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Sexual Aggression Myth Acceptance, Victimization, and Identification: Implications for Tertiary Prevention

Erin E. Ayala and Jill E. DelTosta

Commercial Tobacco Use and Smoking Cessation for American Indian Communities

Alina Alomá, M.A., Ernesto N. Lira, B.A. and Marisela López, M.A.

Native Hawaiian/Pacific Islanders & American Indian/Alaska Natives: Common Barriers to Healthcare

Christopher T. Copeland and Julie Clark
Abstract

While the impact of rape myths in perpetuating rape culture continues to be explored and understood, little investigation has been conducted regarding how myths about sexually aggressive behavior, more broadly, affect women’s conceptualizations of sexual victimization (SV). Women ages 18 - 34 (N = 198) were assessed for de facto SV status and asked to report if they self-identified as ever having experienced forms of SV. Most women who met criteria for having experienced de facto SV “accurately” self-identified as victims. Surprisingly, sexual aggression myth acceptance was not significantly related to whether women conceptualized their experiences “accurately” as a form of victimization. Post-hoc analyses suggested that acceptance of myths about sexual aggression contributed to whether or not victims of de facto sexual coercion “accurately” identified as victims. Analyses further implied that the disparity between de facto and self-identified victims increased as the severity of victimization increased. Further investigation into if, and how, sexual aggression myth acceptance plays a role in women’s conceptualizations of victimization is necessary. Prevention efforts to dismantle rape culture will empower victims and society to revise and broaden conceptualizations of sexual behavior beyond rape to acknowledge that all sexual violence is victimizing, and therefore, not to be further tolerated. Further implications for prevention are discussed.

Main Report

Fisher, Daigle, and Cullen (2010) refer to rape as the “tip of the iceberg” that represents women’s unwanted sexual experiences (p. 85). While rape constitutes a severe form of aggression and victimization, “lesser” forms of unwanted sexual interactions are also victimizing to women (e.g., Koss & Oros, 1982), result in long-term detrimental effects (Black et al., 2011), and are cause for continued public outcry (Ullman, 2010). According to the Centers for Disease Control and Prevention (Black et al., 2011), women who are victims of acts such as rape, sexual coercion, unwanted sexual contact, and stalking are significantly more likely to experience poor mental and physical health. Symptoms include, but are not limited to, difficulty sleeping, activity limitations, chronic pain, and frequent headaches. Clearly, the sexual victimization of women remains a public health concern (Gavey, 2007).

Koss and Oros (1982) were among the first to recognize and define Sexual Victimization from a dimensional view, where rape is one extreme example of sexual aggression along a continuum. Sexual victimization (SV) represents a wider range of unwanted sexual experiences that are victimizing to women (i.e., rape, attempted rape, sexual coercion, unwanted sexual contact; Koss, Gidycz, & Wisniewski, 1987). SV can vary by type of contact, degree of coercion, and degree of action (Fisher et al., 2010). Researchers (e.g., Koss & Gidycz, 1985; Koss et al., 1987) simultaneously sought to investigate the incidence and prevalence of “hidden rape,” or victimization that did not constitute legal definitions of rape and had previously gone unheeded in research and society. Despite this attention to the
broader concept of SV, little research has been conducted on victimization other than rape. To best prevent the damaging effects of all forms of SV, it is imperative to continue to understand nuances of SV and the social context in which it occurs (Gavey, 2007).

Scholars describe a “rape culture” as an environment that supports beliefs conducive to the expectation, and acceptance, of sexually aggressive behavior toward women; these are environments where such behavior is ignored or justified (e.g., Edwards & Headrick, 2008). In other words, rape cultures normalize SV. Importantly, some sexually victimizing experiences may not be legally criminal offenses (Fisher et al., 2010). The criminal justice system is just one example of a societal institution within a rape culture, which can support the beliefs of the culture, and diminish the power of victims and victim advocates. Nuances among the range of sexually victimizing experiences may be particularly important to consider when understanding victims’ responses to SV because, within rape culture, some forms of sexual violence may not even be accepted as morally or legally reprehensible (Fisher et al., 2010).

A salient institution that perpetuates rape culture is the Sexual Aggression Myth. Sexual Aggression Myths (SAMs) are similar to Rape Myths, which are widely held (e.g., Gerger, Kley, Bohner, & Siebler, 2007), false, cultural beliefs about rape, rape victims, and perpetrators that effectively shift blame of rape from perpetrators to victims (e.g., Burnett et al., 2009; Burt, 1980). Ullman (2010) purports that rape myths can silence victims by expecting women to transform their ideas about what SV looks like to something other than sexual aggression. In essence, women learn that certain sexually aggressive behavior is normal and not to be discouraged in perpetrators. This ultimately creates one narrow model for what “legitimate” victimization looks like, while downplaying all other victimizing experiences. SAMs act in a similar manner, yet they refer to sexually aggressive behavior that lies outside of the limited scope of what a woman might experience during a rape.

Importantly, research continues to show that many rape victims do not identify as having been raped (e.g., Koss & Oros, 1982; Rozee & Koss, 2011). One study suggested that 50% or more women who met criteria for experiencing a rape did not label the experience as rape (Koss & Gidycz, 1985). More recent research seems to corroborate the idea that myths about what constitutes “legitimate” rape encourage victims to downplay the severity of sexually victimizing experiences (Fisher et al., 2010) and label SV as simply a “serious miscommunication” (Koss & Gidycz, 1985). Scholars have proposed that victims may not identify with having experienced SV because of fear of negative social reactions (Ullman, 2010), victim blame (e.g., Fisher et al., 2010; Katz, May, Sorensen, & DelTosta, 2010), and the desire to protect the reputation of a perpetrator (Peterson & Muehlenhard, 2004). Although some research has begun to show that women struggle to describe and identify victimizing experiences (e.g., Burnett et al., 2009), further quantitative research about responses to various forms of SV needs to be conducted to more fully investigate the role of myth acceptance in conceptualizations of victimization.

Ultimately, prevention of victimization is the most crucial goal. For many women, first experiences of SV occur between the ages of 18 and 34; those who have such experiences are more likely to face subsequent acts of victimization as young adults (Black et al., 2011; Katz et al., 2010). Beyond revictimization, prevention also circumvents the need to respond with family, peer, psychological, and medical support to heal and address the potential onslaught of health concerns that follow SV. In efforts to prevent future sexual victimization, scholars assert it is necessary to research rape culture as the societal foundation that perpetuates sexual aggression and to understand how victims come to conceptualize their experiences (e.g., Ullman, 2010).

Therefore, the first purpose of this study is to highlight and discuss the broader issues and implications for women who experience SV through the investigation of victimization that goes beyond rape. To do so, we will explore beliefs about sexual aggression beyond rape myths and how
they may influence victims’ conceptualizations of their experiences. The second purpose is to add to literature discussing prevention of SV by dismantling the societal context of rape culture. Specifically, this study seeks to explore the scholarly connections between rape culture and victim conceptualizations of SV by investigating the how and why relations among SV, sexual aggression myth acceptance, and self-identification as a victim. We will discuss the importance of empowering women to reject myths and identify as survivors, so they are no longer silenced by ineffective and inequitable societal norms and structures.

**Conceptualizations of Sexual Victimization**

As previously mentioned, not all individuals who experience sexual victimization are likely to identify as having had such experiences, meaning many of the incidents are never reported (Suarez & Gadalla, 2010). Research consistently suggests that the majority of women who have sexually victimizing experiences do not, in fact, report—or even acknowledge—their experiences as victimizing (e.g., Bondurant, 2001; Kahn, Mathie, & Torgler, 1994; Schwartz & Leggett, 1999). When speaking with women who do and do not label their experiences (e.g., as rape, as sexual coercion), findings suggest that women are least likely to report SV when the assailant was a boyfriend, when they were under the influence of alcohol or drugs, or when the victimization included oral sex (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). On the other hand, when women experienced sexual assault by an unknown perpetrator, especially in a forceful manner, women were more likely to label their experiences as rape.

**Rape Myths**

Stereotypical and pervasive depictions of rape typically include unknown perpetrators, the use of physical force or threat of force, vaginal penetration, and no reasonable accusation for blame toward the woman, amongst other situations (e.g., man jumping out of the bush). Given that the pervasiveness of rape myths might affect victims’ conceptualizations of their experiences, women are most likely to accurately identify rape when the circumstances of a particular incident match the rape myths of the culture (Koss et al., 1987; Peterson & Muehlenhard, 2004). In fact, Peterson and Muehlenhard (2004) found that unacknowledged rapes, versus acknowledged rapes, were less likely to fit the limited parameters of rape as defined by rape myths. It may be that as victimizing experiences become “less severe” and ascribe less rigidly to the standards of myths about sexual aggression, women are even more reticent to identify the event as SV of any kind.

**Myth Acceptance**

A meta-analysis of research conducted about acceptance of rape myths (RMA) confirmed behavioral (e.g., engaging in sexually aggressive behavior, engaging in sexually coercive behavior), attitudinal (e.g., acceptance of interpersonal violence, sexual conservatism, hostility towards women, prostitution myths), and demographic (e.g., masculine gender, elite athlete status, “playboy” status) characteristics related to RMA (Suarez & Gadalla, 2010). Because RMA consistently correlates with other, more general, beliefs about violence and attitudes about sociocultural factors (e.g., age, race; Suarez & Gadalla, 2010), and because of floor effects resulting in skewed data that do not effectively measure actual beliefs, Gerger and colleagues (2007) developed the Acceptance of Modern Myths About Sexual Aggression Scale (AMMSA). Just as rape myths influence the conceptualization of rape in society, myths about sexual aggression justify sexual aggression toward women (Gerger et al., 2007). Given the number of women who are affected by SV that does not fit within the confines of rape myths, the field must also understand how victims make sense of their experiences, particularly with regard to myths about sexual aggression.

Some research also suggests that victims of rape, (Parent, 2010) and those who personally know victims of rape (Talbot, Neill, & Rankin, 2010), are less accepting of rape myths. On the contrary, Gorbett (2006) found there was no significant relation between past victimization or knowing a victim and RMA. Gorbett (2006) explained this non-existent relation with the “Just World Phenomenon” where people attempt to make sense of negative experiences to protect their
sense of justice and security. An example of this would be to assert that the woman “must have done something to deserve” SV. Peterson and Muehlenhard (2004) also state that rape myths allow women to deny their personal vulnerabilities to rape (e.g., “I don’t sleep around, so I won’t get raped”). Within rape culture, where justification for SV is encouraged and limits are placed around what counts as rape (Peterson & Muehlenhard, 2004), blame is thus laid on the victim instead of a reaction that puts blame on the perpetrator (e.g., “How devastating that a person could commit SV against a woman”).

Many victims, therefore, do not label their experiences because of the narrow definitions of rape myths, allowing them to avoid the shame, blame, and helplessness associated with victim status (Peterson & Muehlenhard, 2004; Ullman, 2010). In fact, Bohner and Lampridis (2004) argue that acceptance of rape myths can actually act as a buffer against anxiety such that women can believe they were not raped, and therefore, protect their self-esteem. While the impact of RMA on labeling is inconclusive, myths do influence how people conceptualize what victimizing experiences should be; therefore, it is essential to consider how the endorsement of broader myths about sexual aggression impacts how women conceptualize victimizing experiences beyond rape. In other words, what happens to women’s conceptualizations of their experiences when rape culture does not acknowledge the experiences as wrong, victimizing, or unacceptable? How might women think about their SV experiences when no script exists to describe what “sexual coercion” should look like in reality? Yeater, Treat, Viken, and McFall have shown that people with greater RMA are less sensitive to levels of risk for victimization (2010). Ullman (2010) suggests, women may alter their sense of what victimization is to match the cultural notion of what sexual aggression is and is not, with most SV experiences falling into the “not” category.

To challenge rape culture and the victimization of women, psychologists must work from a social justice perspective to study social context and address the need for an outspoken refusal of rape culture (Gavey, 2007; Ullman, 2010). The field must consider relevant theory and research regarding societal influences on sexual victimization by investigating sexual aggression myth acceptance as a variable that may explain the discrepancy between women who do and do not self-identify as victims. As scholars, we must empower victims to reject blame and shame, identify as survivors, and combat perpetuated global silence that rape culture creates through societal norms and institutions (Burnett et al., 2009).
Current Study

Based on the reviewed literature, two theory-driven, falsifiable, hypotheses were generated. First, it was expected there would be a disparity between de facto victimization status, defined as whether or not a woman met criteria for having experienced at least one form of sexual victimization (SV), and self-identified victimization status, defined as a woman labeling herself as either a victim or a non-victim of SV. That is, participants indicating at least one victimizing experience would be less likely to “accurately” label their experiences as victimizing, while non-victims would be more likely to “accurately” label themselves as non-victims.

Second, it was hypothesized that, for those participants who did endorse at least one experience of SV, sexual aggression myth acceptance would be negatively related to victimization identification. In other words, participants with higher myth acceptance would be significantly less likely to label themselves as having experienced some form of sexual victimization (i.e., self-identify as a victim) as compared to those with lower myth acceptance.

Method

Participants

Women between the ages of 18 and 34 were recruited through a snowball sampling technique using personal contacts, email listservs, and social media sources, to participate in the research survey. Of the 266 women who initially responded to the survey, 198 participants completed all surveys and met age criteria.

Women ranged in age between 18 and 34 (M = 24.99, SD = 3.98). The majority of the sample was White/Caucasian (91.4%); other racial/ethnic backgrounds included Hispanic/Latino (4%), Black/African American (3.5%), Asian (2%), Native Hawaiian/Pacific Islander (1%), “Other” (1%), and American Indian/Alaska Native (0.5%). Reported sexual orientation included 80.3% heterosexual, 10.1% bisexual, 4% lesbian, 2% pansexual, and 3.5% “Other” (e.g., Queer, Questioning, Fluid).

Instrumentation

Demographics. Participants responded to six general demographic questions. To assess whether or not women identified as victims of sexual violence, they were then asked six questions about their identity as a victim/survivor of types of sexual victimization (e.g., “Have you ever experienced unwanted sexual contact?”).

Acceptance of Sexual Aggression Myths. Next, women responded to the Acceptance of Modern Myths about Sexual Aggression Scale (AMMSA; Gerger et al., 2007), which includes 30 questions that address beliefs about sexual violence on a 7 point Likert scale (e.g., “When a man urges his female partner to have sex, this cannot be called rape”). As compared to similar scales that measure Rape Myth Acceptance (e.g., Lonsway & Fitzgerald, 1994), the AMMSA measures a broader construct of sexual violence, has strong validity, high reliability, and a more normal distribution than other similar scales. Internal consistency reliability for the current sample was established (α = 0.94).

Sexual Victimization. To assess whether participants had a history of victimization, the research survey then invited women to respond to ten items on the Sexual Experiences Survey (SES; Koss & Gidycz, 1985). This survey asks women about sexual experiences of unwanted sexual contact, coercion, attempted rape, and rape without using the terminology and labels associated with such experiences. The SES has shown adequate validity and reliability, and research has shown that the large majority of participants answer questions in a candid manner (Koss & Gidycz, 1985). The current sample showed adequate internal consistency reliability for this scale (α = 0.75).

Social Desirability. The last survey given to participants was the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960), used to measure tendency toward social desirability. This scale also has high reliability and substantial validity (Stöber, 2001). This scale was used to assess the potential presence of social desirability bias. Internal consistency reliability for the current sample was established (α = 0.74).
Follow-up questions. Immediately after responding to survey questions, participants responded to three questions addressing the extent to which they were upset after answering questions, the likelihood that they would participate knowing the exact content of the questions prior to participation, and the likelihood that they would participate in similar studies in the future. Answers were provided using a Likert Scale (1 = strongly agree, 7 = strongly disagree).

Data Collection

Potential participants were recruited online via social networking websites and email requests. Using a snowball sampling technique, the researchers solicited individuals to pass along the survey invitation to reach as many potential participants as possible. Participants first read the informed consent, which included resources for sexual assault and mental health services, and indicated consent by clicking a "Next" button to access the survey. After responding to the survey questions described above, participants were debriefed.

On the debriefing page, all participants received definitions, myths, and facts about sexual violence from the Rape, Abuse, and Incest National Network. Researchers provided a list of national sexual violence and mental health resources, including contacts for the National Sexual Assault Online Hotline and National Sexual Assault Hotline, both of which specialize in providing individuals with crisis intervention and support, information about recovery, and referrals to local resources.

Results

Before collecting data, an a priori power analysis was performed to determine an adequate sample size to reach statistical significance, if existent, for the proposed analyses. To assess the discrepancy between self-identified victims and de facto victims using a Chi Square Analysis, 129 women were needed in each group. To research the influence of sexual aggression myth acceptance, 110 participants were needed to adequately perform a simple logistic regression with 80 percent power and a .05 alpha level.

Descriptive

Of the final 198 women, 125 (69.1%) endorsed one or more items that met criteria for sexual victimization (See Table 1). Of these women, 106 (84.8%) self-identified as having experienced at least one type of sexual victimization. Nineteen participants (15.2%) who met criteria for de facto victimization did not identify as victims for any form of victimization. An additional 17 participants (8.6%) from the victimized sample reported that they were “not sure” whether they had been victimized for at least one type.

Hypothesis Testing

To determine the differences between observed proportions of self-identified and de facto proportions, we conducted a chi-square goodness of fit test. Results suggest that the majority of women who endorsed at least one de facto victimizing experience also self-identified as having experienced sexual victimization. Hence, the difference between de facto and self-identified groups was not statistically significant ($\chi^2(1) = 0.223, p = 0.630$).

We then performed a simple logistic regression to assess the extent to which myth acceptance contributed to self-identification of victim status for de facto victims. The model contained one independent variable (myth acceptance) and one dependent variable (self-identification status). The model was not statistically significant ($\chi^2(1) = 3.405, p = 0.065$), suggesting that variance in rape myth acceptance did not predict the identification status of de facto victims.

Post Hoc Analyses

To further assess the differences between de facto and self-identified victims, we conducted a chi-square goodness of fit test for each of the four victimization categories. Proportions did not significantly differ for de facto and self-identified victims of unwanted sexual contact ($\chi^2(1) = 2.358, p = 0.125$), nor did they differ for sexual coercion ($\chi^2(1) = 1.817, p = 0.178$). There were statistically significant differences between observed and expected proportions for attempted rape ($\chi^2(1) = 5.806, p = 0.016$) and rape ($\chi^2(1) = 14.315, p < .001$). Therefore, significantly fewer women who experienced attempted rape or rape actually self-identified as victims for the respective category.
Finally, we assessed whether myth acceptance contributed to variance in self-identification status for each victimization category: unwanted sexual contact, sexual coercion, attempted rape, and rape. Myth acceptance did contribute significantly to the model for victims of sexual coercion. That is, myth acceptance of de facto victims did relate to whether or not they were likely to self-identify as victims ($\chi^2 (1) = 4.193, p = 0.041$). Myth acceptance did not significantly contribute to self-identification status for unwanted sexual contact ($\chi^2 (1) = 0.662, p = 0.416$), attempted rape ($\chi^2 (1) = 2.199, p = 0.138$), or rape ($\chi^2 (1) = 0.286, p = 0.593$).

**Follow up Question Analyses**

The follow-up questions at the end of the survey suggested that most women did not feel upset after responding to the questions and would participate in similar research again. Sixty-eight percent of women endorsed items 5 - 7, reporting they were not upset when answering questions. An additional 11.6% of women endorsed “4” (neutral), reporting they did not agree or disagree that they were upset responding to questions. Approximately 77% of women endorsed items 1, 2, or 3, agreeing that they would have still participated if they knew the questions ahead of time, and 77% also indicated they would participate in a similar study in the future. As a reminder, women who may have felt uncomfortable answering questions received information on sexual violence, in addition to national resources on sexual violence and mental health.

**Discussion**

The general purpose of the study was to research sexually victimizing experiences of women on a broader level than rape, in addition to assessing the contribution of sexual aggression myth acceptance to the identification of having had such victimizing experiences. To further understand these issues, we created two hypotheses.

First, we hypothesized that women who endorsed de facto criteria for victimizing experiences would not be likely to identify as victims of such experiences. We reasoned that, due to societal norms and rape scripts, women may choose to avoid the labels and consequences associated with being seen as a victim, and thus may not identify as victims despite meeting criteria for victimizing experiences. This hypothesis, however, was not significant, and the large majority of women who met objective criteria for victimizing experiences also self-identified as victims of either, unwanted sexual contact, sexual coercion, attempted rape, or rape. Such findings are uplifting and hold positive implications for women, suggesting that victimized women may, in fact, be conceptualizing and labeling their experiences “accurately.” These findings, however, may not be representative of the general population and may instead reflect the sampling bias in the study, discussed below.

The second hypothesis assessed the extent to which rape myth acceptance would affect whether or not women self-identify as having a sexually victimizing experience. Research has shown that women are less likely to identify as rape victims as rape myth acceptance increases (Peterson & Muehlenhard, 2004), likely because their experiences may not fit the stereotypical situations in which rape occurs. It was reasoned that a similar pattern would take place when expanding the construct of rape myth acceptance to sexual aggression myth acceptance. This hypothesis was not significant, suggesting that myth acceptance did not significantly account for self-identification of victim status in the sample. These findings suggest that other constructs may influence the manner in which women conceptualize their experiences. Implications for these findings are discussed below.

To further understand the manner in which women label victimizing experiences, differences between de facto and self-identified experiences were assessed for each level of victimization: unwanted sexual contact, sexual coercion, attempted rape, and rape. There were no significant differences between women who objectively met criteria for sexual contact and sexual coercion, and women who self-identified as having such experiences. As the level of severity increased, however, differences emerged. There was a significant disparity between women who objectively experienced attempted rape and rape, and women who self-
identified as having had attempted rape and rape experiences. Perhaps, as the level of victimization increases, the decision to identify as a victim becomes more difficult due to societal consequences of being a victim, discussed above. As a result, women may choose not to identify as victims despite having such experiences.

We also conducted post hoc analyses on the influence of sexual aggression myth acceptance on identification of victims for each level of victimization. Myth acceptance did not significantly contribute to the logistic regression model for victims of unwanted sexual contact, attempted rape, or rape. It did, however, predict whether or not victims of sexual coercion would self-identify as victims, suggesting that women with higher levels of myth acceptance are less likely to self-identify as victims of sexual coercion.

There are potential implications for this finding in terms of myth acceptance because sexual coercion is, perhaps, one of the grayest areas in terms of giving and receiving consent for sexual activities. Perhaps, due to the confines of what SV is within rape culture, sexually coercive behaviors are not necessarily easily detectable as “wrong,” or are viewed as behaviors that are typical or to be expected from men. In response, women may be unclear how to give consent in a transparent manner, making them hesitant to identify as a victim if they did not clearly fight back, resist, or say “no.” The context of sexual experiences likely contributes to whether women label their experiences as victimizing. Researchers have begun to examine the consequences of such labels, and have suggested benefits and setbacks to women accurately identifying their sexually victimizing experiences, which are discussed below.

Limitations

There are various limitations to consider when understanding the findings of the study. Although a snowball sampling technique was used to recruit women all over the Nation, the initial circle of people who received the call for invitations included peers from the undergraduate and graduate programs of the co-investigators, which largely include women in psychology and women’s studies departments and programs. The women in these circles are likely to have stronger feminist values than typical women, and they may have been more comfortable identifying their experiences than other women in the general population. Thus, it is likely that the sampling bias inflated the number of self-identifying victims. There are some strong implications for our findings with respect to the sampling bias and myth acceptance, which are discussed below.

The current investigation’s sample was also largely Caucasian women, creating a limitation with respect to racial and ethnic diversity. A recent meta-analysis suggested that there are racial and ethnic differences pertaining to rape myth acceptance, revealing lower rape myth acceptance (a) among White individuals than racial and ethnic minorities, and (b) among Black individuals who hold negative views told their own race (Suarez & Gadalla, 2010). On the other hand, results of the same meta-analysis suggested that positively identifying with one’s race relates to lower rape myth acceptance. Further research in this area is certainly warranted in order to address and identify other factors that contribute to rape myth acceptance and the manner in which women understand victimizing experiences.

An additional limitation to the study pertains to the sample size and the proportion of women who were and were not victimized. Overall, there were many more women who were victimized at some point in comparison to women who were not, creating uneven cell sizes for the statistical analyses and potential threats to statistical conclusion validity.

Finally, due to the nature of the Sexual Experiences Survey (1987), we were not able to include gender-neutral language and, by extension, failed to acknowledge that women can also be perpetrators of sexual violence. We intentionally chose not to alter the items in order to maintain the integrity and psychometrics of the scale, but we recognize that this created a large limitation for women who have been victimized by other women. In the future, it will be advantageous to update or create scales that address SV with gender-neutral language, acknowledging the potential for a wide range of circumstances.
Implications for Labeling Victimizing Experiences

According to Peterson and Muehlenhard (2011), women who label their nonconsensual sexual experiences as rape may face both positive and negative consequences, depending on the circumstances. Research by Littleton, Axsom, and Grills-Taquechel (2009), for example, suggested that women who were raped and did not identify as victims were more likely to engage in alcohol abuse, maintain relationships with their assailant, and were nearly twice as likely to face sexual revictimization. Other women under the same circumstances, however, report the belief that they have more control over the situation and can thus avoid it from happening in the future when labeling it as a mistake on their part (Peterson & Muehlenhard, 2011).

Scholars have also examined the changes that occur for women who later decide to label their experiences as rape (Peterson & Muehlenhard, 2011). When discussing this experience with women, they report that they acknowledged it as rape after learning more about rape or after talking with friends who validated their victimizing experiences (Peterson & Muehlenhard, 2011). Many of the women also reported they experienced less self-blame and shame after labeling their experience as rape, and some were reportedly able to end the relationship with their assailant after labeling the incident accurately. Such findings speak to the impact of identifying as a victim and a survivor, as opposed to ignoring or justifying the situation in an effort to protect oneself from adverse consequences. Clearly, the process of understanding and labeling one’s experience of sexual victimization is an extremely personal one, and differs depending on the individual needs, circumstances, and perceived consequences of the survivor. In moving forward to promote sexual violence prevention on larger levels, it is important to consider such differences between individuals, in addition to the underlying assumptions of community members.

Implications for Sexual Violence Prevention

Ultimately, in understanding the social context in which rape myths occur, scholars ought to continue to implement prevention programs and policies that address the acceptance of sexual aggression myths and how they may influence identification as a victim. Initial findings in the current investigation suggested that myth acceptance did not contribute to identification of victimization, with the exception of sexual coercion. However, when looking deeper, some strong implications appeared.

In the current investigation, 86.6% of the sample was college educated, and it is very plausible that many of the women in the sample have feminist roots as a result of the snowball sampling method used for the study. It was reasoned that the sample did not reflect the general population, particularly in terms of myth acceptance. To check this, we ran a norm comparison test to assess whether the sample’s attitudes were statistically different from that of the normed sample. Indeed, the sample of the current investigation had significantly lower myth acceptance than the general population ($t = -7.16, p < .00001$). Perhaps, this explains the non-significant findings for overall lack of significance in terms of myth acceptance and identification; women in the sample were more likely to identify as victims in the first place, and were likely less influenced by myths.

Despite the positive finding that the majority of women in the sample already identified as victims after experiencing sexual victimization, post hoc analyses suggest a great amount of work is needed. The data suggest women are significantly less likely to identify as having been victimized if the form of victimization they experienced was comparatively more severe. If well-educated women and feminists have low myth acceptance, and even they struggle to identify as victims of attempted rape or rape, that speaks to how heavy the weight of such labels are, and how much of a potential burden the victim status may be.

In general, one can hope that by educating the general public about myth acceptance and decreasing these attitudes to promote feminist perspectives, prevention scholars and practitioners can make more progress. Such attitudes and perspectives are deeply embedded in society, however, and are not always easy to challenge, calling for a cultural shift in attitudes and beliefs. As Suarez and Gadalla (2010) found,
attitudes of rape myth acceptance are often associated with other oppressive beliefs in society, including racism and heterosexism, among others. Additional research on the intersectionality of such beliefs will likely lead to a clearer understanding of victim labels, societal structures and oppression, and barriers to social change.

It may also be important to address myths about sexual aggression in prevention programs from a broad, multicultural lens. Unfortunately, research suggests that many rape-prevention programs elicit attitude changes on only a short-term basis (Anderson & Whiston, 2005). Such attitudes and beliefs regarding sexual violence and oppression are pervasive and complex (Rozee & Koss, 2001), so turning to prevention efforts in a multi-faceted manner may elicit the most change.

Knowing that young women (i.e., women between 18 and 34) are especially vulnerable to experiencing SV, it is also important to consider the role of higher education in prevention programs. Some findings have shown that women with more years in college are more likely to label their sexual assault experiences as rape (Kahn et al., 2003), suggesting that education plays a large role in the conceptualization of such experiences. Our sample may be a reflection of this correlation. Perhaps most importantly, the field must not forget the importance of educating potential perpetrators on the underlying issues of obtaining consent, and continuing to promote positive preventative tactics, such as bystander intervention programs.

Over the past few years, colleges have recognized the need for a new perspective and turned to bystander intervention approaches in an attempt to prevent sexual violence (McMahon & Banyard, 2012). Such programs continue to emerge in higher education settings, revealing the potential to create small systematic change and promote social justice amongst college students in a positive and empowering way. The community-wide approach is effective for a number of reasons, particularly in the context of prevention theory and practice. Many programs, for example, focus on primary, secondary, and tertiary prevention to address the continuum of sexual violence. Through this process, they educate men and women on the opportunities available to recognize red flags and reach out to others—both before and after potentially problematic events.

Although bystander intervention programs have been well received (McMahon & Banyard, 2012), scholars must also recognize that they may not always help, being that many acts of sexual violence occur behind closed doors (Koelsch, Brown, & Boisen, 2012). Although it is important to turn to the community and focus our attention on potential bystanders and perpetrators, we must not lose sight of the victims so we can understand how women process and conceptualize their experiences. Doing so can potentially prevent the negative consequences discussed above—particularly emotional troubles, physical difficulties, and revictimization.

In conclusion, the findings in this study reflect the need to increase tertiary prevention efforts. By reducing the negative consequences of victim blame and shame associated with the victim label, women may be more likely to identify as victims and become survivors. They will then be more likely to end the relationship with the perpetrator (Peterson & Muehlenhard, 2004), prevent subsequent assaults, and potentially confront perpetrators to voice their disapproval (McMahon & Banyard, 2012). Ultimately, it is imperative that scholars recognize the complexity of sexual violence and the factors that contribute to conceptualizations of victimization. Identifying the influential factors and unique experiences will allow scholars to create well-informed prevention programs that acknowledge the continuum of sexual violence, address all potential individuals involved, and recognize the need for all forms and levels of prevention.

References
Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens,


### Appendix A

Percentages of de facto and self-identified experiences of sexual victimization

<table>
<thead>
<tr>
<th></th>
<th>Unwanted Sexual Contact</th>
<th>Sexual Coercion</th>
<th>Attempted Rape</th>
<th>Rape</th>
</tr>
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<tr>
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<td>45.0</td>
<td>19.2</td>
<td>24.3</td>
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<td>80.8</td>
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<tr>
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<td>11.1</td>
</tr>
<tr>
<td>no</td>
<td>37.9</td>
<td>57.1</td>
<td>83.3</td>
<td>84.8</td>
</tr>
</tbody>
</table>
Commercial Tobacco Use and Smoking Cessation for American Indian Communities

Alina Alomá, M.A.
Ernesto N. Lira, B.A.
Marisela López, M.A.

University of Wisconsin-Milwaukee

Abstract

The alarmingly high prevalence of commercial cigarette smoking among American Indian/Alaska Native (AI/AN) populations and factors influencing this prevalence are addressed in this literature review. Information on the traditional uses of tobacco among AI/AN communities is presented. The evolution from traditional tobacco use into recreational commercial tobacco abuse and the health risks associated with this shift are discussed. The need for appropriate interventions to prevent the harmful and life threatening effects associated with manufactured cigarette use in these populations is argued. A historical trauma context is utilized to better understand the impact of forced assimilation on smoking practices in these groups, and on smoking cessation efforts faced by many AI/AN communities. Efforts aimed at addressing commercial tobacco abuse in AI/AN communities by other health experts are presented, including efforts that utilized community feedback to create culturally adapted and culturally relevant commercial smoking cessation initiatives. The lack of research in the Counseling Psychology field regarding this health and social justice issue is addressed, and steps counseling psychologists can take to assist in the development and implementation of culturally appropriate smoking cessation programs for AI/AN communities are presented. A call to social action among counseling psychologists is delivered to increase awareness about the issues faced by these marginalized groups, and how the Counseling Psychology field can partner with these communities to assist in increasing their wellbeing.

Keywords: American Indians, Native Americans, smoking cessation, cultural adaptations, historical trauma

Main Report

According to a United States Census report, American Indian and Alaska Native (AI/AN) groups account for 1.6% of the total U.S. population, which makes them the smallest minority group in the U.S. (Norris, Vines, & Hoeffel, 2012). The U.S. Census Bureau defines American Indian and Alaska Native individuals as “person[s] having origins in any of the original peoples of North and South America and who maintain[s] tribal affiliation or community attachment” (U.S. Census Bureau, 2010). Based on the U.S. Bureau of Indian Affairs, there are 566 federally recognized Tribes and about 200 viable native languages that are still in use (Bureau of Indian Affairs, 2013). Although AI/AN individuals account

1 The term American Indian is used herein when discussing American Indian and Alaska Natives communities (AI/AN). It is important to note that given the large diversity among Tribes, not all presented findings or tobacco practices will apply to everyone in these groups.
for a small percentage of the U.S. population, they suffer from high rates of various health issues (Center for Disease Control and Prevention, 2013). In particular, the Surgeon General’s report listed lung cancer and cardiovascular disease as leading causes of death in AI/AN groups (Center for Disease Control and Prevention, 1998). Research has also shown that smoking and commercial tobacco use have a causal relationship with lung cancer and cardiovascular disease (American Heart Association, 2013; U.S. Department of Health and Human Services, 2010).

The high prevalence of recreational/commercial tobacco use among AI/AN groups has been widely documented (Burgess et al., 2007; Daley et al., 2011; Fu et al., 2010; Gryczynski et al., 2010), and the disproportionate use in these groups places them at higher risk for diseases that can affect quality of life, and may lead to their early deaths. A report by the Center for Disease Control and Prevention (CDC) in 2012 found that 31.4% of American Indian/Alaska Native adults were estimated to be cigarette smokers. This finding makes AI/AN groups the highest in smoking prevalence in the United States compared to Whites, Blacks, Hispanics/Latinos, and Asians, with rates of 21%, 20.6%, 12.5%, and 9.2% respectively (Center for Disease Control and Prevention, 2012). In addition, American Indians in the North Plains have the highest prevalence of smoking (44.2%) among AI/AN groups. They also have the highest prevalence (13.5%) of heavy smoking, which is considered to be more than a pack of cigarettes per day (Center for Disease Control and Prevention, 1998). Given that the top two leading causes of death for AI/ANs are heart disease and cancer, these statistics are alarming and integral in understanding health disparities for these populations (Center for Disease Control and Prevention, 2013). More importantly, the causal relationship between cardiovascular disease, lung cancer and smoking, paired with the high prevalence of commercial tobacco smoking in AI/AN groups, signals the need for smoking cessation interventions. Smoking cessation interventions are essential to prevent further illness development and reduce the health disparities gap for these groups.

Traditional and Commercial Tobacco Use

In order to better understand tobacco use and abuse in American Indian/Alaska Native communities, the difference between traditional or sacred tobacco use and recreational or commercial tobacco use must be discussed. According to the information on traditional AI/AN teachings compiled by Brokenleg and Tornes (2013), commercial tobacco comes from a plant scientifically known as, Nicotiana tabacum, and “is the tobacco that is sold in stores and used for cigarettes, cigars, spit tobacco, and packaged pipe tobacco” (p.11). On the other hand, traditional or sacred tobacco typically comes from a plant scientifically known as, Nicotiana rustica, and “when smoked in a pipe ceremonially, tobacco smoke is not inhaled into the lungs, but only held briefly in the mouth and exhaled” and “is used as a spiritual medicine for healing of mind, body and spirit” (Brokenleg & Tornes, 2013, p. 12). As presented by a traditional tobacco brochure, “traditional tobacco is free of chemicals and poisons…it is a gift from Mother Earth and should be respected and used properly…it provides us with spiritual guidance, discipline and protection. You should never abuse such a gift” (“Traditional vs. Commercial,” 2013). Given the differences in languages and cultures among Tribes, it is important to note that some AI/AN groups may refer to other plants, such as red willow, as traditional tobacco (Brokenleg & Tornes, 2013).

Consequently, inhaling the tobacco smoke or smoking cigarettes are not considered appropriate traditional uses of a sacred plant. Furthermore, recreational use of tobacco involves the use of commercial tobacco in ways that are not consistent with sacred teachings and traditions from AI/AN groups, as well as in ways that have been determined to lead to health problems such as cancer and heart disease (American Heart Association, 2013; U.S. Department of Health and Human Services, 2010).

In traditional AI/AN teachings, tobacco can be used as an offering in which the individual giving the tobacco asks something of the receiver, such as guidance with an issue or

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2 For the purpose of this paper, recreational, commercial or non-traditional tobacco use will be referred to as tobacco abuse, as AI/AN individuals who follow traditional ways of living may consider this type of tobacco use as an abuse of a sacred plant.
help with an illness. It is a powerful element in healing, as it
“unites and activates powerful healing forces” (McCabe, 2008, p.146). It can also be an offering to the creator, or spirit world, to ask for help, guidance, or a prayer for thanks giving (Daley et al., 2011), and can assist in the development of the relationship between those spirits, a healer, or another being or person, and the one seeking help (McCabe, 2008). Moreover, there are many ways to utilize tobacco in a ceremonial or traditional way that can vary from Tribe to Tribe. Many AI/AN groups may use traditional tobacco in a sacred pipe, although not inhaled, or by placing it in a fire as an offering. The tobacco smoke carries the energy of the request or prayer into creation (Daley et al., 2011).

Few researchers (Daley et al., 2011; Gryczynski et al., 2010; McCabe, 2008) studying tobacco abuse and commercial cigarette smoking cessation in AI/AN groups have attempted to document the sacred role of tobacco in American Indian cultures. Unfortunately, the limited literature on the subject has not always presented accurate information related to the practices surrounding traditional tobacco use. Accurate information on traditional tobacco has often been presented alongside inaccurate information, such as stating that smoking AND inhaling the smoke is a traditional practice (Burgess et al., 2007; Daley et al., 2011). The inconsistencies in the current literature may be a result of researchers not taking into account their sources of information, and often referring to the explanations of more assimilated participants who do not follow traditional teachings.

Nonetheless, researchers have been able to capture some of the current non-traditional tobacco practices of some AI/AN individuals that might be connected to the numerous health risks these groups face (Burgess et al., 2007; Daley et al., 2011; Fu et al., 2010). As commonly known in mainstream society, “commercial tobacco contains harmful chemicals such as arsenic (poison), acetone (nail polish remover), methanol (anti-freeze), nicotine (insecticide), ammonia (window cleaner), carbon monoxide (car exhaust), cyanide (rat poison), dimethyl benzyl (toilet bowl cleaner), and formaldehyde (preserves dead tissue)” (“Traditional vs. Commercial,” 2013).

Therefore, the carcinogens from manufactured tobacco can make it a very dangerous substitute for traditional tobacco. As traditional sacred tobacco use has evolved to the abuse of commercial tobacco within many AI/AN communities, health problems have increased (e.g., cancer and heart disease) in these communities (Center for Disease Control and Prevention, 1998; Center for Disease Control and Prevention, 2013).

**Historical Trauma Effects**

Many of the changes in tobacco practices that move away from traditional teachings are a result of forced colonization and assimilation (Smith, 2005). In order to understand why many AI/AN individuals no longer have the knowledge of traditional teachings to guide their traditional tobacco practices, we need to better understand the historical context of colonization, and the impact it has had on AI/AN groups. American Indian communities have a long and ongoing history of oppression due to colonization, which resulted for many in relocation, loss of land, culture, language, life, forced removal of children, vilification, assimilationist policies, and genocide (Aragon, 2006; Deloria, 2003; Walters, Simoni, & Evans-Campbell, 2002).

Understanding the concept of historical trauma provides a unique and comprehensive context for understanding smoking use in American Indian populations. The impact of colonization has been carried on through generations and identified as “soul wounds” (Duran, 2006). “Soul wounds,” or intergenerational trauma for AI/AN groups, describe “the understanding that the trauma occurred in the soul or spirit” (Duran, 2006, p.7). Although the term is used to describe trauma, the distinction lies in recognizing the spiritual aspects, which can be passed to future generations, and subsequently magnified, if left unresolved (Duran, 2006). Research has also linked historical trauma to depression, guilt, and substance abuse among other psychosocial issues (Walters et al., 2002).

Additionally, research has also documented that for many AI/AN persons, their first cigarette smoking experiences occur as a part of cultural ceremonies, including powwows.
In particular, for some younger AI/AN generations in many areas, the use of commercial tobacco now appears to be a common part of the American Indian post-colonial culture. For many, being surrounded by high rates of cigarette smoking in their communities has made recreational tobacco use a normative part of their culture (Angstman, Harris, Golbeck & Swaney 2009). A study by Angstman and colleagues (2009) found that higher levels of American Indian cultural identification predicted a smoker status, whereas White cultural identification predicted a non-smoker status. This cultural identity association with commercial tobacco can be linked to the miseducation of newer AI/AN generations regarding traditional teachings and AI/AN spirituality and worldview. In particular, the disconnect between younger and older generations can be linked to the forced assimilation and miseducation that AI/AN groups endured during the boarding school era (Brave Heart & DeBruyn, 1998). The boarding school era refers to a period where the U.S. government forced AI/AN families, by the use of threats and incarceration, to send their children to government-funded schools. At these schools, children were beaten and forced to assimilate to White culture (Brave Heart & DeBruyn, 1998). Many AI/AN people were forced to let go of traditional teachings in order to fit into mainstream U.S. culture. Phrases such as “Save the child, kill the Indian” are representative of the mainstream culture’s views on the need to assimilate AI/AN populations (Barker, 1997). The boarding school era resulted in the loss of culture and tradition for many AI/AN groups, and continues to be one of the main contributors to the loss of knowledge and practices about traditional tobacco use.

**Smoking Cessation Challenges for AI/AN Communities**

There are many challenges to smoking cessation for AI/AN communities, and they vary due to social, biological, and historical factors. Along with the typical biological and physiological barriers associated with smoking cessation, including addiction, cravings and difficulty managing withdrawal symptoms, such as irritability, and fear of weight gain (Burgess et al., 2007), AI/AN communities face many additional barriers to smoking cessation. For example, social barriers such as stress associated with discrimination and racism, extreme poverty, lack of social pressure to quit, and the high likelihood of the acceptance of smoking inside the home, often contribute to cigarette smoking or cause difficulty with quitting (Fu et al., 2010). Moreover, according to data from the U.S. Census, American Indian and Alaska Native groups have a poverty rate of 28.4%, which is almost double the poverty rate of the U.S (15.3%) (United States Census Bureau, 2011). Poverty is often associated with negative health outcomes due to limited access to resources and stressors associated with limited access (Government Accountability Office, 2007). Furthermore, issues surrounding sovereignty and the complex trust relationship AI/AN Tribes have with the U.S. interface with multiple levels of government and private health services, and can affect access to quality healthcare for these groups (Warne, Kaur & Perdue, 2012).

Some studies have examined the role primary care doctors play in smoking cessation efforts. Burgess and colleagues (2007) found that AI/AN participants differed in terms of their preference for medical doctors’ involvement in treatment. This difference in preference for doctor involvement could be due to psychosocial and cultural factors that were not considered in the study, such as participants’ levels of acculturation, enculturation, and cultural mistrust. For example, for more acculturated individuals, it may be important for doctors to provide information and advice on smoking cessation. Whereas others would prefer limited doctor involvement due to feeling misunderstood, judged, or preached at by the doctor, or mistrustful of the doctor and/or system. One participant stated, “everybody loves to go to the Indian doctor instead of the White doctor because they trust them better” (Burgess et al., 2007, p. S24). Based on the historical trauma endured by American Indian populations, mistrust in western medical providers can be seen as justified and adaptive. This is exemplified by one of the participant’s views regarding western healthcare: “we’re constantly being told what to do, how to do it, and when to do it and that has a long history of forced assimilation… I for the longest time did
not believe in doctors if I had anything wrong. I’d go talk to a healer. I’d go try to heal myself” (Burgess et al., 2007, p. S24). Similarly, results from Gryczynski et al. (2010) identified the utility in using a physician as a good approach for smoking cessation. However, they also discussed the difficulty AI/AN groups have accessing medical services due to lack of insurance. In spite of Gryczynski and colleagues’ (2010) findings of physicians being considered a top smoking cessation source, views on physician involvement in smoking cessation approaches vary among AI/AN groups, as observed in these studies (Burgess et al., 2007; Gryczynski et al., 2010).

Moreover, AI/AN groups have a long history of traditional healing practices, and their own medicine system, that are performed by sanctioned healers. Traditional healing practices have often been dismissed by Western medicine, in spite of the great influence these practices have had on the creation of pharmaceutical treatments (Smith, 2005).

Additionally, Daley and colleagues (2011) reported that some American Indian groups have limited knowledge about pharmacotherapeutic options for smoking cessation, which might be due to differences in location. Their findings show that only 20% of participants who smoked were knowledgeable about new drugs, such as Zyban and Chantix, for smoking cessation. Participants also demonstrated limited knowledge regarding over the counter options for smoking cessation, such as nicotine replacement therapies, which include the patch or gum. Only 60% of participants who smoked were familiar with these over the counter options. This finding alludes to the importance of creating more outreach opportunities and collaborative, community partnerships in American Indian communities to address the options and alternatives for smoking cessation treatment. Given Daley and colleagues’ (2011) findings, the general mistrust of western medical providers includes pharmaceutical companies (Burgess et al., 2007). Specifically, Burgess et al., (2007) found that general skepticism with mainstream pharmacotherapy is a challenge because pharmacotherapy is one of the main components of standard smoking cessation programs. Findings from this study show that some American Indian individuals held an overall negative view of mainstream prescribed medications. Some of these views were connected to the distrust of western medicine based on historical issues, such as one participant’s statement, “like in the old days, they tried new medicines on Indian people and they ended up dying or getting sicker… something new, nobody wants to try it” (Burgess et al., 2007, p. S25). Stigma regarding popping pills was also a theme among participants. Some viewed taking prescribed medications the same as using illegal drugs, while others viewed taking pills as against their culture. A participant reported how she was advised by her mother not to take pills: “if you are sick and don’t take pills…the sickness will leave your body” (Burgess et al., 2007, S24).

Conversely, Baezconde-Garbanati, Beebe and Perez-Stable (2007) noted “the reliance of this population on tobacco sales and the revenues these sales bring to Tribes” have become barriers to smoking cessation (p. 114). These authors also listed how financial gain generated from Tribal smoke shops is key to some Tribal communities as these shops often fund vital Tribal programs. Furthermore, there is a need to eliminate “the tobacco industry’s presence in funding of community programs, in the usage of American Indian imagery to sell tobacco products and in reducing the availability of commercial tobacco, especially among adolescents” (Baezconde-Garbanati et al., 2007, p. 116). The 1998 Surgeon General’s report (Center for Disease Control and Prevention, 1998) also acknowledged the tobacco industry’s attempts at building their credibility within American Indian communities. Specifically, by sponsoring events like rodeos and powwows, and advertising their products by using cultural symbols such as pictures of an American Indian smoking a pipe, or advertising their cigarettes as natural products. For smoking cessation and prevention efforts to be effective on a systemic scale, this abusive and exploitative relationship with the tobacco industry must be addressed, and financial support from other sources must be provided to decrease dependency on this toxic industry.
Culturally Congruent Recommendations for Smoking Cessation

In order to effectively collaborate with AI/AN communities in smoking cessation efforts, smoking cessation interventions need to be culturally appropriate and spiritually congruent with traditional beliefs. While physicians are in a position to provide education and information, word of mouth and community education may have more value for many American Indian groups, than so-called medical advice. This is exemplified by Burgess and colleagues’ (2007) findings of participant preference for the dissemination of smoking cessation information through the Tribal Council and other Indian organizations. Participants also stated the importance of hearing personal testimonials from actual American Indian community members on the effectiveness of various nicotine replacement treatments (Burgess et al., 2007). Increased knowledge of nicotine replacement therapies, however, will not be effective without the increased access to smoking cessation tools. This highlights the importance of considering access to resources and socioeconomic status when developing interventions, such as ensuring free access to smoking cessation behavioral and medical healthcare. Additionally, it is important to increase access to over-the-counter nicotine replacement therapies and smoking cessation prescribed medications.

Moreover, findings from D’Silva, Schillo, Sandman, Leonard, and Boyle’s (2011) study of a culturally tailored approach to smoking cessation in American Indians from Minnesota provided important considerations. The findings confirmed that having accessible and free of charge nicotine replacement therapies and prescription medications for smoking cessation increased the use of such methods in American Indians attempting to quit smoking. In total, since enrolling in the smoking cessation program, 81% of participants in the study reported the use of pharmacotherapy. In their study, D’Silva et al. provided free access to nicotine replacement therapies and prescription medications for smoking cessation, along with individual and group counseling. The curriculum developed for this program was culturally adapted from one of the American Lung Association’s smoking cessation programs, and included Ojibwe teachings and language on sacred tobacco use. It also included four counseling sessions aimed at building motivation to quit, managing cravings, increasing social support and maintaining a healthy weight after quitting, and relapse prevention. Results from this program appear valuable since 90% of participants who completed the program stated they would recommend it. Forty-seven percent of participants who partook in the follow-up evaluation indicated they had been abstinent for at least 7 days prior. Most participants who continued to smoke after completion of the program indicated during follow-up that they had cut their daily cigarette use to about half (D’Silva et al., 2011).

Several studies have also highlighted the importance of developing behavioral interventions that involve family and community in smoking cessation (Fu et al., 2010; Gryczynski et al., 2010). Based on Gryczynski et al.’s (2010) findings, participants endorsed encouragement from family and friends as one of their preferred approaches. Fu and colleagues (2010) also found that family involvement was useful in smoking cessation efforts; in particular, they found that the odds of adopting a complete ban on smoking inside the home, often doubled when the individual had the support of family or friends. They also found that completely banning or eliminating smoking inside the home was significantly associated with maintaining smoking abstinence after engaging in smoking cessation efforts (Fu et al., 2010). Additionally, home smoking bans can also positively influence other family members’ smoking behavior, such as decreasing the likelihood of children starting to smoke cigarettes. Home smoking bans can also reduce the amount of cigarettes smoked by other family members who are not ready to quit (Fu et al., 2010).

Other recommendations include the use of advertising campaigns in smoking cessation efforts (Angstman et al., 2009). Specifically, Angstman and colleagues (2009) encouraged the use of campaigns that differentiate traditional versus commercial tobacco use, as these advertisements might
“strengthen the normative value of ceremonial use while weakening the notion that recreational smoking is ‘normal’ for American Indians” (p. 299). More importantly, education must be carried out in a culturally appropriate way that involves community leaders and non-smoking elders living as teachers, and avoid outsiders appearing as experts on a culture that is not their own.

Furthermore, findings from Daley and colleagues’ (2011) study, which focused on the influences of traditional ceremonial tobacco use on smoking abstinence and relapse, indicated that traditional use of tobacco is not an obstacle to quitting smoking, and is related to greater smoking cessation. However, this protective effect seems to decrease if tobacco use involves smoking and inhaling, which is not traditional use. The authors suggested, “traditional tobacco may have a protective effect because individuals feel they disrespect the sacred plant when using it recreationally” (Daley et al., 2011, p. 1007). In their study, participants also noted, “as they start to think about recreational smoking as damaging to their health, they begin to also think about it as an abuse of a sacred plant” (Daley et al., 2011, p. 1007). These findings, once again, point to the importance of increasing awareness among American Indian communities regarding the differences between sacred use and recreational abuse of tobacco.

Finally, the importance of keeping traditional tobacco use as sacred might be incompatible with most mainstream smoking cessation approaches that require being tobacco-free. As addressed by Baezconde-Garbanati, Beebe and Perez-Stable (2007), tobacco-free campaigns are incompatible with American Indian culture, and insensitive to the cultural and spiritual beliefs of these populations. Therefore, the tobacco-free campaigns would not be effective in addressing the high prevalence of commercial tobacco use in these communities. In order to address commercial tobacco related issues in American Indian communities, Tribal leaders must be encouraged to develop and enforce appropriate tobacco abuse policies in Native lands (Baezconde-Garbanati et al., 2007). Culturally appropriate tobacco policies in Native lands, in conjunction with other smoking cessation efforts, could aid in decreasing the overall abuse of commercial tobacco in AI/AN communities.

Another example of a culturally appropriate effort led by an American Indian group is an informational website titled, KeepItSacred.org, that is directing its efforts toward educating American Indian communities on tobacco issues. The website promotes the differences between traditional and commercial tobacco in order to reduce the health disparities associated with tobacco use that these communities face. This type of effort can assist in raising awareness among American Indian communities about the dangers of commercial tobacco, and how it significantly differs from traditional tobacco (“Traditional vs. Commercial,” 2013).

Implications for Counseling Psychologists

After reviewing the current literature on smoking cessation efforts for American Indian and Alaska Native populations, it is clear that this is not only a health issue, but also a psychological and social justice issue. There has been limited empirical research addressing the needs of American Indian populations, and some research may have perpetuated misconceptions about these groups. Most of the current research and interventions appear to have been developed by physicians and public health experts. At the time of this review, limited efforts had been initiated and sustained by counseling psychologists to address the needs of AI/AN communities. Given the myriad of factors associated with smoking cessation for AI/AN groups, such as the cultural and spiritual meaning of tobacco, and the psychosocial barriers to quitting, it is surprising that the Counseling Psychology field has not done more to meet the psychological needs of these marginalized communities.

Although the information and research about culturally congruent practices with American Indians is limited, there are seminal publications that highlight and provide insight into what are culturally congruent practices. LaFromboise, Trimble, and Mohatt (1990) delineated three approaches psychologists should integrate when working with American Indians. They suggested “traditional treatments” practiced by sanctioned healers and spiritual leaders be readily
available for American Indian clients. They also suggested using psychotherapy approaches that are consistent with American Indian traditions. Lastly, they advocated for the integration of traditional methods with that of psychotherapy. LaFromboise et al. (1990) stated that integrating these three areas would make interventions with AI communities more congruent and effective. It is important to highlight, this must be done from a community partnership perspective in which community leaders, and traditional healers, are viewed as partners and integral members of the intervention team. It is in the bridging and true collaboration between these two worlds that we could create effective and congruent interventions.

Counseling psychologists can work on prevention and intervention efforts by partnering with AI/AN communities, and working alongside traditional leaders and sanctioned healers. Additionally, conducting culturally sensitive and multiculturally competent research can assist in increasing the knowledge base around specific needs for American Indian groups. These efforts will allow researchers and AI/AN communities to develop culturally appropriate smoking cessation interventions within a social justice framework. Counseling psychologists can also partner with other health professionals, and provide important insight into the psychological and cultural components necessary for smoking cessation programs to be successful with these communities.

Moreover, counseling psychologists are uniquely positioned to advance smoking cessation research, interventions, and outcomes, among AI/AN communities. Counseling psychologists are skilled at considering critical factors (e.g., multicultural factors, social justice, strength-based orientations, prevention, rehabilitation, etc.) that have been markedly absent from the literature, and which have the potential to greatly affect access, treatment, outcomes, and the specific tailoring of treatment interventions, to meet the needs of individuals and communities. Although counseling psychologists can utilize their knowledge and expertise to tailor treatments and interventions, they should not be considered experts on traditional and cultural teachings. Their training in multiculturalism serves as a valuable tool in working with diverse communities; however, in order to truly work within a multicultural framework, it is important that traditional healing and traditional teachings be incorporated into the treatment and interventions. Native-centric interventions and culturally congruent treatment adaptations cannot be accomplished without the authentic partnership, collaboration, and incorporation of traditional healers, community elders, and traditional teachings.

Gone (2010) stated that the collaborative relationship between experts in the mental health field (counseling psychologists) and experts in cultural and traditional teachings (traditional healers) is essential to integrating traditional healing into mainstream psychotherapy interventions. Furthermore, he states both parties should be involved in the description, translation, integration, and evaluation of traditional healing practices. Without these important considerations, it would not be possible to truly address cultural issues in mainstream psychotherapy. This is of particular importance in smoking cessation interventions, especially since the literature is lacking in incorporating traditional healing perspectives and expertise.

Furthermore, counseling psychologists could also be an asset to smoking cessation treatments through a variety of interventions. Specifically, by assisting clients in increasing motivation for quitting, addressing barriers and assisting in overcoming obstacles, providing therapeutic support, and managing other mental health aspects that could affect smoking cessation efforts, such as co-morbid mental illness. A smoking cessation program is similar to a diet; the program will be successful if the person can successfully follow it. Health experts can design the perfect smoking cessation program, but if psychological, cultural, and spiritual aspects are not taken into account as relevant, the success of the program could be minimal. Therefore, we are in a position to promote both psychological and physical wellness, as well as prevent illness, by collaborating with Tribal leaders and other health experts when assisting American Indian communities with their smoking cessation efforts.
As a profession, it is important for Counseling Psychology to include more underrepresented communities, like AI/AN groups, into research. However, it is also important to caution from starting research and interventions without the needed and required knowledge, skills, and community partnerships. Although well intentioned, research without the proper lens and perspective may only perpetuate, as already mentioned, a strictly Western perspective that excludes important worldviews held by AI/AN groups, and would defeat the purpose of social justice representation. Finally, for AI/AN people, factors such as diversity in culture and language between Tribes, differing needs based on location (urban or rural) and U.S. region, as well as individual differences, are key aspects to consider when designing research and interventions. It is also imperative to remember that a one-size-fits-all approach should not be the standard in smoking cessation and that we should immerse ourselves and work in tandem with the communities we are collaborating with. Working in partnership with American Indian and Alaska Native communities by engaging in prevention and intervention efforts could further promote the health and wellbeing of these communities and close the gap in health disparities for these populations.

References
American Heart Association. (2013). Smoking and Cardiovascular Disease (Heart Disease).
Retrieved from: http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/ QuittingResources/Smoking-Cardiovascular-Disease_UCM_305187_Article.jsp
Eagle River, WI: Hahn Printing, Inc.
Center for Disease Control and Prevention. (2013). American Indian and Alaska Native


Native Hawaiian/Pacific Islanders & American Indian/Alaska Natives: Common Barriers to Healthcare

Christopher T. Copeland  
*Oklahoma State University*

Julie Clark  
*Jack C. Montgomery Veterans Administration Medical Center*

**Author Note**

Christopher T. Copeland, School of Applied Health and Educational Psychology, Oklahoma State University; Julie Gallaher Clark, Jack C. Montgomery Veterans Administration Medical Center, Muskogee, Oklahoma.

Correspondence concerning this article should be addressed to Christopher Copeland, School of Applied Health and Educational Psychology, Oklahoma State University, Stillwater, OK 74078. E-mail: christopher.copeland@okstate.edu

**Abstract**

Compared to the United States’ general population, Native Hawaiians and Pacific Islanders (NH/PI) are disproportionately affected by a number of mental health and physical health problems, including diabetes, cancer, heart disease, substance abuse, infant mortality, and tuberculosis. NH/PI are second highest in being diagnosed with HIV and have the second shortest AIDS survival rate of all people in The United States, as reported by the Centers for Disease Control and Prevention (Stafford, 2010). Similarly, many American Indian/Alaska Native (AI/AN) communities experience comparable health disparities including alcoholism, diabetes, chronic liver disease, risk factors for poor birth outcome, and substance dependence (Castor et al., 2006). Given the commonalities in health disparities and experiences of colonization, we present a review of the literature for both groups which compares and contrasts barriers to health care that lead to underutilization of health care services, and we examine the existence or non-existence of culturally sensitive and effective intervention strategies for overcoming these barriers.

We examine barriers to health care in the context of historical traumas (Brave Heart, 2003; E Duran & Duran, 1995) related to the colonization experiences of NH/PI and AI/AN groups. Stafford (2010) characterized the colonization experience for NH/PI as one of “few educational opportunities or training to make the transition from a communal, agricultural, noncompetitive, and non-technological way of life to an independent, urban, competitive, and highly industrialized society,” and we argue this applies to AI/AN people, as well (p. 787). Both groups continue to face significant socioeconomic barriers that directly impact their underutilization of services, that could improve their mental and physical well-being. Social barriers include stigma and discrimination (Ro & Yee, 2010; Thomason, 2011), varying degrees of assimilation (Heinrich et al., 1990), and community mistrust of Western health interventions (Yancura, 2010). Financial barriers include a lack of access to federal funding.
technology, and specialty physicians (Sequist, 2011; Stafford, 2010).

We examine intervention strategies for overcoming barriers to health care, in light of an ongoing epistemological controversy centered on evidence-based practice (EBP) and a culturally sensitive approach (Hall, 2001). EBP advocates, who value outcome results from randomized controlled trial (RCT) studies (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006), have criticized the dearth of outcome research on culturally sensitive therapies (CSTs). In turn, CST providers have doubted the applicability of Western, scientific methodology. CSTs are built on the notion that mainstream, scientific psychology is overly influenced by the experiences of Europeans and European Americans in ways that are harmful to people from different backgrounds (Sue, 1998).

Given the common historical experiences and contemporary challenges of NH/PI and AI/AN people, the questions the researchers seek to answer are the following: Are there any EBT or CST research investigations that demonstrate positive outcomes for NH/PI or AI/AN? If so, can treatments for one group be customized to be effective with the other group?

**Keywords:** Native Hawaiian, Pacific Islander, health disparities, evidence-based practice, EBP, culturally sensitive therapies, CST

**References**


