2024

Historical Trauma Informed Approach to Treatment: A Proposed Suicide Prevention Program for Native American Youth

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HISTORICAL TRAUMA INFORMED APPROACH TO TREATMENT: A PROPOSED SUICIDE PREVENTION PROGRAM FOR NATIVE AMERICAN YOUTH

A Dissertation

Presented to the Faculty of

Antioch University Santa Barbara

In partial fulfillment for the degree of

DOCTOR OF PSYCHOLOGY

by

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June 2024

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Antioch University Santa Barbara
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

HISTORICAL TRAUMA INFORMED APPROACH TO TREATMENT: A PROPOSED SUICIDE PREVENTION PROGRAM FOR NATIVE AMERICAN YOUTH

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Suicide is a significant public health concern across the world. It is the second leading cause of death for children and young adults ages 10-34 (CDC, 2016). In 2021, suicide rates were highest among American Indian/Alaska Native (AI/AN) persons, and AI/AN youths had the highest rates of suicide compared to their same-aged peers from other racial and ethnic groups (Stone, Mack, & Qualters, 2021). Historical trauma, or unresolved trauma caused by colonization that gets passed down from generation to generation, has been used as a framework for understanding the high rates of social problems and suicide that plague AI/AN communities. Treating suicide and trauma-related symptoms requires an awareness of the historical factors that contribute to contemporary psychosocial problems. This paper will review the research on suicide risk and protective factors, suicide prevention strategies, and therapeutic interventions. This writer proposes a culturally-tailored trauma-informed treatment program specific to AI/AN youth who are impacted by intergenerational trauma and suicide. The program will build on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a treatment that has demonstrated effectiveness with children and adolescents who are struggling with trauma symptoms. AI/AN traditional cultural beliefs and practices will be incorporated into the model, with an emphasis on cultural identity and spirituality. This twelve-week group treatment program will be developed for AI/AN adolescents and their families, and the interventions will focus on psychoeducation, skill building, trauma narration, trauma processing, safety planning, and strengthening family

relationships. Unique elements of the program include interventions that are specifically focused on preventing suicidality and processing historical trauma. The hope is that this approach to treatment will serve as a guideline for addressing historical trauma related symptoms and suicidality in AI/AN community mental health settings. This dissertation is available in open access at AURA, https://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu.

Keywords: suicide, American Indian/Alaska Native, historical trauma, trauma-focused cognitive behavioral therapy, prevention, intervention

ACKNOWLEDGEMENTS

I would like to acknowledge the people who cheered me on and believed in me even when I struggled with believing in myself. First, a huge thank you to my parents Mickie and Brian, for your unconditional love and guidance. Thank you to my dear friend and fellow cohort member Dr. Brian Beasley for helping me get through graduate school. I will always cherish our memories together from that time in our lives. A special thank you to my dissertation committee: Dr. Kia-Keating, Dr. Southern, and Dr. Pines, for supporting me and providing their knowledge and expertise. My sincerest appreciation goes to Dr. Allison Adelman, who guided me and encouraged me throughout the writing process. Finally, I would have never known about this topic if it weren't for the tragic passing of a fellow Antioch student who was passionate about suicide prevention and had made it his legacy to spread awareness about the high rates of suicides plaguing American Indian/Alaska Native communities. Above all, I dedicate this treatment proposal to him and his family, and I hope that this project honors his memory.

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CHAPTER I: INTRODUCTION

Every ten minutes at least one person will die by suicide in the United States. In 2017, 47,000 people died by suicide, 10.6 million American adults seriously thought about suicide, 3.2 million people made a plan to commit suicide, and 1.4 million people attempted suicide (Substance Abuse and Mental Health Services Administration, 2018). Suicide is identified as a major public health concern in the United States and worldwide. The Centers for Disease Control and Prevention (CDC) define suicide as, "death caused by injuring oneself with the intent to die". A suicide attempt is defined as, "a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior which may or may not result in injury" (Stone et al., 2017). Suicide affects individuals of all ages. In a 2016 report conducted by the CDC regarding the ten leading causes of death by age group in the United States, suicide is the tenth leading cause of death in all age groups and is the second leading cause of death for individuals ages 10-14 (436), 15-24 (5,723), and 25-34 (7,366). Suicide is the eighth leading cause of death among individuals ages 55-64 (Centers for Disease Control and Prevention).

Research shows that suicide rates vary by population characteristics such as race/ethnicity, age, and gender, with the highest rates across the life span occurring among non-Hispanic American Indian/Alaska Native (AI/AN), and non-Hispanic white population groups. In 2015, the rates for these groups were 19.9 and 16.9 per 100,000 individuals, respectively (Stone 2017). American Indian youth have consistently had the highest prevalence rates of suicide attempts in the nation. One national study reported 23.1% of American Indian youth had suicide ideation, and 16.4% reported suicide attempts. In comparison, among African American youth, 12.3% reported suicide ideation and 7.8% reported suicide attempts (Pavkov, Travis, Fox, King, & Cross, 2010). The high risk for suicidality in Native populations appears to be related to

intergenerational trauma experienced by Native peoples as a result of a violent history of genocide, disempowerment, and oppression (Brave Heart, 2003). These premature deaths are needless and preventable, compounding the suffering that Indigenous people have experienced across generations. While there has been increasing national attention towards issues of suicide, there is still a significant need for research, preventive programs, treatment, and outcome evaluation within Native American communities. The purpose of this literature review is to identify risk and protective factors for suicide and to distinguish effective elements of suicide prevention programs. For the dissertation, key elements of effective suicide prevention programs will be combined to develop a culturally-tailored, trauma-informed suicide prevention program for Indigenous youth.

CHAPTER II: LITERATURE REVIEW

Historical Trauma

American Indians and Alaska Natives have endured a series of traumatic events that have severely impacted the mental health and well-being of individuals, families and communities (Brave Heart, 1998; Hartmann et al., 2019). In order to understand the challenges that Native communities currently face, it is necessary to discuss the historical events that have led to their collective suffering. Some of these traumatic events include community massacres, genocidal policies, pandemics from the introduction of new diseases, forced relocation, forced separation of children from families through Indian boarding school policies, and prohibition of spiritual and cultural practices. Additionally, Native communities currently have some of the highest rates of lifetime trauma, including interpersonal violence, poverty, child abuse and neglect, poor health, and negative stereotypes and microaggressions (Evans-Campbell, 2008).

The concept of historical trauma has received a lot of attention in the literature over the recent years. Historical trauma refers to the idea that unresolved trauma is passed down to subsequent generations. Duran (2006) argues that this trauma is cumulative, indicating that the unresolved trauma becomes more severe as it is passed down intergenerationally. Duran (2019) became aware of the idea of historical trauma during his work with a Native American community in California. As he began to speak to Native people in the community, he noticed that issues in the community were described as "spiritual injury, soul sickness, soul wounding, and ancestral hurt" (Duran, 2019, p. 17). Elders in the community reported that the "ancestral wounding" was being passed down through generations, referring to the genocide that had occurred in their community between 1870 and 1900, where 80% of their community was systematically wiped out (Duran, 2019). Early research on the idea of historical trauma, or

intergenerational trauma, focused on the development of depressive symptoms in children of Holocaust survivors. An Israeli researcher describes the impacts that this unfinished and unintegrated mourning has on the children of Holocaust survivors by stating: "The members of the second generation suffer from a kind of inborn nostalgia, very similar to a depressive state, which seems to have taken the place of continuous mourning of their parents" (Shoshan, 1989, p. 203). Shoshan (1989) indicates that the most significant trauma experienced by Holocaust survivors appears to be the violent separation from close family members, and that it is this traumatic disruption that determines the extent of the survivors' suffering. Children of Holocaust survivors are not the only ones who react symptomatically to their family's traumatic histories. Children of war veterans, children of Cambodian genocide survivors, children of the World Trade Center attack survivors, and Native American youths, have been identified as "…the modern world's newest victims of transgenerational trauma" (Wolynn, 2017, p.33).

The concept of intergenerational trauma has been more recently explored in research pertaining to clinical issues in Native communities. Duran and Duran (1995) described six phases of historical trauma for Native Americans: 1) first contact, 2) economic competition, 3) invasion war period, 4) subjugation and reservation period, 5) boarding school period, and 6) forced relocation and termination period. Duran and colleagues (1998) note that while historical trauma included acculturative stress, the concept of historical trauma goes beyond acculturative stress to capture the impacts of oppression, racism, and genocide (Duran, Duran, Brave Heart, & Maria Yellow-Horse Davis, 1998).

This legacy of colonization has been used as a framework for conceptualizing the high prevalence rates of mental disorders and social problems that have plagued Native communities across generations. The psychological impacts and dysfunction resulting from acculturation that

has affected tribal structure, religious practices, and personal/community identity, have been identified as risk factors for suicide and other psychiatric disorders (Evans-Campbell, 2008; Kelley, Restad, & Killsback; Alcantrá & Gone, 2007). Further, this colonial legacy has been viewed as a "colonization of the life world", meaning that colonizers disrupted the structure by which Native social and cultural practices are transmitted across generations (Alcantrá & Gone, 2007). Indeed, Native American populations have some of the highest rates of alcoholism, heart disease, diabetes, depression, and suicide in the country (McLeigh, 2010).

The residential boarding school period is frequently mentioned in the literature as having the most significant negative impacts on Native families. During this period, from the 1870s to the 1970s, children were forcibly removed from their families and placed in boarding schools, where they were exposed to physical, sexual, and emotional abuse, and were punished for speaking their Native language (Dunbar-Ortiz, 2014). Many children died of illness, and those that did eventually return to their families had difficulty functioning and struggled to talk about their traumatic experiences with loved ones. As a result, Native adults who were raised in boarding school environments struggled to raise their own families (Riley, 2016). While the most salient imprint of colonization for a lot of Native individuals was the residential school period, there are many other aspects of colonization that have had adverse consequences for Native communities. Governmental policies that disrupt Native ways of life, such as the flooding of hunting grounds for the generation of hydroelectric energy, rob Native communities of their material livelihood. Native people often resort to drinking as a way of coping with these assaults because they have lost their traditional ways of grieving and coping in the process of cultural and spiritual suppression by colonizers (Gone, 2009). Thus, counseling for Native Americans must involve an awareness of historical factors that contribute to contemporary psychosocial problems

in Native communities. Further, healing the legacy of historical trauma must involve a restoration of indigenous cultural and spiritual practices.

Researchers have described three phases of history that highlight the experience of ongoing trauma in Native communities, beginning with first contact with European colonists, followed by the residential boarding school period, and finally forced assimilation (Mcleigh, 2010).

Historical Overview: First Contact

Native historian and activist Roxanne Dunbar-Ortiz provides a history of the United States told from the perspective of Indigenous peoples in her book *An Indigenous People's History of the United States.* Throughout the book, she emphasizes the survival of Indigenous peoples through centuries of resistance and storytelling passed through generations. She challenges the myth of the consensual "encounter" between colonizers and Indigenous peoples under the smokescreen of multiculturalism:

> The history of the United States is a history of settler colonialism—the founding of a state based on the ideology of white supremacy, the widespread practice of African slavery, and a policy of genocide and land theft. Those who seek history with an upbeat ending, a history of redemption and reconciliation, may look around and observe that such a conclusion is not visible, not even in utopian dreams of a better society (p. 2).

The founding myth of the United States was largely based on Calvinist ideology, with the belief that colonists had been summoned by God to trek through the wilderness, conquer whatever heathens they may encounter, and occupy a land on his behalf (Dunbar-Ortiz, 2014). The founding myth also posits that the colonists, "…acquired a vast expanse of land from a scattering of benighted peoples who were hardly using it" (Dunbar-Ortiz, 2014, p. 46). However,

scholarship has shown that this was hardly the case. In fact, it is unlikely that European colonists would've been able to survive if North America was a true, uncultivated, undeveloped wilderness. William Denevan, a professor of Geography at the University of Wisconsin-Madison, challenges the myth of the undisturbed, pristine American wilderness at the time of Columbus. At the time of European colonization, evidence shows that Indian populations were large, "…not only in Mexico and the Andes, but also in seemingly unattractive habitats such as the rainforests of Amazonia, the swamps of Mojos, and the deserts of Arizona (Denevan, 1992, p. 379). The most humanized landscapes were characterized by urban centers, road systems, intensive agriculture, a dispersed but relatively dense rural settlement pattern of hamlets and farmsteads, and widespread vegetation and soil modification and wildlife depletion. Critical to Denevan's argument is the size of the Native population, which he estimates to be approximately 53.9 million in 1492. This number had dropped to approximately 5.6 million by 1650, and Denevan attributes the majority of these deaths to Old World diseases (Denevan, 1992).

Dunbar-Ortiz (2014) writes that historians often blame epidemics and Indigenous peoples' lack of acquired immunity as the main reason why there was such a huge decrease in Indigenous populations, framing what the author refers to as "the most extreme demographic disaster" as a natural process. This rhetoric is dismissive of the socioeconomic factors of the time, specifically the unlivable conditions created and maintained by colonizers, which contributed to Indigenous peoples' vulnerability to minor infections. Denevan (1992) suggests that warfare reinforced the impacts of disease, and points to other killers such as the pitting of Indigenous nations against one another, overwork in mines, outright butchery, malnutrition and starvation due to breakdown of trade networks, subsistence food production and loss of land, loss of will to live or reproduce (including suicide, abortion, and infanticide), deportation and

enslavement, and the breakdown of social order due to the introduction and promotion of alcohol. The rise of Indigenous movements helped to challenge the fatalistic narrative and bring attention to European colonizers active, intentional role in planning and perpetuating the genocide of millions of Indigenous people. Beginning with the settlement of the New England colony by Puritan settlers, colonizers employed any means necessary to destroy Indigenous resistance in their quest for westward expansion, mainly by attacking civilians and food sources. Generations of settlers became experienced “Indian fighters”, and scalp hunting developed into a profitable practice, which also led to the introduction of a market for Indigenous slaves. Thus, irregular warfare, or warfare that is characterized by extreme violence against civilians with the goal of total annihilation of Indigenous populations, became the foundation for wars against Indigenous people across the continent into the late nineteenth century, and these war tactics are still employed by the US military today (Dunbar-Ortiz, 2014).

Residential Education

The boarding school period is just one of the six phases of historical trauma that was outlined by Duran and colleagues (1995). The removal of over ten thousand Native American children from their families in the late 1880s and subsequent placement into residential boarding schools has been described as a “systematic attack” by the U.S. government on Native American families to strip Native peoples of their culture and identity with the goal of assimilation. Native children were given instruction in the English language, Christianity, and Euro-centric cultural values, norms, styles of dress, and manner. Indeed, the mindset behind forced assimilation can be conveyed in the statement, “Kill the Indian in him, and save the man.” U.S Cavalry captain Richard Henry Pratt reportedly made that statement in his dedication speech upon opening the first boarding school of its kind in Carlisle, Pennsylvania. Pratt was reported to have believed

that Native Americans were "equal" to European-Americans, and his idea was that exposing Native Americans to mainstream Euro-American culture would help them advance so that they could survive in the dominant society.

Native Americans were required to give up their land in the Indian Removal act of 1830, which forced Native Americans to move west of the Mississippi to open more Indian land for settlement at a low cost, and it was considered especially important to southeasterners because it would increase the population in the region and thus increase the South's political influence in Congress (Carlson & Roberts, 2006). As the white population grew and people started to settle further west towards the Mississippi, confrontation between Europeans and Native Americans continued as white settlers attempted to expand their frontiers. By the 1880s, the American Indian population was continuing to decline and the government began to develop policies to assimilate the remaining Indians into mainstream American life (Adams, 1988). In 1885, U.S. commissioner of Indian Affairs Hiram Price stated, "It is cheaper to give them education than to fight them" (Little, 2017). While "educating" American Indians as opposed to fighting them was likely viewed as taking the moral approach to dealing with Native peoples, it is clear that this approach was motivated by financial incentives rather than concern for Native peoples' welfare.

One study that sought to examine the interplay of inner psychic conflicts of American Indian boarding school students in Indian boarding school environments referred to the "…often invisible schooling consciousness of racism, meritocracy, and other internalized values" (Robbins et al., 2006). The researchers interviewed both former and current boarding school students, collecting information about the participants' experiences before entering and during their time in boarding school environments. One of the themes that became apparent during the process of coding that were of particular interest to the researchers were aspects and processes of

assimilation. Indeed, many of the participants appear to have identified with and introjected many of the institutional values of usefulness, conventional beliefs, Christianity, practical knowledge, independence, hierarchy based on social position and responsibility, discipline, and punctuality. Many interviewees also felt that their tribal cultural values were being actively undermined during their boarding school experience (Robbins et al., 2006).

Boarding school staff were reported to have told Native students that they were better off at the school than with their tribes, and were generally antagonistic towards Native culture, undermining rituals and belief systems. Children were forbidden from practicing their native languages, religion, or convey anything indicative of Native identity. Native Americans were treated as a problem in the competition for Westward expansion, as the U.S. government struggled to figure out what to do with them. Assimilating Native people appeared to be a better option for the U.S. government as they began to run out of solutions for fixing the "Indian problem". These white supremacist attitudes also promoted negative stereotypes against Native people that have permeated Western society, such as the stereotype that American Indians are lazy or inebriated, or that they are victimized, helpless weaklings in need of rescuing (Robbins et al., 2006).

The shadow of the boarding school period is evident and most of the literature regarding Native Americans and the history of oppression they've experienced refer to the boarding school period as a part of the "soul wound" experienced by Native peoples (Duran, 2006). Some Native Americans report positive aspects of their boarding school experience, such as an appreciation for the regimentation, orderliness, and practical knowledge they learned in Indian boarding schools. Many Native children came from chaotic and dysfunctional home environments, and the structure, knowledge, and personal responsibility they gained from their boarding school

experiences was seen as a benefit (Robbins et al., 2016). However, the shadow of these experiences is that they came at the expense of free expression and spontaneity while American Indian lifestyles were simultaneously being undermined and suppressed. Other more obvious destructive elements of the boarding schools include the comparison of many boarding schools to prison camps, with reports of Indian children being starved, chained, and beaten. Indian health needs were neglected, and children were exposed to illnesses like tuberculosis and the flu which resulted in many deaths (Duran et al., 1998). The long-term impacts on the psychology of Native peoples includes disruption of families and communities, confusion of punitive institutional parenting practices, impaired emotional response (lack of intimacy and warmth in childhood), repetition of physical and sexual abuse, loss of knowledge, language, and tradition, and systemic devaluing of Native American identity. These effects are far-reaching and can be seen in high rates of depression and other psychiatric disorders, suicide, alcoholism, and heart disease on Native American reservations today (McLeigh, 2010). Given that Native peoples have suffered so greatly under these negative stereotypes and the erasure of their culture and its values, the psychological impacts on Native peoples are severe and need immediate attention. Mental health professionals who work with this population should have an awareness of the history of oppression that is still very much alive in the hearts and minds of American Indians, and work side-by-side with Indigenous individuals to promote healing through autonomy and the restoration of cultural values.

Forced Assimilation

Assimilation policies were purported to have started, "…with the belief that indigenous people who learned the European American way of life would then be able to blend tribal traditions with the norms of the dominant culture" (McLeigh, 2010, p. 178). While the ultimate

goal of the boarding school was assimilation, Dunbar-Ortiz (2014) argues that what was learned in these schools, "…was useless for the purposes of effective assimilation, creating multiple lost generations of traumatized individuals" (p. 151). Many of the children who went to boarding schools didn't make it out alive. According to the 1928 Meriam report, a project commissioned by the Institute for Government Research (IGR) that sought to investigate the affairs of Indians in the United States, Native children were six times as likely to die in childhood while at boarding schools than the rest of the children in America. The report also recognized that the boarding schools were a failed attempt at assimilation:

> The generally routinized nature of the institutional life with its formalism in classrooms, its marching and dress parades, its annihilation of initiative, its lack of beauty, its almost complete negation of normal family life, all of which have disastrous effects upon mental health and the development of wholesome personality: These are some of the conditions that make even the best classroom teaching of health ineffective (p. 393).

While tens of thousands of Native children were ripped away from their families and forced to live at residential boarding schools where they were subjected to all kinds of maltreatment, tribal lands were being divided and allotted under the Dawes Act of 1887. Ojibwe anthropologist researcher and author David Treuer, in his book *The Heartbeat of Wounded Knee: Native America from 1890 to the Present* (2019), wrote that the proposed "strengths" of this bill were:

> It promised to break up the tribe as a social unit, encouraged private enterprise and farming, reduce the cost of Indian Administration, fund the emerging boarding school system (with the sale of "surplus land"), and provide a land base for white settlement (p.145).

Treuer goes on to express his disgust that the government stole Indigenous land to fund the

kidnapping of Indian children. Allotment was also accompanied by enrollment, which was a system developed that was used to determine who was Indian and thus who was entitled to receive these allotments. The government used "blood quantum" to determine how much Indian blood a person had, and terms such as "full-blood", "half-blood", and "mixed-blood" were frequently used in Native American assimilation policies. However, the use of these terms, "… was not confined to one statute, one reservation, one agency, or one direction of Indian policy" (Ellingahus, 2022, p. xi). Europeans used blood as:

> …a way of explaining the differences between the variegated bodies that Europeans were encountering in the early modern world of empire and colonialism. Blood became a racial marker that resided unseen inside the body, a vessel that carried different racial traits and transmitted them to offspring (Ellinghaus, 2022, p.xiv).

While blood was and continues to be a way that Native Americans talk about themselves and define their tribal membership, blood quantum has been described as "wildly inaccurate, culturally incongruous, and socially divisive" (Treuer, 2019)**.** Tribal nations did not have comprehensive documentation of tribe members, so the Office of Indian Affairs employees (public servants) were tasked with dividing up reservation land and allotting it to individuals. Employees were not given any instructions on how to decide who was or was not an Indian so they made these decisions arbitrarily based off of, "…crude mathematical estimates according to what they knew of an individual's family—for example, a child of a non-Indian parent was 'half' Indian, and a child with one non-Indian grandparent and three Indian grandparents was 'one-quarter'"(Ellinghaus, 2022, p.xvi). Other factors that influenced decision-making about individual's ethnic Native status included facial features, skin tone, dress, language, and family name, and these judgments were made based off of, "…racial discourses that were available to

them… assumptions of their own about how an 'Indian' should look, sound, and act" (p.xvi).

Tribal members were not involved in the development of the allotment act itself or in the process of determining who was a member of their tribe. In 1906, the Dawes Act was amended by the Burke Act, which attempted to facilitate the process of ownership by allowing "competent" Indians to own their land outright by introducing a fee-simple patent, which also meant that taxes began accumulating on the properties. However, because most Indians didn't even know what taxes were or even had a source of stable income, thousands of Indians owed back taxes almost immediately. Allotment was halted by the Indian Reorganization Act of 1934, "…but the land taken was never restored and its former owners were never compensated for their losses, leaving all the Indigenous people of Oklahoma (except for Osage Nation) without effective collective territories and many families with no land at all" (Dunbar-Ortiz, 2014, p. 159). By 1934, in the span of 47 years, Indian landholding had dropped from 138 million to 48 million, with estimates of about 95 percent of allotted Indian land being passed into white ownership. Treuer (2019) writes: "What the great process of 'civilization' had brought to Indian country was poverty, disenfranchisement, and the breakdown of Indian families" (p.150). The devastating effects of which are still apparent in the quality of life on reservations today.

After the Indian Wars**,** which is a broad term used to describe a series of battles and wars between Native Americans and European settlers beginning in 1622 until the late 19th century, the government increased its efforts to assimilate Native Americans into European American culture and Christian religion, creating policies that were centered around total eradication of traditional Indigenous practices and beliefs. Religious practices were viewed as a "hindrance" to the assimilation and civilization of Natives. Indians were punished by the Court of Indian Offenses for engaging in ceremonial practices through, "…the withholding of rations, the threat

of loss of property, and exclusion from the running of tribal affairs" (Treuer, 2019, p. 155). The isolated reservations that were created by the Dawes Act broke historical relationships between clans and communities, opened areas for European settlement, and allowed the Bureau of Indian Affairs to enforce tighter control. The Sioux Nation had it particularly rough after the 1890 Wounded Knee Massacre, as they continued to fight back and resist Euro-American settlement. After buffalo were purposely slaughtered by the US army between 1870 and 1876, the Sioux Nation became increasingly dependent on the government for rations and commodities that were promised to them in the 1868 Peace Treaty of Fort Laremie. The Sun Dance, which was an annual ceremony that reinforced tribal unity, was also outlawed, as well as plural marriage, practices of medicine men (described as "heathenish" in the code), and traditional mourning practices. Thus, federal policies as well as the Code of Indian Offenses, "…were designed to destroy Indian culture as a means of making Indians American, but Americans on the bottom rung of the ladder" (Treuer, 2019, p. 158). Underlying these policies is the assumption that Indians are inferior and therefore incapable of managing their own affairs.

Risk and Protective Factors

There are a number of complex and inter-related factors that lead to suicide-related behaviors within any population. While individual characteristics are significant, relationships with family, peers, and others, as well as broader influences from social, cultural, economic, and physical environments, are just as important to consider when evaluating risk for suicide. The U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention uses the framework of a social ecological model to examine risk and protective factors for suicide across four levels: individual, relationship, community, and societal. On the individual level, risk factors include mental illness, substance

abuse, suicide attempt, and impulsivity/aggression. Individual protective factors include coping and problem-solving skills, reasons for living (e.g. children in the home), and moral objections to suicide. Relationship risk factors include high conflict or violent relationships, and a family history of suicide. Protective relationship factors include connectedness to individuals, family, community, and social institutions, and supportive relationships with health care providers. Community risk factors include few available sources of supportive relationships and barriers to health care. Community protective factors include safe and supportive school and community environments, and sources of continued care after psychiatric hospitalization. Societal risk factors include availability of lethal means of suicide and unsafe media portrayals of suicide. Societal protective factors include availability of physical and mental health care and restrictions on lethal means of suicide (National Strategy for Suicide Prevention, 2012). While these risk and protective factors are not specific to AI/AN populations, an understanding of the general factors related to suicide can be useful for purposes of comparison.

Native researchers also point to the importance of using a social-ecological model when examining risk and protective factors for Native youth suicide. Much of the previous research seems to focus on risk and protective factors at the individual level, which limits prevention and intervention strategies to focusing solely on individual risk factors for AI/AN youth. Researchers suggest using a transactional-ecological model (Felner & Felner, 1989), similar to a social-ecological model, as a framework in understanding the interactions between individuals and their environments. The transactional-ecological model posits that psychological disorders are a result of deviations in normal developmental pathways and processes, and that roots of pathology can be and often are outside the person. This approach to prevention reduces the tendency to "victim blame" and instead situates the individual within a biopsychosocial framework with the objective

of restoring the individual to normative and developmentally appropriate trajectories (Alcantra & Gone, 2007; Felner & Felner, 1989). Indeed, Native youth face many challenges to development, such as poverty, institutional racism and discrimination, and a high prevalence of chronic health conditions with a lack of appropriate care (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015). Further, this framework allows for integration of the effects of historical trauma on Native populations and its relationship with youth suicide. The historical trauma response is described as, "a constellation of features in reaction to the multigenerational, collective, historical, and cumulative psychic wounding over time, both over the life span and across generations" (Duran, E., Duran, B., Brave Heart, & Yellow Horse-Davis, 1998, p. 3). The authors argue that depressive symptoms in children of trauma survivors are a reaction to their parents' experiences of colonization and genocide. Features associated with the survivor's child complex include:

> Depression, suicidal ideation and behavior, guilt and concern about betraying the ancestors for being excluded from the suffering as well as obligation to share in ancestral pain, a sense of being obliged to take care of and be responsible for survivor parents, identification with parental suffering and a compulsion to compensate for genocidal legacy, persecutory and intrusive Holocaust as well as grandiose fantasies dreams, images, and perception of the world as dangerous (p.3, 1998).

The authors suggest that Native youth suicide is less about the individual, and more about the individual's reaction to environmental stressors. A multi-level framework for conceptualizing Native youth risk and protective factors for suicide is clearly indicated here.

Historical loss and trauma-related symptoms also appear to be related to risky behaviors among Native youth. In a study that examined the relationship between Adverse Childhood Experiences (ACES) and risk behaviors and mental health outcomes among reservation-based

Native youth, researchers found that abuse and neglect, witnessing violence against one's mother, historical loss associated symptoms and discrimination are common and strongly linked to depression symptoms, poly-drug use, PTSD symptoms, and suicide attempt. Of all the ACES studied, physical abuse most strongly and significantly increased the odds of depression symptoms and suicide attempt (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015). This finding is supported by a study that compared risk and protective factors for suicide between AI/AN and non-AI/AN populations. While depression and other mental health issues were strong predictors of reported suicide attempts in both groups, strong predictors for AI/AN youth were related to the stability of and/or abuse from adults in their lives. In comparison, strong predictors for non-AI/AN youth were related to acting-out behaviors like substance use and violence (Mackin, Perkins, & Furrer, 2012). It is likely that parents who perpetrate physical abuse against their children were also victims of physical abuse themselves. Brave Heart (2003) notes that the absence of parenting role models coupled with abuse suffered in boarding schools led to the transfer of uninvolved, non-nurturing, punitive, and authoritarian parenting practices to subsequent generations. Thus, there appears to be a relationship between historical trauma-related factors and suicide risk within Native populations.

One study that sought to document psychosocial risk and protective factors as they relate to suicide ideation among Native youth found significant gender differences in suicidal ideation (Kelley & Killsback, 2018). American Indian females in this sample had significantly higher suicidal ideation scores than males, and also reported significantly lower scores for self-esteem. The authors suggest that gender differences in suicidal ideation may be related to interpersonal trauma experienced by Native females, such as rape, molestation, and intimate partner violence. Their results also showed that depression was the strongest independent risk factor for suicide

ideation in this study. Depression was correlated with stressful live events, and this finding provides further support for viewing risk factors associated with Native youth suicide within a broader framework (Kelley & Killsback, 2018). While Native youth suicide ideation and attempts are most common among unemployed single females between the ages of 15 and 19 years with less than 12 years of schooling, data shows that American Indian males were more likely than females to complete suicide. Indeed, males accounted for 72.5% of suicide completions for Native Americans between 2003 and 2012 (Great Lakes Inter-Tribal Council, 2013).

Finally, substance abuse is a significant risk factor for attempting suicide, and this has been well-established within the general population as well as within Native communities (Stone et al., 2017). The results from the 2013 National Survey on Drug Use and Health indicates that Native Americans 12 years of age and older had the highest rates of substance dependence or abuse (14.9%) in the United States (SAMHSA, 2013). In a sample of Apache adolescents ages 10-19 who attempted suicide, participants endorsed high lifetime alcohol use (91%) and marijuana use (88%) and reported initiating substance use at age 14 or younger. Among this sample who had survived suicide attempt, alcohol/drug overdose was also the most commonly reported method of suicide attempt (32%), and the majority of adolescents indicated that they had an important adult in their lives with an alcohol/drug problem. Researchers identify that substance use and suicide attempts appear to be maladaptive coping functions among Apache adolescents and note that substance use is acting as a risk factor, facilitator (increased impulsivity), and method of suicide (Cwik, Barlow, Tingey, Goklish, Larzelere-Hinton, Craig, & Walkup, 2015). Indeed, in a data analysis of records submitted to the Indian Health Services Division of Behavioral Health between 2003 and 2012, alcohol was indicated as the most

frequently reported substance used in suicide ideation with plan and attempt, suicide attempt, and suicide completion. The most frequently reported contributing factor in all suicidal behaviors was “history of substance abuse/dependency” (Great Lakes Inter-Tribal Council, 2013).

In the U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention 2012 *National Strategy for Suicide Prevention: Goals and Objectives for Action*, connectedness to others is identified as a key protective factor that reduces suicide risk. Connectedness framed within a Native American worldview expands beyond general definitions, and takes special interest in additional factors, such as a connection to the natural world and a connection to historical trauma. Other protective factors against suicide for American Indian and Alaska Native (AI/AN) individuals include caring family relationships, supportive tribal leaders, and connections to AI/AN culture/traditional practices. While AI/AN youths have some of the highest rates of suicide completions when compared with other ethnicities in their age group, AI/AN elders have significantly lower rates of suicides than elders from other ethnic groups. Researchers Rao, Pell, and England-Kennedy (2017) hypothesize that the dramatic declines in suicides seen for both AI/AN males and females may be related to connectedness and resilience across the lifespan. The authors propose that increased connectedness can improve resilience, and thus emphasize the importance of improving connectedness as a primary prevention strategy for suicide. Integrating elders into prevention programs might help create and reinforce connections between identity and cultural roots.

An emerging body of literature has pointed to several protective factors found in American Indian communities, factors including social support, family cohesion, cultural identity, high self-esteem, and lower depression scores. Researchers suggest that risk and

protective factors at the family and community level may be just as, if not more, important than individual level factors such as self-esteem (Cwik, et al., 2015). Findings from another study that sought to document psychosocial risk and protective factors as they relate to suicide ideation among American Indian youth in a reservation community also support the finding that self-esteem is a protective factor against suicide within this population (Kelley, Restad, & Killsback, 2018). Alcántra and Gone (2006) highlight the need to use intervention strategies that establish and reinforce protective factors on an individual, community, and societal level. Individual protective factors include spirituality, perceived strong family connectedness, social support, affective relationships with tribal leaders, positive attitudes toward education, perceived interpersonal communication skills, and habitual discussion of problems with friends or family members. Community and societal factors include cultural continuity, which was measured by the existence of, "…land claims, self-government, police and fire protection services, health services, education, and cultural facilities" (p. 472). Thus, treatment for suicide within Native American communities should aim to foster individual, family, and community protective factors while mitigating risk factors at each of these levels.

Suicide Prevention Programs

Suicide is a major public health issue that has received worldwide attention. Many developed nations have established national suicide prevention plans in response to increasing suicide rates. Evaluating the effectiveness of suicide prevention programs is necessary in order to make recommendations for future prevention programs and research. A systematic review of specific suicide prevention programs distilled key domains of suicide prevention programs from programs implemented worldwide: awareness and education (general public, primary care physicians, and gatekeepers), screening for suicidal behavior and risk factors such as depression

or substance abuse, treatment interventions (psychotherapy and follow-up care after suicide attempts), means restriction (such as firearms in US men, or pesticides in rural China, India, and Sri Lanka), and media blackouts on reporting suicide (Mann, Apter, Betolote, et al., 2010). Another systematic review of best practice strategies of suicide prevention programs conducted by van der Feltz-Cornelis, Sarchiapone, Postuvan, and colleagues (2011) summarized core elements of effective practices within six selected reviews, which covered public-health interventions as well as individually focused psychopharmacological or psychotherapeutic interventions. Their findings revealed evidence for the actual or potential effectiveness of several types of preventive interventions:

> (1) the training of general practitioners in the recognition and treatment of mental disorders, especially unipolar or bipolar depression; (2) awareness campaigns, provided that a clear fast track to treatment is available; (3) the training of gatekeepers and community facilitators in recognizing suicidality and helping at-risk people to access appropriate services; (4) improvement of healthcare services targeting people at-risk, including organizational measures such as making adequate inpatient and outpatient aftercare available to people who have attempted suicide; (5) the training of journalists in responsible reporting about suicide or the imposing of media blackouts; (6) restricting public access to lethal means of suicide (p. 328).

The Centers for Disease Control and Prevention (CDC) developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (2017) to guide and inform prevention decision-making in communities and states. The package includes strategies and approaches to suicide prevention based on evidence from effective programs that address suicide at multiple levels. Strategies recommended in the report include strengthen economic support, strengthen

access and delivery of suicide care, create protective environments, promote connectedness, teach coping and problem-solving skills, identify and support people at risk, and lessen harms and prevent future risk. The package addresses risk factors impacting communities and populations more broadly rather than focusing solely on individual behavior, with the aim of providing multi-level and multi-sectoral support and prevention.

Suicide Prevention Programs for Native Americans

A public health prevention approach has been suggested in the literature to be the most effective method to prevent and reduce suicide. Kelley, Restad, and Killsback (2018) describe a five-step approach, which includes defining the problem, identifying causes, developing and testing interventions, and evaluating interventions. The authors suggest that it can be difficult to define the problem in AI/AN communities because of the differences in how suicide is defined and understood. Further, Indigenous communities tend to be suspicious of research, data, surveys, and the biomedical community in general. In their study, researchers found that there was not a standard definition of suicide, and so the first step in the process was for the community members to define suicide based on cultural and historical definitions. Ultimately, their study helped community members on one American Indian reservation identify psychosocial risk and protective factors, and they found that depression was the strongest independent risk factor for suicide ideation. As a result of this study, the community came up with several solutions for preventing suicide on their reservation:

> Hosting weekly talk circles at local schools led by trained tribal members to facilitate and maintain social connections, regularly scheduling sweats to facilitate belonging and cultural connections, and providing ongoing strengths-based cultural activities for youth

> that strengthen resiliency factors (e.g. block parties, community gatherings, cultural camps)(p. 329).

Gone and Alcántra (2007) also advocate for an approach grounded in community psychology for Native American mental health service delivery. The authors review the treatment outcome literature for mental health interventions targeted toward American Indians and Alaska Natives, and they found that only two out of fifty-six articles and chapters pertaining to the treatment of Native Americans had adequate sample sizes and interpretable results. Gone and Alcántra (2007) concluded that there is an absence of compelling empirical evidence to show the effectiveness of treatments targeted towards Native people and cautioned against endorsing untested approaches and practices until more rigorous research is conducted and reported in the literature. However, the authors appear to support a more radical perspective on Native-specific mental health intervention that call into question the Westernized "multicultural competency" in the delivery of psychotherapeutic services, indicating that the culture of the mental health clinic does not match up with the culture of the Indigenous community. The role of evidence-based practices and the "medical model" for addressing mental health in Native American communities seems irrelevant considering that the current problems Native peoples face is a direct result of genocide and forced civilization imposed upon them by U.S. colonialism and domination. Indeed, it makes sense that Native people would be skeptical of conventional clinical services and the Western mental health professionals who might unintentionally "brainwash" them to be more like the white man. The authors suggest that mental health professionals who want to help American Indian communities should be willing to embrace new kinds of roles and relationships with the individuals they seek to serve, through the use of services that the authors note may not even

exist yet. They provide support for community mental health approaches with Native Americans, and outline the distinctions between traditional clinical services and community-based services:

> Instead of extended psychotherapy, the strategy of service in community mental health is aimed at reaching large numbers of people through brief consultations and crisis intervention; instead of the clinician's office, the location of intervention is in the community; instead of assuming an intrapsychic cause of disorder, the etiological factors of interest are the environmental causes of maladaptation; instead of rehabilitative services or "treatments," the type of service delivery is often preventative in nature; instead of professional control of mental health services, the locus of decision making is shared responsibility between professionals and community members; and so on (p. 361).

Using a community-based approach, one study sought to identify the needs of tribal community members as well as strengths and potential resources. Holliday, Wynne, Katz, Ford, and Barbose-Leiker (2018) define community-based participatory research as, "a scientific research approach that recognizes the need to find sustainable solutions to health disparities using community knowledge and equal partnerships to inform research priorities" (p. 65). Their findings indicated that addressing youth suicide and substance abuse is an overall concern to the community, and that programs targeted towards addressing these concerns should be strengths-based and incorporate culture and resources already available in the community, including past workshops and training (p. 71). Addressing suicide and co-occurring alcohol misuse risk is a significant public health priority for American Indian and Alaska Native communities, and current research supports strengths-based, multi-level, community/cultural interventions. Alaska Native youth benefited from programs that had higher numbers of intervention sessions, with particular focus on targeting young men in treatment interventions due to high suicide risk.

Beliefs and experiences that make life enjoyable and meaningful were demonstrated to protect against suicide risk within this sample (Allen, Rasmus, Ting Fok, Charles, Henry, & Team, 2018).

Introduction to Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was developed by clinical researchers in the 1980s as a treatment for trauma-exposed children and their families and has strong evidence for symptom reduction across diverse populations of traumatized children ages 3-18 years-old (Cohen, Debliger, & Mannarino, 2017). While the researchers were directing clinical treatment programs for child maltreatment victims, they recognized that there were limited efficacious trauma treatments for children, so they developed their own treatment protocol by combining elements from evidence-based trauma treatments for adults and children. The development of this treatment protocol was informed by their previous research which demonstrated a link between a child's development of behavioral problems after experiencing trauma and family factors such as family cohesion, parental support of the child, and parental distress related to the child's abuse. The parent's collaboration with the child and the treatment providers is considered to be a necessary part of the treatment in order to promote positive outcomes (Cohen, Deblinger, & Mannarino, 2017).

TF-CBT has been implemented and evaluated with children and adolescents from diverse ethnic backgrounds in a variety of settings. Traumatic experiences faced by these individuals range from traumatic grief, sexual abuse, exposure to domestic and/or community violence, as well as multiple or complex traumas (Cohen, Deblinger, & Mannarino, 2017). TF-CBT targets symptoms of PTSD, depression, anxiety, and other behavioral and emotional problems associated with these diagnoses. It is a components-based hybrid treatment that utilizes trauma

sensitive interventions, cognitive behavioral principles, as well as aspects of attachment, developmental neurobiology, family empowerment, and humanistic theoretical models (Cohen, Mannarino, & Deblinger, 2017). The components are typically provided separately to children and parents in separate sessions, with conjoint child-parent sessions focused on practicing skills, and later on in the treatment, the conjoint child-parent sessions are focused on processing the traumatic experience. The core values of TF-CBT treatment are encapsulated by the acronym "CRAFTS": Components-based, Respectful of cultural values, Adaptable and flexible, Family-focused, Therapeutic relationship is central, and Self-efficacy is emphasized (Cohen, Mannarino, & Deblinger, 2017).

Mental health interventions such as TF-CBT are usually first developed to target problems within the general population and are then tailored to fit the needs of different cultures. One such cultural adaptation of TF-CBT that was developed for American Indian/Alaska Native youth is called Honoring Children, Mending the Circle (HC-MC). Researchers Bigfoot & Schmidt (2010) partnered with community stakeholders to identify traditional cultural beliefs and practices to incorporate into the model. Some of the most identified traditional concepts included, "…extended family, practices about respect, beliefs regarding the Circle, and the interconnectedness between spirituality and healing" (p. 850). HC-MC's core constructs were developed around AI/AN worldviews that everything is connected, spirituality is inherent to all living things, and existence is dynamic (Bigfoot & Schmidt, 2010).

TF-CBT is a skills and strengths-based model that helps children and families cope with and process traumatic experiences. AI/AN youth experience high rates of trauma such as abuse and neglect, witnessing domestic violence, and discrimination, and these traumatic experiences are linked to depression, PTSD, substance abuse, and suicide attempt (Brockie, Dana-Sacco,

Wallen, Wilcox, & Campbell, 2015). The loss of a loved one to suicide is a trauma that occurs in high rates in AI/AN communities, and it appears that there is a strong link between high rates of trauma within the community and the high rates of suicide within this population. Preventing AI/AN youth suicide therefore requires treatment of the traumas that contribute to it. Building on the core principles of TF-CBT by incorporating AI/AN cultural modifications will help to address trauma and suicidality within this population and promote healing across generations.

Proposed Suicide Prevention Program for AI/AN Youth

The writer plans to use a culturally sensitive, historical trauma-informed approach to TF-CBT treatment. The program will aim to foster resilience and connectedness among Native Americans through therapeutic intervention. Interventions include fostering cultural connections, encouraging physical health, examining/teaching the historical context, promoting positive cultural identity, reducing social isolation/enhance social connections, reducing generational splits, and enhancing coping mechanisms (Garrett, Williams, Portman, Torres Rivera, & Maynard, 2014). The program will implement trauma-informed approaches discussed in Eduardo Duran's book *Healing the Soul Wound: Counseling with American Indians and Other Native People* (2006), as well as other postcolonial recommendations to treatment from other sources. A gatekeeper program will be included as an element of the program, which includes the training of elders and other community members to recognize individuals at risk and create a community safety net (Nasier et al, 2016). Finally, this program will address the effects of colonization by aiming to increase the ability of Native Americans to control their lives and restore their destinies through the promotion of self-determination on an individual, community, and public policy level (including the right to self-govern, maintain language, choose food to eat, and control land) (McLeigh, 2010).

CHAPTER III: METHOD

The goal of this dissertation is to create a novel suicide prevention program for Native American youth, and the program proposal will appear as chapter four of this dissertation. In order to outline the structure I will follow in developing the suicide prevention program, I will describe the process in phases. I will consider this dissertation proposal the first phase of the project because I demonstrated the need for this program in the literature review.

For the second phase of this process, I reviewed the TF-CBT treatment manual and identified the structure and interventions I wanted to include in my own novel program. I also reviewed the research about AI/AN suicide prevention mentioned in the literature review to ensure that my program included elements that strengthened protective factors and reduced risk factors. I researched interventions that have been used specifically with AI/AN individuals and infused them into the program where appropriate.

The final phase of this process was creating an outline of the treatment program which will appear as chapter four of this dissertation. The first part of this process was focused on providing more background information on TF-CBT in general and then specifically on cultural adaptations of TF-CBT for AI/AN youth. Next, I provided background information about my novel program, including who will receive the treatment, where it will be conducted, the length of the program, and the general format. I then created a week-by-week outline of the treatment program, starting with a goal for each week followed by bullet points explaining the details of interventions that will be used. Once this chapter was completed, I began the next chapter by highlighting the importance of historical trauma-informed suicide prevention for AI/AN youth. I concluded this dissertation with a discussion of the implications of my treatment proposal, potential limitations of my program, and recommendations for future research.

CHAPTER IV: TREATMENT PROPOSAL

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a brief (8-25 sessions) evidenced based treatment for children and adolescents experiencing trauma-related symptoms and their caregivers. There are nine components of TF-CBT encapsulated by the acronym "PRACTICE" and divided into 3 phases: Stabilization Skills (phase 1), Trauma Narration and Processing (phase 2), and Consolidation (phase 3). Phase 1 focuses on stabilization skills: Psychoeducation about trauma (e.g. general information about trauma and abuse, education about common reactions to trauma, etc.); Parenting skills to assist the parent with supporting the child with their trauma responses and improve the quality of the parent-child relationship; Relaxation skills to improve coping with physiological responses; Affective skills to assist clients with identifying their feelings and applying skills to cope with emotional dysregulation associated with the trauma; and Cognitive coping skills and education on the relationship between thoughts, feelings, and behaviors. Phase 2 consists of the Trauma narrative and application of cognitive processing techniques to challenge thought distortions associated with the traumatic event. Phase 3 or the consolidation phase includes the development of an in vivo desensitization plan to target avoidant behaviors triggered by trauma reminders; Conjoint child-parent session to share the trauma narrative and improve communication skills; and Enhancing safety by developing a safety plan and teaching assertive communication skills. The therapeutic relationship is considered an essential element of the treatment in the promoting safety and trust between the parent and child (Cohen, Deblinger, & Mannarino, 2017).

Culturally Conscious TF-CBT

HC-MC uses the concept of the circle, a symbol that is considered sacred for many Indigenous peoples, as the framework for the treatment protocol. Instead of using the Cognitive

Triangle, HC-MC uses a circle to demonstrate the link between relational, emotional, physical, mental, and spiritual dimensions. Spirituality is located in the middle of the circle because it is considered to be the core of the individual. According to the tenets of HC-MC, imbalance occurs when there is disharmony in one or more of these dimensions, and trauma exposure is one of the ways that imbalance can occur. This imbalance can manifest as maladaptive behaviors and/or cognitive distortions. The goal of HC-MC treatment is to promote balance within the relational, emotional, physical, and spiritual dimensions (Bigfoot & Schmidt, 2010).

In TF-CBT treatment programs for AI/AN youth, treatment providers collaborate with the children and family to include cultural views and practices into the treatment in a variety of ways. Tribal-specific songs, names, words, or healing ceremonies might be identified by AI/AN individuals and families as important elements to include in the treatment. For example, the teaching of relaxation skills involves the use of culturally specific soothing images, such as the swaying of grass or of a woman's shawl during a traditional ceremony. The trauma narrative can include the use of traditional dances or storytelling techniques based upon the family's wishes. The use of culturally relevant images makes the treatment activities more meaningful for the participants and promotes spiritual and relational connectedness (Bigfoot & Schmidt, 2010).

While TF-CBT has demonstrated effectiveness, this method has limitations because it doesn't address intergenerational trauma or its potential impacts on suicidal behaviors among traumatized youth. This writer suggests that a historical-trauma informed, culturally sensitive adaptation of TF-CBT may not only reduce trauma symptoms among Native American youth but may also prevent suicidality among this population as well. Research shows that American Indian/Alaska Natives have higher average mean ACE (adverse childhood experiences) scores compared to other races/ethnicities. One study found that the highest single ACE domain

prevalence was emotional abuse (43.1%), followed by parental separation/divorce (41.6%) and household substance abuse (40.9%) (Giano et al., 2021). Given the high rates of suicidality among AI/AN youth and the high rates of trauma and mental illness within AI/AN families, this writer suggests that addressing intergenerational trauma is an important element of preventing suicide within this population.

Culturally Conscious Treatment Intervention Protocol

Program Background

The writer recommends that the treatment intervention is utilized while adolescents are actively receiving outpatient or inpatient mental health services. This intervention will serve as a group and/or individual program for adolescents who are experiencing symptoms of mental illness. The intervention will be provided once a week over the course of twelve weeks. Each session will be 120 minutes (60 minutes with the adolescent and 60 minutes with the parent/caregiver) long and will occur in the facility where the adolescent is receiving mental health services. During each session, the therapist meets for about half of the session with the adolescent and about half of the session with the parent or caregiver. If the intervention is conducted within a group format, one therapist can facilitate the adolescent group while another therapist facilitates the parent/caregiver group for 60 minutes each, or one therapist can run both groups separately one after the other. Adolescents aged 14 and above will benefit from participating in this program, as well as their parents. Caretakers, grandparents, siblings, cousins, and other natural supports are also encouraged to participate in this intervention. For the purposes of this dissertation, this treatment protocol will be outlined in a group format, however, it can be easily adapted to an individual treatment protocol.

The key concepts of extended family, respect, interconnectedness between spirituality and healing, and beliefs regarding the Circle that are significant in AI/AN culture will be implemented in each weekly 60-minute session under each of the nine TF-CBT components. A typical individual TF-CBT treatment intervention takes place over 8 weeks, however, the proposed treatment protocol is written for a group format and will take place over the course of 12 weeks to include one session dedicated to screening/referrals and one session focused on psychoeducation about suicide. However, the protocol could be adjusted to add an additional 2-3 sessions for the trauma development and processing phases. Other elements that are unique to this program include psychoeducation about historical trauma and how it gets passed down intergenerationally, and this also includes an opportunity for the caregivers to develop their own trauma narrative.

Who Will Benefit from this Intervention

Adolescents and their family members affected by trauma and suicide within their community will directly benefit from the proposed treatment program (Cohen, Deblinger, & Mannarino, 2017). Family members may include parents, grandparents, siblings, and/or aunts, uncles, and cousins.

A Culturally Conscious Historical Trauma Informed TF-CBT

Week 1: Introduction to the Program, Screening, and Referrals

Goal: The first week of this treatment model focuses on establishing rapport with youth and their families, screening, making referrals, and providing an introduction to the program. The goal is to identify individuals who are at a high risk for suicide and to ensure that they are receiving the appropriate support.

- Prior to beginning the screening process, the treatment providers will introduce themselves to the participants and their family members and facilitate introductions to one another. Duran (2019) emphasizes that great care must be taken when introducing one's self to the participant, specifically during the handshake and when establishing eye contact. Duran (2019) explains that many Native people don't "shake" hands in the traditional Westernized way but merely make contact with the offered hand. Extended eye contact may not be considered appropriate depending on which tribe the participant is from. Once introductions are made, the treatment provider can invite one of the participants to "smudge", which is the ceremonial act of burning traditional herbs such as cedar, sage, or sweet grass. This will cleanse the space of any negativity prior to beginning the session (Duran, 2019, p. 44).The facilitator can then explain the purpose and the structure of the treatment program, provide brief psychoeducation on the link between historical trauma and youth suicide and ask if anyone has any questions regarding the treatment process. The provider will then review the limits of confidentiality and ask participants to sign a release of information so that providers can communicate with the participant's individual therapist if the need arises. Participants will then be asked if they are willing to complete the screening tools. The provider will explain the purpose of the screening instruments, which is to elicit information regarding the trauma symptoms the child is exhibiting and assist with identifying individuals who might need extra support and link participants to the appropriate community resources.
- Screening instruments that could be used to accomplish this goal might include the Columbia Suicide Severity Rating Scale (C-SSRS), the UCLA PTSD reaction index, and the National Institute on Drug Abuse (NIDA) Brief Screener for Tobacco, Alcohol, and

Other Drugs (BSTAD). Another useful screening tool that was specifically developed for American Indian/Alaska Native populations is the Historical Loss and Associated Symptoms Scale (HLAS), a self-report questionnaire which enumerates perceived losses (e.g. loss of land, loss of language, loss of traditional spiritual ways, etc.) and frequency of thoughts about those losses, as well as emotional responses (e.g. sadness/depression, anger, anxiety/nervousness, etc.) that are triggered when reminders of historical losses or thoughts pertaining to historical loss come to mind (Whitbeck, Adams, Hoyt, & Chen, 2004). Once the screening process is completed, the facilitator can provide the participants with a list of referrals and community resources, which could include a local medicine man or shaman.

- Finally, the facilitator(s) will introduce the program, with brief discussion about the common experience of trauma that brings the families together. Group expectations and rules will also be discussed, such as confidentiality and communication between group members outside of sessions. The facilitator will emphasize the importance of attending all weekly group sessions and assist the caregivers with identifying potential obstacles to attendance and discussing strategies for reducing those obstacles. An overview of the plan for treatment will be provided without mentioning the trauma narrative, with the goal of teaching self-soothing skills before gradually exposing the child to the idea of addressing the details of the trauma. While explaining the plan for treatment, it is important that the facilitator tries to steer away from Westernized therapeutic jargon wherever possible, to be sensitive to the patients' level of acculturation.

Week 2: Psychoeducation About Trauma

Goal: The second component of this treatment model focuses on normalizing both the child and caregiver's reactions to the traumatic event, providing information about common emotional and behavioral responses to trauma, and reinforcing accurate cognitions about what occurred.

- The facilitator will begin this session by establishing what Duran (2019) calls the "healing container", which he describes as a "metaphorical spiritual boundary" that contains the treatment process and provides a safe space for healing to occur (p. 44). This healing container can be established by smudging, and the facilitator can lead the smudging ceremony themselves or invite a participant to lead.
- The facilitator will then provide psycho education about trauma symptoms, which have been described by Cohen, Mannarino, and Deblinger as, "emotional, behavioral, cognitive, physical, and/or interpersonal difficulties related to the traumatic experience" (2017, p.7). Emotional trauma symptoms can include fear, sadness or depressive symptoms, anger, and/or severe affective dysregulation (i.e., frequent mood changes and/or difficulty tolerating negative affective states). Behavioral trauma symptoms can include avoidance, dissociation, maladaptive behaviors (e.g. physical violence), sexualized behaviors, substance abuse, self-injury (e.g. cutting, burning, or other forms of self-mutilation), risk-taking behaviors (e.g. high-risk sexual behaviors, driving under the influence of drugs or alcohol, using guns or other weapons, and other high-risk behaviors that could lead to serious injury and/or death). Cognitive trauma symptoms include inaccurate or irrational cognitions about causation as a means of gaining control or predictability (e.g. self-blame, the belief that no one is trustworthy, or inaccurate or unhelpful cognitions about the traumatic event). Physical trauma symptoms include exaggerated startle response, sleep disruption, nightmares, hypervigilance, loss of

appetite, gastrointestinal issues, shortness of breath, sweating, fatigue, and racing heartbeat. Finally, interpersonal trauma symptoms can include being cut off from other relationships due to shame or blame associated with the traumatic incident(s) (e.g. children who were victims of sexual abuse lose relationships with family members who side with perpetrator). The facilitator should emphasize that these are normal reactions to trauma, and explain how these symptoms can be triggered by internal or external reminders of the trauma, such as people, places, things, conversations, activities, objects, situations, thoughts, memories, sounds, smells, or internal sensations.

- Next, the facilitator should discuss how these symptoms get passed down intergenerationally through modeling or traumatic bonding. Modeling refers to when children who grew up in abusive or violent homes and communities might repeat maladaptive behaviors or coping strategies that they observed. Traumatic bonding is an example of the concept coined by Freud as "identification with the aggressor" which occurs when a child adopts, "…the abusive parent's views, attitudes, and behaviors towards the victimized parent and become abusive or violent themselves" (Cohen, Mannarino, & Deblinger, 2017).
- It's important to mention spiritual trauma, or what Duran (2019) refers to as the "soul wound" (p. 18). The facilitator could also mention other common terms used within Native communities, such as "spiritual injury, soul sickness, and ancestral hurt" (p. 17). These terms illustrate the concept of intergenerational trauma or historical trauma, and the facilitator should point out how these terms are used almost interchangeably. Duran (2019) uses the metaphor of the vampire to illustrate the concept of internalized oppression, or identification with the aggressor as mentioned above. When someone is

bitten by a "vampire", or a perpetrator of abuse, the victim becomes infected by the spirit of the aggressor. The metaphor is helpful in illuminating how colonization was an assault on the soul of the land and the people, and subsequently, how some of the problems (e.g. suicidality, substance abuse, domestic violence, etc.) have infected the Native community. Duran (2019) writes, "…abuse occurs at the physical, psychological, and spiritual levels. Therefore, the issue must be addressed at all of these levels. Healing of the body, mind, and spirit is further compounded by the fact that trauma occurs at the personal, community, and collective levels" (p. 23).

- At this point, if the facilitator is non-Native, it is critical that the facilitator acknowledges the role that their ancestors played in perpetrating the trauma of colonization, or that they themselves have played a role by living on occupied Native lands. Duran (2019) suggests that this will serve to enhance the therapeutic relationship because it is honest. Duran (2019) writes, "Honesty is always a good thing, especially in the healing circle" (p. 55).
- In order to promote hope for healing, it might be useful to end the session by mentioning that the pain or trauma that the participants are experiencing already contain the "spirit of healing" within them, which is in line with Indigenous beliefs about the dual nature of reality. Duran (2006) writes, "…the profound suffering of individuals and the collective suffering of Native people can be seen as having an incredible power to transform the immediate situation as well as the world" (p.111).

Week 3: Psychoeducation about Suicide

Goal: The third component of this treatment model focuses on providing information about suicide, including risk and protective factors, warning signs, suicide contagion, impacts of suicide on community, as well as links between trauma symptoms and suicidal ideation. This

component also provides an opportunity for participants to talk about suicide within their community and give an offering to the "spirit" of suicide.

- The facilitator should begin the group session by asking one of the participants to assist with establishing the healing container by performing a smudging ceremony. Next, the facilitator will explain the purpose of the session which is to discuss suicide and how it is linked to trauma. Specifically, the facilitator should explain that experiences of trauma can lead to the development of negative beliefs about the self and the world, which in turn can contribute to self-destructive behaviors such as substance abuse, self-harm (e.g. cutting, burning, hitting), risky sexual behaviors, and suicide attempts (Cohen, Debblinger, & Mannarino, 2017).
- Next, the facilitator will discuss risk and protective factors for suicide. Some common individual risk factors that pertain specifically to Native youth include low self-esteem, substance use, abuse and neglect, witnessing domestic violence, historical loss (e.g. loss of land, language, and culture) and discrimination, depressive symptoms, and PTSD symptoms. Protective factors that should be highlighted include social support, high self-esteem, family cohesion, cultural connectedness, and spirituality (Cwik et al., 2015). It is important to highlight here the finding that while Native youths have some of the highest rates of suicide in the nation, Native elders tend to have some of the lowest rates of suicide when compared to elders in other ethnic groups. Facilitators should call attention to the fact that Native elders are models of resilience and hold a lot of wisdom that can be passed down to younger generations, and thus play an important role in suicide prevention within the community (Rao, Pell, & England-Kennedy, 2017).

- A conversation about the "spirit of suicide" should be introduced to help the participants understand suicide from a spiritual perspective. Specifically, Duran (2019) talks about how suicidal ideation can be viewed as a spiritual entity that visits Native patients who are experiencing emotional pain. The facilitator can introduce the spirit of suicide as the "spirit of transformation", and explain that, "… the idea of wanting to die is literally a misinterpretation of the soul's desire to transform" (p. 100). However, the facilitator can go on to explain that the ego tends to misinterpret the soul's desire to transform as the need for physical death, "…which really serves no purpose in the soul's quest for fulfillment" (Duran, 2019, p. 100).
- Finally, the facilitator will open a talking circle for the youths and the adults to discuss the meaning of suicide within their community as well as possible solutions for reducing suicide. Talking circles, also called healing circles or peacemaking circles, have been identified as a culturally sensitive prevention strategy that is deeply rooted in traditional indigenous practices. Talking circles have been used in community-based participatory research (CBPR) to, "…engage local community members in the development of intervention strategies to address a specific issue" (Doria, Momper, & Burrage, 2021, p. 107). They are widely used amongst Native communities in North America and they can be conducted in various ways, but most basically, members sit in a circle to discuss a problem or question (Mehl-Madrona, 2014). The facilitator begins the talking circle with a prayer, and then a talking stick (usually a sacred object such as an eagle feather or a fan) is passed clockwise around the circle. Each person takes a turn talking while holding the stick, and no one else is allowed to speak while the person who is holding the talking stick is speaking. The circle is complete when the talking stick goes around the circle one

time without anyone speaking out of turn (Mehl-Madrona, 2014). The facilitator should take notes on major themes that emerge during the talking circle, so that they can be referred to throughout the treatment process. The talking circle is an important element of this program because it enhances intergenerational engagement and provides a format for elders to pass down traditional knowledge and cultural values (Doria, Momper, & Burrage).

Week 4: Relaxation Skills and Parenting Skills

Goal: The fourth component of this treatment model focuses on teaching relaxation skills to the youths and parenting skills to the adults.

- This session involves teaching relaxation skills to children and adults, and teaching parenting skills to the parents. The facilitator should explain to the youths how their bodies respond to stress and provide examples of common reactions in order to normalize what they may be experiencing. Visual aids such as pictures of the brain or body can be used to explain the stress response that occurs in the brain. The facilitator then explains how the body might be in a state of high alert after the trauma, which will increase their sensitivity to reminders of the trauma that may occur in their environment. Relaxation strategies can help to cope with these triggers so that the body can return to a state of equilibrium (Cohen, Mannarino, & Deblinger, 2017).
- Examples of relaxation strategies that can be practiced in this session include focused breathing, mindfulness, meditation, progressive muscle relaxation, and guided imagery. The facilitator can incorporate culturally relevant images or tools in the relaxation strategies.

- While the youth are learning relaxation skills, the facilitator in the other group will focus on teaching parenting skills to the parents. The facilitator should explain that even the most competent parents might struggle with parenting effectively in the face of a children's experience of a traumatic event. It is also important to point out that, "…the trauma(s) themselves often directly impact parental functioning, making it difficult to maintain normal routines and consistency in rules and expectations" (Cohen, Mannarino, & Deblinger, 2017, p. 107). Emphasis should be put on the fact that parenting function is extremely important for children's outcomes, and structure and predictability in the family environment are essential to promoting adaptive functioning for children as well as adults in the face of significant stress.
- The facilitator should start by teaching parents how to use functional behavioral analyses to help parents understand the development, persistence, and motivation for children's problem behaviors. A functional behavioral analysis is an approach to examining problem behaviors that provides, "...information about the antecedents (i.e. circumstances that may have preceded and/or triggered the behavior problem), the specific problem behavior itself, as well as the consequences that followed the child's problem behavior" (Cohen, Mannarino, & Deblinger, 2017, p. 108). This is accomplished by examining the antecedents, behaviors, and consequences (i.e. the ABCs) for problem behaviors, and the facilitator can walk the parents through a functional analysis by asking for examples of problem behaviors from the parents. The facilitator will then review parenting skills for responding to problem behaviors such as praise, selective attention, time-out, and contingency reinforcement (Cohen, Mannarino, & Deblinger, 2017).

- The parenting session should close by mentioning the importance of parents developing their own arsenal of relaxation skills, to assist with coping with their own exposure to traumatic events as well as to model self-soothing strategies for their children. The facilitator may want to lead the parents in a brief meditation or relaxation activity.

Week 5: Emotion Regulation Skills

Goal: The fifth component of this treatment model focuses on helping youths and adults express and manage their feelings more effectively.

- In TF-CBT treatment, the "affective expression and modulation skills" phase is critical in helping traumatized children and youth develop a vocabulary for their feelings as well as effective tools for managing emotional dysregulation (Cohen, Mannarion, & Deblinger, 2017). Thus, the beginning of the youth session should focus on a discussion of the importance of being able to identify feelings so that they can be responded to effectively. Following the discussion, the facilitator should engage the youths in TF-CBT activities to teach emotion identification and expression skills. The therapist can begin by asking the youths to write down as many different feeling words that they can think of in 3 minutes. Once the activity is completed, the youths can share the words they came up with by writing them on a white board or on different slips of paper. Youths can share their experience with certain feelings and the situations that caused them. The facilitator can use tools such as a feeling wheel, which is essentially a circular chart that breaks down primary emotions into more specific feeling words, to provide the youths with more words to describe how they are feeling. In this phase of the treatment, the facilitator will refrain from asking youths about feelings that they experienced during the traumatic incident, however, youths may choose to mention these feelings on their own. The

facilitator may need to get creative to engage teens who may struggle with naming their feelings. In TF-CBT treatment, facilitators will utilize the youth's interests, such as music or TV shows, to assist the client with identifying feelings (Cohen, Mannarino, & Deblinger, 2017).

- A SUD (Subjective Units of Distress) scale or feeling thermometer can also be taught to the youths as a useful tool for rating the intensity of their emotions. The facilitator may also mention here how feelings such as sadness, hopelessness, and/or guilt can lead to suicidal thoughts, and should emphasize the importance of reaching out to trusted elders and/or mental health professionals for support if suicidal thoughts occur.
- Techniques such as thought stopping, positive imagery, and positive self-talk should be introduced to the youths in this session with the aim of teaching them how to cope when they are feeling overwhelmed by trauma reminders. Other skills that can be introduced here include personal safety skills, problem solving skills, and social skills. These skills can continue to be practiced throughout subsequent sessions, given that they may take some time to master.
- Concurrently, the parents will also be focusing on developing affective expression and regulation skills in their session. The facilitator should provide the parents a safe space to express and process their feelings by validating and normalizing the parents' reactions to the trauma. Another goal of the session is to teach the parents how to validate their child's feelings, and to praise them for expressing their feelings effectively. In TF-CBT treatment, role plays can be a useful tool for teaching parents how to develop this skill (Cohen, Deblinger, & Mannarino, 2017). All of the aforementioned affect modulation

skills (e.g. thought stopping, positive imagery, and positive self-talk) can also be useful for the parents to learn, and can be taught to the parents as well in this session.

Week 6: Cognitive Coping Skills

Goal: The sixth component of this treatment model focuses on teaching the youths and their parents the link between their thoughts, feelings, and behaviors, as well as how to identify and challenge unhelpful or inaccurate cognitions.

- When individuals experience trauma, it is common for them to develop distorted cognitions related to the traumatic event. A goal of TF-CBT treatment is to help recipients develop an awareness of these cognitions so that they can transform their internal dialogue (Cohen, Deblinger, & Mannarino, 2017). The first step is to assist youths and their caregivers with developing awareness of their internal dialogues. The facilitator should explain how we are often not even aware of our own internal dialogues, and can help children develop awareness of their dialogue by asking what their first thoughts are when they wake up in the morning (re: "I'm hungry"; I wonder what's for breakfast"; "I don't want to get out of bed; etc.). Next, the facilitator can introduce the "cognitive triangle", with an explanation of the relationship between thoughts, feelings, and behaviors. It's important to distinguish here the difference between thoughts and feelings, and to point it out when caregivers or youths share a thought instead of a feeling.
- The next step is to explain to the youths and the caregivers in their separate sessions that changing their thoughts can subsequently lead to changes in their feelings and behaviors. The facilitator can provide examples of scenarios that lead to negative thoughts or ask the youths or their caregivers to contribute their own, and then help them develop alternative

thoughts that are more accurate or helpful. An example of negative thoughts that might lead to suicidal behaviors should also be included here (e.g. “I’m a burden”, “Everyone would be better off if I wasn’t around”, etc.). The facilitator should otherwise try to keep the scenarios relatively benign, as it is not recommended by the TF-CBT developers to process cognitive distortions related specifically to the youth’s trauma before the trauma narration and processing phase (Cohen, Deblinger, & Mannarino, 2017).

- The cognitive triangle is introduced to the parents in a similar manner as the youths, but with a more age-appropriate example. It is also not recommended to delve into the parent’s cognitions about the youth’s trauma at this point in the treatment, unless the parent brings it up on their own. Cognitive coping can be used to teach the caregiver how to challenge pessimistic thoughts with coping statements. The facilitator should encourage the parent’s use of cognitive coping statements by highlighting observations that the facilitator has made about the parent’s resilience and bravery in the face of difficult life events.

Week 7: Introduce Rationale for Trauma Narrative

Goal: The goal of this phase of the treatment is to introduce the theoretical basis for the trauma narrative and to help the youths and their parents begin the process of developing their trauma stories.

- Before beginning the process of developing the trauma narrative, the facilitator should help the youths understand the rationale for creating the trauma narrative in the first place. Trauma narratives are an important component of TF-CBT treatment because they desensitize children to trauma reminders and reduce PTSD symptoms and behaviors such as hyperarousal and avoidance. Further, “...this process also enables the child to integrate

the traumatic experience into the totality of his/her life" (Cohen, Deblinger, & Mannarino, 2017). This can be accomplished by explaining that talking about the frightening aspects of the traumatic event gradually can lead to it becoming less triggering over time. The facilitator may also use analogies to assist with understanding the rationale for trauma narration and processing, such as going to physical therapy for an injury. At the beginning of physical therapy, the exercises might be painful, but as time goes on, the injured body part becomes stronger and maybe even stronger than it was prior to the injury. Similarly, the trauma narrative may trigger some painful feelings for the youth in the early stages, however, it will become easier over time due to desensitization, and by the time it is finished, the youth may feel even stronger than before because of the resilience they have developed in therapy. The facilitator may choose to use another analogy that is more culturally relevant.

- Once the rationale for the trauma narration and processing component is explained, the facilitator should initiate the trauma narration phase to minimize the anticipatory anxiety. The facilitator should provide the youths with a notebook or journal and first ask the youths to write a chapter about him/herself and their favorite activity, or something else relatively benign. This will prime the narrative writing process with something positive and will help their skills with writing a narrative related to the trauma. If the youth is struggling with identifying a specific traumatic event that occurred, the youth can write about a negative or unpleasant experience that triggered mental health symptoms and/or lead to suicidal ideation. The youth could also write about their experience processing the suicide of a loved one or someone they knew in the community and how they were impacted by it. TF-CBT treatment developers noted that children might exhibit

ambivalent feelings about their loved one as a result of the way the person died, and these feelings often come up in the trauma narration and processing phase. They also highlighted the importance of providing psychoeducation about the factors that may have contributed to their loved one's suicidal behavior (e.g. substance abuse, mental illness, etc.), and helping the youth, "...differentiate between the behavior (a bad decision that is not glorified in any way) and the person (toward whom the child may have ambivalent feelings or may love without reservation)" (Cohen, Deblinger, & Mannarino, p. 270).

- The facilitator should give the youths 30 or so minutes to work on the narrative, and remind the youths that they can pause if they need to at any point in the narration process to use some of their coping skills if they are feeling too overwhelmed. The facilitator should explain that this writing session should be focused on developing an outline of the before, during, and after narration of the identified negative/traumatic event. More details will be added to the narrative in the following sessions if desired, and the youths can incorporate creative elements (such as traditional dances, songs, or artwork) into their narrative. The facilitator should empower the youths to use any medium that they desire to tell their story.
- In the parent session, the facilitator should also start by explaining the rationale for creating the trauma/negative life event narrative, using similar analogies that were used with the youths to help the parents understand. Emphasis should also be placed on the fact that the creation of this narrative may not only help the youths reduce their PTSD or other mental health symptoms, but will likely also strengthen the parent-child relationship. The facilitator should remind the parents that a strong parent-child relationship protects against suicide and disrupts the pattern of intergenerational trauma.

The parents should be prepared to provide extra support to their children during this phase of the treatment, and the facilitator should explain to the parents that the youths might need help with decompressing at home after each trauma narration/processing session.

- Similar to the youth's session, the parents will develop their own trauma narrative that tells the story of the colonization of their tribe, and how that trauma got passed down intergenerationally. The facilitator should provide the same instructions that were given to the youths, specifically that the goal of the writing session is to develop a timeline of before, during, and after. The parents are to create a shared narrative that tells the historical trauma narrative of the tribe and its impacts on subsequent generations. However, each parent should also write their own "after" portion that includes how their children and themselves have been impacted by suicide, substance abuse, or family separation linked to the historical trauma of the tribe, and this section will also emphasize the resilience of the individual, their families, and the tribe. The facilitator should explain that the development of this narrative will create an opportunity for collective healing. Specifically, the parents will have an opportunity in the last session to present the narrative of the tribe in a ceremony during the last session.

Week 8: Compose Trauma Narrative

Goal: The goal of this phase of the treatment is to complete the trauma narrative, practice reading it from the beginning, include thoughts and feelings experienced during the traumatic event, and practice coping and parenting skills.

- The development of the trauma narrative is the most intensive and extensive component of the TF-CBT process. The objective of developing the trauma narrative is to, "…unlink

thoughts, reminders, or discussions of the traumatic event from overwhelming negative emotions such as terror, horror, extreme helplessness, avoidance, anger, anxiety, shame, or rage" (Cohen, Deblinger, & Mannarino, 2017, p. 172). The facilitator should begin the session by explaining that the plan for the session is for each youth to have time to share their trauma narrative privately with the therapist. This can be accomplished by having the youths sign up for time slots or pulling numbers to randomly determine the order. If there are some youths who haven't completed their narrative, they can continue working on it while waiting for their turn, or they can use their one-on-one time with the therapist to collaborate to add more details. Youths who have completed their trauma narrative and are waiting for their individual session with the therapist can practice coping skills.

- In the individual session, the facilitator may want to start by using the Subjective Units of Distress Scale (SUDS) to help the youth measure their level of distress during the trauma narration session. The therapist might point out that the youth's SUDS decrease each time the narrative is read to show them the progress that they are making in their treatment. If the youths experience significant emotional distress while reading the narrative, the facilitator can pause the narration and help the client practice relaxation skills. However, according to TF-CBT treatment developers, it is important to return to the narration once the youth is more regulated, so as not to reinforce avoidance (Cohen, Mannarino, & Deblinger, 2017). Once the youth has read through the whole narrative, the facilitator should ask the youth to read it again and insert thoughts/feelings that they were having during the event, as well as any other additional details that may come up. The facilitator should wait until the next session to explore these thoughts and feelings further.

- In the parent session, the facilitator will help the parents develop their historical trauma narrative collaboratively. The parents will also break off into one-on-one sessions with the therapist throughout the session, so that they can review the personal portion of the narrative. The parents who are waiting for their one-on-one session will continue to work on the trauma narrative of the tribe, as well as review and practice parenting skills. In the one-on-one sessions, the parents will be asked to add more details including their thoughts and feelings, as well as the link between the historical trauma of the tribe, their personal trauma history (which might include experiences with suicide), and the subsequent impact on their youth in the treatment. Similar to the one-on-one sessions with the youths, the therapist can implement SUDS with the parent and help the parent to regulate themselves if they become too emotionally dysregulated while reviewing the narrative.

Week 9: Challenge Distortions and Make Meaning

Goal: The goals of this phase of treatment are to help the youths identify the worst moment or worst memory in their narrative, challenge any cognitive distortions, identify areas of resilience, assist with meaning making, and emphasize links to historical trauma in the tribe.

- Once the trauma narrative is completed, the next phase of TF-CBT treatment is focused on helping the youth identify, explore, and correct inaccurate or unhelpful thoughts related to the trauma (Cohen, Deblinger, & Mannarino, 2017). In the youth session, the facilitator will take the youth aside one by one and have them read their narrative from the beginning, but this time the facilitator will ask the youth to include the worst memory or worst part of the traumatic experience and describe it with as much detail as possible. The facilitator will help the youth describe any feelings and accompanying physical

sensations they experience while discussing this part of the narrative. If the youth becomes too distressed while discussing this part of the narrative, the facilitator should remind them that these feelings are temporary and are being elicited in response to talking about something that happened in the past, not something that is currently happening. The facilitator can support the youth with practicing relaxation skills or engaging in a distraction task, with the goal of helping the youth regulate before returning to the narrative.

- Once the narrative has been fully written out with the inclusion of thoughts, feelings, and the worst part/worst memory, the facilitator should employ cognitive processing techniques to help the youth challenge and correct any cognitive distortions about what happened. If they choose to, the youth can include any of the corrections that they made during this phase into their narrative. The youth should also develop a final chapter where they discuss how they have grown since the traumatic event and in the therapy process, and any advice they might want to give to other youths who have gone through similar experiences. In this final chapter, the facilitator should help the youth contextualize their experience of trauma and/or suicidality within a historical trauma framework, specifically, how the youth's narrative is inextricably linked with the original trauma of colonization and the impacts it has had on the youth's ancestors and the tribal community as a whole. The facilitator should point out that the youth's courage in treatment is a powerful offering to the spirit of healing and will help to break the cycle of intergenerational trauma within the community. Toward the end of this session as well as other subsequent sessions, the facilitator should emphasize the youth's hard work and engage the youth in some kind of relaxing or pleasurable activity of the youth's choosing.

This will help the youth develop positive feelings about the trauma narration if it ends in a relatively upbeat manner.

- In the parent session, the facilitator should take each parent aside one by one to help prepare them for the next session, in which the parent and the youth will have a conjoint session and the youth will read their narrative to the parent. It is important that the facilitator uses this session to assess whether the parent has developed adequate coping and parenting skills before reading the narrative, and to fine-tune with the parent any skills that still need some improvement. The facilitator will ask the parent to describe their experience of the youth's trauma and/or experience with suicide/suicidality in detail, including their own thoughts and feelings in reaction to the event. There should also be a reminder about how their child is talking about the event in their own group session, and the facilitator may share parts of the narrative with the parent. This is also an opportunity for the facilitator to engage the parent in a conversation about intergenerational trauma within the community /family, and how it has been subsequently passed down to the parent and the parent's children. The facilitator should end the session by highlighting the child's efforts in treatment and praising the parent for supporting their child with the treatment.

Week 10: Conjoint Child-Parent Session

Goal: The goals of this phase of treatment are for the child to share their narrative with the parent and to engage in more open communication.

- Conjoint child-parent sessions are an important component of the TF-CBT treatment because it enhances the parent-child relationship by creating opportunities to practice skills together and gradually increases the child's comfort in talking about the child's

traumatic experiences or any other issues the child wants to address (Cohen, Deblinger, & Mannarino, 2017). In the youth session, the facilitator should briefly take each child aside and have them practice reading their narrative aloud in preparation for reading the narrative to their parent, if it is deemed that the parent is emotionally ready to cope with hearing the details of the youth's trauma and/or experiences with suicidality. In this brief one-on-one session with the youths, the facilitator should help the youth formulate any questions that they might want to discuss with the parent(s).

- Similarly, the facilitator should briefly take aside each parent and read the youth's narrative with them, to assess whether the parent is ready to review the narrative with their youth. The facilitator should go over the child's questions and assist the parent with developing responses. The parent can also develop their own list of questions for the youth, and the facilitator should help them formulate these questions appropriately.
- During the conjoint session between the youth and their parent(s), the youth reads their narrative to their parent(s) and the facilitator. The facilitator should then help the youth address any questions that they might have with their parent(s), and vice versa. The facilitator's role is to step back and allow the parent(s) and their youth to communicate directly, however, the facilitator can intervene to help the youth or parent(s) to challenge any cognitive distortions that may arise. The facilitator should praise the youth and the parent(s) for reviewing the narrative together, and the facilitator should emphasize how this process will help to heal historical trauma within the family, and how this healing will have ripple effects for generations to come.

Week 11: Safety Planning

Goal: The goal of this phase of treatment is to help the youth develop personal safety skills.

- In TF-CBT treatment, enhancing future safety is the final component of the treatment, however, safety should be emphasized throughout the treatment process (Cohen, Deblinger, & Mannarino, 2017). Before beginning the safety skills training with the youth, it is important to normalize and praise their responses to previous traumas or exposures to suicide. The facilitator should explain that even though their response may not have prevented the trauma, they took steps toward their safety such as disclosing what happened to an adult or even just participating in this treatment to begin with. If the youth is focusing their narrative on an exposure to suicide, the facilitator should emphasize that there is nothing that the youth could've done to prevent their loved one's suicide and explain that there is no "right" way to respond to such a tragic loss.
- In both groups, the youth and their parents will learn safety skills. Some important skills to learn include: (1) how to communicate openly and assertively about feelings and needs; (2) how to listen to gut feelings; (3) how to identify safe people and places; (4) how to define body boundaries; (5) how to distinguish between harmless secrets and dangerous secrets; (6) and how to be persistent in asking for help until a trusted adult provides help. Generally, it's important for youth to learn about potential dangers in their environment and to encourage them to practice discernment with their gut reactions and perceptions of unsafe situations. The facilitator should use role play and coaching techniques to assist the youth with practicing their communication skills.
- In the parent group, the facilitators will teach the parents how to respond effectively when their children express their feelings to them. The facilitator can help the parent(s) reduce their defensive responses when their child expresses feelings of anger so that they

are encouraged to reflect on and express their feelings in a productive way, rather than act them out.

- The facilitators should help the youths develop their own safety plan, which can include lists of warning signs (e.g. thoughts, feelings, and behaviors), coping skills including spiritual practices, contact information for trusted friends or family members they can reach out to for help, and phone numbers of local emergency services or suicide hotlines. The facilitators should also encourage the youths to share their safety plans with their peers or other community members if they feel comfortable, so that the people that they are close to can be aware of their warning signs and support them accordingly. This could lead to a discussion of how the youths and their parents can act as "gatekeepers" to prevent suicide in their community by having this important knowledge about suicide and how to support individuals who may be struggling. The parents should be provided a copy of youth's safety plan and will be given instructions to review it with their child, and prompt them to implement some of the strategies listed on the safety plan when and if the need arises.
- Finally, the facilitators, the youths, and the parents should collaborate to plan for the final session, by asking the youths and their families what food and beverages they would like to have for the celebration. The facilitators should also ask the youth and their families if there are any other family members that they would like to invite to attend.

Week 12: Ceremony

Goal: The goal of this phase of treatment is to bring the families together to celebrate the end of treatment by conducting a ceremony.

- At the end of group TF-CBT treatment, the focus of the final session is to review the skills and knowledge learned in the treatment process and encourage the children and their families to continue using these skills after treatment concludes (Cohen, Deblinger, & Mannarino, 2017). This final session is also dedicated to celebrating the work done in treatment. The facilitators should begin by highlighting the resilience of the families in treatment and the tribe as a whole. This session should begin with a smudging ceremony to unify the group and create a healing container. Once the smudging is complete, the parents will share the story of the tribe that they created together, through traditional song, dance, and artwork. The youths may choose to share their creative projects as well.
- Finally, the facilitators should make sure that the families are linked with any resources that they might need for ongoing support after the treatment. This may include scheduling follow-up sessions with the youth and their families to check in a couple of weeks after treatment concludes, which could also help to determine if there has been a significant reduction in PTSD symptoms and/or suicidal behaviors.

CHAPTER V: DISCUSSION

Suicide is a significant public health issue that disproportionately effects AI/AN communities. AI/AN communities have had consistently high rates of suicide, and the CDC reported that in 2021 AI/AN people had the highest rates of suicide compared with other groups. In addition, AI/AN youths aged 10-24 had higher rates of suicide in 2021 compared to previous years (Stone, Mack, and Qualters, 2023). While suicide has many risk factors, historical trauma is a significant risk factor for suicide that has been linked specifically to AI/AN individuals and is likely the underlying culprit for the high rates of suicide within this population (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015). To prevent suicide for AI/AN youths, it follows that historical trauma needs to be a central focus of suicide prevention programs. Historical Trauma-Focused Cognitive Behavioral Treatment with incorporated AI/AN traditional beliefs and customs will support AI/AN youth and their families with coping with trauma-related symptoms and reducing the risk for suicidality.

This proposed program is constructed to increase protective factors that have been shown to reduce suicide for AI/AN youth, with interventions targeted at improving family relationships, fostering spirituality, building resilience, teaching the historical context, learning adaptive coping mechanisms, and enhancing social and cultural connectedness. The implementation of these interventions in a group format is consistent with AI/AN collectivistic values and provides an opportunity for healing to occur across generations. The group format also creates a space where AI/AN elders and youth can come together to define the meaning of suicide in their community, which can spark ongoing conversations about how tribal members want to address suicide in the community after the program has concluded.

This chapter includes a brief discussion of the implications of this treatment proposal, followed by a discussion of limitations, and ends with recommendations for future research.

Implications

Suicide prevention researchers highlight the need to use community-based intervention strategies for AI/AN individuals that establish and reinforce protective factors on an individual, community, and societal level (Alcántra & Gone, 2006). Many of the identified risk factors for AI/AN youths such as abuse and neglect, witnessing violence against one's mother, historical loss associated symptoms and discrimination, are traumatic in nature (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015). Thus, the theoretical assumption guiding the development of this proposed program is that preventing suicide for AI/AN youth necessitates therapeutic intervention that addresses the many traumas that they face. The proposed program utilizes a well-established evidence-based therapeutic intervention (TF-CBT) to target trauma-related symptoms, reduce risk factors, and enhance protective factors on multiple levels. Future researchers who are interested in suicide prevention may want to ask the question of whether therapeutic intervention should always be an essential element of suicide prevention, or if it is dependent upon the specific risk and protective factors of the target population being examined.

Limitations

There are several important limitations within this treatment intervention proposal that could be addressed by future researchers. One such limitation is that the proposed treatment intervention has not been implemented as a study within this population. While there is significant evidence that TF-CBT is efficacious in improving post-traumatic stress symptoms and other related trauma symptoms in both individual and group formats, this particular adaptation of TF-CBT has not been tested. A second limitation is that the interventions in this

protocol were developed for American Indian/Alaska Native populations, however, each tribe is unique and has its own traditional practices and tribal beliefs. The practitioner should familiarize themselves with the tribe's traditional beliefs and spiritual practices and incorporate them into the treatment as often as possible. However, if the practitioner is not AI/AN themselves, they should seek ongoing support and guidance when incorporating spiritual practices and should include AI/AN spiritual leaders whenever possible. Thus, it is important not to assume that all AI/AN have similar traditions, and to adapt the treatment protocol to honor each tribe's unique traditions. Lastly, the TF-CBT treatment utilizes a lot of Westernized language and concepts, and so the practitioner will need to be mindful of adapting the protocol to accommodate the participant's level of acculturation. As mentioned previously, AI/AN individuals tend to be suspicious of the Western medical model, and so the practitioner of this model will need to have an awareness of that and adapt their approach to this treatment accordingly. More emphasis should be placed on the participants own agency, and the practitioner should encourage the participants to be active in the decision-making process throughout the treatment process. Further, given the disparities AI/AN communities often face, the practitioner should be prepared to use a holistic approach to address any of the family's needs that might interfere with the treatment, which might indicate collaborating with other providers or community members. This will require flexibility on the behalf of the practitioner and a "whatever it takes" mentality, which might include providing extra sessions or allowing for contact in between sessions, conducting meetings in community settings, incorporating other tribal members or leaders into the treatment, providing tangible resources, and tailoring the treatment to the unique needs of each individual and family involved.

Recommendations for Future Research

There is a dire need for more research on culturally conscious suicide prevention programs for AI/AN youths. There appears to be an even bigger gap in the literature regarding suicide prevention programs that address the psychological impacts of historical trauma. Future researchers who are interested in testing this adaptation of TF-CBT protocol may want to investigate whether including the unique elements of this program, such as the introduction of the parent's historical trauma narrative and the focus on suicide, is helpful or harmful to treatment outcomes. Specifically, future researchers may want to measure whether this treatment intervention reduces historical trauma related symptoms and prevents suicidality within this population. The writer hopes that this historical trauma informed approach to may ultimately serve as a template for treating historical trauma related symptoms and suicidality in AI/AN community mental health settings.

References

Adams, D. W. (1988). Fundamental considerations: the deep meaning of native american schooling, 1880-1900. Harvard Educational Review, 58(1), 1–29. https://doi.org/10.17763/haer.58.1.h57152110517nm65

Alcántara, C., & Gone, J. P. (2007). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies*, *31*(5), 457–477. https://doi org.antioch.idm.oclc.org/10.1080/07481180701244587

Allen, J., Qungasvik Team, Rasmus, S., Fok, C., Charles, B., & Henry, D. (2018). Multi-level cultural intervention for the prevention of suicide and alcohol use risk with alaska native youth: A nonrandomized comparison of treatment intensity. *Prevention Science, 19*(2), 174-185. doi:10.1007/s11121-017-0798-9

Bigfoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of clinical psychology*, *66*(8), 847-856.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *8*(2), 60–82. https://doi.org/10.5820/aian.0802.1998.60

Brave Heart, M. Y. H. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. Journal of Psychoactive Drugs, 35(1), 7–13. https://doi.org/10.1080/02791072.2003.10399988

Brockie, T. N., Dana-Sacco, G., Wallen, G. R., Wilcox, H. C., & Campbell, J. C. (2015). The relationship of adverse childhood experiences to PTSD, depression, poly-drug use and suicide attempt in reservation-based Native American adolescents and young adults. American Journal of Community Psychology, 55(3–4), 411–421. https://doi.org/10.1007/s10464-015-9721-3

Carlson, L. A., & Roberts, M. A. (2006). Indian lands, "squatterism," and slavery: economic interests and the passage of the Indian Removal Act of 1830. Explorations in Economic History, 43(3), 486–504. https://doi.org/10.1016/j.eeh.2005.06.003

Centers for Disease Control and Prevention. (2016). Leading causes of death by age group, United States.

Chief Moon-Riley, K., Copeland, J. L., Metz, G., & Currie, C. L. (2018). The biological impacts of Indigenous residential school attendance on the next generation. *SSM - population health*, *7*, 100343. https://doi.org/10.1016/j.ssmph.2018.100343

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in*

children and adolescents. Guilford Publications.

Cwik, M., Barlow, A., Tingey, L., Goklish, N., Larzelere-Hinton, F., Craig, M., & Walkup, J. T. (2015). Exploring risk and protective factors with a community sample of American Indian adolescents who attempted suicide. Archives of Suicide Research, 19(2), 172–189. https://doi.org/10.1080/13811118.2015.1004472

Denevan, W. (1992). *The pristine myth : The landscape of the Americas in 1492* (Annals of the association of American geographers, v. 82, n. 3). Washington: Association of American Geographers. https://doi.org/10.1111/j.1467-8306.1992.tb01965.x

Doria, C. M., Momper, S. L., & Burrage, R. L. (2022). "Togetherness:" the role of intergenerational and cultural engagement in urban American Indian and Alaskan Native youth suicide prevention. In *Indigenous Health Equity and Wellness* (pp. 109-126). Routledge.

Dunbar-Ortiz, R. (2014). *An indigenous peoples' history of the United States* (Vol. 3). Beacon Press.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Suny Press.

Duran, E., Duran, B., Brave Heart, M. Y. H., & Yellow Horse-Davis, S. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), International handbook of multigenerational legacies of trauma. (pp. 341–354). New York, NY: Plenum Press. https://doi.org/10.1007/978-1-4757-5567-1_22

Duran, E. (2019). *Healing the soul wound: Trauma-informed counseling for Indigenous communities*. Teachers College Press.

Ellinghaus, K. (2022). *Blood will tell: Native Americans and assimilation policy*. University of Nebraska Press.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of interpersonal violence*, *23*(3), 316-338. https://doi.org/10.1177/0886260507312290

Felner, R. D., & Felner, T. Y. (1989). Primary prevention programs in the educational context: A transactional-ecological framework and analysis. In L. A. Bond & B. E. Compas (Eds.), Primary prevention and promotion in the schools (pp. 13-49). Newbury Park, CA: Sage.

Garrett, M. T., Parrish, M., Williams, C., Grayshield, L., Portman, T. A. A., Torres Rivera, E., & Maynard, E. (2014). Invited commentary: Fostering resilience among Native American youth through therapeutic intervention. Journal of Youth and Adolescence, 43(3), 470–490. https://doi.org/10.1007/s10964-013-0020-8

Giano, Z., Camplain, R. L., Camplain, C., Pro, G., Haberstroh, S., Baldwin, J. A., ... & Hubach, R. D. (2021). Adverse childhood events in American Indian/Alaska native populations. *American journal of preventive medicine*, *60*(2), 213-221.

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: prospects for evidence-based practice. *Journal of consulting and clinical psychology*, *77*(4), 751. https://doi.org/10.1037/a0015390

Great Lakes Inter-Tribal Council. (2013). Suicidal behaviors among American Indian/Alaska Native populations: Indian Health Service Resource Patient Management System suicide reporting form aggregate database analysis, 2003–2012. Lac du Flambeau, WI: Great Lakes Inter-Tribal Epidemiology Center, Great Lakes Inter-Tribal Council.

Hartmann, W., Wendt, D., Burrage, R., Pomerville, A., & Gone, J. (2019). American indian historical trauma: Anticolonial prescriptions for healing, resilience, and survivance. *The American Psychologist, 74*(1), 6-19. doi:10.1037/amp0000326

Holliday, C. E., Wynne, M., Katz, J., Ford, C., & Barbosa-Leiker, C. (2018). A CBPR approach to finding community strengths and challenges to prevent youth suicide and substance abuse. Journal of Transcultural Nursing, 29(1), 64–73. https://doi.org/10.1177/1043659616679234

Kelley, A., Restad, D., & Killsback, J. (2018). A public health approach: Documenting the risk and protective factors of suicide ideation in one American Indian community. Psychological Services, 15(3), 325–331. https://doi.org/10.1037/ser0000211

Little, B. (2017). How boarding schools tried to 'kill the Indian'through assimilation. *History.com*.

Mackin, J., Perkins, T., & Furrer, C. (2012). The power of protection: A population-based comparison of native and non-native youth suicide attempters. *American Indian and Alaska Native Mental Health Research*, *19*(2), 20–54. https://doi.org/10.5820/aian.1902.2012.20

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... & Mehlum, L. (2005). Suicide prevention strategies: a systematic review. Jama, 294(16), 2064-2074. https://doi.org/10.1001/jama.294.16.2064

McLeigh, J. D. (2010). What Are the Policy Issues Related to the Mental Health of Native Americans?. American Journal of Orthopsychiatry, 80 (2), 177-182. doi:10.1111/J.1939-0025.2010.01021.X

Mehl-Madrona L, Mainguy B. Introducing healing circles and talking circles into primary care. Perm J. 2014 Spring;18(2):4-9. doi: 10.7812/TPP/13-104. PMID: 24867544; PMCID:

PMC4022550.

Nasir, B. F., Hides, L., Kisely, S., Ranmuthugala, G., Nicholson, G. C., Black, E., … Toombs, M. (2016). The need for a culturally-tailored gatekeeper training intervention program in preventing suicide among Indigenous peoples: A systematic review. BMC Psychiatry, 16. https://doi.org/10.1186/s12888-016-1059-3

Office of the Surgeon General (US, & National Action Alliance for Suicide Prevention (US. (2012). 2012 national strategy for suicide prevention: goals and objectives for action: a report of the US Surgeon General and of the National Action Alliance for Suicide Prevention.

Pavkov, T. W., Travis, L., Fox, K. A., King, C. B., & Cross, T. L. (2010). Tribal youth victimization and delinquency: analysis of Youth Risk Behavior Surveillance Survey data. *Cultural diversity and ethnic minority psychology*, *16*(2), 123. https://doi.org/10.1037/a0018664

Rao, S., Pell, D., & England-Kennedy, E. S. (2017). Suicide, resilience, and connectedness across the lifespan: Lessons from American Indian and Alaska Native elders. Family & Community Health: The Journal of Health Promotion & Maintenance, 40(4), 347–356. https://doi.org/10.1097/fch.0000000000000164

Robbins, R., Colmant, S., Dorton, J., Schultz, L., Colmant, Y., & Ciali, P. (2006). Colonial Instillations in American Indian Boarding School Students. *Educational Foundations*, *20*, 69-88.

Shoshan, T. (1989). Mourning and longing from generation to generation. *American Journal of Psychotherapy*, *43*(2), 193-207. https://doi.org/10.1176/appi.psychotherapy.1989.43.2.193

Stone, D. M., Holland, K. M., Bartholow, B. N., Crosby, A. E., Davis, S. P., & Wilkins, N. (2017). Preventing suicide: a technical package of policies, programs, and practice. https://doi.org/10.15620/cdc.44275

Stone, D. M., Mack, K. A., & Qualters, J. (2023). Notes from the Field: Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group - United States, 2021. *MMWR. Morbidity and mortality weekly report*, *72*(6), 160–162. https://doi.org/10.15585/mmwr.mm7206a4

Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Treuer, D. (2019). *The heartbeat of Wounded Knee: Native America from 1890 to the present*. Penguin.

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.* Washington, DC: HHS, September 2012.

Van der Feltz-Cornelis, C. M., Sarchiapone, M., Postuvan, V., Volker, D., Roskar, S., Grum, A. T., … Hegerl, U. (2011). Best practice elements of multilevel suicide prevention strategies: A review of systematic reviews. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 32(6), 319–333. https://doi.org/10.1027/0227-5910/a000109

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American journal of community psychology*, *33*(3-4), 119-130.

Wolynn, M. (2017). *It didn't start with you: How inherited family trauma shapes who we are and how to end the cycle*. Penguin.