom's birthday”.

Other survivors also reported a lack of support by their partners during their pregnancy, which exacerbated their feelings of vulnerability and isolation. Mila, a mother of 3 children, "He hit me when I was pregnant with my youngest. He always denied that (the baby) was his, and he always denied her. He hit me another time while pregnant…and he was drinking and he's trying to fight me while I was holding my son".

Kristi, a participant who was single with a 2-year-old, experienced severe physical IPV while pregnant by the father of her child, including attempted strangulation. She explained how IPV "robbed her of her ability to feel happy while pregnant". She stated, "I feel like I was really sad my entire pregnancy and just really depressed and alone and stressed and just very emotionally unstable".

Danica, a divorced mother with a 4-year-old, experienced sadness, isolation, and fear during her pregnancy: "I would say that it wasn't a happy pregnancy. I was sad during my pregnancy and I didn't want to tell anyone. I had been so withdrawn during that period because I didn't want anyone to see me because I was afraid that they would call the cops (because of the bruises). Some of my friends gave up on me because they were sick of hearing about the drama. I was able to see my doctor; he didn't interfere with that. He still kept hitting me while I was pregnant too. I debated for weeks about whether to get an abortion. It just wasn't a good time".

Lilly, a divorced mother of 3 school aged children, described how she had a negative pregnancy experience because she sometimes feared for her life. "Even while I was pregnant, we would have a fight… it got physical. I thought, 'he's gonna kill me.' I had that mindset that I was in danger and I was very fearful of that". Ella, a divorced mother of 3, also experienced severe IPV during pregnancy at the hands of her ex-husband and father of her children. She explained, "I was probably six months pregnant with my youngest when my husband pushed me down the stairs. The baby was ok".

Amelia, a single mother of three children, experienced IPV by her youngest child's father throughout her pregnancy, including during the time that she was in the hospital for the birth of the baby. She explained, "even when I gave birth in the hospital, there was abuse. The nurse kind of suspected it. She wrote down on a paper, she asked me if I was okay. She didn't say it 'cause he was sitting there, but she wrote it down. And I wrote, 'Yeah', because I was afraid of him".

Adverse Fetal or Infant Outcomes Related to Physical IPV During the Pregnancy Period

Several survivors experienced severe physical IPV during pregnancy that resulted in adverse pregnancy and birth outcomes including miscarriage, preterm labor, and premature birth. Ava, now divorced from her abuser, explained how she sustained injuries from fleeing her abusive ex-husband while pregnant. She explained that he was angry, driving fast and erratic, and she feared that he was going to crash the car. "I jumped out of a moving car while I was pregnant because I feared for my life. I ended up saying that I fell off of a bike because I had road burn scars from hitting the cement when I landed. I ended up having a miscarriage a few weeks later".

Mallory, now single with no children experienced severe physical IPV that resulted in a miscarriage with her ex-partner. "We were in a fight… he punched me, while I'm pregnant in the first trimester. He hit me… I hit the floor. I'm on my hands and knees. He kicked me in the stomach with boots….. so hard that I'm literally coming off the ground. I lost the baby".

Olive, a single Mom of a 1 year old, spoke of physical IPV at the hands of her ex-partner and father of her child. She experienced several miscarriages prior to having her child. She explained, "I think that he's the reason that I had four miscarriages when I was 21 and 22. There was a lot of fighting and mental abuse".

Laurie, a separated mother of four, explained how she experienced severe physical IPV by her ex-partner that resulted in miscarriage because he didn't want her to have any more children. She explained "he would beat me until I would miscarry…I don't remember how many times, it was quite a few. Now I have problems down there".

Maddy, a divorced mother of three, described how she experienced multiple instances of IPV during pregnancy that resulted in preterm labor and a prolonged hospital stay. She explained, "I ended up having my son very early… he had to be in the hospital for 16 days after that 'cause he couldn't breathe after he was born and wasn't doing good".

Cheyenne, a divorced mother of seven children explained how she experienced pre-term labor with her youngest child after an instance of physical IPV. She explained, "my pregnancy with her was miserable and sad. We did some really crazy fighting before the pregnancy, and during the pregnancy. While I was pregnant and (in the third trimester) when we went out on New Year's Eve. I was in this long, beautiful white dress with a black eye and a fat lip, and a big old fat belly". She continued to explain that "He had tried to put a jacket over my head, like one of those rainproof kinds of jacket, so I couldn't breathe. He pushed me, he shoved me, he smacked me, he punched me, and tried to strangle me". Cheyenne ended up going into early labor shortly after the severe IPV experience. "I go into labor early. She was born about seven weeks early. I'm sure part of it was that I was not a happy person during that pregnancy".

Mia, a single mother of two children under the age of five, experienced pre-term labor with her first child that she attributes to the stress from IPV. She explained, "I was just arguing and fighting with him that night and he had pushed me down several times, and in the middle of the night my water had ruptured, and I had to get rushed to the emergency room early that morning. I was at 24 weeks. I got to the hospital in time for them to stop my labor and I was

able to be on bedrest at the hospital for about four weeks, and then I delivered my daughter at like 28 weeks".

Discussion and Recommendations

In this qualitative study, we highlight the voices of survivors, focusing on their experiences with and impacts of IPV during the pregnancy period. Informed by a postcolonial and Indigenous feminist perspective, our analysis affirms that high rates of IPV are deeply intertwined in the history of colonization and the intersection of racism, sexism and poverty for AI women in urban areas of Wisconsin. This legacy of oppression also manifests in maternal child health disparities and poor birth outcomes for AI women and their infants.

While this study was not intended to focus exclusively on IPV experienced by AI women that are currently pregnant, it became apparent through the data that IPV experienced during a pregnancy within the past ten years was reported to be common (68.8%) among the survivors interviewed. The consequences of severe physical IPV during the pregnancy period included devastating pregnancy related consequences such as loss of pregnancy, preterm labor, and premature birth for survivors. This is consistent with evidence that women exposed to IPV were at risk of preterm birth and low birth weight Kiely et al., 2011; Shah &Shah (2010).

Our findings showed that women were unlikely to utilize prenatal care services when experiencing IPV with some women missing appointments and birth classes. These findings are consistent with evidence that shows that pregnant women exposed to IPV are more likely to miss appointments or report later for prenatal care (Cha & Masho , 2014a; Chambliss, 2008; Subramanian et al. 2012 Access to prenatal care is crucial for positive pregnancy outcomes, but this is a challenge when women are experiencing IPV (Cha & Masho , 2014b). This poses a significant concern for the safety of Wisconsin AI women and their infants who like African American women, have poorer rates of prenatal care attendance ad also have adverse birth

outcomes overall. Advocacy, on the part of nurses, is important to ensure safety of women and their infants. Additionally, survivors reported instances of severe physical IPV that occurred both during and outside of pregnancy that resulted in physical injuries, including broken bones, facial injuries, and head injuries, some of which required medical attention.

The study also found that urban AI women experienced multiple layers of stress during their pregnancies related to IPV victimization such as lack of a supportive partner, isolation, fear, caring for other children, combined with the burden of ongoing physical and emotional abuse. Aside from physical injuries, the findings highlight other negative impacts of IPV experienced during the pregnancy period such as lack of consistent or any prenatal care, lack of partner support, and negative pregnancy experience due to stress, fear, and sadness.

These cumulative stressors manifested in negative pregnancy experiences that survivors described as "unhappy and stressful, and too much to handle". Women who experience IPV during pregnancy are at risk for developing mental health concerns such as depression, suicidality, PTSD, poor mental health functioning, and mood disorders (Stockman, Hayashi, & Campbell, 2015). Our findings reveal that many of the survivors who experienced IPV during pregnancy had experienced IPV prior to pregnancy, placing them at higher risk for IPV during the pregnancy period.

Several survivors did not access prenatal care until the second or third trimesters or not at all. Survivors experienced barriers to accessing prenatal care related IPV such as a controlling partner, negative pregnancy experience, and even incarceration. Other barriers included insurance status, and lack of access to transportation. Access to culturally safe and affordable prenatal care that begins in the first trimester is critical to the wellbeing of both the mother and the baby. A consequence of inadequate or no prenatal care visits is that of missed opportunities for screening for IPV. Screening for IPV at every point of care, and especially during the

pregnancy period is critical in order to prevent further injury or death by providing resources for care and support to victims. Therefore, the development of interventions for urban based AI women aimed at increasing access to prenatal care early in the pregnancy is of highest priority.

Although in this study, we did not specifically assess for the occurrence of IPV screening during the prenatal period, it is still critical to address the need for routine screening during prenatal visits. This is because prenatal care may be one of the few available opportunities for IPV survivors to have contact with nurses and allied professionals who can support them in breaking the cycle of violence (Kearney, Haggerty, Munro, & Hawkins, 2003). For many women, the pregnancy period may be a time when many women become motivated to make changes to protect their unborn child and attempt to reduce exposure to or remove themselves from violent relationships (Mercer, 2004).

Normalizing the screening process for IPV on the part of nurses and allied professionals is critical because it allows for an opportunity to provide education about the prevalence of IPV in our society and what resources are available for help (Mkandawire-Valhmu, 2018). Unfortunately, screening for IPV during prenatal visits does not consistently occur and varies from institution to institution, with the biggest barrier to screening being a lack of time by healthcare providers (Fletcher, Clements, Bailey, 2016). There is a critical need to implement or reinforce existing policies that prioritize consistent screening for IPV during prenatal visits.

Additionally, there are disparities in screening for IPV among healthcare providers based on socioeconomic status and race or ethnicity of the patient (Bohn et al., 2003). Nurses and other healthcare providers have also reported that they do not feel they have received adequate training to screen for IPV (Sprague, 2012). Hawkins et al., noted that "the robustness of the training should reflect the seriousness and high prevalence of the problem and should thus be an integral part of medical training" (2019). This is particularly concerning considering the

alarming rates of IPV during pregnancy for women of color, including AI women. Sharps, et. al., (2001) concluded that more than 50% of women who were murdered by an intimate partner were seen by a healthcare provider in the year prior to their murder. Screening for IPV at every prenatal visit is therefore crucial. It is also important to emphasize that research has shown that verbal, emotional, and sexual forms of IPV also predict negative outcomes for mother and child (Taillieu & Brownridge, 2010). It is thus crucial that nurses include non-physical abuse, such as psychological, emotional, sexual or threat of abuse, in their assessments.

In addition to training about culturally safe IPV screening methods, nurses and other healthcare providers also need to learn about the history of oppressive practices in the provision of healthcare to minorities, especially AI women, and how it affects trust, IPV disclosure and even healthcare access or help seeking in the case of survivors. Possessing a deeper understanding of the structural and contextual factors that increase the risk of IPV for various populations of women is essential for nurses and allied professionals. The risk in neglecting to contextualize women's experiences with IPV by considering the oppression and structural racism in which IPV occurs for AI women, only serves to uphold White supremacist ideologies that blame women for their realities.

The findings from this study demonstrate the critical need for nurses and allied professionals to learn about the history of the medical establishment with minorities, in this case AI survivors, and how it may affect trust and women's ability to feel safe enough to make an IPV disclosure and to seek help. Nurses can provide a safe and supportive environment for AI survivors by avoiding the replication of oppression and retraumitization when providing care. Nurses can do this using a strength-based approach when working with survivors. For example, the role of the nurse is to facilitate choices for survivors, rather than giving answers or orders. In the current study, one survivor spoke of the creative way in which one nurse was able to provide

her with the resources necessary to get help by writing “are you safe? Do you need help?” on a piece of paper while her abuser was in the room with her. This survivor felt relieved that the nurse was knowledgeable about subtle signs of IPV.

It is crucial for women who have been victimized to have the opportunity to make their own decisions about their own lives to nurture their sense of self-determination. Frequently, women are not prepared to leave and doing so may endanger them even further. Nurses and allied healthcare professionals need to be cognizant of this and need to trust women as being most knowledgeable about their own realities. Nurses also need to practice self-reflection by checking their implicit biases that may lead to inadvertent victim shaming such as ‘how could you ever put up with that’! or ‘why don’t you just leave’, that could further erode trust in healthcare providers. Nurses can draw on women’s strengths and capacities in creating a safety plan, emphasizing to survivors that the IPV is not their fault while also offering them support and showing them that they are not alone.

Additionally, nurses can advocate for policies to implement evidenced based programming and interventions aimed at improving the health and well-being of AI women during the perinatal period. For example, nurse home visiting programs have been associated with improved health outcomes, including during the pregnancy period (Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008). There are currently no AI specific home visiting programs available in most urban areas in the US, including in Milwaukee. Programs that are nurse led, such as Nurse Family Partnership have been shown to have positive outcomes in the reduction of pre-term births, reduction in rates of pregnancy induced hypertension, reduction in maternal stress, reduction in prenatal smoking, improved rates of prenatal care, and higher rates of breastfeeding (Nurse Family Partnership, 2019). A home visiting program could be an additional service and beneficial extension to the services provided by urban clinics that help

meet the unique needs and improve birth outcomes for American Indian women.

Lastly, the COVID-19 pandemic was just beginning to unravel at the start of this study. While there were no interview questions asked specifically about COVID, survivors spoke openly about their thoughts, feelings and fears about the pandemic because of their concerns for themselves, as well as their communities. The findings from this study demonstrate that the COVID-19 pandemic had a major impact on the lives of survivors in the form of job loss or layoffs, loss of income, exacerbation of housing insecurity, being quarantined with an abusive partner and loss of or restrictions of available resources. Since the completion of data collection, urban, reservation based, and rural AI communities have continued to struggle with the implications of the pandemic. Casinos and summer pow wows, a major source of revenue for tribes and tribal members, have remained closed or events cancelled in order to protect the health of the most vulnerable. These additional financial stressors and barriers impact survivors' ability to leave potentially dangerous situations, and it is anticipated that the problem will only worsen as the pandemic continues. The study findings demonstrate the urgency of informing scholars, nurses, and allied health professional about the impact that the pandemic has had on barriers to help seeking and self-care for urban based AI survivors. Continued research is critically needed to better understand the impact of the ongoing COVID pandemic on experiences of IPV AI women and the barriers to help seeking.

Study Limitations

This qualitative study has some limitations. Our study relied on participant self-reports about their IPV experiences. Knowing that IPV is a very sensitive topic, it is possible that AI survivors may have felt afraid to disclose anything that could be considered unlawful or felt unable to share their true experiences. However, the data obtained regarding women's lived experiences is especially valuable especially as there is a dearth of literature focusing on AI

women's voices and their perspectives on IPV.

A limitation of this study is that we did not ask women whether they were screened for IPV during prenatal care. It's important to determine the extent to which women are being screened as a way of enhancing health outcomes for women by providing services to women when they are experiencing IPV.

An additional limitation was not having all of the interviews in person, due to the need for social distancing related to the social distancing mandates implemented to help curb the COVID-19 pandemic. However, our analysis demonstrated consistency between the in person and phone or video interviews.

Conclusion

This study reveals that IPV is associated with a range of physical health problems and decreased maternal child health outcomes for urban Wisconsin AI women. This is consistent with studies regarding AI women in other areas of the US, but this study highlights urban AI women's specific experiences with IPV as well as their unique needs. Without intervention or support, repeated experiences with IPV may increase in severity, leading to serious injury, or loss of life (Burnette, 2015; Childress, 2013).

There are currently no published studies focused on the impacts of IPV among urban AI women in the state of Wisconsin, particularly during the pregnancy period. Therefore, this qualitative study, informed by feminist epistemologies, helps to address this gap by providing a localized understanding of IPV through the voices of AI women and narratives of their experiences of IPV during pregnancy within urban areas of Wisconsin. The personal descriptions that informed our analysis were made possible through the creation of a safe space for survivors to tell their stories with the end goal being to engage women in participating in meaningful change for their communities.

Our study highlights that urban Wisconsin AI women are at high risk for IPV during the pregnancy period, leading to adverse pregnancy related outcomes. It is clear that IPV during pregnancy is a significant problem within the AI population and is associated with adverse maternal, fetal, and newborn health outcomes. It is imperative that steps be taken to address and mitigate the high levels of IPV against AI women, especially during the pregnancy period in order to improve maternal child health outcomes. Interventions must be survivor led in order to meet the unique needs of AI women and their families. Additionally, nurses must be aware of health disparities within the AI maternal and infant population in order to effectively care for survivors and screen for risk factors that may lead to preterm birth or poor maternal health outcomes. The inclusion of survivors in the development of interventions is a critical component of deconstruction of oppressive research and healthcare practices and promoting the resiliency and empowerment of AI survivors of IPV.

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CHAPTER V: DISCUSSION AND SYNTHESIS

In this critical ethnographic study, I sought to better understand how IPV uniquely manifests in the lives of urban AI women by centering their voices and focusing on their lived experiences. Centering the voices of the AI survivors ensures that meaningful and survivor-led interventions that are tailored to their unique sociocultural needs can be developed. Informed by a postcolonial and Indigenous feminist perspective, our analysis affirms that high rates of IPV are deeply intertwined in the history of colonization and the intersection of racism, sexism and poverty for AI women in urban areas of Wisconsin.

This study contributes to the development of new knowledge gained through the voices and stories of AI survivors of IPV in the local context. There is a gap in the literature specifically about the experiences with IPV of AI women living in urban and metropolitan areas (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). To date, there are currently no studies published about the rates, nor the individual lived experience of IPV in the lives of AI women in Wisconsin. This study addresses a major gap in the literature and serves as an exemplar of Indigenous feminist activism by centering the voices of AI women through research led by an Indigenous nurse researcher and IPV survivor.

Synthesis of Findings

AI women's experience after an IPV experience was exemplified through two major themes. The first theme, *barriers faced when seeking help after an experience of IPV,* uncovers the many complex and intersecting factors that many AI women experience when seeking help after an IPV experience. The findings focus on the contextual and structural barriers women face when engaging in help seeking, which include historical and contemporary racism, sexism and poverty. Additionally, the findings highlight how the COVID-19 pandemic served to exacerbate barriers American Indian women face to help seeking after experiences with IPV. The second

theme, *the impact of IPV on pregnancy experience and outcomes,* deepens our understanding of the experiences and impacts of IPV, specifically during pregnancy, a time in which AI women are particularly vulnerable for victimization of IPV resulting in poor birth outcomes.

Postcolonial and Indigenous feminist frameworks were beneficial in guiding our analysis by enhancing our understanding of the complex barriers that urban AI survivors face when help seeking after experiencing IPV. Postcolonial and Indigenous feminist frameworks center Indigenous ways of knowing and the voices AI survivors who have lived through IPV. These frameworks also acknowledge AI survivors who have experienced IPV as the experts on what they need in terms of interventions. By involving women who are survivors in the generation of knowledge that would affect practice and policy, we are upholding women's right to participatory governance and their right to involvement in making decisions that impact their lives (Nair et al., 2020).

Barriers to Help Seeking

Despite the severe negative impacts of IPV, our study indicates that many AI survivors did not seek help after an experience with IPV and reveals the complexity of women's experiences that make help seeking difficult. Each of the survivors experienced their own individual circumstances or barriers for why they were unable to access or refused help after a particularly dangerous situation. The barriers to help seeking faced by urban AI women after IPV can be largely attributed to the sociopolitical systems that exacerbate poverty, housing insecurity, racism, and discrimination. This study clearly shows how this sociopolitical context manifests in AI women's lives within in their unique local urban context. The 2011 U.S. Census revealed Milwaukee as one of the top 10 impoverished big cities in the U.S., with an overall poverty rate of 29.4%. Milwaukee is also one of the most segregated cities in the U.S., with some of the greatest disparities for health and social outcomes such as housing, unemployment, and

high crime rates. In 2013, Wisconsin had the highest incarceration rate for American Indians in the U.S., with an increase of 42% of American Indians in county and city jails between 1999 and 2013 (U.S. Department of Justice, 2017). Several survivors (N=11) interviewed for this study reported that they had been arrested and incarcerated for various reasons, some of which include being wrongly arrested for defending themselves during an IPV experience.

This study uncovers the unique and personal experiences of urban AI women with interpersonal racism, dehumanizing treatment by law enforcement, and distrust of authority figures or healthcare personnel. These negative experiences contribute to the marginalization and isolation of survivors, placing them at risk for harm by impacting their ability to seek care after experiences with IPV and to mitigate the impact of these experiences on women's health. Survivors shared their stories of struggles with homelessness or housing related challenges, poverty, and lack of transportation that made it difficult to access help and to leave an abusive relationship if they desired to do so.

The critical need for access to safe and affordable housing for AI survivors of IPV in urban areas was emphasized in this study. Many survivors who did not seek care or help after an experience of IPV specifically cited fear of homelessness or housing challenges as a primary barrier to leaving an abusive relationship or dangerous situation. The challenges of accessing safe and affordable housing for AI women experiencing IPV can be attributed to the structural inequities that place women of color, including AI at risk for ongoing victimization from IPV. The literature shows that IPV and sexual assault are the leading causes of homelessness and housing insecurity for women, particularly for women of color (Safe Housing Partnerships, 2019; Gonzales, 2018). Women of color, victims of IPV, and women with children also face the highest rates of eviction (Gonzales, 2018). Some of the AI survivors who participated in this study spoke about their reluctance to leave an abusive relationship for fear of homelessness,

putting them at greater risk for injury or even death.

AI women's need to access safe, affordable, and tribally specific care after experiences with IPV is emphasized based on the findings of this study. From a policy perspective, the findings highlight how the Indian Health Service model makes it difficult for low income and uninsured American Indians living in urban areas to seek healthcare. This is problematic because the Indian Health Service model, which provides the majority of health care to American Indians and Alaska Natives, has allocated only about 1% of its funding to urban areas, despite the high rates of American Indians residing in urban areas (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). Nationally, approximately 70% of American Indians currently live in urban settings, which is contrary to the common stereotype that American Indians reside on reservations or in rural areas (Casselman, 2016). In Wisconsin, 45% of the AI population reside in metropolitan areas, with 13.7% living in Milwaukee (Wisconsin Department of Health Services, 2016). The resulting limited access to needed care exacerbates barriers for urban based AI survivors who have the desire to leave a violent situation. This is especially true for AI women who prefer tribally specific IPV related services, particularly for after-hours emergency care and sexual assault nurse examiner (SANE) services. There is therefore is a critical need for the reallocation of additional federal IHS funding to urban health care facilities to support direct care and support services for AI victims of IPV and sexual assault.

Other financial barriers such as lack of health insurance, inability to pay for care, and a lack of transportation are all important findings of the study. Several survivors refused or reluctantly accepted medical care after injuries because they did not have medical insurance. Survivors who did not seek care or help after an experience of IPV, cited financial barriers, lack of insurance, or transportation as the primary reasons for not seeking help. Survivors expressed concern about how financial barriers coupled with not having insurance or transportation to

access help exacerbated experiences of trauma after an experience of IPV. It is clear that in urban areas, survivors may not be able to easily access services needed to mitigate the consequences of violence in order to begin healing and repairing their lives.

In addition to challenges with access to medical and other services, survivors spoke of their distrust of healthcare workers and fear of accessing the healthcare system or other agencies. Survivors' experiences with racism and dehumanizing treatment by law enforcement, social service, and healthcare agencies contributed to this mistrust. The inherent distrust that survivors have is fueled by the common knowledge in AI communities of the historical disrespect and mistreatment of American Indians by healthcare providers, including the dejected history of nonconsensual sterilization of AI women that occurred up until the mid 1970's. Women who do not anticipate feeling safe when seeking resources tend to avoid doing so. Additionally, many programs or services offered for victims of IPV were originally designed by and for non-AI populations. AI women who manage to access these programs and services often find staff with limited cultural awareness and program supports that have little cultural safety or relevance for them (Klingspohn, 2018).

Survivors spoke openly of their preference to seek care only from agencies or providers that offer services specifically for American Indians. Survivors who did seek and receive help, emphasized that they felt most comfortable utilizing agencies that provide care specifically to AI community members, or they chose to travel back to their reservations to seek help.

It was also evident that not all AI survivors were aware of the resources available to them in the communities where they lived, which impacted their ability to seek help following an experience of IPV. This lack of knowledge may be due to a variety of reasons such as recently moving to a city from a reservation or rural area, or moving from one urban area to another, or just being unaware of the resources existent in the community in which they are living especially

if IPV is a new experience for them.

Lastly, the COVID-19 pandemic was just beginning to unravel at the start of this study. While there were not interview questions asked specifically about COVID, survivors spoke openly about their thoughts, feelings and fears about the pandemic because of their concerns for themselves, as well as their communities. The findings from this study demonstrate that the COVID-19 pandemic had a major impact on the lives of survivors such as job loss or layoffs, loss of income, exacerbation of housing insecurity, being quarantined with an abusive partner and loss of or restrictions of available resources. Since the completion of data collection, urban, reservation based, and rural AI communities have continued to struggle with manifestations of the pandemic. Casinos and summer pow wows are a major source of revenue for tribes and tribal members, which have remained closed or events cancelled in order to protect the health of the most vulnerable. These additional financial stressors and barriers impact survivors' ability to leave potentially dangerous situations, and the problem will only worsen as the pandemic continues. The study findings demonstrate the urgency of informing scholars, healthcare, and social service providers about the impact that the pandemic has had on barriers to help seeking for urban based AI survivors. Continued research is critically needed to address the unique needs of AI survivors of IPV especially due to the uncertainties associated with the trajectory of the COVID 19 pandemic.

Pregnancy

This study highlights the complex factors impacting the experiences as well as the impacts of IPV in the lives of urban Wisconsin AI women, particularly during the pregnancy period. Significant racial disparities exist in the rates of maternal and infant mortality for women of color, particularly for AI women and Black women. According to the CDC (2019), AI women and Black women are two to three times more likely to die from pregnancy-related

causes than white women.

There are complex factors that contribute to the disparities in maternal and infant mortality including racism. The structural racism that exists within the health care system, social service system, and law enforcement manifesting in poorer quality care for women of color than for White women impacts not only health and social outcomes, but affects trust, ultimately, limiting access to services. The cumulative stress and experience of racism and sexism impact birth outcomes manifesting as preterm labor, preterm birth, and poor birth outcomes including high infant mortality rates (Taylor, Novoa, Hamm, & Phadke, 2019). The literature is also clear that IPV victimization is associated with devastating impacts to the physical and emotional wellbeing of women. The burden of IPV during pregnancy for AI women therefore serves to only heighten the risks of adverse birth outcomes that AI women were already facing.

While this study was not intended to focus specifically on IPV experienced by AI women who were currently pregnant, it became apparent through the data that IPV experienced during a pregnancy within AI women's lifetime, was reported to be common (68.8%) among the survivors interviewed. The consequences of severe physical IPV during the pregnancy period included loss of pregnancy, preterm labor, and premature birth for survivors. This poses a significant concern for the safety of Wisconsin AI women and their infants. Additionally, survivors reported instances of severe physical IPV that occurred both during and outside of pregnancy that resulted in physical injuries, including broken bones, facial injuries, and head injuries, some of which required medical attention.

This study showed how IPV is associated with a range of physical health problems and poor maternal child health outcomes for urban Wisconsin AI women. Aside from physical injuries, this study highlights other negative impacts of IPV experienced during the pregnancy period such as lack of consistent or any prenatal care, lack of partner support, and negative

pregnancy experience due to stress, fear, and sadness. These cumulative stressors manifested in negative pregnancy experiences that survivors described as "unhappy and stressful, and too much to handle". Women who experience IPV during pregnancy are at risk for developing mental health concerns such as depression, suicidality, PTSD, poor mental health functioning, and mood disorders (Stockman, Hayashi, & Campbell, 2015). Without intervention or support to help break the cycle of abuse, repeated experiences with IPV may escalate, leading to serious injury, or loss of life (Burnette, 2015; Childress, 2013).

The study also found that urban AI women experienced multiple complex stressors during their pregnancies related to IPV victimization such as lack of a supportive partner, isolation, fear, caring for other children, combined with the burden of ongoing physical and emotional abuse. Aside from physical injuries, the findings highlight other negative impacts of IPV experienced during the pregnancy period such as lack of consistent or any prenatal care, lack of partner support, and negative pregnancy experience due to stress, fear, and sadness.

Strengths of Dissertation

This study prioritized AI women's voices and demonstrates a localized understanding of the experiences of IPV in the lives of urban AI women. The study contributes valuable findings to fill a major gap in the literature about IPV against AI women living in urban and metropolitan areas. To date, there are currently no studies published about the incidence or prevalence of violence, nor the individual lived experience of IPV in the lives of AI women in Wisconsin. This study was also conducted by a nurse researcher who is an enrolled member of the Bad River Band as well as an IPV survivor.

Additionally, survivors provided feedback after the interviews that telling their story was a healing and meaningful experience, with the hopes that their experience with IPV could be helpful or useful to other women in addressing violence in their lives. Storytelling is highly

valued within AI communities because it is through oral tradition that culture has been preserved and passed from generation to generation. It was evident throughout the interviews that survivors cared deeply about the high rates of IPV against AI women. Many expressed a desire to become more active in their communities to address this crisis.

Limitations of Dissertation

This qualitative study is not without limitations. The study relied on self-reports from participants. IPV is a highly sensitive topic and AI survivors may have felt unable to disclose anything that could be considered unlawful. In this regard, there may be important additional information that was not obtained through the interviews. The use of telephone and skype interviews for some of the interviews was not ideal. I would have preferred to interview all of the survivors in person to allow for a closer analysis of non-verbal communication on the part of women participating. However, due to the social distancing mandates related to the COVID-19 pandemic, it was not possible to interview all of the survivors in person. Nevertheless, the analysis demonstrated consistency between the narratives of the women who were interviewed in person and those of women interviewed using other channels.

Policy and Practice Recommendations

In addition to the policy and practice recommendations that are discussed in the manuscripts, this section suggests broad practice and policy recommendations based on the overall findings. The rates of IPV in the lives of AI women is staggering. This study reveals that urban AI women experience deep and lasting impacts from the victimization of IPV. As a result, there has never been a greater need than now for nurses to develop a consciousness about the reality of violence experienced by AI women.

First, there is a critical need for the creation of safe spaces to improve the access to urgently needed services for urban AI women experiencing IPV and sexual assault that is

culturally specific, safe, and accessible, especially outside of typical "business hours". This includes the availability of sexual assault nurse examiner (SANE) services, and advocate support. Most importantly, these services must be accessible for all AI women regardless of tribal affiliation and ability to pay. This may be possible through advocating for the reallocation of or request of additional federal IHS funding to adequately fund urban health care facilities.

Nurses have a unique opportunity to help stop the cycle of abuse through an increased understanding and awareness of the injustice experienced by AI women. Breaking the cycle of violence is possible through the implementation of policies that ensure the careful and consistent screening for IPV, providing validation and support to victims, and through advocacy efforts such as identifying community resources available to women so they may be referred appropriately.

The findings from this study demonstrate the critical need for nurses and allied professionals to learn about the history of the medical establishment with ethnic minorities, in this case AI survivors, and how this affects trust and women's ability to feel safe enough to make an IPV disclosure, and to seek help. Nurses can provide a safe and supportive environment for AI survivors by avoiding the replication of oppression and re-traumatization when providing care. Nurses can do this through a strength-based approach when working with survivors. For example, the role of the nurse is to facilitate choices for survivors, rather than giving answers or orders. We can build upon survivors' strengths and capacities and emphasize that IPV is not their fault. Nurses also need to check their implicit biases that may lead to inadvertent victim shaming such as 'how could you ever put up with that'! or 'why don't you just leave', that could further erode trust in healthcare providers. Nurses can also empower survivors by helping them to create a safety plan and letting them be in charge of it while reminding them that they are not alone. For women who have been victimized IPV, control has been taken from them. The

foundation of an abusive relationship is the perpetrator attempting to have and maintain control over a survivor and her life (Burnette, 2016; Maldonado & Murphy, 2020). For AI women who have been victimized in this way, they are not only facing violence from IPV but also violence resulting from centuries of oppression in the form of systematic racism, genocide, and sexual violence wrought on the bodies of AI women as an entire population (Casselman, 2016; Deer, 2015). Creating spaces where women can take control over their own lives and their own bodies not only helps to reestablish trust with healthcare providers; it is also central to feminist activism.

There is a critical to address the need for consistent IPV screening during prenatal visits. This is because the prenatal care may be the only opportunity for AI women victims of IPV to have contact with nurses and allied professionals who can support her in breaking the cycle of violence (Kearney, Haggerty, Munro, & Hawkins, 2003). For many women, the pregnancy period may be a time when many women become motivated to make changes to protect their unborn child and attempt to reduce exposure to or remove themselves from violent relationships (Mercer, 2004).

Normalizing the screening process for IPV for nurses and allied professionals is critical because it allows for an opportunity to provide education about the prevalence of IPV in our society and what resources are available for help (Mkandawire-Valhmu, 2018). Unfortunately, screening for IPV during prenatal visits does not consistently occur and varies from institution to institution, with the biggest barrier to screening being a lack of time by healthcare providers (Fletcher, Clements, Bailey, 2016). There is therefore a critical need to implement or reinforce existing policies that prioritize consistent screening for IPV during prenatal visits.

There is a need for social services, healthcare, and advocacy agencies to collaborate to ensure that all women are aware of the resources available in their communities. This can be creatively be done through social media campaigns, outreach and collaboration with community-

based agencies where women frequent or access services including grocery stores and gas stations. Outreach to AI community leaders and having information readily available at pow wows and at other AI community events is another way of communicating available resources.

Academic community partnerships may be an impactful way to address IPV within AI communities. The literature shows that community-academic collaborative partnerships are valuable to the implementation of workable and effective community-based interventions and can provide important insights to academics focused in the area of IPV against AI women while also addressing this urgent public health problem. Academic-community partnerships nurture a more holistic approach to addressing gender-based violence that considers the social, cultural, and economic contexts that inform women's experiences of violence. While advocates and community-based organizations work to address real-life challenges, academic partners seek to understand phenomena, assess the effectiveness of programs developed in collaboration with community-based organizations and determine other possible program activities or supports that could help enhance health outcomes (Hamberger et al., 2000). Nursing and other student involvement only adds to the benefit of these partnerships by increasing their knowledge and skills in providing culturally safe care to survivors.

Lastly, this study focuses upon the individual lived experiences and impacts of IPV among urban Wisconsin AI women. Because the experiences and needs of AI women experiencing IPV may differ in urban areas than in rural or reservation-based areas, further research is needed to understand the unique needs of rural based AI women in order for interventions to be effective and survivor-led. This is all the more urgent as the COVID-19 pandemic continues, with the US at its epicenter.

Conclusion

The purpose of this dissertation was to deepen our understanding of the individual lived

experiences of IPV in the lives of urban Wisconsin AI women. This study specifically highlights the continuation of colonial injustice that is manifested by high rates of IPV, experiences of racism, oppression, and poverty that exacerbate barriers to help seeking for urban AI women. A deeper understanding of the individual lived experiences of IPV facilitates the development of survivor led interventions tailored to AI women's unique sociocultural needs. The findings from this study can be used to support urban and tribal care providers in developing interventions that meet the needs of AI survivors that are culturally safe and rooted in AI women's contemporary realities. This cannot be done without centering the voices of AI survivors.

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Appendix A: IRB Approval Letters

UNIVERSITY of WISCONSIN
UWMILWAUKEE
Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3182 *phone*
(414) 229-6729 *fax*

uwm.edu/irb

harries@uwm.edu

New Study - Notice of IRB Full Board Approval

Date: January 29, 2020

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Jeneile Luebke

IRB#: 20.136
Title: Intimate Partner Violence In the Lives of Wisconsin American Indian Women

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board at a fully convened meeting held **January 8, 2020**, your protocol has been approved as governed by 45 CFR 46.

In addition, your protocol has been granted **Level 3** confidentiality for Payments to Research Subjects according to UWM Accounting Services Procedure: 2.4.6.

This protocol has been approved on **January 8, 2020** for one year. IRB approval will expire on **January 7, 2021**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a continuation for IRB approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found in IRBManager.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. It is the principal investigator's responsibility to adhere to the policies and guidelines set forth by the UWM IRB, maintain proper documentation of study records and promptly report to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

This study may be selected for a post-approval review by the IRB. The review will include an in-person meeting with members of the IRB to verify that study activities are consistent with the approved protocol and to review signed consent forms and other study-related records.

As Principal Investigator, it is your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project.

Respectfully,
Melody Harries
Melody Harries
IRB Administrator

UNIVERSITY of WISCONSIN
UWMILWAUKEE

Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3182 *phone*
(414) 229-6729 *fax*

uwm.edu/irb
harries@uwm.edu

Modification/Amendment - IRB Expedited Approval

Date: April 7, 2020

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Jeneile Luebke

IRB#: 20.136
Title: Intimate Partner Violence In the Lives of Wisconsin American Indian Women

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has received expedited modification/amendment approval for the following minor changes to approved research, as governed by 45 CFR 46.110:

- Adding research personnel
- Change in study procedures to conduct interviews remotely during pandemic

IRB approval will expire on **January 7, 2021**. Before the expiration date, you will receive an email explaining how to either keep the study open or close it.

This study may be selected for a post-approval review by the IRB. The review will include an in-person meeting with members of the IRB to verify that study activities are consistent with the approved protocol and to review signed consent forms and other study-related records.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project.

Respectfully,
Melody Harries
Melody Harries
IRB Administrator

HO-CHUNK NATION
INSTITUTIONAL REVIEW
BOARD

March 6, 2020

Ms. Jeneile Luebke
634 Emerson Street
Madison, WI 53715

Dear Ms. Luebke:

Thank you for your patience while our board reviewed your application regarding Intimate Partner Violence in the Lives of WI American Indian Women (20-005P). The IRB held a meeting on March 4, 2020, and it was determined that your study has been approved with conditions/modifications, which include:

1. You deliver a presentation of your results for the Ho-Chunk Nation.
2. You include contact information for local social services and health agencies when interviewing Ho-Chunk members (e.g. county human services or Ho-Chunk Social Services).
3. You must use a device other than your personal laptop when collecting data for Ho-Chunk members (e.g. a laptop from your university).

Please note that these conditions are required in order to conduct human subject research on Ho-Chunk Nation lands, and we both expect and appreciate your cooperation. I congratulate you on the approval of your study and wish you the best with your dissertation data collection.

If you have questions feel free to contact me at (715) 284-4915 ext. 1294.

Respectfully,

Dr. Marcus F. Lewis
HCN IRB Chairperson

Appendix B: Letter to Great Lakes Intertribal Council

UNIVERSITY of WISCONSIN
UWMILWAUKEE

College of Nursing

Cunningham Hall, Office 579
P.O. Box 413
Milwaukee, WI
53201-0413
414 229-6098 phone
414 229-6474 fax
http://www.uwm.edu
UPS/FedEx/Courier only:
1921 East Hartford Avenue
Milwaukee, WI 53211

November 5, 2019

Great Lakes Inter Tribal Council
2932 Highway 47 N.
P.O. Box 9
Lac du Flambeau, WI 54538

Re: Request for permission and support in working with urban Wisconsin American Indian women

Dear Great Lakes Inter Tribal Council staff,

My name is Jeneile and I am an enrolled member of Bad River Band of Lake Superior Chippewa. I am also a Nursing PhD student at UW-Milwaukee and my research topic is intimate partner violence (IPV) in the lives of American Indian women. I hope to conduct in-depth qualitative interviews with American Indian women living in Wisconsin urban areas (specifically Milwaukee, Green Bay, and Appleton) to gain a deeper understanding of their individual lived experiences with IPV, including impacts of IPV, as well as to assess for barriers that may exist in gaining access to healthcare and support services for victims. I am currently working with UW-Milwaukee's IRB to gain approval for this study. I did reach out to the Indian Health Services headquarters to inquire about individual tribal IRB and was told that I do not need individual tribal IRBs to interview American Indian women that are living in off-reservation or urban areas. I am writing to request your permission and support in working with American Indian women who have been victims of IPV residing in the Milwaukee, Green Bay, and Appleton). The overarching goal of this research study is to collaborate with area tribes by sharing the final interview data as well as to identify ways to enhance access to care and culturally safe screening and interventions for American Indian women who have experienced IPV. The participants in the study will remain anonymous and no identifying information will be shared or published. I am happy to share a copy of my dissertation proposal and supporting documents such as screening questions and recruitment flyer if you should wish to see it.

Thank you very much and I look forward to developing a collaborative partnership with you.

Sincerely,

Jeneile M. Luebke, MS, RN, PhDc
4th year Nursing PhD student
jeneile@uwm.edu
608-213-4608

Appendix C: Screening Script

Thank you for your interest and willingness to participate in the study. The purpose of this study is to gain a deeper understanding of the lived experience of IPV and to better understand the barriers to accessing care and services related to IPV for American Indian women in Wisconsin. In order to make sure that you qualify for this study, I need to ask you a few questions:

1. Are you an enrolled member of a federally recognized tribe?
    a. Which tribe?
2. Are you between the ages of 18 and 55?
3. Are you currently, or have you been a victim of intimate partner violence?
4. Are you currently pregnant or have you had a child within the past 5 years?
5. Do you currently live on the Bad River reservation, Menominee reservation, Ho-Chunk tribal trust lands, or in the cities of Madison and Milwaukee?
6. Are you in any immediate danger or would you be in danger if you participated in this interview?

*The individual must respond "yes" to questions 1-5 to qualify for the study
*The individual must respond "no" to question 6 to qualify for the study

Appendix D: Interview Guide

1. Describe your current romantic relationship, if applicable.
2. What does the term intimate partner violence or domestic violence mean to you?
3. Think about a time that was challenging in your most recent romantic relationship. How did you handle this challenge?
4. Thanking about a relationship(s) that you experienced IPV. Describe your experience(s) with IPV.
5. What injuries did you sustain as a result of IPV? If so, did you seek medical care for any injuries?
6. Did the violence have any impact on your pregnancy experience, ability to access prenatal care, or birth outcome?
7. If you sought help for any injuries, can you describe this experience? How were you treated while receiving care? Where did you receive care?
8. When you experienced IPV, did you get formal help from social service system? If yes, describe those experiences.
9. Was the legal system was involved? Was the perpetrator arrested? Tell me about your experience with law enforcement.
10. If the legal system was involved, were you ever arrested? If so, tell me about your experience with law enforcement.
11. Describe how have you been impacted by IPV? (What effect has IPV had on your physical, emotional, or spiritual well-being? Has it affected your feelings about yourself?)
12. How have you coped with IPV? (Have you sought help?)
13. Race/ ethnicity of perpetrator?

14. If someone in your community experiences IPV, what services are available? Has this changed over time?
15. What other resources would have been helpful to you?

Prior to ending the interview, it is essential to ask the following questions:

16. Are you currently safe?
17. What resources are you aware of for women experiencing IPV?

Appendix E: Demographic Questions

1. How old are you?
2. What is your marital status?
3. Do you have children?
    a. How many?
4. What is your tribal affiliation?
5. What city do you currently live in?
6. What is your employment status?
    a. Occupation
    b. How many hours do you work per week?
7. What is your level of education?
8. What is your annual household income?

Appendix F: Study Information Flyer

Research Study about Intimate Partner Violence Against American Indian Women

Are you an American Indian/Indigenous woman ages 18-55 who lives in an urban area (such as Madison, Milwaukee/ Green Bay, etc), currently pregnant or have had a pregnancy in your lifetime (regardless of outcome), AND have been impacted by acts of intimate partner violence (IPV) such as physical abuse, verbal abuse, psychological abuse (humiliation, control, keeping information from you, isolating, and keeping money or basic resources from you), stalking, or sexual abuse by an intimate partner? If so, **I invite you to tell your story to help me better understand how adult American Indian women and their communities are impacted by IPV. Your voice and your story matters!**

Your story and information will be kept confidential, unless you specifically ask to be identified to share your story. The information gathered from this study will be used to help local tribal communities to figure out ways to better support victims of IPV violence and to help to figure out ways to address and prevent IPV.

You will be compensated for your time, effort, and participation in this study with your choice of a $50 Amazon or Wal Mart gift card.

Please contact me with questions or if you would like to be a part of the study!

Jeneile Luebke, MS, RN, PhD candidate
Enrolled member of Bad River/ IPV survivor
UW-Milwaukee, College of Nursing
608-213-4608
jeneile@uwm.edu

This project is funded with a gift from the Forest County Potawatomi Foundation

UW-Milwaukee IRB approval #20.137
Ho-Chunk Nation IRB approval #20.005P

Appendix G: Consent Form

Study title	Intimate Partner Violence in the Lives of Wisconsin American Indian Women: A Continuation of Colonial Injustice
Researcher	Jeneile Luebke MS, RN, PhD candidate, UW-Milwaukee College of Nursing

I'm inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

Overview

Purpose: The purpose of this study is to understand intimate partner violence (IPV) against American Indian women in Wisconsin.

Procedures: For this study, I will ask you questions about your experience with IPV in a safe and private location. Additionally, up to 20 participants may also volunteer to participate in another part of the study called "photovoice". For the "photovoice" portion of the study, you will be given a camera-ready tablet to take photographs to represent your thoughts and feelings about your individual experience(s) with IPV. You may keep the tablet for your time and participation in the "photovoice"

Time Commitment: 1-3 hours for the in-person interview. This may be done in one interview, or in two interviews, if you prefer. It will take an additional 4-5 hours total to participate in the "photovoice" portion of the study, which includes taking the photo and a follow-up meeting to discuss the photos.

Primary risks: You may be "triggered" to feel upset or uncomfortable when talking about difficult times in your life or experience with IPV.

Benefits: A personal benefit to being in this study is gaining awareness of supports and services available to you if you should need them, and others may benefit in the future from what I learn as a result of this study.

What is the purpose of this study?

The purpose of this study is to gain a deeper understanding of IPV (also known as "domestic violence") against American Indian women in Wisconsin and the impacts of IPV on the health and wellbeing of American Indian women and communities. The definition of IPV for this study includes physical, sexual, verbal, psychological violence (humiliating, controlling, keeping information from you, isolating, and denying money or basic resources), and threats of physical or sexual violence.

I am inviting you to be in this study because you may have been affected by IPV. Approximately 60-95 American Indian women will take part in this study through the University of Wisconsin-Milwaukee.

What will I do?

If you agree to participate in this study, we will schedule to meet for an interview that is scheduled at a time and place that you choose.

- When we meet, I will first ask you to complete a form to gather some basic information to make sure that this study is a good fit for you and your personal circumstances.

- The interview will take approximately 1-3 hours, but it may take longer if there is more information to add. During the interview, you will be asked a few questions about your current life and family, past or present romantic relationships, personal experiences with IPV, the effect of IPV on your life and your life now.
- You may skip any questions you do not wish to answer and limit the information you provide on any topic.
- If you agree, I will make a voice recording of our interview. I will use this recording to make an accurate transcript of your interview.
- The voice recording of our interview will be destroyed after I have made the transcript. I will ask your permission at the start of the interview before starting the recording.
- Recording the interview helps to give a correct written version of your story. You can refuse to have your interview recoded. Instead, I will need to take some notes about your story in order to analyze it for themes and data.

If you agree to be in the photovoice portion of this study, you will also receive a camera-ready tablet to take photos with.

- You will be able to take photographs that represent your own reality, personal thoughts or feelings about IPV whether it is coping with or surviving IPV in order to help others better understand the individual lived experiences of IPV. The photos will help to support your story in your own creative way.
- The photos will be analyzed to identify themes to bolster and support the themes identified in the interview data to make it richer and more meaningful.
- You are free to take photos of whatever you wish. However, you cannot take photos of children or of other people.
- You will decide how much personal information you would like to share through your photos. Please keep in mind, that if you are concerned for your privacy for personal or safety reasons, that you should keep this in mind, especially if you live in a small community.
- Further directions and examples of past photovoice projects will be reviewed with you once you agree to participate in this portion of the study.
- You will have two weeks to take photos. Most participants take an average of 5-10 photos each with a brief description of why you took the photo.
- You will choose your five favorite photos to share with me.
- You will be contacted to schedule a follow-up meeting after you finish taking your photos so I can download them from your tablet to my laptop.
- You can expect to spend a total of 2-3 hours taking the photos and meeting with me to download the photos.
- The photos that you take will be used to help support your personal story about IPV, as well as used as examples for future photovoice projects, presentations, or publications.
- I will only use the final five photos that you choose, and the rest of the photos will be permanently deleted.

Risks

Possible risks	How I'm minimizing these risks
Some questions may be personal or upsetting	• Taking part in this research study is completely voluntary. You can skip any questions you don't want to answer.

	• You may take as many breaks as you need to during the interview. • I will ask you for your permission before I begin the voice recording of the interview and I will stop the recording at any time if you ask. • You can end the interview at any time, and it will not jeopardize your ability to receive compensation. • You will be referred to local support and other services, if needed.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• All data in this study is de-identified (you will not be identified in any way), unless you specifically request that it be shared as yourself. • I'll store all electronic data such as recorded interviews and photographs on a password-protected, encrypted laptop. • You will sign the consent form and complete the screening via a fillable PDF form on a password protected iPad. This data will be deleted at the end of the study by 12/30/2022. • All voice recordings of the interviews will be destroyed after I have made the written transcripts. • The data will be analyzed at the group level to ensure the highest level of privacy for participants.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	• A personal benefit to being in this study is gaining awareness of supports and services available to you such as counseling services, shelters, and advocacy services if you should need them. • Others may benefit in the future from what I learn as a result of this study.
Estimated number of participants	• 30 women residing in urban locations (Milwaukee, Green Bay, Oshkosh, Appleton) • 65 women residing in reservation areas (Bad River, Menominee, and Ho-Chunk trust lands). • 20 of the participants will also participate in the photovoice portion of the study.
How long will it take?	• 1-3 hours for the interview • 4-5 hours for taking photographs and meeting with me a second time to download the photographs, if you choose to be a part of the photovoice group.
Costs	None
Compensation	• You will be given a $50 Wal Mart gift card for the interview • You may also receive a camera-ready tablet computer to keep for participating in the photovoice group for the study.

Future research	• I will only share anonymous data (no personal identifying information) with other researchers in the form of published reports or in presentations. • The data will be analyzed at the group level to ensure the highest level of privacy for participants. • Any direct quotes from any interview will be listed as "anonymous", unless you request that you be identified.
Recordings / Photographs	• I will voice record the interview. the interview will be transcribed (put into word format). If you do not want your interview to be voice recorded you may request that the interview not be recorded. • You taking photographs is optional. The photographs will help me to better understand your experiences with IPV.
Removal from the study	If you feel that your safety may be in jeopardy by participating in an interview or by taking photographs (you fear that you may be followed to the interview) then you may be removed from the study.
Funding source	Forest County Potawatomi Foundation

What if I am harmed because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

Where will data be stored?	On my personal laptop that is encrypted, and password protected
How long will it be kept?	Until 12/31/2022

Who can see my data?	**Why?**	**Type of data**
The researchers (Jeneile Luebke and my major professor Dr. Lucy Mkandawire-Valhmu)	To conduct the study and analyze the data	• The contact list to schedule interviews • The data on the demographic sheet • The recorded voice interviews • The photographs that you take if you participate in the photovoice group • The transcribed interviews
The IRB (Institutional Review Board) at UWM The Office for Human Research Protections (OHRP) or other federal agencies	To ensure we're following laws and ethical guidelines	• The contact list to schedule interviews • The data on the demographic sheet • The recorded voice interviews

		The photographs that you take if you participate in the photovoice group
Anyone (public)	If I share my findings in publications or presentations	• Aggregate (grouped) data • Anonymous data • If I quote something from your interview, it will be listed as "anonymous", unless you specifically request to be identified.

Mandated Reporting

Because I am a nurse, I am a mandated reporter. I am obligated to report instances of witnessed child abuse. I am not obligated to report disclosed instances of IPV of an adult by an adult (historic or current disclosed IPV) regardless of your pregnancy status.

Contact information:

For questions about the research	Jeneile Luebke	608-213-4608 jeneile@uwm.edu
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	414-229-3173 / irbinfo@uwm.edu
For complaints or problems	Jeneile Luebke	608-213-4608
	IRB	414-229-3173 / irbinfo@uwm.edu

Participation in *Photovoice*? Yes _____ No_____

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

_____

Name of Participant (print)

_____ _____

Signature of Participant Date

_____

Name of Researcher obtaining consent (print)

_____ _____

Signature of Researcher obtaining consent Date

Give a copy of this form to the research participant

Appendix H: Recruitment Pamphlet

Violence against women is NOT a Native tradition. I invite you to tell your story as part of a research study to better understand how adult American Indian women's health and well-being are impacted by IPV, including impacts on pregnancy experience or birth outcomes as a result of IPV.

I hope to use the information to begin to find ways to better support those who have been impacted by IPV.

If you choose to participate in the study, you will be paid for your time and effort.

I will protect the confidentiality of the information that you share!

CALL/ TEXT IF YOU HAVE QUESTIONS OR ARE INTERESTED IN PARTICIPATING IN THIS

Jeneile Luebke MS, RN
PhD candidate at UW-Milwaukee/
Enrolled Bad River member and IPV survivor

Contact me at:
Call/ text: 608-213-4608
Email: jeneile@uwm.edu

UW-Milwaukee IRB approval #20.137
Ho-Chunk Nation IRB approval #20.005P

Funding for study by: Forest County Potawatomi Foundation.

RESEARCH STUDY ABOUT INTIMATE PARTNER VIOLENCE AGAINST AMERICAN INDIAN WOMEN

Are you an adult American Indian woman currently experiencing, or has past experience with intimate partner violence (IPV) such as: *physical*, *verbal*, *emotional*, *or sexual violence* AND currently pregnant, or have had a pregnancy in your lifetime (regardless of outcome)? If so, I invite you to share your story as part of a research study that aims to better understand the how American Indian women are impacted by IPV, including your health and well-being, pregnancy experience , and birth outcomes.

Curriculum Vitae

JENEILE M. LUEBKE

OBJECTIVE

Currently seeking a professional nursing position in a teaching or academic setting.

PROFILE

- Comprehensive background in education, public health, pediatric, maternal child health, family-centered, medical and surgical nursing.
- Highly rated nursing educator conveying nursing concepts and procedures in classroom, laboratory and clinical settings to groups and individuals.
- Nursing care to children, adults, and families from diverse socio-economic, cultural backgrounds, and at-risk populations.
- Proven excellence in leadership roles and collaboration with multi-disciplinary professionals.

EDUCATION

PhD candidate Nursing, University of Wisconsin- Milwaukee (expected graduation 8/2020)
MS Nursing, University of Wisconsin-Madison 5/2009
BS Nursing, University of Wisconsin-Madison 12/2002
AS Nursing, Northland Community College 5/1999
Diploma Practical Nursing, Northwest Technical College 2/1998
General science, Bemidji State University, Minnesota 9/1996-5/1999

PROFESSIONAL EXPERIENCE

Edgewood College, Madison WI 6/2010-Present
Lecturer, Clinical Instructor, Department Co-Chair (N461- Community Health Nursing)

Direct nursing instruction in the classroom and clinical settings to senior level nursing students in the traditional BSN program as well as Accelerated Nursing program.

- Preparation and delivery of lectures to small and large nursing clinical groups.
- Curriculum development and revision of clinical courses held in the community setting such including at the Ho-Chunk Nation House of Wellness and in barbershops in Madison, WI.
- Assessment and evaluation of student clinical skills in clinical and community setting.
- Collaboration, planning, and communication with other health professionals at external clinical sites.

Group Health Cooperative, Madison WI 3/2005-7/2016
Registered Nurse, Nurse Connect/ Urgent Care (per-diem)

Triage telephone calls in the urgent care and family practice clinics, providing health education and self-care instructions over the phone/ office visits for acute and chronic illness.

- Demonstrate expert nursing knowledge from newborn-gerontological age spectrum.
- IV therapy.
- Physical assessment and implementation of RN protocols as deemed appropriate.
- Appropriately respond to emergent walk-in appointments.

Group Health Cooperative, Madison WI 6/2009-12/2013

Pediatric Complex Medical Home RN Project Coordinator

Coordination and implementation of a Medical Home project for Children and Youth with Special Health Care Needs at GHC-SCW. Position grant funded from the Maternal Child Health Block Grant, on a part-time LTE basis.

- Collaborated with graphic designer to create the Kids Medical Home website.
- Contributed to the implementation of the "green bar" status in GHC Epic system and 30-minute appointment times for members with complex medication needs
- Author of quarterly Medical Home newsletter, pamphlet, and other publications.
- Provided coordination of care for special needs children and families as needed.
- Coordination and planning program activities such as Family Focus meetings.

Madison Metropolitan School District 8/2009-12/2013

School Nurse/ Program Support Nurse

Provide population-based nursing care to children and staff in the elementary school setting. Also provide assistance to MMSD health services coordinator with district wide immunization projects and activities.

- Provided direct care to children and staff such as assessment, triage, emergency and non-emergency treatment, referrals for further care, medication administration, and providing other treatments.
- Served as an expert in health in the planning, development, and implementation of health curricula and staff in-services.
- Developed educational strategies for the promotion of health to groups and individuals.
- Collaborated with other professionals within the school setting, and parents/ guardians to develop Individual Education Plans for students with special health care and other needs.
- Provided guidance and daily schedule to the school nursing assistant.
- Provided direct instruction in classroom setting regarding various health and prevention topics.
- Served as immunization expert and immunization program support for the entire district.

Public Health- Madison & Dane Co., Madison WI 3/2006-9/2008

Immunization Program Coordinator

Assisted program manager with the coordination of the day to day logistical operations of the Immunization Program, provided staff and public with resources and education, policy and procedure development/ revisions utilizing evidence-based practice principles.

- Collaborated with many community partners to create and implement community wide immunization promotional campaigns.
- Communicated and collaborated with local media to provide press release information regarding outbreak or new vaccine information, including on camera interviews.
- Provided patient and family education and the administration of childhood and adult immunizations.
- Provided administration of vaccines to children and adults in the clinic and community setting.
- Wisconsin Immunization Registry site administrator responsible for vaccine ordering, registry
  maintenance, and statistic/ reporting functions.
- Implemented and managed community-based immunization specialty/ outreach clinics.
- Developed and implemented policies and reference materials for immunization program manual using evidence-based practice and current best practice recommendations.
- Developed educational and reference materials for Immunization Program staff and for the general public.
- Provided ongoing staff education in the area vaccine preventable disease/ pediatric communicable disease, facilitated monthly staff meetings, and assessed continuing program needs.
- Assisted program manager with staff vaccine administration errors/ provided individualized education to prevent future errors. Provided education and training for new staff on Immunization Program team.
- Provided community education presentations in Dane County (correctional facility staff, police department staff, animal services staff, and other health care providers).
- Facilitated and coordinated the Dane County Immunization Coalition and all related activities.
- Maintained and updated the Dane County Immunization Coalition website.
- Mentored and precepted UW and Edgewood College nursing students.

Ho-Chunk Nation Health Department 8/2002-3/2006

Public Health Nurse/ Supervisor

Provided prenatal and postpartum client and family education, developed a comprehensive prenatal care coordination program, provided health promotion and disease prevention for the community.

- Performed physical assessment and education to prenatal and postpartum clients through the PNCC program. Created and implemented a grant funded comprehensive prenatal education program.
- Performed assessments, screening, health education, and referrals to WIC participants.
- Provided breast feeding education and support to post partum client and families.
- Performed community needs assessments, client home visits, and office visits.
- Provided case management of individual clients and families within the community.
- Implemented and maintained the “Mothers Room” at the Ho-Chunk Casino, which encouraged and promoted a breastfeeding friendly workplace.
- Provided instruction/ mentored UW and Edgewood nursing students.
- Worked collaboratively with clinic physicians, advanced practice nurses, nutritionists, and other multi-disciplinary staff.

- Provided client assistance with accessing tribal and governmental resources such as Medicaid, Badger Care, and Wisconsin Well Woman program.
- Wrote for and awarded grants and awards, managed grant budget and grant reporting requirements.
- Managed day to day needs of the Care Givers Program such as the management of timesheets, hiring, discharge, performance reviews, disciplinary action, and collaboration with human resources.

OTHER EXPERIENCE

UW School of Medicine/Pediatric Pulmonary Center 6/2008-5/2009
Graduate Student Trainee

Provided family-centered, community-based, culturally sensitive, interdisciplinary coordinated care within an academic health-care setting.

- Developed skills to integrate principles of coordinated, family-centered care into clinical practice, establish and maintain community-based linkages, apply interdisciplinary team skills with the care of children with pulmonary disorders.
- Participated in advocacy and legislative process, developed skills in administrative management and strategic planning.
- Integrated evidenced based practice into care of children with pulmonary disorders, gained more understanding of public and private systems of care, and incorporated the public health principles of health promotion and disease prevention.

PROFESSIONAL LICENSURES/ CREDENTIALS

Wisconsin license as a Registered Nurse- current
AHA BLS healthcare provider- current
ANCC pediatric clinical nurse specialist (CNS-BC)
Lamaze® Certification: Breast Feeding Support Specialist

RESEARCH EXPERIENCE

Doctoral Dissertation Research UW-Milwaukee College of Nursing 9/2019-current

The purpose of my qualitative dissertation study is to better understand the experiences of intimate partner violence among Wisconsin American Indian women of childbearing age that may impact their health, wellbeing, and pregnancy outcomes. This study will address gaps in the literature surrounding the phenomenon of IPV against American Indian women, specifically American Indian women residing on reservations and tribal areas as well as urban areas in Wisconsin.

- In depth individual interviews conducted (N=30) with American Indian women who are victims or survivors of IPV living in the urban area of Milwaukee or Fox Cities areas.
- In depth individual interviews with 30-60 women will be conducted with American Indian women (within the next 12 months) living on the Bad River and Menominee reservations, and the Ho-Chunk tribal trust lands (all tribal IRB's or approval from tribal council obtained).
- The interview data will be analyzed to identify themes that can allow us to better understand how to provide care and support to victims and survivors of IPV. The results can be used to inform policy, and support the creation of best practice

recommendations, culturally safe screening and interventions for healthcare practitioners.

- Additionally, a subset of 20 participants can participate in the *photovoice* portion of the stud, which puts cameras in the hands of participants so they can create photos to help others see the world through their eyes. The participants will take photos with a camera-ready tablet and the photos become an extension of their voice. The participants to be active in the research process because their own words will be used as a caption of the photo that they take.

Clinical Research Practicum UW-Milwaukee College of Nursing 9/2017-8/2018

This research practicum will satisfy a portion of the PhD- Nursing graduation requirements. The purpose of this study is to explore symptom self-management strategies reported by adolescents and young adults with cancer using an iPad-based symptom heuristics tool, the Computerized Symptom Capture Tool. This study is part of a multi-site study in 5 states and 150 participants. My role in the practicum is to perform qualitative data analysis from the study, "A Symptom Heuristics iPad App to Improve Symptom Self-Management in Adolescents and Young Adults with Cancer".

- Develop competency in the steps of qualitative data analysis, including transcription, coding, and interpretation of data.
- Communication and collaboration with the five investigators of the study as it relates to management of and qualitative data such as coding, categorization, interpretation, and validation of data across sites.
- Identify elements of qualitative research to include in the dissemination of study results
- Contribution to manuscript that presents results of qualitative data from the C-SCAT study to be submitted to the *Journal of Clinical Oncology* or *Journal of Adolescent and Young Adult Oncology* in summer 2018.

Clinical Research Practicum UW-Madison School of Nursing 1/2009-5/2009 This research practicum satisfied MS-Nursing graduation requirements. The purpose of this study was to assess if an MRSA eradication protocol created by the UW School of Medicine Pediatric Pulmonary staff has been successful at 6 and 12-month intervals. The goal of the study was to reach a sustained eradication of MRSA in children with cystic fibrosis.

- Conducted thorough literature review, writing for and obtaining IRB approval for study, created data collection form to conduct chart reviews, performed analysis of preliminary and background data to assess for validity of the study
- Conducted chart reviews and analyzed preliminary data.

PUBLICATIONS

- Weitzel, J., Luebke, J., Wesp, L., Del Carmen Graf, M., Ruiz, A., Dressel, A., Mkandawire-Valhmu, L. (2020). The role of nurses as accomplices against racism and discrimination: An analysis of key resistance movements of our time. *Advances in Nursing Science.* 43(2).
- Luebke, J., Hawkins, M., Lucchesi, A., Weitzel, J., Deal, E., Ruiz, A., Jorns, J., & Mkandawire-Valhmu, L (2020). The Utility of Using a Postcolonial and Indigenous Feminist Framework in Research and Practice about Intimate Partner Violence against American Indian Women. *Journal of Transcultural Nursing*. (Revise/ resubmit in process: manuscript # JTN-20-065).

- Ruiz, A., Luebke, J., Klein, K., Mkandawire-Valhmu, L (2020). A Critique of Intersectionality Theory. *Nursing Inquiry*. (Revise/ resubmit in process. manuscript # NIN-19-12-OA-0196).
- Ruiz, A., Luebke, J., Klein, K., Hawkins, M., Callari-Robinson, J., Mkandawire-Valhmu, L (2020). The Role of Hegemonic Masculinities in the Lives of Ethnic Minority Women. *Advances in Nursing Science*. (In review).
- Dressel, A., Mkandawire, E., Gondwe, K.W., Mkandawire-Valhmu, L., Nordin, S., Vilakazi, N., Scheer, V., Kako, P., Ngui, E., Neiman, T., Ruiz, A., Luebke, J., & Minjale, P. (2020). The Intersection of Food Insecurity and Health for Rural Malawian Women at End of Life. *International Journal of Palliative Nursing*. (Accepted/ In press).
- Mkandawire-Valhmu, L., Kendall, N., Dressel, A., Wendland, C., Scheer, V., Kako, P., Neiman, T., Valhmu, W., Ruiz, A., Luebke, J., Merriman, A., Kishindo, L., & Egede, L. (2020). Women's work at end of life: The intersecting gendered vulnerabilities of patients and caregivers in rural Malawi. *Global Public Health*. https://doi.org/10.1080/17441692.2020.1730930
- Erickson, J., Ameringer, S., Linder, L., Macpherson, C., Elswick, R., Luebke, J., & Stegenga, K. (2018). Using a Heuristic App to Improve Symptom Self-Management in Adolescents and Young Adults with Cancer. *Journal of Adolescent and Young Adult Oncology*. 8(2). https://doi.org/10.1089/jayao.2018.0103
- Pfeil, D., Rock, M., Amond, K., & Luebke, J. (2010). Successful Eradication of First Acquisition of MRSA: A Study of an Eradication Protocol. *Pediatric Pulmonary Journal*, *45*, 333.
- Author and editor of Immunization Pearls newsletter that is published twice yearly on behalf of the Dane County Immunization Coalition.
- Acknowledgment in the Wisconsin Medical Journal "Pregnancy Associated Deaths and Pregnancy Related Deaths in Wisconsin, 1998-2001". 2004. Volume 103, No. 5.

PRESENTATIONS

- Guest lecture (Topic: Intimate Partner Violence Against Native American women) at UW-Madison School of Nursing 9/2018, 3/2019, 9/2019, 3/2020
- Guest lecture (Topic: Intimate Partner Violence Against Native American women) at UW-Madison, American Indian Studies, 3/2019, 10/2019, 3/2020
- Panel presentation (Geographic and other Barriers that Impact Access to Care for Wisconsin American Indian Women Impacted by Gender Based Violence) accepted for the Resistance and Reimagination conference at UW-Madison in April 2020 (cancelled due to COVID-19).
- Poster presentation (Intimate Partner Violence in the Lives of Wisconsin American Indian Women) at Futures Without Violence Conference in April 2020 (Rescheduled due to COVID-19).
- Podium speaker at UW-Madison Native Nations Summit in Baraboo, WI on 11/15/19.
- Poster presentation (*The Utility of Postcolonial and Indigenous Feminist Frameworks in Nursing Research about Intimate Partner Violence Against American Indian Women)* at Transcultural Nursing Society conference in Richmond, VA on 10/17/19 & 1/18/19.
- Panel presentation at UW-Madison Native Nations Summit in Keshena, WI on 11/16/18.

GRANTS

- Forest County Potawatomi Foundation award for dissertation study support ($25,000). Received October 2019.
- Co-author/ co-manager of grant awarded from the Department of Justice- Office of Violence Against Women. Grant title: Tracking our Truth: Providing culturally relevant,

advocacy driven, medical forensic access and care to American Indian tribes in urban and rural Wisconsin using indigenous epistemologies (Grant# MIL116349). Received May 2020. Award amount: $2 million.

AWARDS

Recipient of the UW-Milwaukee Womxn's Achievement Award- March 2020
Academic Excellence Award from UW-Milwaukee American Indian Studies- March 2017, March 2018, March 2019

HONORS

Sigma Theta Tau Nursing Honor Society- 2007-2009, 2016-current
Golden Key International Honour Society- 2008-2009, 2016-current
Advanced Opportunity Graduate Fellow 2007-2008, 2017-current
Helen Denne Schulte Minority Scholarship recipient 2008-2009
Advanced Education Nursing Traineeship Recipient 2008-2009
American Indian Graduate Center Fellow 2008-2009, 2016-2017