

Culturally Responsive Suicide Prevention in Indigenous Communities: Unexamined Assumptions and New Possibilities

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Indigenous communities have significantly higher rates of suicide than non-Native communities in North America. Prevention and intervention efforts have failed to redress this disparity. One explanation is that these efforts are culturally incongruent for Native communities. Four prevalent assumptions that underpin professional suicide prevention may conflict with local indigenous understandings about suicide. Our experiences in indigenous communities led us to question assumptions that are routinely endorsed and promoted in suicide prevention programs and interventions. By raising questions about the universal relevance of these assumptions, we hope to stimulate exchange and inquiry into the character of this devastating public health challenge and to aid the development of culturally appropriate interventions in cross-cultural contexts. (*Am J Public Health*. 2012;102:800–806. doi:10.2105/AJPH.2011.300432)

Suicide is a significant public health problem that accounts for approximately 30 000 deaths each year in the United States alone.¹ Striking cross-cultural variability, however, is found in prevalence of suicidal behavior.^{1–7} For example, suicide disproportionately affects Native Americans, and young indigenous men have the greatest risk.^{8–14} In some locales, these youths complete suicide at a rate of 17 times the US average.^{13,15} This stands in marked contrast to the patterns of nonindigenous suicide in the United States, in which older men are at highest risk,¹ and in China, where suicide disproportionately afflicts young rural women.¹⁶ These disparities suggest diverse motivations and meanings for suicidal behavior across cultural and demographic divides, underscoring the need for culturally specific interventions.^{17,18}

American Indian/Alaska Native (AI/AN) communities display a striking association between suicide and community-level factors, indicating a need for a broader approach to prevention. Indigenous suicide is associated with cultural and community disruptions,^{12,19–21} namely, social disorganization, culture loss, and a collective suffering.^{10,22–24} Conversely, lower suicide rates and increased well-being have been associated with community empowerment, connectedness, family cohesion, and cultural affinity among Native people.^{25–27}

Yet despite the connection between personal and community health in AI/AN communities, suicide prevention interventions are often individually focused and clinically based. Thus, mental health services in tribal communities are not always structured to be culturally meaningful^{28,29} and are frequently underutilized.^{13,30–32}

Here we explore potential cultural misalignment by contrasting 4 normative assumptions that underpin standard suicide prevention interventions with indigenous understandings common in North America: (1) suicide expresses underlying psychological problems versus suicide expresses historical, cultural, community, and family disruptions; (2) suicide is primarily an agentic expression of personal volition versus suicide is primarily an enacted consequence of social obligation; (3) suicide prevention is best achieved by mental health professionals versus suicide prevention is best achieved by nonprofessional community members; and (4) suicide prevention most properly falls within the purview of formal mental health service delivery systems versus suicide prevention most properly falls within the purview of locally designed decolonization projects.

Drawing on more than 30 years of combined experiences in clinical, administrative, and research settings in AI/AN communities, we examine the relevant meaning systems

of both dominant prevention–intervention models as well as AI/AN perspectives concerning suicide because greater understanding of the cultural meanings of mental health problems such as suicide may help public health and mental health professionals improve access and remove barriers to treatment, develop culturally responsive practices, and improve the quality of care for vulnerable populations.³³ Although diverse indigenous beliefs and practices are necessarily conflated here, our comparison is intended to offer innovative ways to understand and effectively prevent suicide in indigenous communities in North America. Moreover, because different understandings of emotional expression and self-representation are associated with other issues, such as alcohol misuse,^{34,35} our perspective may be similarly useful for promoting many culturally appropriate behavioral health interventions in tribal communities.

PREVENTION AND INTERVENTION AS CULTURAL PRACTICE

Questions have been raised about the indiscriminate application of Western health and social services models to non-Western societies without critical consideration of the applicability of these professional regimens for a targeted cultural community within its local context.^{28,36–46} Although the importance of cultural differences for the provision of mental health services to ethnic/racial minority communities has been established, the literature rarely reflects consideration of such helping services as “thoroughly enculturated practice[s]—not simply in [their] superficial and overt conventions . . . but also in [their] constituent and covert presumptions.”^{44(p14)} In short, the fact that health services are culturally constituted—both in identifying needs and in choosing how they are addressed—is regularly overlooked or ignored.

Culture can be understood as the dynamic framework by which a society makes meaning, constitutes ways of being, and reproduces itself as a recognizable community. Culture comprises webs of significance⁴⁷ whereby different communities' health beliefs, practices, and bodily experiences are constructed and managed. As Pumariega et al. write,

Attributional beliefs about physical and mental illness are largely culturally determined, with illness viewed through Western biopsychosocial beliefs, or through religious, spiritual, interpersonal, and/or supernatural beliefs.^{48(pp541-542)}

Culture, then, sets the parameters around sick and healthy roles and thus structures the most appropriate forms of remedy. Thus, it is imperative to carefully assess the local meanings surrounding a health issue to determine the usefulness of health-related services in non-Western contexts.^{49,50} This has not yet been adequately done with suicide prevention and intervention practices in native communities in North America.

Suicide prevention and intervention contain tacit cultural commitments and assumptions.³⁴ These understandings reflect specific ideas about the nature of suicide, the appropriate levels of intervention, and who is best able to enact these. Standard suicide prevention considers the act to be both personal and agentic. Suicidality is commonly associated with psychological issues and is therefore best addressed through rapid crisis responses of mental health services and mental health treatment. Considering whether these assumptions are aligned with indigenous communities' conceptualizations is crucial for developing effective services.³¹ This assertion is supported by the Institute of Medicine's treatise on reducing suicidality:

Suicide is not everywhere linked with pathology but represents a culturally recognized solution to certain situations. As such, understanding suicide and attempting risk prevention requires an understanding of how suicide varies with these forces and how it relates to individual, group and contextual experiences.^{51(p193)}

Despite this acknowledged cultural variance, most suicide prevention and intervention programming in North America relies on a particular constellation of cultural understandings.

For example, according to the American Foundation for Suicide Prevention,

The most effective way to prevent a friend or loved one from taking his or her life is to recognize the factors that put people at risk for suicide, take warning signs seriously and know how to respond.⁵²

This first step is invariably followed by the recommendation to seek professional help. The *National Strategy for Suicide Prevention* adheres to this prescription and outlines 11 goals and objectives for action, many of which reflect this standard approach to suicide prevention programming and clinical services (referred to here as preventive intervention).⁵³ They include reducing the stigma associated with mental health help seeking, identifying suicidal persons and referring them to mental health treatment, and improving linkages and services provided by mental health and substance abuse services. In this conceptualization, preventive intervention for suicide involves identifying suicidal people and increasing access to (and acceptance of) clinical treatment based on psychological expertise.

PSYCHOLOGICAL VERSUS SOCIAL FRAMING

Typically, suicide is considered to be an unfortunate response to an individual's psychological pain, frequently in the context of psychiatric illness (e.g., clinical depression). This understanding reflects the idea that the root of one's pain is individual, that its primary manifestation is psychological, and that it is rather than remains readily amenable to clinical intervention. Suicide intervention is therefore best conducted by people with psychological or medical expertise. The act of killing oneself is foremost an individual act, undertaken in response to one's personal situation and psychology. This understanding, however, does not fit many native people's realities.

Suicide in indigenous communities is frequently identified as the terminal outcome of historical oppression, current injustice, and ongoing social suffering. Indigenous societies' concept of personhood differs from Western ideas. First, the expression of selfhood for many tribal people is relationally defined rather than oriented toward individual characteristics; indigenous people often describe themselves through their kin.^{24,54,55} These relationships—their

texture, strength, availability, configuration, and so on—define a person's state of being in myriad ways. Briggs's ethnography of an Inuit child, aged 6 years, describes how this orientation is actively cultivated in young children as a form of moral education through everyday interactions.⁵⁶ Fienup-Riordan extends this to a different indigenous context by documenting how the Yupik language equates awakening to others and awareness as essential parts of becoming a real (adult) person.⁵⁷ Understanding one's role in a shared and cocreated reality is an important marker of maturity for many indigenous societies. This stands in stark contrast to Erikson's classic notion of individuation as an essential stage in becoming an adult in Western culture.⁵⁸

This social idea of selfhood can extend to include deceased relatives and other spirits who can influence and affect the living⁵⁹ (as well as animals and the environment⁶⁰) and to the more culturally salient relational orientation that structures daily life. The notion of a shared reality in tribal communities is evident in even rudimentary encounters. An Inupiaq woman told a researcher (L. M. W.) about "a sick father, new grandbaby, and bingeing daughter in response to [the] question, 'how are you?'"^{61(p213)} This orientation can also be seen in O'Neill's finding that a feeling of loneliness was the central affective symptom of depression for Salish tribal members.⁶² This broad concept included feelings of bereavement, loss, and aggrievedness related to past injustices.⁵⁵

Suicide can be understood as a way of expressing social distress and despair. This orientation is consistent with tribal associations between suicide and culture loss,⁶³ historical trauma,^{64,65} and social suffering.^{19,23,66} Historical trauma has been defined as cultural stress and grief that is related to genocide and racism that have been generalized, internalized, and institutionalized.⁶⁷ This form of trauma has been described as both historical and ongoing²² and as cumulative and unresolved.⁶⁸ Without resolution, indigenous people can be seen as sometimes misattributing their present struggles to personal and collective failings rather than to oppressive systems and structures.⁶⁹ This perspective leaves some AI/AN people with a pervasive sense of

having no future, a sentiment that can be strongly linked to suicide.

PERSONAL CHOICE VERSUS SOCIAL OBLIGATION

The Institute of Medicine's report states that "suicide is ultimately a private act,"^{70(p17)} which is consistent with the view of many mental health professionals that suicide is both personal and a choice. By contrast, many tribal members consider suicide to be essentially a social and spiritual dilemma that is constituted and inextricably tied to family, community, and tribal context. When these relationships "feel broken," when the village "drags them down," or dead relatives (or the devil) "call to them," it may not be perceived that the individual really has any choice in the matter.⁶¹ This could explain why many suicides in tribal communities are considered to be tragic occurrences linked to collective suffering, especially as a result of culture loss.^{19,63,71,72} Not only has this understanding of suicide as an expression of shared social anguish been supported by evidence from research,^{65,67,73} but the great variability in suicide rates between tribal communities also lends credence to this perspective.⁷⁴ High suicide rates in tribal communities have been linked to a lack of cultural continuity, and low rates have been associated with efforts to revitalize indigenous cultures and institute political control over local tribal institutions.⁷⁵

Instead of being understood primarily as a private solution to unbearable psychic pain, suicide is rather seen as a public expression of collective pain and is regarded as a predictable (though regrettable) outcome of rampant social disorder initiated by European colonization.⁷⁶ An excerpt from an e-mail message sent to 500 coworkers by a bereaved mother 2 weeks after her son killed himself illustrates this point:

We received a very touching letter from Junior [the decedent] postmarked on the day he left us. Just knowing he is so sorry and he loved us and everyone he knew has brought us a lot of comfort, and that he didn't mean to end this way.

Junior's mother does not perceive his suicide to be his fault. Suicide is bigger than the merely personal—his death reflects collective suffering and the powerlessness of a person to rise above it. The tragedy moves beyond individuality

and private culpability and is instead considered to be a reflection of collective disease. In a sense, through messages like these, a person's death provides the community with an opportunity to begin to address this collective burden. Together, extended family and community members grieve for the deceased while also acknowledging and expressing anguish over their shared cultural loss.

Funerals provide a public space to grieve and to offer (and receive) active support. An indigenous woman related, "When [someone dies], the whole community gets together and has fund raising and raises money for the family and cooks for the family, (and gives) donations."^{61(p291)} This outpouring of support is more pronounced with suicide. As a young indigenous man explained, "[T]hey [the family and community] get more respect [if a member died of suicide]. . . . [E]verybody [is] always nice to them, giv[ing] them comfort."^{61(p142)} A young Alaska Native man also expressed this way of thinking: "If somebody killed their self [compared to when] somebody died accidentally, the person who killed their self, that family probably gets more . . . one-on-one attention."^{61(p142)} One explanation for this special attention stems from suicide's connection to cultural loss: suicide somewhat distinctively serves as a catalyst for collective grieving. As many indigenous people have reflected, a suicide allows the whole community to come together to mourn for the deceased and his or her family, but also affords an opportunity to acknowledge other losses, including culture loss.

In addition, death in many societies spurs a host of activities in which people enact their highest ideals of community. In small, rural indigenous settings, this often involves the whole community in hosting guests, digging the grave, making the coffin, washing the body, and so on. Funerals call for collective action and provide dedicated "time out of time" to express emotions and support one another. Often, school is canceled, stores are closed, and people flock to help and attend the memorial service. These activities emphasize community connectedness, and members are reminded of their social role and their place in society. A young indigenous man described this in a focus group:

Everybody around here kind of, kind of knows their role when something like that happens like the elders and the friends, they know who to talk

to and who to comfort. It's kind of like a *crisis response team*, everybody has their role. Some people comfort the family, others take care of family chores so they don't have to worry while they are thinking about the suicide [emphasis added].^{61(p142)}

In several AI/AN communities in which we have worked, tribal members have described funerals as distinctive times when the community comes together and feels whole. Thus, depending on the cultural context, suicide can be formulated not only as the tragic death by choice of an individual but also as a public expression of shared social suffering (with deep historical and sociostructural roots). The shared cultural response to this tragedy provides the family and community with sanctioned social space for healing. This understanding of suicide—quite different from viewing it as an individual response to psychological pain—may offer insight into the most appropriate intervention strategies.

CLINICAL EXPERTISE VERSUS SOCIAL RELATIONS

Important service implications arise from disparate assumptions about the meaning of suicide. As a psychological problem, suicide is best addressed through targeted mental health intervention. Typically, these efforts involve identifying individual warning signs (pathology), with the belief that suicide can be prevented through knowledgeable surveillance of individual risk factors and symptoms of mental illness. These signs indicate the presence of psychological disorders, which have been associated with (nonnative) suicidality.⁷⁷ Because clinicians have knowledge and skills to treat mental health disorders, they are believed to be most able to effectively intervene in suicide crises. As a result, Western suicide intervention invariably recommends referring the suicidal person to the mental health system if they are at high risk.

If, however, suicide is primarily considered in light of its societal origins and social significance rather than its psychological origins and significance, who is best able to prevent it? A young native man who was reflecting on his own suicide attempt explained,

Well if they have problems and then they try to turn away from it, the problems will just keep

following them because it's part of them, too, until *someone else* that wasn't part of it tries to help them out and get the story straight and end the problem [emphasis added]. (unpublished interview for Circumpolar Indigenous Pathways to Adulthood study, conducted by Stacey Glaser, 2009)

Suicide prevention, then, is best undertaken by someone who has relationships with the key people but is not directly involved in the interpersonal issue. Of course, mental health professionals often view themselves as filling precisely this role, but in native communities such professionals are typically short-term residents (and therefore unknown to most community members) and ethnically different from the population they serve (and therefore unlikely to engender trust quickly). They are also often unfamiliar with local customs (and therefore not especially competent to intervene in existing relational networks or established community routines). In other words, these nonnative professionals lack necessary local knowledge—an understanding of the social networks and histories of individuals and their communities—to most appropriately influence the social context of an individual. It is no wonder that there is a common sentiment in many indigenous communities that “White people don't know anything about being Native here.”^{61(p207)} Without this knowledge, clinicians and counselors are handicapped in their efforts to address a suicide crisis.

Within local contexts characterized by their pronounced relational orientation, effective interventions for suicide necessitate having established relationships prior to the suicide event. Thus, in many tribal communities, suicide prevention is best undertaken by community members, friends, and family who understand the social context of the suicidal person. For instance, it is not unusual for indigenous parents to recruit a close peer to talk to their suicidal child. This is because peers are most likely to have trusting friendships with each other and can thus begin to create relational solutions in the context of age-based status hierarchies. A peer might intervene by talking to the suicidal person's boyfriend or girlfriend and negotiating a way to get the couple back together. The following example is taken from a focus group transcript.

Interviewer: Your friend attempted suicide? And what was going on? What happened?
Clara: When her and her boyfriend broke up.
Interviewer: Yeah, and what happened to her?
Clara: We talked to her and made it better.
Interviewer: Cause she was talking about killing herself?
Clara: Um-huh.
Interviewer: And what did you guys do?
Clara: Talked to her, talked to him.
Interviewer: Talked to the boyfriend?
Clara: Um-hum.
Interviewer: And then what happened?
Clara: They got back together and she got good.
Interviewer: So they did get back together?
Clara: Um-hum.
Interviewer: Oh, okay. What do you think would have happened if they didn't get back together?
Clara: Maybe she would kill herself.^{61(pp118-119)}

Although this example raises other provocative issues that lie beyond the scope of this article, relational intervention was understood to be critical. This can be achieved through social maneuvering, as in this example, or through trusted intimates' caring actions.

Suicidal acts, in the indigenous communities in which we have worked, signal to close associates that they need to engage with the person differently. Thus, the suicide attempt communicates a clear and acute need within a relational network and provides intimates an opportunity to address it. In this way, suicide ideation and attempts can draw out and reconstitute important relationships, inviting significant others to surround the person in solidarity and support or otherwise alter the nature of their interpersonal interactions. These responses can foster community efficacy, belongingness, and family cohesion, all of which have been associated with positive behavioral health indicators⁷⁸⁻⁸⁰ and reduced suicide rates.^{75,81}

HEALTH SERVICES VERSUS COMMUNITY PROJECTS

Suicide prevention is commonly understood to be best realized through timely interventions by well-trained, clinically based mental health professionals. Efforts are made to extend the reach of services and reduce the stigma of mental health help seeking so that suicidal people will access the help they need.⁵³ This course of action is built on the belief that suicide is a clinical outcome in the face of mental illness, rather than an outcome of an unjust historical legacy that leads to a host of

undesirable social outcomes, including suicide. The latter belief is often espoused by indigenous researchers and tribal members^{55,63,82} and underscores the importance of considering the neocolonial implications of current practices, in which conventional professional approaches to presumed indigenous mental health problems harbor the potential for implicit Western cultural proselytization.⁸³

Suicide intervention, particularly in a crisis, can compound and extend the experience of colonialism for indigenous people. The professional mandate—to ensure a person's safety—can sometimes lead to the infringement of individual liberty for the management of imminent danger. Several AI/AN young people we have worked with view this kind of treatment as “being sent to jail for feeling suicidal.”^{61(p128)} It is not uncommon to hear tribal members express to mental health workers such sentiments as “you people always come in here and tell us what's wrong” or that such workers are “shoving programs down local people's throats.” This distrust and sense of disempowerment can be further illustrated by the question an elderly man posed to a therapist undertaking a suicide intervention with his grandchild: “Who do you think you are, coming in here and telling us about our children?”^{61(p209)} In a very real way, the typical intervention protocol privileges a Western, psychological understanding of suicide and places community outsiders—mental health professionals—in authoritative, decision-making roles that can result in removal of indigenous children from their home communities to distant inpatient facilities.

If a professional believes a person is at imminent risk of self-harm, that person can be held involuntarily (and without family consent) for up to 48 hours. Indigenous people we have worked with in North America have been outraged by clinicians who have taken children away against their parents' wishes. For many families, this experience echoes the coercive removal of entire generations of indigenous children who as a matter of government policy were forcibly sent to assimilative, church-sponsored industrial schools for preparation as menial laborers in adulthood. This common historical experience shattered families, undermined indigenous language proficiency, and purposefully destroyed the cultural heritage of

indigenous peoples across the continent.^{65,84} Although taking away suicidal people's (and their families') civil rights might provide immediate safety, it can also be seen as an extension of cultural subjugation and colonial intrusion. Moreover, this standard practice also runs counter to the working assumptions that many AI/AN communities have about the social underpinnings of suicide and can further alienate the person who is suicidal from the social and cultural context in which effective assistance is most likely to emerge.

This distancing between suicidal community members and their local milieu is particularly problematic in indigenous communities, for which suicide has been linked to cultural, social, and community causes,^{85–88} such as acculturation stress, identity conflicts, and discontinuities between past and present.^{21,89} For instance, a study looking at acute psychiatric care with First Nations people in Canada found that mental health challenges were often associated with social and cultural dislocation.⁹⁰ If the original cause of the problem is European colonization, as subsequently mediated by community distress, then prevention efforts should be wary of exacerbating and extending the postcolonial predicament of tribal communities. Understanding suicide as a postcolonial disorder⁷¹ would lead to prevention efforts focused on remedying the unbalanced power relationships between Western and indigenous societies rather than reinforcing them. Figuring out how to maximize local control even in suicide crises is key. Decolonizing efforts in the form of community activism and cultural engagement have been associated with significantly reduced suicide rates and increased well-being in Native North Americans.^{75,91,92} These collective efforts have included a variety of activities, such as fighting for sovereignty rights and convening regular, culturally based community gatherings.

CONCLUSIONS

The need and desire for effective suicide prevention among native peoples is uncontested, but the best way to achieve this is not. Serious gaps between the assumptions and practices of typical prevention programming and indigenous understandings of suicide stand in the way of effective interventions. Often,

suicide in tribal communities is associated with culture loss, colonialism, and social disruption. Professional suicide interventions often ignore these conceptions, placing suicidal acts in the realm of psychopathology—internal to each person—to be addressed through individual mental health treatment. This rendition of the problem reduces complex experiences and sociocultural phenomena to individual pathology devoid of relevant context and in need of professional intervention.^{93,94} This transmutation (what sociologists refer to as the medicalization of the social) deprives matters rich in cultural meaning, historical situatedness, and social significance of their local intelligibility.

Indigenous suicide prevention must be formulated in response to local cultural meanings and practices. Understanding the culturally mediated and socially negotiated ideas about the causes of and appropriate responses to suicide in indigenous communities provides clues for developing culturally based preventive interventions. It is important to consider an individual's historical context, social network, and community resources outside of clinical systems of support. If suicide is an expression of collective as well as personal suffering, then interventions must address the community and family as well as the suicidal individual. This approach requires social interventions facilitated by intimates, as augmented (perhaps) by professional protocols that can aid in these efforts.

Suicide prevention should not represent and extend aspects of colonialism in tribal communities. Instead, prevention activities might focus on and fund locally driven decolonization efforts. This reconceptualization of indigenous suicide prevention repositions the mental health worker as an advocate for community and family action in response to communal distress. This collaborative orientation can enable mental health professionals to build on local meanings and strengthen community resources to develop suicide preventive interventions that are in concert with indigenous beliefs and practices. By extension, this cultural realignment of services can be used as a model for reconfiguring other health care interventions in other non-Western cultural contexts. ■

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L. M. Wexler constructed the major arguments and wrote most of the article. J. P. Gone participated in the conceptualization, editing, and revision of the article.

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