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EDITORIAL

Suicide in U.S. Indigenous Persons: Reframing the Etiology and Solutions

Indigenous persons in the United States are distinguished by who we count as kin. Indeed, our lives are organized by expansive kinship connections and relations. These ties convey strength but also vulnerability, as suicide haunts most of our extended families. Thus, we urgently need more and better research on who tries and who dies by suicide. We recognize that these community losses recreate long legacies of social suffering, often referred to today as "historical trauma" (1). We seek conceptual frameworks that will recast our understanding of suicide as deeply entangled with conditions of coloniality. We desire creative inquiry that will motivate and mobilize the innovative development of new and expansive forms of effective suicide prevention (2).

Anecdotal accounts yield a harrowing prototype of Indigenous suicide: An adolescent boy residing on an Indian reservation with a long history of family disruption drinks excessively in the wake of a personal romantic breakup, ruminates about a recent community death by suicide, loads his uncle's shotgun, and impulsively ends his life. There have been consistent findings across decades of epidemiologic inquiry into Indigenous suicide. Suicide mortality is alarmingly high. Indigenous men are more likely than women to die by suicide (often by firearms), whereas women are more likely to attempt suicide (often by poisoning). Our youth have higher rates of suicide than other age groups. Youth suicide clusters within our communities are especially devastating (3).

Dhungel and colleagues (4) contribute to this evolving knowledge base, reporting that age-standardized rates of suicide mortality in the United States increased by 35% among Indigenous men and by 65% among Indigenous women between 1999 and 2020. Moreover, they reported a marked increase in suicide by hanging during this period, especially among Indigenous women (relative to other means). Alongside consideration of inequality and racism, they underscored the need to consider the "underlying mental health issues" of Indigenous populations and sought improved screening by clinicians to better identify high-risk persons. And yet, evocative anecdotes and aggregate statistics mask more complicated realities.

There is diversity in incidence over time, such as when grievous suicide clusters end and community mortality rates subside to prior baseline levels. There is diversity in prevalence across communities. For example, from 1996 to 1998, the Alaska Area within the federal Indian Health Service reported some of the highest suicide mortality rates in Indian country (42.0 per 100 000 persons). However, this rate obscured considerable variation across the 9 administrative regions within this area, with rates ranging between 17.0 and 72.4 per 100 000 persons (5). Disparate findings across time and place are difficult to interpret, given the dearth of comparative and longitudinal investigations of Indigenous suicide that undermines explanation of local diversity or recommendation of tailored interventions.

Future efforts to prevent Indigenous suicide would benefit from conceptual reframing that recognizes and counterbalances the hazards of dominant medicalizing discourses (6). Suicide is routinely described as a mental health phenomenon that is framed and understood as the tragic endpoint of unrecognized or untreated psychiatric conditions, such as clinical depression. This discourse formulates suicide as a preventable outcome stemming from ineffective illness management by health professionals who treat individual patients for their medical problems within clinical settings. As a clinical endeavor, improved suicide prevention would change the ways that doctors and patients interact so that at-risk persons are identified and rehabilitated through medical expertise.

Medicalization of Indigenous suicide discursively transforms the collective legacy of social suffering stemming from long histories of U.S. colonial subjugation into an individual diagnosis of psychiatric distress requiring biomedical treatment of patients by health care professionals. Medicalization thus serves a notable ideological function: It favors explanations based on intrapersonal deficits (such as mental health problems, low self-esteem, or poor impulse control) rather than structural disadvantages (such as poverty, unemployment, and underfunded schools), thereby blaming victims for their own suffering (7). And yet, Indigenous communities already shoulder overwhelming burdens of stigma, marginality, and stereotype without being "held responsible" for suicide among our youth.

We need alternative research that will motivate and mobilize new ways of understanding Indigenous suicide and new approaches to prevention. Hicks (8) traced the historical emergence of epidemic suicide among the Inuit in Alaska, Canada, and Greenland. Inuit in all 3 locales were subjected to "processes of incorporation and sedentarization" by government policy in which they were coercively settled into permanent villages, ending their mobile hunting way of life in exchange for reliance on wage labor, schooling, and commercial foods. Although sedentarization occurred at different times during the 20th century in each country, an epidemic of suicide arose for each Inuit group one generation after their forced settlement in response to "active colonialism at the community level".

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This study of Indigenous suicide provides a systemic rather than intrapersonal explanation of disorder that avoids victim blaming.

Chandler and Lalonde (9) found wide variability in youth suicide rates across 196 First Nations communities in British Columbia. These rates were statistically predicted in a linear fashion by 6 community variables reflecting local administration of self-government, education services, land claims, local police and fire services, health services, and communal cultural facilities. These indicators were tallied (with total scores from 0 to 6) and plotted against community youth suicide rates. Communities reporting none of these indicators had the highest suicide rates, whereas those reporting all 6 indicators had almost no suicides. These findings suggest that Indigenous "nation building" could be an effective form of suicide prevention, with an emphasis on systemic (for example, development of cultural centers) rather than intrapersonal (for example, individual counseling) intervention.

In summary, there are clear precedents for investigating Indigenous suicide as a function of societal processes and structural arrangements in general and of colonial subjugation and coercive assimilation in particular. This resocialization of suicide starkly contrasts with with the intrapersonal and individuating discourses of medicalization, powerfully contests the reigning formulation of the problem, and effectively recasts Indigenous suicide as a postcolonial disorder in need of not just more or better medical treatment but also of social justice and societal reparation (1). In the end, no amount of medical care can resolve the harrowing predicaments of Indian Country unless the unjust structural disadvantages that resulted from ruthless colonial subjugation are confronted and dismantled (10).

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