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## Historical Trauma and American Indian/Alaska Native Youth Mental Health Development and Delinquency

Jessica L. Garcia 

### Abstract

*Health disparities in American Indian/Alaska Native (AI/AN) youth are well documented in the literature, as AI/AN youth appear to be more likely to experience trauma and engage in high-risk behavior, such as substance misuse and risky sexual behavior. These youth also appear disproportionately affected by the criminal justice system. Scholars contend that much of these disparities can be traced back to the history of colonization of Indigenous peoples and the transgenerational effects of forced suppression of cultural ideology. This paper reviews the relevant literature on AI/AN youth mental and behavioral health, and this author highlights studies which examine the plausible relation between historical trauma and contemporary AI/AN youth mental health and delinquency. This author proposes that future research should target the high number of AI/AN youths in juvenile justice settings given that these youths appear neglected in current research. © 2020 Wiley Periodicals, Inc.*

It can be argued that Indigenous peoples of the Americas are among the most resilient, having survived near complete genocide by European colonizers through war, famine, and the introduction of European diseases for which they had no immunity. They were removed from their ancestral lands and forced onto sequestered territories designated by their

colonizers, their children forced into European-based boarding schools to “kill the Indian, save the man,” and it is now up to their youth to revitalize the cultures, historic languages, and traditional practices that were, for centuries, forcibly suppressed. Unfortunately, this resilience comes with a price, which is reflected in the physical and mental health disparities observed in tribal communities today. There are over 500 federally recognized tribes in the United States, and roughly 2% of the United States population self-identifies as being American Indian/Alaska Native (AI/AN). It has been consistently demonstrated that AI/AN youth have disparate outcomes in a number of medical and mental health needs compared to non-AI/AN youth. For instance, AI/AN youth have the highest rates of fetal alcohol syndrome, a serious birth defect caused by repeated exposure to alcohol in utero which is associated with numerous intellectual and neurodevelopmental disabilities, with rates nearly double that of the average across all ethnic groups in the United States (Fox et al., 2015). Notably regarding mental health disparities, AI/AN youth aged 15–24 have the highest suicide rate among all racial and ethnic groups in the United States (Curtin & Hedegaard, 2019), as well as the highest rates of alcohol and drug addiction (Swaim & Stanley, 2018; U.S. Department of Health and Human Services, 2018). In general, AI/AN youth living on a reservation also appear to have worse outcomes than their urban-dwelling AI/AN counterparts (Freedenthal & Stiffman, 2004), though research comparing the two is limited.

Somewhat unique to mental health needs for AI/AN youth is the concept of historical trauma, which many scholars have suggested plays a role in the mental health disparities observed in these youth (Maxwell, 2014). Historical trauma responses can manifest in a number of psychological, physiological, and behavioral ways which can mimic symptoms of PTSD, depression, substance abuse, grief, or a combination thereof (Brave Heart, 2003; Brave Heart, Chase, Elkins, & Altschul, 2011; Grayshield, Rutherford, Salazar, Mihecoby, & Luna, 2015; Kirmayer, Gone, & Moses, 2014).

It is also important to consider the proportion of AI/AN youth involved in various stages of the juvenile and criminal justice systems, including federal systems. Some research suggests that AI/AN youth are four to ten times more likely to be committed as compared to White youth depending on the state, and this racial disparity appears to be growing (Rovner, 2016). In the early-to-mid 2000s, an estimated 40–70% of juveniles in the federal system were AI/AN, despite only accounting for 1% of the total U.S. youth population (Adams et al., 2011; Rolnick & Arya, 2008). Additionally, these youth appeared to be more likely to be arrested and tried at the federal level (as opposed to the state level) when compared to non-Native youth with similar offense profiles (Rolnick & Arya, 2008). These differences do not necessarily appear to be due to higher rates of crime, but rather because the state is unable to prosecute crimes committed on tribal land, thus these crimes will often fall under federal jurisdiction even if the case is also processed within the tribal courts (Adams et al., 2011). Measuring the actual

proportion of AI/AN youths in the juvenile justice system proves to be challenging, given that the ratio of AI/AN youths to non-Native youths depends on the state (roughly 90% of AI/AN youth live in half of the states; Rovner, 2016). Furthermore, the use of vague and ambiguous criteria when assigning non-White youth to racial categories leaves many AI/AN youths in the juvenile justice system misclassified (National Research Council and Institute of Medicine, 2001). Unfortunately, despite an apparent 250 AI/AN youth per 100,000 being committed to juvenile detention facilities (Rovner, 2016), an extensive review of the literature revealed that research on the mental health profiles of AI/AN youth either currently involved in the justice system or reintegrated back into the community appears minimal, despite the fact that youth involved in the criminal or juvenile justice systems are highly likely to have a diagnosable mental health condition (Underwood & Washington, 2016). This of course is also compounded by the fact that AI/AN youth, compared to non-Native youth, are at an increased risk of developing numerous mental health conditions (BigFoot, Willmon-Haque, & Braden, 2008; Curtin & Hedegaard, 2019; Freedenthal & Stiffman, 2004; Swaim & Stanley, 2018).

Given these considerations, the aims of this paper are trifold: (a) to present a brief history of colonization of Indigenous peoples in the United States and make an argument for the lasting impact colonialism has on Indian Country and AI/AN youth today; (b) to summarize briefly, with primary focus given to papers published on or after 2010, the current literature on mental health needs and delinquency in AI/AN youth, up to age 25, including the literature on effective interventions and common barriers to treatment; and, (c) to offer comments for future research in order to address the unique needs of AI/AN youth that are not currently being met in contemporary mental health research, particularly those youth involved in both juvenile and adult justice systems.

## Historical Impact

In order to understand contemporary Indigenous mental health, it is important to recognize some of the most important historical events and government policies that severely impacted the lives of Indigenous peoples living in what is now known as the United States and Canada. Colonization of AI/AN peoples began in the Americas in the late 1400s and persisted for several centuries, killing an estimated 95% of Native peoples in this time period. The passing of the 1851 Appropriations Act established the reservation system but also disallowed tribal members from leaving their land without explicit permission.

The creation and proliferation of European-run boarding schools was an attempt to “assimilate” AI/AN youth into Euro-American culture. Though these boarding schools had been in place since the 1600s, in the late nineteenth century a “compulsory attendance” law was enacted which

allowed federal officers to forcibly remove youth from their families and their reservations and enroll them in these non-reservation schools. The consequences of this forced assimilation were catastrophic and tragic, as AI/AN children and youth were required to strip themselves of their cultural identities by way of cutting their hair, attending Christian services, being forbidden to speak their native languages, and changing their names. Youth who failed to follow these orders were often abused or had basic nutrition withheld until they complied, resulting in severe malnourishment and death for many. For over 100 years, AI/AN youth were removed from their homes, and upon returning they had a difficult time connecting with their families and their communities as a result of no longer understanding their native languages or abiding by their cultural customs. It was not until 1978 when, in response to the large number of AI/AN youths (25–35%) being forcibly removed from their homes and placed outside of their families and communities (National Indian Child Welfare Association, n.d.), the Indian Child Welfare Act was passed, which allowed AI/AN parents the legal right to deny their children's placement in these boarding schools. Unfortunately, scholars argue that the centuries of cultural suppression and the forced removal of Native youth had understandably detrimental effects on the cultural identities and the mental health of AI/AN peoples today (Brown-Rice, 2013; Grayshield et al., 2015).

Though most of today's youth have not attended non-reservation boarding schools, nor have their parents, many scholars have nonetheless argued that the effects of forced colonization and institutionalization continue to impact Indigenous peoples by way of historical trauma (Brave Heart, 2003; Brown-Rice, 2013; Grayshield et al., 2015). Historical trauma, a form of intergenerational trauma resulting from a long history of systematic oppression of a cultural group, is best described by Brave Heart, one of the pioneering scholars in the identification and measurement of historical trauma in AI/AN peoples: "Historical trauma is cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003). Initially used to describe the lasting effects of the Holocaust on the children of Holocaust survivors, the concept of historical trauma was first applied to AI/AN peoples in the 1990s (Brave Heart, 2003; Gone, 2014; Maxwell, 2014), and it is often cited as being one of the explanations for the stark mental health disparities seen in AI/AN peoples (Brave Heart et al., 2011; Brown-Rice, 2013; Campbell, Evans-Campbell, & Fitzgerald, 2011; Fast & Collin-Vézina, 2019). For instance, some AI/AN people cite the effects of having parents and grandparents who attended residential schools, with one young Indigenous woman stating the following: "We're all damaged, and we'll pass it on to our children, so it will never end" (Maxwell, 2014). Brave Heart (1999) asserted that parents who attended non-reservation may be more authoritarian, punitive, non-nurturing, and emotionally unavailable with their own children. The relation between parenting styles, caregiver

emotional availability, and child outcomes is well cited in the literature (Gorostiaga, Aliri, Balluerka, & Lameirinhas, 2019; Rivers, Mullis, Fortner, & Mullis, 2012), and therefore it is more than plausible to understand how the legacy of boarding schools in AI/AN tribes continue to affect their youth today. An example of this is illustrated in *Brave Heart* (1999), where Native youth with weak Native identities and poor family relations were at higher risk for developing alcohol and substance use disorders.

In sum, for clinicians and researchers working with AI/AN youth, it is imperative for these professionals to understand the lasting impact that centuries of systemic oppression and attacks on their culture can have on AI/AN peoples, their way of life, how they relate to colonizers (including mental health providers and researchers), and their mental health even if they were not the direct receivers of forced assimilation and cultural oppression.

### **AI/AN Youth Mental Health and Delinquency**

The prevalence and manifestation of substance abuse disorders is arguably the most well-researched area in contemporary AI/AN research. Substance and drug use among tribal members continues to pose a significant problem, as the rates of substance use are significantly higher in AI/AN youth, with 23–56% of AI/AN youth between the eighth and twelfth grades report having been drunk in the last 30 days, compared to 8–45% in national U.S. adolescents (Swaim & Stanley, 2018). Research conducted by Stanley and colleagues (2014) also revealed that AI/AN youth had higher rates of substance use across all drug categories with the exception of amphetamines and tranquilizers. A similar study which examined the patterns of drug use among AI/AN adolescents over the past 30 years found that rates of youth reporting they have ever used drugs and/or alcohol remained relatively stable, typically around 80% for alcohol and between 40% and 75% for marijuana, both of which were found to be significantly higher than rates in non-Native American youth (Beauvais, Jumper-Thurman, & Burnside, 2008). An examination of AI/AN youths aged 17 and less receiving mental health services in a major metropolitan area in the United States revealed that nearly 70% regularly drank alcohol and 50% smoked marijuana (Dickerson & Johnson, 2012). Pavkov and colleagues (2010) discovered that when compared with non-Hispanic White youth, AI/AN youth were more likely to have reported using heroin, using a needle to inject drugs directly into their system, and to have been under the age of 13 when they first tried alcohol. Almost 15% of AI/AN youth in this sample also reported drinking and driving in the past month (Pavkov et al., 2010).

Substance use may to be linked to suicidality in these youth, as a study of suicide and suicidal behavior among White Mountain Apache tribal youth revealed that three-fourth of youth attempting suicide were “drunk or high” at the time of the attempt (Barlow et al., 2012). Epidemiological research on suicide across the lifespan has revealed that AI/AN youth have

the highest rate of suicide for youth ages 15–24 (33 per 100,000), with the rate of suicide for both male and female AI/AN youths nearly doubling from 1999 to 2007 (Curtin & Hedegaard, 2019). Overall, it is estimated that suicide accounts for 26.5% of deaths among AI/AN youth ages 15–19 (LaFromboise & Malik, 2016). Preliminary research suggests that these rates appear to be similar between AI/AN youth living on a reservation and urban-dwelling AI/AN youth, though youth on tribal land appear to have higher rates of suicide ideation (Freedenthal & Stiffman, 2004). An examination of young AI/ANs reasons behind not seeking professional help when suicidal ideation is present revealed that these youth frequently held the belief that they did not need help, or were reluctant to seek help due to the stigma and embarrassment behind receiving mental health treatment (Freedenthal & Stiffman, 2007).

The rates of trauma and post traumatic stress disorder (PTSD) among AI/AN youth are difficult to determine given the dearth of research conducted in this area, but some studies suggest that these youth are more likely to experience a traumatic event than the general population (Big-Foot et al., 2008). The rates of PTSD among these youth appear to exceed 20% (Dorgan et al., 2014), whereas The National Institute of Mental Health (NIMH, 2017) estimate the lifetime prevalence of PTSD among adolescents between the ages of 13 and 18 to be around 5%. For comparison, the rates of PTSD among these youth appear to be comparable to the rates of PTSD among veterans returning from combat (Dorgan et al., 2014). The high rates of trauma and PTSD are likely explained in part by the violence and abuse that are all too prevalent in Indian Country, with AI/AN children and youth appearing to be the victims of child abuse and neglect at higher rates than any other race or ethnicity. The most recent report by the U.S. Department of Health and Human Services, Children's Bureau (2019) indicates that in 2017, AI/AN youth had the highest rate of victimization across all races and ethnicities, with 14.3 out of 1,000 children being the victim of a crime. This rate is roughly 1.5 times that of the average victimization rate for all children in the United States. By the time they reach adulthood, over 80% of AI/AN men and women report having been the victim of some form of violence in their lifetime (Rosay, 2016). With such elevated rates of exposure to violence, abuse, and neglect, it is easy to see why AI/AN youth appear to be at higher risk to develop trauma-based mental health disorders.

AI/AN youth also appear to be more likely to engage in other high-risk behaviors, such as risky sexual behaviors. Though data are limited, rates of adolescent pregnancy among female AI/AN youth aged 15–19 in 2007 were 25% more than the national average, though this does appear to be trending downward (Ventura, Hamilton, & Mathews, 2013). Not only are AI/AN youth significantly more likely to report having been under the age of 15 the first time they had sex (de Ravello, Everett Jones, Tulloch, Taylor, & Doshi, 2014; Pavkov, Travis, Fox, King, & Cross, 2010), AI/AN youth also appear disproportionately more likely to be diagnosed with sexually transmitted

infections. When compared to non-Hispanic White youth in 2018, AI/AN youth aged 10–19 were noted to have 2.5 times the rates of chlamydia, 4 times the rates of gonorrhea, and nearly 5 times the rates of primary and secondary syphilis, though HIV rates appear to be similar to other racial demographics (Centers for Disease Control and Prevention, 2019).

Evidenced by the disproportionate amount of AI/AN youth involved in the juvenile justice system (Adams et al., 2011; Crosby, 2016; Rolnick & Arya, 2008; Rovner, 2016), delinquent behaviors among AI/AN youth appear to be common. An analysis of self-reports from youth of varying racial and ethnic backgrounds indicated that AI/AN youth were the most likely to carry a weapon in the past month, with nearly 25% of AI/AN youth reporting this behavior (Pavkov et al., 2010). Self-reported dating violence among AI/AN adolescents appear 1.5 times greater than their non-Hispanic White peers, and rates of forced sexual contact appear to be higher as well (de Ravello et al., 2014). Though research on AI/AN youth gangs is limited, gang involvement appears to be a growing concern. The most comprehensive study conducted on AI/AN youth involvement in gangs was conducted nearly 20 years ago, and at the time, 16% of male youth and 11% of female youth reported having some involvement with a gang, though the rates of actual gang membership were 6% and 1%, respectively (Donnermeyer, Edwards, Chavez, & Beauvais, 2000). A more recent study reported similar percentages, with 6.7% of participants reporting gang membership and nearly one out of ten participants reporting gang initiation during the study period (Hautala, Sittner, & Whitbeck, 2016). Analyses for this sample revealed that youth with some gang involvement were more likely to have engaged in delinquent behaviors within the past month, including stealing, unlawful entry, and selling marijuana. Qualitative data gathered by Mmari and colleagues (2010) from AI/AN youth suggests that many of the youth joined gangs as an opportunity to “fit in” with multicultural peer groups, though it is likely that these youth join gangs for many of the same reasons cited by youth of other racial and ethnic backgrounds, including protection, money, and respect (Howell, 2010).

**Risk Factors.** The high co-occurrence between substance abuse, suicide, risky behavior, and other mental health symptoms appear to be explained in large part to common risk factors. Common risk factors for both suicidal behavior and substance use, as well as PTSD symptomology and depressive symptoms among AI/AN youth appear to be abuse, neglect, and exposure to violence (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015; Burnette & Figley, 2016). Exposure to traumatic events, such as the death of a close family member, physical, emotional, or sexual abuse, and familial history of substance abuse have all been cited as prominent risk factors in the development of mental health problems in AI/AN youth (Burnette & Figley, 2016; Cwik et al., 2015; Donnermeyer et al., 2000; Freedenthal & Stiffman, 2004). Freedenthal and Stiffman (2004) found that both drug use and sexual abuse were significantly associated with suicide



attempts, and this trend was noted in other literature as well (Cwik et al., 2015). Drug and alcohol abuse were both identified as being predictors of gang involvement (Hautala et al., 2016), though it is difficult to tell the directionality of this association as it is possible that gang involvement leads to higher rates of substance abuse.

Family and peer relations have been noted to be related to a number of mental health concerns as well, especially given the importance of family and the greater community in the cultural beliefs for many tribes (Cwik et al., 2015; Hautala et al., 2016; Heavyrunner-Rioux & Hollist, 2010; Lowe, Liang, Riggs, Henson, & Elder, 2012). In an examination of suicide attempts, Cwik and colleagues (2015) found that the suicide of a parent or sibling, as well as verbal abuse and arguments with friends were risk factors for suicide attempts. Low parental monitoring was noted to be positively associated with gang involvement in one study (Hautala et al., 2016). A systematic review of mental health risk factors in AI/AN youth suggests that low parental warmth, caretaker rejection, and coerciveness were predictive of depressive symptoms and suicidality (Burnette & Figley, 2016). The authors of this review also highlight how parent mental health plays a role in the youth's emotional wellbeing, as parental substance abuse and suicide attempts were both predictive of identical behaviors in their children. Spirituality and a strong cultural identity in many Indigenous communities is not separated from psychological well-being, and thus several scholars have suggested that a strong spiritual basis and connection with one's cultural background could be a protective factor against developing mental health concerns (Burnette & Figley, 2016; Harder, Rash, Holyk, Jovel, & Harder, 2012; Kulis, Hodge, Ayers, Brown, & Marsiglia, 2012; Mohatt, Fok, Burket, Henry, & Allen, 2011).

On a societal level, several risk factors have been examined in the literature. Poverty is often cited as a risk factor for youth of varying racial and ethnic backgrounds (Aber, Jones, & Cohen, 2000; West et al., 2011; Yoshikawa, Aber, & Beardslee, 2012). Given that the rates of poverty among AI/AN communities are the highest of any racial/ethnic group (U.S. Census Bureau, 2018), the potential for this factor to negatively affect AI/AN youth is high. Low family income for AI/AN youth has been noted to be predictive of gang involvement, depressive symptoms, and substance abuse (Burnette & Figley, 2016; Hautala et al., 2016). Perceived discrimination and racism have also been associated with suicide attempts (Freedenthal & Stiffman, 2004), interpersonal violence and self-destructive acts (Mmari, Blum, & Teufel-Shone, 2010), and also gang involvement (Hautala et al., 2016).

Though much of the research written on historical trauma as it relates to AI/AN youth is theoretical in nature, some scholars have been able to empirically measure this construct. For example, the development of the Historical Loss Scale by Whitbeck and colleagues (2004) allowed scholars to measure the effects of historical loss by evaluating affect, substance use, and delinquency as a function of thoughts about historical loss (Armenta



et al., 2016; Brave Heart et al., 2011; Whitbeck, Adams, Hoyt, & Chen, 2004). Another study which examined suicidality among Canadian First Nations adults demonstrated that participants who had a parent or grandparent attend a non-reservation boarding school had more frequent suicidal thoughts and attempts (Elias et al., 2012). Empirical research on effects of historical trauma on AI/AN youth is still in the early stages, but these cited studies imply that events deemed “historical” to many nonetheless continue to affect the lives of Native peoples.

## Barriers to Treatment

Structural barriers, such as lack of federal mental health funding for tribal members, appear to play a significant role in the lack of mental healthcare seeking for AI/AN youth. For instance, funding for AI health care is significantly less than it is for the average American, and minimal funding for behavioral health through the Indian Health Service (IHS) leaves many AI/AN youth with mental, emotional, and behavioral difficulties with very few options (Dorgan, 2010; Gone, 2004; Goodkind et al., 2011), especially given the 25% rate of poverty noted among self-identified AI/ANs (U.S. Census Bureau, 2018). In addition, the rural location of many reservations may impede upon their ability to seek care. A review of literature for obstacles to participating in health-focused randomized controlled trials for Indigenous peoples in New Zealand, Australia, the United States, and Canada revealed that many participants in the United States cited a lack of a telephone and difficulty travelling long distances to the study sites as barriers (Glover et al., 2015), and it is likely that these results can be generalized to mental health research and treatment as well.

Another often-cited barrier to appropriate mental healthcare treatment for AI/AN youth is the overreliance on evidenced-based practices and subsequent lack of research and focus on modified interventions for these youth (Goodkind et al., 2011). Though the establishment of evidence-based practices in psychotherapy is arguably what distinguishes psychology as a science, and what separates the “good” from the “bad” in terms of psychotherapy practice, the literature cited as the evidence for certain modalities of treatment fails to recognize that much of this early research neglected Indigenous populations. Whether through intentional means or due to an inability to acquire a nationally representative sample, what has been accepted as “evidence-based” for the majority of the population cannot necessarily be assumed for AI/AN peoples or their youth. While there may exist great diversity in notions about mental health between tribes, and though it is important for both researchers and treating clinicians to avoid adopting a “western” versus “other” mentality when conducting research or providing therapy, research on Indigenous beliefs about mental illness does support that Native peoples tend to approach mental health from a more community-oriented and spiritually based point of view as compared to

their Western counterparts (BigFoot & Schmidt, 2010; Goodkind, LaNoue, & Milford, 2010; Jackson & Hodge, 2010; Morsette, van den Pol, Schuldberg, Swaney, & Stolle, 2012; Vukic, Gregory, Martin-Misener, & Etowa, 2011; Wexler & Gone, 2012). For instance, a study of Mi'kmaq youth, an Indigenous tribe located in the Atlantic provinces of Canada, revealed that these youth use the term "wholistic," as opposed to holistic, when describing their approach to mental health in order to more accurately represent the interdependence and interconnectedness of the spirit, the body, the people, and the land (Vukic et al., 2011). A similar paper highlighted that tribal communities often view suicide as a spiritual dilemma rather than a personal decision due to unbearable psychological pain (Wexler & Gone, 2012). As such, when conceptualizing what traditional Western culture would view as a malady or disease, these youth appear to view substance use disorders and mental illness as a symptom of one's imbalance or lack of harmony with the world. While scholars astutely identify that differences do not imply a complete absence of common ground, they highlight the importance of taking these cultural values into consideration when assessing, treating, and conducting research with native youth (Vukic et al., 2011).

Spirituality and family/community connectedness are frequently cited as the most influential protective factors for AI/AN youth, and thus within the last 15 years, there has been numerous studies on strength-based modified treatments for AI/AN youth which incorporate these elements (BigFoot & Schmidt, 2010; Goodkind et al., 2010; Jackson & Hodge, 2010; Wexler & Gone, 2012). For instance, Goodkind and colleagues (2010) tested an adapted version of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for AI/AN youth. Among the adaptations were considerations for the integration of traditional healing practices for youth who might find it beneficial, referring youth to traditional practitioners when necessary. The results of their research suggested that the adapted CBITS was effective in reducing symptoms of depression, anxiety, and PTSD, as well as an avoidant coping at post intervention and a 3 month follow up (Goodkind et al., 2010, Morsette et al., 2012). Honoring Children, Mending the Circle (HC-MC; BigFoot & Schmidt, 2010) was a similar intervention developed for the treatment of trauma in AI/AN youth. Like the modified version of the CBITS, HC-MC incorporates spirituality given the believed interconnectedness between spirituality, relationships, and healing observed in most tribal communities. Holding Up Our Youth is yet another example of a culturally tailored, community-based curriculum for AI/AN youth developed for the prevention of substance abuse in tribal youth (Donovan et al., 2015). These are just a few examples of treatment packages for AI/AN youth, though the community- and school-based approaches neglect the significant amount of AI/AN youth currently incarcerated. In reviewing the literature, this author was unable to identify any interventions for delinquent tribal youth specifically. This is not to say that none exist, but rather any culturally tailored interventions for AI/AN youth in the justice system do not appear to be

empirically tested, and thus the efficacy of these interventions cannot be inferred. In conclusion, more studies are needed to establish these treatments as effective and add them to the repertoire of evidence-based treatments, especially for AI/AN presently incarcerated in adult correctional facilities or residing in juvenile justice placements, but the ones that do exist provide hope in reducing the stark mental health disparities observed in tribal youth.

## Conclusion

Given the reviewed literature, this author proposes several future directions for research.

Foremost, because AI/AN youth are more likely to receive mental health services through the juvenile justice system than are non-Native youth (BigFoot & Schmidt, 2010), and given that the combination of substance use, impulsivity, and other risky behaviors observed in this population places them at higher risk of being involved in the justice system (BigFoot, 2007), more research should focus on this subpopulation of AI/AN youth. Unfortunately, the voices of these youth and their experiences with residential placement and community reintegration are missing from the literature. Their understandings of their experiences, their relations to the transgenerational effects of trauma, and how they navigate post-incarceration life in colonist society would no doubt provide valuable insights to both researchers and mental health providers developing and implementing effective interventions for these youth. As noted earlier, it would be helpful to understand the portion of AI/AN youth who end up in federal correctional facilities and how they differ from AI/AN youth in traditional juvenile justice placements. Further, though empirical research on historical trauma as it relates to mental health development in AI/AN youth continues to burgeon, very few scholars have tied symptoms associated with historical trauma to delinquency in AI/AN youth. Understanding how historical trauma responses affect AI/AN youth's likelihood of engaging in delinquent behaviors is a necessary step in treating the large amount of AI/AN youth involved in the juvenile and criminal justice systems.

Furthermore, comparing AI/AN youth involved in the justice system and AI/AN youth with no known criminal involvement in terms of cultural identity and mental health indices could be helpful to determine possible risk and protective factors for delinquency in these youth. On an institutional level, it is recommended that forensic settings with a high proportion of AI/AN youth not only provide trauma-informed care training, but also historical trauma-informed care training for any direct-care staff as this would better prepare staff to recognize historical trauma responses in AI/AN youth and intervene accordingly.

Additionally, it is crucial to note that, when considering mental health concerns and risk factors among AI/AN youth, it would be important for

researchers to consider unique characteristics of AI/AN youth living in urban settings, especially since the majority of AI/AN youth do not live on a reservation. Though some scholars have suggested that AI/AN youth living in cities may be at greater risk of developing mental health concerns such as higher levels of hopelessness when compared to youth living in urban areas (LaFromboise, Albright, & Harris, 2010), perhaps due to greater difficulty with maintaining their cultural identity and traditions (Johnson & Tomren, 1999), other research suggests that urban-dwelling AI/AN youth appear to be at lesser risk for developing various mental health concerns (Freedenthal & Stiffman, 2004). Though the reasons behind this disparity are unclear, the authors hypothesize that the higher rates of poverty and alcoholism on some reservations could explain these differences. Nonetheless, it would be important for future scholars to consider the unique challenges these youth may face living on a reservation versus in an urban area, and how these experiences can serve as either risk or protective factors in mental health development.

There are several issues related to research recruitment that should be rectified in future studies. Though a majority of AI/ANs live in metropolitan areas, a significant portion of Native peoples still live in rural areas, and thus research recruitment may be a problem. As such, scholars conducting research focused on AI/ANs, or even scholars who wish to have a more representative sample in their data, should make concerted efforts to reach tribal members who may not have access to methods traditionally used for research recruitment, such as internet postings. Another issue related to research with Native communities is trust in the research process. Unfortunately, there have been many documented instances where research conducted on tribal land or with Native peoples had ill effects on the community (Harding et al., 2012; Native American Center for Excellence, n.d.), and thus many communities are rightfully reluctant to participate in research being conducted by experts outside of their tribe.

Perhaps the best method for combatting these difficulties is to use Community-Based and Tribal Participatory Research (CBPR/TPR) approaches, such as by establishing a relationship with tribal communities (and, in the case of AI/AN youth, tribal schools or schools with a high proportion of AI/AN youth) prior to conducting any research (Harding et al., 2012). An example of this can be viewed in The Healing of the Canoe Project, a collaboration between the University of Washington and the Suquamish and Port Gamble S'Klallam tribes which had existed for several years prior to the development of the intervention being studied (Donovan et al., 2015). The Native American Center for Excellence (NACE; n.d.) also suggest that attending Native meetings, ceremonies, or other important events could assist prospective researchers in establishing rapport with tribal members and developing an appreciation for their culture, both of which would likely increase research participation and retention. To address issues related to trust of the research process, researchers should conduct

research in a collaborative, respectful manner and always be transparent in how the data will be used and results disseminated. Many tribes, such as the Diné tribe in the Southwestern United States, have established their own institutional review board (IRB) to facilitate ethical and effective research practices, and thus abiding by their specified research protocol is of utmost importance. In the absence of such a board, NACE recommends researchers establish one with elders and other tribal members to ensure the well-being of research participants from their community. For more examples on CBPR/TPR approaches, readers are encouraged to view the chapter written by Thomas and colleagues (2011).

Finally, it is important for researchers and mental health providers to understand that the effects of colonization of Indigenous peoples in America still reverberate throughout the lives of the Native peoples today, as they shoulder the burden of historical trauma and grief for the loss of their people, their culture, and their way of life. Thus, professionals involved in treatment and research for historically oppressed communities, such as American Indians and their youth, must strive to understand the socio-political factors which propagate(d) the health disparities observed in tribal communities, recognize how colonization is still in effect, and advocate for corrective policies. Though these historical and modern injustices cannot be undone, acknowledging how these injustices are reflected in the mental health of Indigenous peoples today is the first of many steps to rectifying these disparities.

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JESSICA L. GARCIA is a current clinical psychology PhD student at the University of Houston working with Dr. Elena Grigorenko. She is most interested in the biopsychosocial factors related to the development of externalizing disorders in childhood and adolescence. She is also interested in the development and implementation of interventions for American Indian/Alaska Native youth, particularly those involved in the justice systems.