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Rates and Correlates of Intimate Partner Abuse Among Indigenous Women Caregivers

Katie M. Edwards[1], **Emily A. Waterman**[2], **Natira Mullet**[3], **Ramona Herrington**[1], **Skyler Hopfauf**[1], **Preciouse Trujllo**[1], **Naomi Even-Aberle**[1], **Lorey A. Wheeler**[1], **Sloane Cornelius**[1], **Arielle R. Deutsch**[4,5]

[1]University of Nebraska-Lincoln, NE, USA

[2]Bennington College, Bennington, VT, USA

[3]North Dakota State University, Fargo, ND, USA

[4]Avera Research Institute, Sioux Falls, SD, USA

[5]University of South Dakota, Vermillion, USA

Abstract

Intimate partner abuse (IPA) is a public health crisis that disproportionately impacts indigenous women. We know little about rates and correlates of IPA victimization (IPAV) and abuse directed at one's partner (ADP) among indigenous women caregivers (people who take care of children). The purpose of the current study was to address this critical gap in the literature. Participants were 44 indigenous women caregivers in the United States in a current relationship who completed a survey. Most women reported IPAV and ADP experiences in the past 6 months, and IPAV and ADP abuse directed at partner were positively associated. Further, IPAV was positively associated with adverse childhood experiences (ACEs), participants' engagement in harsh parenting, and depressive symptoms. IPAV was negatively associated with age, income, indigenous cultural identity, and social support. ADP was positively associated with ACEs, harsh parenting, and depressive symptoms. ADP was negatively associated with age and income. ADP was not associated with indigenous cultural identity and social support. These data suggest the urgency with which efforts are needed to prevent and respond to IPA among indigenous women caregivers, especially those who are younger and of lower income, and that culturally grounded initiatives that seek to build social support may be especially impactful.

Corresponding Author: Katie M. Edwards, University of Nebraska-Lincoln, 160 Prem S. Paul Research Center at Whittier School, Lincoln, NE 68583-0858, USA. Katie.Edwards@unl.edu.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Disclaimer

The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Ethical Approval

The research procedures were approved by the University of Nebraska-Lincoln's Institutional Review Board (IRB protocol number: 20210921287FB-COLLA) as well as the Great Plains Indian Health Services IRB.

Keywords

intimate partner abuse; domestic abuse; indigenous; ACEs

Intimate partner abuse (IPA)—which includes psychological, physical, and sexual abuse toward a current or former romantic or sexual partner—is a public health crisis in the United States (U.S.) (Black et al., 2011). Although IPA disproportionately impacts indigenous women in the U.S. (Rosay, 2016; Wahab & Olson, 2004), we know little about rates and correlates of IPA victimization (IPAV) and abuse directed at partner experiences among indigenous women caregivers (people who take care of children). Given research showing the damaging effects of caregivers' IPA experiences on their children (Artz et al., 2014; Rousson et al., 2022; van Heugten & Wilson, 2008), examining IPA among indigenous women caregivers is a timely topic of study. The purpose of the current study was to address this critical gap in the literature.

Context of IPA

IPA and adverse childhood experiences (ACEs; traumatic or stressful events [e.g., childhood abuse] that happen prior to the age of 18) were less common in traditional indigenous communities than today and believed to have increased after colonization and multiple historical traumas (e.g., cultural genocide, boarding schools) (Deer, 2015; Hawk Wing, 2022; Iron Cloud Two Dogs, 2022). In fact, researchers have documented that some indigenous communities were without family violence (Levinson, 1988). The current paper focuses on the Lakota people Oceti Sakowin Oyate (People of Seven Council Fires, known to some as the Sioux Nation) who originate from the He Sapa (Black Hills), what is present day South Dakota. Today there are approximately 100,000 Lakota/Dakota/Nakota (e.g., "Sioux") individuals in the U.S., mostly in the Northern Great Plains region of the U.S.(Census, 2021). In Lakota, *wakanyeja* means "little sacred ones" (children). Further, the *tiwahe*, (immediate family), and *tiospaye*, (extended family), are systems of support that are key to traditional Lakota society. As such, IPA and child abuse are highly incongruent with Lakota culture and the seven Lakota virtues (e.g., caring, respect, compassion, as applied to the self, family, community, and all life) which make up the bedrock of traditional practices and norms. Furthermore, prior to colonization and multiple historical traumas, other ACEs (e.g., poverty, caregiver mental health, caregiver substance use) were rare if nonexistent (Iron Cloud Two Dogs, 2022).

Rates of IPA

Nationally representative data in the U.S. documented that approximately 40% of indigenous women have experienced rape, physical abuse, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). Other studies among indigenous women have documented concerning rates of physical, sexual, and psychological IPA even over short periods of time (Harwell et al., 2003; Kong et al., 2018; Schultz et al., 2021). Experiences of IPA among indigenous women often start in early adolescent relationships (Edwards et al., 2022; Jones et al., 2021). Further, research suggests that women can engage in abuse directed at one's partner (ADP) (Neal et al., 2015; Straus, 2009) and that ADP are often

connected to their own histories or trauma (Edwards et al., 2009; Jones et al., 2021). This research, however, is largely not specific to indigenous women caregivers.

Correlates of IPA

A large body of literature has documented correlates of IPA at individual, relational, and community levels of the social ecological model, although little of this research has been specific to indigenous women (Gerino et al., 2018; Hardesty & Ogolsky, 2020; Laskey et al., 2019; Ullman, 2021). Research generally suggests that among indigenous women, IPA is associated with ACEs, including childhood abuse (Burke et al., 2022; Jones et al., 2021; Koss et al., 2003; Spencer et al., 2022; Zhu, 2022). A number of studies, including a few with indigenous women, have also found associations between IPAV and depression (Kong et al., 2018; Yakubovich et al., 2018), but to our knowledge have not examined how depression relates to ADP among indigenous women (Spencer et al., 2022). Although research suggests that social support is inversely related to experiences of IPAV among non-indigenous women (Spencer et al., 2022; Yakubovich et al., 2018) and indigenous women (Roh et al., 2015; Schultz et al., 2021), we are not aware of research examining ADP and social support specifically among indigenous women.

Similarly, although there is a large body of literature on positive associations between caregivers' IPA and caregiver's use of harsh parenting (Germán et al., 2017; Rousson et al., 2022), these associations have not been examined in populations of indigenous women. Finally, although one study with indigenous adolescents found mixed results regarding the association between interpersonal violence victimization and indigenous cultural identity (Edwards et al., 2022), we are not aware of any research that has examined how indigenous cultural identity relates to IPAV and ADP among indigenous women caregivers. As previously discussed, IPA is the antithesis of Lakota virtues and cultural practices and belief systems and as such may help to protect against both IPAV and ADP. Having a better understanding of the correlates of IPA experiences among indigenous women caregivers can help to inform the development and/or refinement of culturally grounded, strengths-focused IPA prevention and response efforts.

Current Study

The purpose of the current study was to examine past 6-month incidence rates (Aim 1) and correlates (Aim 2) of IPA among indigenous women caregivers. Given the exploratory nature of this study, we did not venture any a priori hypotheses.

Method

Research Design and Setting

These data are part of a larger controlled trial to evaluate a culturally grounded, strength-focused, family-based program to prevent ACEs. The current study used baseline data before any programming occurred. The project took place in a small-sized city in the Northern Great Plains region of the United States, adjacent to several large, highly impoverished, and rural Indian Reservations. Youths and their caregivers participated. To be eligible: (a)

youth had to be aged 10 to 14, and (b) identify as either indigenous and/or from a family living below the poverty line as determined by a series of screener questions (e.g., “Does your family receive SNAP [monthly funds for low-income families in the U.S. to buy food], this is like food stamps?” “Are there times when your family feels like there is not enough money for things like clothes or food?”). Participating adults had to be the caregiver of youth that met those same criteria. Caregivers were broadly defined and could be parents, grandparents, aunts/uncles, or anyone else who is the adult who takes care of the child participating in the program. In the current paper, we only include women who identify as indigenous/Lakota given the focus on connection to indigenous/Lakota culture. Further, in the current paper, we excluded the 12 men given that IPA is a highly gendered phenomenon (Hamby, 2016; Laskey et al., 2019), and the small sample size of men limited power to conduct moderation analyses.

Participants/Relatives[1]

Participants were 44 indigenous women in a relationship at the time of the baseline survey. Participants were also caregivers, broadly defined and could be parents, grandparents, aunts/uncles, or anyone else who is the adult who takes care of the child participating in the program. We excluded all women who were not in a relationship since the IPA items would not be relevant. The mean age of caregivers was 38.8 years (SD = 9.4; range 29–74). All caregivers were indigenous, but one (2.2%) also identified as White, two (4.3%) identified as Black, and eight (17.4%) identified as Latinx. Two (4.4%) identified as a sexual minority (bisexual specifically). Nearly half (43.5%) reported that their annual family income was under $10,000, 19.6% reported that their annual family income was $10,001 to $20,000, 13.0% reported that their annual family income was $20,001 to $30,000, and 23.9% reported that their annual family income was more than $30,001.

Procedure

A variety of recruitment methods were used in the current project. First, we posted recruitment ads on Facebook and boosted them so that individuals in the city and surrounding areas would see the ad. The social media ads reached over 30,000 people and received more than 4,000 likes, comments, shares, and clicks. Second, we knocked on approximately 200 doors in key neighborhoods. Our population included indigenous youth aged 10 to 14 and their relatives and/or from a family living below the poverty line. Neighborhoods with our target population were identified using publicly available census data coupled with income guidelines as well as knowledge of indigenous staff immersed in the community. Third, we set up tables outside of stores and shared information about the study with people coming and going from the stores. We also attended approximately 10 events frequented by families, such as holiday and cultural events. Fourth, we held recruitment events such as a chili dog feed, where families could stop by for a meal and information about the project. Fifth, we posted fliers in community centers and businesses. Sixth, we asked community partners such as the local domestic abuse programs, after-school programs, and other youth-serving organizations to distribute fliers and tell eligible families about the project. Seventh, staff used their knowledge of the community to recruit families

[1]We prefer to use relatives instead of participants as it honors the importance of Lakota kinship and is more respectful.

less likely to be reached by other methods described above (e.g., families without houses or transient families). Families enrolled in the project also told other families about the project (i.e., snowball sampling).

Interested families contacted the project team for a screening call, and those who were eligible then met a project staff to complete consent/assent. Written consent was gathered from all relatives for their own participation. Legal guardians (usually the same caregiver who completed their own survey) consented for their youth to participate, and youths provided written assent. Legal guardians also provided consent for other relatives to participate in programming sessions with their youth when applicable. After consenting, relatives completed a baseline survey. All surveys were conducted on paper and administered by trained research assistants or project managers. Surveys were completed at the location of the program (a local church), at the project office, or on rare occasions when transportation was prohibitive, at relatives' homes. Surveys were double entered by research assistants to ensure accuracy.

Relatives were compensated with $30 for the baseline survey (from where these data are drawn). Confidentiality was ensured via a Certificate of Confidentiality from the Centers for Disease Control and Prevention (CDC) (funding organization), and the study was approved by the IRB as well as the Great Plains Indian Health Service IRB. The publication of this paper was approved by the indigenous Advisory Board and the Indian Health Services IRB.

Measures

Intimate Partner Abuse.—The Conflict Tactics Scale (CTS) (Straus et al., 1996) measured IPAV and ADP experienced by caregivers. Participants indicated which experiences they had over the past 6 months. Response options included *yes* (1) and *no* (0). Participants responded to four subscales from the CTS: negotiation (6 items; e.g., "During the past 6 months, did your partner show that they cared about you even though you all disagreed?"), psychological (8 items; e.g., "During the past 6 months, did your partner call you fat or ugly?"), physical (12 items; e.g., "During the past 6 months, did your partner slam you against a wall?"), and sexual coercion, (7 items; e.g., "During the past 6 months, did your partner use threats to make you have sex?"). Thirty-three items measured victimization and 33 mirrored items measured ADP. Items were summed and dichotomized (0 = *no* IPA; 1 = *yes* IPA) for each subscale.

Adverse Childhood Experiences.—Relatives responded to 30 questions about their own experiences when 18 years of age or younger. This measure was developed for this study to be inclusive of all possible ACEs (for information on the development of this measure and psychometrics see AUTHORS, MASKED FOR REVIEW). Response options included were *yes* (1) or *no* (0). Similar items were asked to both relatives and youth; however, items were adjusted to be developmentally appropriate. Items for this measure were adapted after reviewing previous ACEs measures (Bethell et al., 2017). Items were summed such that higher scores indicated more ACEs.

Indigenous Cultural Identity.—This measure was adapted from Orthogonal Cultural Identification Measure (Oetting & Beauvais, 1990). Items were also adapted from those

created for previous research on a nearby Indian Reservation (Edwards et al., 2022). Caregivers were asked to answer seven questions based on their own experiences about their connection to their culture on a Likert scale from *not at all* (0) to *a lot* (3). For example, "How much does your family do special things together or have special traditions that are based on indigenous/Indigenous/Lakota/Nakota, Dakota culture?" Relatives' composite score was a mean, such that higher scores indicated higher levels of indigenous cultural identity. Internal reliability for this measure was acceptable ($\alpha = 0.78$).

Depressive Symptoms.—Caregivers indicated how often they had each of the thoughts/feelings during the last 30 days. They answered seven questions from the Center for Epidemiologic Studies Depression Scale (CESD-7) (Mirowsky & Ross, 1990). Response options ranged from: *rarely or none of the time* (0) to *most or all of the time* (3). An example question includes: "I felt that I could not shake off the blues." Items were summed so that scores indicated higher levels of depressive symptoms. Internal reliability for this measure was good ($\alpha = 0.81$).

Social Support.—Relatives responded to the emotional/informational support subscale of the Social Support Survey Instrument (Sherbourne & Stewart, 1991). The scale included eight items such as, "Someone you can count on to listen to you when you need to talk" and response options ranged from *none of the time* (0) to *all of the time* (4). Items were averaged, such that higher scores indicated higher levels of perceived social support. Internal reliability for this measure was good ($\alpha = 0.96$).

Harsh Parenting.—We used eight questions related to harsh parenting ("How often have you spanked/hit one or more of your children ages 10 to 14 (participating in this project) when they did something wrong?"); (Germán et al., 2017) Response options for caregivers included: *never* (0) to *always* (4). Final score was a mean so that higher scores indicated higher levels of harsh parenting. Internal reliability was acceptable ($\alpha = 0.74$).

Data Analysis Plan

Regarding Aim 1, descriptive statistics were calculated to document the past 6-month incidence rates of IPAV and ADAP. Regarding Aim 2, we computed point biserial correlations. For the association between IPAV and ADAP, we conducted a Chi-square. Given the small sample and exploratory nature of this study, we used $p < .10$ to indicate significance (Cohen, 1992).

Results

Aim 1

As displayed in Table 1, consistent with hypotheses, most women reported that they experienced IPAV in the past 6 months, with the most common type of victimization being psychological IPAV, although one in four women reported recent physical IPAV and nearly one in five women reported a recent sexual assault by a partner. Further, most women reported ADP, most commonly psychological ADP. Whereas nearly one in five reported physical ADP in the past 6 months, women's sexual ADP was rare.

Aim 2

As displayed in Table 2, IPAV and ADP were strongly related, X^2 (1) = 25.53, $p <$ .001. Moreover, IPAV was positively correlated with ACEs, harsh parenting, and depressive symptoms. IPAV was negatively correlated with age, income, indigenous cultural identity, and social support. ADP was positively correlated with ACEs, harsh parenting, and depressive symptoms. ADP was negatively correlated with age and income. ADP was not correlated with indigenous cultural identity and social support.

Discussion

The purpose of the current study was to examine the rates and correlates of recent IPAV and ADP. Most women reported high rates of IPAV and ADP in the past 6 months, and IPAV and ADP were strongly associated. Psychological IPA was the most common type of IPA although a concerning number of women reported physical and sexual IPAV in a short period of time (6 months). These findings add to the extant body of literature that has mostly focused on IPAV among indigenous women over the lifespan, rather than both recent IPAV and ADP (Rosay, 2016; Schultz et al., 2021; Wahab & Olson, 2004).

Although we did not measure the extent to which children of indigenous women witnessed abuse, it is likely that many of them witnessed it and/or are aware of it happening, which we know from previous research has devastating impacts on children and increases their own risk for childhood abuse (MacDonell, 2012; van Heugten & Wilson, 2008). Indeed, in the current study we found that indigenous female caregivers' use of harsh parenting was positively associated with caregivers' IPAV and ADP.

Similarly, experiences of ACEs in childhood were positively associated with indigenous female caregivers' experiences of IPAV and ADP. This is consistent with several studies that have documented these associations among indigenous women (Jones et al., 2021; Koss et al., 2003; Spencer et al., 2022). These findings highlight the complex interplay of abuse across generations and are a reminder of the urgency with which prevention and response efforts are needed to reduce the intergenerational transmission of abuse among indigenous caregivers and their children.

Despite concerning rates of IPA and ACEs among indigenous women caregivers, the current study identified several sources of resilience among indigenous female caregivers, including social support and indigenous cultural identity. Both social support and indigenous cultural identity were associated with lower levels of IPAV. Although speculative, it is possible that women who have more social support, an important part of Lakota culture from both one's immediate (*tiwahe*) and extended (*tiyospaye*) families, are less likely to remain in abusive relationships, which subsequently reduces their risk for IPAV. This is related to research more broadly that social support is inversely related to IPA (Roh et al., 2015; Schultz et al., 2021; Spencer et al., 2019, 2022; Yakubovich et al., 2018). Similarly, indigenous cultural identity was inversely related to lower IPAV. Pillars of Lakota culture include the importance of kinship, shared language, traditional practices and belief systems, and active reciprocal kinship with one's tribal community and homelands along with virtues of love, respect, and honor (Hawk Wing, 2022; Iron Cloud Two Dogs, 2022; Marshall, 2002). Thus, it is

likely that individuals who embody this way of life and engage in traditional practices (e.g., ceremonies, sweats) are likely to be engaged in relationships with others that are characterized by respect and non-abuse, thus reducing indigenous women caregivers' risk for IPAV. Future research on the mechanisms through which social support and indigenous cultural identity reduce risk for IPAV among indigenous female caregivers is clearly needed.

Interestingly, social support and indigenous cultural identity were not correlated with ADP. Also, it is important to note that we did not measure indigenous women caregivers' motives for IPA abuse directed at partner. Although among non-indigenous women self-defense is not a commonly cited reason for use of aggression toward one's partner (Neal & Edwards, 2015, 2017), it may be a factor for indigenous women, especially those experiencing more severe forms of ADP or women who are using ADP to protect their children from harm from an abusive partner.

Similar to previous research (Roh et al., 2015; Schultz et al., 2021; Spencer et al., 2019, 2022; Yakubovich et al., 2018), depressive symptoms were positively associated with both IPAV and ADP. Maternal depression is an ACE for children and predicts child maltreatment, another ACE (Centers for Disease Control and Prevention, 2019), which again underscores the need for comprehensive prevention and intervention services for indigenous female caregivers. The finding that depressive symptoms were inversely related to both social support and indigenous cultural identity among indigenous women caregivers underscores the utility for prevention and intervention services that seek to enhance women's social support and indigenous cultural identity. These approaches may help not only to prevent depression and IPA, but other health inequities, as well as the intergenerational transmission of abuse among indigenous. It is important to note, however, that larger efforts that target structural inequalities that perpetuate racism and poverty are also critical, as these are robustly related to health inequities, including IPA among indigenous populations.

Limitations

Several limitations should be noted. First the sample is small and limited to one geographic region. Although we did not measure tribal affiliation, it is likely that that vast majority were either Oglala Lakota or Sicangu Lakota. There are over 570 federally recognized indigenous tribes, among which there is vast heterogeneity. Thus, the extent to which these findings apply to other indigenous communities is unknown. Future research is needed to replicate and extend these findings to other tribal communities. Data were also cross-sectional, and we used bivariate correlations; thus the directionality and temporal sequencing of variables is unknown. We were also not able to examine associations between variables while controlling for others. Further, data were self-report, which introduces potential issues with recall bias and social desirability. Future research that is prospective, longitudinal, and multiformat is thus needed. There are also other likely important correlates (e.g., alcohol use, positive coping) and contexts (partner/family dynamics) of IPA among indigenous female caregivers that we did not measure that should be included in future research. Further, we did not assess motives for women's use of ADP, which may have included self-defense. Finally, we assessed IPA during the past 6 months rather than longer periods of

time and thus do not have a more complete understanding of female caregivers' experiences with IPA over the life course.

Implications

Notwithstanding limitations, these data have critically important implications for practice and policy. First, these data highlight the need for initiatives that enhance indigenous cultural identity and social support among indigenous caregivers to reduce the risk for IPA. These types of efforts may also reduce harsh parenting and maternal depression, which may ultimately help to break the intergenerational transmission of ACE. Indeed, there is a growing focus in the prevention and intervention science literature on the importance of culturally grounded initiatives for indigenous populations (Bassett et al., 2012; Brown et al., 2016; Whitesell, 2017). Most of this work, however, has focused on suicide prevention and substance abuse prevention. Far less research has focused on the prevention of IPA and abuse of children and other ACEs. Initiatives—such as family-based, strengths-focused, culturally grounded programs—are needed that seek to revitalize language, traditional practices and belief systems, and active reciprocal kinship with one's tribal community and homelands (Hawk Wing, 2022; Iron Cloud Two Dogs, 2022; Marshall, 2002). Efforts that target lower income indigenous women caregivers and younger indigenous women caregivers may be especially needed given the inverse associations between IPA and age and IPA and income although all indigenous relatives should be provided access to such interventions. These interventions should be Indigenous-led (Brown & Strega, 2005; Olson-Pitawanakwat & Baskin, 2021) and available to indigenous peoples both on reservations and in urban settings; urban indigenous peoples often report the greatest disconnect from their Native cultures (Haozous et al., 2021). While efforts targeting indigenous people are critically important, so too are macro-level interventions that dismantle systems of oppression (e.g., structural racism, structural poverty). By doing so, we likely will see reductions in IPA among indigenous populations.

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Biographies

Katie M. Edwards, is an Associate Professor at the University of Nebraska—Lincoln where she directs the Interpersonal Violence Research Laboratory. Using community-based participatory action research, Dr. Edwards seeks to answer two questions in her work: (1) How do we prevent sexual and related forms of violence? and (2) How do we most effectively support survivors in the aftermath of violent victimization? Much of Dr. Edwards work focuses on minoritized populations, specifically Native American/Indigenous youth and families as well as LGBTQ2S+ youth and emerging adults.

Emily A. Waterman is a faculty at Bennington College. Her work focuses on developmental approahces to violence prevention and response. She has published multiple papers on these topics and has secured funding for her research from diverse sources.

Natira Mullet, is an Assistant Professor in Human Development and Family Science at North Dakota State University. Her research focuses on examining community-based programming which promotes intergenerational cultural and familial protective factors to reduce interpersonal trauma and resulting substance use and mental health outcomes among minoritized populations.

Ramona Herrington is an enrolled member of the Oglala Sioux Tribe. She is a cultural outreach manager at the University of Nebraska-Lincoln. Mona is deeply committed to reserach, programming, and advocacy efforts that use cultural teachings and empowerment to support Indigeneous children and their families.

Skyler Hopfauf is a graduate student at the University of South Dakota working on her Master's in Public Health. She is currently a Project Manager at the Nebraska Center for Research on Children, Youth, Families, and Schools at the University of Nebraska-Lincoln. Her work uses an array of research methods including longitudinal surveys, photovoice, and qualitative interviews for sexual and domestic violence prevention and response efforts.

Preciouse Trujillo is an enrolled member of the Rosebud Sioux Tribe. She is a senior community liason at the University of Nebraska-Lincoln. She is passionate about work that helps Indigeneous children.

Naomi Even-Aberle, is the Executive Director for Full Circle Martial Arts Academy and an Assistant Project Coordinator at the University of Nebraska-Lincoln. Naomi Even-Aberle is an artist and educator who uses visual art, digital technology, and culturally grounded pedagogical practices to establish learning strategies for the body, mind, and spirit. Naomi specializes in providing inclusive movement practices, healing art processing, and working collaboratively toward community health.

Lorey A. Wheeler is an Associate Research Professor in the Nebraska Center for Research on Children, Youth, Families and Schools and the Co-Director of the Nebraska Academy for Methodology, Analytics and Psychometrics at the University of Nebraska–Lincoln. Her major research interests include the role of family and cultural contexts in development, including psychosocial adjustment, interpersonal relationships, and educational and occupational attainment among minoritized and understudied populations.

Sloane Corneluis is an enrolled member of the Oglala Sioux Tribe and employed at the University of Nebraska-Lincoln. Sloane's professional interest center around Indigeneous health and well-being. Sloane endeavors to make positive research contributions to the field, to Native communities, and to global indigenous communities by creating improved culturally-relevant modalities and by providing direct clinical services to Native peoples

Arielle R. Deutsch is a research Scientist at Avera Health. Her program of research focuses on deepening our knowledge of the external contexts and underlying mechanisms that drive health, health behavior, and health equity in translatable ways, particularly in the areas of substance use, intimate partner violence, and reproductive health. She has published on these topics and has federal funding supporting this work.

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Table 1.

Past 6 Months Incidence Rates of Intimate Partner Violence.

IPV Type	IPA Victimization (IPAV)	Abuse Directed at Partner (ADP)
Any/Overall	63.0% (*n* = 29)	54.3% (*n* = 25)
Psychological	63.0% (*n* = 29)	54.3% (*n* = 25)
Physical	26.1% (*n* = 12)	17.4% (*n* = 8)
Sexual	17.4% (*n* = 8)	6.5% (*n* = 3)

IPA = intimate partner abuse; IPV = Intimate Partner Violence.

Table 2.

Correlations Among Study Variables.

Variable	*M*, (*SD*) or %	1	2	3	4	5	6	7	8	9
1. IPAV	63.0%	—	**.745****	**−.378***	**−.303***	**.390****	**.339***	**.385****	**−.296***	*−.282*$^{+}$
2. ADP	54.3%		—	**−.314***	**−.371***	*.263*$^{+}$	**.333***	**.354***	−.131	−.173
3. Age	38.80 (9.14)			—	**.411****	−.219	−.220	*−.276*$^{+}$	*.281*$^{+}$	*.288*$^{+}$
4. Income	2.44 (1.84)				—	−.012	−.028	−.172	.130	.186
5. ACEs	12.64 (8.81)					—	.094	.235	−.231	−.206
6. Harsh parenting	0.61 (0.49)						—	.247	.020	−.187
7. Depressive symptoms	14.89 (4.54)							—	*−.274*$^{+}$	**−.380****
8. Connection to culture	2.36 (0.45)								—	.038
9. Social support	2.99 (1.07)									—

Note. IPV was past 6 months. IPA = intimate partner abuse; IPV = Intimate Partner Violence; ADP = abuse directed at one's partner; ACEs = adverse childhood experiences.

$^{***}p < .001$,

$^{**}p < .01$,

$^{*}p < .05$,

$^{+}p < .10$.