Inquiry: The University of Arkansas Undergraduate Research Journal

Volume 20 Article 6

Spring 2016

Investigating Disparities in Behavior and Care between Alaska Native and Non-Hispanic White Victims of Sexual Violence: The Importance of Culturally Competent Nursing Care

Danielle Koster
University of Arkansas, Fayetteville

Investigating Disparities in Behavior and Care between Alaska Native and Non-Hispanic White Victims of Sexual Violence: The Importance of Culturally Competent Nursing Care

By: Danielle Koster, Honors Student
College of Education and Health Professions

Faculty Mentors: Professor Cathy Hale & Dr. Marie-Rachelle Narcisse
College of Education and Health Professions

Abstract

The purpose of this research was to determine the existence of health care disparities experienced by Alaska Native women victims of sexual violence and to address the need for sexual assault nurse examiners (SANEs) to provide culturally competent care. This was a secondary data analysis of research collected from over 1,600 Alaska SANE surveys between 1996-2006. Variables investigated included: behaviors during examination, condition during assault, time from assault to report, hospital admittance, injuries sustained, and victim-suspect relationships. Alaska Native women were described as having less controlled behavior, being less cooperative, and less likely to be sober; they also often suffered more physically traumatic assaults than non-Hispanic white women victims. This research provides support for the need to include cultural competency training in the preparation curriculum for SANEs working with the Alaska Native population and urges SANEs to collaborate with cultural groups to ensure the delivery of culturally sensitive care.

Background and Significance

"*Alaska has an epidemic. It's not bear attacks or deadly roads. It's rape and violence against women*" (Sutter, 2014, p. 1). This poignant statement from Alaska Governor, Sean Parnell, is emblematic of a growing public health issue that has plagued the state for decades. The average rate of forcible rape reported to law enforcement from 1996-2006 was 77.8 per 100,000 individuals in Alaska as compared to 33.1 per 100,000 individuals in the contiguous U.S. and Hawaii (Rosay, 2006). According to the 2012 FBI crime estimates, reported rape is more common in Alaska than any other state; the per capita rate of rape is about three times the national average (U.S. Department of Justice, 2012). Data indicate that while one in five women has been sexually assaulted in her lifetime in the United States (Black et al., 2011), over one-third of adult women (37%) in Alaska report having been victims of sexual assault (Rosay, 2011). In spite of these alarming statistics, rape is still underreported in Alaska (U.S. Department of Justice, 2012).

Researchers suggest multiple, complex factors to explain the higher rates of rape in Alaska. For example, Alaska Native communities are often "geographically isolated, and at an increased risk for alcoholism, unemployment, health problems and high poverty levels" (Office for Victims of Crime, 2012, p.1). Rural communities with minimal roads, little law enforcement presence, and an abundance of male-dominated industries are also listed as risk factors. In addition, a breakdown in family structure and a lack of discussion regarding sexual violence and alcohol abuse are attributed as probable factors. Linda Chamberlain, director of the Alaska Family Violence Project, notes that there are "so many factors that tip the scale for Alaska…it's easier for perpetrators to isolate their victims and not get caught. And for people not to get help" (Bernard, 2014, p. 6-7). While silence has been the norm for several decades, a cycle of sexual violence has existed among Alaska Native communities. In regards to sexual or intimate partner violence, a public health nurse working in several Alaskan villages indicated that "people get mad when I say it's become tradition, but it has. We're talking about third-generation violence. That's tradition" (Bernard, 2014, p. 18). The heightened and additive exposure to these traumas and stress has amplified the effect of sexual violence on tribal communities (Office for Victims of Crime, 2012).

Sexual assault is not only detrimental to the victims, it is pervasive and has far-reaching personal, social, and economic implications. For example, sexual violence can lead to unintended pregnancies, induced abortions, gynecological problems, and sexually

transmitted infections and disease, including human immunodeficiency virus (HIV). Sexual violence has been associated with depression and post-traumatic stress disorders. Sexual violence against Alaska Native women is more likely to result in injury, more likely to involve a weapon, and less likely to be reported by the victim than those of non-Hispanic white women in the United States (Bachman, Zaykowski, Kallmyer, Pateyeva, & Lanier, 2008). Drug and alcohol abuse are considered critical links that attribute to the heightened level of violence experienced by Alaska Native women. Because of complicated relations and regulations between tribal and state authorities, an environment has been created that aids attackers in getting away with violent crimes with little to no fear of facing legal consequences (Alleyne, n.d.). According to the U.S. Department of Health and Human Services, reducing sexual violence is a necessity for the well-being of individuals and is listed as a Healthy People 2020 goal [Objective IVP-40. (Healthy People, 2014)].

In the face of complex challenges brought about by sexual violence, the White House Council on Women and Girls has recently implemented a series of initiatives to protect Alaska Native women from sexual violence. Changes listed in this report include: increasing resources for hiring more law enforcement, strengthening victim services, and updating the protocol for Sexual Assault Medical Forensic Examinations (Office of Vice President, 2014). When victims seek help at a medical center following an incident of rape, the preferred standard of care is for them to meet with a sexual assault nurse examiner (SANE). In an effort to improve services to victims of rape, initiatives are underway to train a larger number of nurses to become Forensic Nurse Examiners in Alaska (Angaiak, 2014).

Organizational efforts within the healthcare field that provide sexual assault education and services to women have gained attention in the past 15 years. For example, in 2002, the Institute of Medicine (IOM) called for health professional organizations to develop and provide guidance to their members, constituents, institutions, and stakeholders regarding violence and abuse education. Specifically, these recommendations emphasized the need for organizations to provide guidance in terms of (1) competencies to be addressed in health professional curricula, (2) effective teaching strategies, and (3) approaches to achieving sustained behavior changes among health professionals (Cohn, Salmon, & Stobo, 2002).

Furthermore, the Academy on Violence and Abuse proposed a series of health system competencies, institutional competencies, and individual learner competencies that health care professionals should acquire to create a supportive environment where the system and clinicians model best practices related to violence and abuse (Ambuel et al., 2011). Despite these renewed and acclaimed efforts, the reports from the White House Council on Women and Girls, the IOM, and the Academy on Violence and Abuse have omitted the primacy of *cultural competence* as a fundamental skill that SANEs should obtain in order to better assist and care for the victims of sexual violence.

Health Disparities Experienced by the Alaska Native Population

According to the National Alaska Native American Indian Nurses Association (NANAINA), health disparities and the burden of illness and death are a major concern for Alaska Native populations (Parker, Haldane, Keltner, Strickland, & Tom-Orne, 2002). Alaska Native women are three times more likely to be victims of sexual assault or rape compared to non-Hispanic white, African American or Asian women (Bachman et al., 2008). Six out of ten American Indian/Alaska Native (AI/AN) women reported being physically assaulted in their lifetime (Oetzel & Duran, 2004).

The Alaska Native population has many markers of disadvantage worthy of discussion. For example, 32% of AI/ANs live below the poverty level compared to 13% of all races in the United States (Parker et al., 2002). The AI/AN infant mortality rate, which serves as an important measure and indicator of the health status of a population, is 30% higher than that for all races in the United States (Maurer & Smith, 2013). These statistics, along with several others that present a population possessing lower education levels and higher levels of unemployment, shed light on the quality of life disparities experienced by individuals in the expansive region of Alaska (Parker et al, 2002).

Underfunded healthcare systems available to AI/ANs negatively affect accessibility and quality of care. The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, provides federal health services to American Indian and Alaska Natives. Unfortunately, over the past few decades a pattern of underfunding has developed

which has contributed to the disparity in health status. For example, per capita funding for Native American health care is 60% less than the amount spent on the average American (Goodkind et al., 2010). With the IHS currently operating with 59% of what is needed to provide adequate healthcare, it is important for the government to immediately and earnestly reevaluate the amount of funding allocated for Native Americans (U.S. Commission on Civil Rights, 2003).

In addition, the rural and isolated nature of many Alaska Native women places unique barriers to receiving quality healthcare in the absence of a healthcare infrastructure, which can lead to increased risk of repeated violence for victims (Oetzel & Duran, 2004). Cultural barriers also present a challenge (Parker et al., 2002). For example, mainstream interventions commonly used to help women victims of violence are not uniquely designed for Alaska Natives and are "not necessarily consistent with cultural practices" (Oetzel & Duran, 2004, p.56). The National Institute of Justice acknowledged that there was a lack of understanding regarding the needs of the Alaska Native people (Crossland, Palmer, & Brooks, 2013). More accurate, comprehensive information is critically needed to gain a better understanding of the health disparities and healthcare needs of the Alaska Native population as compared to the rest of the country. The next section will focus on the importance of cultural competence when providing care to differing patient populations.

Cultural Competence of Sexual Assault Nurse Examiners: A Core Necessity in Nursing Care Delivery

Over the years, the landscape of the United States has morphed into a mosaic of diversity in terms of race, ethnicity, and cultural traditions. Alongside this richness, cultural and language barriers have emerged. In healthcare settings, culture and language differences may result in misunderstanding, decreased regimen compliance, decreased medication adherence and other factors that can negatively affect the short- and long-term health outcomes of patients. The Institute of Medicine has noted that (1) minorities receive lower quality of healthcare even when socioeconomic and access-related factors were controlled; and (2) bias, stereotyping, prejudice, and clinical uncertainty may contribute to racial and ethnic disparities in health care (Nelson, 2002).

Nurses are at the forefront of healthcare services and play a pivotal role in the provision of care. The diversity of cultures within our nation has made it imperative for nurses to become better trained in the ability to achieve cultural competence in healthcare settings. Cultural and linguistic competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, in an agency, or among professionals; together, they enable effective work in cross-cultural situations (Bazron, Cross, Dennis, & Isaacs, 1989). The need for cultural awareness is fundamental in the delivery of effective, comprehensive, and respectful care for all patients. Given that Alaska Native women are living in an environment in which rape is more prevalent, more expected and perceived differently than in other cultures, it is vital that nurses receive cultural competency education. For example, historically, the sexual assault so many Alaska Native women experienced was considered *huklani*, or 'bad luck'; considered taboo. A woman said discussing the abuse you experienced was "like, bad, you don't talk like that, you don't say that…you learn not to talk when you're a kid" (Bernard, 2014, p.21). It is of paramount importance for nurses to consider the patient's individual beliefs and behaviors as their oversight could lead to disparities in care (Office of Minority Health, 2013). The meaning that victims give to the sexual assault and the victims' experiences of the post-assault services they receive are key in their recovery, healing and coping (Dudley et al., 2002).

Patients benefit when nurses learn more about health disparities and become proficient in their ability to provide culturally competent care for diverse groups. Specifically, patients who are treated by culturally competent medical practitioners may be more satisfied with their healthcare treatment and may, in turn, increase treatment compliance. Nurses must be more cognizant of cultural and linguistic barriers as well as their own biases that could affect their ability to provide culturally competent care. Yet, in providing care to Alaska Native patients, there is often a lack of concordance between patient needs and provider services. Concordance is the process of matching patient-provider racial, ethnic, and/or language characteristics. The underlying assumption is that sharing or at least understanding these characteristics leads to a higher degree of comfort, communication and empathy in clinical encounters. The topic of patient-provider racial, ethnic, and language concordance has propelled increasing interest

as it relates to the lack of diversity in knowledge and practice in the healthcare workforce (Office of Minority Health, 2013). Nurses who are culturally competent are better equipped to incorporate Alaska Native women traditions and cultural beliefs into effective plans of care. In turn, this could create more concordance in the patient-provider relationship and reduce disparities.

In 2000 the United States Department of Health and Human Services Office of Minority Health released national standards for culturally and linguistically appropriate services (CLAS). These standards were intended to advance health equality, improve quality and help eliminate healthcare disparities (Lehman, Fenza, & Hollinger-Smith, 2012). In regards to this research, three standards stood out:

> "CLAS 1: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
>
> CLAS 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
>
> CLAS 4: Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis" (Office of Minority Health, 2013, p. 1).

In addition to the Department of Health and Human Services, another federal agency, The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), works to improve safety and quality of care by accrediting healthcare organizations to improve performance. In their policies, JCAHO states they view the delivery of care in a culturally and linguistically appropriate manner as a safety and quality of care issue (Lehman et al., 2012).

Nurses working with diverse population groups need to be knowledgeable of cultural differences and need to continually grow in awareness and skills related to cultural discrepancies. A culturally competent nurse instills confidence in their patients and can improve patient satisfaction and compliance (Office of Minority Health, 2013). A major aspect of minimizing culturally insensitive care is to develop self-awareness. It is important for nurses to examine their own beliefs, values and behaviors to minimize the risk of stereotyping or discrimination. Another essential facet in respecting a patient's culture is providing patient-centered care. Patient-centered care improves the patient-provider relationship and ensures the decisions made and actions taken respect the needs, wants and preferences of the patient.

Josepha Campinha-Bacote created a model that serves as a framework for implementing culturally responsive care in healthcare organizations. The model suggests that cultural competence is an ongoing process. In other words, healthcare providers must be actively working towards becoming more and more culturally competent to achieve the ability to efficiently work within the cultural context of the patient. The model is called "The Process of Cultural Competence in the Delivery of Healthcare Services" and it assumes that there is a direct relationship between the cultural competence of healthcare workers and their ability to deliver culturally sensitive care.

The model can be visualized symbolically as a volcano, with cultural desire serving as the catalyst that erupts into the process of cultural competence. *Cultural desire* is defined as the personal desire of the nurse to want to engage in the process of becoming culturally aware and knowledgeable. Once a healthcare provider harnesses the desire, they commit to caring for the patient, accepting differences and building on similarities, and being willing to learn about another culture. Once the desire is there, the process begins. *Cultural awareness* is associated with the self-examination mentioned above. It involves exploring personal biases, stereotypes and assumptions in order to avoid engaging in cultural imposition. *Cultural knowledge* involves seeking out and building a strong educational foundation about various cultural groups. By investigating the worldviews of patients, healthcare providers can obtain a stronger understanding of health-related beliefs and values (Campinha-Bacote, 2002). *Cultural skill* means having the ability to perform culturally-based physical assessments and provide culturally sensitive care (Campinha-Bacote, 2003). Madeleine Leininger, the founder of the theory of transcultural nursing, defined a cultural assessment as a "systematic appraisal or examination of individuals, groups and communities as to their cultural beliefs, values and practices to determine explicit needs and intervention practices within the context of the people

being served" (Leininger, 1978, p. 85-86). Lastly, *cultural encounters* are instances in which the nurse directly interacts, face-to-face, with people from another culture. Interacting with people from other cultures expands personal perspectives and shifts thinking to prevent stereotyping (Campinha-Bacote, 2003).

In applying this model, Campinha-Bacote (2003) developed a mnemonic device for nurses and healthcare providers to review mentally to ensure they are providing culturally responsive services. The mnemonic "ASKED" (awareness, skill, knowledge, encounters, and desire) will help remind those providing care to a diverse population if they have "ASKED" themselves the right questions. An example of a question in regards to cultural awareness would be, "Have I examined my own personal assumptions in regards to this cultural group?" (Campinha-Bacote, 2003).

Including a model such as Campinha-Bacote's in the training programs for sexual assault nurse examiners serving diverse patient populations would likely provide multiple benefits. SANEs who have received training in cultural competence are able to (a) demonstrate the importance of culture as a central factor in health care, (b) identify barriers to cultural understanding among providers and patients, and (c) assess and respond to differences in values, beliefs, and health behaviors (Lehman et al., 2012). Next, the role of the sexual assault nurse examiner will be discussed.

Sexual Assault Nurse Examiners (SANEs)

The Sexual Assault Nurse Examiner plays a pivotal role in post-assault care. Following the recognition of the heightened occurrence of sexual violence in tribal populations, the Office for Victims of Crime established the American Indian/Alaska Native Sexual Assault Nurse Examine-Sexual Assault Response Team (SANE-SART) Initiative. A sexual assault nurse examiner (SANE) is a registered nurse who has advanced education and extra clinical experience in forensic examination of sexual assault victims (Littel, 2001). A sexual assault response team (SART) is a multidisciplinary team consisting of a law enforcement officer, a local victim advocate and a specially trained health care professional (such as a SANE). The purposes of a SART team include: meeting the immediate needs of the victim, providing a joint, effective, sensitive approach to the victim, conducting a police investigation, and documenting collected evidence (Alaska Network on Domestic Violence & Sexual Assault, 2015).

The sexual assault nurse examiner has several tasks once a victim arrives post-assault, but their main task is to work to maintain the victim's dignity and reduce psychological trauma (Henry & Force, 2011). The SANE meets with the patient and begins with a preliminary patient history to help prioritize care by identifying potentially emergent issues (Markowitz, 2007). The nurse conducts an in-depth interview and performs a physical exam, including a pelvic exam, in order to collect evidence that will be provided to law enforcement. SANEs collaborate with law enforcement officials and may be asked to testify in court. In addition, SANEs educate the victim about sexually transmitted infection and pregnancy risks, and make referrals for follow-up care if necessary (Henry & Force, 2011).

Research has shown the use of a SANE program improves effectiveness in several domains: psychological, medical, forensic, legal and community. When the nurses attend to the victims in a culturally competent manner, victims report that they feel safe, reassured, cared for and respected. The SANE programs have been found to provide more comprehensive and consistent medical care than typically provided in a normal Emergency Department setting. SANEs are trained and capable of collecting and recording evidence correctly. SANE programs also influence the political realm because survivors are more likely to participate in prosecution. With the evidence collected by SANEs during the exam, police are more likely to file charges, prosecutors are more likely to pursue prosecution, and attackers are more likely to be convicted. In regards to community change, SANE programs can help initiate improved relations and communication between health and legal professionals (Campbell, 2005).

SANE programs may be located in hospitals, community clinics, and police departments (Littel, 2001). According to the International Association of Forensic Nurses, Alaska, the state where rape is the most prevalent, has eight SANE programs. Alaska is the largest state in the U.S. spanning over 600,000 square miles. Texas is the second largest state with a little over 250,000 square miles; it has 41 SANE programs. In terms of comparison, Texas has one SANE program for every 6,500 square miles while Alaska has one SANE program for every 80,000 square miles. Although Alaska is not as densely populated, there are still over

200 native tribes inhabiting the vast landscape.

Recruiting and retaining qualified nurses to work with sexual assault victims is a difficult task; the turnover rate for a sexual assault nurse examiner in Alaska is typically two to three years (Angaiak, 2014). The high turnover rate in this position has been attributed to burnout as SANEs experience vicarious trauma, the cumulative effect on the helper working with others who have suffered traumatic life events. Providing SANEs with opportunities to express their concerns and enhancing support are important to maintain job retention (Logan, Cole, & Capillo, 2007). However, currently serving the Native Alaskan population is a group called the National Alaska Native American Indian Nurses Association (NANAINA). NANAINA represents nurses who are spread across the country positioned strategically in order to improve health outcomes for hard to reach populations. Although not all members of NANAINA are American Indian/Alaska Native, they work with native populations and promote culturally sensitive models of nursing interventions for their patients. NANAINA has the potential to significantly increase the number of qualified healthcare providers serving sexual assault victims; unfortunately, only a small number of their nurses are educated at the baccalaureate level, which is required in order to become a forensic nurse examiner (Parker et al., 2002).

Actions Taken to Tackle Sexual Violence in Alaska

The data examined in this research study were collected from 1996-2006. The substantial amount of data collected regarding sexual violence has provided valuable insight regarding the magnitude of the issue. Since the collection of data, an annual collaborative project between the University of Alaska at Anchorage Justice Center and the Council on Domestic Violence was designed to measure the prevalence of violence against women. The principal investigator on this project is André Rosay, who was also the principal investigator of the Alaska SANE data upon which this research study is based. Prior to these investigations, comprehensive statewide data were not available to guide planning and policy development in Alaska (Alaska Victimization Surveys). With the information from these surveys, the state is able to evaluate the impact of prevention and intervention services, provide greater support for preventing and responding to violence against women, and work to reduce the occurrence of violence against women (UAA Justice Center, 2013).

The Office for Victims of Crime developed the American Indian and Alaska Native Sexual Assault Nurse Examiner-Sexual Assault Response Team Initiative in 2010, which provided potential solutions to complex issues in order to improve the provision of coordinated community, victim-centered care. However, many barriers existed to the efforts to enhance and create new programs to address sexual violence. These barriers include a difficult-to-navigate maze of jurisdictional issues, the immense diversity of tribes, the lack of accurate, consistent data, and a general lack of resources. However, through efforts by the federal government and the Office for Victims of Crime, funding was provided to support the implementation of three SANE programs and the creation of a National Coordination Committee on the AI/AN SANE-SART Initiative to oversee development. It was intended that with these reinforcements, responses to victims of sexual violence could be improved through victim advocacy, law enforcement, and the criminal and tribal justice systems (Office for Victims of Crime, 2012).

The National Coordination Committee on the AI/AN SANE-SART Initiative submitted a report to the U.S. Attorney General in June 2014, a few years after the suggestions were made, which included issues and recommendations to the federal agency's response to sexual violence in tribal nations (National Coordination Committee, 2014). Although the committee noted significant short-term improvements in policy and legislation had been made, they developed a set of concrete recommendations to improve efficiency and effectiveness of the federal system's response to ensure long-term progress. The recommendations covered several critical areas; however, the ones applicable to this research included a policy change that required employees who performed investigative or victim assistance functions to be provided with a local, community-specific orientation on tribal customs and the unique challenges facing the particular tribal nation. Another policy required responders to sexual violence to facilitate the victim's access to cultural, spiritual and ceremonial practices. For example, researchers discovered that many Native victims would prefer to take part in a cleansing or healing ritual following a sexual assault. Several times throughout the report the importance of properly educating and training workers on respecting culture and practicing in a culturally competent manner was noted, indicating movement in

a positive direction (National Coordination Committee, 2014).

Purpose of the Study and Research Questions

The purpose of this research study is to investigate disparities in behaviors and medical healthcare experienced by Alaska Native women who were sexually assaulted as compared to non-Hispanic white victims. More specifically, our research questions are:

1. How do Alaska Native and non-Hispanic white patients' behaviors differ during medical examination?
2. How do Alaska Native and non-Hispanic white patients' conditions during the assault differ? Condition refers to whether the victim was under the influence of drugs or alcohol at the time of assault.
3. Are there differences in time from assault to report between Alaska Native and non-Hispanic white women who have been sexually assaulted?
4. How likely are Alaska Native victims of sexual assault to be admitted to the hospital as compared to non-Hispanic white victims?
5. How likely are Alaska Native victims to experience injuries from the sexual assault as compared to non-Hispanic white victims?
6. Is the victim-suspect relationship difference between Alaska Native and non-Hispanic white women?

Hypotheses

Based on the review of the literature, the following hypotheses were posited, (1) Alaska Native patients behave differently from non-Hispanic white patients during medical examination, (2) Alaska Native patients are in a different condition as a result of drug and alcohol use than non-Hispanic white patients during the assault, (3) There are statistically significant differences in time from assault to report between Alaska Native and non-Hispanic white women who have been sexually assaulted, (4) Alaska Native victims of sexual assault are less likely to be admitted to the hospital compared to non-Hispanic white victims, (5) Alaska Native victims of sexual assaults are more likely to sustain injuries compared to non-Hispanic white victims, and (6) Victim-suspect relationships are different between Alaska Native and non-Hispanic white women.

Methodology

Data Source and Sample

The focus of our research is on female victims. Male victims were excluded due to a very small sample size represented in the surveys. We conducted a secondary data analysis using the Alaska Sexual Assault Nurse Examiner (SANE) Survey. The data for this study were collected from medical/forensic evaluations of sexual assault victims to provide supplemental information on sexual assault victimizations. The study examined the characteristics of sexual assault victimization in Alaska, as observed and recorded by sexual assault nurse examiners. The data included all SANE examinations conducted in Anchorage, Homer, Kodiak, Kotzebue, Nome, and Soldotna from 1996 to 2006. Data from a total of 1,383 examinations were collected and used in this research study. The majority (98%) of the victims are female. Over half (55%) of patients are Native; 35% are non-Hispanic white, and 8.7% are comprised of other race/ethnicities. Twenty percent of the patients are under the age of 18, 30% are 18 to 24 years of age, 23% are 25 to 34 years of age, 17% are 35 to 44 years of age, 10% are 45 years of age or older.

Variables and Statistical Analysis

This research was conducted after approval was received by the University of Arkansas Institutional Review Board. All variables pertaining to the aforementioned hypotheses as well as the demographic characteristics of the women are included in the SANE dataset.

The study contains 453 variables, although all variables were not reviewed. We explored the demographic characteristics of victims, assault characteristics, post-assault characteristics, exam characteristics and findings, and suspect characteristics. Male respondents and respondents other than non-Hispanic whites and Alaska Natives were excluded from our analysis. Assault characteristics included information on the victim's condition at the time of the assault (as a result of the victim's use of drugs

or alcohol). Post-assault characteristics included information on post-assault actions taken by the victim and the time elapsed from the assault to the exam. Exam characteristics included information on the victim's behavioral and emotional state during the exam, whether the woman needed emergency medical care and whether injuries were documented by medical staff. Injury characteristics included descriptions of both non-genital and anogenital injury. Injuries included bruising, redness, lacerations, swelling, fractures, and pain to various sites on the body.

The dataset is restricted. A description of the victims' socio-demographic characteristics was completed by conducting univariate analysis (frequencies for categorical variables and descriptive statistics for continuous variables). To test the hypotheses a bivariate analysis was performed (chi-square test of independence) and a level of significance of alpha=0.05 was set to determine statistical significance.

Data

Behaviors during examination. The SANE nurses analyzed the woman's behavior during the examination. Seventy-five percent of non-Hispanic white women were described as having controlled, composed behavior during the exam compared to roughly 50% of Alaska Native women. Approximately half of non-Hispanic white women were considered quiet as compared to 6 in 10 Alaska Native women who appeared quiet during their examination. Twice as many Alaska Native women compared to non-Hispanic white women were described as staring, with a fixed look, during the examination. Almost 15% of Alaska Native women were described as sleeping while less than 10% of non-Hispanic white women were described that way. Non-Hispanic white women were described as being more cooperative during the post-assault examination. Nine out of ten of non-Hispanic white women were considered cooperative as documented by the SANE nurses. Half of the Alaska Native women appeared tearful during the exam and 1 in 10 was described as sobbing. Close to four out of ten (38.94%) non-Hispanic white women were labeled as being tearful and less than 10% reported sobbing. Twice as many Alaska Native women were described as angry compared to the proportion of non-Hispanic white women.

Table 1

Differences in Behaviors During Post-Assault Examination Among Female Victims of Sexual Assault in Alaska

	Non-Hispanic White	Alaksa Native	Total	
	N=511 Count (%)	N=821 Count (%)	N=1332 Count (%)	
Controlled				
Yes	366 (72)	479 (58)	845 (63)	$x^2(1)=23.951$
No	145 (28)	342 (42)	487 (37)	$p=0.000$
Quiet				
Yes	238 (47)	490 (60)	728 (55)	$x^2(1)=21.835$
No	273 (53)	331 (40)	604 (45)	$p=0.000$
Staring				
Yes	33 (6)	78 (10)	111 (8)	$x^2(1)=3.8172$
No	478 (94)	743 (91)	1221 (92)	$p=0.051$
Cooperative				
Yes	415 (81)	591 (72)	1006 (76)	$x^2(1)=14.5098$
No	96 (19)	230 (28)	326 (24)	$p=0.000$
Tearful				
Yes	199 (39)	406 (50)	605 (45)	$x^2(1)=14.0304$
No	312 (61)	415 (51)	727 (55)	$p=0.000$
Sobbing				
Yes	27 (5)	74 (9)	101 (8)	$x^2(1)=6.2521$
No	484 (95)	747 (91)	1231 (92)	$p=0.012$

Note. Pearson chi-square and asymptotic significance (2-sided). For this test we use alpha of 0.05.

Victim's condition during assault. The SANE nurse documented the woman's state or condition during the assault. Half of non-Hispanic white women victims claimed to have drunk alcohol compared to 83% of Alaska Native women. In addition, 50% of the non-Hispanic white women victims were alcohol intoxicated at assault compared with over 80% Alaska Native women at assault. Moreover, 16% of non-Hispanic white women noted using drugs compared to 10% of Alaska Native victims. Approximately 14% of non-Hispanic white women were drug intoxicated at the time of assault as compared to 7% of Alaska Native women. One-third of the non-Hispanic white women victims were sober at assault compared to approximately 10% of Alaska Native women victims. Finally, one-fifth of non-Hispanic white women victims were unconscious during the assault as a result of alcohol or drug ingestion compared to one-third of Alaska Native women.

Time from assault to report. Among women who had been sexually assaulted, Alaska Natives were twice as likely to report assault within two hours

Table 2

Condition During Assault among Female Victims of Sexual Assault in Alaska

	Non-Hispanic White	Alaksa Native	Total	
	Count (%)	Count (%)	Count (%)	
Patient's Use of Alcohol	N=532	N=870	N=1402	
Yes	295 (55)	720 (83)	1015 (73)	x^2 (1)=123.305
No	196 (37)	122 (14)	318 (23)	p=0.000
Patient's Use of Drugs	N=522	N=828	N=1350	
Yes	81 (16)	83 (60)	164 (12)	x^2 (1)=15.9551
No	392 (75)	695 (84)	1087 (81)	p=0.000
Alcohol Intoxicated at Assault	N=520	N=875	N=1395	
Yes	281 (54)	686 (78)	967 (69)	x^2 (1)=91.0175
No	239 (46)	189 (22)	428 (31)	p=0.000
Drug Intoxicated at Assault	N=520	N=875	N-1395	
Yes	71 (14)	62 (7)	133 (10)	x^2 (1)=16.3139
No	449 (86)	813 (93)	1262 (90)	p=0.000
Sober at Assault	N=520	N=875	N=1395	
Yes	178 (34)	110 (13)	286 (21)	x^2 (1)=90.5766
No	344 (66)	765 (87)	1109 (80)	p=0.000

Note. Pearson chi-square and asymptotic significance (2-sided). For this test we use alpha of 0.05.

Table 3

Time from Assault to Report Among Female Victims of Sexual Assault in Alaska

	Non-Hispanic White	Alaksa Native	Total	
	Count (%)	Count (%)	Count (%)	
Less than 2 hours	N=580	N=922	N=1502	
Yes	38 (7)	142 (15)	180 (12)	x^2 (1)=26.4344
No	542 (93)	780 (85)	1322 (88)	p=0.000
1-3 days	N=580	N=922	N=1502	
Yes	122 (21)	125 (14)	247 (16)	x^2 (1)=14.4858
No	458 (79)	797 (86)	1255 (84)	p=0.000

Note. Pearson chi-square and asymptotic significance (2-sided). For this test we use alpha of 0.05.

Table 4

Injuries Sustained from Assault Among Female Victims of Sexual Assault in Alaska

	Non-Hispanic White	Alaksa Native	Total	
	Count (%)	Count (%)	Count (%)	
Non-genital trauma	N=512	N=825	N=1337	
Yes	226 (44)	484 (59)	710 (53)	x^2 (1)=26.7685
No	286 (56)	341 (41)	627 (47)	p=0.000
Anogenital trauma	N=504	N=811	N=1315	
Yes	193 (38)	353 (44)	546 (42)	x^2 (1)=3.5054
No	311 (62)	458 (56)	769 (58)	p=0.061

Note. Pearson chi-square and asymptotic significance (2-sided). For this test we use alpha of 0.05.

compared to non-Hispanic white women victims. In contrast, 20% of non-Hispanic white women are likely to report within 1-3 days as opposed to approximately 10% of Alaska Native women.

Admitted to hospital. In most instances, SANE examinations were conducted off-site, for example, at a multidisciplinary center. If it was determined that the victim needed additional medical assistance, they were transferred to the hospital or emergency room. There was no statistically significant difference found between the number of non-Hispanic white women who were admitted to the hospital following sexual assault compared to the number of Alaska Native women. Overall the number of women who were admitted to either the hospital or emergency room following an assault is too small of an amount to report in order to protect confidentiality.

Injuries sustained from assault. Alaska Native women are more likely to sustain both non-genital and anogenital trauma than non-Hispanic white women. Of the non-Hispanic white women victims, 44% sustained non-genital trauma and 38% had anogenital trauma. Six in 10 Alaska Native women suffered non-genital trauma and almost half of them experienced anogenital trauma.

Victim-suspect relationship. The most statistically significant piece of data from this section can be found in the victim-suspect relationship in

Table 5

Victim-Suspect Relationships Among Female Victims of Sexual Assault in Alaska

	Non-Hispanic White	Alaksa Native	Total	
	N=537 Count (%)	N=870 Count (%)	N=1407 Count (%)	
Friend/ Acquaintance (24+hrs)				
Yes	217 (40)	314 (36)	531 (38)	$x^2(1)=2.6345$
No	321 (60)	556 (64)	876 (62)	$p=0.105$
Acquaintance (<12hrs)				
Yes	94 (18)	185 (21)	279 (20)	$x^2(1)=2.9525$
No	443 (83)	685 (79)	1128 (80)	$p=0.086$
Relative				
Yes	<10%**	83 (10)	97 (7)	$x^2(1)=24.8660$
No	523 (97)	787 (90)	1310 (93)	$p=0.000$
Stranger				
Yes	88 (16)	132 (15)	220 (16)	$x^2(1)=0.3715$
No	449 (84)	738 (85)	1187 (84)	$p=0.542$

Note. Pearson chi-square and asymptotic significance (2-sided). For this test we use alpha of 0.05.
**Exact proportions cannot be reported due to confidentiality

which the attacker was a relative. One in 10 Alaska Native victims of sexual violence are assaulted by one of their relatives. This is significant compared to the small number of non-Hispanic white women who are assaulted by a relative. The other variables in this dataset provide valuable evidence in helping to determine the most prevalent victim-suspect relationships. For example, 40% of non-Hispanic white women and 36% of Alaska Native women suffered an attack in which the suspect was a friend/acquaintance known by the victim for over 24 hours. Less than two out of ten (17.5%) of non-Hispanic white women and 21% of Alaska Native women suffered an attack in which the suspect was an acquaintance the victim had known for less than 12 hours. Finally, 16% of non-Hispanic white women and 15% of Alaska Native women suffered from an attack in which the suspect was a stranger.

Discussion

Analyzing the documented behaviors of Native Alaskan and non-Hispanic white women during the post-assault examination revealed interesting results. For example, the majority of Native Alaskan women were considered less cooperative, less controlled, and more tearful in comparison to non-Hispanic white women. Alaska Natives have unique demographic, historic and healthcare delivery characteristics that play a role in their perspectives and demeanor (Parker et al., 2002). Being documented as quieter or less cooperative could be attributed to a lack of trust with the healthcare system and/or healthcare providers. Many native researchers and healthcare providers recognize that there is a lack of cultural competency and issues of trust and power present as challenges (Goodkind et al., 2010).

Telling results in the data regarding victim's condition during assault help shed light on a major issue in Native Alaskan culture not previously mentioned heavily in detail, but carrying its own negative consequences. Alcohol abuse, alcohol dependence and binge drinking are common among the Alaska Native population and are associated with high levels of violence (Seale, Shellenberger, & Spence, 2006). Experts often link the high rates of sexual assault with the high rates of alcohol and drug abuse. One local advocate says "It's putting a Band-Aid on the hurt… That's why there's so much rape. They don't feel good, they black out, and alcohol and drugs cover the pain" (Bernard, 2014, p.11). Alcohol and drugs can be unhealthy coping mechanisms for individuals who have suffered a traumatic experience. In the sample, eight out of ten Alaska Native women victims reported using alcohol and being alcohol intoxicated during the assault. The overuse of alcohol is a major health issue and a substantial risk factor for increased sexual violence. Alcohol and drug abuse have both short and long-term negatives effects, such as: impaired judgment, decreased perception, impaired decision making, as well as livery and kidney disease (National Health and Medical Research Council, 2009).

When examining the time from assault to report, more Alaska Native women immediately reported the incidence than non-Hispanic white women. Historically, silence has been the norm and violence is almost expected, but in recent years a few Alaskans have begun to speak publicly about the issue of sexual violence. In fact, a prevention initiative called *Alaska Men Choose Respect* was launched in 2009 and it uses a combination of pervasive public service announcements, annual rallies, and other incentives, such as increased sentencing for sex offenders, to discourage victims from suffering in silence (Bernard, 2014). Although the Alaska Native women were more

likely to report within the first two hours, the number of Alaska Native and non-Hispanic white women to immediately report the incident were small. These results suggest the need for additional public education and support programs to encourage victims to seek assistance in the event of an assault. The earlier victims are able to report, the more accurate the evidence is and steps taken to promote healing and reduce trauma can begin.

As mentioned briefly in the results section, women seeking treatment from SANEs arrive at various designated locations, including a multidisciplinary center. If it is decided that the victim needs further medical assistance that cannot be provided in the current setting, they are transferred and admitted to either the hospital or emergency department. Although there were not significant differences for admittance between non-Hispanic white and Alaska Native women, it is interesting to note that the numbers for hospital and emergency department admittance are overall very low. This fact could support the effectiveness of SANE programs in providing necessary, post-assault care, although further research is needed. Before the start of the SANE/SART protocol, victims who needed medical care were referred to the emergency department where they would wait for several hours before being treated. Sexual assault nurse examiners are able to treat the majority of victims in a timely manner. The installation of SANE/SART programs have led to significantly better responses to sexual violence, by providing a triage for sexual assaults so that the emergency department now only deals with the most physically severe cases (Rosay & Henry, 2007).

The results of our study indicate that in comparison to non-Hispanic white women victims, Alaska Native women victims are more likely to experience physical trauma from the assault and are significantly more likely to have been attacked by a relative. Alaska Natives suffer domestic violence and physical assault at rates far exceeding women of other ethnic groups (Bachman et al., 2008). For example, 60% of AI/AN women reported being physically assaulted in their lifetime as opposed to 50% of women overall. In addition, the prevalence of intimate partner violence (IPV) for AI/ANs ranges from 50-90% as compared to the prevalence of IPV in non-Native women, which ranges from 5-50% (Oetzel & Duran, 2004).

There are unique challenges that face Alaska Native women. The research questions and variables analyzed in this study show that Alaska Native women victims of sexual violence are diverse from the non-Hispanic white women victims and indicate a need to provide care that is unique and culturally sensitive.

Conclusion and Policy Implications

"*Sexual abuse ends when we begin to talk*" (Sutter, 2014, p.2).

The ongoing problem of sexual violence in Alaska is high on the list of major national social justice issues. As stated previously, the rate of sexual violence in Alaska is great. Almost one in four women in Alaska are raped or sexually assaulted and almost one in six are victims of intimate partner and/or sexual violence (Sutter, 2014). The process to begin addressing this problem started by investigating previous research involving the issue. This research was conducted due to an evident lack of information available, specifically regarding the cultural aspect of sexual violence in Alaska and the health care disparities between Alaska Native and non-Hispanic white women victims. Preliminary research indicated, "accurate, comprehensive, and current information…is critically needed to improve understanding…and to educate and inform policy-makers and the public" (Crossland et al., 2013, p.786).

Comparing multiple variables related to sexual assault of Native Alaskan women and non-Hispanic white women victims showed obvious notable differences that warrant recognition. The behaviors of the women during the examination were significantly different. The Native Alaskan women were described as less controlled, less cooperative, and less likely to be sober at the time of the assault. In addition, the Native Alaskan women suffered more physically traumatic assaults that led to more emergency department admittances. In many aspects Native Alaskan women are different from non-Hispanic white women in terms of their behaviors, reactions to trauma, preferred treatments and interventions, relationships with their attacker, family dynamics and cultural practices. Overall, we conclude from these results that the differences between the two groups show a need for more culturally tailored examination components, interventions and treatments post-assault for Alaska Native women victims of sexual violence.

Cultural competence is inarguably a vital part of treating and caring for any patient population. There has been progress made at the federal level to address

cultural competence nationwide. In 2000 the United States Department of Health and Human Services Office of Minority Health released national standards for culturally and linguistically appropriate services (CLAS) in an effort to eliminate healthcare disparities (Lehman et al., 2012). More recently, and specifically related to the current sexual violence epidemic, in 2010 The Office for Victims of Crime developed the American Indian and Alaska Native Sexual Assault Nurse Examiner-Sexual Assault Response Team Initiative providing a potential solution that focused on coordinated community, victim-centered care (Office for Victims of Crime, 2012).

However, the most recent update regarding this issue at the government-level was a report to the U.S. Attorney General from the National Coordination Committee on the AI/AN SANE-SART Initiative in 2014. The report states that although there have been improvements, there is still much more to be done in terms of coordination and collaboration at the local level, Department of Justice personnel policy changes and funding, and public health and safety (National Coordination Committee, 2014).

Fortunately, there has been progress made in terms of policy, initiatives and governmental actions, but a problem that has amassed over several decades demands solutions from multiple angles to prove effective. Analyzing the current situation and progress, this research supports the need for recommendations to help reduce health disparities within the sexually assaulted Alaska Native women population. Recommendations include (1) requiring the incorporation of cultural competency training in the preparation curriculum for sexual assault nurse examiners (SANEs) working with the Alaska Native population, and (2) collaborating with the National Alaska Native American Indian Nurses Association in SANE training.

Experiencing rape or sexual assault is a traumatic experience; thus it is vital that sexual assault nurse examiners develop rapport with the victims they treat. Learning new skills and techniques related to culturally competent practice and having an accurate understanding of the Alaska Native culture is necessary in order for SANEs to connect with victims and provide equal, high-quality care. Cultural competency training curriculum to prepare SANEs for working with the Alaska Native population would include: education on Alaska Native family dynamics, the role and behaviors of women, traditional cultural healing practices and preferred methods of accessing healthcare. Campinha-Bacote's model titled "The Process of Cultural Competence in the Delivery of Healthcare Services" could be instituted to help guide SANEs as they work to develop their individual cultural knowledge, identify barriers, and assess and respond to the differences present in Native Alaskan culture (Campinha-Bacote, 2002, p. 184).

The National Alaska Native American Indian Nurses Association is a valuable agency and there are many potential benefits available through collaboration. The AI/AN nurses are more likely to work in native communities than healthcare providers of other ethnic groups and have the capacity to improve health and wellness in these populations (Parker et al., 2002). However, a challenge facing the NANAINA is that the highest level of education for the majority of AI/AN nurses is an associate's degree. Without a bachelor's degree, nurses are unable to organize, plan, initiate, implement and evaluate community-level programs and they are also unable to become sexual assault nurse examiners (Parker et al., 2002). NANAINA, the local, state and federal governments, and current SANEs could collaborate and form an interdisciplinary network ready to tackle the sexual violence issue against Native Alaskan women in culturally sensitive ways. The government could assist in finding means for NANAINA nurses to achieve baccalaureate degrees and to assist them in training to become SANEs: providing access to online BSN programs, assistance with funding, and availability of SANE trainers. In exchange, the NANAINA could be a valuable mediator between native communities and healthcare providers. The NANAINA nurses could provide experiential knowledge about Alaskan culture and educate SANEs of other ethnicities on how to best respect the tradition and values of the patients they will be treating.

There was an extensive investigation of the available literature prior to beginning this research. Previous research findings were unanimous in concluding that sexual violence in Alaska was a major issue. They were also in agreement on the fact that there is a drastic need for more information regarding the cultural disparities affecting Alaska Native women. This research has begun to fill that gap.

Comparing the variables in the data collection produced some expected results and others were more surprising, but overall the results pointed to one major

theme: Alaska Native women are different than non-Hispanic white women. These women need to be treated by healthcare providers who understand them: their reactions, situation, and their culture. Not only have the Alaska Native women who come in to be treated by SANEs been victims of a traumatic sexual assault, they are also victims of healthcare disparities. This research has highlighted that there is a pressing need to include cultural competence in SANE education curriculum. Alaska Native women deserve quality, culturally sensitive, and holistic care centered around maintaining their dignity and respecting their wishes.

The implications for this research do not stop here. By answering the call to present evidence indicating disparities in care, now is the time to act. As stated in the beginning of this section, "sexual abuse ends when we begin to talk" (Sutter, 2014, p.1). The government, NANAINA, and the sexual assault nurse examiners need to collaborate in order to start developing solutions to the issue of health disparities in the care of Alaska Native women victims of sexual violence.

Study Limitations

A limitation of this study is that the demographic of the sexual assault nurse examiners was undocumented. Therefore, there is no way to know whether the documenting SANE had an adequate understanding of Alaska Native culture: behavioral norms, and typical cultural responses to trauma. Culture affects behavior. If the sexual assault nurse examiner is unfamiliar with an individual's cultural behavior, there is the risk of misinterpretation when judging a patient's reaction.

Other difficulties pertain to conducting secondary data analysis of variables available in the survey. Other important factors, including education level, marital status, income level, and insurance coverage that could have explained the disparities observed in the victims' behaviors, post-assault attitudes, and care received could not be investigated. In addition, the data reflect sexual assault victims who presented for post-assault care and were treated by a SANE, and thus the findings of this study are not generalizable to survivors who sought care at a health care facility without SANEs. Furthermore, since the data were not weighted, our results cannot be extrapolated to the population of sexual assault victims living in cities other than those considered in the survey.

This research analysis was based on a 10-year-period; however, the years were aggregated to protect the confidentiality of the victims. Similarly, although the study was conducted in Anchorage, Kotzebue, Nome, Kodiak, Kotzebue, and Soldotna, information on the actual location of respondents was not provided to protect their confidentiality. We were therefore not able to establish causality, or ascertain the prevalence of sexual assaults based on the city of residence. Despite these limitations, the findings can be used to update the protocol for Sexual Assault Medical Forensic Examinations and to properly educate sexual assault nurse examiners so they are readily equipped to provide more equitable, culturally competent care with the hope that a better concordance in patient-provider relationship would encourage victimized women to refrain from suffering in silence.

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