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Investigating Disparities in Behavior and Care Between Alaska Native and White Victims of Sexual Violence: The Importance of Culturally Competent Nursing Care

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TABLE OF CONTENTS

ABSTRACT

Sexual violence is a major issue in the state of Alaska where women are twice as likely to experience sexual assault compared to other women in the United States. The purpose of this research was to determine the existence of health care disparities experienced by Alaska Native women victims of sexual violence and 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 Sexual Assault Nurse Examiner surveys performed by SANEs between 1996-2006. The SANE examinations were conducted in Anchorage, Homer, Kodiak, Kotzebue, Nome and Soldotna. The populations in this research included both the Alaska Native women victims of sexual violence and the white women victims of sexual violence. It was hypothesized that significant differences would be present between the Alaska Native and white women victims in regards to behavior during the post-assault examination, condition at time of assault, the time from assault to report, hospital admittance, injuries sustained from assault, victim-suspect relationships, and the decision to engage in consensual intercourse following assault. A bivariate analysis was performed to test the hypotheses and a level of significance of alpha=0.05 was set to determine statistical significance. Results showed that Alaska Native women were described as less controlled, less cooperative and less likely to be sober and often suffered more physically traumatic assaults than the white women victims. Analysis of the results indicated that the Alaska Native women differ significantly from white women victims in several aspects: different behaviors, reactions to trauma, cultural practices, etc. Cultural competence when caring for Alaska Native victims of sexual violence needs to be a top priority in order to provide these women with high quality, patient-centered care. 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 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). This poignant statement from Alaska Governor, Sean Parnell, is emblematic of the public health plague that has been afflicting the state for decades, and is growing exponentially. While one in five women has been sexually assaulted in her lifetime in the United States (Black et al., 2011), over a third of adult women (37%) in Alaska have been victims of sexual assault (Rosay, 2011). The average rate of forcible rape reported to law enforcement from 1996-2006 was 77.8 per 100,000 in Alaska as compared to 33.1 per 100,000 in the U.S. (Rosay, 2006). According to the 2012 FBI crime estimates, reported rape is more common in Alaska than any other state, the per capita rate is about three times the national average (US Department of Justice, 2012). In spite of these gruesome statistics, rape is still underreported in Alaska (US Department of Justice, 2012). 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). The heightened and additive exposure to this trauma 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 implications. Sexual violence can lead to unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV. Moreover, 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 white women

in the United States (Bachman, Zaykowski, Kallmyer, Pateyeva & Lanier, 2008). According to the U.S. Department of Health and Human Services, reducing sexual violence is a "necessity" and is listed as a Healthy People 2020 goal (objective IVP-40) (Healthy People 2020).

In the face of complex challenges brought about by sexual violence onto our society, 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 the report include: increasing the 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). Efforts are ongoing to train more nurses to become Forensic Nurse Examiners in Alaska (Angaiak, 2014). 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 (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* has 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 all remained lamentably silent on the primacy of *cultural competence* as a fundamental skill that SANE should obtain in order to better assist and care for the victims of sexual violence.

HEALTH DISPARITIES EXPERIENCED BY THE ALASKA NATIVE POPULATION

Alaska Native women are three times more likely to be victims of sexual assault or rape compared to 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). According to the National Alaska Native American Indian Nurses Association, health disparities and the burden of illness and death are a major concern for Alaska Native populations (Parker et al., 2002). There are shocking statistics that characterize the Alaska Native population. 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 of 11% is 30% higher than that for all races in the United States. Infant mortality rates serve as an important measure and indicator of the health status of a community or population (Maurer & Smith, 2013). These statistics, along with several others that showcase a population possessing lower education levels and higher levels of unemployment, shed light on the devastating differences in terms of quality of life experienced by our fellow American citizens in the expansive region of Alaska (Parker et al, 2002). In the face of inaccessible and inadequate health care, Alaska Natives' health situation, as with other ethnic minority populations, is one of continuing disparity. Per capita funding for Native American health care is 60% less than the amount spent on

the average American (Goodkind et al., 2010). The rural and isolated nature of many Alaska Native women place unique barriers to providing efficient health care in the absence of infrastructure, which can lead to increased risk of repeated violence for victims (Oetzel & Duran, 2004). Cultural barriers also present a challenge and require priority research funding to begin alleviating the disparities (Parker et al., 2002). 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" (Oetazel & Duran, p.56, 2004). The National Institute of Justice confessed 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 observed in 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 diverse races, ethnicities, and cultures. Alongside this richness, cultural and language barriers have emerged. In health care settings, culture and language differences may result in misunderstanding, lack of regimen compliance, lack of medication adherence or other factors that can negatively affect the health outcomes of patients. In another publication, the Institute of Medicine has stated the following: (1) Minorities receive lower quality of health care even when socioeconomic and access-related factors were controlled; (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 health care services and play a pivotal role in providing care. The melting pot of cultures that shape our nation has made it imperative for nurses to become more aware of the importance of cultural competence in health care delivery. 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, but even more so for Alaska Native women who live in an environment in which rape is more prevalent than in any other state and for which rape is *symbolically* different than in other cultures. Patients benefit when nurses learn more and become confident in their ability to care for diverse cultural groups. Specifically, patients may be more satisfied with their health care interactions and may 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, especially because their biases may be unconscious. It is of paramount importance for nurses to consider the patient's individual beliefs and behaviors as their oversight could lead to disparities in caring for patients (Office of Minority Health, 2013). The victims' experiences of the post-assault services they receive are key in their recovery, healing and coping (Dudley et al., 2002). Yet, in providing care to Alaska Native patients, there is a blatant lack of concordance between patients and providers. Concordance is the process of matching patient-provider racial, ethnic, and/or language characteristics. The underlying assumption is that sharing 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 interests as it relates to the lack of diversity in the health care workforce (Office of Minority Health, 2013). Nurses who are culturally competent are better equipped to incorporate Alaska Native women traditions and cultural beliefs successfully 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 et al.). 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).

In addition to the Department of Health and Human Services, another federal agency, The Joint Commission, works to improve safety and quality of care by accrediting health care organizations to improve performance. In their policies, The Joint Commission 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.).

Nurses working with diverse population groups need to be knowledgeable of cultural differences and continually grow in awareness and skills related to cultural discrepancies. Nurses who practice cultural competency provide care that is effective and respectful. 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, PhD, created a model for delivering culturally competent care that serves as a framework for implementing culturally responsive care in healthcare organizations (Campina-Bacote, 2002). The model suggests that cultural competence is an ongoing process. 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 (Campinha-Bacote, 2002). 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 motivation of the nurse to "want to", rather than "have to", engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters" (Campinha-Bacote, 2002). Once a healthcare provider harnesses the desire, they commit to caring for the patient, accepting differences and building on similarities, being willing to learn about another culture, etc. 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 (Campinha-Bacote, 2002). *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 (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). 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 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). If a model such as Campinha-Bacote's were to be included in the training programs for sexual assault nurse examiners serving diverse patient populations there would be multiple benefits. SANEs who have received training in cultural competence are able to demonstrate the importance of culture as a central factor in health care, able to identify barriers to cultural understanding among providers and patients, assess and respond to differences in values, beliefs, and health behaviors, etc. (Lehman et al.). 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 SANE-SART Initiative (Sexual Assault Nurse Examine-Sexual Assault Response Team). 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 (Little, 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 an investigation, and documenting collected evidence (Alaska Department of Public Safety, 1999).

The sexual assault nurse examiner has several jobs once a victim arrives post-assault, but their main task is to maintain the victim's dignity and reduce psychological trauma (Henry & Force, 2011). The SANE nurse starts with a preliminary 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 (Henry & Force, 2011). SANE nurses collaborate with law enforcement officials and may be asked to testify in court. In addition, SANE nurses educate the victim about sexually transmitted disease and pregnancy risks, and make referrals for follow-up care if necessary (Henry & Force, 2011).

Research has shown that the use of a SANE program improves effectiveness in several domains: psychological, medical, forensic, legal and community. The nurses' listening to the victims helps during the crisis as the victims feel safe, reassured, care for and respected (Campbell, 2005). 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 more likely to pursue prosecution, and attackers have increased conviction rates. In regards to community change, SANE programs serve as a

spark for improving relations and communication between health and legal professionals. (Campbell, 2005).

SANE programs can be located in hospitals, community clinics, police departments, etc. (Little, 2001). According to the International Association of Forensic Nurses, Alaska, the state where rape is the most prevalent, has 8 SANE programs. Alaska is the largest state spanning over 600,000 square miles. Texas comes in second at a little over 250,000 square miles; they have 41 SANE programs. Therefore Texas, just for comparison, has 1 SANE program for every 6,500 square miles. However, Alaska has 1 SANE program for every 80,000 square miles. Although Alaska is not densely populated, there are over 200 native tribes inhabiting the vast landscape.

Finding enough qualified nurses to work with sexual assault victims is a difficult task in general and the turnover of a sexual assault nurse examiner in Alaska is typically two to three years (Angaiak, 2014). However, currently serving this diverse population is a group called the National Alaska Native American Indian Nurses Association (NANAINA). The NANAINA represent nurses who are spread across the country positioned strategically in order to improve health outcomes for those hard to reach populations (Parker, 2002). 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. The NANAINA has the potential to significantly increase the number of healthcare providers serving the sexually assaulted victims, but 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 we examined in this research study was collected from 1996-2006. There was a substantial amount of data collected regarding sexual violence and it provided valuable insight regarding the magnitude of the issue. Since the data was collected, 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, which this research study is based upon. Prior to these investigations, comprehensive statewide data was not available to guide planning and policy development in Alaska (Alaska Victimization Surveys). With the information being obtained 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 (Office for Victims of Crime, 2012). 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 (Office for Victims of Crime, 2012). 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).

A few years after the suggestions were made, the National Coordination Committee on the AI/AN SANE-SART Initiative submitted a report to the U.S. Attorney General in June 2014 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 improvements in policy and legislation that had been made, they developed a set of concrete recommendations to improve efficiency and effectiveness of the federal system's response to ensure that progress made by the Department of Justice would be lasting (National Coordination Committee, 2014). The recommendations covered several critical areas, but 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 (National Coordination Committee, 2014). It was reported that many Native victims would prefer to take part in a cleansing or healing ritual following a sexual assault. Although this could potentially disrupt the collection of evidence, participation in cultural practices is the right of the victim and should be respected. Several times throughout the report the importance of properly educating and training workers on respecting culture and being

culturally competent 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 care in Alaska Native women who were sexually assaulted as compared to white victims. More specifically, our research questions are: (1) How do Alaska Native and white patients' behaviors differ during medical examination?; (2) How do Alaska Native and white patients' conditions during the assault differ?; (3) Are there differences in time from assault to report between Alaska Native and 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 white victims?; (5) How likely are Alaska Native victims to experience injuries from the sexual assault as compared to white victims?; (6) Is the victim-suspect relationship different between Alaska Native and white women?; (7) How do Alaska Native and white women differ in their decision to engage in consensual intercourse following an assault?

HYPOTHESES

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

compared to white victims; (6) Victim-suspect relationships are different between Alaska Native and white women; (7) Alaska Native and white women differ in their decision to engage in consensual intercourse following an assault.

METHODOLOGY

Data Source and Sample

The focus of our research is on female victims; male victims were excluded. We conducted a secondary data analysis using the Alaska Sexual Assault Nurse Examiner (SANE) Survey. The data for this study was collected from medical/forensic evaluations of sexual assault victims to provide supplemental information on sexual assault victimizations and to gain better understanding of the effects of the patient condition at the time of the assault and of the time elapsed from assault to report. 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. A total of 1,699 examinations were collected and used in this research study. The vast majority (98%) of patients are female. Over half (55%) of patients are Native; 35% are white, and 8.7% are of other races. 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 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 we did not look at all variables, 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 white and Alaska Natives were excluded from our analysis. Assault characteristics included information on the victim's condition at the time of the assault and the victim's use of drugs or alcohol. Post-assault characteristics included information on post-assault actions taken by the victim, whether the woman engaged in consensual sexual activity after the assault 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. Injury characteristics included descriptions of both non-genital and anogenital injury. Injuries included bruising, redness, lacerations, swelling, fractures, pain, etc. 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). A level of significance of alpha=0.05 was set to determine statistical significance.

DATA

1) Behaviors During Examination

The SANE nurses analyzed the woman's behavior during the examination. Three out of four white women were described as being controlled during the exam compared to roughly 50% of Alaska Native women. Approximately half of white women were considered quiet

as compared to the 6 in 10 Alaska Native women who appeared quiet during their examination. Twice as many Alaska Native women compared to white women were described as staring during the examination. Almost 15% of Alaska Native women were described as sleeping while less than 10% of white women were described that way. White women were described as being more cooperative during the post-assault examination. More than eight out of ten of white women were considered cooperative as documented by the SANE nurses. Half of the Alaska Native women appeared tearful during the exam and every 1 in 10 was described as sobbing. Close to four out of ten (38.94%) of white women were labeled as being tearful and less than 10% reported sobbing. Twice as many Alaska native women came across as angry as compared to the proportion of white women.

Table 1-1: Behavior During Post-Assault Examination			
	White	Alaska Native	Statistically Significant
Controlled	71.62%	58.34%	Yes, P=0.000
Quiet	46.58%	59.68%	Yes, P=0.000
Staring	6.46%	9.50%	Yes, P=0.05
Sleeping	<10%*	14.13%	Yes, P=0.000
Cooperative	81.21%	71.99%	Yes, P=0.000
Tearful	38.94%	49.45%	Yes, P=0.000
Sobbing	5.28%	9.01%	Yes, P=0.012
Angry	<10%*	6.21%	Yes, P=0.007

* Exact proportions cannot be reported due to confidentiality

2) Victim's Condition During Assault

The SANE nurse also documented the woman's state or condition during the assault. Half of white women victims claimed to drink alcohol compared to a staggering 83% of Alaska Native women. In addition, half of the white women victims were alcohol intoxicated at assault compared to over 8 in 10 Alaska Native women who were alcohol intoxicated at assault. Moreover, 16% of white women noted using drugs compared to 10% of Alaska

Native victims. Approximately fourteen percent of white women were drug intoxicated at assault compared to 7% of Alaska Native women. One-third of the white women victims were sober at assault compared to only approximately 1 in 10 Alaska Native women victims that were sober at assault. Finally, one-fifth of white women victims were passed out or blacked out at assault. One-third of Alaska Native women reported being passed out or blacked out during the assault.

Table 1-2: Condition of Victim During Assault			
	White	Alaska Native	Statistically Significant
Patient's Use of Alcohol	55.45%	82.76%	Yes, P=0.000
Patient's Use of Drugs	15.52%	10.02%	Yes, P=0.000
Alcohol Intoxicated at Assault	54.04%	78.40%	Yes, P=0.000
Drug Intoxicated At Assault	13.65%	7.09%	Yes, P=0.000
Sober at Assault	33.85%	12.75%	Yes, P=0.000
Passed Out/Blacked Out at Assault	20.90%	30.66%	Yes, P=0.000

3) Time from Assault to Report

Among those women who had been sexually assaulted, Alaska Natives were twice as likely to report assault within 2 hours compared to white women victims. In contrast, 2 out of 10 white women are likely to report within 1-3 days as opposed to approximately 1 in 10 Alaska Native women.

Table 1-3: Time from Assault to Report			
	White	Alaska Native	Statistically Significant
Less than 2 hours	6.55%	15.40%	Yes, P=0.000
1-3 days	21.03%	13.56%	Yes, P=0.000

4) Admitted to Hospital

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

5) Injuries Sustained from Assault

The numbers showed that Alaska Native women are more likely to sustain both non-genital and anogenital trauma than white women. Of the white women victims, 44% sustained non-genital trauma and 38% had anogenital trauma. Almost 6 in 10 Alaska Native women suffered from non-genital trauma and almost half of them experienced anogenital trauma.

Table 1.5: Injuries Sustained from Assault

	White	Alaska Native	Statistically Significant
Non-genital trauma	44.14%	58.67%	Yes, P=0.000
Anogenital trauma	38.29%	43.53%	No, P=0.061

6) Victim-Suspect Relationship

The most statistically significant piece of data from this section can be found in the victim-suspect relationship in which the attacker was a relative. Every 1 in 10 Alaska Native victims of sexual violence were assaulted by one of their relatives. This is significant compared to the small number of white women who are assaulted by a relative. The other variables in this data set might not have produced statistically significant results in regards

to the comparison of race, but provide valuable evidence in helping to determine the most prevalent victim-suspect relationships. Forty percent of white women and thirty-six percent of Alaska Native women suffered an attack in which the suspect was a friend/acquaintance the victim had known for over 24 hours. Less than two out of ten (17.5%) of 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 white women and 15% of Alaska Native women suffered from an attack in which the suspect was a stranger.

Table 1.6: Victim-Suspect Relationship			
	White	Alaska Native	Statistically Significant
Friend/Acquaintance (24+ hrs)	40.41%	36.09%	No, P=0.105
Acquaintance (<12hrs)	17.50%	21.26%	No, P=0.086
Relative	<10%*	9.54%	Yes, P=0.000
Stranger	16.39%	15.17%	No, P=0.542

7) Patient had Consensual Sex Post-Assault

Over a quarter of white woman and close to three out of ten of Alaska Native women chose to engage in consensual vaginal sex within 96 hours of assault. Although there is no statistical significance when race was looked at as a variable, these percentages are still high and telling.

Table 1.7: Consensual Sex Post-Assault			
	White	Alaska Native	Statistically Significant
Patient had consensual vaginal sex within 96 hours of assault	26.89%	28.78%	No, P=0.452

DISCUSSION

Analyzing the documented behaviors of Native Alaskan and white women during the post-assault examination revealed interesting results. The majority of Native Alaskan women were considered less cooperative, less controlled, and more tearful in comparison to the white women. Alaska Natives have unique demographic, historic and health care delivery characteristics that play a role in their perspectives and demeanor (Parker et al., 2002). Being documented as quieter or less cooperative could also 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 shed light on major issue in Native Alaskan culture not previously mentioned, but carrying its own plaguing consequences. Alcohol abuse, dependence and binge drinking are common among the Alaska Native population and are associated with high levels of violence (Seale, Shellenberger & Spence, 2006). Eight out of ten Alaska Native women victims use alcohol and reported being alcohol intoxicated during the assault. The overuse of alcohol is a major health issue and a substantial risk factor for increased sexual violence.

When looking at the time from assault to report, it was an unexpected finding that more Alaska Native women immediately reported the incidence than white women. There are a few potential explanations to these surprising results. Sexual assault in the Alaska Native population is very prevalent and it might be considered, unfortunately, more of a "normal" occurrence. It could just be a known fact that after the assault, you go report and get checked out by a healthcare professional. There might also be differing stages of grief or

reactions to traumatic events between Alaska Native and white women victims that affect accepting the event occurred and taking the necessary further actions. Although the Alaska Native women were more likely to report within the first two hours, the percentages for both groups are still very low. These results suggest the need for the general public to be educated so they know if an assault occurs the victims should be encouraged to report it as soon as possible. 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, the women seeking treatment from SANEs arrive at various designated locations, for example, 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 white and Alaska Native women, it is interesting to note that the percentages for hospital and emergency department admittance are overall very low. This supports the effectiveness of SANE programs in providing necessary, post-assault care. Before the start of the SANE/SART protocol, victims who needed medical care were referred to the emergency department where they would wait for hours until being treated. Sexual assault nurse examiners are able to treat the majority of victims and the installation of SANE/SART programs have led to significantly better responses to sexual violence, largely eliminating the need for unnecessary ER visits (Rosay & Henry, 2007).

The results show that in comparison to white women victims, Alaska Native women victims are more likely to experience physical trauma from the assault and 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 (Futures Without Violence). For example, 6 out of 10 AI/AN women reported being physically assaulted in their lifetime as opposed to half of women overall (Oetzel & Duran, 2004). 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). This evidence suggests that Native Alaskan women suffer rougher, more violent attacks, and frequently at the hand of a relative or close loved one. There were no statistically significant results in terms of the victims' decision to engage in consensual sex ninety-six hours after the assault. Approximately one quarter of both Alaska Native and white women made the decision. It was originally thought that this variable could indicate differences about how trauma affects intimacy.

There are unique challenges that face Alaska Native women. Several research questions and variables analyzed in this study show Alaska Native women victims of sexual violence as diverse from the white women victims and in need of care that is unique and culturally sensitive.

CONCLUSION AND POLICY IMPLICATIONS

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

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 appalling. Almost 1 in 4 women in Alaska are raped or sexually assaulted and almost 1 in 6 are victims of intimate partner and/or sexual violence (Sutter, 2014). The process to begin tackling this problem started with asking the right questions and investigating previous research involving this issue. This research was conducted because there is 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 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, Palmer & Brooks, p.786, 2013).

Through comparing multiple variables related to sexual assault of Native Alaskan women and white women victims, the results 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 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 white women. They have different 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 released national standards for culturally and linguistically appropriate services (CLAS) in an effort to eliminate healthcare disparities (Lehman et al.) 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 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 and it is vital that sexual assault nurse examiners develop rapport with the victims they treat. Growing in cultural competence 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 health care, etc. 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). 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). The 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 assist them in training to become SANEs: providing access to online BSN programs, assistance with funding, availability of SANE trainers etc. 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 women they will be treating.

There was an extensive investigation of the available literature prior to beginning this research. The literature and previous research was 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 the gap, to answer the need.

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 white women. These women need to be treated by healthcare providers who understand them: understand their reactions, understand their situation, and understand 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. This is just the beginning. 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). So let’s talk: the government, the NANAINA, the sexual assault nurse examiners. Let’s talk 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, typical cultural responses to trauma, etc. 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 minority's reaction up against a different ethnicity's standard.

Other pitfalls pertain to conducting secondary data analysis of variables available in the survey. Other important factors (e.g. education level, marital status, income level, 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 SANE, and thus the findings of this study are not generalizable to survivors who sought care at a health care facility without SANE. Furthermore, since the data was 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 provider-patient relationship would encourage victimized women to refrain from suffering in silence.

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APPENDIX

PATIENT BEHAVIOR DURING EXAM: CONTROLLED	White	Alaska Native	Total
0 (NO)	145 (28.38%)	342 (41.66%)	487 (36.56%)
1 (YES)	366 (71.62%)	479 (58.34%)	845 (63.44%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 23.9513 Pr = 0.000

PATIENT BEHAVIOR DURING EXAM: QUIET	White	Alaska Native	Total
0 (NO)	273 (53.42%)	331 (40.32%)	604 (45.35%)
1 (YES)	238 (46.58%)	490 (59.68%)	728 (54.65%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 21.8359 Pr = 0.000

PATIENT BEHAVIOR DURING EXAM: CALM	White	Alaska Native	Total
0 (NO)	331 (64.77%)	551 (67.11%)	882 (66.22%)
1 (YES)	180 (35.23%)	270 (32.89%)	450 (33.78%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 0.7698 Pr = 0.380

PATIENT BEHAVIOR DURING EXAM: STARING	White	Alaska Native	Total
0 (NO)	478 (93.54%)	743 (90.50%)	1,221 (91.67%)
1 (YES)	33 (6.46%)	78 (9.50%)	111 (8.33%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 3.8172 Pr = 0.051

PATIENT BEHAVIOR DURING EXAM: COOPERATIVE	White	Alaska Native	Total
0 (NO)	96 (18.79%)	230 (28.01%)	326 (24.47%)
1 (YES)	415 (81.21%)	591 (71.99%)	1,006 (75.53%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 14.5098 Pr = 0.000

PATIENT BEHAVIOR DURING EXAM: STOIC	White	Alaska Native	Total
0 (NO)	466 (91.19%)	739 (90.01%)	1.205 (90.47%)
1 (YES)	45 (8.81%)	82 (9.99%)	127 (9.53%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 0.5098 Pr = 0.475

PATIENT BEHAVIOR DURING EXAM: AGITATED	White	Alaska Native	Total
0 (NO)	481 (94.13%)	755 (91.96%)	1,236 (92.79%)
1 (YES)	30 (5.87%)	66 (8.04%)	96 (7.21%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 2.2139 Pr = 0.137

PATIENT BEHAVIOR DURING EXAM: FEARFUL	White	Alaska Native	Total
0 (NO)	480 (93.93%)	764 (93.06%)	1,244 (93.39%)
1 (YES)	31 (6.07%)	57 (6.94%)	88 (6.61%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 0.3919 Pr = 0.531

PATIENT BEHAVIOR DURING EXAM: TEARFUL	White	Alaska Native	Total
0 (NO)	312 (61.06%)	415 (50.55%)	727 (54.58%)
1 (YES)	199 (38.94%)	406 (49.45%)	605 (45.42%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 14.0304 Pr = 0.000

PATIENT BEHAVIOR DURING EXAM: FIDGETING	White	Alaska Native	Total
0 (NO)	419 (82.00%)	704 (85.75%)	1,123 (84.31%)
1 (YES)	92 (18.00%)	117 (14.25%)	209 (15.69%)
Total	511	821	1,332

	(100.00)	(100.00)	(100.00)

Pearson chi2 (1) = 3.3535 Pr = 0.067

PATIENT BEHAVIOR DURING EXAM: TENSE	White	Alaska Native	Total
0 (NO)	419 (82.00%)	690 (84.04%)	1,109 (83.26%)
1 (YES)	92 (18.00%)	131 (15.96%)	223 (16.74%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 0.9475 Pr = 0.330

PATIENT BEHAVIOR DURING EXAM: SOBBING	White	Alaska Native	Total
0 (NO)	484 (94.72%)	747 (90.99%)	1,231 (92.42%)
1 (YES)	27 (5.28%)	74 (9.01%)	101 (7.58%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 6.2521 Pr = 0.012

PATIENT BEHAVIOR DURING EXAM: TREMBLING	White	Alaska Native	Total
0 (NO)	445 (87.08%)	737 (89.77%)	1,182 (88.74%)
1 (YES)	66 (12.92%)	84 (10.23%)	150 (11.26%)
Total	511 (100.00)	821 (100.00)	1,332 (100.00)

Pearson chi2 (1) = 2.2712 Pr = 0.132

PATIENT'S USE OF ALCOHOL	White	Alaska Native	Total
0 (NO)	196 (36.84)	122 (14.02%)	318 (22.68%)
1 (YES)	295 (55.45%)	720 (82.76%)	1,015 (72.40%)
Total	532 (100.00)	870 (100.00)	1,402 (100.00)

Pearson chi2 (2) = 123.3053 Pr = 0.000

PATIENT'S USE OF DRUGS	White	Alaska Native	Total
0 (NO)	392 (75.10%)	695 (83.94%)	1,087 (80.52%)
1 (YES)	81 (15.52%)	83 (10.02%)	164 (12.15%)

Total	522 (100.00)	828 (100.00)	1,350 (100.00)

Pearson chi2 (2) = 15.9551 Pr = 0.000

PATIENT CONDITION AT ASSAULT: ALCOHOL INTOXICATED	White	Alaska Native	Total
0 (NO)	239 (45.96%)	189 (21.60%)	428 (30.68%)
1 (YES)	281 (54.04%)	686 (78.40%)	967 (69.32%)
Total	520 (100.00)	875 (100.00)	1,395 (100.00)

Pearson chi2 (1) = 91.0175 Pr = 0.000

PATIENT CONDITION AT ASSAULT: DRUG INTOXICATED	White	Alaska Native	Total
0 (NO)	449 (86.35%)	813 (92.91%)	1,262 (90.47%)
1 (YES)	71 (13.65%)	62 (7.09%)	133 (9.53%)
Total	520 (100.00)	875 (100.00)	1,395 (100.00)

Pearson chi2 (1) = 16.3139 Pr = 0.000

PATIENT CONDITION AT ASSAULT: SOBER	White	Alaska Native	Total
0 (NO)	344 (66.15%)	765 (87.43%)	1,109 (79.50%)
1 (YES)	176 (33.85%)	110 (12.57%)	286 (20.50%)
Total	520 (100.00)	875 (100.00)	1,395 (100.00)

Pearson chi2 (1) = 90.5766 Pr = 0.000

PATIENT CONDITION AT ASSAULT: PASSED OUT/BLACKED OUT	White	Alaska Native	Total
0 (NO)	439 (79.10%)	622 (69.34%)	1,061 (73.07%)
1 (YES)	116 (20.90%)	275 (30.66%)	391 (26.93%)
Total	555 (100.00)	897 (100.00)	1,452 (100.00)

Pearson chi2 (1) = 16.5874 Pr = 0.000

TIME=UNKNOWN	White	Alaska Native	Total
0 (NO)	534 (92.07%)	841 (91.21%)	1,375 (91.54%)
1 (YES)	46 (7.93%)	81 (8.79%)	127 (8.46%)

Total	580 (100.00)	922 (100.00)	1,502 (100.00)

Pearson chi2(1) = 0.3356 Pr = 0.562

TIME= < 2 HOURS	White	Alaska Native	Total
0 (NO)	542 (93.45%)	780 (84.60%)	1,322 (88.02%)
1 (YES)	38 (6.55%)	142 (15.40%)	180 (11.98%)
Total	580 (100.00)	922 (100.00)	1,502 (100.0)

Pearson chi2(1) = 26.4344 Pr = 0.000

TIME= 2 TO < 4 HOURS	White	Alaska Native	Total
0 (NO)	484 (83.45%)	744 (80.69%)	1,228 (81.76%)
1 (YES)	96 (16.55%)	178 (19.31%)	274 (18.24%)
Total	580 (100.00)	922 (100.00)	1,502 (100.00)

Pearson chi2(1) = 1.8107 Pr = 0.178

TIME= 4 to < 12 HOURS	White	Alaska Native	Total
0 (NO)	442 (76.21%)	711 (77.11%)	1.153 (76.76%)
1 (YES)	138 (23.79%)	211 (22/89%)	349 (23.24%)
Total	580 (100.00)	922 (100.00)	1,502 (100.00)

Pearson chi2 (1) = 0.1646 Pr = 0.685

TIME= 12 to < 24 HOURS	White	Alaska Native	Total
0 (NO)	474 (81.72%)	772 (83.73%)	1,246 (82.96%)
1 (YES)	106 (18.28%)	150 (16.27%)	256 (17.04%)
Total	580 (100.00)	922 (100.00)	1,502 (100.00)

Pearson chi2 (1) = 1.0142 Pr = 0.314

TIME = 1 TO 3 DAYS	White	Alaska Native	Total
0 (NO)	458 (78.97%)	797 (86.44%)	1,255 (83.56%)
1 (YES)	122 (21.03%)	125 (13.56%)	247 (16.44%)
Total	580 (100.00)	922 (100.00)	1,502 (100.00)

Pearson chi2 (1) = 14.4858 Pr = 0.0000

PATIENT ADMITTED FOR EMERGENCY CARE	White	Alaska Native	Total
0 (NO)	472 (90.42%)	738 (89.02%)	1,210 (89.56%)
1 (YES)	50 (9.58%)	91 (10.98%)	141 (10.44%)
Total	522 (100.00)	829 (100.00)	1,351 (100.00)

Pearson chi2 (1) = 0.6702 Pr = 0.413

PATIENT NONGENITAL TRAUMA	White	Alaska Native	Total
0 (NO)	286 (55.86%)	341 (41.33%)	627 (46.90%)
1 (YES)	226 (44.14%)	484 (58.67%)	710 (53.10%)
Total	512 (100.00)	825 (100.00)	1,337 (100.00)

Pearson chi2 (1) = 26.7685 Pr = 0.000

PATIENT ANOGENITAL TRAUMA	White	Alaska Native	Total
0 (NO)	311 (61.71%)	458 (56.47%)	769 (58.48%)
1 (YES)	193 (38.29%)	353 (43.53%)	546 (41.52%)
Total	504 (100.00)	811 (100.00)	1,315 (100.00)

Pearson chi2 (1) = 3.5054 Pr = 0.061

RELATION1= FRIEND/ ACQUAINTANCE (24+ HRS)	White	Alaska Native	Total
0 (NO)	321 (59.59%)	556 (63.91%)	876 (62.26%)
1 (YES)	217 (40.41%)	314 (36.09%)	531 (37.74%)
Total	537 (100.00)	870 (100.00)	1,407 (100.00)

Pearson chi2 (1) = 2.6345 Pr = 0.105

RELATION1= FRIEND/ ACQUAINTANCE (< 12 HRS)	White	Alaska Native	Total
0 (NO)	443 (82.50%)	685 (78.74%)	1,128 (80.17%)
1 (YES)	94 (17.50%)	185 (21.26%)	279 (19.83%)

Total	537 (100.00)	870 (100.00)	1,407 (100.00)

Pearson chi2 (1) = 2.9525 Pr = 0.086

RELATION1= STRANGER	White	Alaska Native	Total
0 (NO)	449 (83.61%)	738 (84.83%)	1,187 (84.36%)
1 (YES)	88 (16.39%)	132 (15.17%)	220 (15.64%)
Total	537 (100.00)	870 (100.00)	1,407 (100.00)

Pearson chi2 (1) = 0.3715 Pr = 0.542

PATIENT HAD CONSENSUAL VAGINAL SEX WITHIN 96 HRS OF ASSAULT	White	Alaska Native	Total
0 (NO)	378 (73.11%)	589 (71.22%)	967 (71.95%)
1 (YES)	139 (26.89%)	238 (28.78%)	377 (28.05%)
Total	517 (100.00)	827 (100.00)	1,344 (100.00)

Pearson chi2 (1) = 0.5647 Pr = 0.452