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RESEARCH

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Family strengths among Native American families and families living in poverty: Preventing adverse childhood experiences

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Abstract

Objective: The purpose of this study was to understand how youth, caregivers, and community professionals perceive family strengths and adverse childhood experiences (ACEs) in their community. Specifically, this study was focused on the protective role of caregivers and families, positive youth development, and how Native American families and families living in poverty support adolescents' social–emotional development and help them thrive in the face of adversity.

Background: Research documents the concerning rates and negative outcomes of ACEs. However, very little research has examined the views of families and professionals on how to prevent ACES among these populations.

Method: Participants were youth aged 10 to 14 years ($n = 20$), caregivers ($n = 13$), and an occupationally diverse group of professionals whose work intersected with ACEs ($n = 7$). Participants were all Native American and/or living in poverty in a small city in the Northern Plains region of the United States.

Results: Themes that emerged from the child and caregiver focus groups regarding protective factors included (a) family engagement, (b) family and cultural values, (c) personal and family safety, (d) future orientation, and (e) community strengths and needs. Themes that emerged from the professionals' focus group included (a) families in crisis, (b) intersectionality of family challenges, (c) community

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collaboration, (d) trauma-informed practices and violence prevention, and (e) cultural connections.
Conclusion and implications: These data provided foundational information relevant to understanding families' strengths and needs and the important role of culture in program development to prevent ACEs.

KEYWORDS
adverse childhood experiences, culture, family strengths, trauma

Adverse childhood experiences (ACEs) are a public health epidemic in the United States. ACEs are upsetting or potentially traumatic events that occur in children from birth to age 17 (Centers for Disease Control and Prevention [CDC], 2019). ACEs include childhood abuse (i.e., physical, sexual, psychological, neglect) and various aspects of household dysfunction such as parent/caregiver substance abuse, mental illness, incarceration, and separation/divorce (CDC, 2019). ACEs also include parent/caregiver death, exposure to intimate partner violence among caregivers, experiencing discrimination, exposure to neighborhood violence, and economic hardship (CDC, 2019). Rates of ACEs are higher among some populations of individuals, such Native Americans (Kenney & Singh, 2016; Warne et al., 2017). In fact, in South Dakota, where the current study took place, Native Americans were nearly 3 times as likely as White individuals to report experiencing five or more ACEs as a child (Sacks et al., 2014). More specifically, whereas 6% of White adults reported experiencing five or more ACEs as a child, 17% of Native American adults reported experiencing five or more ACEs as a child (Warne et al., 2017). Research suggests that although they are varied, experiences of ACEs frequently co-occur and are similar in their impact (Bucci et al., 2016; Giano et al., 2020), and the greater the number of ACEs experienced, the more deleterious the outcomes (Petruccelli et al., 2019).

ACEs have been consistently associated with a host of short- and long-term deleterious outcomes (CDC, 2019), and thus the prevention of ACEs is an important public health priority, as are efforts to help build resilience in the face of ACEs (Finkelhor, 2020; Shalev et al., 2016; Warne et al., 2017). ACEs among Native Americans must be understood within the context of colonialism and the multiple historical traumas that have resulted in the dehumanization, invisibility, and disposability of Native American people (A. M. K. Pacheco, 2009). Before colonization, traditional tribal communities were historically egalitarian, structured to show respect for one another and viewed children as sacred beings who are to be protected (Deer, 2015; Smith, 2003). However, through government policies, establishment of reservations, creation of boarding schools, genocide, and forced assimilation, Native Americans have experienced systematic and persistent loss of land, language, and cultural identity. These adversities, known as historical traumas, have resulted in the normalization of violence, substance use, incarceration, and parental absence (i.e., ACEs; CDC, 2019). Further, while the transmission of ACEs across generations has yet to be fully explored, these events may have major implications for Native families and the intergenerational transmission of this trauma.

Intergenerational transmission of trauma describes the secondary impact of trauma that is experienced from one generation to the next within family systems (Gone, 2013). Specifically, intergenerational transmission of trauma may occur through relationship dysfunction within the family unit (Vasquez et al., 2014). In addition to children's own experiences, their caregivers' experiences can also play an important role in children's functioning and well-being (Stargel & Easterbrooks, 2020). For example, families are still dealing with the repercussions of cultural genocide via the use of boarding schools to remove children from their communities and assimilate them into colonized traditions and belief systems (Running Bear et al., 2018). Despite these atrocities, Native American families are highly resilient (M. Freeman & Ammerman, 2021).

Previous studies that have examined interventions to prevent the intergenerational transmission of ACEs recommend raising awareness about ACEs in the community, building and nurturing a supportive community, and providing accessible parenting education and support which includes services for mental health treatment for parents (Woods-Jaeger, 2018).

Further, research has documented risk and protective factors for ACEs (including child abuse and intimate partner violence) among caregivers and youth. Given that the family is the proximal environment for childhood experiences, family functioning can lead to or protect against ACEs. For example, family stress and lack of discipline skills can lead to psychological and physically abusive discipline techniques (e.g., insults, humiliation, physical abuse), which are ACEs (Black et al., 2001; Stith et al., 2009). In contrast, positive family behaviors such as support, bonding, and closeness are protective against ACEs (Stith et al., 2009). Parental monitoring is also protective against some ACEs such as sexual abuse (Mendelson & Letourneau, 2015). Moreover, a common ACE is witnessing caregiver intimate partner violence. Thus, risk factors for caregiver partner violence such as drug use and aggression are risk factors for ACEs, whereas protective factors for caregiver partner violence such as conflict resolution skills and economic security are protective against ACEs (Capaldi et al., 2012; Jewkes, 2002; Lundgren & Amin, 2015). The extent to which Native American children and their caregivers perceive these to be effective strategies to prevent ACEs, however, remains unexplored.

In the current study, a participatory action research (PAR) approach was used to understand how to use family strengths to prevent ACEs among Native communities. PAR engages researchers and stakeholders alike to understand the history, culture, and context of an issue and take actionable steps to improve related practices (Baum et al., 2006). Importantly, a PAR approach legitimizes participants' knowledge by using their experiences to inform practices (Baum et al., 2006; Kolb, 1984). When working with Native communities, PAR can be a particularly beneficial approach as it orients community members and researchers as equal partners and promotes action to improve health outcomes (Blue Bird Jernigan et al., 2015). Further, unique considerations must be made to promote ethical research and practices with Native communities (Yuan et al., 2014). For example, trust between Native communities and professionals, who are often not Native (although arguably efforts should be made to change this), is a crucial consideration to be made for successful intervention and prevention of ACEs, similar to other health issues (Gonzales et al., 2018). However, given the historical mistreatment of Native communities, building trust and connection between families and community professionals can be a challenge. While community professionals who work with families experiencing ACEs hold key roles in preventing and responding to child adversity, professionals must also have skills for relationship development and emotion regulation, and practice self-reflexivity in complex situations when working with Native families (Albaek et al., 2018). Participatory and community-led research, which engages many stakeholders, may be one strategy to facilitate open dialogue and promote the development and implementation of prevention strategies (Yuan et al., 2014). Therefore, it was prudent to include the perspective of both families and professionals in the current study.

In sum, research suggests high rates and comorbidity of ACEs among Native American children as well as children living in poverty. More information is needed to understand the ways in which families and professionals can prevent ACEs by focusing on family strengths and ways professionals can identify and support the challenges that ACEs present. The purpose of the current study was to examine this gap in the literature using a focus group design that would bring forward the words and stories from these families. Specific research questions were (a) What family strengths do caregivers and youth employ to support positive youth development? and (b) How do community professionals understand ACEs and utilize family strengths in their work to help families thrive in the face of adversity?

METHODS

Participants

Three types of individuals were recruited to participate in separate focus groups: youth, caregivers, and professionals. Valid percentages are presented throughout the participants section; thus, numbers may not always add up to total.

Youth participants

Youth participants were 20 youth aged 10 to 14 years (M = 12.1 years; SD = 1.5) in Grades 3 to 9. Fifty percent (n = 10) of youth were girls, and 50% (n = 10) were boys. Youth could identify as more than one race/ethnicity; 85% (n = 17) identified as Native American/Lakota, 20% (n = 4) identified as White, and 20% (n = 4) identified as Hispanic/Latino. Of participants, 83.3% (n = 15) identified as heterosexual/straight, 11.1% (n = 2) identified as lesbian, and 5.6% (n = 1) identified as pansexual. Regarding poverty, 30% of participants (n = 6) reported sometimes worrying about not having enough food to eat. Sixty percent (n = 12) had a computer in their home, 95% (n = 19) had Wi-Fi/Internet in their home, and 75% (n = 15) had a washer/dryer in their home. Regarding living arrangement, 55% (n = 11) reported that they lived with biological/adopted mom(s), 20% (n = 4) with biological/adopted dad(s), 40% (n = 8) with grandmother(s), 10% (n = 2) with grandfather(s), 15% (n = 3) with aunt(s), 15% (n = 3) with uncle(s), 45% (n = 9) with sister(s), 60% (n = 12) with brother(s), 10% (n = 2) with cousins(s), and 5% (n = 1) with other children unrelated to them.

Caregiver participants

Caregiver participants were 13 caregivers aged 31 to 63 years (M = 45.5 years; SD = 9.5); 76.9% (n = 10) were women, and 23.1% (n = 3) were men. Caregivers could identify as more than one race/ethnicity; 92.3% (n = 12) identified as Native American/Lakota, 7.7% (n = 1) identified as White, and 7.7% (n = 1) identified as Hispanic/Latino. Of participants, 84.6% (n = 11) identified as heterosexual/straight, and 15.4% (n = 2) identified as gay. Regarding poverty, 76.9% of participants (n = 10) reported sometimes worrying about not having enough food to eat. Of participants, 30.8% (n = 4) had a computer in their home, 92.3% (n = 12) had Wi-Fi/Internet in their home, and 53.8% (n = 7) had a washer/dryer in their home. Household income ranged from approximately $6,120 to $75,000 per year ($M$ = $24,365.0; SD = 23030.9). In regard to caretaking, 23.1% (n = 3) participants took care of two children, 46.2% (n = 6) three children, 7.7% (n = 1) five children, 7.7% (n = 1) six children, and 7.7% (n = 1) seven children. Regarding relationship status, 69.2% (n = 9) were single, 15.4% (n = 2) were seriously dating, and 15.4% (n = 2) were married. Regarding living arrangement, 84.6% (n = 11) reported that they lived with (grand)children, 23.1% (n = 3) with spouse/partner, 15.4% (n = 2) with parent(s), 7.7% (n = 1) with grandparent(s), 7.7% (n = 1) with sister(s), 7.7% (n = 1) with other children unrelated to them, and 23.1 (n = 3) with other adults unrelated to them.

Professional participants

Professional participants were seven professionals aged 26 to 63 years (M = 45.6 years; SD = 12.6); 71.4% (n = 5) were women, and 28.6% (n = 2) were men. Professionals could identify as more than one race/ethnicity; all participants identified as White (100.0%; n = 7, and

14.3% ($n = 1$) identified as Hispanic/Latino. Professionals held jobs at organizations such as crisis centers, family services organizations, juvenile detention services, and the policy department; their titles include case manager, community education coordinator, health care worker, program associate, and lieutenant. Time in current position ranged from 6 months to 20 years. Six professionals (85.7%) had children.

Procedures

Before the start of recruitment, approval for the project was given by the university's institutional review board. Participants were recruited via flyers posted at community organizations, through the project social media posting, emails to community partners and supporters, and by word of mouth. Interested individuals contacted the research office via phone and responded to eligibility questions. To be eligible, youth had to be aged 10 to 14 and identify as either American Indian/Native American and/or from a family living below the poverty line as determined by a series of screener questions. Caregivers had to be the caregiver of youth who met those same criteria. Professionals had to hold a part- or full-time position in a job related to family services and address ACEs in their work. Caregivers and professionals signed consent forms before participating. For youth, legal guardians signed consent forms, and youth signed assent forms. Data were deidentified and stored in a secure location before the coding process. Youth and caregivers received $20 cash for participating. As long as it was permitted by their job, professionals were also provided with $20 cash for participating.

There were two youth focus groups and two caregiver focus groups; these focus groups occurred in person at a local community organization. Youth and caregiver focus groups occurred at the same time and location in different rooms considering many families participated together. There was one professional focus group, which occurred via video conference. Focus groups lasted approximately 45 minutes. A semistructured interview guide was created by both research and programming staff. This guide solicited responses regarding family strengths, challenges, and perceptions of resources (see Tables 1–3).

Analysis plan

We used a thematic analysis approach (Vaismoradi et al., 2013) to assess the gestalt of the data and to identify, analyze, and report patterns or themes within the data (Braun & Clarke, 2006). A thematic analysis was chosen for these data because of its alignment with participatory research, which includes participants as collaborators (Braun & Clarke, 2006). The authors analyzed the interview data, and initial codes were developed using the semistructured interview guide. The team members then added open coding by independently reading and coding each interview for emergent themes. They then met to discuss each interview. These meetings resulted in a list of major themes that arose during the interviews. This coding occurred while the interview data were still being collected so that we could determine when the data were saturated and thus when the interview data collection was complete. After coding all interviews, the team members independently read all interviews a second time; this second reading resulted in a final list of major themes, which were agreed on during discussion.

RESULTS

Data from each focus group were evaluated separately for themes. In general, similar themes were found for the caregivers and youth focus groups, and therefore results are presented

TABLE 1 Youth focus group structured guide

1. Let's start with having you each tell a fun fact about you. This could be your favorite subject in school, a hobby that you have, your favorite TV show, or anything else!
2. What are some things you like to do with your family? What makes those things fun?
3. What things do your caregiver do that make you feel loved?
4. What are your goals and dreams? What can your caregiver do to help you reach your goals and dreams?
5. What are some of the rules at your house? What do you think about them? What happens when you do follow the rules?
6. What types of things does your caregiver do to make you feel safe, especially to keep you safe from other adults hurting you?
7. When you are feeling mad, sad, or scared, what do you do to make yourself feel better?
8. How does your caregiver do to help you feel better when you are sad or scared or feeling some other type of feeling that you do not like?
9. When you're upset with your family or they are upset with you, how do you work things out?
10. How does your family work together to solve problems?
11. What types of things do you do in your community, like are you part of any organizations like [names]? Why or why not?
12. To end, please tell us about a fun day you had with your family recently.

TABLE 2 Caregivers focus group structured guide

1. Let's start with having each of you telling us a fun fact about you. This could be a hobby, your favorite thing to do with your family, your favorite TV show, or anything else that you feel comfortable sharing!
2. What are some things you like to do with your family? What makes those things fun?
3. What are some of the goals/hopes/dreams that you have for your children and your family? How do you support your child's goals/dreams?
4. How do you help your children deal with strong emotions, things like anger and sadness?
5. What things do you do to show your child that you love them? That you are proud of them? That you want them to do well in life?
6. What things do you do to keep your child safe, for example, from other adults hurting them?
7. What are some of the problems that your family has had to solve together? How does your family work together to solve problems?
8. What are some of values that are important to your family? Oftentimes values are related to one's culture, religion, and/or spirituality.
9. Who do you go to for support around family issues? What types of supports would you like to see in [location] to help families?
10. What are ways that you involve your children and family in community and/or cultural activities?
11. How do you manage conflict with your spouse/partner? What would be helpful to you in figuring out ways to handle conflict better?
12. We asked you all of these questions today because as we said earlier, we want to make a program that builds off family strengths to help families overcome difficulties. One difficulty that we know about happens in [location] is adverse childhood experiences or ACEs. Have you heard of ACEs? What do you know about ACEs? Why do you think ACEs, especially things like child abuse and children's exposure to domestic violence, happen? What can we do in the program to help prevent ACEs and children's exposure to domestic violence?
13. To end, tell us about a fun day you had with your family recently.

Note. ACEs = adverse childhood experiences.

together. Themes that emerged from the child and caregiver focus groups regarding family strengths included (a) family engagement, (b) family and cultural values, (c) personal and family safety, (d) future orientation, and (e) community strengths and needs. Data from the

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TABLE 3 Professionals focus group structured guide

1. Let's get started by having each of you share what you do professionally in the community and how the work you do is related to ACEs and/or domestic violence.
2. What types of work is happening in the community right now to prevent and respond to ACEs?
3. What features of a family-based program do you think would be effective in reducing ACEs among children and domestic violence in their caregivers?
4. What types of skills do caregivers need to keep their kids safe? What do you foresee as challenges to teaching these skills to caregivers?
5. What types of skills could we teach children that would help keep themselves safe?
6. What types of things do you think helps families be strong and safe, especially those who are living in poverty where resources are limited?
7. What strengths do you see in the families you work with?
8. What are some of the values of families that you work with that could help promote resilience? These could be values related to Lakota culture and/or religious/spiritual values.
9. What types of things do you do with families in your work to help keep kids safe? How do families respond to this type of work? What types of things do families like in your work with them?
10. What are some of the challenges to working with families? How can these challenges be overcome?
11. What types of things would be helpful to you as a professional in understanding more about ACEs and how to prevent them?
12. What resources are available in the community to families? [Show them resource sheet.] Are we missing any important resources on this list?

Note. ACEs = adverse childhood experiences.

community professionals focus group produced different themes, and therefore results are presented separately. Themes that emerged from the community professionals focus group for the ways in which ACEs impact families included (a) families in crisis, (b) intersectionality of family challenges, (c) community collaboration, (d) trauma-informed practices and violence prevention, and (e) cultural connections. It is important to note that the results of this study are not meant to be generalized to the entire population of Native Americans and/or those living in poverty in the United States. Instead, we aimed to report ways families and professionals could prevent ACEs in this community in the Northern Plains region of the United States. The opportunity to amplify the voices of a an understudied and highly underserved, silenced, oppressed, and minoritized population and use this information to support their resilience and program development efforts is a worthwhile cause.

Youth and caregivers perspectives

Family engagement

Youth and caregivers discussed engaging as a family through time spent together, showing love to one another, and managing conflict. Participants shared that they enjoy doing activities as a family, especially outdoor activities, because it gets them away from technology and allows them to engage with one another more fully. One caregiver shared:

> Electronics is big in our house and so they kind of go their own separate ways. So, I try to get them to go out. So, like this summer we did the free bowling and they really, really, really liked that and they didn't think they would, and they looked forward to it every week.

Further, participants said that spending time together was more than occupying space in the same room but was their time to build relationships with one another via interactive activities. One youth shared: "Sometimes we play board games with each other which is fun cause like we get to spend time together." Whereas parents stated that they wished for more affordable options for activities outside of the home, youth described wanting simple, inexpensive activities to do as a family (e.g., walks outside, playing with the family dog, baking, playing sports, go for drives). For example, one youth shared: "I like when we go to the lake with packed lunches."

Participants also described how they show love to their families and how their families show love to them. Youth mentioned physical touch, such as hugs, and vocalizing their love and appreciation. One youth shared that their parent vocalizes their encouragement: "Uh, my mom cheers me up and … when I'm like sad, when I give up, and she cheers me up, so I don't have to give up." Another shared: "My mom always comes in my room to check on me, just talk for a bit." Caregivers also mentioned physical touch and vocalizing their love. For example, one caregiver said, "I always tell them I love them. When they walk by me or something I hug them. … Just show them that unconditional love. … Anytime you pass them. All day." However, caregivers also mentioned putting in the time to show up for their youth as a way they show love.

> Time. … My parents didn't have time for me. … I had a mother and two stepfathers, and I had a dad. I don't know. You know just time … you know. I … you know … the Christmas … you know it's Christmas time and they go to the Christmas programs. Be there. Go there. Support them. I didn't have that you know … all the kids are like where's your family at … you're talking and I'm like my mom's drunk. She can't come here you know.

Lastly, in relation to family engagement, participants discussed managing family challenges. Participants shared that the most important piece to managing family challenges and strong emotions was having a solid support system and good communication. Active listening and compromising were included in participants' definitions of communication. They also shared the importance of using friends and other relatives as resources for advice and other help. As one youth said,

> Um, I have a pretty good support system with my friends and I'm usually always with my boyfriend so he's always there to help me with any [anxiety] attacks or anything like that. Or I just listen to music. … Stuff to make me like feel better, like I can do this or I don't know, Like upbeat, maybe not sad anymore.

Youth also emphasized the importance of giving people space after conflicts occur to manage challenges successfully. For example, one youth said, "Me and my mom we usually never really, 'cause we usually agree cause we like the same stuff … but if something like a problem then we usually just talk it out or give each other space." Caregivers focused on communicating through issues to find solutions:

> Yeah. Talk. Um … my older two have … um … to deal with a lot of anxiety and depression. So, we talk. We go to play basketball … umm … they're really good about letting me know how they feel. You know when they're angry … they get mad about so they can just start fresh. They've actually come a long way with it.

Family and cultural values

In this theme, participants shared the virtues their families live by and their engagement in traditional ceremonies. Families shared the importance of respect, having a strong work ethic,

honesty, trust, and communication. Caregivers shared that these values were critical for their youth's futures as they would need these skills throughout their lives to be successful. For example, one caregiver shared the following:

> I think a lot of kids they don't want to work for what they have. So, there's a lot of umm … entitlement. Even when … even when you know I don't think my kids are spoiled but compared to somebody else they might think my kids are spoiled, but to just want things without having to you know do chores … or like this is the real-world things are not free you are not spoiled. What are you doing? You have to work for what you get.

Some caregivers disclosed intentionally engaging with youth in cultural ceremonies, such as Sundance, because the caregivers did not feel a strong sense of connection with their culture due to growing up without being taught about it.

> Like religion. My grandson went to Sundance so you know we … we go to a Sundance and we sit and we observe. I mean I danced already but I want him to know what it takes to being a Sundancer, you know. You know because I don't just want him to jump in there.

Some youth shared about engaging in local mentorship programs grounded in traditional culture: "I learned how to bead earrings and I learned a lot more. We always did a lot of stuff." Some youth had more experience and insight into their culture than the caregivers.

Personal and family safety

In this theme, caregivers talked about how their ideas surrounding caregiving were informed by their life experiences. They implemented ways of caring that they felt were helpful in their own lives and were intentional about not repeating behaviors done to them that they felt were harmful. This included teaching them to recognize and respond to red flags. One youth shared: "My mom always tells us to defend ourselves and to notice red flags like about strangers." Youth discussed rules their families have to keep them safe. For example, one youth disclosed: "We have to close the curtains before noon. … Our mom is very protective, she doesn't want people staring at us through the windows."

Caregivers discussed teaching skill building, life lessons, and parental monitoring. As one caregiver recalled,

> my mother never discussed periods with me and you know I do have a daughter. But what I know they know now. We are are … we are basically their first teachers. As parents you know. Like I said my mom wasn't told and I wasn't told but my daughter knows now. Yeah breaking that cycle of not of being in the dark you know. Everything my mom … when she first had her period, she thought she was dying. She got back from school and she thought she was dying. But no its okay.

Youth talked about practical skills their parents taught them, such as locking doors and being aware of their surroundings: "Notice your surroundings whenever you walk home."

Caregivers also discussed other skills it is important for youth to have, such as understanding autonomy over their own bodies. For example, one caregiver said, "And then also just let him know what's safe and what's not and what's good and what's bad about anyone touching you or talking to you or trying to get to you to go somewhere." Caregivers also talked about

monitoring who has access to their youth. For example, one caregiver shared that they gatekeep by "watching who I allow around them like my friends or my … uh … their … my boyfriend's friends or even you know. … I kind of quit hanging out with a lot of people." Youth also recognized their parents' monitoring efforts. For example, one youth shared: "Um, I guess I always got to tell her where I'm going first and then check in here and there. But I usually check in with her so."

Future orientation

Participants described their hopes, goals and dreams for themselves and their families. Caregivers discussed providing support to their youth to encourage them to pursue their future goals in hopes of deterring them from experiencing negative events they themselves were exposed to as children. While the caregivers focused more on education and personal traits when discussing their youth's future, youth focused more on future occupations. One youth shared: "Um, and my grandma says, um, if you want to reach your dreams, um, you have to stay in school and get good grades." Another said, "I want to be a professional NFL player or a blacksmith." Further, caregivers discussed their hopes that their youth would be good people who are able to provide for their communities in the future. As one caregiver noted,

> Just that they are decent human beings that when they launch themselves out into the world that they are kind and smart and fun. You know you don't want them to be a nuisance or a burden on society. You want them to contribute just what every parent wants for their child is just the best possible you know beginning. There's a lot of challenges on the way and just to know that they are supported and loved and they can always come back and that they have a lot of family that wants to see them succeed and lift them up and so you know just so that they don't ever feel alone or hopeless.

Community strengths and needs

Participants discussed how community interactions provide opportunities for engagement and barriers or challenges regarding the support they desire. Several families discussed engaging in community service. One caregiver shared:

> One thing is like with my boys is they … we … umm … we volunteer to feed … to help feed. And they're like you know why are we doing this? You know there's less fortunate than us and we … I want you to you know be humble.

Another shared: "Umm … my kids and I help with the school supply drive and my daughter and I … umm … volunteer at the foodbank." Youth also discussed being involved in community activities. One youth said,

> I'm a part of [organization] because [organization] is like this place full of activities and like there are places to a do sports stuff like main gym and the boys gym and there are like these, not like video games, but like these mini games I want to say, and there's like a library and [science] lab and stuff like that.

Participants discussed needing access to basic resources such as transportation, healthy food, and free or inexpensive activities for families to do together. They shared that even when

resources are free to youth they are not for caregivers, and this creates barriers for families being able to spend time together. One participant also mentioned racism as a barrier to accessing community resources and hindering connections between community members. One caregiver described this as follows:

> Biggest one is racism … I'm glad they [my kids] don't look Indian like I look you know 'cause everybody hated me and all they hated me 'cause I was Indian … that's here in this town. Yeah it's a big problem. Big, big problem.

Some participants also discussed desiring more resources that provide support for behavioral issues and families going through recovery. For example, one caregiver shared:

> Maybe a better drug treatment program or like a detox to help families struggling with drugs and alcohol and how common it is and how overlooked it is you know, I know umm that's just umm something I can see for my family.

Another caregiver shared:

> Something like a hotline for … like me like I'm raising a grandson. And he's 13 years old and I got him. And you know sometimes I … I have issues on you know his behavior or you know. Just in general, like for anybody… you know talk to me about it and you know don't be mad all day. They weren't happy or they were uncomfortable with me you know they could call somebody and say hey.

Community professionals perspectives

Families in crisis

Professionals noted that it can be difficult to work with at-risk families because they reach out when they are in crisis and cut off communication soon after the crisis has been handled. They speculated that families fear they will be reprimanded for having made a mistake, which in turn prevents them from consistently engaging in services. One professional shared the following:

> I lose a lot of client communication when they do what they think is like messing up. So, they make a mistake and they just they just cut contact until again they're in crisis and then they, they know that I help them in crisis mode so we're like, smooth sailing and all of a sudden they like hit a hiccup or they quit their job or you know they use, maybe their treatment in the US and so then, rather than … build that resilience, they just leave. They just cut contact and usually hear from again and they're in crisis.

Another said,

> I think, to one of the frustrating things is, you know, families who are so used to doing functioning out of a crisis kind of response or crisis situation. So, they're in crisis and they reach out for help. For the immediate need, but they don't do the follow through to help in between times so they wait until the next crisis and that's a survival thing but it doesn't help improve the situation because you're only doing, you're just dealing with crisis after crisis after crisis.

Professionals also discussed that clients can become so used to being in crisis that they at times sabotage their own progress:

> And then I have other clients who would I call self-sabotage—they're doing a really good job and they get like so panicked because they're not used to having, like celebrating all those great things happening, they don't know what to do when they're not in crisis because they've always operated in crisis, and they create a crisis for themselves.

Intersectionality of family challenges

Professionals discussed how there are many different layers of problems families are dealing with when they seek treatment. For example, one provider described the following:

> I would maybe say, like, the complexity of, you know, sometimes your interaction with them was for one reason but there's so many more layers to that and that can be daunting as a provider but also for the family to dive in and work on those, those layers. So maybe just complexity of some of the needs and the means that families need to do the healing together.

Further, while crisis situations were discussed as typically being a presenting issue, there is usually much more going on, and it is difficult to know where to start. Often agencies try to address interpersonal issues when families do not even have their basic needs met. As one professional stated,

> I think in order for any positive outcome to take place, you have to address, you know, Maslow's hierarchy of needs. Because if there's not safety, if there's not those kinds of a home for them, food, all of their needs taken care of, they're not going to progress any further to do any prevention work or doing any treatment work so in a family based model you'd have to make sure that there are pieces of that, and you know one heart is a great place that they can take care of some of those in, in regards to a place to live and getting other wraparound services and that's the other thing of family model needs to have wraparound services. If not, not one agency can necessarily do it all but a group of agencies together.

Further, some professionals discussed how for minority communities, stigma surrounding help-seeking is an issue: "I think to a big a huge issue for a lot of my clients is like the stigma of asking for help." Another noted that

> there's this stigma about them having a coach or a mentor … and it takes time to build that rapport and build that trust and we have so much stigma in our community about asking for help. It is a huge barrier to overcome. I think for everybody in our field that sometimes it is so hard because we, we can identify like how we can help that person, but they must be ready for that help. And, and sometimes they just are not because they are too embarrassed.

In general, professionals held the viewpoint that stigma stops people from reaching out and asking for help when they are in need.

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Community collaboration

Professionals shared that there is a lot of collaboration happening between organizations in the community, but communities are not always made aware that these collaborations are happening. For example, one professional said

> … what astounds me is the interagency collaboration, like maybe we'll have a case manager, whose job will be to focus on clients that are over [program] collaboration, and we work with [agency] so we're working with the youth that work with [agency] and [agency] comes and works with our youth, and there's all these things that you do see that are overlapping to make sure that that we are touching all those bases, but I think that's a big strength is that interagency collaboration. That's just going on everywhere.

Getting resources to communities seems to be the biggest challenge and is the area in need of the most improvement. Community professionals are working together to make sure their services are not overlapping, but they are not successful at communicating this information to the communities they serve. Professionals also shared that it would be helpful for there to be protocols about whom to call during situations based on which organizations are meant to help with which pieces.

Professionals also shared that street outreach may be the most helpful way for professionals to reach families in need:

> I think going to more of a kind of a street outreach where we bring the services to people, versus expecting that people to get to the services would be a big step in the right direction. We respond to, you know, child abuse, domestic violence. And we don't, we don't have any one on scene that we can, that we can turn that victim over to, there's usually some, some gap between that, that, that act of violence that they experienced and when they connect with services. So, we would love a co-responder model where there's a domestic violence team that responds with us, and their services provided on scene to the, to the, to the victim to the kids in the household, so that we really cut down that gap and services between. When that happens, and when they first come in contact with someone who's going to help them.

Trauma-informed practices and violence prevention

Professionals expressed concern about the lack of knowledge about working with trauma and addressing ACEs. Although some shared that they were aware of ACEs, their background was not specific to understanding them. For example, one professional said:

> So, we're definitely, you know, becoming more aware as a police department on how we respond to things whether it's juvenile issues or, or the homeless population that trauma is at. Kind of … the core of a lot of the issues that we're dealing with so my educational background is chemical engineering which has nothing to do with social work or being a police officer but that is what it is.

Others were trained to recognize and assess for ACEs but felt there was a lack of training around what to do with ACEs scores:

> And we have that, we look at it and then we just say okay and then we move on. And so, I think, just getting that knowledge on how to be trauma informed like great we know they have trauma now what do we do with that information has been like pivotal for me is just hearing [name] talk about that experiencing your own and ACE score and sitting with that and working through that I think is, is really eye opening for professionals, and you know it was kind of a basepoint for me the first time I just saw [name] and I went, Oh, holy cow this all of a sudden makes sense.

Even with a perceived lack of understanding or training on addressing ACEs, most professionals acknowledged the importance of providing trauma-informed practices.

Other key components professionals identified for preventing violence included positive role-modeling, helping caregivers deal with their own trauma, and helping caregivers and youth understand age-appropriate responsibilities and expectations. Specifically, helping caregivers understand what is appropriate for their child's level of development. As one professional remarked,

> … the other thing that happens that we see a lot of times, is that parents' own trauma, makes it hard for them to respond in ways to protect the kids it is that fight, flight, freeze that a lot of times they are frozen they are numb. They are, they are not aware of what is happening to their child or how it is affecting their child, because they're stuck in their own trauma history.

Cultural connection

Professionals disclosed feeling that they lacked understanding of the cultural needs of Native families. They shared that they perceive a lack of understanding on their part about the family dynamics for Native families. They also shared that they feel a distinct lack of connection with Native communities. From their perspective, helping Native people connect back to their culture is important because it fosters growth and resilience for families. Although culture has been lost in the Native community, connecting families back to those resources can help them increase their knowledge of traditions and help them find a sense of cultural identity. This further provides Native people with a feeling of community, and they then stick together and take care of one another. For example, one professional said:

> I think sometimes to the cultural background, so they have a cultural connection that they can maintain or foster growth, whether that be also a spiritual, they have a spiritual connection a spiritual a church or something else that helps with the support for them, can help families be resilient.

Professionals also mentioned the relevance of formal and informal support systems among Native families. They shared that both types are important, but informal support systems see to be more prevalent for families. In particular, families that have experienced difficult situations may at times come together with others in their community who have experienced similar things and work through rough times together. One professional shared:

> They stick together, like in the shelter and the families have to be, they tend to want to do that anyway and I see, I do see these kids, stepping up for them and the older ones stepping up and helping with the younger ones or we've had clients who they have a mom whose health is not great, and the other child will help them out and

> do things for her. I think that loyalty and that down in it together can be a real strength for them because they did stay kind of connected and in contact with each other.

Professionals also shared that they believed strengthening informal sources of support would reduce the need for formal support systems. Reducing reliance on formal sources of support may also help create a sense of independence and confidence for families. Informal supports also help families feel more connected to their community:

> I would maybe offer up that you know there is a strong network of what I would call formal support. But there's also a strong network for many families of informal support, and families knowing how to create those informal support to help one another is truly a really cool thing how families will help each other out. So, I'd say a strength is just that informal network that families create, whether it be in times of crisis or, you know, just maybe not full, full crisis but times where they need help.

DISCUSSION

This study used focus groups to understand how youth, caregivers, and community professionals perceive family strengths and ACEs in a small community in the Northern Plains. Youth and caregiver focus groups provided information about using family strengths to prevent ACEs directly (e.g., positive role-modeling, identifying support systems, street outreach) and indirectly (e.g., trauma-informed training, destigmatizing experiences, community collaboration). Incorporating components into programming that focus on increasing effective communication between caregivers and youth, teaching youth about appropriate and inappropriate touch and having autonomy over their bodies, and incorporating parental monitoring skills are all elements that may have an immediate impact on ACE prevention. Examples of programs that have previously used components such as these include the Strengthening Families Program (SFP) to prevent substance use and initiation (Kumpfer, 1998) and the Bii-Zin-Da-De-Da Program (a culturally adapted version of the SFP; Whitbeck, 2017); more recently, the IMpower program has been shown to reduce sexual assault among middle and high school girls on an Indian reservation (Edwards et al., 2021). Thus, programming that seeks to promote family bonding, build skills in both caregivers and youth, and enhance cultural identity and connection to culture may be effective tools in preventing some types of ACEs, in addition to promoting resilience in the face of ACEs.

Families and professionals also illuminated more long-term methods of preventing ACEs, including helping Native families further connect to traditional values, emphasizing future orientation and goal setting, and helping caregivers recognize their own trauma to reduce intergenerational transmissions of trauma. For Native youth and their families, positive effects on family and individual functioning have been described as outcomes (B. J. Freeman et al., 2016). Lakota traditions, customs, and values may also be valuable for everyone, not just for Lakota people, and are considered the Lakota people's gift to the world (Marshall, 2001). As such, non-Native families may also benefit from culturally grounded programming to prevent ACEs. Another programming implication that emerged from these findings is consistent with research that individuals with low future orientation have been found to be more likely to engage in risky health behaviors (Brezina et al., 2009; Piquero, 2016). Thus, promoting future orientation is an important component to include in ACE prevention programming for families. Lastly, literature has identified the necessity of addressing unresolved mental health symptoms for caregivers, which are often rooted in their own histories of ACEs and may interfere with personal functioning, parenting, and family well-being; these can become additive risks for child

ACEs (Chemtob et al., 2013; Narayan et al., 2021). In all, these data highlight the complex intersections between caregiver and child factors, family dynamics, history, and culture.

Extending data collected from children and their caregivers, the community professionals' focus group highlighted a disconnect between families' current needs and what is being addressed by professionals. For example, working on emotional regulation skills may not be helpful if families are struggling to have consistent access to food and shelter. This indicates a need for organizations to assess for basic and crisis needs before beginning further work with families. Professionals also illuminated the importance of trust and connection between families and professionals. Although trust is important with all families, it may be especially important for families from groups who have experienced historical mistreatment by various systems. It is important to keep in mind that all the professionals in this study were White and non-Latinx, which is representative of the community in which this study took place despite the large presence of Native Americans in the community. Efforts are needed to increase the number of professionals who are Native American as well as the extent to which services are culturally grounded. Finally, the professionals' focus group brought forth the importance of normalizing setbacks and mistakes when seeking help. Perhaps framing treatment as nonlinear would help normalize behaviors that may contribute to premature termination of services and for Native families linking setbacks to the Lakota virtue of perseverance and courage.

Limitations

Although this study aimed to address current gaps in literature via a focus group design that emphasized family strengths instead of deficits, it is not without limitations. First, there was a small sample of participants. Participants were mostly in agreement about their answers, but a small sample size increases the possibility that opposing viewpoints were not addressed. Nevertheless, the data appeared to be saturated. Second, the majority of caregiver participants were female. The male perspective on the topics addressed are missing and may differ. Future research should make concerted efforts to include more participants and to include male caregivers in the focus groups. Third, because the presence of Native American professionals is limited in the location where the study took place, all the participants in the professionals' focus group identified as White; more research is needed to gather the perspectives of Native American professionals in social services and increase their presence. Finally, the interviews were held in a group setting and therefore were not private. This could have affected participants' responses. Future research may use qualitative questions to ask more pointedly about the role of culture and quantitative methods that can more specifically examine the role of culture as a protective factor against ACEs and their deleterious outcomes.

Conclusion and implications

Associations between ACEs and heightened rates of physical and mental health concerns have been identified in literature (Radford et al., 2021). However, to date, few studies have examined these relationships in Native populations or considered links to historical trauma, racism, and systemic discrimination. Importantly, this study highlights insights from professionals who work with Native families and youth who have experienced ACEs. Understanding these perspectives is important because there has been a historical distrust between government systems and Native and impoverished communities (C. M. Pacheco et al., 2013). Additionally, the current study illuminated numerous important themes about using strengths to prevent ACEs among Native American youth and youth living in poverty.

The information in this study highlights the importance of understanding the protective role of caregivers and families in addressing positive youth development to support adolescents' social–emotional development. A sustained focus on strength and resilience, moving away from "damaged-centered" research and practice, is critical to future work in these fields. As shown in the current study, caregivers and youth could readily identify the strengths of their families, even while acknowledging challenges. Further, using strengths-focused, culturally grounded work for programming will assist in decreasing these families being viewed as damaged and reducing the stigma that prevents Native families and families living in poverty from accessing care. The information in this study will also be used to develop a program to prevent ACEs for this community, focusing on the strengths highlighted by these families (e.g., family engagement, cultural values, future orientation). Using data from the local community is one way to ensure that program development is in line with local culture and systems, giving the program the best chance of success.

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