

Exploring Possibilities for Indigenous Suicide Prevention

Responding to Cultural Understandings and Practices

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Indigenous communities have disproportionate rates of suicide compared with non-Native communities in North America, and prevention and intervention efforts based on scientific evidence and good intentions have yet to affect this trend. Perhaps this is because the underlying assumptions and tacit understandings driving prevention initiatives are culturally incongruent for many Indigenous communities. Instead, strategies for suicide prevention need to take into consideration the culturally mediated and socially negotiated ideas about the causes of and appropriate responses to suicide in Indigenous communities. This will provide clues for developing culturally specific prevention and intervention strategies that extend community strengths.

This chapter begins by outlining several key assumptions about standard suicide prevention and intervention services in North America and then juxtaposing those assumptions with the ones we, the authors, have encountered in the Indigenous communities in which we have worked. The areas of cultural misalignment we have found are conceptualized as three normative assumptions, and their obverse: (1) Suicide indicates underlying psychological issues (rather than suicide reflects historical, cultural, community, and family trauma). (2) Intervention is best achieved through mental health treatment (rather than suicide is best prevented through interpersonal, social intervention). And (3) suicide intervention needs to involve rapid crisis response from mental health services (rather than suicide prevention should be undertaken through locally designed decolonization projects).

In the last part of the chapter, we suggest how suicide prevention efforts could be aligned with the values and orientations found in many Indigenous communities. For example, we call for suicide prevention strategies that consider the historical context, social networks, and community resources to be put in place alongside clinical systems of support. If suicide is an expression of collective as well as personal suffering, then interventions must address the community and/or family as well as the identified individual. A more responsive approach might involve social interventions facilitated by intimates, in tandem with professional protocols that can aid these efforts. We describe how intimates could be supported in doing suicide prevention, and what kind of role psychologically trained professionals might play in this. Lastly, suicide prevention should not represent and enact yet another aspect of colonialism in tribal communities. Instead, prevention efforts might focus on and fund locally driven decolonization efforts. We explore ideas for how this might be done within current systems.

Suicide Prevention and Intervention as Cultural Practice

There has been some debate about the indiscriminate application of Western health and social service models to non-Western societies absent critical consideration of how well these regimes can be applied to the targeted communities in their local contexts (Bar-On, 1999; Gone, 2003, 2006, 2007, 2008; Gone and Trimble, 2012; Lynn, 2001; McCabe, 2007; McIntyre, 1996; McKenzie, 1985). The importance of cultural difference when mental health services are being provided to ethnoracial minority communities has been established, yet 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" (Gone, 2004, p. 14). That health services are culturally constituted – both in terms of anticipated needs and in terms of how those needs are addressed – is regularly overlooked or ignored.

For our purposes, 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 significance whereby different communities' health beliefs, practices, and bodily experiences are constructed and managed. According to Pumariega and colleagues (2005, pp. 541–42), "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." Cultural understandings, then, set the parameters around sick and healthy roles, and in so doing, they structure the most appropriate remedies. So it is imperative that the local meanings surrounding a health issue be carefully assessed to determine the usefulness of health-related services in non-Western contexts (Brislin and Yoshida, 1994; Huff and Kline, 1999). This has not yet been adequately undertaken with suicide prevention and intervention practices in Native North American communities.

Tacit cultural assumptions and commitments have long been embedded in approaches to suicide prevention and intervention (Calabrese, 2008). These understandings reflect specific ideas about the nature of suicide, the appropriate levels of intervention, and who is best able to enact those interventions. Standard suicide prevention conceives the act to be both personal and agentic. Suicidality is commonly associated with psychological issues and thus is viewed as best addressed through rapid crisis response by mental health services. To develop effective services, it is crucial to consider the ways in which these assumptions are aligned (or not) with Indigenous communities' conceptualizations (Walls, Johnson, Whitbeck, and Hoyt, 2006). This supposition 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" (Goldsmith, Pellmar, Kleinman, and Bunney, 2002, p. 193). Despite this acknowledged cultural variance, most suicide prevention and intervention programming in North America relies on an established constellation of dominant cultural understandings.

For example, according to the American Foundation for Suicide Prevention (2010), "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." This first step is invariably followed by the recommendation to seek professional help. The US National Strategy for Suicide Prevention (US Department of Health and Human Services, 2001) adheres to this prescription and outlines eleven goals and objectives for action, many of which reflect this standard approach to suicide prevention programming and clinical services (which we refer to here as preventive intervention). These eleven include reducing the stigma associated with mental health help-seeking, identifying and referring suicidal persons to mental health treatment, and improving the services provided by mental health and substance abuse services. According to this particular

conceptualization, preventive intervention for suicide involves identifying suicidal people and increasing their access to (and acceptance of) psychological expertise in a clinical milieu. We will be exploring these assumptions, as well as their implications, and contrasting them with our own observations within the Indigenous communities in which we have worked.

Suicide as a Psychological Issue Rather Than a Social Issue

Alternatives: "Suicide expresses underlying psychological problems" versus "Suicide expresses historical, cultural, community, and family disruptions"

Suicide is typically viewed as an unfortunate response to psychological pain, often 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 such pain can be alleviated by clinical intervention. From all of this, it follows that suicide intervention is best conducted by people with psychological and/or medical expertise. The act of killing oneself, then, 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. Instead, suicide in Indigenous communities is often conceived as the terminal outcome of historic oppression, current injustice, and ongoing social suffering.

This conception warrants some explanation, beginning with the contrasting ideas of self and personhood found in Western discourse and Indigenous societies. First, many tribal people define selfhood relationally rather than in terms of individual characteristics. This means that they often describe themselves through their kin (Kirmayer, Brass, and Tait, 2000; Stairs, 1992; Waldram, 2004). Simply put, these relationships – their availability, strength, texture, configuration, and so on – define a person's state of being in myriad ways. For example, Jean Briggs (1998) in her ethnography of an Inuit six-year-old described how this orientation is actively cultivated in young children as a form of moral education through everyday interactions. Ann Fienup-Riordan (1986) extended 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. In many Native societies, understanding one's role in a shared and co-created reality is an important marker of maturity. This stands in stark contrast to Erikson's (1959/1980, 1968) classic notion of "individuation" as an essential stage in becoming an adult in Western culture.

This social idea of selfhood can extend to include deceased relatives and other spirits, who can influence the living (Garrouette, Goldberg, Beals, Herrell, and Manson, 2003) as well as animals and the environment (Vitebsky, 2006). In tribal communities, this culturally salient relational orientation that structures daily life underlies the notion of a "shared reality" that is evident in even the simplest encounters. Wexler (2005) described how an Inupiaq woman talked about "a sick father, new grandbaby, and bingeing daughter in response to (the) question, 'how are you?'" This orientation can also be seen in O'Neil's (1996) finding that a feeling of loneliness was the central affective symptom of depression for Salish-Flathead people. This broad concept included "feeling bereaved," "feeling aggrieved," and "feeling worthless" in association with interpersonal histories and community oppression. Suicide, then, can be understood as a way of expressing communal distress and despair in response to historical circumstances shaped by violent domination and colonial power.

Kleinman, Das, and Lock (1997) applied the term "social suffering" to these categories of experience to preserve the complex intersection of moral, political, and medical domains (rather than "medicalizing" such problems as the deficits of relatively decontextualized individual psyches). This framing is consistent with tribal associations between suicide and culture loss (Wexler, 2006), historical trauma (Brave Heart and DeBruyn, 1998; Duran, 2006; Evans-Campbell, 2008), and "postcolonial disorders" more generally (DeVecchio-Good, Hyde, Pinto, and Good, 2008; Durie, Milroy, and Hunter, 2009; Jervis, Spicer, Manson, and AI-SUPERPPF Team, 2003; Musharbash, 2007; Tatz, 2001). Historical trauma has been defined as the communal stress and collective grief associated with shared experiences of genocide and racism (Duran and Duran, 1995). This form of complex trauma reaction has been described as historic and ongoing (Durie, Milroy, and Hunter, 2009) and as cumulative and unresolved (Danieli, 1998). The concept was intended to rebut misattributions of Native social problems to personal and collective failings rather than to oppressive systems and structures (Gone, 2013; Wexler, 2009). The absence of this sort of contextual reframing leaves some Indigenous people with a pervasive sense of having "no future" – a sentiment that can be strongly linked to suicide.

Mental Health Intervention Rather Than Social Intervention

Alternatives: "Suicide prevention is best achieved by mental health professionals" versus "Suicide prevention is best achieved by nonprofessional community members"

Important service implications arise from the disparate assumptions about the meaning of suicide. Suicide as a psychological problem is best addressed through targeted mental health intervention. Typically, such efforts involve identifying individual warning signs (or pathology), the belief being that suicide can be prevented through knowledgeable surveillance of individual risk factors and warning signs. These signs indicate the presence of psychological disorders that have been associated with (usually non-Native) suicidality (Harris and Barraclough, 1997). Supposedly, because clinicians have the knowledge and skills to treat mental health disorders, they are best able to intervene effectively in suicide crises. Based on this understanding, Western suicide intervention invariably recommends referring the suicidal person to the mental health system if he or she is at high risk.

If, however, suicide is considered primarily in light of its societal origins and social significance rather than solely its psychological origins and medical significance, who is best positioned to prevent it? A young Native man who was reflecting on his own suicide attempt told the first author: "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." Suicide prevention, then, is often best undertaken by someone who has relationships with the key people but who is not directly involved in the interpersonal issue. Of course, mental health professionals often view themselves as filling precisely this role, but in these communities such professionals are often short-term residents (who are unknown to most community members) and ethnoracially different from the Native people they are serving (who are unlikely to trust outsiders quickly). They are also often culturally unfamiliar with local lifeways and therefore are not especially competent to intervene in existing relational networks or established community routines. In other words, these non-Native professionals lack the necessary local knowledge – an understanding of the social networks and histories of individuals and their communities – to most appropriately influence an individual's social context. It is no surprise, then, to detect a common sentiment in many Indigenous communities that "white people don't know anything about being Native here" (again as expressed to the first author). Without this knowledge, clinicians and counsellors are handicapped in their efforts to address a suicide crisis.

In the local context of a pronounced relational orientation, effective interventions for suicide may rely on relationships that were established 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 Native parents to recruit a close peer to talk to their suicidal child. This is because peers are most likely to have trusting friendships with one another 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 exchange is excerpted from a focus group comprised of seven Inupiaq adolescents convened in a rural Alaska Native village to discuss suicide and related responses in their community (Wexler, 2005):

- 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.

Although this example raises other provocative issues that are beyond the scope of this chapter, relational intervention was understood to be critical. This can be carried out through social manoeuvring, as in the example above, or through trusted intimates' caring actions.

In the Indigenous communities in which we have worked, suicidal acts signal to close others that they need to engage with the person differently. That is, the suicide attempt communicates a clear and acute need within a relational network and provides intimates with 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 their interactions. Doing so can foster community efficacy, belongingness, and family cohesion, all of which have been associated with positive behavioural health indicators (Duran, 2006; Walters, Simoni, and Evans-Campbell, 2002; Whitbeck, Chen, Hoyt, and Adams, 2004) and reduced suicide rates (Chandler and Lalonde, 1998, 2008; Maimon, Browning, and Brooks-Gunn, 2010).

Suicide Prevention from Health Systems Rather Than Community Projects

Alternatives: "Suicide prevention most properly falls under the purview of mental health service systems" versus "Suicide prevention most properly falls under the purview of locally designed decolonization projects"

Suicide prevention is commonly understood as best achieved through timely interventions by well-trained, clinically based mental health professionals. Efforts have been made to extend the reach of services and to reduce the stigma of mental health help-seeking so that suicidal people will access the "help they need" (US Department of Health and Human Services, 2001). All of this is built on the belief that suicide has its roots in mental illness rather than in an unjust historical legacy that has fostered a host of undesirable social outcomes, suicide being one of them. That said, the latter perspective is more typically espoused by Indigenous researchers and tribal members (Gone, 2007; Waldram, 2004; Wexler, 2006), which underscores the importance of considering the neocolonial implications of current practices, in which conventional professional approaches to Indigenous "mental health" problems harbour the potential for implicit Western "cultural proselytization" (Gone, 2008).

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 lead to the infringement of individual liberty in order to manage imminent danger. Several Indigenous young people we have worked with have told us unambiguously that this kind of treatment is "being sent to jail for feeling suicidal." Indeed, we have heard tribal members tell mental health workers things like, "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 who was doing a suicide intervention with his grandchild: "Who do you think you are, coming in here and telling us about our children?" 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 the removal of Native children from their home communities to distant in-patient facilities. In Alaska, for example, a professional who believes someone is at "imminent risk" of self-harm can have that person held (against their and their family's will) for up to forty-eight hours.

Indigenous people we have worked with in North America have expressed outrage at clinicians who intervene by removing children from the community against their parents' wishes. For many families, this experience echoes the coercive removal of entire generations of Indigenous children, who were sent to assimilative, government-funded "industrial" schools for preparation as menial labourers in adulthood. This common historical experience shattered families, undermined Indigenous language proficiency, and purposefully decimated the cultural heritage of Indigenous peoples across the continent (Brave Heart and DeBruyn, 1998; Evans-Campbell, 2008). Infringing on a suicidal person's (and perhaps their parents') autonomy might provide immediate safety, but it can also be seen as an extension of cultural subjugation and colonial intrusion. This standard practice also runs counter to the working assumptions that many Indigenous communities have about the social underpinnings of suicide, and it can further alienate the person who is suicidal from the social and cultural context in which effective assistance is most likely to emerge.

The extraction of suicidal community members from their local milieu is especially problematic in Native communities, where suicide has been linked to cultural, social, and community drivers such as acculturation stress, identity conflicts, and discontinuities between past and present (Chandler, Lalonde, Sokol, and Hallett, 2003; Kvernmo and Heyerdahl, 2003). A study that looked at acute psychiatric care with First Nations people in Canada found that mental health challenges were often associated with social and cultural dislocation (Dalrymple, O'Doherty, and Nietschei, 1995). If an original cause of an epidemic suicide problem is European colonization as mediated by community distress in its aftermath, then prevention efforts should be wary of exacerbating and extending the (post)colonial predicament of tribal communities. By contrast, understanding suicide as a "postcolonial disorder" (DelVecchio-Good, Hyde, Pinto, and Good, 2008;

Kral, 2012) would lead to prevention efforts focused on remedying rather than reinforcing the enduring power asymmetries between Western and Indigenous societies. Figuring out how to maximize local control even in the midst of 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 American communities (Kral, 1994). These collective efforts have included a variety of activities, including fighting for sovereignty rights and holding culturally based community gatherings on a regular basis.

Implications for Suicide Prevention

The need and desire for effective suicide prevention is uncontested. How to practise this best is the question. There are broad and deep spaces between the assumptions and practices of typical prevention programs and Indigenous understandings of suicide. Suicide in tribal communities is often 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 individual – and therefore to be addressed through individual mental health treatment. This rendition of the problem reduces complex experiences and socio-cultural phenomena to individual pathology devoid of relevant context and in need of professional interventions (Kral, 2003; Kral and Idlout, 2009; Kral, Idlout, Minore, Dyck, and Kirmayer, 2011). As a consequence of this transmutation (what sociologists refer to as the "medicalization of the social"), matters rich in cultural meaning, historical situatedness, and social significance are deprived of their local intelligibility or dismissed as inconsequential irrelevancies.

Precisely because suicide is a human action filled with meaning, Indigenous suicide prevention must be formulated in response to local Indigenous 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. Building on the understandings outlined here, it is important to consider the person's historical context and social network, as well as the community resources outside the bubble of clinical systems of support. Indeed, if suicide is an expression of collective as well as personal suffering, then interventions must address the community and/or family as well as the identified individual.

This approach requires social interventions facilitated by intimates along with (perhaps) professional protocols that can aid these efforts. Lastly, suicide prevention in tribal communities should not represent and extend aspects of colonialism. Instead, prevention efforts might focus on and fund locally driven decolonization efforts. This reconceptualization of Indigenous suicide prevention would reposition the role of the mental health worker less as a clinical practitioner and more as an advocate for community and family action in response to communal distress. This collaborative orientation could enable mental health professionals to build on local meanings and strengthen community resources in order to develop suicide preventive interventions that are in concert with Indigenous beliefs and practices. This cultural realignment of services could then be used as a model for reconfiguring other health care interventions in other non-Western cultural contexts.

Conclusion

We have offered a critique of the current approach to suicide prevention as it is expressed in Indigenous communities and have suggested some alternative, culturally responsive ways forward. These reconceptualizations of Indigenous suicide prevention reposition mental health workers as advocates for community and family action in response to personal pain and social suffering. A collaborative orientation could enable clinicians to build on local meanings and strengthen community resources in order to develop suicide prevention and intervention strategies that coincide rather than conflict with Indigenous beliefs and practices. This cultural realignment of services could then be used as a model for other cross-cultural contexts.

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4

Risky Bodies

Making Suicide Knowable among Youth

JONATHAN MORRIS

"We all remember what SOS stands for, right?" I ask the thirty students looking back at me. A student raises his hand, "Signs of Suicide?" I nod affirmatively, "Yes, you got it. Now, if you notice that one of your friends is sending out an SOS, what would you do next?" The class sits quietly for a few moments. A student at the back of the class gingerly raises her hand and says, "I would probably ask them about it." I nod even more affirmatively, "Absolutely, bingo. That's probably one of the most important things to do if you're worried that your friend is suicidal. What I'd like us to do now is practise asking The Question – Are you thinking about suicide? After three ... one, two, three." The students en masse ask the fictitious suicidal student, "Are you thinking about suicide?" Now let's talk about what we should do next ...

Over the past several years, I have been spending considerable time thinking about classroom moments like the one above, remembering how phrases and words like "SOS" and "The Question" flowed out of my mouth with ease. I have delivered countless Suicide Awareness for Youth (SAY) presentations over the past decade, and as a result, I have developed fluency with the particular language of youth suicide prevention work. Phrases like "signs of suicide," "risk factors," "don't keep it a secret," and "ask, listen, help" have all

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