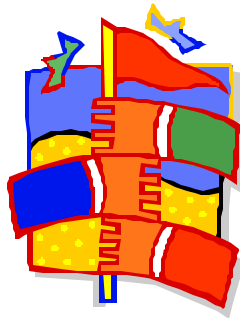


Chapter 3

Native American Children



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A Review of the Literature

Healing the *Wakanheja*⁴: Evidence Based, Promising, and Culturally Appropriate Practices for American Indian/Alaska Native Children with Mental Health Needs

INTRODUCTION

American Indian and Alaska Native (AI/AN) children experience a myriad of risk factors for developing psychopathology, yet there is a paucity of evidence based prevention and intervention practices specifically addressing their needs. There is a dichotomy between evidence based models alleged to be effective with AI/AN, which are not culturally grounded nor sufficiently tested with the population, and culturally grounded AI/AN models whose efficacy have not been demonstrated. There are a number of evidence-based practices assumed effective for AI/AN children because they were utilized with diverse ethnic groups. These practices are then applied to AI/AN children with minimal, superficial and often stereotypical “cultural adaptation,” including such things as substituting Native names or themes in the curriculum content and serving fry bread at a meal. The result in this first scenario is that the practice remains inherently based upon the culture of the non-Native developers with “Indian window-dressing” so that the model appears AI on the outside but is internally flawed and culturally irrelevant on a deeper more meaningful and more profoundly important level. This is akin to a non-Native person dressing up in an “Indian” costume for Halloween.

The opposite scenario is the culturally based, culturally congruent, and culturally grounded practice that emerges from traditional AI/AN worldviews. Native philosophies, behavioral norms, relationships and attributes are included and Natives develop the program for their own population. Such practices often have never been evaluated or adequately replicated. Claims of success are based upon observations and anecdotal information. While these observations plausibly reflect participant experience of the Native model as effective, the model has not advanced to the level of being promising or evidence based.

We are proposing some solutions to this dichotomous dilemma: (a) one must facilitate culturally congruent research and evaluation of Native-driven practices. Ideally, AI/AN evaluators lead the efforts utilizing empowerment and participatory action research or other evaluation approaches that promote AI/AN involvement and ownership. These methods would incorporate the needs of and consideration for the AI/AN community; (b) Native-developed and designed practice models should be encouraged and fostered, rather than simply applying practices developed with other populations; (c) culturally appropriate and Native-developed models should be chronicled and then resources should be devoted to conduct evaluations that lead to declaration of promising or evidence based practices; (d) evidence based and promising practices, with potential to be effective with AI/AN population, should be adapted and evaluated. Program fidelity could be maintained while augmenting components that suit AI/AN children. Evaluation methods would incorporate culturally appropriate research instruments and methods and utilize focus groups of AI/AN community members, key informants, and consultants.

This paper divides practices into three categories. First is a review of the evidence based and promising practices that have reported use with American Indians, without noting cultural adaptation. Second are evidence-based practices that may show promise for cultural adaptation for AI/AN

⁴ Wakanheja is a Lakota (Teton Sioux) word meaning “children who are sacred beings.”

communities because of the issues they address and their relevance for the risk factors AI/AN children face. Third, are culturally appropriate practices that AI/AN communities are using, whether or not these are deemed promising practices. We conclude with recommendations for further research and development of best practices for AI/AN children. Because of the diverse tribal AI/AN groups represented in Washington State, we also present diverse models that can potentially be adapted and tailored to meet the needs of AI/AN groups in the state.

In keeping with the same format used in a previous literature review that examined measurement with American Indians (Moran & Yellow Horse, 2000), we first sought out best practice programs in NIMH, NIH, SAMHSA, OJJDP, NIDA, Office of Education, and NCAP Web Sites and found 34 programs listed. We also attempted a “backdoor approach” by seeking information about best practices through Indian research literature. Using the PsycINFO, Social Work Abstracts and Social Science Index databases, we identified approximately six programs that specifically addressed the mental health needs of American Indian children and families. We then proceeded to narrow this list to research based best practices, promising practices, and promising alternatives. The outcome produced approximately 40 practices related to mental health needs of American Indian children. The authors reviewed the program for their relevance to mental health needs for American Indian/Alaska Native children and entered them into the attached resource guide.

EVIDENCE BASED AND PROMISING PRACTICES WITH AMERICAN INDIANS

Few studies focus specifically on Alaska Native or American Indian children. They are usually combined with other populations and the actual number participating is lost. The degree of cultural adaptation is rarely presented, thus it is difficult to assess efficacy for American Indian and Alaska Natives. Practices included in this section may reflect this condition. Most practices address substance abuse and/or mental health risk and protective factors.

Greenberg, Domitrovich, & Bumbarger (1999) advocate the use of preventive interventions prior to the development of significant symptomology in children. A variety of practices target individual behavior disorders and engage family, peers and teachers in the treatment process designed to decrease risk factors and to increase protective factors. Several models focus on parents as the target for intervention, addressing the child’s relationship with them as a way to reduce risk factors, such as communication problems, family disorganization, and poor bonding and increasing protective factors, such as improving the quality of the child’s interaction with the environment.

Parenting Wisely, a SAMHSA designated Effective Program, is a self-administered computer-based program that teaches parents and their children important skills for combating substance abuse. Practitioners can use this versatile program alone or in a group in a variety of situations. It promotes effective parenting skills including communication, positive reinforcement, problem solving, contingency management, assertive discipline and supervision. Research reveals significant improvements in reaction, behavior, and learning (Schinke, Brounstein & Garner, 2002).

PATHS – Promoting Alternative Thinking Strategies (Greenberg & Kusche, 1997, 1998; Greenberg, Domitrovich & Bumbarger, 1999) is an evidence based classroom program which focuses on cognitive skill-building to assist elementary school students with identifying and self-regulating their emotions. It has been used with a variety of children with special needs. It promotes social competency and reduces acting out and aggressive behavior.

A promising practice that reports application to American Indians is the *Life Skills Training Program*, which may significantly reduce substance use, i.e. tobacco, alcohol, and marijuana (Botvin, Baker, Dusenbury, Tortu & Botvin, 1990). This program teaches youth how to resist peer pressure and helps enhance self-esteem. Another promising program used with AI is *Preparing for the Drug Free Years*.

This program focuses on enhancing bonding and reducing family-related risk factors (Hawkins, Catalano, & Kent 1991). This program is highly researched and is based on defining and working with risk and protective factors.

The *Families and Schools Together (FAST) program* is a family-based practice that promotes protective factors and improves family functioning for children (aged 4-12) manifesting behavioral and academic problems (McDonald & Sayger, 1998). One of the primary strategies of this program is parent empowerment. It aims to achieve four main goals: enhance family functioning, prevent school failure, prevent substance abuse and reduce stress in the family.

Strengthening Multiethnic Families and Communities (SMFC) has been utilized by a number of American Indian communities with promising results. This program was designated a promising practice by the Center for Substance Abuse Prevention. Among American Indian parents, SMFC leads to improvement in the perceived quality of parent-child relationships, including increased positive and decreased negative interactions, as well as perceived improvement in parental competence (Steele, 2002).

EVIDENCE BASED PRACTICES THAT MAY BE RELEVANT FOR AMERICAN INDIAN AND ALASKA NATIVE CHILDREN: EFFECTIVE MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS (SAMHSA)

The Cognitive Behavioral Therapy (CBT) for Child Traumatic Stress is a research based treatment model for children and adolescents ages 3 to 18, addressing trauma-related psychiatric symptoms seen in children following 9/11 (Schinke, Brounstein & Garner, 2002). There are parallel sessions for children and parents, incorporating feeling identification, cognitive coping/processing, gradual exposure, stress management, and psycho education. Randomized control trials revealed significantly greater reductions in PTSD, depression, anxiety, problem behaviors, and parental emotional distress for children receiving treatment. This model dealing with traumatic grief may be relevant to American Indians. Manson et al (1996) found a high incidence of trauma exposure among AI adolescents. Cognitive Behavioral Therapy for Child Sexual Abuse includes components such as psycho education, coping skills training, processing of traumatic memories, and training in personal safety skills (Schinke, Brounstein & Garner, 2002). Parental involvement is included, with joint sessions focused on communication about the abuse and associated issues. Parents also receive behavioral training to help reinforce healthy child behavior. Randomized control trials revealed significantly greater reductions in PTSD, depression, problem behaviors, and parental emotional distress, as well as increased personal safety skills in children.

Stress Inoculation Training I targets stress reduction, since the consequences of stress include anxiety, poor academic performance, delinquency, depression, and suicidal behavior. The practice focuses on enhancing coping skills and relaxation training for high school youth. Evaluation results indicate a significant reduction in anxiety compared with controls, as well as increased self-esteem, but showed no impact upon depression (Hains & Szyjakowski, 1990; Greenberg, Domitrovich & Bumbarger, 1999). Because of the high trauma exposure among AI adolescents (Manson et al, 1996), stress is clearly a risk factor, so this intervention would be beneficial for AI/AN youth.

CULTURALLY APPROPRIATE PRACTICES IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

Programs summarized in this section are grounded in indigenous culture and are being developed by and utilized in American Indian and Alaska Native communities. These programs show promise in our eyes, but have not yet officially been designated best or promising practices by national organizations.

A number of AI/AN substance abuse prevention models now incorporate traditional cultural activities. Spiritually oriented practices, such as purification lodges, smudging, talking circles, dream work and traditional, help youth facilitate healing (Sanchez-Way & Johnson, 2000). Additional cultural activities also include learning traditional languages and crafts, cooking traditional foods, and subsistence activities such as hunting, fishing, and berry picking. In their review of the literature, Sanchez-Way and Johnson (2000) found that, although the effect of culture upon substance abuse is indirect and acts through family and peers, some literature indicates that AI teens who identify with their culture are less likely to drink alcohol (Sanchez-Way & Johnson, 2000). Sanchez-Way and Johnson advocate that AI substance abuse prevention projects combine traditional cultural components with other demonstrated approaches.

Segal (2003) has led focus groups on Alaska Native practices. He defines best practices for Alaska Natives as utilizing traditional customs and indigenous healing practices, along with appropriate non-Native healing approaches, to address substance abuse and co-occurring intergenerational trauma, including physical and/or sexual abuse. Segal found that Alaska Native cultural identification issues were highly interrelated with drug abuse, which can in part be seen as a symptom of cultural identity (Segal, 2001, 2003). Implicitly treatment can be informed by this understanding and thereby be a focus of intervention. Segal (1999) also found that cultural identification could successfully predict treatment completion and treatment outcome for Alaska Native women.

Segal (2003) reported that focus groups with AN consumers revealed that service providers needed to have familiarity and experience with AN clients and an understanding of community beliefs about healing. Furthermore, practices must acknowledge cultural beliefs and incorporate them in the intervention. The respondents emphasized that spirituality is an important part of healing and that it should be an important component of effective intervention. Segal (2003) advocates that historical trauma and multi-generational grief should also be a focus of the intervention. Staff training needs to include recognizing and treating trauma. Further, the incorporation of family members in treatment was advocated by AN focus group respondents, as was Native advisory boards, talking circles, and parenting education.

The AN focus groups identified some key best practice strategies that were consistently found to contribute to successful treatment with AI/ANs. These include spirituality, community support, ceremonies, elder involvement, Natives values, Native staff and Native peer support (Segal, 2003).

Years earlier, Silver and Wilson (1988) identified the therapeutic properties of AI purification lodge ceremonies, including role modeling affect tolerance (the capacity for one to tolerate her/his emotions), promoting group collectivity, bonding, and ego-enhancement.

The following culturally oriented programs incorporate the key best practice strategies Segal (2003) highlighted. One project (HTUG), used by the authors, is described in detail to give the reader an idea of what a culturally appropriate program would look like.

In a Center for Substance Abuse Treatment-funded project of the Alaska Federation of Natives (AFN), a prototype model of care for substance abuse treatment for Alaska Natives was identified (Segal, 2003). The model incorporated traditional ways. Literature on traditional Native healing practices for mental health disorders as such is limited. However, other studies on Natives in treatment for substance abuse have demonstrated that cultural factors are important elements related to treatment outcome (Segal, 2001, 2003). Gutierrez, Russo and Urbanski (1994) found that acculturation issues were related to treatment outcome and a higher treatment completion rate was found for women, indicating that they practiced traditional Native activities while growing up and during the past year, with over 50 percent of these women viewing themselves as traditional.

Storytelling for Empowerment is a SAMHSA-designated promising practice for middle school rural/reservation American Indian youth and Latino urban youth (Schinke, Brounstein & Garner, 2002). The focus is on risk factors such as confused cultural identity and the lack of positive parental role models. Goals are to decrease substance abuse, reduce risk factors, and increase resilience.

One of the few AI/AN programs designated as a promising practice is the *Zuni Life Skills Curriculum*. The model focuses on building social-emotional competence and reducing suicidal risk for Zuni Pueblo adolescents. Evaluation revealed that participants reported significantly less hopelessness and manifested higher suicide intervention skills. Another promising practice is the *Sacred Child Project*, serving several North Dakota tribes (Cross, Earle, Echo-hawk Solie, & Manness, 2000). It uses the Wraparound approach (Burns & Goldman, 1999) with children having diagnosable emotional disturbances or who are in danger of or transitioning back from placement outside of the home. The program integrates western treatment and traditional methods. "The whole idea about sacred child is to keep the child in the home or at the very least keep the child in the community."

The Historical Trauma & Unresolved Grief Intervention (HTUG):

A culturally appropriate practice that has not yet been included on the SAMHSA Model Programs is the *Historical Trauma and Unresolved Grief Intervention*. HTUG was recognized as an exemplary model by CMHS through the award of a Lakota (Teton Sioux) Regional Community Action Grant on Historical Trauma to the Takini Network, a Native non-profit community based organization. The authors are involved with this project and are presenting it in detail to give the reader an idea of what a culturally appropriate program might look like. The description includes background information on historical trauma and unresolved grief and how these experiences affect American Indians in this country. The program was developed for the Lakota, but it is applicable to other American Indians as well.

HTUG has been validated through formal evaluation and research, documented in peer reviewed journals as well as other publications (Brave Heart-Jordan, 1995; Brave Heart, 1998, 1999a, 1999b, 2000, 2001a, 2001b; Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998). Literature on AI trauma (Manson et al., 1996; Robin, Chester & Goldman, 1996) and general trauma literature (van der Kolk, McFarlane, & van der Hart, 1996) supports the theoretical constructs underpinning HTUG and the need for specific culturally based trauma theory and intervention.

Historical trauma (HT) is cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences. The historical trauma response (HTR) is the constellation of features in reaction to this trauma (Brave Heart, 1998, 1999a). The HTR often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions (Brave Heart, 1998, 1999 a & b). The HTR may include substance abuse, often an attempt to self-medicate to avoid painful feelings. The HTR is passed on across generations, and intervening with parents can ameliorate the intergenerational transfer of substance abuse (Garbarino, Dubrow, Kostelny & Pardo, 1990).

HTUG, a psycho educational group intervention, targets parents. Its goal is to reduce mental health risk factors and increase protective factors for children. It has several components: (a) education about traumatic Lakota history and its impact upon current lifespan trauma, (b) utilization of visual stimuli such as videotapes and slides to facilitate processing of that trauma through abreaction and catharsis, (c) fostering a re-connection to traditional Lakota cultural values that can serve as protective factors against mental health and substance abuse issues, and (d) promoting group collectivity, bonding, and ego-enhancement as well as emotional containment by using traditional Native rituals such as the Lakota purification lodge which aids in that process (Brave Heart, 1998; Silver & Wilson, 1988).

Although HTUG was initially designed as a Lakota intervention, it can be modified for other tribal groups, and is being adapted by other communities such as the Eastern Band of Cherokee Indians. Historical trauma workshops have been delivered to AN communities as well as several other AI regions. HTUG is typically delivered ideally in a retreat setting, which affords a traditional milieu and emotional container. HTUG begins with a greeting circle, prayer, and burning of sage/sweet grass to foster group collectivity and honesty (traditional belief). HTUG includes a review of traditional ground rules based on traditional Native values. The first day focuses on the communal historical trauma (HT) such as massacres and boarding schools. Videos and slides are used with didactic presentation of facts about AI/AN massive group traumatic history. Opportunities for small and large group sharing as well as sharing in pairs are interspersed throughout the presentation of HT. Day Two focuses on completion of boarding school trauma and imparting traditional knowledge, which can serve as protective factors. Information about trauma response features and the physiological as well as emotional impact of trauma is imparted. Participants share life span trauma, after drawing a timeline of their trauma and loss experiences. Self-care plans are then developed and shared. There are also warm up and experiential exercises, using humor as an emotional container. Each day begins and ends with prayer and sometimes traditional singing. A key component is the facilitation of a consolidated positive Native identity through transcendent AI/AN cultural experiences such as the *oinikage* (purification ceremony), which permits cathartic self-disclosure, ego enhancement, collectivity, reformation of self, transfers expectations of healing, and further models affect tolerance (Brave Heart, 1998; Silver & Wilson, 1988). There is a *lowanpi* or *yuwipi* (healing ceremony) or an *inipi* or *oinikage* (purification lodge/ceremony) typically the 3rd night. The last day is more sharing re: self care, plans for the community to continue the process of healing, and a wiping of the tears ceremony or exercise.

The techniques and key operational components of HTUG are analogous to those utilized with other massive group trauma survivors such as group sharing, videotape stimulus material to facilitate retrieval of repressed memories, cognitive content about traumatic history as well as responses to that history, and traditional Native practices aimed at facilitating abreaction and catharsis (emotional processing and releasing) and transcendence (Brave Heart, 1995, 1998). The intervention facilitates disclosure, cohesiveness, bonding and mutual identification, and provides opportunities for role modeling affect tolerance, self-regulation, and trauma mastery comparable to other group intervention models with PTSD clients, massive group trauma survivors and their descendants (Brave Heart, 1998; Fogelman & Savran, 1979). HTUG is also equivalent to the Phase Oriented Treatment strategies for PTSD (van der Kolk, McFarlane, & van der Hart, 1996), utilizing (a) stabilization which includes education and identification of feelings, (b) reconditioning of traumatic responses and memories, (c) restructuring traumatic internal systems, (d) reestablishment of safe social connections and efficacy in relationships, and (e) amassing a collection of restorative emotional experiences (p. 426). HTUG results in symptom normalization (Koller, Marmar & Kansas, 1992) and a healthy sense of connection with deceased ancestors rather than fixation to the trauma (Fogelman, 1991).

The importance and impact of HTUG upon American Indian children can be understood through a description of the challenges for their parents. Many AI and some AN parents have most likely been the victims of punitive or “boarding school style discipline,” which is perceived as negatively impacting parenting interaction with children and contributes poor mental health, substance abuse, violence, and other problems (Brave Heart, 1998, 1999a). Protective factors against psychosocial problems such as parental emotional availability and support, parental competence, and parental involvement with a child’s schooling have all been negatively impacted by parental or generational boarding school experiences. Parents who have been traumatized as children are less likely to be emotionally present for their children. Parents raised in boarding schools lack role models of healthy parenting, thereby being at risk for parental incompetence. The lack of control over the school environment, choices about schooling, and negative boarding school experiences (see Brave Heart, 1995, 1999a) place AI parents at greater risk for a lack of involvement in the schooling of the current

generation. Hence, there is a significant need for healing from this traumatic history among AI parents, which includes an emphasis on parental competence and parental support.

There is an increased risk of substance abuse and other emotional problems in children who experience: un-nurturing and ineffective parental disciplinary practices, absence of family rituals, alcohol-related violence, parental psychiatric problems such as depression, sibling alcohol use, and stressful life events such as verbal, physical, and sexual child abuse perpetrated by a family member (see Chassin, Pillow, Curran, Molina & Barrera, 1993; Jacob & Leonard, 1994; Jennison & Johnson, 1998; Miller, Maguin & Downs, 1997; Molina & Chassin, 1996; Orenstein & Ullman, 1996; Sher, 1997; Smyth & Miller, 1998; Sher, Gershuny, Peterson & Raskin, 1997).

A lack of effective AI/AN parenting role models and the lack of nurturing as well as abuse in boarding schools have resulted in punitive, authoritarian, uninvolved, and non-nurturing parents to varying degrees (see Brave Heart, 1995, 1999a, 2000; Morrisette, 1994). Poor spiritual foundations, weak Native identity, and poor family affiliation – consequences of the boarding school legacy and spiritual oppression (Brave Heart, 1999a) – are associated with Indian youth alcohol and other substance abuse (Oetting & Beauvais, 1989; Guyette, 1982).

An analysis of CSAP's High Risk Youth Cross-site study indicated that positive family relations with supervision, monitoring, and anti-drug family norms serve as protective factors against youth substance abuse (Nye, Zucker, & Fitzgerald, 1995). Protective family factors include positive discipline methods, high parental involvement, spiritual involvement, bonding with family and social groups that value non-use of alcohol and other substances, and external social support (see Alvy, 1991/1993). The literature on protective factors suggests that parents' encouragement of their children to dream and to establish goals and purpose in life is an important protective factor. The disempowerment and oppression of AI/ANs as well as the prohibition against the open practice of Native spirituality historically has impaired Native ability, to varying degrees, of being able to dream about the future, to set life goals, and to find one's spiritual purpose in life.

Intergenerational Transfer of Trauma Research

Often associated with parental substance abuse, childhood trauma exposure influences the emotional and the sensory perceptual experiences of childhood events and these effects persist into adulthood (Segal, in press). Among Alaska Native females, substance abuse is related to emotional problems, parental neglect and abuse, and sexual victimization of offspring (Segal, in press).

An examination of risk factors for PTSD among descendants of Jewish Holocaust survivors is relevant to American Indians. Yehuda (Brave Heart & DeBruyn, in press) found that, despite the lack of statistically significant differences in actual self-reported number of traumatic events or in the degree of trauma exposure, adult children of survivors had a higher degree of cumulative lifetime stress (Brave Heart, 2003; Brave Heart & DeBruyn, in press). Implicitly, there is a tendency among offspring to experience or perceive events as more stressful and traumatic. Children of Holocaust survivors were found to be more likely to develop PTSD in response to their own traumatic lifetime events when having a parent living with chronic PTSD. Rather than trauma exposure itself, the parental trauma symptoms are the critical risk factors for trauma responses among the children of survivors. For AI/AN, PTSD prevalence is 22 percent compared with 8 percent for the general population. For AI/AN veterans, PTSD rates are significantly higher than both African Americans and the general population, attributed at least in part to greater trauma exposure (Office of the Surgeon General, 2001). PTSD nomenclature inadequately represents AI/AN trauma (Robin et al., 1996), specifically historical trauma (Brave Heart, 2003). Despite the pervasiveness of trauma exposure, AI youth often do not meet the criteria for PTSD because their culture may mask symptom presentation and assessment (Brave Heart, 1999, 2003; Brave Heart & DeBruyn, in press; Manson et

al., 1996). The Takini Network is developing more accurate trauma assessment and evaluation efforts and studying the effectiveness of HT interventions.

First-degree relatives of trauma survivors with PTSD manifest a greater prevalence of mood and anxiety as well as substance use disorders (Brave Heart, 2003; Yehuda, 1999). Children of substance abusers attempt suicide at a higher rate (Segal, in press). Childhood sexual abuse reported by many AI/AN boarding school survivors is implicated in intergenerational trauma transfer and is a significant risk factor for depression and/or anxiety disorders and substance abuse (Brave Heart, 1999a; 2003; Brave Heart & DeBruyn, in press; Robin et al., 1996). Offspring of parents with anxiety or depressive disorders have an increased risk of developing a similar disorder (Beardslee & Wheelock, 1994). Depression and substance abuse are correlated with PTSD and are both common among AI/AN (Robin et al., 1996; Brave Heart, 1999b, 2003; Brave Heart & DeBruyn, in press); high trauma exposure is significant among AI/AN adolescents (Manson et al., 1996). All these factors of childhood and trans-generational trauma are considered in the HTUG program.

CONCLUSION AND RECOMMENDATIONS

The sparse literature regarding promising and evidence based practices with AI/AN children does not specify sample size, degree of cultural adaptation, if any, significance for treatment effect, and the outcome measures. Information regarding replication is not documented. There is a paucity of evidence based prevention and intervention practices *specifically* addressing the needs of Native children and youth and the issues that these young people face. Existing evidence based models are often not culturally grounded, adapted, nor sufficiently tested with AI/AN populations.

Culturally based, culturally congruent, and culturally grounded practices that emerge from traditional AI/AN worldviews, philosophies, behavioral norms, relationships and attributes, and developed by Natives, need to be fostered, promoted, and evaluated. Federal agencies should promote and fund culturally congruent research and evaluation of Native-driven practices conducted by AI/AN evaluators primarily and incorporating a consideration for the AI/AN community. Native-developed and designed practice models should be encouraged and fostered, rather than simply applying practices developed with other populations. Federal agencies can facilitate the development of an AI/AN practice database, which the authors are currently exploring with CMHS staff. Finally, those evidence based and promising practices that have the potential to be of help to the AI/AN population should be adapted and then evaluated, utilizing focus groups of AI/AN community members, AI/AN key informants, and AI/AN consultants for such adaptation. Culturally appropriate measurement instruments and research and evaluation designs need to be utilized.

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