

University of Wisconsin Milwaukee UWM Digital Commons

Theses and Dissertations

May 2013

The Service and Re-Entry Needs of Juvenile Offenders: American Indian Girls Impacted by Sexual Trauma

Rae Anne Marie Frey
University of Wisconsin-Milwaukee

Follow this and additional works at: <https://dc.uwm.edu/etd>

 Part of the [Cognitive Psychology Commons](#), [Criminology Commons](#), and the [Indigenous Studies Commons](#)

Recommended Citation

Frey, Rae Anne Marie, "The Service and Re-Entry Needs of Juvenile Offenders: American Indian Girls Impacted by Sexual Trauma" (2013). *Theses and Dissertations*. 97.
<https://dc.uwm.edu/etd/97>

This Thesis is brought to you for free and open access by UWM Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of UWM Digital Commons. For more information, please contact open-access@uwm.edu.

THE SERVICE AND RE-ENTRY NEEDS OF
JUVENILE OFFENDERS: AMERICAN INDIAN GIRLS
IMPACTED BY SEXUAL TRAUMA

by

Rae Anne M. Frey

A Thesis Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Master of Science

in Educational Psychology

at

University of Wisconsin – Milwaukee

May 2013

ABSTRACT
THE SERVICE AND RE-ENTRY NEEDS OF JUVENILE OFFENDERS: AMERICAN
INDIAN GIRLS IMPACTED BY SEXUAL TRAUMA

by

Rae Anne M. Frey

The University of Wisconsin – Milwaukee, 2013
Under the Supervision of Professor Leah M. Rouse Arndt, Ph.D.

American Indian (AI) youth experience incarceration (Bureau of Justice Statistics, 2011; Easy Access to the Census of Juveniles in Residential Placement, 1997-2010) and sexual abuse (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Ellison, 2005; Hamby, 2008; Robin, 1997) at disparate rates in the United States. The present qualitative project utilized Extended Case Method to explore the service and re-entry needs of AI girls who are juvenile offenders and have been impacted by sexual abuse. This project includes secondary data detailing 58 cases of detained AI girls at a state-run female juvenile detention facility in the Midwest. Results indicated 26 of the 58 (45%) AI girls reported sexual abuse and 47 of the 58 (81%) girls reported involvement in ‘consensual’ sex before the age of 18. Findings revealed a need for comprehensive data collection procedures within correctional facilities as well as a need for trauma-informed prevention, intervention, and post-vention services. Specific service needs included culturally congruent care including advocacy around tribal enrollment and eligibility, psychoeducation around consent for sexual activity and gynecological health, trauma-informed physical health services including gynecological care, and trauma-informed mental health assessment and programming.

TABLE OF CONTENTS

CHAPTER	PAGE
I: Introduction.....	1
II: Literature Review.....	4
Historical Trauma.....	5
Incarceration.....	9
Lifetime Trauma.....	10
Sexual Trauma.....	11
Physical Health Disparities.....	13
Mental Health Disparities.....	14
III. Methodology.....	16
Participant/Sample Characteristics.....	18
Instrument.....	18
Research Team.....	18
Academic Team Biases.....	19
Procedure.....	20
Procedural Reflexivity and Trustworthiness.....	20
Data Analysis.....	21
IV. Findings.....	21
Reported Sexual Abuse.....	22
Age of First Sexual Abuse.....	22
Nature of Sexual Abuse.....	23
Relationship of the Perpetrator.....	24
Tribal Membership Reported.....	25
Reported Family History of Sexual Abuse.....	26
Statutory Sexual Assault.....	26
Age at First Statutory Assault.....	26
Age of Statutory Perpetrator.....	27
Number of Statutory Perpetrators.....	29
Gender of Statutory Perpetrators.....	29
Reported Sexual Abuse History.....	30
Tribal Membership Reported.....	30
Runaway History.....	30
History of Sex Trafficking.....	31
Gynecological Treatment Needs.....	32
Reported Sexual Abuse History.....	32
Statutory Sexual Assault History.....	32
No Reported Sexual History.....	33
Sexually Transmitted Disease History.....	33
Pregnancy History.....	34
Mental Health Diagnoses.....	34

CHAPTER	PAGE
Reported Sexual Abuse History.....	35
Statutory Sexual Assault History.....	35
No Reported Sexual History.....	36
Tribal Membership Reported.....	37
V. Discussion.....	38
Missing Data.....	39
Trauma-Informed Care.....	41
Trauma-Informed Prevention.....	42
Trauma-Informed Intervention.....	42
Gynecological Health Service Needs.....	42
Mental/Behavioral Health Service Needs.....	43
Trauma-Informed Post-vention.....	44
Historical Trauma-Informed Service Provision.....	44
Limitations.....	45
Implications.....	45
Future Research.....	47
VI. References.....	49
VII. Appendices.....	57
Appendix A: Protocol for Data Collection.....	57
Appendix B: Table B1 and B2.....	60

The Service and Re-Entry Needs of Youthful Offenders:

American Indian Girls Impacted by Sexual Trauma

American Indian (AI) persons are incarcerated at disparate rates in the United States (Bureau of Justice Statistics, 2011). In the Midwestern state where this project took place, in 2007, the rate of incarceration for AI youth was 4.5 times that of White youth (Easy Access to the Census of Juveniles in Residential Placement, 1997-2010). For young women and girls, risk factors for delinquency include family issues, substance abuse, gangs or fighting, sexual, physical, and emotional abuse, and running away from home (Bloom, Owen, Rosenbaum, & Deschenes, 2003). Of particular interest to this project, is the rate of sexual abuse within the population of AI girls who are juvenile offenders. A juvenile offender is defined as a person under the age of 18 who has committed a crime or delinquent act that has led to his/her detention or incarceration in a youth correctional facility. In their seminal work exploring the adverse childhood experiences (ACE) of incarcerated American Indian/Alaska Native (AI/AN) women, de Ravello, Abeita, and Brown (2008) found that over half of the women had experienced sexual abuse prior to their incarceration. Similarly, in an unpublished study examining the service and advocacy needs of AI juvenile offenders in New Mexico, Parker, Kipp, and Dine'Chacon (2007) found that over 60% of the girls had been sexually abused.

Young women and girls who have been sexually abused are significantly more likely to run away from home before the age of 16 (Curtis, Leung, Sullivan, Eschback, & Stinson, 2001) and to abuse substances (Goodkind, Ng, & Sarri, 2006). This becomes problematic for AI girls who already experience disparate rates of sexual trauma as a group (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Ellison, 2005;

Hamby, 2008; Robin, 1997), given the population's historical legacy of colonization. Both historical and proximate events can affect AI girls who may become incarcerated for behaviors (e.g. running away) that are intended to escape the abuse and/or disparity conditions created by colonization (Goodkind et al., 2006).

The disproportionate rates of sexual trauma and incarceration are not easily understood without their historical context within AI populations, as well as an understanding of the resultant disparities. Historical trauma has been characterized as trauma within a population with effects that accumulate over time and are transmitted intergenerationally (Brave Heart-Jordan, 1995). The historical trauma experienced by AI persons as a result of colonization has laid the foundation for centuries of health and social disparities in the population (Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998) including disparities in physical health, mental health, poverty, lifetime trauma, and incarceration.

Researchers have suggested that historical trauma as a result of colonization pressures may be the root of the high rates of physical illness in AI populations (Duran et al., 1998). In fact, AI persons have a life expectancy of 5.2 years less than the general U.S. population in part due to disparate rates of physical illnesses including: tuberculosis, diabetes, and pneumonia/influenza (Indian Health Service, 2011). The underlying cause for the disparate rates of mental health problems in AI populations may also be attributed to historical trauma (Duran et al., 1998; Evans-Campbell, 2008). AI persons experience alarmingly high rates of anxiety and mood disorders, substance abuse disorders, and suicidality (Manson, Beals, O'Neil, Bechtold, Keane, & Jones, 1996). Duran et al., (1998) suggested that historical trauma may be the cause of the high rates of alcohol

abuse among AI populations, with alcohol induced deaths accounting for 43 deaths per 100,000 AI persons each year compared to seven for the general population (Indian Health Service, 2011). As alcohol use is also a risk factor for juvenile delinquency (Bloom et al, 2003) and is a risk factor for and a consequence of sexual assault (Goodkind, Ng, & Sarri, 2006), one can see how tightly interwoven historical trauma is with physical health, mental health, and social disparities.

As a result of colonization, American Indians also face many barriers to adequate health care including historically wavering government health care systems (Warne, 2011), limited access to the Indian Health Service for those living off reservation (Office of Minority Health & Health Disparities, 2012; Warne, 2011), and poverty (Office of Minority Health, 2012). In 2010, the median income for AI/AN persons was \$39,664 compared to \$67,892 for White persons, 28% of AI/AN persons lived at or below the poverty level compared to 10.6% of White persons, and nearly 30% of AI persons were uninsured (Office of Minority Health, 2012).

These disparities set the stage for the disproportionate rates of trauma experienced by AI persons for a variety of events. In a study conducted with 3,084 AI participants, Manson, Beals, Klein, Croy, & the AI-SUPERPPF Team (2005) found a 62.4% - 69.8% lifetime prevalence of exposure to a traumatic event. Researchers have found that nearly half of young AI women have experienced some form of sexual trauma (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Robin, 1997). Rates of sexual trauma are similar among incarcerated AI girls (de Ravello et al., 2008; Goodkind, Ng, & Sarri, 2006).

An examination of historical trauma and the subsequent health and social disparities experienced by AI persons illuminates the complexity of the issues faced by AI girls who arrive at detention and/or correctional facilities. The justice system and corrections settings often act as the first-time gatekeeper of mental and medical health services for AI youth who are detained and incarcerated there (Manson, 2000). This fact begs the question: “What are the service and re-entry needs for AI girls who have been impacted by sexual trauma, particularly as related to culturally-congruent service provision?”

The present work explored the experiences of AI girls who are juvenile offenders and have been impacted by sexual trauma in order to gain insight into their service needs upon entry related to medical, behavioral, and mental health, education, and social services.

Literature Review

American Indians are overrepresented for incarceration in the United States (Curtis et al., 2001; Siegel & Williams, 2003; McGrath, Nilsen, & Kerley, 2011; Robin, 1997) and also experience disparate rates of sexual trauma (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Ellison, 2005; Hamby, 2008; Robin, 1997). Little research exists that specifically examines the experiences of AI girls who are incarcerated or detained. In one unpublished study, Parker, Kipp, and Dine’Chacon (2007) explored the service and advocacy needs of incarcerated AI youth in New Mexico. They found that AI youth had low educational attainment, were placed in special education at disparate rates, began using substances on average at 11 years of age, struggled with a variety of mental health concerns, and experienced high rates of physical and sexual

abuse. de Ravello et al. (2008) examined the adverse childhood experiences among incarcerated AI women and provided insight into their past experiences. While this information is important, symptoms of sexual trauma manifest differently in adolescence and the needs of adult women may be different than the needs of young girls. Other researchers and institutions who have reported findings for AI girls tend to lump AI persons into artificial categories such as “Non-White” (Goodkind et al., 2006) and “other” (Morris et al., 1995) or miscategorize their racial/ethnic identities (Parker, Kipp, Dine’Chacon, 2007) which provides a diluted image of the experience of AI girls who are incarcerated or detained. What the literature does tell us is that AI girls experience trauma at alarmingly high rates (Jones et al., 1997; Kaufman et al., 2004; Manson et al., 1996) and suffer the consequences of trauma throughout their lifetimes. This literature review specifically examines the way American Indian girls are affected by sexual trauma, with an emphasis on the AI worldview regarding the implications of colonization, or historical trauma.

Historical Trauma

Duran (1990) was the first to publish on the concept of soul wound. He articulated the traditional AI perspective that colonization pressures have unleashed negative symptomology upon AI populations in the form of a multitude of disparities and negative outcomes. He conceptualized soul wound as the individual and collective traumatic response to colonization, which is experienced both in its historical perspective and in real-time, and is healed via communal recognition and ceremony. Brave Heart-Jordan (1995) expanded upon the soul wound perspective and the concept of historical trauma as the “collective and compounding emotional and psychic wounding over time,

both over the life span and across generations...the trauma is multi-generational and not limited to the life span” (p. 6). American Indians continue to experience the traumatic effects of colonization including: community massacres, genocide of people and culture, diseases, forced relocation, loss of children to boarding schools, the dumping of contaminated and radioactive materials on tribal lands, flooding of homelands, (Evans-Campbell, 2008) and systemic racism, discrimination, and oppression (Duran & Duran, 1995). According to Evans-Campbell (2008), historical trauma impacts the mental health of individuals, impairs family communication, and increases parental stress. Further, Duran et al. (1998) suggest that historical trauma includes cultural genocide within AI populations, the loss of traditional rites of passage, internalized racism, and high rates of physical health disparities, posttraumatic stress disorder, suicidality, and alcoholism. Historical trauma, namely the sexual assault perpetrated in slavery and boarding schools, also accounts for the legacy of sexual abuse. When paired with the loss of puberty—or specifically women’s rites, these assaults can leave AI girls and women without means of healing in their cultural or traditional ways.

Sexual abuse was introduced to AI populations during the first phase of colonization which included enslavement of AI persons and sexual exploitation. Centuries later, sexual abuse at the hands of the colonizers was systemically perpetrated in AI populations at boarding schools adding to the cumulative stress accrued by AI populations. The boarding school movement traumatically removed children from their families, stealing their parental rights and ability to enculturate their children. In a case study conducted by Maupin and Maupin-Bond (2005) participants explained that entire generations of AI parents never learned how to parent as “[b]oarding schools severed the

lines of how these kids were raised” (p. 77). Sadly, boarding schools often relied upon harsh physical punishment, a method of discipline uncommon in most tribes and AI children were sexually abused at high rates (Horejsi, Heavy Runner Craig, & Pablo, 1992). The boarding schools introduced methods of authoritarian, institutionalized parenting that would not have been learned had the children stayed with their tribes. These dynamics are transmitted intergenerationally and continue to impact parenting and AI youth today (Horejsi, Heavy Runner Craig, & Pablo, 1992; Maupin & Bond-Maupin, 2005).

The enslavement of AI persons, the subsequent sexual exploitation, and the removal of children from AI communities are a few examples of the many transgressions committed against AI populations by the U.S. government. The government, in an attempt to atone for these atrocities, set up treaty agreements in exchange for tribal lands and promised certain rights to AI persons including the right to health care (Warne, 2011) and the right to tribal jurisdiction (Ellison, 2005). American Indians continue to honor the treaty agreements made by their ancestors, for example, serving at high rates in the military; however, the U.S. government wavers in fulfilling its end of the bargain.

The areas of health care and tribal jurisdiction are particularly important when examining the barriers to treatment faced by AI girls. Although the right to healthcare was part of treaty agreements, historically, government spending on healthcare for AI persons has been lower than for any other federally funded entity, including prisoners. Expenditures for 2005 included \$7,631 for Medicare, \$5,234 for Veteran’s Administration benefits, \$5,010 for Medicaid recipients, \$ 3,985 for prisoners in the Federal Bureau of Prisons system, and a mere \$2,130 to the Indian Health Services

(Warne, 2010). Approximately 50% of AI persons do not live on tribal lands and therefore do not have immediate access to Indian Health Services (Office of Minority Health & Health Disparities, 2012) further limiting their care. These persons are forced to interface with multiple healthcare systems, including Medicaid, and often fall through the cracks in the process (Warne, 2011). In 2010, nearly 30% of AI/AN persons were uninsured (Office of Minority Health, 2012) adding increased barriers to treatment for the mental and physical wounds caused by historical and subsequent traumas (e.g. sexual abuse).

The U.S. government has also created barriers for AI communities to handle crimes on tribal lands as historically, tribal jurisdiction does not apply to non-AI persons, even if the crime was committed on tribal lands (Ellison, 2005). This is problematic as most crimes committed against AI persons are committed by non-AI persons (Bubar & Thurmsan, 2004; Ellison, 2005). This makes reporting crimes of sexual assault and violence particularly tricky, as a small percentage of perpetrators are actually prosecuted in the general population, and AI persons have to report to cultural outsiders who may not be knowledgeable about or sensitive to cultural differences. In 2013, the current administration passed the Violence Against Women Reauthorization Act. After centuries of domestic and sexual violence perpetrated against AI women, AI tribes are just now being granted the right to wholly investigate, prosecute, convict, and sentence non-Indians partners who assault an AI. However, tribes will unlikely be able to prosecute non-Indian abusers until March of 2015. Also, while the act covers violence between partners living on reservation, it does not extend the same rights to assaults by non-Indian strangers or assaults that occur off reservation (U.S. Department of Justice, Tribal Justice

and Safety, 2013). Historically, if AI girls are unable to safely report crimes committed against them and are unable to afford adequate health care, it is no wonder they turn to other, sometimes illegal, behaviors as an outlet to escape their pain.

American Indians have been subjected to massive group trauma which has greatly changed their way of life. The majority culture has done little to remedy the problems created at the hands of colonization and a context of blaming the victim continues. This historical trauma has become a risk factor for future incarceration, lifetime trauma, and physical and mental health problems.

Incarceration

Women and girls who have experienced sexual abuse are incarcerated at higher per capita rates than women and girls who have not (Curtis et al., 2001; McGrath et al., 2011; Robin, 1997; Siegel & Williams, 2003). A number of authors have hypothesized that girls are being arrested for behaviors that are intended to avoid the abuse. For example, childhood sexual abuse is related to running away which is a status offense that can lead to incarceration (Bloom, Owen, Rosenbaum, & Deschenes, 2003; Curtis et al., 2001; Goodkind et al., 2006; Siegel & Williams, 2003). Siegel and Williams (2003) found that in their sample of 411 incarcerated women, of those who had been arrested for running away, all but one had been sexually abused. Similarly, young women who run away from home may need to rely on ways of surviving that are illegal, such as prostitution (Widom, 1996) or stealing. In addition, survivors of sexual trauma use drugs and alcohol at high rates which can also lead to arrests.

According to the U.S. Census Bureau (2010), AI persons make up about 0.9% of the total United States population, yet over half of the youth involved in the federal courts

in 2008 were AI youth (Bureau of Justice Statistics, 2011). In 1999, for every 100,000 AI youth, 632 were involved in corrections. This is over three times the number of White youth who were placed in custody during the same time period, and higher than any other racial minority besides African American youth (Office of Juvenile Justice and Delinquency Prevention, 2004).

Lifetime Trauma

American Indians experience trauma at higher rates than their U.S. counterparts (Manson, Beals, Klein, Croy, & the AI-SUPERPPF Team, 2005) which includes acute, episodic, and chronic stressors. According to the American Psychological Association (2013), acute stressors are short term and are the most common form of stressors, episodic acute stress is the frequent occurrence of acute stressors, and chronic stress is the on-going experience of a stressor with an unforeseeable way to escape. In an examination of four studies conducted by the National Center for American Indian and Alaskan Native Mental Health Research, Manson et al., (1996) found overall prevalence rates of trauma for AI adolescents to be between 50 and 60 percent. Other researchers have found similar rates of trauma in AI populations (Jones, Dauphinais, Sack, & Somervell, 1997; Kaufman, Beals, Mitchell, LeMaster, & Fickenscher, 2004). In 2005, Manson et al. conducted a study with 3,084 AI participants and found 62.4% - 69.8% lifetime prevalence of exposure to a traumatic event. Female tribal members reported more interpersonal trauma (e.g. physical abuse) and were raped and sexually assaulted more often than men. Female tribal members witnessed traumatic events occurring to loved ones and experienced physical attacks more than the general U.S. population (Manson et al., 2005). In another study of 247 AI participants, researchers found that

over 40% of the women had experienced physical assault (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Similarly, Evans-Campbell, Lindhorst, Huang, and Walters (2005) found that 65.5% of AI/AN women in their sample had experienced some form of interpersonal trauma. Pavkov, Travis, Fox, King, and Cross (2010) found that 11.56% of American Indian/Alaskan Native (AI/AN) youth reported having been hurt by their significant other in the past 12 months. Other traumatic experiences include poverty, suicide attempts or exposure to completed suicides in adolescents, domestic violence, (Willmon-Haque & BigFoot, 2009), and automobile accidents (Management Services for Health, 2012).

Compared to the general population, AI females have a heightened lifetime prevalence of posttraumatic stress disorder (Beals et al., 2005; Robin et al., 1997) and are less likely to seek treatment from medical providers (Beals et al., 2005). Also, over 60% of AI adolescents have experienced at least one traumatic event (Jones et al., 1997; Kaufman et al., 2004; Manson et al., 1996), with female adolescents reaching a prevalence rate as high as 66% (Manson et al., 2005). In their seminal work examining adverse childhood experiences (ACEs) in the incarcerated population of American Indian/Alaskan Native (AI/AN) women, de Ravello et al. (2008), found that all but one woman in their sample had experienced at least one adverse childhood experience, with 81% having had two or more adverse child experiences.

Sexual trauma. American Indian girls and women experience sexual trauma at alarmingly high rates. Rates of childhood sexual abuse among AI women have been found to be between 49% (Robin, 1997) and 58% (Bachman et al., 2010). Further, one-third of AI women are survivors of rape (Ellison, 2005; Hamby, 2008). The rates of

sexual trauma among the population of incarcerated women are also startlingly high. Among the general population of incarcerated women, approximately half have been sexually abused (Simoni, Sehgal, & Walters, 2004) with other researchers finding rates between 32% (Goodkind et al., 2006) and 45.6% (Morris et al., 1995). Similarly, rates of sexual abuse among incarcerated AI girls have been found to be between 32% (Goodkind et al., 2006) and 53% (de Ravello et al., 2008). In an unpublished study, Parker et al. (2007) examined the experiences of AI youth who were incarcerated in New Mexico and found that over 60% of the girls had been sexually abused.

The consequences of sexual trauma are well documented. Girls who have experienced childhood sexual abuse are more likely to have sex before the age of 18 (Curtis et al, 2001; Goodkind et al., 2006; Robin, 1997), are more likely to have multiple sexual partners (Curtis et al., 2001; Goodkind et al., 2006; Kaufman et al., 2004), and are more likely to engage in risky sexual behaviors in general (Goodkind et al., 2006) including prostitution (Widom, 1996). Childhood sexual abuse is related to dropping out of school (Curtis et al., 2001), having multiple school problems, being expelled from school (Goodkind et al., 2006; Robin, 1997), and running away from home (Goodkind et al., 2006; Robin, 1997; Widom, 1996). Girls who have been sexually abused are more likely to use substances (de Ravello et al., 2008; Goodkind et al., 2006; Robin, 1997) and have increased mental health problems including depression, suicidality (Goodkind et al., 2006), antisocial personality disorders, affective disorders, anxiety disorders and posttraumatic stress disorder (Robin, 1997). It comes as no surprise that AI girls are engaging in behaviors, as outcomes of their historical and lifetime traumatic experiences, which are leading to their detentions and/or incarcerations.

Physical Health Disparities

American Indians have a life expectancy of 5.2 years less than the general U.S. population (Indian Health Service, 2011). AI youth are twice as likely to die as the general population of 0 – 24 year olds. Suicide is a leading cause of death for this age group, with 14 – 24 year old AI persons being twice as likely to complete suicide as other 14 – 24 year olds (Management Services for Health, 2012). AI persons are significantly more likely than other ethnic groups to die from an alcohol induced death, tuberculosis, diabetes, unintentional injuries, suicide, homicide and pneumonia/influenza (Indian Health Service, 2011).

The U.S. government is obligated, through treaty agreements to provide health care for AI persons. The government has created the Indian Health Service (IHS) to provide care for AI/AN persons; however, with half AI/AN persons living off reservation, access to IHS is limited (Office of Minority Health & Health Disparities, 2012). Medicare has been relied upon for AI persons living off reservation and in extreme poverty. However, there have been periods of time that, despite treaty agreements, AI/AN persons have been billable for Medicare due to the non-renewal of the Indian Health Care Improvement Act (Rouse-Arndt, Under Review). Although the U.S. government has legally contracted to provide health care to AI persons, in 2010 nearly 30% were uninsured and 41% carried private insurance (Office of Minority Health, 2012). This is another example of the ramifications of historical trauma and the barriers AI persons still face.

Mental Health Disparities

American Indians have higher rates of mental health disparities than the general U.S. population. In their seminal work investigating the probability and severity of psychiatric impairment in an AI village, Shore, Kinzie, Hampson, and Pattison (1973) found that 54% of the participants qualified for a rating of “definite psychiatric disturbance” and 15% qualified for “probable psychiatric disturbance.” Over 30% were judged to be moderately to severely impaired due to their disturbances. The younger the adult, the more likely they were to qualify for a psychiatric disturbance and be impaired. For the 27% who were diagnosed with alcoholism, most had experienced trauma. Eighteen percent (mostly women) of participants had experienced psychoneurotic reactions and 15% (mostly women) had peptic ulcers, compared to 3% of the general population. Shore et al.’s (1973) work stimulated research with AI populations that has spanned decades and has provided a more accurate picture of the mental health disparities in AI populations. Many of these mental health disparities have been found to be correlated with the experience of trauma to include posttraumatic stress disorder (PTSD) (Beals et al., 2005; Robin et al., 1997), conduct disorder (Kunitz et al., 1999; Manson et al., 1996), anxiety and mood disorders (Jones et al., 1997; Manson et al., 1996), substance abuse disorders (Jones et al., 1997; Kinzie et al., 1992; Mason et al., 1996; Shore et al., 1973), behavior disorders (Jones et al., 1997), risky sexual behavior (Kaufman et al., 2004), and suicidality (Mason et al., 1996). In their study of incarcerated AI/AN women, de Ravello et al. (2008) found that 36% of the women had a mental health diagnoses. Further, the majority of women had used alcohol or drugs in their lifetimes, with 54% using alcohol before the age of 15. Other researchers have also

found that substance abuse is a risk factor for incarceration (Ashberg & Renk, 2012; Bloom, Owen, Rosenbaum, & Deschenes, 2003). In a study of 120 juvenile offenders, Lyons, Baerger, Quigley, Erlich, and Griffin (2001) found that mental health problems, including substance abuse, were significant risk factors for incarceration.

After centuries of undertreated mental health disparities, under the new healthcare reform, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), the current administration attempts to address these concerns by developing a comprehensive treatment plan for AI persons, including behavioral and mental health treatment, whether they live on or off reservation. Changes will see increased funding for specific programs targeting AI women and children to reduce the rates of domestic abuse, sexual violence, and suicide completions, including the use of telehealth technology (Rouse-Arndt, Under Review).

American Indians face physical health, mental health, and social disparities as a result of the historical trauma experienced beginning with the colonization of their lands. AI youth have inherited the consequences of historical trauma and continue to face the disparities of their ancestors. Although much research exists examining the prevalence of these disparities in AI populations, little research exists that specifically addresses the disparities in incarceration and sexual trauma, particularly for AI girls. In their unpublished study, Parker et al. (2007) explored the service needs of incarcerated AI youth in New Mexico. They found that AI youth had low educational attainment, were placed in special education at disparate rates, began using substances on average at 11 years of age, struggled with a variety of mental health concerns, and experienced high rates of physical and sexual abuse. Although this research is known to a community of

insiders, the work was unable to be published and widely distributed, given the political implications of results.

The current research project examined the service and re-entry needs of AI girls who are juvenile offenders and have been impacted by sexual trauma through the qualitative analysis of 58 cases of AI girls incarcerated in a Midwest detention facility. Secondary data detailing cases for the 58 AI detained girls were provided by the community partner. The data include case abstraction of all services rendered to all identifiable AI girls detained at a state-run facility in the Midwest. Data include services provided for 10 years prior to the start of this project for education, social service, justice, and medical, behavioral, and mental health records. Case notes within the records were written by clinicians and others providers at the detention facility. Specific research questions include the following: What were the sexual abuse experiences of the AI detained girls; what medical services did the AI detained girls who reported sexual abuse require; what behavioral health services did they require; what social service needs did they require; and what were the unique cultural needs of the AI girls who reported sexual abuse?

Methodology

Extended Case Method, developed by Michael Burawoy (1991; 1998), was selected for this project because its process of data collection is congruent with AI ways of knowledge gathering (Arndt & Davis, 2011). ECM considers all sources of relevant information and is not constricted by time or space (Burawoy, 1998). ECM researchers, then, study the everyday world, through comprehensive contextual case studies, utilizing information from the past and present. Case studies are appropriate for populations who

have been underserved and topics that have been under-researched (Arndt & Davis, 2011). Further ECM is appropriate for AI girls who may struggle with understanding and disclosing sexual trauma histories. By triangulating several sources of data (medical records, self-reported sexual contacts, and self-reported sexual abuse history, historical records, etc.) a broader, more complex picture of the girls' sexual histories appears.

ECM researchers acknowledge that their role can never be that of a true insider-participant. Researchers come to the table with innate power differentials and biases that influence and intervene within systems and contexts, as well as areas of expertise to guide the research process. ECM responds to these dynamics by insisting researchers use the principles of reflexivity (there are many ways of knowing) and triangulation which serve to establish trustworthiness and credibility throughout the process (Burawoy, 1998).

ECM is unique in qualitative traditions in that it uses both inductive and deductive processes based on the needs and permissions of the population. A primary aim of the ECM is to confirm or re-construct existing theories as indicated by project findings with the populations and to construct new theoretical approaches as necessary. Although an understanding of existing theories is important, theory of methodology in ECM does not drive the data gathering process; ECM researchers gather data depending on the needs, suggestions, and desires of the population. Unlike positivistic approaches which discard divergent or 'negative' cases as outliers, ECM researchers attempt to understand variation by focusing on the outliers (Burawoy, 1998). These differences provide rich information in examining existing theory, and can guide the development of new theories in some cases.

Participant/Sample Characteristics

This project included secondary data detailing 58 cases of detained or adjudicated AI girls at a state-run female juvenile detention facility in the Midwest. Case files consisted of all medical, behavioral, and mental health records, as well as, all social service, education, and justice system files available on the individuals. The sample included all identifiable cases of AI females at the site between 2000 and 2010.

Instrument

A comprehensive data protocol form was utilized to record information from case files. The protocol used by Parker et al. (2007) provided the foundation for the protocol used in this project and was further developed in consultation with a group of eight detained AI girls at the partner site. Protocol domains included: demographic information, status of each biological parent, history and characterization of out-of-home placements, educational history, substance use history, gang affiliation, history of physical abuse, history of sexual abuse, history of sexual contacts and pregnancy, physical and mental health history, treatment history, access to spiritual/cultural resources, and family history of detention/incarceration, foster care, adoption, mental health, domestic violence, substance use/abuse, and sexual abuse (See Appendix A). The protocol captured the clinician and provider notes as the data used for this project.

Research Team

The academic research team consisted of researchers. The primary researcher is a White woman, graduate student in Educational Psychology/Community Counseling whose research and practicum experiences have focused on sexual trauma. The academic advisor is a Métis woman, Counseling Psychologist specializing in trauma with forensic

populations and consultation for the AI community in regards to culturally competent research practices, intergenerational historical trauma, and cross-cultural issues in service delivery. The third member is a Mexican-American/Navajo woman, Counseling Psychologist specializing in depression, identity development and group dynamics using community based participatory research model. The fourth member is a White doctoral student in Counseling Psychology completing her practicum experience at the community site. The fifth member is a Ho Chunk woman, undergraduate student in community education. The academic team worked closely with the corrections partner team, which included the Director of Medical Services, the Chief Psychologist, a Doctoral Counseling Psychology Practicum Student, and the Superintendent. Additionally, an insider advisory group of eight AI detained girls provided guidance to the team in design development and data collection.

Academic Team Biases

The primary investigator brings her experience as an urban teacher, member of the military, and counselor in training. Her primary interest is trauma research, specifically sexual trauma. The academic research advisor brings her cultural experiences as a Métis woman which include a personal, familial, and ethnic experience of intergenerational historical trauma. Additionally, she has worked in a number of professional capacities including law enforcement and education. She has extensive training and research experience using ECM. The researcher who identifies as a Mexican-American/Navajo woman also brings her cultural experiences as a member of two historically marginalized groups. Her work tends to focus on social justice with marginalized groups using the community based participatory research model. The

doctoral student has worked extensively with marginalized populations, particularly AI youth and sexual-identity minority youth. The team member who identifies as a Ho Chunk woman also brings her cultural experiences as a member of an AI community and a knowledge of trauma. While the cultural backgrounds and academic interests of each team member could introduce biases into the process, the identities intersect to cover a diverse spectrum of demographic and cultural identities, as well as, academic knowledge. As a team there is insider experiential knowledge of AI populations and expert knowledge in the areas of sexual trauma, AI populations including AI youth, law enforcement, and education. The diversity in the team allows for triangulation which establishes trustworthiness and credibility throughout the process.

Procedure

Deidentified secondary data were provided to the research team by the corrections partner. Data were presented for each case using the project data protocol form. The secondary data set included all identifiable cases at the partner site, for a 10-year time span. Data were sorted into the NVivo analysis program according to the deductive themes included in the form, and cross-checked twice. Quotations used throughout this paper represent the clinicians' and providers' case notes regarding services to the participant cases that were included in the records at the detention facility.

Procedural Reflexivity and Trustworthiness

Three team members cleaned the data in NVivo to ensure triangulation of data inclusion. Team members met throughout the analysis process to debrief, unfold the reflective and reflexive procedures, and explore biases. All team member notes and journaling were also included as data in the final analysis phase.

Data Analysis

De-identified, secondary data were analyzed by the research team for themes and trends in the qualitative and categorical data in respect to American Indian girls' biopsychosocial programming and reintegration needs. The ECM provided the guiding theoretical framework for analysis. Data sorted into deductive themes were also analyzed inductively for additional themes, categories, and possible subcategories. Analysis also included a final review of the literature to examine any relevant contextual or historical literature, events, or items. Data were additionally triangulated with the community team.

Findings

Demographic findings indicated the girls ranged in age from 12 - 21. The mean age for first detention was 15.5 years with a mode of 16 years; age information at first detention was unknown for four girls. The mean age at last release was 16.6 years, with a mode of 17 years. Twenty girls' cases (34%) contained data for tribal affiliation including: Cherokee (1), Chippewa (3), Ho-Chunk (2), Menominee (7), Oneida (7), Potawatomi (1), and Sioux (1). Two of the 20 girls identified with multiple tribes. Data on tribal affiliation were unavailable for 38 of the girls. In-text quotations presented throughout this section represent the clinicians' and providers' narratives from case files. In order to protect the identity of the girls, pseudonyms were assigned to each case.

Tables B1 and B2 (Appendix B) display the relevant domains, themes, categories, and subcategories indicating whether general, typical, or non-typical (adapted from the recommended standards of Miles & Huberman, 1994; and Hill, Thompson, & Williams, 1997). When examining the various domains, themes, and categories,

subgroups were created to get a better understanding of the needs of the girls who experienced sexual abuse (SA) compared to those who either experienced statutory assault, or had no sexual history; therefore the themes and categories vary in regards to the total number of cases used to determine general, typical, or non-typical cases. The entire sample includes 58 cases with general (45-58), typical (14-44), and non-typical (0-13) cases. The case numbers and categorizations for each subgroup are reported in the following summary of the findings represented in Tables B1 and B2.

Reported Sexual Abuse

The sexual abuse theme was defined as the self- or court-reported history of sexual assault or abuse for each case. Sexual abuse (SA) in this sample refers to inappropriate touching, molestation, fondling, rape, and/or forcing the child to perform sexual acts. A child in the state where the sample was detained is defined as a “person who is less than 18 years of age, except that for purposes of investigating or prosecuting a person who is alleged to have violated a state or federal criminal law or any civil law or municipal ordinance” (Children’s Code, Wis. Stat. §§ 48-48.02-2, 2011-12).

Twenty-six of the 58 (45%) girls in this project reported SA, with general (19-26), typical (8-18), and non-typical (0-7) cases. Sexual abuse history was recorded as “unknown” for three cases and one girl refused to answer any questions regarding her sexual history. Four categories emerged related to the girls’ histories of sexual abuse: (a) age of first sexual abuse, (b) nature of sexual abuse, (c) relationship of the perpetrator(s), and (d) tribal membership reported.

Age of first sexual abuse. This category captured the girls’ reported age at the time of first sexual abuse which included the following developmental subcategories: 10

or less years of age, 11 - 13 years of age, and 14 -15 years of age. The girls who reported sexual abuse ranged in age from 4 – 15 years old, with a mean of 10 years and a mode of 8 years of age. Age information was unreported for two of the girls. Twelve of the girls were 10 years or younger. For example, Penny “reports that [her] biological father’s friend molested her between the ages of 5 - 6 years old.” Eight of the girls were reportedly between the ages of 11 – 13. For example, Anna “reported that she was sexually assaulted at the age of 11 by her cousin and at the age of 13 by a stranger.” Six of the girls were between 14 – 15 years of age:

[Angela] reports being raped when she was 14. She said she filed a police report, but would not tell the police the male's name. She reported that this man raped her twice when she was 14 and once when she was 15...they were drinking and she had taken 2 trazadone the first time the rape occurred. Youth further reported being raped at age 15 by two different males.

Nature of sexual abuse. This category captured the temporal context of sexual abuse and included the subcategories of acute, episodic acute, and chronic SA. For the purposes of this project, acute SA was defined as one incident of sexual abuse, episodic acute SA was defined as more than one acute incident (most often perpetrated by different offenders), and chronic SA was defined as repeated and on-going SA, usually perpetrated by the same offender. Twenty-five of the girls’ records contained information regarding the nature of the SA. Data indicated that six of the girls reported acute SA. Ginny’s case represents acute SA. She “reports being raped once at the age of 11 by a friend. County reports indicate that this incident was reported.” Eleven of the

girls reported episodic acute SA. The following case of Frieda is an example of episodic acute SA:

[Frieda] reports that she was sexually assaulted by a stranger at the age of 13.

Youth further reported that [she] was sexually assaulted at the age of 14 by a 64 year old man while...on the run. This last incident was reported.

Eight of the girls reported chronic SA. Elise represents an example of chronic SA. “Yes [Elise was sexually abused]. At the age of 5-11 by step-father, and 12 by family friend.” Details regarding the nature of SA was not reported for one case.

Relationship of the perpetrator. This category examined the relationship of the perpetrator for each incident of SA. Eighteen girls’ records had some information regarding the relationship of the perpetrator. Among these 18 girls, there were at least 31 cases of SA, with perpetrator relationship information for 23 cases. Six subcategories emerged from this data: (a) blood relative (grandfather or father), (b) extended family (step-family member or cousin), (c) neighbor, (d) friend of family, (e) stranger, and (f) friend. In three of these incidents of SA, the perpetrator was a blood relative of the girl. For example, Caylee “reports that she has been sexually abused by her biological father from the age of 8-11.” In eight incidents of SA, the perpetrator was an extended family member. An example is the case of Franny who “[r]eported being sexually abused by step-father’s brother at the age of 10 [and] [r]eported being sexually abused by Great-Aunt’s boyfriend at the age of 15.” In three incidents, a neighbor was the perpetrator. For example, case records indicated that Chloe “...[r]eported being sexually abused at the age of 15 by a neighbor.” A friend of the family was the perpetrator in four incidents of SA. The case of Yasmin represents an example of a friend of the family perpetrating SA.

“[She] reported being sexually abused by a friend of her dad's when she was 8 or 9 years old. Youth reported that she told her mom it was happening; however, it was never officially reported.” A stranger was the perpetrator for four of the cases, three of these girls were assaulted while they were runaways. However, for each of these four cases, the stranger assault was not the only assault in the girl's history. For example,

[Zahra] reports being sexually abused by a neighbor boy when she was 13. She further reported that at the age 14, [two] men that she did not know sexually assaulted her when she was on the run. She also reported that she was raped and physically assaulted by 5 men at the age of 16.

Lastly, in one incident of SA, the perpetrator was someone the girl considered a friend. In the case of Ginny, she “[r]eports being raped once at the age of 11 by a friend. County reports indicate that this incident was reported.”

Of the 26 girls who reported SA, 18 case records had information about the perpetrators. There were at least 31 perpetrators among those 16 cases, with relationship information for only 22 of the perpetrators. For the other 8 girls who experienced SA, there was little to no information regarding their perpetrators.

Tribal membership reported. Of the 20 girls who reported tribal membership, five reported a history of sexual abuse, with general (16-20), typical (5-15), and non-typical (0-4) cases. Sexual abuse history was reported as “unknown” for one girl who indicated tribal membership.

Reported Family History of Sexual Abuse

The family history of sexual abuse domain was defined as self-reported knowledge of SA that occurred within the girls' families of origin. Of the 58 cases, only one girl reported knowledge of other sexual abuse survivors in her family.

Statutory Sexual Assault

The statutory sexual assault theme was defined as the self-reported history of 'consensual' engagement in sexual contact before the age of 18. In the Midwestern state where the girls were incarcerated, the legal age of consent for sexual contact is 18 years of age with no close-in-age exemption (Age of Consent by State, 2012). Anyone who has sexual contact with a person under the age of 18 can be prosecuted under state law. The cases of statutory sexual assault are separate from the cases of reported sexual abuse. Forty-seven of the 58 (81%) girls reported involvement in a statutory sexual assault, with general (36-47), typical (12-35), and non-typical (0-11) cases. One girl refused to answer questions regarding her sexual history. Six categories emerged from the data including: (a) age at first statutory assault, (b) age of statutory perpetrator, (c) number of statutory partners, (d) gender of statutory partners, (e) reported SA history, and (f) tribal membership reported.

Age at first statutory assault. This category delineates the age of the girls the first time they were involved in a statutory sexual assault. Ages of first involvement ranged from 10-16, with a mean of 13 and a mode of 13 years of age. Age was unreported for six of the girls. Four developmental subcategories emerged from the data: (a) thirteen years of age or younger, (b) 14 – 15 years of age, (c) 16 years of age, and (d) Unknown. Alarming, 29 of the girls were 13 years old or younger the first time they

were involved in a statutory sexual assault. The case of Hannah serves as an example. “Youth reported that she first had sex at age 10 and has had approximately 30 sexual partners, both male and female that range in age from 15-27.” There were 11 girls between the ages of 14 – 15 who were involved in a statutory assault. For example, Gabriella “...states that she was 15 the first time she had intercourse and has had over 20 male partners ranging in ages from [16 to 27].” There was one girl who reported that she first engaged in sexual contact at the age of 16. In this case, Opal “...stated she first had sexual intercourse at the age of 16. She states having 6 male partners ranging in the age of 16 to 19.” Lastly, there were six cases with missing or unreported data for this category.

Of the 47 cases of statutory assault, 40 of the girls were 15 years old or younger the first time they were involved in a statutory sexual assault. Further, of the 26 girls who reported a history of SA, 17 of them also related they had engaged in sexual contact prior to the age of 15. Fourteen of the girls who had a history of SA were under the age of 13 the first time they were involved in ‘consensual’ sexual contact.

Age of statutory perpetrator. For the purposes of this project, a statutory perpetrator is defined as anyone who engages in sexual contact with a child (a person under the age of 18). This category examined the age of the statutory perpetrators, first looking at perpetrators who were legally considered adults versus those who were not, and then considering them by age ranges for the perpetrators who were legally adults. The oldest perpetrator for each case was the one counted for purposes of this category. The perpetrators ranged in age from 12 – 43 years old. The mean age of the oldest perpetrator for each case was 22 and the mode was 17 years of age. Perpetrator age

information was unreported for eight cases. Six subcategories were created to better understand the ages of the statutory perpetrators. The first two subcategories were created to differentiate between perpetrators who were adolescents and adult perpetrators. The next three subcategories were created to show the age ranges of the adult perpetrators. The subcategories included: (a) Seventeen years of age or younger, (b) 18 years of age or older, (c) 20 – 29 years of age, (d) 30 – 39 years of age, (e) Forty years of age or older, and (f) Unknown. Seventeen of the girls were involved in sexual contact with an individual under 17 years of age. Although the perpetrators were not legally considered adults, there was often a significant age difference between the girl and the perpetrator. For example, Valerie "...reported first having sex at age 12 and has had 3 consensual partners between the ages of 15-17." Twenty-eight of the girls were involved in sexual contact with someone 18 years of age or older. Of these 28 cases, 20 of the girls were involved in sexual contact with a perpetrator between the ages of 20 – 29. Rachel's case is an example of a child engaging in what she deems 'consensual' sex with partners who are legally adults.

Youth reported that she first had sex when she was 12. She said the ages range from 12-27. She has had about 25 partners, but couldn't remember the exact number. All of the partners were male, except for one female partner. Youth's first sexual partner was 24 years old (she was 12). She does not consider this as rape or assault and considered it to be consensual.

Four of the girls were involved in statutory assault with a perpetrator between the ages of 30 – 39. For example, Olivia "...stated that she first had sex when she was 13 and has had 12 partners, one female and 11 male. They range in age from 14-33." Two girls

were involved with perpetrators who were 40 years of age or older. For example, Lara “...reported that she first engaged in sexual intercourse at age 11. She has been with 5 male partners, ages 18-42.” The ages of the statutory perpetrators were unknown or unreported for 8 of the cases.

Of the 45 girls who reported being involved in sexual contact, 36 of them engaged in sexual acts with a partner two or more years older than themselves. Only three of the girls reported ever having been involved in sexual acts with a partner of equivalent age.

Number of statutory perpetrators. The 45 girls who reported involvement in statutory SA had a total of 354 ‘partners.’ Again, considering these girls are children, the term statutory perpetrator is used as it describes an individual who engaged in sexual contact with a child under the age of 18. The average number of statutory perpetrators was eight, with a range of 1 – 50. The number of statutory perpetrators was unreported for three cases. To better understand the girls’ sexual history, four subcategories were created: (a) 1 – 4 perpetrators, (b) 5 – 10 perpetrators, (c) 11 – 19 perpetrators, and (d) 20 or more perpetrators. Fourteen of the girls reported involvement in statutory SA with 1-4 perpetrators. Twenty of the girls reported 5 – 10 perpetrators. Four of the girls reported between 11 - 19 perpetrators. Six girls reported more than 20 perpetrators. Of the girls who reported more than 10 statutory perpetrators, only four reported any history of SA. However, an additional two reported that they first had sex at the ages of 12 and 13. The following examples represent both ends of the spectrum: Donna “...reports having one male sexual partner. He was 16 and she was 14.” Hannah “...reported that she first had sex at age 10 and has had approximately 30 sexual partners.”

Gender of statutory partners. Thirty-five of the girls reported the gender of their partners in statutory sexual assault contact. Four categories emerged including: (a) only men, (b) only women, (c) both men and women, (d) unknown. Twenty-seven of the girls reported having sexual contact with only men. Eight of the girls reported engaging in sexual contact with both men and women. None of the girls reported sexual contact with only women. Gender information was unknown or unreported for 12 of the cases.

Reported SA history. Of the 26 girls who reported a history of SA, 20 of them also reported involvement in statutory assault. For example, Penny "...reports that [her] biological father's friend molested her between the ages of 5-6 years old...[and she] reports first having sex at age 13 and having 6 partners - 5 male and 1 female. The age range of the partners was 15-17."

Tribal membership reported. Of the 20 girls who reported tribal membership, 13 of them also reported involvement in statutory sexual assault.

Runaway History

The runaway history theme was defined as any reported period of time a girl was homeless due to running away from primary caretaker's home, regardless if runaway status was the precipitate to detention. Two categories emerged from this data: (a) reported sexual abuse history and (b) statutory sexual assault history with no reported SA history. Of the 58 cases, data revealed that 27 of the girls had a runaway history and one had been forced out of her home by her mother. Of the 27 girls who had a runaway history, 20 of them also had a reported SA history (including the girl who was forced out of her home). Franny, for example, was on runaway status "for all three detentions..." and "[r]eported being sexually abused by step-father's brother at the age of 10 [and]...by

Great-Aunt's boyfriend at the age of 15." Only 4 girls with a history of SA did not report running away at some point in their adolescence. The other 7 girls with a runaway history also had a history of statutory sexual assault. For example, Rebecca

...[R]eported that she first had sex at age 15 and has had 4 partners ages 18 and 19. She said she was always using birth control, but did get pregnant in September 2004... she did not go to the doctor right away because she was "on the run."

History of Sex Trafficking

The history of sex trafficking theme was defined as the self-reported engagement in prostitution and/or trading of sex for money. The two categories for this theme included: (a) reported SA history and (b) statutory sexual assault history, no reported SA. There were 26 cases which indicated statutory sexual assault, no reported SA with general (19-26), typical (8-18), and non-typical (0-7) cases. Six girls reported a history of sex trafficking. Of these six, five had self-reported histories of SA. The other girl had been involved in statutory sexual assault before 15 years of age, prior to her involvement in sex trafficking. Notably, four of the girls were homeless during sex trafficking activities. The case of Caylee serves as an example of a girl with a reported SA history who engaged in sex trafficking while she was a runaway.

Youth reports that she has been sexually abused by her biological father from the age of 8-11...[h]as had a total of 8 male sexual partners since the age of 11 ranging from the ages of 17-27. Youth also reported that she has been prostituting for money while on the run for the past 6 months...

Gynecological Treatment Needs

The gynecological treatment needs theme was defined as any reported gynecological medical service needs the girls had prior to or upon entry to the detention facility. These data were collected by examining the medical records which included the gynecological services received while at the detention facility. Data indicated that 48 of the 58 girls received some form of gynecological services while detained. Medical treatment history was not recorded or was missing for two cases. Categories in this theme included: reported SA history, statutory sexual assault history, no SA reported, and reported no sexual history.

Reported SA history. Of the 26 girls who reported SA, 22 of them received one or more gynecological services while detained. In this category, the following seven subcategories emerged: (a) pap smear, (b) STD diagnosis and treatment, (c) pre-natal care, (d) treatment following a still birth, (e) yeast infection, (f) urinary tract infection, and (g) seen for menstrual cramps. Of these 22 girls, 16 of them received pap smears while detained, two were diagnosed with and treated for a sexually transmitted disease (STD) while detained, one girl was given pre-natal care during her detention, one girl was treated after she had a stillbirth while detained, three girls were seen and treated for yeast infections, two girls were treated for urinary tract infections, and one girl was seen for menstrual cramps.

Statutory sexual assault, reported no SA. Of the 26 girls who had a history of involvement in statutory sexual assault (no reported SA history), 21 of them received one or more gynecological services while detained, with general (19-26), typical (8-18), and non-typical (0-7) cases. In this category the following subcategories emerged: (a) pap

smear, (b) STD diagnosis and treatment, (c) pre-natal care, (d) yeast infection treatment, (e) menstrual cramps treatment, (f) urinary tract infection, (g) bedwetting, and (h) unknown abdominal pain. Of these 21 girls, 18 received pap smears while detained, five were diagnosed with and treated for an STD, two received pre-natal care, one girl was treated for a yeast infection, one was seen for menstrual cramps, one was seen for bedwetting, and four were seen for unknown abdominal pain.

No reported sexual history. Of the six girls who reported no sexual history, five received one or more gynecological services while detained, with general (5-6), typical (2-4), and non-typical cases (0-1). The following subcategories emerged in this category: (a) pap smear, (b) urinary tract infection, and (c) unknown abdominal pain. Four of the five girls received pap smears while detained, one received treatment for a urinary tract infection, and one was seen for unknown abdominal pain.

Sexually Transmitted Disease History

STD history is defined as the self-reported diagnosis and treatment of a sexually transmitted disease prior to detention or the medically reported diagnosis and treatment of an STD during detention. This theme examined the STD history of two categories: (a) girls who reported SA and (b) girls who had a statutory sexual assault history, but did not report SA. There were a total of 14 girls who had a lifetime STD history. Of the girls who reported an SA history, data indicated that only three had a known STD history. Two of the girls self-reported diagnosis and treatment prior to their detention for herpes simplex (1) and genital warts (1). One of the girl's medical records indicated she was diagnosed with and treated for chlamydia during her detention. Of the girls with a statutory assault history, data indicated that 11 had a lifetime STD history. Six of the

girls self-reported diagnosis and treatment of an STD prior to their detention including: chlamydia (3), gonorrhea (1), and unknown STD (1). Five of the girls' medical records indicated diagnosis and treatment of an STD while detained including: chlamydia (4) and unknown STD (1).

Pregnancy History

This theme examined the pregnancy history of the young girls incarcerated at the detention facility. Of note, this domain is one the girls suggested be added to the comprehensive data collection protocol. Four categories emerged in this theme: (a) miscarriage, (b) pregnant at discharge, (c) living child, and (d) reported she attempted to get pregnant. Self-reports indicated that 11 girls having a lifetime history of miscarriage. One girl was pregnant when she was discharged from the detention facility. One girl had a living child. Six girls shared having attempted to become pregnant, although not all did come to be with child.

Mental Health Diagnoses

The mental health diagnoses domain was defined as any documented mental health diagnosis a girl had prior to entry or during her stay at the detention facility. As of this writing, the DSM-V is scheduled to be printed; however, the diagnoses listed in this domain are abstracted from case files and are according to the DSM-IV-TR. Of the 58 AI girls, 34 had at least one mental health diagnosis. Three themes emerged from the data: (a) reported SA history, (b) statutory sexual assault, no reported SA history, and (c) no reported sexual history. In each theme, two categories were examined: diagnosis at admit to the detention facility and diagnosis at discharge. Within each category are subcategories that include each of the diagnoses that were revealed in the data.

Reported SA history. Fifteen of the girls with a reported SA history had one or more diagnoses at admit including: adjustment disorder (1), ADHD (5), anxiety disorder (1), bi-polar disorder (6), cannabis dependence (1), conduct disorder (3), depression (2), depressive disorder NOS (4), major depressive disorder (2), mild retardation (1), obsessive compulsive disorder (1), oppositional defiant disorder (2), PTSD (3), schizophrenia (2), sleep disorder (1), stress disorder (1), and trichotillomania (1). Ten of the girls' records indicated no diagnosis at admit and records were missing for one case. The number of diagnoses per girl at admit ranged from 0 – 6, with a mean of 2.1, and a mode of 0 diagnoses per girl.

At discharge, 18 of the girls had one or more diagnoses including: adjustment disorder (5), ADHD (7), bi-polar disorder (6), cannabis dependence (1), conduct disorder (5), depressive disorder NOS (1), impulse control disorder NOS (1), major depressive disorder (1), oppositional defiant disorder (1), personality disorder NOS with cluster B traits (3), polysubstance dependence (2), PTSD (3), psychotic disorder NOS (1), and schizophrenia (2). Seven of the girls' records indicated no diagnosis at discharge from the detention facility and records were missing for one case. The number of diagnoses per girl at discharge ranged from 0 – 5, with a mean of 2.2, and a mode of 1 diagnosis per girl.

Notably, eleven of the girls were assigned different diagnoses at discharge than they had at admit and three of the girls who had no diagnosis at admit were given a diagnosis during their detention.

Statutory sexual assault, no reported SA history. Twelve of the girls in this theme had one or more diagnoses at admit including: ADHD (3), bi-polar disorder (3),

bulimia (1), conduct disorder (4), depression (1), depressive disorder NOS (5), dysthymia (1), impulse control disorder NOS (1), major depressive disorder (5), mild retardation (1), and personality disorder NOS with cluster B traits (1). Twelve of the girls' records indicated no diagnosis at admit and two cases were missing records. The number of diagnoses per girl at admit ranged from 0 – 4, with a mean of 1.75 and a mode of 0 diagnoses.

At discharge, ten of the girls had one or more diagnoses including: ADHD (3), bipolar disorder (2), bulimia (1), conduct disorder (6), depression (1), depressive disorder NOS (2), impulse control disorder NOS (2), and major depressive disorder (2). Thirteen of the girls' records indicate that an absence of a diagnosis at discharge, records were missing for two of the cases, and one girl refused services. The number of diagnoses per girl at discharge ranged from 0 – 3, with a mean of 1.7, and a mode of 1.

Six of the girls in this theme were assigned different diagnoses at discharge than their records indicated at admit and two girls who had a recorded diagnoses at admit, had no recorded diagnoses at discharge.

No reported sexual history. Of the girls who reported no sexual history, four had one or more diagnoses at admit including: ADHD (1), bi-polar (1), traits of borderline personality disorder (1), conduct disorder (1), depressive disorder NOS (1), generalized anxiety disorder (1), mood disorder NOS (1), and oppositional defiant disorder (1). Records indicated an absence of a diagnosis for two girls. The number of diagnoses per girl at admit ranged from 0 – 6, with a mean of 2.25, and a mode of 1 diagnosis per girl.

At discharge, four girls had one or more diagnosis including: ADD inattentive type (1), bi-polar (1), conduct disorder (2), depressive disorder NOS (1), impulse control disorder (1), and polysubstance dependence (1). Records indicated an absence of a diagnosis for two girls. The number of diagnoses per girl at discharge ranged from 0 – 4, with a mean of 2, and two modes of 0 and 1 diagnosis per girl.

All four of the girls in this theme had different diagnoses at admit and discharge.

Tribal membership reported. Thirteen of the 20 girls who reported tribal membership had one or more mental health diagnoses at admit including: ADHD (3), anxiety disorder (2), bipolar (2), conduct disorder (3), depression (1), depressive disorder NOS (4), dysthymia (1), major depression (3), mild retardation (1), obsessive compulsive disorder (1), oppositional defiant disorder (1), personality disorder NOS with cluster B traits (1), PTSD (1), schizophrenia (1), and sleep disorder (1). Records indicated an absence of a diagnosis for seven girls. The number of diagnoses per girl at admit ranged from 0 – 6, with a mean of 2.15, and a mode of 0 diagnoses.

Discharge records indicated 11 girls had one or more diagnosis including: adjustment disorder (1), ADHD (4), anxiety disorder (1), bipolar disorder (1), conduct disorder (6), depressive disorder NOS (2), impulse control disorder NOS (1), major depression (1), personality disorder NOS with cluster B traits (1), polysubstance dependence (2), psychotic disorder NOS (1), and PTSD (2). Records indicated an absence of a diagnosis for 10 girls. The number of diagnoses per girl at discharge ranged from 0 – 5, with a mean of 2.2, and a mode of 0 diagnoses per girl.

Of note was the inconsistency of diagnoses assigned to individuals. Many of the diagnoses at discharge were markedly different than at admit. For example, at admit

Penny's records indicated that she was diagnosed with "Conduct Disorder (Note: a screening 2 weeks earlier diagnosed youth with Major Depressive Disorder, Conduct Disorder, Stress Disorder, and features of PTSD)." At discharge, Penny's records indicate a diagnosis of "Bi-Polar Disorder."

Discussion

American Indian populations presently display extreme health and social disparities. Their disproportionate detention rates in juvenile justice facilities speak to the cumulative and multigenerational stress experienced within this population. The AI girls in this project represent a sample with high rates of both acute and episodic stress, and likely trauma as a result of the chronic and cumulative nature of such stressors encountered throughout the lifespan, intergenerationally, and historically. These disparities can be amplified by the loss of cultural ways of healing and fortifying youth against the effects of such trauma (e.g., adolescent rites of passage). The final blow of colonization is to blame AI people for these disparities. However, these disparities are only understood within the context of historical trauma and can be traced back to slavery and the boarding school era. As AI juvenile offenders are forced to interface with the majority culture upon incarceration, it is the responsibility of these facilities to provide prevention, intervention, and post-vention services for the AI youth.

The aim of this project was to examine the contextual factors surrounding the sexual abuse experiences of detained American Indian girls, as well as, to understand their service and re-entry needs including medical and mental health services. The existing literature provides a limited understanding of AI girls, juvenile offenders, and their experiences regarding SA, and could be much improved by integrating a traditional

AI ways of understanding. Considering detention facilities are often the gatekeepers of wellness for American Indian youth (Manson, 2000), the current findings add to this body of literature and illuminate the service and re-entry needs of these youth. Two major themes emerged throughout this project including the frequent occurrence of missing data and the need for trauma-informed care within correctional facilities.

Missing Data

Data was missing in several facets. In several cases entire records for certain services were missing including medical health treatment records and mental health diagnostic records. In many cases, specific information was never asked and/or recorded, for example, the majority of records did not include tribal membership or enrollment eligibility and some records did not include the age(s) when the girl was sexually abused, the relationship of the perpetrator, the age at first 'consensual' sex, or the age of partners. Findings on missing data are important as they inform best practices for data collection procedures. American Indians are already underserved with regards to medical and mental health needs. As the gatekeepers of wellness, detention facilities can begin to rectify this disparity by collecting accurate and consistent information.

An area that displayed considerable need for comprehensive data collection was assessment in regards to cultural identity. There are currently 566 federally recognized AI tribes in the U.S. each with their own culture and wellness traditions. Since tribal affiliation data was recorded for only about one-third of the girls, the provision of culturally congruent care would be nearly impossible. The data demonstrate a clear need to include questions at the time of intake and service provision that address tribal membership, enrollment status, and spiritual/cultural orientation.

Another area which evidenced need for more thorough assessment included history of sex trafficking and other risky sexual behaviors. Contrary to findings with other populations, very few of the girls who reported SA reported being involved in sex trafficking. This likely represents a need for specific questioning upon intake and consistent record keeping within the detention facility on account of the youth not being explicitly asked about their sexual trafficking histories. Although girls with sexual assault history did not report sex trafficking, when crossed with the statutory sexual assault cases, all of the girls who engaged in sex trafficking also had a history of statutory sexual assault. Although it is encouraging that lower numbers of sex trafficking were reported, this question was not explicitly asked of the girls themselves, but rather was abstracted from information about each girl's sexual history. Had the question been asked it is possible more girls would have reported a sex trafficking history. Since the previous literature reports that girls who have experienced SA are more likely to engage in risky sexual behaviors (Goodkind et al., 2006), including prostitution (Widom, 1996), it is advised that questions regarding sexual trafficking be added to intake forms at youth detention facilities. Questions should inquire about each girl's history of trading sex for money, drugs, shelter, or other commodities.

Lastly, although the nature of SA was able to be pieced together by thoroughly examining many protocol domains, detention facilities could benefit from specifically asking about and recording this information as the nature of the SA partially determines psychological and behavioral outcomes. For example, a young child who experiences chronic SA throughout her childhood perpetrated by a close family member can fail to develop healthy boundaries or may run away from home to escape the SA presenting

different service needs than a girl who experienced an acute incident of SA perpetrated by a stranger. The data not collected for these AI girls represent yet another symptom of historical trauma, and play out the ‘invisible vanishing race’ stereotype in real-time. Incarcerated AI girls become invisible when their mere presence is not attended to.

Trauma-Informed Care

American Indian populations continue to experience the impacts of historical trauma which is compounded by the accumulation of acute and chronic lifetime stressors. With this history comes great disparities in physical and mental health. The data in this project demonstrate a clear need for trauma-informed care in all service provision areas for AI juvenile offenders. The current project found that nearly half of the girls in this sample reported acute, episodic acute, or chronic SA which is likely an underestimate as some of the girls refused to respond to questions regarding sexual history, others may not have felt safe disclosing, many may not have realized that their sexual experiences constitute SA, and AI girls may have been left out of the sample due to racial miscategorization. An alarming finding, not discussed elsewhere in the SA literature concerning detained girls, was the number of AI girls without SA histories who engaged in sexual contact prior to 18 years of age. Although these children did not report their sexual contact as abuse or assault, a child cannot legally or developmentally consent to engage in sexual contact with an adult. The girls may not define these incidents as traumatic; however, it is assumed that sexual contact as a child is stressful and developmentally-disruptive. The findings from this project inform recommendations for trauma-informed prevention, intervention, and post-vention within detention facilities.

Trauma-informed prevention. American Indian populations experience trauma at disparate rates. Therefore, upon re-entry into the community, it is likely the AI girls will encounter events that may be traumatic or physically harmful. This project found that AI girls are highly likely to engage in risky sexual behaviors. Detention facilities are in a position to provide psychoeducation to AI girls in order to prevent future risky behaviors. Specific education should include information about boundaries, consent, and gynecological health. Gynecological health topics should include information about prevention and contraction of sexually transmitted diseases, contraceptives, pregnancy and pre-natal care, and overall gynecological health services.

Trauma-informed intervention. Detention facilities are often the gatekeepers of wellness for American Indian youth (Manson, 2000) and have great opportunity and responsibility to provide trauma-informed intervention for AI girls. The intervention service needs that emerged from this project include medical health services (i.e. gynecological health) and mental/behavioral health services.

Gynecological health service needs. Regardless of a history of SA, the AI girls came to the detention facility with a variety of gynecological needs. The majority of the girls were seen at least once for gynecological services. Interestingly, the girls with a history of SA did not strongly differ in their gynecological health needs from the girls who did not experience SA. The experience of STDs was actually more prominent in the group of girls who did not report SA. This finding in conjunction with an understanding that trauma, not just sexual trauma, sets the stage for health disparities, underscores the importance of gynecological health screening for all AI juvenile offenders, not just those reporting SA.

Mental/behavioral health service needs. Considering the number of girls who reported acute, episodic acute, and chronic stressors, assessment and treatment should be designed from a trauma-informed care perspective. Assessment in this area should include questions targeting specific trauma symptomology including, but not limited to: anxiety, depression, compulsive behaviors, suicidal ideation, self-harm, hypervigilance, flashbacks, nightmares, intrusive memories, anger, guilt, shame, and self-blame. Diagnoses should be made only after gathering a full trauma history.

Consistent with the mental health disparities in the general population of American Indians, the AI girls, regardless of SA history, entered the detention facility with a wide range of mental health needs. More than half had a least one lifetime mental health diagnosis. Of the girls who reported a history of SA, approximately two-thirds had one or more lifetime mental health diagnoses compared to half of those who were involved in statutory assault with no reported SA history. The most common diagnoses for girls who had a history of SA were mood disorders and attention deficit and disruptive behavior disorders, which have been found to be correlated with the experience of untreated or unrecognized trauma. This again highlights the need for trauma-informed care when designing and implementing mental health treatment for the AI girls.

Of interest was the inconsistency of diagnoses assigned to individuals. Many of the diagnoses changed between admit and discharge. This may be due to the variability in diagnosis between community clinicians and corrections personnel. As mentioned previously, the first time many AI girls come into contact with health services is upon detention or incarceration. The gatekeepers of wellness at these facilities have more time

with the girls and are likely to more accurately diagnosis mental health disorders. Considering diagnoses guide treatment, it is imperative that thorough and accurate assessments are completed during admission processes and throughout detention so the AI girls receive the most consistent and effective treatment possible during their detention.

Trauma-informed post-vention. Upon re-entry, detention facilities should work diligently to connect AI girls to their cultural communities. In order to do this, staff must receive cultural training relevant to the needs of AI youth including training around tribal enrollment status and eligibility. Similarly, it is critical that assessment questions include tribal membership, enrollment status/eligibility, and spiritual/cultural orientation. Prior to re-entry, advocacy should be done to ensure enrollment of eligible AI youth. Tribal enrollment will foster connection to community resources and support, as well as, facilitating access to medical and mental health services, a legal right of all AI persons.

Historical trauma-informed service provision. One factor nearly absent in the service provision records was the presence of historical trauma as a factor of trauma-informed care. A trauma-informed orientation augmented by a historical trauma perspective recognizes the presence of ongoing colonization effects and their relevance for treating incarcerated AI youth. It asks questions during intake that address family and personal exposure to colonization trauma, such as boarding school experiences. Since the injuries in the traditional AI perspective are experienced in both a historical and real-time perspective, they continue to manifest in negative symptomology until a healing is completed and communal acknowledgement is achieved. Institutions serving AI youth would benefit from including tribally sanctioned traditional AI knowledge-holders,

healers, and spiritual guides to help provide services the youth through a culturally appropriate, historical trauma-informed lens.

Limitations

This qualitative project adds to the limited body of research that examines the sexual abuse experiences of detained American Indian girls. However, caution should be taken when making generalizations based on the outcomes of this project. Firstly, data collection was done ex-post facto. Information is missing for some of the cases, entire records for particular services are missing for others, and not all of the cases had information for all domain/theme areas. It is also unclear as to how many girls may not have been captured in this project, due to miscategorization by race/ethnicity. Tribal identity was unreported for the majority of the cases. Nonetheless, tribal identities vary from case to case; and therefore, cultural and other needs may also vary. This sample included cases from seven tribes and is not representative of the 566 tribes across the U.S.

Implications

This project has implications for detention and correctional facilities that serve American Indian girls in that it provides insight into the sexual abuse experiences and service needs the AI girls bring with them to the facilities and the need for trauma-informed care in service provision. The findings in this project affirm the manifestations of historical trauma as contemporary disparities in sexual abuse experiences and mental and physical wellness. As the gatekeepers of wellness, detention facilities are in a unique position to provide prevention, intervention, and post-vention services for AI youth.

First, it is imperative that racial/ethnic identities are captured during intake procedures in order to provide AI juvenile offenders with culturally congruent care. In the same realm, correctional facility staff should be trained in historical trauma, disparities relevant to American Indian youth, tribal enrollment processes, cultural/community resources, and trauma-informed care. With knowledge in these areas it is more probable the staff will feel competent in providing AI youth with the trauma-informed and culturally congruent care that is fundamental to their healing. Further, the information presented in this project can help detention facilities determine specific programming for AI girls including sexual education, information about consent, mental/behavioral health counseling, medical services, and culturally specific programming.

Additionally, this project can inform data collection procedures for detention facilities. A protocol, like the one used in this project, can be used to ensure all relevant information is being collected at intake and throughout detention, not only for AI girls, but also for juvenile and adult offenders throughout the U.S. It is imperative that detention facilities take care to assess girls' full sexual histories in addition to their SA histories. Knowing the girls may feel unsafe or uncomfortable reporting sexual behaviors, it is recommended that several individual sessions take place to give the girls space and time to tell their stories. Data collection in this realm should focus on sexual abuse, 'consensual' partners, history of sex trafficking, history of sexually transmitted diseases, and pregnancy history.

While detention facilities act as the gatekeeper of care for AI juvenile offenders and are able to provide many first time mental and physical wellness services, it is

equally important the AI girls receive similar care upon re-entry into the community. Although it was not within the scope of this data set to examine the specific tribal protective factors, it is notable that only five of the girls who reported tribal membership also reported a history of SA. Cultural protective factors may be at work for the other 15 girls who reported tribal membership. Knowing this, it is imperative to connect AI girls to their communities and facilitate tribal enrollment upon re-entry. Tribal enrollment can lead to culturally congruent community care for AI girls, as well as, access to much needed medical and mental health services. With that said, it is essential the AI girls be connected with medical and mental health services in the community in order to receive follow-up care upon re-entry, regardless of tribal enrollment status.

Future Research

This project provides insight into the unique needs of detained AI girls who have experienced sexual abuse or statutory sexual assault and can be a catalyst for further research regarding this underserved population. For example, considering there are currently 566 federally recognized tribes in the U.S., future research can examine the cultural/tribal specific sexual abuse experiences and the mental health and medical needs of the AI girls in addition to examining culture/tribal specific protective factors, treatment, interventions, and programming, including culture-specific women's teachings and trauma-informed care. Other research may examine the salience of cultural identity and connectedness to the community as a protective factor against sexual abuse. For example, of the twenty AI girls reporting tribal membership in this project, only three reported a SA history. Are there fewer incidents of SA when girls are more connected with their tribal community? Or are AI girls who are more connected with their tribal

communities less likely to report SA? Future research might also explore the difference in effective interventions and treatments for AI girls who experienced statutory sexual assault versus those who report sexual abuse. Lastly, it is important to understand the strengths of the AI community. With that said, other research might examine the protective factors that are keeping AI girls who have experienced SA mentally healthy and from running away and engaging in risky sexual behaviors.

References

Age of Consent by State. (2012). *Legal age of consent by state*. Retrieved on April 6, 2013 from <http://www.age-of-consent.info/>

American Psychological Association. (2013). *Stress: The different kinds of stress*.

Retrieved on April 10, 2013 from <http://www.apa.org/helpcenter/stress-kinds.aspx>

Bachman, R. , Zaykowski, H. , Lanier, C. , Poteyeva, M. , & Kallmyer, R. (2010).

Estimating the magnitude of rape and sexual assault against American Indian and Alaska Native (AIAN) women. *Australian & New Zealand Journal of Criminology (Australian Academic Press)*, 43(2), 199-222.

Beals, J. , Novins, D. , Whitesell, N. , Spicer, P. , Mitchell, C. ,&Manson, S. M. (2005).

Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *The American Journal of Psychiatry*, 162(9), 1723-1732.

Bloom, B., Owen, B., Rosenbaum, J., & Deschenes, E. P. (2003). Focusing on girls and

young women: A gendered perspective on female delinquency. *Women & Criminal Justice*, 14(2/3), 117-136.

Brave Heart-Jordan, M. Y. H. (1995). The return to the Sacred Path: Healing from

historical trauma and historical unresolved grief among the Lakota. (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses (PQDT). Smith College, School for Social Work, Northhampton, Massachusetts.

- Bubar., R. & Thurman, P. J. (2004). Violence against Native women. *Social Justice*, 31(4), 70-86.
- Burawoy, M. (1991). *Ethnography unbound: Power and resistance in the modern metropolis*. Berkeley, CA: University of California Press.
- Burawoy, M. (1998). The Extended Case Method. *Sociological Theory*, 16(1), 4-33.
- Center for Disease Control and Prevention, Office of Minority Health & Health Disparities. (no date). *American Indian & Alaska Native (AI/AN) Populations*. Retrieved from www.cdc.gov/omhd/populations/aian/aian.htm
- Children's Code, Wis. Stat. §§ 48-48.02-2 (2011-12).
- Curtis, R. L. Jr., Leung, P., Sullivan, E., Eschback, K., & Stinson, M. (2001). Outcomes of child sexual contacts: Patterns of incarcerations from a national sample. *Child Abuse & Neglect*, 25(5), 719-736.
- Department of Health and Human Services, Indian Health Service. (2011). *Indian Health Disparities*. Retrieved on October 26, 2012 from <http://www.ihs.gov/PublicAffairs/IHSBrochure/Disparities.asp>
- de Ravello, L., Abeita, J., & Brown, P. (2008). Breaking the cycle/mending the hoop: Adverse childhood experiences among incarcerated American Indian/Alaska Native women in New Mexico. *Health Care for Women International*, 29, 300-315. doi: 10.1080/07399330701738366
- Duran, E. (1990). *Transforming the Soul Wound: A theoretical/Clinical Approach to American Indian Psychology*. Berkley, CA: Folklore Institute.
- Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany, NY: State University of New York Press.

- Duran, E., Duran, B., Brave Heart, M. Y. H., & Yellow Horse-Davis, S. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341-354). New York, NY: Plenum Press.
- Easy access to the census of juveniles in residential placement: 1997-2010: Race/ethnicity by state. Retrieved on November 6, 2012 from http://www.ojjdp.gov/ojstatbb/ezacjrp/asp/State_Race.asp
- Ellison, T. (2005). Surviving racism and sexual assault: American Indian women left unprotected. *The Modern American*, 1(2), 21-27.
- Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, 23(3), 316-338.
- Evans-Campbell, T., Lindhorst, T., Huang, B., & Walters, K. L. (2005). Interpersonal violence in the lives of urban American Indian and Alaska Native women: Implications for health, mental health, and help-seeking. *American Journal of Public Health*, 96(8), 1416-1422.
- Goodkind, S., Ng, I., & Sarri, R. C. (2006). The impact of sexual abuse in the lives of young women involved or at risk of involvement with the juvenile justice system. *Violence Against Women*, 12(5), 456-477. doi: 10.1177/1077801206288142
- Hamby, S. (2008). The path of helpseeking: Perceptions of law enforcement among American Indian victims of sexual assault. *Journal of Prevention & Intervention in the Community* 36(1-2), 89-104.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual

qualitative research. *The Counseling Psychologist*, 25(4), 717-572.

Horejsi, C., Heavy Runner Craig, B., & Pablo, J. (1992). Reactions by Native American parents to child protection agencies: Cultural and community factors. *Child Welfare League of America*, LXXI(4), 329-342.

Jones, M. C., Dauphinais, P., Sack, W. H., & Somervell, P. D. (1997). Trauma-related symptomatology among American Indian adolescents. *Journal of Traumatic Stress*, 10(2), 163-173.

Kaufman, C. E., Beals, J., Mitchell, C. M., LeMaster, P., & Fickenscher, A. (2004). Stress, trauma, and risky sexual behaviour among American Indians in young adulthood. *Culture, Health & Sexuality*, 6(4), 301-318.
doi:10.1080/13691050310001645032

Kunitz, S. J., Gabriel, K. R., Levy, J. E., Henderson, E. E., Lampert, K. K., McCloskey, J. J., & Vince, A. A. (1999). Risk factors for conduct disorder among Navajo Indian men and women. *Social Psychiatry & Psychiatric Epidemiology*, 34(4), 180.

Lyons, J. S., Baerger, D. R., Quigley, P., Erlich, J., & Griffin, E. (2001). Mental health service needs of juvenile offenders: A comparison of detention, incarceration, and treatment settings. *Children's Services: Social Policy, Research, and Practice*, 4(2), 69-85.

Management Sciences for Health (no date). American Indians and Alaska Natives: Health disparities overview. *The Provider's Guide to Quality & Culture*. Retrieved from <http://erc.msh.org/quality&culture>

- Manson, S. M. (2000). Mental health services for American Indians and Alaska Natives: Need, use, and barriers to effective care. *Canadian Journal of Psychiatry, 45*, 617-626.
- Manson, S. M., Beals, J., Klein, S. A., Croy, C. D., & the AI-SUPERPPF Team. (2005). Social epidemiology of trauma among 2 American Indian reservation populations. *American Journal of Public Health, 95*, 851–859.
- Manson, S., Beals, J., O’Neill, J. P., Bechtold, D., Keane, E., & Jones, M. (1996). Wounded spirits, ailing hearts: PTSD and related disorders among American Indians. In Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder; Issues, Research, and Clinical Applications*, (pp. 255-283). Washington, DC, US: American Psychological Association.
- Maupin, J. R., & Bond-Maupin, L. J. (2005). Delinquency and justice: Tribal court data and tribal members’ perspectives from one American Indian nation. *Journal of Ethnicity in Criminal Justice, 3*(3), 65-86.
- McGrath, S. A., Nilsen, A. A., & Kerley, K. R. (2011). Sexual victimization in childhood and the propensity for juvenile delinquency and adult criminal behavior: A systematic review. *Aggression and Violent Behavior, 16*, 485-492.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. (2nd ed.). Thousand Oaks, CA: Sage.
- Morris, R. E., Harrison, E. A., Knox, G. W., Tromanhauser, E., Marquis, D. K., & Watts, L. L. (1995). Health risk behavioral survey from 39 juvenile correctional facilities in the United States. *Journal of Adolescent Health, 17*(6),334-344.

- Parker, T., Kipp, B. J., & Dine'Chacon, G. (2007). Incarcerated Native American Adolescents: Reclaiming Our Youth At Risk: An Albuquerque Area Indian Health Board NARCH Project [PowerPoint Slides].
- Pavkov, T. W., Travis, L., Fox, K. A., King, C., & Cross, T. L. (2010). Tribal youth victimization and delinquency: Analysis of Youth Risk Behavior Surveillance Survey data. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 123-134. doi:10.1037/a0018664
- Robin, R. , Chester, B. , Rasmussen, J. , Jaranson, J. , & Goldman, D. (1997). Prevalence and characteristics of trauma and posttraumatic stress disorder in a southwestern American Indian community. *The American Journal of Psychiatry, 154*(11), 1582-1588.
- Rouse-Arndt, L. (Under Review). It moves like a spider: Social justice, American Indians, and cancer.
- Rouse-Arndt, L. M. & Davis. A. R. (2011). Warrior spirit: Soul wound and coping among American Indians in law enforcement. *The Counseling Psychologist, 39*(4), 527-569.
- Shore, J. H., Kinzie, J. D., Hampson, J. L., & Pattison, E. M. (1973). Psychiatric epidemiology of an Indian village. *Psychiatry, 36*(1), 70-81.
- Siegel, J. , & Williams, L. (2003). The relationship between child sexual abuse and female delinquency and crime: A prospective study. *Journal of Research in Crime and Delinquency, 40*(1), 71-94.

- Simoni, J. M., Sehgal, S., & Walters, K. L. (2004). Triangle of risk: Urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS and Behavior*, 8(1), 33-45.
- U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau. (2011). *2010 Census Briefs: Overview of Race and Hispanic Origin: 2010*. Retrieved from www.census.gov/prod/cen2010/briefs/c2010br-02.pdf
- U.S. Department of Health & Human Services, Office of Minority Health. (2012). *American Indian/Alaska Native Profile*. Retrieved on October 31, 2012 from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52>
- U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. (2004). *Juvenile Offenders and Victims National Report Series: Juveniles in Corrections*. Retrieved on October 26, 2012 from www.ojp.usdoj.gov/ojjdp
- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (2011). *Summary: Tribal Youth in the Federal Justice System* (Report No. NCJ 234218). Retrieved on October 26, 2012 from bjs.ojp.usdoj.gov/content/pub/pdf/tyfjs.pdf
- U.S. Department of Justice, Tribal Justice and Safety. (2013). *Violence Against Women Act (VAWA) Reauthorization 2013*. Retrieved on April 10, 2013 from <http://www.justice.gov/tribal/vawa-tribal.html>
- Warne, D. (2010). American Indian Health Policy: Where we've been and where we're going. Panel presentation, Families USA, January 30, 2010.

- Warne, D. (2011, August 19). American Indian cancer policy: Policy approaches to reducing cancer disparities; Native American Cancer Research; CDC: Regional AI Cancer Conference, Portland, OR. Retrieved on November 19, 2012 from <http://natamcancer.org/WorkGroups/DonWarne2>
- Widom, C. S. (1996). Childhood sexual abuse and its criminal consequences. *Society*, 33(4), 47-53.
- Willmon-Haque, S. & BigFoot, D. S. (2009). Violence and the effects of trauma on American Indian and Alaska Native populations. In Geffner, R., Griffin, D., & Lewis, J., III. *Children Exposed to Violence: Current Issues, Interventions and Research*, (pp. 48-63). London: Routledge.

Appendix A

Protocol for Data Collection

SOGS Data Form		
1	ID CODE:	
2	Date of Data Collection	
3	Data Source (e.g., clinical services file)	
4	Gender (F, M, T)	
5	Racial/Ethnic identification(s) (e.g., white, AI)	
6	Tribal affiliation(s) (include band/clan if known)	
7	Specify enrollment status if applicable (e.g., enrollable, not yet completed)	
8	Languages spoken	
9	Primary setting of upbringing (e.g., urban, off-reservation rural, reservation), specify distance from family to SOGS	
10	Family income status (e.g., poverty level or below):	
11	Religious affiliation (e.g., Methodist)	
12	Spiritual identity (e.g. Longhouse)	
13	Status of each biological parent(s) (e.g., custodial, deceased):	
14	Age at first out of home placement	
15	Age at first detention	
16	Age at last detention release date	
17	Release status #10 (e.g., adult jurisdiction, age-out, off supervision)	
18	Total number of detention placements	
19	Total number of out of home placements	
20	Specify #19 by type totals and length of stay for each	
21	Specify causal factors for each detention, out-of-home placement)	
22	Residence at time of detention	
23	Guardian at time of detention	
24	Placement at time of detention	
25	Runaway status at time of detention (Yes, No): Youth was a runaway status when sentenced to SOGS her second time.	
26	Adoption status (Yes, No, Pending) If 'yes', ICWA relevant (Y/N)	
27	Grade level at admit most recent placement at SOGS	
28	Grade level at discharge most recent placement at SOGS	
29	History of Special Education (specify curricular areas, modifications needed, and/or special status)	
30	HSED or GED completed at SOGS if applicable (Yes, No, N/A)	
31	College credit completed at SOGS if applicable (Yes, No, N/A)	
32	Reported alcohol/drug use at time of last placement at SOGS (Yes, No) (list substances and indicate dependency if relevant)	
33	Reported frequency of use for substances listed in #32	
34	Reported first age of use for substances listed in #32	
35	Reported gang membership (Yes, No, characterize if Yes)	

36	Reported gang membership in family (Yes, No, characterize if Yes)	
37	Family history of detention/incarceration (Yes, No) (specify relationship and type):	
38	Number of pregnancies for youth (specify number of living children and disposition)	
39	Family history of foster care (Yes, No) (specify relationship)	
40	Family history of adoption (Yes, No) (specify relationship)	
41	Family history of MH issues/diagnoses (Yes, No) (specify)	
42	Family history of domestic violence (Yes, No) (specify)	
43	Family history of alcohol abuse/addiction (Yes, No) (specify)	
44	Family history of illicit drug abuse/addiction (Yes, No) (specify)	
45	Family history of sexual abuse (Yes, No) (specify)	
46	Personal history of physical abuse (Yes, No):	
47	Personal history of sexual abuse (Yes, No):	
48	Psychiatric/Mental Health treatment prior to placement (Yes, No) Briefly describe:	
49	Psychiatric diagnoses, briefly describe any changes in diagnosis from admit to discharge:	
50	Medications at admit (list all that apply): none	
51	Medications at release (list all that apply): currently on:	
52	Youth placement at last release data (parents, relative, State facility adult, State facility youth, group home, MH treatment center, foster care, other)	
53	Social Service programming utilized with youth at SOGS over lifetime List:	
54	Clinical/Mental Health Services programming utilized with youth at SOGS over lifetime	
55	Medical programming utilized with youth at SOGS over lifetime	
56	Medical history of AODA-related conditions? Briefly describe	
57	Medical history of AI youth diagnoses (carcinoma, colorectal cancer, ear infection, obesity, diabetes, coronary/heart disease, drug use – related disorder, HIV/AIDS) Briefly describe:	
58	Summarize lifetime Hx of suicidal threats and gestures:	
59	Characterize visit Hx:	
60	Characterize access to spiritual/cultural resources:	
61	Characterize disciplinary Hx at SOGS:	
62	Specify jurisdiction Hx at SOGS (e.g., municipal, county, State, federal, Tribal):	
63	Characterize OJOR Hx:	
64	Characterize reintegration planning/Hx:	
65	Entered the adult system	

Appendix B

Tables B1 and B2 below display the relevant domains, themes, categories, and subcategories indicating whether general, typical, or non-typical (adapted from the recommended standards of Miles & Huberman, 1994; and Hill et al., 1997). When examining the various domains, themes, and categories, subgroups were created to get a better understanding of the needs of the girls who experienced SA compared to those who either experienced statutory assault, or had no sexual history; therefore the themes and categories vary in regards to the total number of cases used to determine general, typical, or non-typical cases. The entire sample includes 58 cases with general (45-58), typical (14-44), and non-typical (0-13) cases. The subgroup that reported sexual abuse includes 26 cases with general (19-26), typical (8-18), and non-typical (0-7) cases. The subgroup that indicated statutory sexual assault includes 47 cases, with general (36-47), typical (12-35), and non-typical (0-11) cases. The subgroup that indicated statutory sexual assault and reported no sexual abuse history includes 26 cases with general (19-26), typical (8-18), and non-typical (0-7) cases. The subgroup that reported no sexual history includes six cases with general (5-6), typical (2-4), and non-typical cases (0-1). The subgroup that indicated tribal membership includes 20 cases with general (16-20), typical (5-15), and non-typical (0-4) cases. A summary of the themes, domains, categories, and subcategories are presented in the findings section.

Table B1

Themes, Categories, Subcategories, Number of Cases, and Classification

Theme	Category	Subcategory	<i>N</i>	<i>Classification</i>		
Reported SA ^a			26	Typical		
			Age of first SA ^b	≤ 10	12	Typical
				11-13	8	Typical
				14-15	6	Non-typical
				Unknown	2	Non-typical
			Nature of SA	Acute	6	Non-typical
				Episodic Acute	11	Typical
				Chronic	8	Typical
				Unknown	1	Non-typical
			Relationship of the perpetrator	Blood relative	3	Non-typical
	Extended family	8	Typical			
	Neighbor	3	Non-typical			
	Friend of family	4	Non-typical			
	Stranger	4	Non-typical			
	Friend	1	Non-typical			
	Tribal membership reported ^c		5	Typical		
Reported Family History of SA ^a			1	Non-typical		
Statutory SA ^a			47	General		
			Age at first statutory assault ^d	≤ 13	29	Typical
				14-15	11	Non-typical
				16	1	Non-typical
				Unknown	6	Non-typical
			Age of statutory perpetrator	≤ 17	17	Typical
				≥ 18	28	Typical
	20 - 29	20	Typical			

	# of statutory perpetrators	30 - 39 ≥ 40 Unknown	4 2 8	Non-typical Non-typical Non-typical
	Gender of statutory perpetrators	1-4 partners 5-10 partners 11-19 partners ≥ 20 partners Unknown	14 20 4 6 3	Typical Typical Non-typical Non-typical Non-typical
	Reported SA Hx ^b	Only men Only women Both men and women Unknown	27 0 8 12	Typical Non-typical Non-typical Typical
	Tribal membership reported ^c		20	General
Runaway Hx ^a			13	Typical
	Reported SA Hx ^b		27	Typical
	Statutory assault Hx, no reported SA ^e		20	General
			7	Non-typical
Sex Trafficking Hx ^a			6	Non-typical
	Reported SA Hx ^b		5	Non-typical
	Statutory assault Hx, no reported SA ^e		1	Non-typical
Gynecological Services Received During Detention ^a			48	General
	Reported SA Hx ^b	Pap Smear STD Dx and Tx Pre-natal care Tx following still birth Yeast infection Urinary tract infection	16 2 1 1 3 2	Typical Non-typical Non-typical Non-typical Non-typical Non-typical

	Statutory Assault, reported no SA ^e	Menstrual cramps	1	Non-typical
		Pap smear	18	Typical
		STD Dx and Tx	5	Non-typical
		Pre-natal care	2	Non-typical
		Yeast infection	1	Non-typical
		Menstrual cramps	1	Non-typical
		Bedwetting	1	Non-typical
	Reported no sexual Hx ^f	Unknown abdominal pain	4	Non-typical
		Pap smear	4	Typical
		Urinary tract infection	1	Non-typical
		Unknown abdominal pain	1	Non-typical
STD Hx	Reported SA Hx ^b		14	Typical
			3	Non-typical
		Dx and Tx prior to detention: Herpes Simplex	1	Non-typical
		Genital Warts	1	Non-typical
		Dx and Tx during detention: Chlamydia	1	Non-typical
	Statutory assault, reported no SA Hx ^e		11	Typical
		Dx and Tx prior to detention: Chlamydia	3	Non-typical
		Gonorrhea	1	Non-typical
		Unknown STD	2	Non-typical
		Dx and Tx during detention: Chlamydia	4	Non-typical
		Unknown STD	1	Non-typical
Reported Pregnancy Hx ^a			12	Non-typical
	Miscarriage		11	Non-typical
	Pregnant at discharge		1	Non-typical

	Living child		1	Non-typical
	Reported she attempted to get pregnant		6	Non-typical

^aFor themes, the total N=58, with general (45-58), typical (14-44), and non-typical (0-13) cases. ^bThis category includes only data for cases that indicated a history of sexual abuse (N=26) with general (19-26), typical (8-18), and non-typical (0-7) cases. ^cThis category includes data for the cases that indicated tribal membership (N=20) with general (16-20), typical (5-15), and non-typical (0-4) cases. ^dThis category includes data for all cases that indicated statutory assault (N=47) with general (36-47), typical (12-35), and non-typical (0-11) cases. ^eThis category includes only data for cases that indicated statutory assault and did not report a sexual abuse history (N=26) with general (19-26), typical (8-18), and non-typical (0-7) cases. ^fThis category includes only data for cases that did not report any sexual history (N=6) with general (5-6), typical (2-4), and non-typical cases (0-1).

Table B2

Domain, Themes, Categories, Subcategories, Number of Cases, and Classification

Domain	Theme	Category	Subcategory	N	Classification
Diagnosed with Mental Health Disorder ^a	Reported SA Hx ^b	Diagnosis at admit		34	Typical
				15	Typical
			Adjustment disorder	1	Non-typical
			ADHD	5	Non-typical
			Anxiety disorder	1	Non-typical
			Bi-polar disorder	6	Non-typical
			Cannabis dependence	1	Non-typical
			Conduct disorder	3	Non-typical
			Depression	2	Non-typical
			Depressive disorder NOS	4	Non-typical
			Major depressive disorder	2	Non-typical
			Mild retardation	1	Non-typical
			Obsessive compulsive disorder	1	Non-typical
			Oppositional defiant disorder	2	Non-typical
			PTSD	3	Non-typical
			Schizophrenia	2	Non-typical
Sleep disorder	1	Non-typical			
Stress Disorder	1	Non-typical			
Trichotilomania	1	Non-typical			
None	10	Typical			

		Diagnosis at discharge	Records missing	1	Non-typical
				16	Typical
			Adjustment disorder	5	Non-typical
			ADHD	7	Non-typical
			Bi-polar disorder	6	Non-typical
			Cannabis dependence	1	Non-typical
			Conduct disorder	5	Non-typical
			Depressive disorder NOS	1	Non-typical
			Impulse control disorder NOS	1	Non-typical
			Major depressive disorder	1	Non-typical
			Oppositional defiant disorder	1	Non-typical
			Personality disorder NOS with cluster B traits	3	Non-typical
			Polysubstance dependence	2	Non-typical
			PTSD	3	Non-typical
			Psychotic disorder NOS	1	Non-typical
			Schizophrenia	2	Non-typical
			Trichotilomania	1	Non-typical
			None	7	Non-typical
			Records missing	1	Non-typical
	Statutory assault Hx, no reported SA Hx ^c	Diagnosis at admit		12	Typical
			ADHD	3	Non-typical
			Bi-polar disorder	3	Non-typical
			Bulimia	1	Non-typical
			Conduct disorder	4	Non-typical
			Depression	1	Non-typical
			Depressive disorder NOS	5	Non-typical
			Dysthymia	1	Non-typical
			Impulse control disorder NOS	1	Non-typical
			Major depressive disorder	5	Non-typical
			Personality disorder NOS with cluster B traits	1	Non-typical

	No reported sexual Hx ^d	Diagnosis at discharge	None	12	Typical
			Records missing	2	Non-typical
				12	Typical
			ADHD	3	Non-typical
			Bi-polar disorder	2	Non-typical
			Bulimia	1	Non-typical
			Conduct disorder	6	Non-typical
			Depression	1	Non-typical
			Depressive disorder NOS	2	Non-typical
			Impulse control disorder NOS	2	Non-typical
			Major depressive disorder	2	Non-typical
			None	13	Non-typical
			Records missing	2	Typical
					Non-typical
			Diagnosis at admit		4
		ADHD			
		Bi-polar	1	Non-typical	
		Borderline PD (traits)	1	Non-typical	
		Conduct disorder	1	Non-typical	
		Depressive disorder NOS	1	Typical	
		Generalized anxiety disorder	1	Non-typical	
		Mood disorder NOS	1	Non-typical	
		Oppositional defiant disorder	1	Non-typical	
			1	Non-typical	
		Diagnosis at discharge		4	Typical
		ADD inattentive type			
		Bi-polar	1	Non-typical	
		Conduct disorder	1	Non-typical	
		Depressive disorder NOS	2	Typical	
		Impulse control disorder	1	Non-typical	
		Polysubstance dependence	1	Non-typical	
			1	Non-typical	

	Tribal membership reported ^e	Diagnosis at admit	13	Typical
		ADHD	3	Non-typical
		Anxiety disorder	2	Non-typical
		Bipolar	2	Non-typical
		Conduct disorder	3	Non-typical
		Depression	1	Non-typical
		Depressive disorder NOS	4	Non-typical
		Dysthymia	1	Non-typical
		Major depression	3	Non-typical
		Mild retardation	1	Non-typical
		Obsessive compulsive disorder	1	Non-typical
		Oppositional defiant disorder	1	Non-typical
		Personality disorder NOS with cluster B traits	1	Non-typical
		PTSD	1	Non-typical
		Schizophrenia	1	Non-typical
		Sleep disorder	1	Non-typical
		None	7	Typical
		Diagnosis at discharge	10	Typical
		Adjustment disorder	1	Non-typical
		ADHD	4	Non-typical
		Anxiety disorder	1	Non-typical
		Bipolar disorder	1	Non-typical
		Conduct disorder	6	Typical
		Depressive disorder NOS	2	Non-typical
		Impulse control disorder NOS	1	Non-typical
		Major depression	1	Non-typical
		Personality disorder NOS with cluster B traits	1	Non-typical
		Polysubstance dependence	2	Non-typical
		Psychotic disorder NOS	1	Non-typical
		PTSD	2	Non-typical
		None	10	Typical

^aFor the domain, the total N=58, with general (45-58), typical (14-44), and non-typical (0-13) cases. ^bThis theme includes only data for cases that indicated a history of sexual abuse (N=26) with general (19-26), typical (8-18), and non-typical (0-7) cases. ^cThis theme includes only data for cases that indicated statutory assault and did not report a sexual abuse history (N=26) with general (19-26), typical (8-18), and non-typical (0-7) cases. ^dThis theme includes only data for cases that did not report any sexual history (N=6) with general (5-6), typical (2-4), and non-typical cases (0-1). ^eThis theme includes data for the cases that indicated tribal membership (N=20) with general (16-20), typical (5-15), and non-typical (0-4) cases