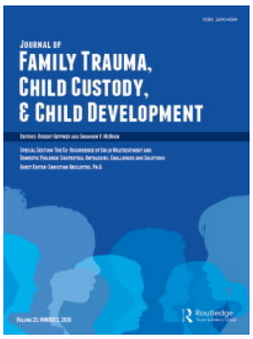

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Culture and trauma-informed treatment with youth: Current practices and suggestions for adaptation from two studies

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ABSTRACT

The paper examines trauma-informed interventions for externalizing behavior among culturally diverse youth via two connected studies. The first involved a Delphi study with researchers and clinicians ($N=10$) who identified consensus on best practice in addressing trauma and externalizing behavior with youth. A second study addressed gaps in Indigenous and non-Western perspectives by reviewing psychoeducational reports for Indigenous youth ($N=20$) and undertaking interviews with First Nations and non-Indigenous educators ($N=7$). Results highlighted limitations in current assessment practices for First Nations youth experiences and highlighted the importance of holistic, community-centered and land-based approaches to treatment. Findings indicated a predominance of Western frameworks in practice and emphasized the need for culturally relevant, trauma-informed assessment and intervention models for First Nations communities.

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Culturally informed assessment; First Nations; historical trauma; intergenerational trauma; psychological trauma

Research has linked the experience of early trauma to the development of externalizing and antisocial behaviors such as conduct disorder, substance misuse, and delinquency in youth (e.g., Basto-Pereira et al., 2016; Stinson et al., 2023). Several causal pathways have been theorized, such as maladaptive self-regulation (e.g., Meddeb et al., 2023), behavioral modeling (Bandura, 1986), hypervigilance and/or heightened responses to perceived aggression (e.g., Martinelli et al., 2018). When managing externalizing behaviors in the classroom, schools often rely on exclusionary practices such as suspensions and expulsions (Pesta, 2022). These strategies can exacerbate school disengagement, which is a known criminogenic risk factor (Farrington et al., 2015) and may escalate until police involvement is required (Skiba et al., 2014). When attending mainstream schools, minority youth, many with a history of adversity, are disproportionately targeted by exclusionary disciplinary policies (Erickson & Pearson, 2022;

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Goldstein et al., 2019), potentially perpetuating behavioral difficulties and increasing risk of exposure to further trauma.

One of several challenges when working with adversity-exposed youth who are demonstrating externalizing behavior is agreeing on a definition of trauma. While trauma-informed practice is a popular concept, it is inconsistently defined and enacted (e.g., Dublin et al., 2021). Adverse childhood experiences (ACEs) is one heuristic commonly referred to (Felitti et al., 1998). ACEs encompass experiences such as abuse, household substance misuse, incarceration, mental illness, witnessing violence toward one's caregiver, caregiver separation/divorce, and physical or emotional neglect (Wolff et al., 2018). However, there is also accumulating evidence of the impact of racism and discrimination on the health outcomes of visibly minoritized groups (e.g., Bernard et al., 2021). Furthermore, when working with Indigenous populations, the impacts of historical and intergenerational trauma are impossible to ignore. Historical trauma, initially referred to as *historical unresolved grief,* was a term first applied to the experiences of Indigenous people by Brave Heart and DeBruyn (1998) and encompassed the "pervasive sense of pain from what happened to their ancestors and incomplete mourning of those losses" (p. 64). Indigenous historical trauma therefore goes beyond personal grief, encompassing a profound sense of cultural and spiritual loss, and is referred to as a *soul wound* (Duran, 2006). A more common and related term is *intergenerational trauma,* which describes the transmission of trauma across generations through mechanisms such as epigenetics, learning, collective remembrance, or family or community dynamics. However, while intergenerational trauma can occur for several reasons and across many contexts (e.g., *Cycle of Violence*; Maxfield & Widom, 1996), historical trauma is specifically rooted in systemic oppression that is driven by differences in ethnicity, culture, religion, and/or worldview (Hamby et al., 2020). Furthermore, Gone (2023) outlines the "four Cs" of historical trauma, that is: (a) it is rooted in *colonization*, (b) it impacts a group *collectively*, (c) the effects are *cumulative,* and (d) they are experienced *crossgenerationally*.

Cultural diversity is an important consideration in contemporary behavioral and psychological assessment and intervention. In psychological assessment, cultural adaptations most often occur as surface level adaptations, such as linguistic translation of existing instruments (e.g., Reynolds & Kamphaus, 2015), while frameworks intended to account for broader cultural differences (e.g., *Cultural-Linguistic Interpretive Matrix*; Flanagan et al., 2007) are comparatively rare and often applied across several cultures. In the behavioral programming literature, there are remarkably few examples of cultural modification. Examples include recruitment of local facilitators (e.g., Johnston, 2003), integration of translators (e.g., Tol et al.,

2012), or altering content (e.g., O'Callaghan et al., 2013). In North America, increased attention in psychological assessment and treatment has been given to the unique needs and worldviews of Indigenous peoples (e.g., Linklater, 2017). However, Indigenous youth remain a neglected group in the research on trauma and the connection to externalizing behavior (Cain, 2021; Watts & Iratzoqui, 2019).

Purpose of the present study

The current study aimed to address gaps in the existing literature by exploring first the perspectives and practices of researchers and clinicians experienced in trauma-informed behavioral intervention with culturally diverse youth. In Study One, the aim was to capture culture-specific insights into Indigenous and non-Indigenous experiences and perspectives, as related to psychological assessment and treatment. This was achieved with a Delphi survey that aimed to reach consensus on theoretical frameworks relevant to trauma treatment and cultural needs. Study Two built on these findings by more explicitly integrating the experiences of Indigenous Youth and the educators working directly with them. This involved reviewing psychoeducational assessments of such youth and conducting semi-structured interviews with Indigenous and non-Indigenous educators in Canada, informed by the results of Study One, to discuss how to meet the behavioral and mental health needs of potentially traumatized youth. Given the exploratory nature of the topic and methodology, no a priori predictions were made.

Study one: Delphi Study of professional views

This study focused on an analysis of professional views, seeking consensus. These views were later integrated with the findings from Study Two, where information relating to the direct experiences of Indigenous youth were captured explicitly through the views of educators and completed assessments on this population.

Method

Sample

Initial recruitment targeted both researchers and practitioners through advocacy and regulatory bodies for psychology, counseling, psychotherapy, and social work in the United Kingdom, Canada, and the United States. Researchers included those who had published at least twice on the topic. Practitioners self-identified as competent in the treatment of challenging behaviors in trauma-exposed, culturally diverse youth. Ten participants

responded to Round 1 of the Delphi survey. Three identified as researchers or practitioner-researchers while seven were solely practitioners (three psychologists, two therapists, counselors, or psychotherapists, one social worker, and one psychiatrist). Of these, seven completed the final survey (i.e., 78% retention: Round 3).

Procedure and Delphi questions

A Delphi survey method was adopted as a means of achieving a consensus view from an expert panel. A Delphi is a structured means of gathering opinions to achieve consensus through iterative rounds, which involved summarizing and presenting collective responses, before then repeating this across rounds (see Shang, 2023). Here the rounds (three in total) were designed to reach consensus on theories relevant to trauma treatment and cultural needs and on the essential characteristics of treatment.

Delphi surveys were completed online using the Qualtrics survey platform. Round 1 involved a series of open-ended and multiple-choice questions. These questions were divided into (a) terminology, (b) theories or conceptual frameworks, (c) culturally responsive practice, and (d) essential characteristics of treatment (see Online Supplemental Table S1 for full outline of questions). Round 2 synthesized feedback and participants were asked to indicate their agreement with the conclusions. A total of 80% agreement was adopted as the threshold indicating consensus (e.g., Howarth et al., 2019). Round 3 offered the opportunity for participants to review aggregate group responses and amend their answers, if they wished. At each round, participants reflected on how their approach would change with clients from another cultural background. Participants were given three weeks to complete each round with a two-week break in between. Ethical approval was granted by the University of Lancashire Science Research Ethics Committee.

Results

Areas of consensus and disagreement

Distinct areas of consensus and disagreement emerged in the first round. In terms of theories most relevant to treating ACEs and externalizing behaviors in young people, preferences appeared evenly distributed among Developmental Trauma (van der Kolk, 2005) ($k = 6$), Cognitive Behavioral Theory (Beck, 1976) ($k = 5$), Attachment Theory (Ainsworth et al., 2015) ($k = 6$), Social Cognitive/Learning Theory (Bandura, 1986) ($k = 3$), and Emotional Processing Theory (Foa et al., 2006) ($k = 3$). Participants rated Adaptive Information Processing Theory (Shapiro, 1995) ($k = 4$), Theory of Planned Behavior (Azjen, 1991) ($k = 4$), and the Biosocial Model (Linehan, 1993) ($k = 3$) as least relevant. Additional theories and approaches

identified by participants as useful included *Conservation of Resources* (Hobfoll, 1989), *Risk Factor Caravans* (Layne et al., 2014), positive behavior intervention and supports, positive psychology, and general structural approaches (e.g., anti-oppression).

In response to whether their theoretical scope changed dependent on their client's cultural background, a third of the sample ($k = 3$) indicated it would not. For those who selected "yes," Cognitive Behavioral Theory ($k = 2$), Social Cognitive/Learning Theory ($k = 2$), Developmental Trauma ($k = 1$), Social Information Processing Theory ($k = 1$), Attachment Theory ($k = 1$), Emotional Processing Theory ($k = 1$), Social and Emotional Wellbeing Model (SEWM; Gee et al., 2014) (k = 1), and Compassionate Inquiry (Mate, 2014n.d.) ($k = 1$) were selected as more relevant when working with clients from other cultural backgrounds. Notably, the SEWM (Gee et al., 2014) represented the only non-Western approach cited, emphasizing the shared Indigenous values of holistic health, cultural awareness, recognizing the impact of historic trauma and discrimination, centering of family and community connections, and strengths-based interventions. Overall, practitioners valued drawing from multiple theories.

Participants were closely aligned in round one in ratings regarding the effectiveness of several methods for culturally adapting assessment and treatment and identifying essential components for intervention. The option "Consultation with someone who has expertise or experience with the young person's cultural background (e.g., asking about behavioral expectations)" was most frequently selected ($k = 9$). When rating the least effective approaches, "use of behavioral measures that have been normed with people from similar backgrounds" was voted least helpful ($k = 4$). Four participants chose "none of these" in response to this question, implying all options were somewhat useful. Regarding intervention essentials, mindfulness and relaxation training ($k = 6$), psychoeducation focused on biopsychosocial responses to trauma ($k = 6$), and social problem-solving skill development and practice ($k = 5$) were most popular. Most participants noted how components they rated as essential would not change based on the client's cultural background ($k = 7$). Participants were also given the opportunity to revise provided definitions of the terms *cultural* and *externalizing behavior* as well as share their views on the impact of cultural differences on their practice with youth clients.

Consensus (80% threshold) was reached regarding approaches to cultural adaptation and essential components of intervention in round two. Most participants agreed that open discussion about cultural background, access to language supports, and consultation with someone who had culturally relevant experience was the most effective way of adapting treatment to youth from different cultural backgrounds and that mindfulness and relaxation training, psychoeducation focused on biopsychosocial responses to

trauma, and social problem-solving skill development and practice were the most essential components of trauma-informed behavioral intervention.

Consensus was also reached in round two on working definitions of *cultural* and *externalizing behavior* as well as barriers to accessing trauma-informed care for people from nondominant cultural backgrounds. In Round Three, consensus was reached on three of the identified impacts of cultural differences and eight items were removed as agreement levels remained

Consensus in rounds two and three (80% threshold) was reached for four items, with eight below 60%. A summary, which includes both the items and consensus ratings, can be found in Table 1.

Study Two: Integrating First Nations' perspectives

Study One demonstrated that agreement was most readily achieved in relation to terminology, effective approaches to account for cultural differences, and with barriers affecting the access of members of cultural minority groups. However, Study One also found that there was little engagement with non-Western theorizing and limited evidence of changes in practice based on Indigenous perspectives. Consequently, Study Two aimed to address this neglected area by incorporating First Nations voices and contextual data through two parallel sources: psychoeducational record review and educator interviews. Thus, where Study One generated a conceptual baseline of current professional practice and understanding, Study Two aims to contextualize and enrich that baseline using lived experiences, progressing from expert-derived generalization to lived-experience-derived, and culturally situated, validation.

Here, information was gathered directly from a population highly impacted by Eurocentric psychological practices: First Nations communities in Canada. Collaboration with the Meadow Lake Tribal Council (MLTC), a First Nations council in Northwestern Saskatchewan, Canada, was facilitated through a connection with the first author. The study entailed a review of child and youth psychoeducational assessment records and mental health focused interviews with people living in Indigenous and non-Indigenous communities in rural Saskatchewan.

Method

Participants

Regarding the psychoeducational assessment reviews, 24 of 65 caregivers or eligible participants were reachable during recruitment, 18 of whom consented, resulting in 20 reports being reviewed. Students' ages ranged from five to eighteen years ($M = 8.75$, $SD = 3.34$), with all but one falling

Table 1. Delphi Round Two ($n = 9$) and Round Three ($n = 7$) showing consensus ($n = \leq 80$) and consensus not reached (NR).

Item	Agree %	Consensus Round
Definitions		
Cultural: Pertaining to the unique worldview, traditions, customs (e.g., clothing), identity, language, activities, symbols, art (e.g., literature), and behavioral or social norms of a given group of people. It may also refer to religious or spiritual beliefs, morals, values, and/or guiding principles.	100	Two
Externalizing behavior: Behavior directed outwardly toward others or the environment in response to external or internal stimuli that may be a result of low self-control, a lack of alternative coping strategies, an attempt to communicate one's needs, or as a form of emotional processing. These may be rule-breaking or harm-causing behaviors or actions that violate social norms. Examples include physical or verbal aggression, defiance, hostility, or self-harm.	100	Two
Cultural service adaptations		
Most effective: Open discussion with the young person and/or their caregiver about their cultural background, access to language supports when needed, and consultation with someone who has expertise or experience with the young person's cultural background.	89	Two
Least effective: Use of behavioral measures that have been normed with people from similar backgrounds.	55	NR
Essential intervention components		
Essential: Mindfulness and relaxation training, psychoeducation focused on biopsychosocial responses to trauma, and social problem-solving skill development and practice.	100	Three
Barriers – Is this list comprehensive?		
• Historical trauma related to mental health and medical services	89	Two
• Systemic racism at the policy and individual levels		
• Lack of accessible transportation		
• Population health outcomes (e.g., genetic susceptibility to disease or illness, beliefs and behaviors related to physical and psychological well-being, and accessibility or effectiveness of local healthcare services)		
• Poor access to health-supportive technology		
• Inadequate access to complementary services (e.g., poor availability of pediatricians, child psychiatrists, etc.)		
• Lack of culturally appropriate supports offered locally (e.g., traditional medicines or healing practices)		
• Expressive and receptive language differences		
• Poor literacy in the dominant language		
• Transience/No fixed address; lack of stable housing options		
• Immigration or legal issues and stressors (e.g., risk of deportation)		
• Finances/Poverty		
Impact of own cultural identity (generated in Round 1)		
Cultural competence is essential.	100	Three
It can be problematic if the practitioner believes their world view is the 'right' one and does not consider the view of their client.	100	Three
It is important to recognize and respect cultural differences as well as create a safe space to generate understanding of how culture is influencing or impacting young people.	100	Three

(*Continued*)

Table 1. Continued.

Item	Agree %	Consensus Round
The client's past negative experience being in the system may be projected onto the new working therapist.	56	NR
If the parents and child deem the practitioner's views or attitudes about treatment as being too foreign, it may limit their engagement.	56	NR
The practitioner's own beliefs in the effectiveness of one type of intervention over the other, which are culturally rooted, may impact the type of intervention delivered and the emphasis placed on these interventions.	56	NR
A practitioner should compartmentalize one's "self" from those to whom they provide services. If not, issues can arise due to conflicting viewpoints. We must be aware of how our identities can act as a catalyst or barrier for growth.	44	NR
In cases where there is a shared cultural background, effectiveness would be increased as there will likely be more acceptance/understanding/buy-in from the practitioner.	44	NR
The effectiveness of the intervention should not be changed, as steps should be taken in advance to mitigate the impact.	56	NR
Additional considerations		
It is important to acknowledge the limitations of translation and interpretation. Linguistic differences go beyond word usage and involve the understanding of meaning of language within sociocultural context.	44	NR

between ages five and 14. Participants were of Cree, Dene, and Métis backgrounds and 90% were male ($k = 18$). Reviewed assessments were completed across a seven-year period.

Regarding the structured interviews, participants were seven female-identifying educators living and working in rural Saskatchewan, Canada. Three identified as Cree, one as Dene (referred to as Participants 1–4), and three as non-Indigenous (Participants 5–7). Two were student services teachers (i.e., providing academic and behavioral supports), three were classroom teachers, one was a half-time teacher and half-time administrator, and one was a peripatetic behavior consultant.

Cultural considerations

When working in Indigenous contexts, it is essential to consider the ways in which the Eurocentric research lens may be inappropriate and limiting. Kovach (2020) outlines an alternative, six-part *Nêhiyaw* (Cree) conceptual and research framework, as follows: (a) *Nêhiyaw kiskeyihtamowin* (Cree epistemology); (b) Decolonizing ethics; (c) Researcher preparation (spiritual and cultural protocols); (d) Research preparation (involving qualitative design); (e) Action and meaning making (from knowledges gathered); and (f) Giving back. These principles were applied as the research was designed and developed. For example, while Western epistemologies tend to privilege the observable and measurable, *Nêhiyaw kiskeyihtamowin* is rooted in individual experiences and the interplay between external, internal, intuitive, and spiritual knowledges (Kirmayer, 2007). In addition, with *decolonizing ethics*, relationships are at the core of Indigenous research methodology and culture (Gone, 2023). *Researcher Preparation* involved the exploration of "motivations, purpose, [and] inward knowing" (Kovach, 2020, p. 36). Through providing multiple opportunities to revise or withdraw their contributions, it was ensured that participants' felt that they, their perspectives, and their communities, were well-represented by what was shared.

Materials

Psychoeducational Reports. Reports were reviewed and collated including referral information, developmental history, and behavioral questionnaire responses. Questionnaires included the Behavior Assessment System for Children - Second and Third Editions (BASC-2 and BASC-3; see Kamphaus, 2015; Reynolds & Kamphaus, 2015) and the Conners Third Edition (Conners 3rd Edition; Conners, 2008). The BASC-2 and BASC-3 were utilized as these were already collected data, some of which pre-dated common use of the BASC-3. Documents were coded for any reference to

one of the identified ACEs (i.e., physical, sexual, emotional abuse; mental health/addictions issues in the home; divorce/separation or death of caregiver; witnessing violence or abuse; imprisonment of household member; physical or emotional neglect; Felitti et al., 1998). Behavior measures captured the presence of externalizing behaviors occurring at *clinically significant* levels (i.e., T-scores of 70 or higher on scales involving aggression or conduct problems). Because the BASC measures identify hyperactivity as an externalizing behavior as well, clinically significant scores on these scales were documented. Following the first review of the data, two additional stressors relevant to historical trauma (Gone, 2009) were noted and coded for thereafter: inequitable or limited access to healthcare (i.e., primarily related to vision and hearing screening) and language (i.e., a child's primary language reportedly differed from that of close family members).

Semi-structured Interview Development. In Cree and Dene cultures, oral transmission of knowledge is privileged, so the use of conversational, qualitative data collection is a more culturally relevant method (Kovach, 2020). Composition of interview questions referenced past conversations with educators and parents on the reserve as well as the views of the colleagues of the first author who provided services to First Nations communities. The following topics were explored: how behavior is assessed, local barriers to engagement with mental health professionals, community perspectives on trauma, and views on local supports including services, traditions, community events, or other activities.

Procedure

Recruitment for the file review took place in schools located on two Northern Saskatchewan reserves, one Cree and one Dene. Parents or caregivers of children who expressed interest were given the option to discuss the study with the researcher and, if needed, access translator support; however, no one requested this service. Recruitment occurred in two phases. Initially, the first author invited contacts within the school division with whom rapport had been established, sharing her identity as a settler and psychologist committed to supporting local youth. Next, an email with an introduction and advertisement was sent to school staff, inviting interested individuals to contact the researcher. To provide a comparison group, educators from non-Indigenous rural communities (i.e., fewer than 10,000 residents) in Saskatchewan were recruited via Facebook using a modified advertisement inviting them to share their perspectives on supporting youth in their communities. Approval for Study Two was granted by the Meadow Lake Tribal Council (MLTC) and the University of Lancashire Science Research Ethics Committee.

Online interviews were audio recorded. While transcription focused primarily on content, some basic conventions based on those outlined by Jefferson (2004) were applied to identify pauses, overlapping or unintelligible speech, and laughter. Participants were given the opportunity to read and revise their transcribed interviews prior to inclusion in this paper.

Results

File analyses

Due to low participant numbers, behavior was collapsed into two types: externalizing (including aggression and conduct problems) and hyperactivity. A summary of the findings can be found in Table 2. Sixty-five percent of children had a reported history of at least one ACE ($k = 13$), usually involving the divorce or separation of caregivers, removal from the home, or absence of at least one parent. One had experienced the death of a caregiver, and two others had experienced either domestic or peer violence. Notably, all who had lost or been separated from a caregiver were residing with another custodial family member (e.g., grandparent) during the assessment. Just under half of the assessments identified externalizing behavior occurring at clinical levels ($k = 9$), of which 67% ($k = 6$) had also reported a prior ACE. Of the 10 children showing clinically significant hyperactivity, just over half had documentation of at least one ACE ($k = 6$). However, nearly identical numbers of students who were *not* identified as demonstrating externalizing or hyperactive behaviors had experienced ACEs ($k = 5$). In addition, nearly three-quarters of reports mentioned inequitable access to healthcare or to family members who spoke a traditional language, which the child did not ($k = 14$).

Interview data

Interview interpretation was informed by Indigenous methodology (Kovach, 2020) alongside Reflexive Thematic Analysis (Braun & Clarke, 2006, 2019). Thematic analysis steps (i.e., immersing in data, coding, theme development)

Table 2. Psychoeducational Reports: Presence of externalizing behavior, hyperactivity, and ACEs.

Variable	Any ACEs *n* (%)	Divorced/ Separated Caregivers *n* (%)	Death of/ Separation from Caregiver *n* (%)	Violence Exposure *n* (%)	*n*	Sample %
Gender						
Male	13 (72)	7 (39)	8 (44)	2 (12)	18	80
Female	0 (0)	0 (0)	0 (0)	0 (0)	2	20
Behavior						
Externalizing	6 (67)	4 (44)	3 (33)	1 (11)	9	45
Hyperactivity	6 (60)	3 (30)	3 (30)	1 (10)	10	50
Total	13 (65)	7 (35)	8 (40)	2 (10)	20	100

ACE = adverse childhood experiences.

were paired with reflexive practices, acknowledging the researcher's influence and positionality. Both frameworks stress awareness of biases: Western approaches highlight prior conceptual exposure, while Indigenous perspectives emphasize relationality and community responsibility. Their flexibility supported integration of narrative data. In keeping with relational ethics, all included content was contextually approved by participants. The reflects the need for settler researchers to bear particular responsibility to ensure accurate representation of participants' meanings and intent (Kovach, 2020).

Participants 1–4 were Cree and Dene educators who lived and worked on reserve in Northern Saskatchewan, while Participants 5–7 were non-Indigenous and living in rural Central or Southern Saskatchewan. Three superordinate themes, or categories, were identified in the interviews (see Figure 1), namely (a) Improving assessment and behavior supports, (b) Community challenges, and (c) Perspectives on treatment and healing.

Superordinate Theme One: Improving Assessment and Behavior Supports. Participants shared several ways to improve assessment and behavior supports, spanning data collection itself, relationship building, and identification of assessment obstacles. There were three subordinate themes, which are shown in the following sections.

Holistic Data Collection to Enhance Interpretation (1.1). Five participants mentioned changes to data collection, with three suggesting increased information from children and youth directly. Participant Three noted, "You have to be able to consider how they're feeling mentally, physically, you know?… We don't know where the child is coming from." Two participants emphasized repeated classroom observations, with Participant Six saying, "I think—like classroom observations are great, but one observation is just a super small picture of what maybe happens on a daily basis."

Obstacles to Assessment (1.2). Two First Nations participants shared concerns that assessment was intended to evaluate their parenting, with Participant Four reflecting, "Like that one lady said, 'You're trying to take away my kid!' I'm like, no. We're trying to help your kid, if anything." Three participants emphasized cultural considerations related to the assessments. Participant One, from a Northern Saskatchewan Dene community, said, "Questionnaires aren't culturally relevant […] sometimes [caregivers] don't understand the questionnaire," emphasizing further that, "That form [the BASC-3] is pretty daunting." Coming from a Southern Saskatchewan rural community, Participant Six shared similar thoughts, that is:

> […] We definitely have traditionally in education been very Eurocentric. And so, as we start seeing more students coming in, you know, with traumatic pasts, […] refugees, different languages being spoken. In the past, I feel like a lot of assessments have really negated those experiences or made them not as significant or like not valued them as much […] yet there are so many things […]that we might be missing just even on a cultural level.[…] you know, who created these tests? With whom in mind?

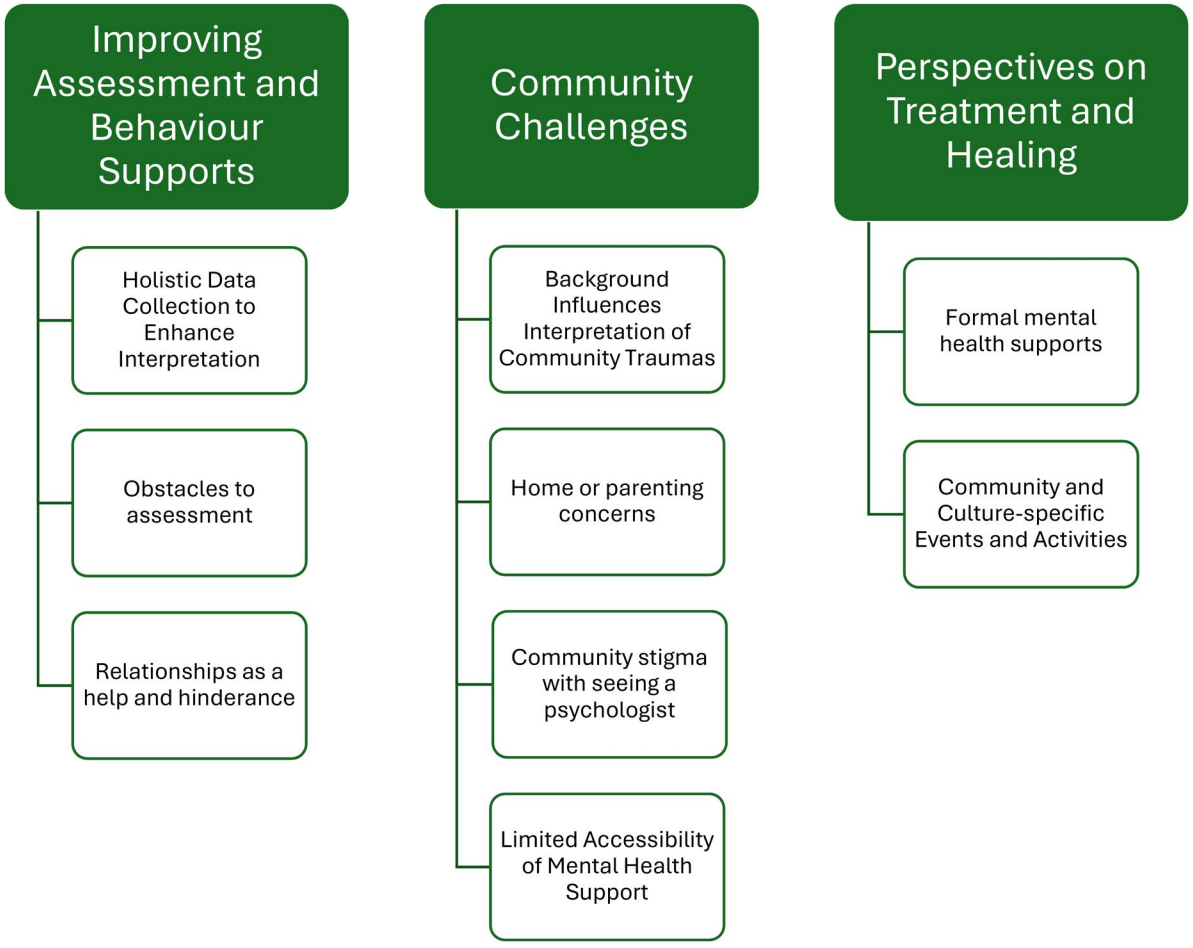

Figure 1. Interviews: summary of superordinate and subordinate themes. Figure shows the superordinate and subordinates themes that emerged from the interviews.

Relationships as a Help and Hindrance (1.3). Relationships were mentioned by five participants. Participant One said, "[The family] need to have a good working relationship with the whole school, not just with one teacher," and "[…] building relationships with the - within the families in the community, like, positively would be a good way." Participant Four encouraged, "More engagement [with families]—because it takes a while for them to even like—warm up to you," suggesting, "Maybe we could have like an evening where you bring them in […] bring dessert or supper or, you know?" Participant Three, speaking to the struggle of providing mental health services in one's own community said, "…sometimes as a community guidance counsellor, you're from the community, you're working with your people. You don't wanna—um—ruffle any feathers, maybe? Or open a can of worms [laughing], […] because you're related to everybody, right?" Participant Two noted this challenge as well, saying, "…if a student wanted to go talk to the counsellor and they're like, 'Oh, I don't - I don't get along with that person,' or 'I don't like their family,' or something - they don't have any other options."

Superordinate Theme Two: Community Challenges. A variety of community challenges were shared, captured by four subordinate themes.

Background Influences Interpretation of Community Traumas (2.1). The three non-Indigenous contributors all mentioned community traumas, typically in the form of unexpected losses. Participant Six commented:

> Like in my community specifically we have lost a number of students […] it was interesting because a small school, right? So, everybody knows everybody, the people that were really close to him were obviously feeling it, but even people who maybe weren't super close with him, but were like, "Wow, he was in my class."

Among First Nations participants, it was notable that only Participant Four mentioned any community traumas, saying, "…would residential school trauma go under that?" This may denote a common understanding of the existence of historical trauma within these communities—such that the negative impact of residential school is self-evident or unremarkable.

Home or Parenting Concerns (2.2). Difficulties related to home life and parenting were described by all four First Nations participants and one non-Indigenous interviewee.

> […] you go back to their family, one of them was just dealing with separation - their parents separating, and the other one they have really lots of people in their house and it's like overcrowded, and they don't get enough attention. (Participant Two)

In reserve communities, multi-generational households are not uncommon, and housing shortages can exacerbate overcrowding. Participant Three spoke of parenting challenges including a lack of attention or supervision, saying,

> … a lot of students go-go home after school and they have nothing to eat or they're not given routines, they're not expected to do chores or expected to, uh, you know? They're just—they just go back home and they're on their iPad or on their game and that's it […] Like they're on there for the rest of the night, and nobody's really caring about it.

They went on to focus on the prevalence of substance misuse, saying,

> …there's a lot of drugs and alcohol and stuff, and most families, probably, I would say 75% of our families in our community are probably affected by drugs and alcohol, and gangs […]it's like an everyday thing. "Oh, my parents are doing this. They're drinking all night last night," and, you know?

Community Stigma with Seeing a Psychologist (2.3). This was a topic raised by two participants. Participant Five spoke of the hesitation of some parents in consenting to an assessment, saying,

> the fact that other members in the community will know that their kid saw the psychologist, and for some reason there are lots of people who see that as a really bad thing […] in rural settings, um people are really protective of their privacy in-in some ways. So—and in a small community, now everybody knows your kid's seeing the psychologist. And they feel that's a stigma.

Participant Six concurred, saying, "I think stigma is still a thing […] but there doesn't seem to be as much of a stigma. […] I would say the older generation, that would still be some stigma about going and accessing a psychologist."

Limited Accessibility of Mental Health Support (2.4). Limited mental health supports were mentioned by all participants, with Participant One sharing, "No, there's not much resources in town. We live in a small area […] same with anybody that - resources too, I guess, right? Like even doctors." Discussing counseling services, Participant Two said, "It's that one person. Otherwise, they'd have to travel to the city." Participant Three spoke to the challenges associated with even trying to pull resources from other centers, saying, "…then when you try to make an appointment with mental health or somebody in [City 1] or [City 2], it takes weeks."

Superordinate Theme Three: Perspectives on Treatment and Healing. Participants were enthusiastic in sharing views on how to support youth in their communities through both mental health care and community-specific activities and events, highlighted by two subordinate themes.

Formal Mental Health Supports (3.1). Four participants outlined a need for and benefit of counseling services. Participant Two highlighted benefits of online counseling, citing the value of "[…] just having somebody to talk to and some coping tools to have." Participant Three emphasized art therapy in her Cree community, saying of the facilitator that, "students are open, more open to him."

Community and Culture-specific Events and Activities (3.2). Participants described several local approaches to well-being. Participant Two highlighted community programming:

> …everybody's always doing stuff together and it's nice. And the clinic is always putting on stuff for the kids like they have toddler gym night, they have – […] night for the kids, they do hangouts and stuff, and last night they had men's night. […] They have the community kitchen here too, and they do, like, cooking they have like themes every week….

Participant Two also outlined the role of the land, saying,

> When they go to the school cabin and stuff, they seem to really enjoy that, and I feel like that's therapy without being therapy. [laughing]. You know what I mean? Like doing stuff with your hands and, I guess, connecting with your body and with the land and stuff, it's kind of—it's healing in its own way.

Participant One also drew on somatic approaches, saying, "I think it's mostly being hands on, working with your hands. Because you heal—with your hands—you're healing your mind through keeping your hands busy…"

Similarly, all three non-Indigenous participants mentioned sports, with two focusing on the social benefits. Participant Five said, "that is a good connection because it often puts them in contact with a—with another safe adult. […] Often kids who are going through trauma develop a really strong relationship with their coach." Participant Six reiterated the social advantages, saying, "…a lot of people also go to [nearby city] to play their sports. Uh, to have something that might give them a sense of belonging that might help with behavior?"

However, some First Nations participants commented on the infrequency of cultural activities. Participant One said, "For 30 wk, we're in school, but only one week is culture week, you know what I mean?" Participant Three also spoke of disappointment in the limited run of these events, saying,

> I think it's a positive thing that they plan these activities, but they only go through these activities maybe once or twice and then they're done and the rest of the time—it's—I don't know, lost? […] During the school year, they have those activities maybe once a month.

Several First Nations participants highlighted the important role Elders or grandparents could play in supporting young people. Participant One said, "Like a cultural area too […] Elder support or an Elder room […] kids coming in, just visiting, knowing that there's someone there that's available to help talk to them." A less formal approach was echoed by other participants, with Participant Four noting,

> …maybe having a full-time grandma or grandpa in the building might be a-a good thing too for our kids. Because a lot of them don't have it, for whatever reasons, going back to, uh, residential school again, right? Have a lot of loss of parenting.

Five of the participants described cultural or community events and supports that were available locally or that they would like to see more of. For example, the school cabin, a feature of the Dene community, was identified as a place of cultural healing. Participant Four mentioned, "They have a sweat lodge there - they bring the kids in there too. So, I guess we're turning back to ceremony, and our traditional ways is one way."

Discussion

Implications and conclusions

The studies collectively provide insight into current mental health practices and limitations when providing behavior-focused treatment to culturally diverse, ACE-affected youth. Delphi participants endorsed adapting practice to the needs of the individual clients, though approaches were largely Western-centric. One participant referred to Gee and colleagues' (2014) Social and Emotional Wellbeing Model (SEWM), which recommends addressing mental health with reference to physical, spiritual, ancestral, familial, emotional, and psychological factors. This aligns with the four quadrants of the Medicine Wheel (Linklater, 2017), a common framework in North American Indigenous contexts. Overall, findings were consisistent with substantial evidence of Eurocentrism in mental health care (Gone, 2009).

Delphi respondents broadened the definition of culture to include identity, religiosity, and morality, underscoring the importance of interpreting behavior within a wider framework of cultural norms (Kirmayer, 2007). However, findings from Study Two showed this context is often missing in psychological intervention. Relational rigidity and disconnection of formal, Western assessment and counseling practices often clash with Indigenous ways of knowing and healing. In contrast, culturally congruent care may prioritize revitalization of cultural practices over Western style mental health services (Gone, 2023), emphasize informal, communal engagement (Linklater, 2017), and adopt holistic approaches that integrate physical, spiritual, emotional, and mental wellbeing (Gee et al., 2014).

Delphi respondents and interviewees consistently highlighted that externalizing behavior essentially functions as a communication strategy for individuals who lack adaptive ways to express emotions or needs. This view fits well with research linking 'chaotic' home environments, where healthy communication is rarely modeled, and increased externalizing behavior is evidenced (Bonner et al., 2020). First Nations interviewees expressed significant concerns about community-level trauma, such as addiction, mental illness, and gang violence, even though such issues appeared underreported in the formal assessments. However, the report and interview data both suggested high prevalence of ACEs generally, consistent with previous findings (Richards et al., 2021), with the most common experiences involving parental

separation and placement with other custodial family members. Indigenous familial systems intentionally integrate extended family more closely (Choate et al., 2020), and so separation from a parent may not carry the same impact across cultures. Nonetheless, the increased frequency of separation is decidedly rooted in systemic inequities and historical trauma (Gone, 2023).

Delphi responses emphasized how cultural differences could be addressed through intervention, for example through open discussion, consultation with someone who has expertise or experience with the young person's cultural background, and access to language supports. This approach reflects the strong emphasis First Nations interviewees in Study Two placed on relationship-building and particularly the involvement of extended family. Inviting collaboration from these individuals and facilitating their bonds is a way that psychologists and other mental health care providers could contribute to the goals of decolonization and wellness when working with Indigenous communities. Shifting attention away from solely psychological factors and toward the broader influences of community, family, and environmental influences fits more closely with a more collectivist, indigenized view of wellness (Burrage et al., 2022; Linklater, 2017).

Study One highlighted practitioners' awareness of both the necessity and inherent limitations of cultural competency, noting the importance of creating safe spaces for cultural expression and recognizing how ethnocentrism can hinder the therapeutic alliance. Study Two further illustrated this point through clear differences regarding the types of activities First Nations and non-Indigenous participants viewed as helpful in supporting youth struggling with trauma and behavior difficulties. While both valued formal mental health services, First Nations participants more often emphasized somatic, nature-based, and cultural practices. By contrast, while non-Indigenous participants also shared suggestions related to physical activity, their responses generally focused on sports, social belonging, and the role of a supportive coach. While First Nations participants' suggestions appeared to focus on the body-spirit connection and deep relational ties to the land, non-Indigenous respondents identified more cognitive and emotional benefits of physical activity. Indeed, healing and ceremony in Indigenous culture often centers connection between body, spirit, and land (Burrage et al., 2022; Linklater, 2017). Given the demonstrated importance of these strategies for improving well-being and health in Indigenous populations and specifically for First Nations youth (e.g., Snowshoe et al., 2015), these types of culture and community-based initiatives warrant meaningful support.

Limitations

Limitations of the research are unavoidable and should be acknowledged. Study One had low participation, possibly due to a narrowly defined scope

of practice, and initial questionnaires did not include non-Western wellness models as response options. Study Two also faced recruitment challenges owing to community transience and communication barriers. ACEs were not directly addressed in psychoeducational assessments and generalizability was limited, as assessments focused primarily on academic or behavioral issues. Lastly, the use of Indigenous methodology was constrained by the lack of community consultation prior to finalizing interviews. Future research should place more emphasis on direct community engagement and adopt more inclusive, culturally grounded frameworks.

Conclusion

Nonetheless, the results offer some initial valuable guidance for researchers and service providers working with culturally diverse groups, especially First Nations populations in Northern Saskatchewan. The Delphi study outlined common practices among experts treating externalizing behaviors in ACE-exposed youth, while also showing that many practitioners, despite recognizing the need for cultural adaptation, lacked awareness of non-Western healing models. Study Two further highlighted both shared and distinct youth needs across communities. One participant's reference to the term "cultural humility" aptly captured the necessity to balance self-education and acknowledging one's limits. Taken together, these studies highlight current practice limitations and point toward future directions, including deeper community engagement, more inclusive theoretical frameworks and the meaningful integration of Indigenous perspectives.

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Author contributions

CRediT: **Lisa Gaylor**: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing; **Jane L. Ireland**: Conceptualization, Methodology, Resources, Supervision, Writing – original draft, Writing – review & editing; **Simon Chu**: Conceptualization, Methodology, Supervision, Writing – original draft, Writing – review & editing.

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Data availability statement

The data that support the findings of this study are not publicly available due to privacy and ethical restrictions. Ethical permission does not permit this.

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