


What Kinds of Support are Alaska Native Youth and Young Adults Reporting? An Examination of Types, Quantities, Sources, and Frequencies of Support

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American Indian and Alaska Native (AI/AN) youth, particularly males, experience disproportionately high rates of suicide compared to other young people in the United States. Therefore, enacting suicide prevention efforts for AI/AN youth is especially important. Since research shows that strengthening social, cultural, and emotional support can reduce suicide risk, many recent prevention efforts focus on these strategies. Yet, to reinforce and to extend the positive impact of these strategies for suicide risk reduction, we argue it is useful to identify baseline levels and other features of already-existing support. Toward this end, we describe the types (i.e., category), quantities (i.e., distribution and average number), sources (i.e., from whom), and frequencies (i.e., how often) of social support that AN young people report receiving, and we examine if these “support profiles” differ by age and sex. We use survey data from 165 ANs under age 30, collected as part of a participatory intervention study focused on Promoting Community Conversations About Research to End Suicide (PC CARES). We find that: 1) most ANs reported receiving nearly all supports, 2) compared with females, males reported receiving fewer supports on average, 3) family was the most selected support source, followed by close friends and service providers, and 4) family (e.g., parents, siblings, and grandparents)

provided support regularly (i.e., monthly or more). Though our findings may suggest fruitful avenues for interventions targeted toward AN males, we discuss these findings in relation to the gendered nature of suicide prevention and assessment.

Keywords: Alaska Native; mental health; community-based participatory research; child/adolescent health; health disparities; social capital

► BACKGROUND

Suicide is a serious concern for American Indian and Alaska Native (AI/AN) communities. It is the leading cause of death for Alaska Natives (ANs) aged 15–29, and risk is especially pronounced for AN males (National Center for Injury Prevention and Control, Centers for

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Disease Control and Prevention [CDC], 2021). Within the United States, suicide rates among AI/AN adolescents are the highest of any racial/ethnic group (Leavitt et al., 2018); in 2019, for example, Non-Hispanic AI/AN suicide deaths totaled nearly 40 per 100,000—a rate over 3 times higher than all other groups (National Center for Injury Prevention and Control, CDC, 2021).

This disparity in youth suicide has emerged only in the past 50 to 100 years and can be traced to intergenerational trauma perpetuated by decades of forced social, cultural, economic, and political change via colonization (Wexler, 2006, 2009). Though effects are widespread among Indigenous communities, youth are uniquely impacted because they are subjected to ongoing oppression and marginalization during formative periods of identity development (Trout et al., 2018). Especially for those from remote communities, this occurs alongside complex negotiations of intersecting sociocultural, racial, and geographic identities (Brown et al., 2016). AI/AN young people thus endure distinct circumstances that should specifically be considered when developing and enacting prevention efforts (Wexler et al., 2015). Suicide prevention efforts that build on community strengths and cultural values are crucial (Wexler & Gone, 2012).

Informed by these insights, recent suicide intervention and prevention efforts have shifted primarily from risk detection—which is especially challenging in heterogeneous AI/AN communities (Williamson et al., 2014)—to bolstering social connections as an upstream approach to prevention. Indeed, research shows that strengthening social and emotional support, particularly within the family, school, and larger community, protects against AI/AN suicide attempts (Bush & Qeadan, 2020). This linkage is in part due to the coping skills, social connections, and help-seeking behaviors fostered by these supports, which attenuate the effect of poor mental wellness on suicidal thoughts and behaviors (Beaudoin et al., 2018). Building on informal familial supportive relationships may also be more aligned with Indigenous beliefs, practices, and values (Kirmayer et al., 2016).

Previous work, though important, lacks descriptive information about the types of support AI/AN youth already receive (preintervention). Particularly lacking is information from young people’s perspectives about the *types* (i.e., category), *quantities* (i.e., distribution and average number), *sources* (i.e., from whom), and *frequencies* (i.e., how often) of support they receive, including if there are differences across demographic characteristics. We refer to these dimensions of support as “support profiles.” Assessing existing support profiles is critical because it can inform prevention initiatives by strategically building upon current support systems to amplify the efficacy of interventions aimed for those most at risk.

► AIMS

In this paper, we assess the existing state of support profiles among AN youth and young people in rural Alaska. Given the sex (and age) disparities in suicide risk across AI/ANs (Gracey & King, 2009; Wexler et al., 2008, 2012), we ask if certain ANs (e.g., males, teenagers) have more (or less) robust support profiles than others (e.g., females, young adults). Our goal is to provide a snapshot of young people who reported on a range of supportive interactions in the past few months. The results can be used to improve current strategies geared toward AI/AN populations.

► METHOD

We use baseline survey data collected as part of the Promoting Community Conversations About Research to End Suicide (PC CARES) initiative. PC CARES is a suicide prevention program which builds the capacity of local people in rural Alaskan villages to take preventive and health-promotive actions based on their existing relationships, roles, and priorities. Like other successful multifaceted, community-based strategies employed to improve health-based problems among adolescents (see, e.g., Kristjansson et al., 2019), the PC CARES community intervention seeks to engage multiple sectors of the community in learning about and using scientific research to guide their self-determined suicide prevention actions (see Wexler et al., 2016, 2019 for more information on PC CARES).

Baseline survey data were collected in-person, electronically on iPads, and included items assessing beliefs, actions, and supportive interpersonal experiences. Survey items were developed in partnership with local community members and service providers, and items reflect both local patterns of support as well as those that may be affected by the PC CARES intervention. Data were collected in the fall of 2019 from members of five remote communities in rural Alaska. Each village was surveyed over a period of 1–2 days by a PC CARES research coordinator who had spent significant time in the region and was familiar with the villages.

Participants were recruited by posting informational flyers in high traffic areas around each village. The flyers introduced the PC CARES model, the main points of contact for the project, and the dates, times, and locations for participation. It also noted that compensation for participation was \$20 in cash. All five participating villages are extremely rural, with limited infrastructure connecting them to adjacent areas, and village population ranged from about 200–900 people. As word of mouth is commonly used to share information in these

communities, many participants were recruited indirectly by hearing about it from others. This means that the participants reflect a convenience sample of AI/AN villagers. All research was reviewed and approved by PC CARES researchers' affiliated university Institutional Review Boards as well as a regional ethics review board composed of local people.

A total of 419 individuals participated in the survey (about 15% of the pooled population across participating villages), 182 of whom were young (aged 15–29). The sample used here includes data from 165 of these young people who provided answers to all seven support items included in the survey version specific to participants under the age of 30. Each item asked participants to indicate whether the statement reflected a supportive interaction they had in the past few months (see Table 1). Four items involved “general wellness” support (e.g., “Someone helped me talk about how I was feeling”). The other three involved “support in times of stress” (e.g., “When I was down, someone reached out to me”).

If participants selected “Yes” to an item, they received up to three follow-up questions. The first asked who provided the support. Participants could select all that applied from the following broad sources: “Family member,” “Someone else,” or “Service Provider.” Next, depending on the broad sources selected, participants further specified by selecting all that applied from a detailed list. Collectively, this second question provided an exhaustive list of 31 specific sources (see Table 1). Finally, if any of the specific sources were selected, participants indicated the frequency with which they received support from each. Response options were anchored on a scale from 1 to 7: 1 = “Once,” 2 = “A Couple Times,” 3 = “Once per Month,” 4 = “A Couple Times per Month,” 5 = “Weekly,” 6 = “A Couple Times per Week,” and 7 = “Daily.”

Our analysis proceeds in four sequential steps. First, we examine the overall distribution and average number of supports that were selected (i.e., *quantity*). Second, we examine each support separately (i.e., *types*). Third, we examine the broad sources of support for each support item (i.e., *sources*). Last, we examine how often support was received from each broad source for each item (i.e., *frequency*); we also briefly explore the specific sources selected. Throughout, we test for differences by age and sex with multiple pairwise comparisons. If no age by sex differences were significant, we tested for differences by sex and age separately. We use chi-square tests of independence, *t*-tests, and one-way ANOVAs as appropriate, using a Bonferroni correction for multiple tests to evaluate statistical significance.

► RESULTS

Study Sample

In this sample of 165 people under 30 years of age, 102 indicated they were male (62%), and 63 indicated they were female (38%). This reflects a slightly higher proportion of males under age 30 in the sample than in the pooled population of participating villages (about 56%; U.S. Census Bureau, 2021). We suspect that this reflects greater availability of males in the late fall (when the survey was administered), as it is after caribou migration when many hunters have completed the bulk of their harvests and have more free time. Consistent with previous research, our analysis separates the sample into two age groups: youth aged 15–19, and young adults aged 20–29 (Wexler et al., 2008, 2012). Just over half the sample were aged 15–19 (85; 51%), while just under half were aged 20–29 (80; 49%). See Table 2 for a demographic breakdown of the sample by sex and age.

Quantities of Support

We begin by describing the distribution of the number of supports reported. Considering all support items together, participants reported a wide range—anywhere from none to all seven kinds of support. However, nearly everyone (96%; 158 people) reported receiving *at least* one kind of support over the past few months. On average, participants selected just under five supports ($M = 4.88$, $SD = 2.14$), including about two general wellness supports ($M = 2.25$, $SD = 0.95$) and about three supports in times of stress ($M = 2.64$, $SD = 1.38$). Across sex (no tests by age alone or by age and sex combined were significant), females reported significantly more general wellness supports ($M = 2.48$, $SD = 0.96$), $t(163) = -2.47$, $p = .007$, supports in times of stress ($M = 2.95$, $SD = 1.22$), $t(163) = -2.34$, $p = .010$, and aggregated support ($M = 5.43$, $SD = 1.84$), $t(163) = -2.60$, $p = .005$, than males ($M = 2.11$, $SD = 0.88$; $M = 2.44$, $SD = 1.45$; and $M = 4.55$, $SD = 2.26$, respectively).

Types of Support

Next, we examined each type of support in more detail. Table 3 shows item selection frequencies and tests for differences by sex (no tests by age alone or by age and sex combined were significant). Though only two support items show selection differences, in both cases, more females selected the item compared to males. Thus, differences in these two items likely drive the aggregated differences discussed above.

TABLE 1
List of Support Items and Source Options

<i>Support item</i>	<i>General sources</i>	<i>Specific sources</i>
<i>In the past few months. . .</i>	<i>With whom?</i> <i>(Mark all that apply.)</i>	<i>With which family members?</i> <i>With which service providers?</i> <i>With whom, among someone else?</i> <i>(Mark all that apply.)</i>
“Yes” or “No”	“Yes” or “No”	“Yes” or “No”
General wellness		1. Grandparent
1. I talked to an adult about what is happening in my life.		2. Parent
2. Someone taught me something about my culture.		3. Sibling
3. An adult made me feel special by spending time with me.		4. Son/Daughter
4. Someone helped me talk about how I was feeling.	Family member	5. Partner/Husband/Wife
		6. Grandchild
		7. Family member your same age
		8. Family member younger than you
		9. Family member older than you
		10. Another Elder in your family
		11. Close friend
Times of stress		12. Client/Patient/Congregant
5. When I was down, someone reached out to me.		13. Co-worker/Colleague
6. When I had a problem, I talked to an adult about it.		14. Tribal or Community leader
7. Someone went out of their way to help me feel better when I was down.	Someone else	15. Religious leader (Pastor or Priest)
		16. Teacher/School staff
	Service provider	17. Elder
		18. Adult community member
		19. Youth/young person (aged < 30)
		20. A group of people
		21. Kawerak staff ^a
		22. Village Police Officer/Safety Officer
		23. BHS clinician/counselor/Psych Intern
		24. Norton Sound (NS) Traveling Health Provider (Doctor, PA, Public Health Nurse)
		25. NS Village Health Provider (Clinic worker, Health Aide, Tribal Healer)
		26. Behavioral Health Aide/Village-based Counselor
		27. TANF/Family worker
		28. Social Services worker
		29. School Counselor
		30. Foster Parent
		31. Statewide Services

Note. BHS = Behavioral Health Services; TANF = Temporary Assistance for Needy Families.

^a Kawerak is a regional nonprofit organization that provides services throughout the Bering Straits Region.

Broad Sources of Support

We then examined broad sources of support (family, close friends, and service providers) among those that selected “Yes” to each support item (158 people). These results are presented in Table 4. In general, majority (63% or more) selected family as the most common

source of support (with one exception). This was followed by close friends; here, frequencies for nearly all support in times of stress items closely resembled those for family, though frequencies for general wellness support items are less than half those for family. Across all items, service providers were the least commonly

TABLE 2
Demographic Characteristics

<i>Age Groups</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
	<i>n (%)</i>	<i>n (%)</i>	<i>N (%)</i>
15–19	56 (34%)	29 (18%)	85 (51%)
20–29	46 (28%)	34 (20%)	80 (49%)
Total	102 (62%)	63 (38%)	165 (100%)

selected source of support, with frequency of selection ranging from 0% to 9%. Due to the small number of individuals selecting service providers, we were not able to test for differences by age and/or sex. No significant age and/or sex differences emerged across those selecting family or close friends.

Frequencies of Support

Last, we examined how often participants reported receiving support from family and friends for each support item (service providers were excluded due to such few selections). As shown in Table 5, the average frequency with which participants received each support from family ranged from about once a month (coded as 3) to almost weekly (coded as 5). Frequencies of support receipt from close friends closely resemble those from family. No significant differences emerged by age and/or sex for frequency of interaction with family. By contrast, one significant difference emerged by sex for friends: females reported close friends going out of their way to make them feel better more frequently than males.

On a final note, we briefly examined the 10 specific sources of support for family. The sample selected an average of 1–2 family positions across all items for which family was selected as a source of support (see Table 5). Parents were selected most across all items on average, followed by close friends, siblings, and grandparents (results not shown here).

► DISCUSSION

The purpose of this study was to examine support profiles among AN youth and young people, including the types of support received as well as the quantity, sources, and frequencies of such support. Using our sample of 165 AN people under age 30, our analyses point to four main findings. First, we found that AN young people report receiving a majority of the seven

types of supports we measured, with an average of nearly five kinds of support. Second, we found that on average, males reported receiving fewer supports than females. Third, though we found sex differences in reported support, we found no differences in the broad categories or specific kinds of people that provided support. Family was the most frequently selected source of support, followed by close friends. By contrast, service providers were very rarely selected as a source providing support. Last, we found that support was received often, typically once a month to almost weekly. The most frequently selected specific support providers were parents, close friends, siblings, and grandparents.

Our findings show several similarities to past work. First, previous studies find that it is common, and protective, for young people to have multiple sources of support across the community, including family members and friends (Colarossi, 2001; Miller et al., 2015). This aligns with our results, which is encouraging because it indicates that family (and to a lesser extent, friend) supports already exist at baseline, prior to enacting the PC CARES intervention. In addition, though some work shows that the primary source of support tends to shift from parents to peers and/or romantic partners as youth move through adolescence (Collins & Laursen, 2004), more recent work finds that parental support does not diminish even as peer support increases during this time (Rueger et al., 2010). Here, we find a similar trend to the latter: across all ANs under age 30 in our sample, there were no age differences in sources providing support. This finding underscores the consistent and central role of family, and specifically parents, throughout adolescence and young adulthood for AN people.

Our second finding supports the importance of close friends in AN youth/young people’s lives. Specifically, after parents, close friends provided the most support. The role of friends as a support source is promising, as having friends is generally adaptive (Colarossi, 2001; Miller et al., 2015). Previous research, however, highlights the potential negative effect friendship has on adolescents: peer contagion can cause anxiety and depression through a process called “co-rumination,” where young people engage in repeated discussions of personal problems without offering additional tools for coping or problem-solving (Schwartz-Mette & Rose, 2012; Spindel et al., 2017). Since our study did not assess the specific nature of conversations surrounding support, future work should examine how support unfolds among close friends and what kinds of peer-to-peer support may increase suicide risk or enhance prevention efforts.

Our third finding is that males reported receiving fewer supports than females. This is consistent with

TABLE 3
Frequencies of Selecting Support Items, Tested by Sex and Age

Support item	Sample selecting "Yes" out of full sample (N = 165)	Males in sample selecting "Yes" out of all males (N = 102)	Females in sample selecting "Yes" out of all females (N = 63)
	N (%)	N (%)	N (%)
General wellness			
1. I talked to an adult about what is happening in my life.	106 (64%)	55 (54%)^a	51 (81%)^a
2. Someone taught me something about my culture.	140 (85%)	—	—
3. An adult made me feel special by spending time with me.	125 (76%)	—	—
Age 15–19	—	46 (45%) ^b	22 (35%)
Age 20–29	—	28 (27%) ^{b,c}	29 (46%) ^c
Times of stress			
4. Someone helped me talk about how I was feeling.	106 (64%)	58 (57%) ^d	48 (76%) ^d
5. When I was down, someone reached out to me.	119 (72%)	—	—
6. When I had a problem, I talked to an adult about it.	96 (58%)	—	—
7. Someone went out of their way to help me feel better when I was down.	114 (69%)	62 (61%)^e	52 (83%)^e

Note. Sample sizes and percentages are shown by sex and/or age only when significant differences were found. Bonferroni *p*-value correction is $p < .003$; comparisons are in bold where values are at or below this threshold.

^a $\chi^2(1) = 12.39, p < .001$. ^b $\chi^2(1) = 5.74, p = .017$. ^c $\chi^2(1) = 5.69, p = .017$. ^d $\chi^2(1) = 6.33, p = .012$. ^e $\chi^2(1) = 8.63, p = .003$.

previous research: for example, in their review, King and Merchant (2008) note that girls spend more time than boys sharing their feelings and thus engaging in emotional support exchanges. Since emotional support is protective against suicide (Bush & Qeadan, 2020), this finding makes sense in the context of higher suicide rates for AI/AN males (National Center for Injury Prevention and Control, CDC, 2021).

Although an intuitive finding, we urge caution when making conclusions from the sex differences seen here, as it is possible that the males in our sample received more support than our results show. Entrenched gender norms, which begin early in life, promote a male stigma against emotional support engagement and help-seeking (Chandra & Minkovitz, 2006); however, these same norms provide other avenues for support among males that were not assessed here and that, if not assessed alongside emotional support, may paint an incomplete picture. For example, in rural Alaska, masculinity is associated with traditional activities and social relationships that are based on hard work, family roles, autonomy, and subsistence (Bodenhorn, 1990; Wexler et al., 2014). Thus, engaging with others in subsistence or other

activities “on the land” may constitute different kinds of support that AI/AN males may engage in more than females, but how this compares with the level of engagement in emotional support among females’ remains an open question.

Whether or not males and females differ in their engagement within and across gender-specific supports, these considerations are important for contextualizing the implications of our findings for common suicide prevention initiatives and assessments more generally, especially those that are support promotion-focused. By primarily promoting communication-based suicide prevention programs designed to strengthen social and emotional connections, AI/AN boys/men may not connect with or benefit as readily from such programs as young girls/women (Hamilton & Klimes-Dougan, 2015), even though they exhibit the highest risk. Thus, we encourage the development of mental wellness and suicide prevention programs that can build on local systems of support and facilitate a range of support experiences across gender.

Alaska Native Elders residing in rural Alaska have spoken on the mental health of young men. In the book

TABLE 4
Frequencies of Broad Sources of Support (Out of Those Who Selected “Yes” to Each Item)

<i>Support item</i>	<i>Sample selecting “Family” N (%)</i>	<i>Sample selecting “Close Friend” N (%)</i>	<i>Sample selecting “Service Provider” N (%)</i>
General wellness			
1. I talked to an adult about what is happening in my life. (Total “Yes” = 106)	72 (68%)	34 (32%)	4 (4%)
2. Someone taught me something about my culture. (Total “Yes” = 140)	112 (80%)	16 (11%)	0 (0%)
3. An adult made me feel special by spending time with me. (Total “Yes” = 125)	92 (74%)	38 (30%)	4 (3%)
Ages 15–19 (N = 68)	—	15 (22%) ^a	—
Ages 20–29 (N = 57)	—	23 (40%) ^a	—
Times of stress			
4. Someone helped me talk about how I was feeling. (Total “Yes” = 106)	52 (49%)	56 (53%)	10 (9%)
Age 15–19 (N = 59)	—	—	—
Age 20–29 (N = 47)	—	—	—
5. When I was down, someone reached out to me. (Total “Yes” = 119)	75 (63%)	65 (55%)	3 (3%)
Ages 15–19 (N = 59)	31 (53%) ^b	—	—
Ages 20–29 (N = 60)	44 (73%) ^b	—	—
6. When I had a problem, I talked to an adult about it. (Total “Yes” = 96)	64 (67%)	29 (30%)	5 (5%)
Ages 15–19 (N = 48)	—	10 (21%) ^c	—
Ages 20–29 (N = 48)	—	19 (40%) ^c	—
7. Someone went out of their way to help me feel better when I was down. (Total “Yes” = 114)	73 (64%)	55 (48%)	2 (2%)

Note. Sample sizes and percentages are shown by sex or age only when significant differences were found. The Bonferroni *p*-value correction for each column is $p < .004$; no values are below this threshold.

^a $X^2(1) = 4.90$, $p = .027$. ^b $X^2(1) = 5.52$, $p = .019$. ^c $X^2(1) = 4.00$, $p = .045$.

Yuuyaraq: The Yup'ik Way of Being, edited by Fienup-Riordan (2018), they shared that dances and stories were prominent emotional outlets for young men, as stories are an entry to men’s interpersonal connections and their “inner self.” One Elder, John Phillips, explained,

If I notice that a boy is feeling badly, I might not say anything to him directly, at first. I will look for a time when he is around others and I will talk to the

others about funny stories I know. I can see that when they laugh it will help this boy. Then, when I see this, I will start to bring more attention to the youth I am worried about. Only then can I ask him what is wrong and help him talk about it. (Fienup-Riordan, 2018, p. 294)

Promoting engagement in these activities as well as keeping young men busy by giving them a helping role may thus be an important intervention opportunity

TABLE 5
Average Support Receipt Frequencies and Number of Family Selected

<i>Support item</i>	<i>Family interaction frequency</i>	<i>Friend interaction frequency</i>	<i>Average number of family selected</i>
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
General wellness			
1. I talked to an adult about what is happening in my life. (Total “Yes” = 106)	3.98 (2.10)	3.76 (2.23)	1.74 (1.06)
2. Someone taught me something about my culture. (Total “Yes” = 140)	3.75 (1.99)	2.88 (1.67)	2.24 (1.64)
3. An adult made me feel special by spending time with me. (Total “Yes” = 125)	4.70 (2.14)	4.21 (2.26)	2.40 (1.90)
Times of stress			
4. Someone helped me talk about how I was feeling. (Total “Yes” = 106)	3.93 (1.99)	3.79 (2.25)	—
Ages 15–19 (<i>N</i> = 59)	—	—	0.64 (0.12)^a
Ages 20–29 (<i>N</i> = 47)	—	—	1.40 (0.26)^a
5. When I was down, someone reached out to me. (Total “Yes” = 119)	3.15 (2.02)	3.20 (2.17)	—
Ages 15–19 (<i>N</i> = 59)	—	—	1.00 (0.17) ^b
Ages 20–29 (<i>N</i> = 60)	—	—	1.50 (0.20) ^b
6. When I had a problem, I talked to an adult about it. (Total “Yes” = 96)	3.89 (2.19)	3.24 (1.84)	1.61 (0.94)
Ages 15–19 (<i>N</i> = 48)	—	—	—
Ages 20–29 (<i>N</i> = 48)	—	—	—
7. Someone went out of their way to help me feel better when I was down. (Total “Yes” = 114)	3.98 (2.08)	—	1.95 (1.36)
Males (<i>N</i> = 32)	—	3.00 (0.37)^c	—
Females (<i>N</i> = 23)	—	4.61 (0.41)^c	—

Note. Sample sizes and percentages are shown by sex or age only when significant differences were found. The Bonferroni *p* value correction for each column is *p* < .004, and values are in bold when comparisons are below this threshold.

^a *t*(104) = -2.90, *p* = .002. ^b *t*(117) = -1.88, *p* = .031. ^c *t*(53) = -2.88, *p* = .003.

for AN male-targeted intervention, though future work should strive to assess the extent to which these lines of traditionally masculine support already exist.

► LIMITATIONS

Our findings should be interpreted with a few limitations in mind. First, our sample reflects a convenience sample of AI/AN youth and cannot be generalized to the wider AI/AN population. However, this limitation is endemic to much research on the population, given the difficulties associated with identifying and reaching AI/ANs due to geographical dispersion (Castor et al., 2006). On a related note, it is possible that the opt-in nature of the convenience sample attracted and/or reached those

youth with the most social connections and pre-existing support, inflating the prevalence of support reported here. That said, our results did reveal varying support experiences, including those that reported no support engagement at all. Identifying these individuals and devising ways to effectively reach them thus appears to be key.

Second, in addition to potentially assessing support in a gendered way, items asking specifically about support from adults may be interpreted differently by participants in the younger (15–19) compared with the older (20–29) group. Even though we found no differences across age groups in endorsement of these items, a related limitation is that our study used numerical age to group older and younger participants. Our community partners

indicate that traditional milestone markers (e.g., parenthood) may be more meaningful than age differences among AN young people. We unfortunately were not able to assess if patterns in support emerge across these transitional, as opposed to age-based, indicators; thus, it is likely that our sample contained parents in both age categories, possibly obscuring these emergent patterns and potentially explaining the lack of age-based findings seen here. Future work should seek to examine possible differences in support across statuses like parenthood, assess support in ways that encompass the range of gendered experiences, and seek innovative ways to improve the representativeness of AI/AN samples in research, verifying the prevalence of those with little to no support.

► CONCLUSION

This paper provides new and detailed information about existing baseline support among young Alaska Natives, with important implications for suicide prevention practice in this region. Specifically, our findings highlight youth reliance on community support systems, particularly within families, though they may tend to do so less in times of stress (see Ulturgasheva et al., 2014). This information is especially important for public health practitioners. Preexisting supports, like family and other adults, are vital points of collaboration for the design and implementation of mental wellness and suicide prevention activities in rural Alaska communities. Specifically focusing community trainings toward strengthening relationships between supportive adults and young people *before* there is a crisis may be particularly fruitful because it widens support and can increase the likelihood that youth regard adult family as a viable source of support during crisis. Such may be particularly important in underserved communities, where formal help-seeking is infrequent for a variety of reasons (Turner et al., 2016). Our findings build upon existing work which encourages practitioners in formal helping roles to engage in early identification of these community supports for at-risk young people (King et al., 2006). Though we found that male youth reported fewer supports than females overall, we urge that this finding be contextualized by gender bias in assessment and prevention as well as the cultural norms of communities. Future prevention work and research should prioritize suicide prevention efforts which build on community systems of support and respond to local understandings of the unique support needs of young AN men and women.

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