
CONTINUING EDUCATION

Behavioral Health of American Indian and Alaska Native Adolescents: Historical Trauma, Protective Factors, and Culturally Responsive Practice for Psychologists

Reading Manual for Licensed Psychologists
and Graduate-Level Clinicians

FRANKLIN CARVAJAL

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Abstract

American Indian and Alaska Native (AI/AN) adolescents occupy a distinctive position in the epidemiology of adolescent mental health in the United States. They carry generations of Indigenous knowledge, language, and cultural strengths that have supported survival and continuity across centuries, while simultaneously bearing a disproportionate burden of psychological suffering that reflects the accumulated impact of colonization, forced assimilation, and ongoing structural inequity. This continuing education manuscript synthesizes contemporary epidemiologic surveillance, systematic evidence synthesis, and community-partnered scholarship to provide licensed psychologists and graduate-level clinicians with a comprehensive foundation for competent, ethical, and culturally responsive practice with AI/AN youth. Drawing on the 2023 Youth Risk Behavior Survey supplemental sample of AI/AN high school students (Jones et al., 2024), a systematic review and meta-analysis of depression and anxiety among AI/AN adolescents (Chan et al., in press), and community-partnered policy work grounded in the Project TRUST collaborative (Goodkind et al., 2010, 2011), the manuscript integrates findings across substance use, emotional well-being, suicide risk, and violence exposure. Particular attention is given to the protective role of adult caretaker engagement, parental monitoring, and school connectedness; to the conceptual and clinical implications of historical and intergenerational trauma; and to the limitations of Western evidence-based practice frameworks when applied uncritically to Indigenous youth. The manuscript concludes with concrete practice recommendations, ethical considerations rooted in the American Psychological Association's principles of competence, informed consent, and cultural responsiveness, and directions for future research and policy engagement. Case scenarios distributed throughout illustrate how the evidence base translates into decision-making at the level of the individual clinical encounter, the family system, and the community.

Introduction

The mental health of American Indian and Alaska Native adolescents represents one of the most persistent and consequential health disparities in the United States. For at least two decades, epidemiologic and clinical scholarship has documented that AI/AN youth experience elevated rates of suicide, substance use, exposure to violence, and psychological distress, and that these disparities exist against a backdrop of structural underinvestment in behavioral health services, historic disruption of cultural continuity, and ongoing racialized inequity (Goodkind et al., 2010; Jones et al., 2024). Suicide has ranked as the second leading cause of death among AI/AN youth aged 15 to 24 for more than two decades, with rates approximately three times the rate for the overall United States population in this age group (Goodkind et al., 2010). Contemporary surveillance confirms that attempted suicide, current electronic vapor product use, current marijuana use, and lifetime experience of forced sexual intercourse remain significantly more prevalent among AI/AN high school students than among their non-AI/AN peers (Jones et al., 2024).

At the same time, an increasingly rigorous literature has begun to articulate the sources of resilience, cultural strength, and protective connection that support the healthy development of AI/AN youth. Research grounded in Indigenous frameworks and community-partnered methods emphasizes that Indigenous traditions, language, ceremony, and relational values are not peripheral to healing but constitute the primary infrastructure of well-being for many AI/AN adolescents and families (Goodkind et al., 2011). Empirical work drawing on the Youth Risk Behavior Survey has documented that when AI/AN students report having a household adult who consistently attempts to meet their basic needs, when parents or other caregivers exercise high monitoring of the adolescent's activities and companions, and when students feel close to people at school, the prevalence of substance use, poor emotional well-being, suicide-related outcomes, and violence exposure is meaningfully lower (Jones et al., 2024).

The purpose of this manuscript is to provide licensed psychologists and advanced clinicians with a synthesized, integrated, and clinically actionable understanding of the current evidence base regarding AI/AN adolescent behavioral health. The manuscript is written for practitioners who may encounter AI/AN youth and families across settings that include tribally operated behavioral health programs, urban Indian health centers, Indian Health Service facilities, school-based health centers, integrated primary care, private practice, and academic medical centers. It is also

intended for psychologists engaged in supervision, program evaluation, policy consultation, and community-based research.

Three broad aims organize the manuscript. First, it integrates the epidemiologic evidence regarding the prevalence and correlates of depression, anxiety, substance use, suicide risk, and violence exposure among AI/AN adolescents, drawing attention to areas of convergence and disagreement across data sources. Second, it advances a conceptual account of the mechanisms linking historical and contemporary contextual stressors to psychological outcomes, emphasizing the mediating and moderating roles of family caretaking, parental monitoring, school connectedness, and cultural continuity. Third, it translates this synthesis into concrete implications for clinical assessment, formulation, treatment planning, ethical practice, and systems-level engagement. Case scenarios embedded throughout illustrate the translation of evidence into decision-making at multiple levels of clinical work.

Several orientations shape the manuscript. It approaches AI/AN adolescent mental health as inseparable from the historical and structural context in which it unfolds. It regards Indigenous knowledge as a legitimate and often primary form of evidence, consistent with federal guidance recognizing Indigenous knowledge as a valid basis for policy, research, and decision-making (Jones et al., 2024). It treats the diversity of AI/AN peoples—more than 574 federally recognized tribes with distinct histories, languages, and cultural systems, together with substantial urban Indian populations and complex multiracial and multiethnic identities—as a foundational fact that constrains any attempt at generalization (Goodkind et al., 2011; Jones et al., 2024). And it recognizes that psychologists occupy a particular ethical position: a profession whose scientific and clinical traditions have too often functioned as instruments of assimilation rather than healing, and which therefore carries a specific responsibility to practice with humility, accountability, and community accountability.

Historical and Theoretical Foundations

Colonization, Federal Policy, and the Origins of Behavioral Health Disparity

Any credible account of AI/AN adolescent behavioral health must begin with the historical and political context that produced contemporary disparities. The United States government pursued, over more than two centuries, a sequence of policies whose intent and effect were the physical, cultural, and spiritual disruption of Indigenous peoples. These policies included military campaigns and forced removals such as the Long Walk of the Diné; the reservation and allotment systems, which fragmented land bases; the federal boarding school era, which forcibly separated children from families and prohibited Indigenous languages, ceremonies, and cultural practices; termination and relocation policies of the mid-twentieth century, which severed federal recognition from certain tribes and moved Indigenous families to urban centers; and structural underfunding of the health, education, and social service systems responsible for AI/AN communities (Goodkind et al., 2010, 2011; Jones et al., 2024). The Executive Office of the President has explicitly acknowledged this history in its guidance on Indigenous knowledge, noting that federal actions have included ethnocidal and genocidal policies whose ongoing consequences must be recognized in contemporary policy and research (Jones et al., 2024).

These policies were not incidental to Indigenous suffering; they were designed to sever Indigenous peoples from land, language, ceremony, kinship, and self-governance. Their behavioral health consequences are neither indirect nor remote. The forced removal of children to boarding schools disrupted the intergenerational transmission of parenting knowledge, contributing to what community members and providers describe as a rupture in traditional parenting practices that continues to shape family systems today (Goodkind et al., 2010, 2011). The prohibition and pathologization of Indigenous healing practices reinforced the primacy of Western biomedical and psychological approaches while marginalizing the practitioners and knowledge systems that had, as Goodkind and colleagues (2010) note, sustained Indigenous well-being since time immemorial.

The Concept of Historical Trauma

The concept of historical trauma has emerged as a central theoretical framework for understanding the intergenerational psychological consequences of colonization. Originally developed in scholarship on the children of Holocaust survivors and extended to AI/AN populations by Brave Heart and others, historical trauma refers to the cumulative emotional and psychological wounding across generations that results from massive group trauma (Goodkind et al., 2011). Related terms in the literature include colonial trauma, intergenerational trauma, multigenerational trauma, cumulative psychic wounding, and the phrase *soul wound* offered by Duran and Duran to capture the spiritual dimension of colonial injury (Goodkind et al., 2011).

Whitbeck and colleagues have contributed empirical operationalization of historical trauma through the development of measures assessing thoughts of historical loss and associated emotional responses, and their work has linked historical loss to depressive symptoms, anxiety, and substance use in AI/AN adults and adolescents (Goodkind et al., 2010, 2011). Symptoms associated with the historical trauma response include intrusive imagery, unresolved grief, survivor guilt, identification with deceased ancestors, elevated rates of cardiovascular mortality and suicide, psychic numbing, and impaired affect tolerance (Goodkind et al., 2011). Brave Heart's argument, subsequently developed by others, is that posttraumatic stress disorder as defined in Western nosology fails to capture the enduring, widespread, and intergenerational quality of historical trauma, and that historical trauma is therefore a more clinically and culturally accurate framework for many AI/AN individuals and communities.

The concept has generated productive scholarly debate. Some critics have argued that historical trauma risks essentializing suffering or displacing attention from present-day structural violence; others have raised methodological concerns about how the construct is measured and how its causal pathways are specified. A systematic review of historical trauma research in AI/AN and Indigenous Canadian populations found consistent associations with health outcomes but noted heterogeneity in operationalization (Jones et al., 2024). For the practicing psychologist, the central clinical implication is neither that every AI/AN adolescent presents with the sequelae of historical trauma nor that historical trauma can be reduced to individual symptoms. Rather, historical trauma provides a conceptual bridge between the political and the psychological, allowing clinicians to hold the individual patient's presentation within a larger frame of collective experience and

community history.

Cultural, Social, and Collective Resilience

Alongside the historical trauma literature has developed a parallel and equally important body of scholarship on resilience. Teufel-Shone and colleagues have argued that resilience is an underexplored framework in AI/AN public health, and that resilience among Indigenous peoples is fundamentally cultural, social, and collective rather than individual (Jones et al., 2024). Whitbeck and colleagues' work on enculturation has demonstrated that identification with and embeddedness within one's Indigenous culture buffers the effects of discrimination and historical loss on depressive symptoms and substance use (Goodkind et al., 2011). Yoder and colleagues have shown that AI/AN youth with higher cultural involvement have lower rates of suicidal ideation, and Rieckmann and colleagues found that Diné cultural identity protects against depression in Diné adolescents (Goodkind et al., 2010, 2011).

The 2019 National Indian Education Study, cited in the CDC surveillance report, found that Native language and culture programs were associated with higher academic achievement, motivation, self-esteem, and pride among AI/AN students in grades 4 and 8 (Jones et al., 2024). Family involvement in schools, including participation in volunteer programs and parent-teacher organizations, was associated with higher academic performance. These findings converge with clinical and community observations that cultural connectedness functions as a foundational protective factor and that its erosion, through boarding school separation, relocation, or the pathologizing of Indigenous practices, produces measurable psychological cost.

The Divergence and Potential Complementarity of Western and Indigenous Healing Traditions

A third theoretical foundation concerns the relationship between Western behavioral health systems and Indigenous healing practices. Goodkind and colleagues (2010, 2011) describe the fundamental divergence between these systems and the primacy that federal, state, and local funding structures have historically given to Western approaches. Indigenous traditional practices—including ceremonies, healers, herbal medicines, sweat lodges, storytelling, and cultural teachings—have been prohibited at various points in U.S. history, disregarded in others, and consistently marginalized in reimbursement and credentialing systems. This has produced, as Goodkind and colleagues describe, a replacement system of behavioral health care that may not meet the needs of AI/AN youth and may in some cases cause harm (Goodkind et al., 2011).

Empirical work has documented that AI/AN adults and adolescents often prefer traditional cultural services over formal behavioral health services and view traditional practices as more effective. Beals and colleagues found that 34 to 49 percent of American Indian adults with depressive or anxiety disorders sought help from traditional healers (Goodkind et al., 2010). Walls and colleagues found that AI/AN parents and caregivers in the northern Midwest strongly preferred traditional cultural services and believed them more effective than formal services (Goodkind et al., 2010, 2011). Studies of specific practices, including use of Indigenous herbs, sweat lodges, and traditional spiritual orientations, have linked these practices to positive health outcomes (Goodkind et al., 2010, 2011). Garrouette and colleagues found that commitment to cultural spiritual orientation was significantly associated with reduced attempted suicide among American Indian adults and adolescents (Goodkind et al., 2011).

The theoretical implication is that behavioral health care for AI/AN adolescents cannot be adequately understood as the delivery of Western services to a distinct population. It must be understood as a domain in which the primacy of Western frameworks itself constitutes a barrier to care, and in which the goal, as Goodkind and colleagues (2010) articulate, is not the integration of Native practices into Western systems but the transformation of behavioral health systems to support Indigenous healing traditions.

Conceptual Models and Mechanisms

An Integrated Contextual Model

The evidence reviewed thus far supports a contextual, multilevel model of AI/AN adolescent behavioral health. At the most distal level are structural and historical determinants: federal policies of colonization and assimilation, the disruption of Indigenous language and cultural transmission, the systematic underfunding of AI/AN health and education systems, and ongoing racialized inequity in wealth, employment, education, and criminal justice. These distal determinants shape more proximal community-level conditions: rates of community violence, availability of traditional practitioners, access to Indigenous language and ceremony, quality of local schools, and adequacy of behavioral health infrastructure. Community-level conditions in turn shape family systems: intergenerational patterns of parenting, availability of extended kin networks, family experiences of loss and grief, and family engagement with cultural practice. Family systems then shape the immediate contexts of adolescent development: caretaking, monitoring, connection to school, exposure to violence, and opportunities for cultural learning. These proximal contexts, in interaction with individual biological, cognitive, and developmental characteristics, produce the psychological outcomes observed in surveillance and clinical data.

Walters and Simoni's indigenist stress-coping model, referenced by Goodkind and colleagues (2011), provides an empirical framework for understanding how these levels interact. In this model, historical trauma, discrimination, and traumatic life events function as stressors that increase risk for substance use, posttraumatic stress, and depression, while cultural factors—enculturation, participation in traditional health practices, Indigenous identity, and spiritual coping—function as buffers that mediate stress effects. Empirical support for this model comes from studies showing that traditional participation and traditional spirituality are associated with alcohol cessation among American Indian adults, and that cultural identity buffers the effects of perceived discrimination on depressive symptoms.

Mechanisms Linking Protective Factors to Outcomes

The findings from the 2023 YRBS supplement (Jones et al., 2024) allow us to specify the immediate protective mechanisms with new empirical precision. Three exposures were examined: whether the student had a household adult who always tried to meet their basic needs across their lifetime; whether parents or other caretakers exercised high monitoring of the adolescent's activities and companions; and whether the student felt close to people at school. Each was associated with lower prevalence of multiple health-risk outcomes among AI/AN students.

Household adult caretaking, defined as a lifetime pattern of an adult who consistently attempts to meet the student's basic needs of safety, clothing, and food, was associated with lower prevalence of current electronic vapor product use (adjusted prevalence ratio 0.58), persistent feelings of sadness or hopelessness (aPR 0.77), having seriously considered attempting suicide (aPR 0.64), attempted suicide (aPR 0.30), ever having been physically forced to have sexual intercourse (aPR 0.54), sexual violence victimization by anyone (aPR 0.46), and being electronically bullied (aPR 0.45) (Jones et al., 2024). The magnitude of these associations is substantial. For attempted suicide, the adjusted prevalence ratio of 0.30 corresponds to a roughly two-thirds reduction in the prevalence of attempted suicide among AI/AN students who reported consistent adult caretaking compared with those who did not.

High parental monitoring, defined as parents or other adults in the family knowing where the student was going and with whom most of the time or always, was associated with dramatically lower prevalence of current cigarette use (aPR 0.07), current electronic vapor product use (aPR 0.44), current prescription opioid misuse (aPR 0.28), attempted suicide (aPR 0.36), and sexual violence victimization by anyone (aPR 0.51). The particularly strong effect on cigarette use, with a prevalence approximately 93 percent lower among students with high monitoring, is notable and reflects the developmental salience of parental oversight for substance initiation.

High school connectedness, defined as strongly agreeing or agreeing that one feels close to people at school, was associated with lower prevalence of current electronic vapor product use (aPR 0.53), persistent feelings of sadness or hopelessness (aPR 0.67), poor mental health (aPR 0.61), having seriously considered attempting suicide (aPR 0.47), and being electronically bullied (aPR 0.59).

Several mechanisms plausibly account for these associations. First, consistent caretaking and monitoring appear to reduce exposure to risk contexts and to increase opportunities for adaptive coping. An adolescent whose caretaker knows

their whereabouts and companions is less likely to be present in settings where substance initiation occurs, and is more likely to receive early intervention when distress emerges. Second, these relational contexts likely function as sources of secure attachment and co-regulation of affect, supporting the development of emotional regulation capacities. Third, they signal social value: an adolescent who experiences consistent adult concern and school-based belonging receives the implicit message that they matter, which appears to buffer against the internalizing symptoms that predict suicidal ideation and attempt. Fourth, in the specific context of AI/AN communities, adult caretaking and school connectedness may function as vehicles for cultural transmission, exposing the adolescent to Indigenous values, language, and practices that carry independent protective effects.

The 2023 YRBS findings also situate these associations against a baseline of concerning disparity. Among AI/AN students, 67.7 percent reported having a household adult who always tried to meet their basic needs, compared with 75.3 percent of non-AI/AN students—a statistically significant difference (Jones et al., 2024). This disparity, though modest, indicates that structural conditions have differentially compromised the availability of consistent adult caretaking for AI/AN youth, and it points toward family and community support as intervention targets with both immediate and structural implications.

Integrated Review of the Evidence

Substance Use

The 2023 YRBS supplement provides the most contemporary and methodologically inclusive national data on substance use among AI/AN high school students (Jones et al., 2024). Overall prevalence estimates included current cigarette use of 3.5 percent, current electronic vapor product use of 16.8 percent, current alcohol use of 22.1 percent, current marijuana use of 17.0 percent, and current prescription opioid misuse of 4.4 percent among all high school students. Among AI/AN students specifically, current electronic vapor product use (22.1 percent) and current marijuana use (23.0 percent) were significantly higher than among non-AI/AN students (17.0 percent and 17.3 percent respectively). Current cigarette use, alcohol use, and prescription opioid misuse were statistically comparable between AI/AN and non-AI/AN students, though clinical concern remains substantial given the elevated consequences of substance use in AI/AN communities.

These contemporary findings are consistent with longer-standing observations documented by Beauvais, Beals, Novins, and colleagues, cited in the community-partnered scholarship, that AI/AN youth are more likely to initiate substance use at younger ages, to use substances in combination, to meet criteria for alcohol abuse or dependence, and to have comorbid substance use and psychiatric disorders than non-AI/AN peers (Goodkind et al., 2010). Alcoholism death rates among AI/AN youth aged 15 to 24 have been reported at 3.7 per 100,000, compared with 0.3 per 100,000 for the overall U.S. population in this age group (Goodkind et al., 2010). Novins and colleagues found that AI/AN adolescents in a tribally operated residential substance abuse treatment program used a mean of 5.26 substances and that 82 percent had comorbid psychiatric disorders, most commonly conduct disorder (Goodkind et al., 2010).

Kilpatrick and colleagues, cited in both community-partnered papers, demonstrated the strong association between violence exposure and substance use, with physical or sexual victimization doubling the risk of alcohol, marijuana, and hard drug abuse or dependence, and witnessing violence tripling the risk of substance use disorders (Goodkind et al., 2010, 2011). Importantly, when victimization and other adverse experiences were controlled for, AI/AN youth had substance use risks comparable to Caucasian youth, suggesting that trauma exposure, rather than any inherent group vulnerability, accounts for a substantial share of observed substance use disparity (Goodkind et al., 2011).

The 2023 YRBS supplement adds a critical protective dimension. Among AI/AN students, high parental monitoring was associated with roughly 93 percent lower prevalence of current cigarette use, 56 percent lower prevalence of current electronic vapor product use, and 72 percent lower prevalence of current prescription opioid misuse (Jones et al., 2024). Consistent adult caretaking was associated with 42 percent lower prevalence of current electronic vapor product use, and high school connectedness was associated with 47 percent lower prevalence of the same outcome. These findings collectively suggest that while AI/AN adolescents face elevated substance use risk driven substantially by trauma exposure and structural inequity, protective family and school contexts exert powerful mitigating effects.

Depression and Anxiety: The Systematic Review Evidence

Chan and colleagues' (in press) systematic review and meta-analysis constitutes the most rigorous evidence synthesis to date on depression and anxiety among AI/AN adolescents in the United States. Their systematic search of Medline, Embase, PsycINFO, and gray literature identified 82 relevant studies, of which 77 reported depression data and 15 reported anxiety data. The scope of the review illuminates both what is known and what remains alarmingly underdeveloped in the empirical base.

For depression, the two most commonly used measurement instruments were the Center for Epidemiologic Studies Depression scale (CES-D) and the Children's Depression Inventory (CDI). Meta-analysis of three studies using the CES-D with a clinical cutoff of 16 yielded an aggregate point prevalence of depression of 34.6 percent (95% CI 11.5 to 68.4 percent) across a combined sample of 664 AI/AN adolescents. Meta-analysis of two studies using the CDI with a clinical cutoff of 19 or 20 yielded an aggregate point prevalence of 14.5 percent (95% CI 2.5 to 52.9 percent) across 365 participants. The discrepancy between these estimates reflects both the different sensitivities of the two instruments and the substantial heterogeneity across studies.

Meta-analysis of CDI mean scores across 11 studies ($n = 2,275$) yielded an aggregate mean of 9.81 (95% CI 9.50 to 10.13), which falls below the clinical cutoff of 16 for mild depression but is higher than the means reported for White, Asian, Black, and Latino adolescents in a comparably diverse study, which ranged from 5.13 to 8.31 (Chan et al., in press). Meta-analysis of CES-D mean scores across seven studies ($n = 1,512$) yielded an aggregate mean of 12.6, with substantial heterogeneity across geographic regions.

For anxiety, the evidence base was strikingly thin. Only 15 studies reported anxiety data, using 10 different instruments, and the Generalized Anxiety Disorder 7-item scale (GAD-7) was the most frequently used but appeared in only three studies. Insufficient data precluded meta-analysis of anxiety prevalence. One notable finding from a study by D'Amico and colleagues cited in the review found that 18 percent of urban AI/AN adolescents reported clinically significant anxiety in 2020 during the COVID-19 pandemic (Chan et al., in press).

The Indian Health Service, which maintains extensive electronic health record data on AI/AN patients, reported diagnostic prevalence estimates of depression among AI/AN adolescent patients ranging from 14.42 to 130.94 per 10,000, substantially

lower than the screening-based prevalence estimates in the meta-analysis. This discrepancy reflects the well-documented gap between screening-detected symptomatology and clinical diagnosis, which is likely amplified in AI/AN populations by stigma, provider shortages, and cultural mismatch in diagnostic assessment.

Regional variation appeared meaningful in the meta-analysis, particularly for CES-D mean scores, which differed significantly across the Northern Plains, Southeast, Southwest, and multiple/unspecified geographic categories, though the number of studies in each category was small. Prior work cited by Chan and colleagues (in press) by Novins and colleagues suggested that tribes in the Northern Plains showed somewhat higher rates of adolescent depression than tribes in the Southwest, potentially related to differences in cultural orientation between more individualist and more collectivist tribal traditions.

Suicide and Suicide Risk

Suicide occupies a central position in the epidemiology of AI/AN adolescent behavioral health. The 2023 YRBS supplement found that 20.9 percent of AI/AN students had seriously considered attempting suicide in the past 12 months, statistically comparable to non-AI/AN students (20.8 percent), but that 14.4 percent had attempted suicide, significantly higher than the 9.4 percent rate among non-AI/AN students (Jones et al., 2024). This pattern—comparable rates of suicidal ideation but elevated rates of attempt—suggests that AI/AN adolescents are not more likely to consider suicide but are more likely to act on suicidal thoughts, a pattern with important implications for means restriction, access to lethal means, and clinical intervention.

The community-partnered scholarship documents that suicide has been the second leading cause of death among AI/AN youth aged 15 to 24 for more than two decades, with rates approximately three times the rate for the overall U.S. population (Goodkind et al., 2010). Whitbeck and colleagues found that 23 percent of 736 AI/AN youth aged 10 to 12 met criteria for at least one mental disorder, suggesting that risk for later suicide and substance use emerges early (Goodkind et al., 2010).

The 2023 YRBS supplement documents that protective factors are particularly potent for suicide-related outcomes. Consistent adult caretaking was associated with a 70 percent reduction in attempted suicide prevalence among AI/AN students (aPR 0.30), high parental monitoring with a 64 percent reduction (aPR 0.36), and high school connectedness with a 53 percent reduction in serious suicide consideration (aPR 0.47) (Jones et al., 2024). Freedenthal and Stiffman, cited in Goodkind and

colleagues (2010), found that embarrassment and stigma were central reasons AI/AN youth with suicidal thoughts and behaviors did not seek help, underscoring the need for confidential, low-stigma care settings and integration of mental health services with primary care and school-based health centers.

Violence and Trauma Exposure

The 2023 YRBS supplement documented substantial disparities in violence exposure. Among AI/AN students, 13.4 percent reported having ever been physically forced to have sexual intercourse, significantly higher than the 8.6 percent rate among non-AI/AN students (Jones et al., 2024). Sexual violence victimization by anyone in the past 12 months was reported by 14.1 percent of AI/AN students. Bullying on school property was reported by 20.3 percent, and electronic bullying by 19.1 percent.

These findings are consistent with earlier work demonstrating high rates of traumatic loss, violence exposure, and posttraumatic stress among AI/AN youth. Manson and colleagues, cited in Goodkind and colleagues (2011), found higher rates of witnessing traumatic events, experiencing trauma to loved ones, and being victimized by physical attacks in a random sample of 3,084 members of two American Indian tribes than in the overall U.S. population. Jones and colleagues, cited by Goodkind and colleagues, and Gnanadesikan and colleagues documented associations between traumatic loss and trauma exposure and posttraumatic stress disorder, substance use, and psychological distress among AI/AN youth (Goodkind et al., 2011).

The protective factors examined in the 2023 YRBS supplement showed strong associations with violence outcomes. Consistent adult caretaking was associated with substantially lower prevalence of ever having been physically forced to have sexual intercourse (aPR 0.54), sexual violence victimization (aPR 0.46), and electronic bullying (aPR 0.45). High parental monitoring was associated with lower prevalence of sexual violence victimization (aPR 0.51), and high school connectedness with lower prevalence of electronic bullying (aPR 0.59) (Jones et al., 2024). These findings suggest that adult presence, oversight, and school-based belonging materially reduce adolescent exposure to violence, likely through both direct and indirect pathways including reduction in unsupervised time in risky contexts and increased likelihood that violence, when it occurs, is disclosed and responded to.

The community-partnered work also documents forms of trauma exposure that are not captured in standard surveillance measures. These include microaggressions, defined by Walters and Chae as ongoing and current trauma involving appropriation of traditional and cultural practices, romanticization and eroticization of AI/AN persons, invisibility in mainstream discourse, and religious defamation (Goodkind et al., 2011). Whitbeck and colleagues have linked perceived discrimination to depressive symptoms in AI/AN adults and to internalizing and externalizing symptoms and substance use in AI/AN adolescents (Goodkind et al., 2011). One youth participant in the Project TRUST community advisory work articulated the psychological consequence directly: "Even when your grandparents teach you all this Navajo stuff—when you go through years of discrimination—you end up hating yourself for who you are" (Goodkind et al., 2011).

Professional Interpretation and Critical Analysis

Convergence Across Sources

The three principal source strands—epidemiologic surveillance (Jones et al., 2024), systematic evidence synthesis (Chan et al., in press), and community-partnered scholarship (Goodkind et al., 2010, 2011)—converge on several conclusions.

First, they converge on the reality of behavioral health disparity. AI/AN adolescents experience elevated rates of specific substance use behaviors, particularly electronic vapor product and marijuana use; substantially elevated rates of suicide attempt; and elevated exposure to sexual violence. Depression is present at concerning levels, with screening-based prevalence estimates that exceed those reported for most other racial and ethnic groups even when the underlying evidence base remains thin.

Second, they converge on the centrality of context. Neither the surveillance data nor the systematic review nor the community-partnered work supports an interpretation of disparity as reflecting inherent group vulnerability. Rather, disparities are situated within contexts of historical trauma, ongoing structural inequity, elevated exposure to violence and adversity, and disrupted access to cultural continuity and traditional healing.

Third, they converge on the protective significance of relationship. Family engagement, parental monitoring, and school connectedness emerge across sources as robust predictors of reduced risk. Cultural connectedness, enculturation, and participation in traditional practice appear both as independent protective factors and as vehicles through which family and community relationships transmit

protection.

Fourth, they converge on the inadequacy of current systems of care. Whether framed in terms of underfunding of the Indian Health Service, the paucity of AI/AN participants in intervention trials, the mismatch between Western evidence-based practices and Indigenous healing traditions, or the shortage of AI/AN behavioral health providers, all sources articulate a system that has not been designed for, and does not adequately serve, AI/AN adolescent behavioral health needs.

Areas of Conflict and Tension

The sources also reveal tensions that deserve explicit examination. The most significant concerns the appropriate role of Western evidence-based practices in AI/AN adolescent care. The community-partnered work of Goodkind and colleagues (2010, 2011) articulates a substantial critique: the promotion of evidence-based practices, most of which have not been tested with AI/AN participants, functions as another form of institutional racism when it excludes traditional healing from reimbursement and legitimacy. Miranda and colleagues, cited in this work, were unable to identify studies evaluating outcomes of mental health care for AI/AN populations. The result is that the evidence base for "evidence-based" practice with AI/AN adolescents is thin at best. Goodkind and colleagues therefore advocate a shift from evidence-based practice to practice-based evidence, drawing on frameworks developed by White Bison and the Oregon Department of Human Services that expand what counts as evidence to include science-validated, science-replicated, culturally validated, and culturally replicated programs.

The Chan and colleagues (in press) systematic review adds methodological texture to this tension. The heterogeneity of measurement instruments used across studies of AI/AN adolescent depression and anxiety complicates any attempt at synthesis, and the review authors note that instruments developed with non-Indigenous samples may misclassify, over-detect, or under-detect symptoms in AI/AN populations. This is not merely a technical methodological issue but a substantive epistemic one: it raises the question of whether the very constructs being measured adequately capture Indigenous experiences of distress.

The 2023 YRBS supplement takes a more integrative stance. Its analytic strategy of including all students who identified as AI/AN, whether or not they also identified with other races or as Hispanic, represents an important methodological advance that captures the multiplicity of contemporary AI/AN identity. Its findings support both the significance of specific disparities and the potent protective effects of family

and school connectedness, and its policy recommendations reference CDC resources including the Suicide Prevention Resource for Action and Promoting Mental Health and Well-being in Schools alongside acknowledgment of the need for culturally informed adaptations.

The productive tension between these positions is not resolved by any of the sources and is unlikely to be resolved in the near term. The clinical implication, however, is clear. Psychologists working with AI/AN adolescents cannot rely on an unexamined importation of standard evidence-based protocols. They must instead engage in what Goodkind and colleagues (2011), drawing on Tervalon and Murray-Garcia, term cultural humility: ongoing self-reflection, decreasing power differentials, forming genuine partnerships, and recognizing that expertise about Indigenous healing rests in communities and traditional practitioners rather than in professional credentials alone.

Methodological Limitations

Several methodological limitations across the source materials deserve explicit acknowledgment. The 2023 YRBS supplement is cross-sectional and cannot support causal inferences. It excludes Bureau of Indian Education-funded schools, which serve substantial numbers of AI/AN students on tribally controlled lands, limiting generalizability. It measures complex constructs including parental monitoring and school connectedness with single questions that may fail to capture their full complexity. And it does not include information about tribal affiliation or residence on or off tribal lands, foreclosing analysis of variation across specific tribal communities.

The Chan and colleagues (in press) systematic review is limited by the small number of eligible studies, the heterogeneity of measurement instruments, the concentration of studies in certain geographic regions, and the substantial proportion of studies with missing information on covariates including geographic location. Meta-analyses were possible only for a small subset of outcomes.

The community-partnered scholarship of Goodkind and colleagues (2010, 2011) draws on advisory meetings with 71 AI/AN youth, parents, and elders, surveys of 25 service providers, and consultation with four traditional practitioners, primarily in Diné communities in the Southwest. The authors explicitly note that findings may not generalize to all AI/AN youth and families, particularly in urban settings and smaller tribes.

Taken together, these limitations reinforce a caution against overgeneralization. AI/AN peoples comprise more than 574 federally recognized tribes with distinct histories, languages, cultural systems, and contemporary circumstances, along with substantial urban and multiracial populations. Findings from any single study or synthesis provide starting points for understanding, not endpoints.

Psychological Pathways and Stress Responses

Trauma, Attachment, and Emotional Regulation

The developmental psychopathology of AI/AN adolescents can be productively understood through an integrated stress-and-attachment framework. Adverse childhood experiences, including household dysfunction, violence exposure, and disrupted caretaking, elevate risk for a broad range of behavioral health outcomes across populations, and AI/AN adolescents experience elevated rates of these adverse experiences (Jones et al., 2024). The mechanisms are well-characterized in the broader developmental literature: chronic stress dysregulates the hypothalamic-pituitary-adrenal axis, produces neurobiological changes affecting emotional regulation and executive function, and disrupts the attachment relationships that scaffold the development of these capacities.

For AI/AN adolescents, these general mechanisms operate against a backdrop that includes intergenerational transmission of trauma effects. Parents and caretakers who themselves experienced boarding school separation, community violence, or the sequelae of historical trauma may have compromised capacities for consistent caretaking, even in the presence of profound love for their children. This is one plausible interpretation of the 2023 YRBS finding that AI/AN students are somewhat less likely than non-AI/AN students to report a household adult who always tried to meet their basic needs. It is not that AI/AN families care less; it is that the intergenerational transmission of trauma has, for some families, disrupted the material and psychological resources necessary for consistent caretaking.

Case Scenario 1: Presentation and Formulation in a School-Based Setting

Ava is a 15-year-old Diné (Navajo) student who was referred to a school-based behavioral health clinician after a teacher noticed that she had been increasingly withdrawn over several weeks and had submitted a creative writing assignment containing themes of hopelessness. Ava lives with her maternal grandmother, who has primary caretaking responsibility, and two younger siblings. Her mother lives in a nearby city and visits inconsistently; her father died when Ava was seven. Her grandmother is a fluent Diné speaker who participates actively in traditional ceremonies and is well regarded in the community. Ava reports that she has been "tired all the time," that she cries at night, and that she has thought about "not being here anymore," though she denies a specific plan or intent. She has never spoken with a counselor before and expresses ambivalence about the referral.

The clinician recognizes that a standard depression screening protocol would likely yield a positive result and that a determination of moderate to severe depression with passive suicidal ideation would follow. However, a competent formulation for Ava requires more than symptom counting. It requires understanding of her caretaking context—the presence of a grandmother who provides consistent care and cultural continuity is a substantial protective factor, though the inconsistency of maternal presence and the unresolved grief around her father's death represent stressors. It requires attention to her school connectedness—the teacher's noticing and responding suggests that at least one adult at school pays attention to her, though Ava's own subjective sense of connection remains to be assessed. It requires awareness of the cultural resources available to her family—her grandmother's active participation in ceremony suggests pathways for cultural engagement that may complement or, from Ava's grandmother's perspective, replace formal behavioral health treatment. And it requires acknowledgment of the historical and structural context: Ava is a Diné adolescent whose family carries the memory of the Long Walk, of boarding school separations, of livestock reduction, and of contemporary structural inequities that shape her daily experience.

The clinical response, therefore, is not simply the delivery of an evidence-based depression treatment. It is a careful process of building trust, consulting appropriately with Ava's grandmother about her preferences for care, considering whether traditional support—perhaps a ceremony her family already recognizes—should be part of the response, coordinating with the primary care provider at the school-based health center, and offering Ava the choice of how she wants to engage. This case illustrates the principle articulated by Goodkind and colleagues (2010, 2011) that effective care for AI/AN adolescents requires transformation of individual clinical practice, not merely application of existing protocols.

The Role of Discrimination and Microaggressions

Chronic exposure to discrimination and microaggressions represents a distinct pathway to psychological distress that operates alongside more acute trauma. Whitbeck and colleagues' work, cited in Goodkind and colleagues (2011), demonstrates that perceived discrimination is associated with depressive symptoms, internalizing and externalizing symptoms, and substance use in AI/AN populations across age groups. The mechanisms are multiple. Discrimination and microaggression signal social devaluation, undermining developing identity. They generate chronic vigilance and psychological load. They interrupt the transmission of positive cultural identity by suggesting to the developing adolescent that their Indigenous identity is a source of vulnerability rather than strength.

Walters and Chae's articulation of microaggressions in AI/AN contexts is particularly instructive. Being asked by a non-Native person whether one is a "real Indian," hearing authoritative discussions that treat Indigenous peoples as extinct, or being told by non-Natives that they feel a spiritual connection to Indian people are experiences that, individually, may seem minor but that, cumulatively, communicate invisibility and appropriation (Goodkind et al., 2011). For adolescents developing identity, these experiences shape the internal narrative about what it means to be Indigenous in contemporary America.

The clinical implication is that assessment of AI/AN adolescents' behavioral health must include attention to discrimination experiences, and that treatment must sometimes include explicit work on positive Indigenous identity as protective. This is not identity politics; it is developmental psychology.

Mental Health Outcomes and Severity Spectrum

The Depression Spectrum

Depression among AI/AN adolescents spans a spectrum from subclinical symptomatology to severe major depressive episodes with high suicide risk. The meta-analytic evidence synthesized by Chan and colleagues (in press) suggests that mean depression scores fall below clinical cutoffs but exceed those observed in comparably diverse samples of other racial and ethnic groups, indicating a pattern of elevated distress without necessarily elevated diagnosable disorder in the majority of youth. At the same time, the surveillance data document that 45.1 percent of AI/AN students report persistent feelings of sadness or hopelessness in the past year, meaningfully higher than the 39.5 percent rate among non-AI/AN students, and that 30.4 percent report poor mental health most of the time or always in the past month (Jones et al., 2024).

This pattern has implications for how psychologists conceptualize what they are seeing when they assess an AI/AN adolescent. A negative screen on a standard depression instrument does not rule out significant psychological suffering. Conversely, a positive screen may reflect the effects of ongoing contextual stressors that are not addressable through symptom-focused treatment alone. The clinical task, therefore, is to move fluently between symptom assessment and contextual understanding, and to build treatment plans that address both.

Anxiety and Its Underrecognition

The evidence base regarding anxiety among AI/AN adolescents is strikingly limited. Chan and colleagues (in press) identified only 15 studies reporting anxiety data, using 10 different instruments, and were unable to conduct meta-analysis. The single reported prevalence estimate from D'Amico and colleagues found 18 percent of urban AI/AN adolescents endorsing clinically significant anxiety on the GAD-7 during the COVID-19 pandemic, but the generalizability of this figure is unclear.

The underrecognition of anxiety in this population is clinically consequential. Anxiety disorders in adulthood often begin as elevated anxiety in childhood and adolescence, and untreated adolescent anxiety predicts a range of adult psychopathology including depression, substance use, and impaired functioning. The absence of an adequate evidence base for AI/AN adolescent anxiety does not mean that anxiety is absent; it means that we do not know what we do not know. Clinicians should therefore include structured assessment of anxiety symptoms in their routine

evaluation of AI/AN adolescents and should recognize that culturally specific expressions of anxiety—which might include hypervigilance related to historical trauma, spiritual concerns interpreted through Indigenous frameworks, or somatic presentations—may not be captured by standard instruments.

Case Scenario 2: The Complexity of Substance Use Assessment

Marcus is a 17-year-old male student who identifies as AI/AN and Latino. His mother's family is from a Pueblo community in the Southwest; his father is Mexican American, and Marcus lives with both parents in an urban setting. He was referred for behavioral health assessment after his school counselor learned that Marcus had been using nicotine vapor products and marijuana, and after his primary care provider at the urban Indian health center noted symptoms of anxiety and low mood. Marcus's parents are worried but ambivalent about behavioral health treatment; his father in particular expressed concern that Western therapy "doesn't work for us" and that Marcus should perhaps spend time with his maternal grandfather, who is a respected community elder.

A rigorous assessment for Marcus must address several intersecting concerns. His substance use pattern is consistent with epidemiologic patterns among AI/AN adolescents documented in the 2023 YRBS supplement, and his risk for continued escalation is elevated by his subjective distress. However, his substance use is also potentially serving affect-regulation functions in the context of his anxiety and low mood, meaning that treatment that addresses only the substance use without addressing the underlying distress is unlikely to be effective. His identity is complex: identifying as AI/AN and Latino, with an urban rather than reservation upbringing, places him within populations that Chan and colleagues (in press) note are often underrepresented in the empirical literature. His father's ambivalence about Western therapy is not an obstacle to be overcome but a legitimate perspective grounded in the historical experience Goodkind and colleagues (2010, 2011) describe.

The clinical response, therefore, incorporates several elements. The clinician engages Marcus in a way that treats his substance use as a coping strategy rather than a moral failing. She uses motivational interviewing, which Goodkind and colleagues (2011) note traditional practitioners have recognized as consistent with traditional guidance in its emphases on self-sufficiency, expressing empathy, and supporting positive change. She invites family engagement in ways that respect the family's autonomy and their own resources. She explicitly asks about Marcus's connection to his maternal grandfather and to Pueblo cultural practice, and she conveys that these connections are potentially therapeutic rather than incidental. She coordinates with the urban Indian health center's primary care provider and asks whether the center offers or can refer to traditional healing. She addresses Marcus's anxiety and low mood with evidence-informed intervention while remaining aware that the evidence base is limited and that adaptation may be needed.

This case illustrates the principle that competent care for AI/AN adolescents is a matter of clinical judgment integrating evidence, cultural knowledge, family perspectives, and community resources—not the application of a protocol.

System-Level and Contextual Psychological Effects

The Impact of Underfunded Systems

The material context of AI/AN behavioral health care shapes what is clinically possible in ways that psychologists must recognize. Per capita funding for AI/AN health care through the Indian Health Service is approximately 60 percent lower than average U.S. per capita health spending, and lower than per capita spending on Medicaid recipients, prisoners, veterans, or military personnel (Goodkind et al., 2010, 2011). Funding for behavioral health care through IHS is less than \$30 per year per person served, including hospitalization. These figures reflect a systemic underinvestment that constrains the capacity of behavioral health systems serving AI/AN youth and that is not reducible to any local decision-making.

The consequences of underinvestment cascade through the system. Provider shortages mean that AI/AN adolescents often wait weeks or months for behavioral health appointments, and when appointments are available, session frequency is often inadequate. Provider turnover, driven partly by the difficulty of sustained work in under-resourced settings, undermines the continuity of relationship that Goodkind and colleagues' (2011) work identifies as essential for effective care. Youth participants in the Project TRUST advisory meetings described the effect directly:

"When you see a counselor, they look at the folder, like the folder is going to fix the problem. They need to get to know you" (Goodkind et al., 2011).

Providers themselves experience the consequences. Goodkind and colleagues (2011) document that high rates of trauma exposure among AI/AN adolescents combine with inadequate resources to produce provider vicarious traumatization, secondary traumatic stress, and burnout. Providers who cannot deliver the care they know is needed develop what may function as learned helplessness. Sustainable, high-quality care therefore requires structural investment, not merely improved individual competence.

The Role of School-Based Health Centers and Integrated Care

Against this backdrop, school-based health centers and integrated behavioral health-primary care models emerge as particularly promising service delivery structures for AI/AN adolescents. Kaplan and colleagues, cited in Goodkind and colleagues (2010), found that adolescents with access to school-based health centers were more than ten times more likely to access mental health or substance abuse care than adolescents without such access. Anglin and colleagues found that youth users of school-based health centers had higher use of medical, mental health, and substance abuse counseling services than adolescents in the general population.

The integration of behavioral health with primary care and with school-based services addresses several of the barriers Goodkind and colleagues (2010, 2011) identify: stigma, transportation, provider shortages, and the fragmentation of services across mental health, substance abuse, and physical health. For AI/AN adolescents, whose approach to health is often holistic, this integration is not merely logistically convenient but conceptually consonant with Indigenous frameworks. As one traditional practitioner cited by Goodkind and colleagues (2011) noted regarding the Diné concept of Ke': "Ke' is holistic healing and how we come together and acknowledge each other."

The Erosion and Restoration of Cultural Continuity

At the level of community context, the erosion of cultural continuity through boarding schools, relocation, and prohibition of ceremony has interacted with contemporary conditions to produce what one AI/AN Project TRUST member described as "the sick community" to which recovering youth return (Goodkind et al., 2011). Individual clinical treatment, however skilled, cannot substitute for community-level healing. This recognition has motivated a shift in Indigenous mental health scholarship toward community-based, culturally grounded prevention and intervention. It has also motivated recognition that some clinical outcomes—the sustained recovery of a young person from suicidal crisis, the successful transition of an adolescent through substance use recovery—depend on community conditions that individual providers cannot single-handedly create.

Clinical Implications for Psychologists

Assessment

Competent assessment of AI/AN adolescents begins with acknowledgment of the clinician's own position. Psychologists who are not themselves AI/AN, and who have not developed sustained relationships with the specific communities from which their patients come, enter the clinical encounter with limitations that no amount of cultural competence training can fully address. The appropriate stance is cultural humility (Tervalon and Murray-Garcia, cited in Goodkind et al., 2011): ongoing self-reflection about one's own assumptions, willingness to decrease the power differential inherent in the clinical relationship, and formation of genuine partnerships with clients, families, and communities.

Assessment should be broadly conceived. Symptom-focused instruments provide one lens but should be supplemented by understanding of the adolescent's family and caretaking context, school engagement, cultural involvement, connection to traditional practices, experiences of discrimination and microaggression, exposure to violence and traumatic loss, family and community history of loss and grief, and preferred sources of help. The 2023 YRBS domains provide a useful framework: caretaker engagement, parental monitoring, and school connectedness are protective factors that should be actively assessed as they may indicate targets for support even in the absence of clinical intervention (Jones et al., 2024).

Standardized instruments should be used with awareness of their limitations. The Chan and colleagues (in press) systematic review documents substantial variation

across studies in how depression and anxiety have been measured in AI/AN adolescents, and it raises the possibility that some instruments may over- or under-detect symptoms. Instruments should be used to complement rather than replace clinical interview, and clinicians should attend to whether the constructs measured align with the adolescent's own understanding of their experience.

Case Scenario 3: Assessment Across Multiple Levels

Nizhoni is a 14-year-old Diné student who lives on a reservation with her parents and three siblings. She was referred by her school counselor after peers reported that she had been talking about wanting to hurt herself. Assessment reveals a young person who is bright, artistic, and engaged in her Diné identity through her participation in a school Native language program and through weekend visits with her paternal grandmother, a weaver. She reports recent onset of low mood and irritability, difficulty concentrating, and thoughts that "my family would be better off without me," though she denies specific plan. She also discloses that a male cousin sexually assaulted her approximately six months ago; she has not told her parents, though she has told her older sister.

Comprehensive assessment for Nizhoni requires attention to multiple levels simultaneously. At the individual level, her depressive symptoms and suicidal ideation require immediate safety assessment and planning. At the traumatic experience level, the recent sexual assault represents an acute trauma requiring specialized evaluation and, potentially, forensic and medical response consistent with mandated reporting obligations. At the family level, her parents must be engaged in her care, but the disclosure of the assault to her sister and not to her parents indicates a family communication pattern that will need to be worked with carefully. At the cultural level, her Diné identity, her language program participation, and her relationship with her grandmother are significant protective factors that should be actively integrated into her care. At the community level, the psychologist must consider whether traditional support—perhaps consultation with a traditional practitioner, or a specific ceremony—should be part of the healing response, and how such support can be facilitated in a manner respectful of the family's own preferences and resources.

The clinician's task is not to sequentially address these levels but to hold them simultaneously in formulation. The safety plan is developed with attention to family monitoring capacities; the disclosure of the assault is managed with attention to family communication patterns and cultural expectations around such disclosure; the ongoing therapeutic work integrates evidence-informed trauma-focused approaches with recognition of the specific meanings of trauma and healing within Diné frameworks.

Case Formulation

Formulation of AI/AN adolescent presentations should be explicitly multidimensional. A useful framework incorporates several elements. Symptom presentation and diagnostic considerations, using DSM criteria while recognizing their limitations in Indigenous contexts. Developmental context including cognitive, emotional, and identity development. Family system, including caretaking patterns, family history of trauma and loss, family engagement with cultural practice, and family preferences for care. School context, including engagement, connection, and specific stressors or supports. Cultural and spiritual context, including tribal affiliation, involvement with Indigenous language and practice, and beliefs about healing. Historical and structural context, including community history and contemporary conditions. Protective factors, including specific relationships, connections, and resources that support well-being.

Formulation should be shared with the adolescent and family in language that is accessible and respectful, and it should invite their contribution and correction. Psychologists should be prepared to revise formulations as they learn more, particularly as trust develops and the adolescent and family become willing to share aspects of their experience that were initially private.

Treatment Planning

Treatment planning for AI/AN adolescents requires balancing several considerations. Evidence-informed intervention should be offered, but with awareness of the limitations Goodkind and colleagues (2010, 2011) articulate: most evidence-based practices have not been developed or tested with AI/AN participants, and their fit with Indigenous frameworks cannot be assumed. Adaptation is often necessary, and psychologists should be prepared to describe explicitly what adaptations they are making and why.

Traditional healing should be considered as a legitimate and often preferred pathway. Psychologists should routinely ask about the family's engagement with traditional practices and their interest in traditional support, and should develop referral relationships with traditional practitioners in the communities they serve. Where formal collaboration between behavioral health providers and traditional practitioners is not established, psychologists can at minimum communicate respect for and openness to traditional healing, and can support the family's use of traditional resources alongside or in place of formal behavioral health treatment.

Family and community engagement should be integral to treatment. The 2023 YRBS finding that consistent adult caretaking and parental monitoring are strongly protective suggests that treatment plans that engage caretakers as partners are likely to be more effective than those focused exclusively on the individual adolescent (Jones et al., 2024). At the same time, family engagement must be handled sensitively, particularly when family systems have been affected by historical trauma or when parent-adolescent communication is compromised.

School engagement is often clinically valuable. High school connectedness is associated with lower prevalence of multiple risk outcomes, and psychologists working with AI/AN adolescents should consider how their work can support the adolescent's connection to positive school relationships (Jones et al., 2024).

Case Scenario 4: Treatment Planning in an Integrated Care Setting

James is a 16-year-old Alaska Native (Tlingit) adolescent who lives with his mother and two younger siblings in an urban area of the Pacific Northwest. He was referred to the behavioral health clinician co-located in his urban Indian health center pediatric clinic after presenting with symptoms of depression and disclosing that he had been drinking alcohol daily for approximately three months. His mother, who works two jobs, is supportive but exhausted; his father lives in their village of origin, several hours away, and their contact is limited. James has some connection to his Tlingit heritage through his father's family but describes feeling "in between" and "not really Native but not really white either."

Treatment planning for James incorporates several elements. Given his substance use pattern and depressive symptoms, integrated treatment addressing both is appropriate; the community-partnered scholarship documents that fragmentation of substance use and mental health services is a longstanding problem in AI/AN behavioral health (Goodkind et al., 2010). Given his mother's limited availability, the clinician considers how to engage her meaningfully without overburdening her, and explores whether extended family or community resources can supplement her caretaking. Given his identity concerns, the clinician recognizes that positive Indigenous identity development may be an important therapeutic target, and explores with James whether he would be interested in connecting with youth programming at the urban Indian center that includes cultural activities. Given his father's distance, the clinician considers whether increased father-son contact could be facilitated, recognizing that this is a decision for the family rather than the clinician.

The evidence base for specific interventions for James's presentation is limited. The clinician draws on cognitive behavioral approaches for depression and motivational enhancement for substance use, while explicitly holding open the possibility that traditional Tlingit resources might contribute to healing. She discusses with James and his mother the option of consultation with traditional practitioners in the urban Indian community and provides referral information. She monitors outcomes carefully, prepared to revise her approach based on what appears to be helping and what is not.

Ethical Considerations in Practice

Competence

The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct requires that psychologists provide services only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. For AI/AN adolescent care, this principle carries specific implications. Psychologists who lack specific training and experience with AI/AN populations are not automatically competent to provide care simply because they have general adolescent mental health training. Competence in this domain requires developing familiarity with AI/AN history and contemporary circumstances, cultivating relationships with AI/AN communities, engaging in ongoing consultation with AI/AN colleagues and traditional practitioners, and maintaining humility about the limits of one's competence.

Competence also has structural dimensions. Systems that expect psychologists to provide care to AI/AN adolescents without providing time, training, and supervision for developing appropriate competence are creating conditions in which ethical practice is difficult. Individual psychologists, professional organizations, and training programs have distinct but complementary responsibilities.

Informed Consent

Informed consent processes with AI/AN adolescents and families must be substantive rather than perfunctory. Families should understand what is being proposed, why, what alternatives exist including traditional healing and community resources, what the limits of confidentiality are, and how information will be shared with other providers and systems. Given the historical experience of AI/AN communities with research and health systems that have not honored consent or that have used information in ways that damaged communities, particular care is warranted. Psychologists should be prepared to answer questions about their own background, their relationship to the community, and their reasons for the work they do.

Consent processes should acknowledge the developmental context of adolescence. Adolescents have a growing capacity for autonomous decision-making but remain within family systems that appropriately hold significant decision-making authority. In AI/AN families, decisions about health care may involve extended family or community authority beyond parents alone. Psychologists should ask about who should be involved in decision-making and should respect the family's understanding of appropriate consultation.

Confidentiality

Confidentiality in AI/AN adolescent care operates within specific contexts that require attention. In small tribal communities, confidentiality is both especially important and especially difficult to maintain. Psychologists should be explicit about what will and will not be shared, and with whom, and should recognize that concerns about privacy identified by Duran and colleagues, cited in Goodkind and colleagues (2010, 2011), constitute a significant barrier to care that must be actively addressed.

Mandated reporting obligations, including reporting of child abuse and suicidal risk, must be honored, but the process should be handled with care to preserve trust and to minimize unintended harm. Where possible, psychologists should discuss with families the actions they are taking, why, and what to expect, rather than acting without explanation.

Multiple Relationships

In small communities, multiple relationships are often unavoidable. A psychologist working in a tribal behavioral health program may encounter clients through community events, family relationships, or overlapping professional networks. The ethical response is not avoidance—which would often be impossible—but transparent management, including discussion with clients about how overlapping relationships will be handled, consultation with colleagues, and honest acknowledgment of the specific considerations that small community settings raise.

Cultural Responsiveness

The APA's revised guidance on multicultural practice, and the growing scholarship on cultural humility, articulate cultural responsiveness as an ongoing ethical obligation rather than a discrete competency to be acquired. For AI/AN care, cultural responsiveness includes several specific elements. Psychologists should not assume that they understand the specific cultural context of a client based on general information about AI/AN populations; each tribal community has distinct traditions and each family has its own relationship with those traditions. Psychologists should recognize the diversity within AI/AN populations, including the range from traditional to Christian to non-religious orientations, the differences between reservation and urban contexts, and the specific circumstances of multiracial and multiethnic AI/AN individuals. Psychologists should approach traditional healing and cultural practice with respect, without either romanticizing or dismissing them, and should be prepared to work in collaboration with traditional practitioners where appropriate.

Scope of Practice

The scope of psychological practice with AI/AN adolescents extends beyond individual clinical work. Psychologists have opportunities and, arguably, obligations to engage with the structural conditions that shape AI/AN adolescent behavioral health. This may include advocacy for adequate funding of behavioral health services, participation in tribal or community health planning, support for research that respects tribal sovereignty and community control, and contribution to policy at local, state, and federal levels. Psychologists should be thoughtful about how such engagement is structured, ensuring that their contributions are welcomed by and accountable to AI/AN communities rather than imposed on them.

Practice Recommendations

The following recommendations synthesize the evidence and community-partnered guidance reviewed in this manuscript. They are organized by degree of empirical support, distinguishing well-supported recommendations from tentative ones. Recommendations should be adapted to specific settings, tribal communities, and clinical situations.

Well-Supported Recommendations

Psychologists should routinely assess adult caretaker engagement, parental monitoring, and school connectedness in their work with AI/AN adolescents, and should recognize these as significant protective factors amenable to support. The 2023 YRBS supplement provides robust evidence that consistent adult caretaking is associated with substantially lower prevalence of attempted suicide, sexual violence victimization, electronic bullying, and multiple other outcomes; that high parental monitoring is associated with dramatically lower prevalence of substance use; and that high school connectedness is associated with lower prevalence of emotional distress and suicide-related outcomes (Jones et al., 2024). These associations support both direct assessment of these factors and interventions that strengthen them.

Psychologists should assess violence exposure and traumatic loss comprehensively. AI/AN adolescents experience elevated rates of forced sexual intercourse and other forms of violence exposure, and these experiences are associated with substantial risk for substance use, posttraumatic stress, depression, and suicidality (Jones et al., 2024; Goodkind et al., 2010, 2011). Assessment should include both direct victimization and vicarious exposure to community and family violence, and should extend to historical and intergenerational losses that carry psychological significance for the adolescent and family.

Psychologists should engage families as partners in treatment. The evidence for the protective role of caretaking and monitoring, combined with the community-partnered guidance from Project TRUST, supports family engagement as a core rather than adjunctive element of care (Jones et al., 2024; Goodkind et al., 2011). Youth participants in the Project TRUST advisory work explicitly identified their willingness to engage with providers when parents were involved and expressed care.

Psychologists should attend to school connectedness as both an assessment target and an intervention pathway. The strong association between school connectedness

and reduced risk across multiple outcomes suggests that supporting the adolescent's positive relationships at school is itself therapeutic (Jones et al., 2024). Psychologists working in school-based settings have particular opportunities to influence school connectedness through their own relationships with students, and psychologists in other settings can support connectedness through coordination with school personnel.

Psychologists should recognize the limits of Western evidence-based practice with AI/AN adolescents. Most evidence-based practices have not been developed or tested with AI/AN participants, and their application should be accompanied by explicit awareness of this limitation, willingness to adapt, and commitment to outcome monitoring (Goodkind et al., 2010, 2011; Chan et al., in press). Psychologists should be transparent with clients and families about the empirical basis for what they propose and the areas where evidence is limited.

Psychologists should develop familiarity with the specific tribal and cultural contexts of the communities they serve. This includes learning about tribal history, contemporary circumstances, language, cultural practices, and community resources. It does not require becoming an expert in Indigenous cultures but does require sufficient familiarity to engage respectfully and to recognize the limits of one's knowledge.

Tentative Recommendations

Psychologists should consider incorporating referrals to traditional practitioners and cultural teachers as a component of care where available and appropriate. Evidence for the effectiveness of traditional practices comes primarily from observational and preference studies rather than randomized trials, but the strength of preference for traditional care among AI/AN adults and adolescents, combined with the theoretical and community-based rationale, supports its consideration (Goodkind et al., 2010, 2011). Where formal collaboration with traditional practitioners is not established, psychologists can at minimum communicate openness to traditional healing and support the family's own engagement with traditional resources.

Psychologists should consider addressing positive Indigenous identity development as a therapeutic target where relevant. The evidence for the protective role of enculturation and cultural identity supports this consideration, though the specific therapeutic approaches to identity work with AI/AN adolescents are less well developed empirically (Goodkind et al., 2011).

Psychologists should consider integrating behavioral health and primary care where feasible. School-based health centers and integrated primary care-behavioral health models appear to reduce stigma, improve access, and support the holistic frameworks often preferred by AI/AN clients (Goodkind et al., 2010, 2011). Individual psychologists cannot single-handedly create such integration but can advocate for it and can collaborate within it where it exists.

Psychologists should consider incorporating motivational interviewing techniques where appropriate. Motivational interviewing has been identified by traditional practitioners as consonant with traditional guidance in its emphases on self-sufficiency and respect for the individual's autonomy, and has an evidence base for adolescent substance use and behavior change (Goodkind et al., 2011).

System-Level Recommendations

Psychologists should support adequate funding for AI/AN behavioral health services. The chronic underfunding of the Indian Health Service and tribal behavioral health programs represents a structural barrier to care that individual clinical competence cannot overcome (Goodkind et al., 2010, 2011).

Psychologists should support tribal data sovereignty and tribal-driven research. The 2023 YRBS supplement highlights the importance of tribally coordinated surveillance for supporting tribal decision-making, and psychologists engaged in research should structure their work in ways that respect tribal sovereignty and community control (Jones et al., 2024).

Psychologists should support alternative credentialing pathways for AI/AN behavioral health workers. The Alaska Native Tribal Health Consortium's Behavioral Health Aide Program, described by Goodkind and colleagues (2010), offers one model for expanding the AI/AN behavioral health workforce that psychologists in leadership positions can support.

Psychologists should engage in professional development that includes AI/AN behavioral health as a substantive rather than peripheral component. Continuing education, supervision, and training programs should include content on AI/AN history, culture, and clinical care as part of ongoing competence development.

Synthesis Table: Integrating the Evidence Base

The following synthesis integrates key findings across the primary sources reviewed. This is an original synthesis constructed for this manuscript.

Domain	2023 YRBS Surveillance Findings (Jones et al., 2024)	Systematic Review Findings (Chan et al., in press)	Community-Partnered Findings (Goodkind et al., 2010, 2011)
Depression prevalence	45.1% of AI/AN students reported persistent sadness/hopelessness; 30.4% poor mental health	CES-D aggregate 34.6%; CDI aggregate 14.5%; wide heterogeneity	Historical trauma, discrimination, and traumatic loss identified as key contextual drivers
Suicide risk	14.4% attempted suicide (vs. 9.4% non-AI/AN); 20.9% seriously considered	Not primary focus	Highest rate among 15–24 year-olds; embarrassment and stigma major barriers to help-seeking
Substance use	Elevated e-vapor product use (22.1%) and marijuana use (23.0%)	Not primary focus	Higher prevalence, earlier initiation, more comorbidity documented in prior literature
Violence exposure	13.4% ever physically forced to have sexual intercourse (vs. 8.6% non-AI/AN)	Not primary focus	High rates of traumatic loss and violence documented across tribes
Adult caretaking	Protective: aPR 0.30 for attempted suicide; 0.46 for sexual violence victimization	Not directly examined	Central protective factor; disrupted by boarding school legacy
School connectedness	Protective: aPR 0.47 for suicide consideration; 0.61 for poor mental health	Not directly examined	Identified as important; school-based health centers recommended
Cultural continuity	Not directly measured	Regional variation suggests cultural context matters	Enculturation, traditional practice, cultural identity are core protective factors
System capacity	Highlighted resource gaps for tribally driven surveillance	Highlighted scarcity of research, especially anxiety	Chronic underfunding, provider shortages, credentialing barriers documented

Future Directions and Research Gaps

The evidence reviewed in this manuscript points to several priorities for future research and practice development. First, the empirical base for anxiety among AI/AN adolescents is inadequate. Chan and colleagues (in press) were able to identify only 15 studies reporting anxiety data across a range of instruments, and no meta-analysis of anxiety prevalence was possible. Given the developmental importance of adolescent anxiety and its association with later depression, substance use, and functional impairment, systematic epidemiologic work on AI/AN adolescent anxiety is urgently needed.

Second, intervention research with AI/AN adolescents remains sparse. Miranda and colleagues, cited by Goodkind and colleagues (2010, 2011), were unable to identify studies evaluating outcomes of mental health care for AI/AN populations, and while the field has advanced since, substantial gaps persist. Research designs that respect tribal sovereignty, engage communities as partners, and consider culturally validated as well as science-validated approaches, as articulated by White Bison and the Oregon Department of Human Services (Goodkind et al., 2010), are needed to develop and evaluate interventions that serve AI/AN adolescents effectively.

Third, research on the integration of traditional healing with Western behavioral health services is limited. The models for integration proposed by Duran and Duran, cited by Goodkind and colleagues (2011), and the frameworks for practice-based evidence articulated in the community-partnered literature, need empirical development. Gone's work on cultural proselytization and appropriate integration provides theoretical grounding, but more empirical work is needed to identify effective models.

Fourth, longitudinal research on the developmental trajectories of AI/AN adolescents is needed. The predominantly cross-sectional evidence base makes it difficult to distinguish transient from persistent difficulties, to identify developmental windows of particular risk and opportunity, and to understand how protective factors operate across development.

Fifth, research is needed on urban AI/AN adolescents and on multiracial and multiethnic AI/AN populations. As Jones and colleagues (2024) document, most AI/AN youth do not fit the single-race, non-Hispanic classification often used in traditional surveillance. The 2023 YRBS supplement's inclusive coding strategy represents progress, but analytic approaches, measurement, and clinical understanding of urban and multiracial AI/AN adolescents need continued

development.

Sixth, methodological development in measurement is needed. The Chan and colleagues (in press) systematic review documents the wide variety of instruments used across studies and raises appropriate concerns about their validity in AI/AN populations. Development, cultural adaptation, and validation of measurement instruments for use with AI/AN adolescents would support both research and clinical practice.

Seventh, research on the specific tribal and community contexts within which behavioral health unfolds is needed. Federal recognition includes more than 574 tribes with distinct cultures and circumstances, and the field's tendency to aggregate across tribal groupings, while sometimes necessary for statistical power, obscures the specific contexts that shape adolescent development.

Finally, structural and policy research on the funding, delivery, and workforce infrastructure of AI/AN behavioral health is needed. The recommendations articulated by Goodkind and colleagues (2010, 2011) regarding reimbursement of traditional healers, integration of behavioral and primary care, alternative credentialing, and adequate funding provide directions that require ongoing empirical and policy development.

Conclusion

The behavioral health of American Indian and Alaska Native adolescents presents contemporary psychology with a set of challenges and possibilities that cannot be met through the routine application of standard clinical protocols. The empirical evidence documents both the reality of significant disparities—elevated rates of attempted suicide, forced sexual intercourse, current electronic vapor product and marijuana use, and depressive symptomatology—and the power of protective relationships and cultural continuity. Consistent adult caretaking, high parental monitoring, and school connectedness emerge from surveillance data as robust protective factors with effect sizes that would be considered clinically important in any area of psychological practice (Jones et al., 2024). The systematic evidence base for depression and anxiety, while limited, points to elevated but heterogeneous distress that varies across regions and cultural contexts (Chan et al., in press). The community-partnered scholarship articulates the historical and structural conditions that produced current disparities and points toward frameworks for care that center Indigenous knowledge, respect tribal sovereignty, and integrate traditional healing (Goodkind et al., 2010, 2011).

For the practicing psychologist, the implications are substantial. Competent care for AI/AN adolescents requires familiarity with the historical and contextual conditions that shape presentations; attention to protective factors as targets of assessment and intervention; humility about the limits of Western evidence-based practice and openness to traditional healing; sensitivity to the diversity of AI/AN identities and communities; and engagement with the structural conditions that shape what is clinically possible. These requirements go beyond cultural competence understood as a body of knowledge to acquire. They call for cultural humility understood as an ongoing orientation—one characterized by self-reflection, decreasing power differentials, and partnership with communities.

The evidence also carries hope. AI/AN adolescents live within communities whose Indigenous traditions, language, and knowledge have sustained peoplehood across centuries of attempted destruction. The protective effects of family and school connectedness documented in contemporary surveillance data reflect, in part, the ongoing capacity of AI/AN families and communities to raise resilient children under difficult conditions. Traditional practitioners, cultural teachers, and community members continue to offer healing resources that predate and exceed the reach of Western behavioral health systems. Psychologists who approach this work with respect, patience, and genuine partnership have the opportunity to contribute to

healing not only for individual adolescents but for the systems within which behavioral health care is provided.

The task, in the words of one Project TRUST member quoted by Goodkind and colleagues (2011), is not to help AI/AN adolescents adjust to conditions that continue to harm them, but to work toward "beautiful, healthy Native communities that thrive and are successful, and are not only resilient, but are really, really strong and powerful." That vision is not the work of any single clinician or any single generation. But it is the appropriate horizon against which the work of psychologists with AI/AN adolescents should be measured.

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