

**Responding to Victimized Alaska Native Women
in Treatment for Substance Abuse**

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ABSTRACT

High rates of physical and sexual abuse have been found among Alaska Native women entering a residential treatment program in Fairbanks, Alaska. However, little information is available describing the nature of such abuse and its relationship to treatment outcome. This article describes the extent of this physical and sexual abuse, and reviews factors involved in its onset. The implications of the findings are discussed with an emphasis on how they can be applied to enhance treatment outcome.

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I. INTRODUCTION

Although the treatment of drug dependence has become increasingly successful during the past three decades, treatment providers must continue to learn more about how client characteristics, lifestyles, and needs are related to favorable outcomes if treatment effectiveness is to improve (Howard & Beckworth, 1996). Although researchers are addressing these issues, there is nevertheless a paucity of information about these factors among women, especially minority groups, and in particular Alaska Native and American Indian women. Wallen (1998) indicated that "relatively little is known about the characteristics and treatment needs of women in drug abuse treatment" (p. 230), and LaDue's (1991) earlier commentary continues to be relevant: "Critical problems facing Native women today include the particularly high rate of alcoholism and the increasing rate of drug abuse found in Indian communities" (p.23). The question thus arises as to whether treatment programs are sufficiently respon-

sive to the emotional, social and cultural needs of Native American women entering treatment for substance misuse.

For many Alaska Native women, behavioral and lifestyle problems arise from dealing with the impacts of cultural change that have resulted from alterations in traditional roles, and which contribute to a loss of personal, familial and cultural identity (Alaska Federation of Natives, 1989). A common way of coping with these problems, for many Alaska Native women, is to turn to alcohol and other drugs which puts them and their children at high risk for physical and sexual violence (Langeland & Hartgers, 1998; Segal, 1997a, 1999a). As substance misuse impacts their lives, their behavioral pattern may also involve promiscuity, and they thus become at risk for HIV, other sexually transmitted diseases, and unwanted pregnancies. A related fact is that Alaska has been reported to have one of the highest Fetal Alcohol Syndrome rates in the nation (Egeland et al., 1998).

Women caught in a cycle of misuse and addictive drug-taking behaviors who enter treatment show high drop out rates (Szuster et al., 1996; Segal, 1997a), and their experiences with violence often result in lifelong problems. Dealing with their experiences of personal violence must become an important treatment element, complementing efforts directed at cessation of drinking and other drug-taking behaviors.

Wallen (1998) noted that, although there has been a dramatic promulgation of programs specifically for women, the treatment

models they pursue may nevertheless stem from traditional male programs and may not be totally responsive to women's needs, especially women from minority groups such as American Indians and Alaska Natives. There are, as Wallen (1998) indicated, "wide gaps between the kinds of services that are appropriate for drug-addicted women and their children and the kinds of services that are provided in the treatment system" (p. 230).

II. PURPOSE

This paper describes some of the characteristics and treatment needs of Alaska Native women being treated for substance misuse, as well as reviews how treatment programs can best respond to the needs of such women. It specifically describes women entering a residential treatment program and the relationship between their experiences of victimization, substance misuse and response to treatment. It also emphasizes treatment efforts made to retain them in the program and to improve treatment outcome.

Although the paper's focus is on Alaska Native women who were physically or sexually abused, the information provided can be used as a foundation for developing treatment programs responsive to other Native American women, and to abused women in general. The findings also have implications for guiding further research on treatment outcome for substance abusing women who have experienced physical and/or sexual abuse.

III. METHOD

A. The Treatment Program

The present research was conducted at a women's treatment program in Fairbanks, Alaska, as part of its evaluation component. The conceptual model governing the evaluation represents an interactive framework that specifies that some potential post-treatment functioning is related, singularly and in combination, to the clients' (a) social background characteristics and functioning prior to treatment, (b) treatment received, and (c) extra-treatment factors.

The treatment program is divided into three phases. Phase I (averaging 91 days per client, SD=33, range = 40-199 days) represents initiation into treatment and is a stabilization period. Immediately upon admission, informed consent is obtained to participate in the research, and client confidentiality is assured. Several days after admission, and encompassing a period lasting several weeks, a comprehensive assessment of the client is undertaken, obtaining both clinical and baseline evaluation data. Children, if admitted with their mother, are also assessed, and treatment plans are formulated. Shortly thereafter, individual and group counseling are started, alcohol and drug education efforts are initiated, parenting and family classes are established, and participation in culturally-related activities are inaugurated.

Phase II represents a recovery period (averaging 75 days per client, SD=38, range=21 to 183 days) that concentrates on treatment, encompassing individual, group, and family counseling. It also focuses on relapse prevention, problem/conflict resolution, the parent-child relationship, and on other personal and life issues. Some intake measures are readministered during this Phase.

Phase III (averaging 149 days, SD=128, range=33 to 383 days) concentrates on assisting clients to resolve personal issues and to establish ties to the community. Transitional care and aftercare are integral components of this phase, along with educational and occupational efforts.

After a client has been discharged from any phase or left early from any phase, follow-up information is obtained through an interview, either person to person or via telephone, and is conducted by a trained interviewer. Three months subsequent to having left the program, either by program completion or by dropping out or being dismissed, the interviewer attempts to locate former clients and arrange the interview using a follow-up assessment interview. The same procedure is repeated three months later (or six months after having left the program), and at 12 months, using the same follow-up measure. Eighteen month follow-up interviews were instituted as of January 1, 1998, but data from these interviews are currently insufficient for study.

B. Subjects

As of December 30, 1998, a total of 157 (unduplicated) women were admitted to the program between August 1994 and December 1999. Of these, 122 consisted of Alaska Native women who comprised the study group for the findings reported below. Table 1 provides a description of the characteristics of the sample.

Table 1
Characteristics of Alaska Native Women
Having Entered the Residential Treatment Program (WCRP)
(N=122)

<u>Age</u>	
Mean	30.2
SD	6.6
Range	18-47
 <u>Highest Grade Completed</u>	
Mean	11.1
SD	1.6
 <u>Marital Status</u>	
	<u>Percent</u>
Unmarried	49.2
Married	15.5
Divorced	10.7
Separated	13.1
Living as Married	8.2
Widowed	3.3
 <u>Ethnicity</u>	
	<u>Percent</u>
Athabaskan	48.5
Inupiat	16.1
Yupik	20.9
Tlingit	5.8
Aleut	8.7

C. Assessment

The assessment protocol obtains data at four treatment stages: (1) baseline data, which is conducted upon admission and consists of screening and assessment interview data and supplementary measures; (2) process data, which represents documentation of the kinds and duration of treatment received, (3) exit interviews, which are conducted at time of leaving

treatment, either prematurely or at graduation, and (4) follow-up data. All instruments and scales used have demonstrated reliability and validity, reported earlier (Segal, 1999b).

The first part of the assessment protocol is a structured interview that covers seven areas: (1) Referral/Screening Information, (2) Demographics/Background Information, (3) Treatment History, (4) Family History, (5) Health and Medical History, (6) Legal Status, and (7) Drinking and Drug-Taking Behavior. A DSM-IV criteria checklist is also utilized.

The second part consists of: The Cultural Issues and Interests Scale (Segal, 1993a), a measure of cultural identity; The Life Experience Questionnaire (Segal, 1993b), which obtains a detailed history of abuse and victimization, including signs and symptoms of PTSD; The Family Conflicts Scale (Straus, 1979); The Social Support Scale (Gurley, 1990); and a Personal Health Questionnaire (Segal, 1993c), which inquires about birth control procedures, sexual practices (e.g., high risk HIV activity), and AIDS knowledge and risks. Information from the intake and follow-up protocols were used for this study.

IV. RESULTS

A. Prevalence of Violence-Related Experiences

Table 2 provides a description of the forms of personal violence and related experiences encountered by the women entering the residential program; it also shows data pertaining to their children's experience of violence. From the total of 122 eligible respondents, the data in Table 2 represents the number of women answering each question about their personal experiences of physical or sexual abuse, and the percent of women responding positively to each question.

The data reveal that 90% of the women encountered some form of physical abuse, of which 64% of the incidents originated before age 13. Over three-quarters (78%) of the women responding also reported being victims of sexual abuse, with 76% of the incidents also occurring before the age of 13.

Nearly half (48%) of the respondents were physically abused by their parents; 89% were beaten in a relationship, 70% were pushed or slapped by an adult, and 81% were battered by a significant other. Other physical abuse-related events also show high prevalence levels.

**Table 2. Personal Violence and Other Related Experiences
of Alaska Native Women Entering a Substance Abuse Treatment Program***

	<u>(N)**</u>	<u>(Percent)***</u>
<u>Physical Abuse</u>		
Ever physically abused	107	90
Before age 13	98	64
After age 13	98	36
Parents physically abused you	107	48
Abuse alcohol-related		
Adult hit you with an object	75	49
Adult push or slap you	74	70
Beaten in a relationship	78	89
Battered by significant other	118	81
Adult kick or beat you	75	39
Adult threaten you with a weapon	76	16
Adult use weapon on you	75	7
Spent night in a shelter to avoid violence	75	44
<u>Sexual Abuse</u>		
Ever sexually abused	83	78
Before age 13	63	76
After age 13	63	24
Adult exposed genitalia to you	75	49
Adult fondled you	75	61
Forced vaginal intercourse		
before 12	74	29
Raped (any age)	19	84
Your child(ren) physically abused	103	24
Your child(ren) sexually abused	103	19
<u>Personal Harm</u>		
Ever harmed yourself	107	52
Attempted suicide	105	51
Attempt alcohol/drug related	57	58
<u>Other</u>		
Lost someone close due to suicide or murder	105	68
Loss alcohol/drug related		
Ever arrested	111	85
		77

*Source: Segal, 1999

**Represents the number of women responding to each item.

***Represents the percent of respondents who gave an affirmative answer.

Further, of the women reporting having been abused by their parents, 69% described the abuse incidents as alcohol-related. That is, the abuser was drinking at the time of the incident.

Over half the women (52%) in this study attempted to harm themselves in some way, and 51% attempted suicide at least once. Fifty-eight percent of the suicide attempts were reported to be alcohol-related.

Twenty-four percent of the women indicated that one or more of her children was physically abused, while 19% of the women reported that one or more of her children was sexually abused.

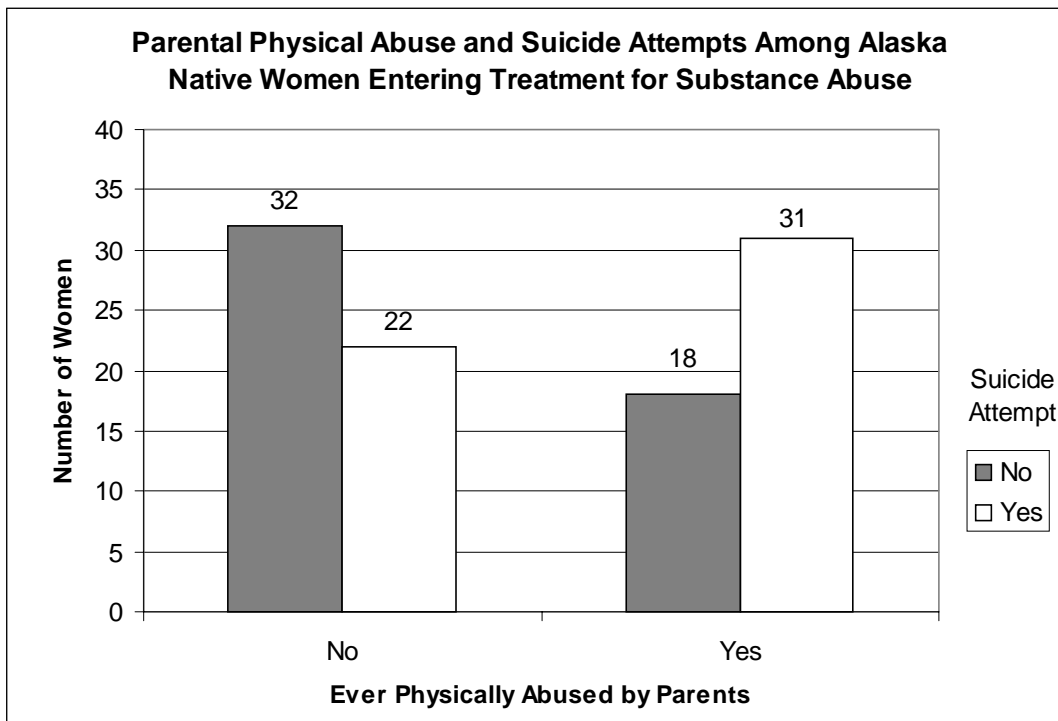
However, further analysis of the data revealed no statistical demonstration that if a mother was physically abused, her child was also abused ($\chi^2 (1, N = 97) = 3.262, p < .068$), and that if a mother was sexually abused, her child was also sexually abused $\chi^2 (1, N = 72) = 873, p < .575$.

Almost three-quarters of the women (68%) lost someone close due to suicide or murder, and of these losses 85% were alcohol-related. Over three-quarters of the women (77%) reported having been arrested at least one time.

B. Abuse, Self-Harm and Suicide Attempts

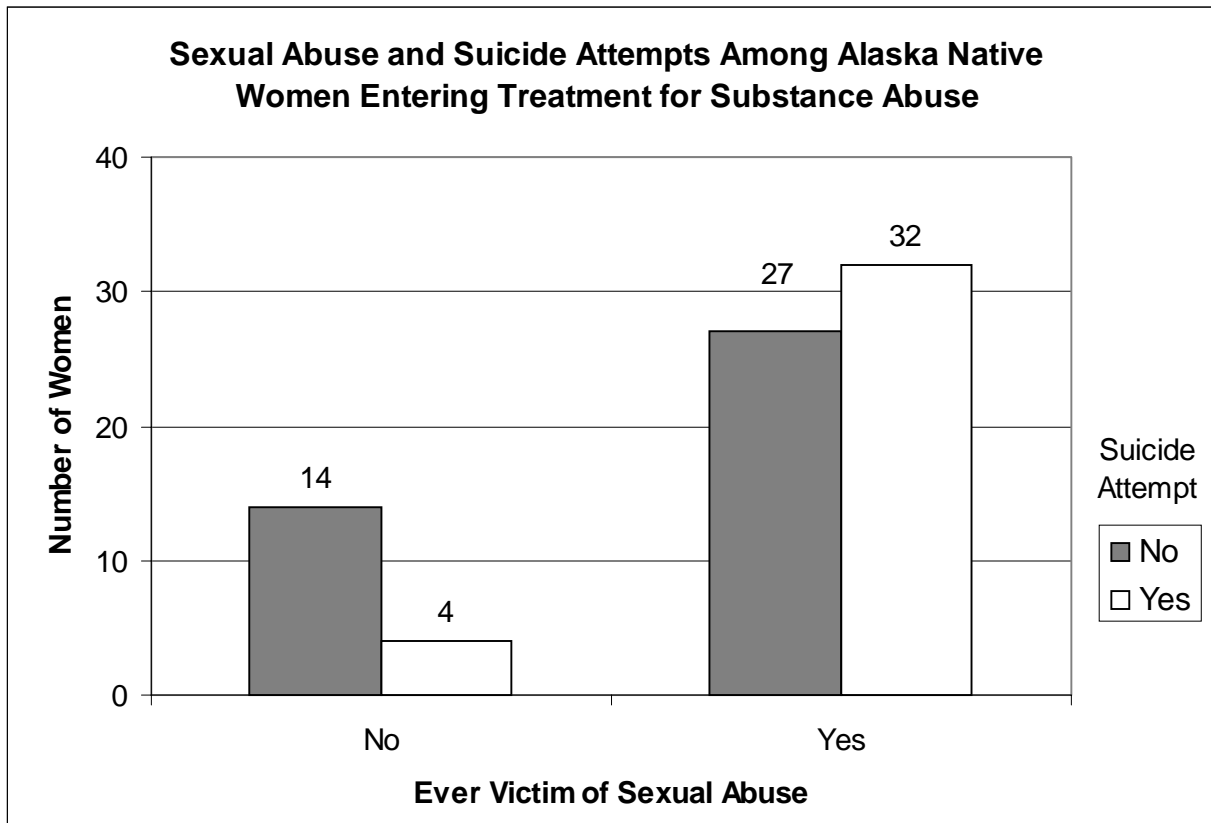
Figure 1 shows the results from a Chi-square analysis that tested the null hypothesis that there is no relationship between having been physically abused by one's parents and a suicide attempt. The results of the analysis indicate that the null hypothesis can be rejected, specifying an association between a woman's experience of parental physical abuse and a suicide attempt $\chi^2 (1, N = 103) = 5.218, p < .018$. Further, the risk estimate, or odds ratio for logistic regression, derived from the Chi-square analysis, indicates that if a woman was abused by her parents, she would be six times more likely to attempt suicide than a non-abused woman.

Figure 1



A second Chi-square analysis was undertaken to determine the relationship between sexual abuse and suicide attempts. The results of the analysis (see Figure 2) showed this relationship to be significant $\chi^2 (1, N = 77) = 5.679, p < .016$, and produced a risk estimate indicating that women who are sexually abused are almost four times more likely to attempt suicide than women who are not sexually abused.

Figure 2

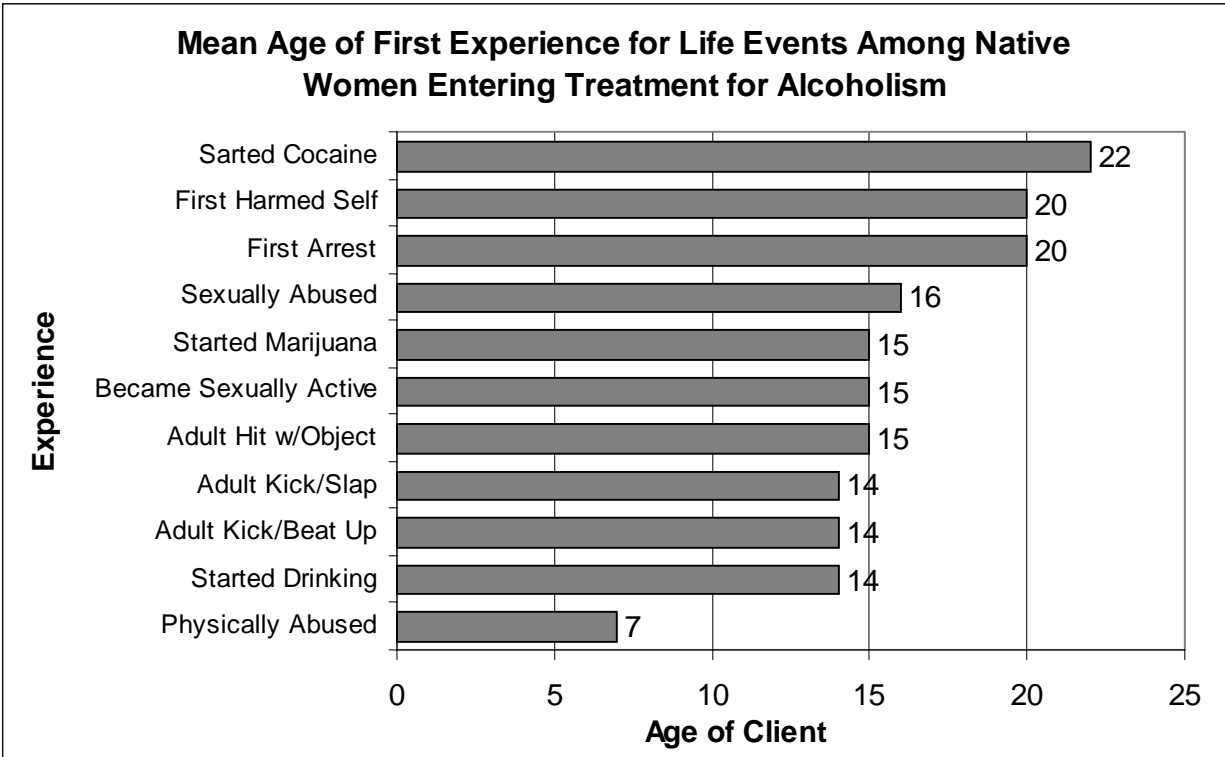


C. Sequential Patterns of Violence and Substance Misuse

This part of the research was concerned with determining if a discernable pattern of experiences of violence and the onset of substance misuse could be identified. Stated differently, is it possible to demonstrate a relationship between experiences of personal violence and initiation of drinking and use of other drugs? This question was answered by examining milestones representative of the (a) mean ages of onset of substance misuse, and (2) mean ages of violence-related experiences.

The data in Figure 3 illustrate the time period beginning with the average age of onset of physical abuse to the mean age of first use of cocaine. A distinguishable pattern can be observed. Physical abuse is reported to start early in childhood, averaging 6.6 years of age. Initiation into drinking occurs, on the average, at 13.9 years. Age fourteen reflects the average inauguration age of relationship problems, and the mean age of onset of being physically assaulted. At 15, on the average, the women become sexually active, sexually abused and start using marijuana. By about age 20, they undergo their first arrest, and try to harm themselves in some way for the first time. Initiation into cocaine starts around their 21st year.

Figure 3

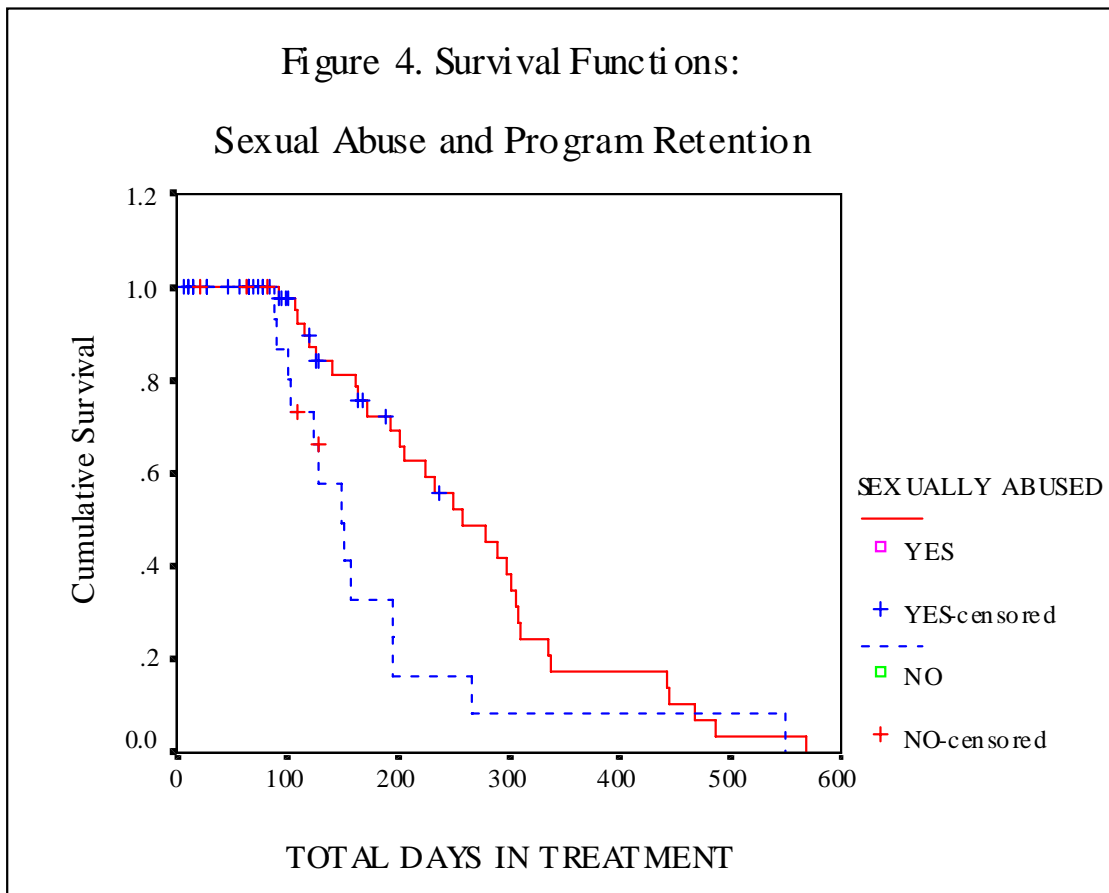


A sequence of events precede alcohol or drug use. Alcohol follows, although several years later, early physical abuse. Marijuana immediately follows a cycle of physical abuse and sexual activity, while cocaine occurs right after having been sexually abused, arrested, and harming oneself. It appears that progression of drug use coincides with an apparent need for more intense drug effects, which may correspond to a desire to self-medicate; that is, to become oblivious to or dull intense pain.

D. Program Retention and Sexual Abuse

Given the prevalence of sexual abuse among the women entering the treatment program, the following question arises: Did sexual abuse factor into retention? The results of a survival analysis (see Figure 4), in which days in residence was the independent variable, and sexual abuse the dependent variable, revealed that sexually abused women stayed in treatment for longer periods of time (Mean = 270 days) than non-abused women (Mean = 183 days). This difference was significant (Log Rank = 5.28 (df = 1), $p = .0216$).

The differences in length of times in the program (survival time) between abused and non-abused women are described in Table 3, along with the number of censored cases. As discussed further below, a major reason that abused women may stay in treatment longer than non-abused women is that the treatment program provides safety. Further, the special emphasis placed on responding to abuse-related problems may also contribute to client retention.



**Table 3:
Survival Analysis Functions: Abuse and Length of Time in Residence Among
Alaska Native Women Entering Treatment for Substance Misuse**

Factor: **No Sexual Abuse**

	<u>Survival Time</u>	<u>Standard Error</u>	<u>95% Confidence Interval</u>
Mean:	183	35	(114,252)
Median:	149	19	(111,187)

Factor: **Sexually Abuse**

	<u>Survival Time</u>	<u>Standard Error</u>	<u>95% Confidence Interval</u>
Mean:	270	22	(227,313)
Median:	258	36	(187,329)

	<u>Total</u>	<u>Number Events</u>	<u>Number Censored</u>	<u>Percent Censored</u>
No Sexual Abuse:	18	13	5	27.78%
Sexual Abuse:	59	31	28	47.46%
Overall:	77	44	33	42.86%

V. DISCUSSION

The findings demonstrate that victimization experiences among Alaska Native Women in treatment for substance misuse are highly prevalent, and that there are relationships between parental physical abuse, sexual abuse, and suicide attempts. The prevalence rate of 75% for sexual abuse is dramatically higher than the range of 27% to 62% reported for the general United States-based female population by Kilpatrick (1992). Further, nearly half the women (49%) attempted to harm themselves in some way, and 50% attempted suicide at least once. Twenty-five percent of the women indicated that one of her children was physically abused by another person, and 18% reported that her child was sexually assaulted by another person. Almost three-quarters of the women (74%) lost someone close due to suicide or murder.

A. Physical and Sexual Abuse

The rates for physical and sexual abuse among these Alaska Native women are also higher than rates reported in an early statewide study of domestic violence toward women in Alaska (Stockholm & Helms, 1986). These authors reported that the prevalence of domestic violence was 26% (approximately 1 in 4) of adult women having been abused by a spouse or live-in partner at some time during their adult life. Sixty five percent of these women reported alcohol as a contributing factor to the violence they experienced.

The data pertaining to the Alaska Native women are also higher than data on women from a Southwestern American Indian Tribe. Of the Native American women, 49% (107/217) had experienced at least one episode of childhood sexual abuse (Robin et al., 1997), compared with the Alaska finding that 75% of the women were sexually abused as children.

When comparing the finding for Alaska Native women to non-Native women, Copeland and Hall (1992) found that 47% of the women in treatment for substance misuse were sexually violated, while Roshenow, Corbett and Devine (1988) reported that 74% of their sample of women in treatment were sexually abused. This latter figure is slightly lower than that for the Alaska Native sample. Jarvis and Copeland (1997) related that 70% of women in treatment for child sexual abuse (CSA) had tried suicide, compared with 36% of women in treatment for substance misuse. These authors also found that 58% of the CSA group reported self-harm, compared to 30% for the substance misuse treatment group. Further, Miller, Downs and Testa (1993) found that two-thirds (70/178) of the alcoholic women in their sample experienced some form of childhood sexual abuse as compared to approximately one-fifth (21/100) of a sample of "women drinking drivers" and one-third (35/82) of the women from a household sample. In summary, the prevalence rates cited above pertaining to the Alaska Native sample attests to a relationship between physical and sexual abuse, some form of self-harm, and substance misuse. This finding

is supported by Kilpatrick et al. (1998) and Miller (1996), based on their research on victimization experiences among substance abusing women.

More specifically, it appears that sexual victimization has a specific connection to women's substance misuse problems. It is also evident that Alaska Native women demonstrate higher levels of victimization than their non-Native counterparts. Moreover, multiple violence is present, and the current data indicate that intergenerational violence (i.e., abuse of children) has occurred.

The connection between abuse experiences and increased risk for self-harm and/or suicide attempts reported herein is consistent with reports in the literature about this relationship (e.g., The Massachusetts MOTHERS Project, 1997, Kilpatrick et al., 1997, Kilpatrick et al., 1998, Miller, 1996). This linkage heightens the importance of recognizing that the problems women bring to treatment are more than just substance misuse. Grice et al. (1995), Epstein et al. (1998), Kilpatrick et al. (1997, 1998) and Saladin et al. (1995) have all indicated that there is a strong relationship between women's victimization, Posttraumatic Stress Disorder (PTSD) and substance misuse, with PTSD possibly serving as a contributing factor to starting substance misuse.

An attempt to study the relationship between experiences of personal violence and relapse (use of alcohol and other drugs and/or return to treatment) was not feasible because there was

little or no variance associated with relapse. That is, the proportion of women who experienced some form of personal violence was so positively skewed that it precluded any inferential analysis using relapse as an independent variable. Further studies will be undertaken to examine this relationship as the number of women completing follow-up interviews increase, providing there is an increase in the number of non-abused women within this follow-up group.

B. Age and Onset Patterns

The findings also revealed a fairly clear descriptive pattern of age of experiences of traumatic events and onset of drug-taking behaviors. Consistent with the findings of Kilpartick et al. (1998), the first substance used was alcohol, but in contrast to Kilpatrick et al.'s findings, drinking, on the average, occurred subsequent to (early) childhood experiences of parental abuse, not after their first assault experience. The onset of marijuana and cocaine use, respectively, appears to a sequence of experiences of interpersonal physical violence followed by sexual activity and abuse, self-harm and one's first encounter with the justice system.

C. Retention

Abused women stayed in treatment significantly longer than non-abused women. As noted above, a "safety" factor may be

present that helps retain the abused in treatment. Several factors contribute to this difference: (a) a women's residential program does not provide a setting, such as a coed program, that places women at risk for sexual harassment or sexual abuse, (b) a women's program provides a social support system specific to women's needs, and (c) the victim is sheltered from the abuser. Further, many of the abused women also have children accompanying them in treatment, which also provides a safe environment for them. Additional research on the same clinical population has found that women accompanied by their children remained in treatment longer than women with children who were not in treatment with their mother (Segal, 1998).

D. Implications

Two major implications of these findings for prevention of substance misuse are: (a) the need for early identification of high risk women by identifying those abused early in life and targeting them for intervention efforts, and (b) early identification of adolescents experiencing physical abuse, and targeting such youth for therapeutic intervention. Of primary importance, however, is the necessity to develop means of curtailing the conditions that give rise to physical and sexual abuse in the first place.

The question these findings also raise is what contributes to the high level of violence experienced by Alaska Native women entering treatment for substance misuse. One significant factor appears to be the historical and current disruption of traditional Alaska Native cultures. This predicament has contributed to the development of a host of problems including but not limited to changing social and economic conditions. A report by the Alaska Federation of Natives (1989) stated that "these changes have been so rapid and dramatic that they have served as a prerequisite to healthy and productive life being lost in a haze of alcohol-induced despair that not infrequently results in violence-perpetrated upon self and family" (pp. 1-2).

Gutierrez et al. (1994) noted that among American Indian women entering treatment for substance misuse, sexual issues are important elements related to long-term recovery, but that this

aspect of a woman's life is often overlooked in treatment programs. These researchers concluded that "Family dysfunction (substance use and physical and sexual abuse) appeared to undermine the individual's ability to respond to treatment...The self esteem of individuals who reported not having a history of physical and sexual abuse improved more with treatment than did that of individuals who reported such abuse" (p. 1780).

Gutierrez et al. (1994) also found that acculturation issues were related to treatment outcome, in that a higher treatment completion rate was found for women who indicated that they practiced traditional activities while growing up and during the past year. Over 50% of those completing treatment also viewed themselves as traditional women.

Adult women carry the scars of personal violence well into adulthood and often throughout their entire lives. Thus, it is thus likely that the issue of violence and its effects has become a central theme in the lives of abused women, and many of these women may even be unaware of the relationship between their current problems and their early experiences of personal violence (Russell and Wilsnack, 1991).

These findings have direct implications for treatment. Of primary importance is that treatment programs with Native American women clients must adopt an intervention approach that addresses the unique cultural and personal characteristics of their clients. The program also must be responsive to the

problems the women bring with them by seeking to uncover and confront issues related to violence in their client's past, and make sure that this topic remains in focus throughout the continuum of care provided. The establishment of a focused treatment component may be the most effective method to help women identify and deal with the effects of abuse. This intense intervention should help to enhance treatment retention, improve treatment outcome, and decrease the probability of relapse.

It is also imperative that sexually abused women continue to explore related issues after inpatient treatment, during transitional care, in outpatient treatment, and during aftercare. This effort is particularly important because women are much more likely to seek help for the consequences of abuse rather than deal with the abuse itself (Russell & Wilsnack, 1991). Many of the issues that women need to address after treatment are the same ones that existed before treatment (e.g., low self-esteem, lack of social support, self-stigmatization, and the need for supportive services such as child care). Continuing to participate in group counseling after residential treatment would be helpful in maintaining a focus on these issues. Attention also needs to be given to the impact of violence on their children, with an emphasis on identifying cases where violence occurred, and on obtaining immediate therapeutic intervention.

Concerning Alaska Native women, and abused women in general, treatment advances may also be achieved by interpreting their

substance misuse-related problems as a possible symptomatic representation of the effects of personal violence and cultural loss, a suggestion in keeping with the research findings from an American Indian population (Gray, 1998). This problem is compounded because the drinking and drug-taking behavior itself conflicts with cultural values and attitudes that the woman may be struggling to retain. The substance misuser places a higher value on using than on maintaining what cultural values she was struggling to preserve. However, drinking and drug use eventually become motivating forces in their own right, further diverting a woman away from the basic values of her cultural group and directing all her energy to obtaining alcohol, sustaining drinking, and staying intoxicated longer, or to feeding a drug habit, which leaves little energy or time for social, spiritual and family investments.

These findings emphasize the importance of examining how victimization experiences and PTSD become linked. One possible explanation is that the experience of victimization is so traumatic that it contributes to the onset of PTSD. Research has demonstrated that severe childhood sexual abuse may be important to consider as a risk factor for PTSD, as reviewed above. Research also shows that female patients with substance misuse-related PTSD were more likely to report childhood victimization than women with primary substance misuse diagnoses (Brady et al., 1994). Robin et al. (1997) also found that the most predictive

factor for lifetime PTSD among women from a Southwestern Tribe was the experience of physical assault. These findings are consistent with the literature linking sexual abuse and substance abuse in women (cf. Fergusson, Horwod, & Lynskey, 1997; Wilsnack et al., 1997).

The relationship among trauma (specifically sexual assault), PTSD, and substance misuse has been well documented (cf. Brown, 1994; Harvey et al., 1994; and Zweben et al., 1994). Indeed, as Harvey et al. Stated, "Clinical reports suggest that unresolved trauma-related symptoms can contribute to relapse, as individuals may eventually return to alcohol and other drug use to cope with unresolved long-term effects of trauma" (p. 361). Zweben et al. (1994) also stated that, "Clinicians have noted that many patients describe a pattern of alcohol or drug use motivated by a desire to obscure or escape from uncomfortable experiences. Some are now conceptualizing the alcohol and other drug use as one method (among several) to dissociate painful states" (p. 330).

In conclusion, the problems of violence and substance misuse are exceptionally severe among Alaska Native women and, as revealed in the literature, for abused women in general. It is essential that treatment programs develop specialized treatment components that help women, especially Native American women, identify and resolve what may be chronic stress (manifested as PTSD) related to sexual and physical abuse in order to maximize

treatment effectiveness. Brown et al. (1998), Gutierres, Russo, & Urbanski (1994), and Watts and Gutierres (1997) have all indicated a need for specialized intervention for abused women. Gutierres et al. (1994) particularly noted that the "fact that victimized individuals may use alcohol or drugs to deal with (even repress) trauma, particularly childhood trauma, complicates the treatment of substance abusers" (p. 1780).

It would also be appropriate, when responding to the needs of Native American women, to adopt traditional cultural methods to assist them in overcoming their problems and to help them gain a sense of personal identity. A fundamental premise on which treatment must proceed is to assist Native women to establish a sense of self-esteem to become motivated to enjoy the benefits of a life no longer impacted by violence and substance misuse.

Footnotes

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