THE BIGGER PICTURE: THE EFFECTS OF INTIMATE PARTNER VIOLENCE ON ABORIGINAL WOMEN'S MENTAL HEALTH

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ABSTRACT

Aboriginal women's accounts of intimate partner violence are much more severe and frequent. This, along with the many other challenges Aboriginal women face (such as poverty, discrimination, a lack of resources and accessibility), cause the experiences of violence to be magnified. This is clearly demonstrated in the high rates of mental health problems for Aboriginal women. This paper outlines how all of these factors connect, and encourages researchers and health professionals to adopt more holistic approaches to mental health.

Keywords: Aboriginal women; intimate partner violence; family violence; mental health; well-being

While intimate partner violence is not unique to Aboriginal[1] peoples, some of the root causes and experiences are (Royal Commission on Aboriginal People, 1996). The purpose of this paper is to explore the experiences of Aboriginal women, focus on intimate partner violence, discuss the associated mental health effects of these experiences, and highlight the need for a holistic approach to mental health.

This paper is a first step to demonstrate the interconnectedness of experiences of violence and oppression on mental health. Research has demonstrated that Aboriginal women experience higher rates of intimate partner violence (Brownridge, 2003), but the factors that often contribute to violence (such as poverty, substance abuse, etc.), are often considered in isolation from each other. While it is impossible to undergo an investigation of all connecting factors, several factors seem to be more prominent than others — this paper highlights some of these. Researchers and clinicians should use this to better understand such experiences, and refer to the literature cited within this paper for a more in-depth understanding of such relationships.

INTIMATE PARTNER VIOLENCE

According to the Centres for Disease Control and Prevention (2009, n.p.), intimate partner violence can include

> physical, sexual, or psychological harm by a current or former partner or spouse. This type of vio-

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1 Aboriginal is a term used to describe First Nation, Métis, and Inuit peoples. Many studies do not identify a specific population of target and use the blanket term of Aboriginal, thus the same approach necessarily had to be taken for this paper. It is important to note that individuals of Métis and Inuit heritage do not traditionally live on reserves, and are often governed by a different set of rules than individuals who identify as First Nations (Wotherspoon and Satzewich, 2000). Moreover, very often bands will only allow status Indians to live on the reserve and have access to the services and "benefits" of status Indians.

lence can occur among heterosexual or same-sex couples and does not require sexual intimacy.[2]

Furthermore, they state that intimate partner violence

> can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering. (Centres for Disease Control and Prevention, 2009, n.p.)[3]

In many Aboriginal communities, the rates of intimate partner violence are extremely high. According to Statistics Canada (2006), Aboriginal women are three times more likely to report spousal abuse than non-Aboriginal women.[4] The Ontario Native Women's Association (1989) and LaRocque (1994) suggest that this does not reflect a higher rate of reporting but a higher rate of incidence of violence. Moreover, the National Association of Friendship Centres (2010) suggests that the high rate of reporting may be due to increased severity of the violence, as it is more severe violence that is likely to be reported (Johnson, 2008). Considering there are many more barriers to reporting intimate partner violence for Aboriginal women living on reserves (LaRocque, 1994; Ontario Native Women's Association, 1989), it is likely that fewer women are able to report incidences of violence than those who are living in urban areas or who are less impoverished. For example, fewer families have access to telephones, the Internet, or the ability to leave the community (Assembly of First Nations, 2007; Ontario Native Women's Association, 1989). Factors such

as shame, fear, loss of privacy, concern over family break-up, threats, and being unaware of available services influence the rates of reporting violence[5] (Ontario Native Women's Association, 1989). Thus it is likely that there are many Aboriginal women who cannot or choose not to report such violence.

Studies show that Aboriginal women are more likely to experience more severe forms of violence than non-Aboriginal Canadian women (National Association of Friendship Centres, 2010; Statistics Canada, 2006). For example, in 2004, of those who reported experiencing intimate partner violence, 54% of Aboriginal women reported being beaten, choked, sexually assaulted, threatened, or having a gun or knife used against them. In comparison, 37% of non-Aboriginal women reported the same levels of violence (Statistics Canada, 2006). According to the Canadian Centre for Justice Statistics (2001), between 1991–1999, spouses were responsible for killing 62 Aboriginal women and 32 Aboriginal men. These rates are significantly higher than for non-Aboriginal Canadians (8 times higher for Aboriginal women than non-Aboriginal women, and 18 times higher for Aboriginal men than non-Aboriginal men; Canadian Centre for Justice Statistics, 2001).

Abuse is not always physical. It may include sexual and/or emotional abuse, or a combination of the different types. Many women report control and isolation as parts of their experience (McGillivray and Comaskey, 1999). They describe being isolated from friends and family, threatened with abuse and having their children taken away (something that happens quite frequently in Aboriginal communities; Blackstock and Trocmé, 2004), and not having financial control (McGillivray and Comaskey, 1999).

EFFECTS OF INTIMATE PARTNER VIOLENCE ON MENTAL HEALTH

While experiences of physical and sexual violence can be extremely painful, some may argue that the psychological impacts of abuse are often the worst. According to Statistics Canada (2006), rates of psych-

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2   While most intimate partners are sexually intimate, not all are. If intimate partners are not sexually intimate, this does not deny the possibility that they may be experiencing intimate partner violence.

3   Many studies use the term domestic violence when they are referring to partner abuse, and specifically to cohabiting intimate partners (and therefore domestic partners). I will solely use the term intimate partner violence when discussing this type of violence, as well as intimate partner violence occurring in noncohabiting relationships. Only studies that provide similar definitions of domestic violence as the definition of intimate partner violence provided by the Centres for Disease Control and Prevention (2009) will be used, to ensure that the same type of violence is being referred to throughout the study. I chose not to use the term domestic violence because it excludes noncohabiting partners and can refer to violence occurring in a domestic environment that is not between intimate partners (e.g., parent-child violence).

4   Of course there is much variation within different groups of non-Aboriginal women, and I am not assuming homogeneity across the two groups; however, for the purposes of this paper, comparisons will be drawn between Aboriginal and non-Aboriginal groups.

5   This is not to say that these factors exist solely in Aboriginal populations — such allegations would be false. However, according to LaRocque (1994) and other experts, they are much more prevalent in Aboriginal populations due to historical and cultural dynamics, making such reasons for low-report rates more prominent.

ological abuse are also higher for Aboriginal women, including increased jealousy, put-downs and name calling, preventing access to income, damaging property, and harming or threatening to harm someone close to the woman. In her discussion of violence in Inuit communities, Louise Mallioux states:

> Few people who have not experienced violence can understand the pain of being slapped, punched, kicked, burned, shoved, bitten, physically or sexually assaulted, forced to surrender a pay, pension or welfare cheque, threatened with a razor, a knife, a rifle and having no one to turn to because of the shame, the degradation, the hopelessness and the isolation. People who have not experienced violence cannot really fathom the emotional pain of being routinely insulted, screamed at or called a bitch, slut, useless piece of meat and worse. Yet, this is the reality for many women.... The cost of violence is felt primarily by the recipient of that violence, the person at the big end of the stick, the person lying on the floor pleading or flying against the wall. It is not possible to put a price on that pain, the mental exhaustion, the crushed spirit, the loss of self-esteem, the dreams that can't be dreamed anymore, or the nightmares you can't wake up from. (in Lane et al., 2003, p. 36)

Intimate partner violence has been associated with mental health problems, including depression, anxiety (Campbell, 2002; Lafta, 2008; World Health Organization [WHO], 2008), phobias (Lafta, 2008; WHO, 2008), panic disorders (Lafta, 2008), post-traumatic stress disorder (Campbell, 2002; Lafta, 2008; WHO, 2008), self-harm and suicidality (Lafta, 2008; WHO, 2008), poor self-esteem (Lafta, 2008), eating and sleep disorders (Campbell, 2002; Lafta, 2008), and alcohol and drug abuse (Campbell, 2002; Lafta, 2008; WHO, 2008). Moreover, Johnson and Leone (2005) explain that women who experience severe and persistent violence are more likely to abuse alcohol and drugs, and to experience symptoms of post-traumatic stress disorder (PTSD).

Unfortunately, mental illness has also been associated with increased rates of intimate partner violence. In a meta-analysis conducted by Trevillion and colleagues (2012), it was found that women experiencing depressive disorders (Odds Ratio [OR] 2.8), anxiety disorders (OR 4.1) and PTSD (OR 7.3) were more likely to experience partner violence.

Such findings have been asserted by others as well (Friedman and Loue, 2007). This is not a unidirectional occurrence.

OTHER FACTORS TO CONSIDER

In the discussion of Aboriginal women's experiences of intimate partner violence, it is necessary to consider other circumstances that may shape their lives.

POVERTY

Aboriginal individuals, whether they are living in an isolated community (such as a reserve) or in more urban areas, experience disproportionate rates of poverty (Assembly of First Nations, nd; Cazabon, 2010; Government of Canada, 2008; McGillivray and Comaskey, 1999; Ontario Federation of Indian Centres, 2000). For example, in an urban Aboriginal peoples' study conducted within different cities in Ontario, it was found that 47.2% of the Ontario Aboriginal population receives less than $10,000 per year, and that rates of poverty are increasing (Ontario Federation of Indian Friendship Centres, 2000). Research supports a strong and positive correlation between poverty and intimate partner violence (Bassuk et al., 2006; Goodman et al., 2009). Thus, it is likely that poverty and intimate partner violence are not occurring in isolation.

Poverty and mental illness have their own complex relationship as well. According to Raphael (2007), poverty, and the social and material deficiencies associated with it, is a primary cause of poor health among Canadians. For example, poverty is a correlate of psychological distress and diagnosable mental disorder (Belle, 1990). Psychopathology has been found to be at least 2.5 times more prevalent in the lowest social class than in the highest (Belle, 1990). Poverty in women has been associated with depression (Belle, 1990), schizophrenia, schizoaffective disorder, bipolar disorder, anxiety disorders, some personality disorders (Groh, 2007), and drug and alcohol abuse (Murali and Oyebode, 2004). Poverty can lead to stress due to difficulty or inability to meet basic costs, including food, housing, health care, often having to live in dangerous or violent conditions, and family disruption (Murali and Oyebode, 2004). This information is correlational in nature, and therefore causality cannot be assumed;

however this demonstrates the complexity of these associations.

Health and Health Care

Aboriginal individuals lack access to many of the health resources that their Canadian counterparts generally have (Assembly of First Nations, 2007; Cazabon, 2010; Health Canada, 2010). For example, Aboriginal peoples experience high rates of heart disease, increasing rates of lung cancer, poor prenatal care, and food insecurity (Reading and Wien, 2009). Only 40% (versus 61% of Canadian[6] respondents) of First Nations individuals surveyed self-reported having "excellent" or "very good" perceived health, while 27% (versus 12% of Canadian respondents) reported "fair" or "poor" perceived health (National Aboriginal Health Organization [NAHO], 2003).

While Canada is thought by some to have an advanced health care system, one must have access to reap its benefits. Significantly fewer Aboriginal individuals living off reserve have a regular physician, while almost 20% of on-reserve Aboriginal individuals mentioned that there was no doctor or nurse in their area (Reading and Wien, 2009). According to the National Aboriginal Health Organization's 2002 poll (2003), First Nations individuals reported having "very" or "somewhat" difficult access to midwives (59% of respondents), obstetricians/gynecologists (52%), mental health workers (45%), pediatricians (43%), eye doctors (37%), family doctors (33%) and more. Being unable to afford transportation to seek services or unable to afford the service needed were also barriers to accessing health care services for these individuals.

Women who have experienced violence are more likely to contract sexually transmitted infections and other gynaecological problems, and report their health as fair or poor (Plictha, 1996). They have twice the number of days in bed due to illness as other women (Gelles and Straus, 1990), and are six to eight times more likely to use health services (Rath et al., 1989). When health services are unavailable or inadequate, as is the case for many Aboriginal women, these health needs remain unmet. Women who have experienced intimate part-

ner violence are also likely to have increased rates of disability preventing work, arthritis, chronic pain, sexually transmitted infections, chronic pelvic pain, stomach ulcers, spastic colon, digestion concerns, hearing loss, angina and other heart or circulatory concerns, and kidney infections (Coker et al., 2000).

Physical illness is associated with the development and maintenance of mental illness. Physical illness often leads to increases in emotional stress and chronic pain, both of which are associated with depression and anxiety (Canadian Mental Health Association, 2008). Serious mental illness can increase rates of poverty and homelessness, thereby increasing barriers to accessing necessary health care. These factors can, directly and indirectly, increase stress levels and affect mental health (Canadian Mental Health Association, 2008). Diabetes, heart disease, cancer, arthritis, and asthma have all been linked to increases in mental illness (Canadian Mental Health Association, 2008).

Aboriginal women experience elevated rates of health problems, lower perceived overall health, and less access to health care, all of which can contribute to mental health concerns. Elevated rates and more severe violence can affect one's physical health, magnifying this experience.

Organizational and Systemic Effects

There are also larger scale discrepancies between how Aboriginal peoples and non-Aboriginal individuals are treated by institutions and organizations within Canada.

For example, the education system offered to many Aboriginal peoples often disregards traditional teachings and many communities are without secondary education (Reading and Wien, 2009). Even when actual institutions are in place, they lack the funding to provide adequate education to their students. Community infrastructure is often quite poor, and access to individuals who can develop and implement programming is virtually nonexistent. When communities experience fragmented and underfunded programs, with bureaucracy ever increasing and autonomous power generally decreasing, it can lead to an increase in community-level stress (Reading and Wien, 2009). Aboriginal peoples are generally treated unfairly by police (McGillivray

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6   Individuals living on reserves and other Aboriginal settlements in the provinces (among other special groups) were excluded from this survey (Statistics Canada, 2002).

and Comaskey, 1999; Native Women's Association of Canada, 1994), the courts (Department of Justice Canada, 2011; Green, 1998; McGillivray and Comaskey, 1999) and the Canadian government in general (Amnesty International, 2004; Assembly of First Nations, 2007; McGillivray and Comaskey, 1999).

Systemic discrimination occurs when policies, procedures, or laws disadvantage a specific group or limit their rights (Social Health Reference Group, 2004). Such forms of discrimination can create feelings of being an outsider within one's community, not having access to many of the same or same quality resources as others (especially those from a more dominant culture), and institutional inequity, amongst other things (Assembly of First Nations, 2007; Kafele, 2004).

Kafele (2004) explains that racialized groups who experience discrimination often have higher incidence rates of anxiety, stress, depression and suicide, feelings of helplessness, hopelessness, fear, mistrust, despair, alienation, loss of control, damaged self-esteem, addiction, and violence. A study exploring mental health in another minority group demonstrated that not having the same rights as others led to increases in any mood disorder, generalized anxiety disorder, alcohol use disorders, and comorbidity (Hatzenbuehler et al., 2010). The study explored the ban of marriage amongst individuals within the gay, lesbian, and bisexual communities. Marriage for Aboriginal peoples is not illegal, but in the past, First Nations women who married a non-First Nations man lost their status, as did their children (Bourassa and Peach, 2009). Status can still be lost through marriage, although this occurs over a couple of generations (Bourassa and Peach, 2009). The past and current laws of status and marriage contribute to an overall goal of eradicating Aboriginal identity by discouraging marriage, in a similar manner to the gay community. The gay community's experience of marriage is both different from, and similar to, the First Nations experience. Experiences of racism are positively correlated with obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, and somatisation[7] (Landrine and Klonoff, 1996).

Archibald (2006) argues that the historical process of colonization may still be having traumatic effects on individuals. She quotes Wesley-Esquimaux and Smolewski (2004, p. iv, in Archibald, 2006, p. 25) in her argument that

> hidden collective trauma, or a collective non-remembering, is passed from generation to generation, as are the maladaptive social and behavioural patterns that are symptoms of many social disorders caused by historic trauma.

While some may argue that the process of colonization should no longer be considered in the current evaluation of Aboriginal people's health and well-being,[8] many argue that it still plays a significant role. Brownridge (2003, p. 81) argues that

> in demonstrating that several important risk markers of violence do not account for the significantly higher prevalence of violence against Aboriginal women, the results indirectly lend empirical support to the theory that the unique experience of colonization of Aboriginals in Canada plays a large role in their disproportionate likelihood of violence against women.

Archibald (2006) draws helpful parallels between healing from post-traumatic stress and from historic trauma, and the role that decolonization can play within this.

The Bigger Picture

The issue and the experience of intimate partner violence cannot be discussed in isolation, as this does not provide an accurate picture of the situation (Oetzel and Duran, 2004; see Alani, 2010 for a more detailed discussion).

When all of these circumstances are considered, a clear understanding of the experience can be better achieved. Few studies have aimed to understand the complex relationship between life circumstances and intimate partner violence, however. As Goodman and colleagues (2009) explain, the negative effects of such circumstances "including stress, powerlessness, and social isolation — magnify each other" (p. 311). In this paper they only talk about the effects of intimate partner violence and poverty, but they mention that "when still other aspects of

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7   Recurrent medical symptoms without a discernible cause.

8   A perspective generally found more frequently in popular media.

women's identities (e.g., race, immigration status, or sexual orientation) are marginalized, the experience may be still more harmful" (p. 311). Thus, it should come as no surprise that the well-being of many Aboriginal women is compromised in comparison to women who belong to more dominant and mainstream identities, who are living in better conditions with more access to resources and less discrimination. There are often thoughts of "having no option" (Goodman et al., 2009, p. 312) and subsequently feeling powerless.

Aboriginal Women's Mental Health

This is reflected in the mental health status of many Aboriginal women. Aboriginal women report higher levels of mental health problems than Aboriginal men (Grace, 2003). Rates of suicidality are consistently higher for Aboriginal populations than for the Canadian population as a whole, with ranges between 3.6–7.5 times the rate of the Canadian population depending on age (Grace, 2003). Aboriginal women also attempt suicide more frequently than Aboriginal men (as is the case for the rest of the Canadian population), and suicide clusters pose a special problem in Aboriginal communities (Grace, 2003). Depressive symptomatology is a concern, with 9.8% of First Nations women reporting that "everything was an effort" all or most of the time (Grace, 2003). Another study noted that 18.2% of First Nation women in Ontario experienced depression, compared to 9.2% of the women included in the National Public Health Survey of Ontario (MacMillan et al., 2007). The most frequent cause of death among registered Aboriginal women is alcoholism/cirrhosis (at 29.8 per 100,000 people; Grace, 2003). First Nations women are more likely to drink heavily than non-Aboriginal women (Grace, 2003), while non-Aboriginal women drink more frequently (Grace, 2003; MacMillan et al., 2007). Drug use is frequent in First Nations populations, with 14% of women reporting having used marijuana, cocaine, LSD, glue, or gasoline in the previous month (Grace, 2003). The use of solvents is an increasing concern in Aboriginal populations (Grace, 2003). First Nations women are more likely to feel severe distress to the point where it interferes with their life (MacMillan et al., 2007).

Discussion and Conclusions

It is clear that the more constrained and severe life experiences of Aboriginal women magnify the effects of intimate partner violence. Mental health problems are more common and apparently more severe for Aboriginal women, a result of the high rates and extreme forms of intimate partner violence interacting with other forms of discrimination and injustice. Wheeler (2007, in Green, 2010, p. 798) suggests that

> an individual's vulnerability to trauma depends on the developmental stage, genetic vulnerability, gender, past experiences, pre-existing neural physiology, cognitive deficits, emotional maturity, coping skills, relationship with others, along with other sociocultural factors. If trauma is particularly prolonged and severe, pervasive mental and emotional problems can develop.

This seems to be the case for Aboriginal women experiencing intimate partner violence The mental health situation of Aboriginal women demonstrates how all these life circumstances contribute to these high rates.

To adequately address the problem of high rates of mental disorders within Aboriginal communities, the issue of intimate partner violence must be discussed. However, women's experiences of violence cannot be understood without comprehensively considering the rest of their environments and circumstances. While many women may experience mental health problems due to violence, violence against Aboriginal women is often more severe, and their life circumstances often offer fewer options and opportunities for solace, guidance, and escape (Alani, 2010).

Researchers and health practitioners should no longer look at one situation independently (e.g., intimate partner violence), without consideration of the holistic, layered, and complex life situation of Aboriginal women — not only is it ineffective, but it may also be unethical (McCabe, 2007). Aboriginal women often feel a lack of sensitivity from health care providers (Ontario Native Women's Association, 1989), and much of this may come from their lack of concern for the other areas and

experiences of Aboriginal women's lives. It has been suggested that in order to heal, Aboriginal women reclaim their womanhood (Anderson, 2001), while Archibald (2006, p. 26) advocates for a process of decolonization, which includes rediscovery and recovery of Indigenous history and culture, mourning, dreaming, commitment, and action.

In terms of mental health problems and the issue of intimate partner violence within Aboriginal populations, holistic approaches, patience, and an understanding of life circumstances may be the best approaches. Not addressing the interconnectedness of experiences may be perceived as another process of colonization and cause additional harm to individuals (McCabe, 2007). The process of holistic healing must be in line with the client's needs and beliefs, and must include the diversity of experiences women have in their lives while celebrating their womanhood, traditions, and culture (Anderson, 2001; Hays 2000, McCabe, 2007).

References

Alani, T. (2010). Behind closed doors: Aboriginal women's experiences of intimate partner violence. Unpublished thesis. Halifax, NS: Dalhousie University.

Amnesty International. (2004). *Canada. Stolen Sisters: A Human Rights Response to Discrimination and Violence Against Indigenous Women in Canada.* Ottawa: Amnesty International Canada.

Anderson, K. (2001). *A Recognition of Being: Reconstructing Native Womanhood.* Toronto: Sumach Press.

Archibald, L. (2006). *Decolonization and Healing: Indigenous Experiences in the United States, New Zealand, Australia and Greenland.* Ottawa: Aboriginal Healing Foundation.

Assembly of First Nations. (2007). *RHS: Our Voice, Our Survey, Our Reality.* Ottawa: Assembly of First Nations.

Assembly of First Nations. (n.d.). *Fact Sheet: The Reality for First Nations in Canada.* Retrieved 28 June 2010, from http://www.afn.ca/article.asp?id=764#_edn9.

Bassuk, E., Dawson, R., and Huntington, N. (2006). Intimate partner violence in extremely poor women: Longitudinal patterns and risk. *Journal of Family Violence, 21,* 387–399.

Belle, D. (1990). Poverty and women's mental health. *American Psychologist, 45,* 385–389.

Blackstock, C. and Trocmé, N. (2004). Community based child welfare for Aboriginal children: Supporting resilience through structural change. In M. Ungar, ed., *Pathways to Resilience: A Handbook of Theory, Methods and Interventions.* Thousand Oaks, CA: Sage.

Bourassa, C. and Peach, I. (2009). *Reconceiving Notions of Aboriginal Identity.* Ottawa: Institute on Governance.

Brownridge, D. (2003). Male partner violence against Aboriginal women: An empirical analysis. *Journal of Interpersonal Violence, 18*(65), 65-83. doi: 10.1177/0886260502238541

Campbell, J.C. (2002). Health consequences of intimate partner violence. *The Lancet, 359,* 1331–1336.

Canadian Centre for Justice Statistics. (2001). *Family Violence in Canada: A Statistical Profile 2001.* Ottawa: Statistics Canada. Retrieved 4 August 2010, from http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/fv-85-224-x2000010-eng.pdf.

Canadian Mental Health Association. (2008). *The Relationship between Mental Health, Mental Illness and Chronic Physical Conditions.* Retrieved 19 March 2013, from http://www.ontario.cmha.ca/backgrounders.asp?cID=25922

Cazabon, A. (Producer). (2010). *Third World Canada* [Motion Picture/Documentary]. (Available from Productions Cazabon).

Centres for Disease Control and Prevention. (2009). *Intimate Partner Violence: Definitions.* Retrieved 11 June 2010 from http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/definitions.html.

Coker, A.L., Smith, P.H., Bethea, L., King, M.R., and McKeown, R.E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9,* 451–457.

Department of Justice Canada. (2011). *A Review of Research on Criminal Victimization and First Nations, Métis and Inuit Peoples 1990–2001.* Retrieved 3 June 2012,

from http://www.justice.gc.ca/eng/pi/rs/rep-rap/2006/rr06_vic1/p9b.html.

Friedman, S.H. and Loue S. (2007). Incidence and prevalence of intimate partner violence by and against women with severe mental illness. *Journal of Women's Health, 16*(4), 471–480. doi: 10.1089/jwh.2006.0115

Gelles, R.J. and Straus, M.A. (1990). The medical and psychological costs of family violence. In M. Straus and R.J. Gelles, eds., *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families.* New Brunswick, NJ: Transaction.

Goodman, L.A., Smyth, K.F., Borges, A.M., and Singer, R. (2009). When crises collide: How intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma, Violence, and Abuse, 10*(4), 306–329.

Government of Canada. (2008). Aboriginal women and family violence. Ottawa: Public Health Agency of Canada.

Grace, S.L. (2003). A review of Aboriginal women's physical and mental health status in Ontario. Retrieved 16 July 2011, from http://pi.library.yorku.ca/dspace-jspui/bitstream/10315/2552/1/A%20Review%20of%20Aboriginal%20Women's%20Physical%20and%20Mental%20Health%20Stauts%20in%20Ontario.pdf.

Green, B.L. (2010). Applying interdisciplinary theory in the care of Aboriginal women's mental health. *Journal of Psychiatric Mental Health Nursing, 17*(9), 797–803.

Green, R.G. (1998). *Justice in Aboriginal Communities: Sentencing Alternatives.* Saskatoon, SK: Purich Publishing.

Groh, C.J. (2007). Poverty, mental health, and women: Implications for psychiatric nurses in primary care settings. *Journal of the American Psychiatric Nurses Association, 13*(5), 267–274. doi: 10.1177/1078390307308310.

Hatzenbuehler, M.L., McLaughlin, K.A., Keyes, K.M., and Hasin, D.S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health, 100*(3), 452–459. doi: 10.2105/AJPH.2009.168815

Hays, P.A. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*(4), 354–360. doi: 10.1057/a0016250

Health Canada. (2010). *Drinking Water and Wastewater: First Nations, Inuit and Aboriginal Health.* Retrieved 1 June 2010, from http://www.hc-sc.gc.ca/fniah-spnia/promotion/public-publique/water-eau-eng.php#how_many.

Johnson, M.P. (2008). *A Typology of Domestic Violence.* Boston: Northeastern University Press.

Johnson, M.P. and Leone, J.M. (2005). The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence Against Women Survey. *Journal of Family Issues, 26*(3), 322–349.

Kafele, K. (2004). Racial discrimination and mental health: Racialized and aboriginal communities. *Ontario Human Rights Commission.* Retrieved 2 June 2012, from http://www.ohrc.on.ca/en/racial-discrimination-and-mental-health-racialized-and-aboriginal-communities

Landrine, H. and Klonoff, E.A. (1996). The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences. *Journal of Black Psychology, 22*(2), 144–169.

Lafta, R.K. (2008). Intimate partner violence and women's health. *The Lancet, 371*, 1140–1142.

Lane, P., Bopp, J., and Bopp, M. (2003). *Aboriginal Domestic Violence in Canada.* Ottawa: Aboriginal Healing Foundation.

LaRocque, E.D. (1994). *Violence in Aboriginal Communities.* Ottawa: Health Canada.

MacMillan, H.L., Jamieson, E., Walsh, C.A., Wong, M.Y.Y., Faries, E.J., McCue, H..., Technical Advisory Committee of the Chiefs of Ontario. (2008). First Nations women's mental health: Results from an Ontario survey. *Archives of Women's Mental Health, 11*, 109–115.

McCabe, G.H. (2007). The healing path: A culture and community-derived indigenous therapy model. *Psychotherapy: Theory Research, Practice, Training, 44*(2), 148–160. doi: 10.1037/0033-3204.44.2.148

McGillivray, A. and Comaskey, B. (1999). *Black Eyes All of the Time: Intimate Violence, Aboriginal Women, and the Justice System.* Toronto: University of Toronto Press.

Murali, V. and Oyebode, F. (2004). Poverty, social inequality and mental health. *Advances in Psychiatric Treatment, 10*, 216–224. doi: 10.1192/apt.10.3.216

National Aboriginal Health Organization. (2003). *What First Nations People Think about their Health and Health Care: National Aboriginal Health Organization's Public Opinion Poll on Aboriginal Health and Health Care in Canada. Summary of Findings.* Ottawa: NAHO.

National Association of Friendship Centres. (2010). *Ending Violence Against Aboriginal Women & Girls.* Retrieved 21 November 2010, from http://www.nafc.ca/docs/NAFC%20Violence%20against%20Aboriginal%20Women%20Policy%20Position%20Paper.pdf.

Native Women's Association of Canada. (1994). *Aboriginal Women: Police Charging Policies & Domestic Violence.* Ottawa: NWAC.

Oetzel, J. and Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: A social ecological framework of determinants and interventions. *American Indian and Alaska Native Mental Health Research, 11*(3), 49–68.

Ontario Federation of Indian Friendship Centres. (2000). *Urban Aboriginal Child Poverty: A Status Report on Aboriginal Children and their Families in Ontario.* Toronto: OFIFC.

Ontario Native Women's Association. (1989). *Breaking Free: A Proposal for Change to Aboriginal Family Violence.* Ontario: ONWA.

Plichta, S.B. (1996). Violence, health and use of health services. In *Women's Health and Care Seeking Behaviour.* Baltimore, MD: John Hopkins University Press, pp. 231–270.

Raphael, D. (2007). *Poverty and Policy in Canada: Implications for Health and Quality of Life.* Toronto: Canadian Scholars' Press.

Rath, G.D., Jarratt, L.G., and Leonardson, G. (1989). Rates of domestic violence against adult women by men partners. *The Journal of the American Board of Family Practice, 2*(4), 227–233.

Reading, C.L. and Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health.* Prince George, BC: National Collaborating Centre for Aboriginal Health. Retrieved 30 May 2012, from www.nccah-ccnsa.ca/docs/.../NCCAH-loppie-Wien_report.pdf.

Royal Commission on Aboriginal Peoples. (1996). *Report of the Commission on Aboriginal Peoples, 1.* Retrieved 12 June 2010, from http://www.collectionscanada.gc.ca/webarchives/20071124130216/http://www.ainc-inac.gc.ca/ch/rcap/sg/sgm10_e.html.

Social Health Reference Group. (2004). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well-being 2004–2009.* Canberra, AU: Australian Department of Health and Ageing.

Statistics Canada. (2002). *Canadian Community Health Survey (CCHS).* Retrieved 19 March 2013 from http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SurvId=3226&SurvVer=0&InstaId=15282&InstaVer=1&SDDS=3226&db=imdb&dis=2

—— (2006). *Violence against Aboriginal Women.* Retrieved 29 November 2010 from http://www.statcan.gc.ca/pub/85-570-x/2006001/findings-resultats/4054081-eng.htm.

Trevillion, K., Oram, S., Feder, G., and Howard, L.M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS ONE, 7*(12). Retrieved 18 March 2013 from http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0051740

World Health Organization. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet, 371*, 1165–1172.

Wotherspoon, T. and Satzewich, V. (2000). *First Nations: Race, Class, & Gender Relations.* Saskatchewan: Canadian Plains Research Centre.

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