Narrative Approaches to North American Indigenous People Who Attempt Suicide

Lewis Mehl-Madrona, MD, PhD[1,2,3,4,5]; Barbara Mainguy, MA, MSW[3,4]

Perm J 2020;24:19.032

E-pub: 11/22/2019

https://doi.org/10.7812/TPP/19.032

ABSTRACT

Introduction: Suicide is a major problem within North America's indigenous communities. There is debate about the best way to approach indigenous people who have attempted suicide. Conventional methods of cognitive behavior therapy have been criticized for not being indigenous friendly.

Methods: Case files from an academically affiliated, rural psychiatric practice focused primarily on indigenous patients were reviewed for 54 indigenous patients who attempted suicide. Grounded theory methods were used to identify common strategies for approaching those patients who were able to stop attempting suicide. A comparison population had a greater than 90% incidence of a second attempt.

Results: Nine major strategies within a narrative approach that appeared to be successful with this population were identified. Introducing novel contradictory ideas to the beliefs people held about suicide appeared helpful. Using stories to introduce the idea that the desired effects of suicide might not be forthcoming seemed beneficial, including the use of story to find means other than attempting suicide to reach the same ends. Creating stories of a positive future appeared helpful. Finding ways to bring humor into the discussion and to refer to and involve traditional culture in which suicide was rare aided in changing perspective. Of 29 patients engaged in this narrative approach, 26 had no further suicide attempt. Retention in counseling was high, and patients reported enjoying the process.

Conclusion: A narrative approach to indigenous people who attempt suicide is compatible with indigenous culture and appears to be successful.

INTRODUCTION

"Davis Inlet [Newfoundland and Labrador, Canada] burst onto the world's consciousness … when six gasoline-sniffing children were pulled from an unheated shack on a frigid night, screaming that they wanted to die."[1] Suicide disproportionately affects indigenous peoples,[2,3] a reality that has not changed since this well-publicized description from Newfoundland in 1994. Historically, suicide was an infrequent occurrence among First Nations and Inuit peoples.[4] Suicide became prevalent only after contact with Europeans and especially during the 20th century as a result of the effects of colonialism and colonization. For example, suicide rates for Inuit youth are among the highest in the world, at 11 times the national mean. In the Northern Ontario communities around James Bay and Hudson Bay, suicides and overdoses among teens and those in their 20s are high, with overdoses accounting for 17% of medical evacuations.[5]

Culture matters. In Canada, communities with a strong sense of culture, language, and community ownership have lower rates of suicide than the Canadian mean and sometimes none at all.[4] A qualitative study of an indigenous community in the northern Ontario James Bay and Hudson Bay region of Canada addressed the question of why this community had markedly lower rates of mental health services use and suicides than 5 other Cree communities in their vicinity, despite a shared history of trauma and oppression in all these communities and a recent natural disaster and forced relocation. This finding was despite the considerable efforts of mental health workers and the allocation of substantial federal and provincial financial resources in the other communities, all of which appeared to have no effect.

Results indicated that the differences emerged from strong connections to the land and traditions, openness to both traditional and Christian spirituality, community engagement, and a value for shared parenting as a strength.[6] In a qualitative study of 22 Native American adolescents who attempted suicide, risk emerged from individual, family, community, and societal factors.[7] Some of the themes paralleled established models of suicide risk. Other themes, including the effect of overtaxed households and family composition, substantial grief burden, contagion, and stigma surrounding treatment seeking, were unique to this group.

The first response of psychiatric practitioners to people who have attempted suicide is to determine whether inpatient admission is necessary. Whether outpatient or inpatient, such patients are usually offered medication and psychotherapy. Most of the psychotherapy is provided by nonindigenous practitioners and is not necessarily culture informed or proceeding from a social justice perspective. The methods and values of conventional mental health services may be incompatible with indigenous peoples, and the provision of services may further alienate and subjugate indigenous communities.[8,9]

Culturally relevant care ideally consists of advocacy, outreach, community-based interventions, and inclusion of indigenous psychotherapists.[10] However, cognitive behavior therapy is the modality typically offered in most health service settings. We wondered if a narrative approach would be acceptable to indigenous patients. We wondered what stories they would tell about their reasons for attempting suicide and what therapeutic stories the therapist would tell to offer counternarratives.

Author Affiliations

[1] Family Medicine Residency, Northern Light Health, Bangor, ME

[2] Associate Professor of Family Medicine, University of New England College of Osteopathic Medicine, Biddeford, ME

[3] Coyote Institute, Orono, ME

[4] Wabanaki Health and Wellness, Bangor, ME

[5] Graduate School, University of Maine at Orono

Corresponding Author

Lewis Mehl-Madrona, MD, PhD (mehlmadrona@gmail.com)

Keywords: aboriginal peoples suicide risk, indigenous culture, narrative in suicide therapy, recreating story, suicide risk of indigenous peoples, suicide risk of aboriginal peoples

We previously presented the results of in-depth interviews for 54 indigenous suicide attempters.[11] Psychotherapy proceeded with 27 in this group. We added 2 additional suicide attempters after the in-depth interview project ended for a total of 29 patients. Twenty-six of these patients made no further suicide attempts. No patients completed suicide. Psychotherapy lasted a mean of 9 sessions (range, 1-16). Frequency ranged from weekly to monthly. We followed-up a comparison group of 27 patients who did not engage in psychotherapy. Of these, 21 attempted suicide again, at least once. The mean length of follow-up for those receiving psychotherapy was 17 months (range, 5 months to 5 years). The mean duration of follow-up for the comparison group was 15 months (range, 5-27 months). Medication was available to all patients who desired it. Twelve patients chose to take medication (primarily selective serotonin reuptake inhibitors): 5 in the group did not select psychotherapy and 7 in the group did. Of those who started taking medication, 2 continued taking medication after the completion of psychotherapy.

The 3 common themes that preceded the suicide attempts were relationship breakup, public humiliation, and chronic, unremitting life stress. Alcohol and drugs were frequently involved. The 5 common purposes for attempting suicide were revenge, stopping the pain, saving face, communicating the depth of hurt, and "can't remember/made sense at the time." The 5 common beliefs about death were everything disappears, traditional view of the spirit world, Christian heaven and hell, a better place, and "don't know/don't think about it."[12]

Review of the clinical records revealed the following reasons for not attempting psychotherapy: 1) distances to travel for appointments were too great,[11] 2) previous bad experience with psychotherapy,[9] 3) patient convinced that s/he did not have any problem substantial enough to be addressed,[4] and 4) the belief that talking does not do anything.[3]

We previously proposed that the striking discrepancies between the rate of repeat suicide attempts among those who did not engage in therapy compared with those who did suggest that something was happening during the therapy. However, we could not exclude the possibility that people who decline therapy are radically different from people who will try it. They did not seem different at the time. Assuming that something was happening in the therapy, the aim of this analysis was to determine what it was that the therapist did during the therapy and how the patients responded. Rarely do psychotherapy studies look at what was actually done as opposed to what the theory says should be done.

We wanted to develop theory and therefore guidelines about how to effectively work with North American indigenous people who attempt suicide to prevent future suicide attempts. The theory and guidelines arise from our unique therapeutic perspectives and are not necessarily the only or even the best way to engage psychotherapeutically with this population. However, they arise from a psychotherapeutic process in which the mutual goal was to avoid subsequent suicide attempts. We do not compare methods of psychotherapy but rather examine if one method developed after a process described by Fishman[13] would be effective and what made this method effective.

METHODS

The process[12] began with a focus on the patients and their presenting problem (component A: A recent suicide attempt). We selected a guiding concept (component B: The suicide attempt makes sense within the patient's existing narrative identity and his/her stories about how to manage relationships with other people) with accompanying clinical experience and research support (component C: Changing the narrative identity and providing or finding alternate narratives about relationships will change the presenting problem). We then conducted a comprehensive assessment (component D: Hearing all the stories), applying the guiding conception to the assessment results in a customized formulation and treatment plan (component E: Finding, presenting, or rehearsing alternate narratives). We implemented the plan during the course of therapy (component F: Doing the work). We made modifications as needed during the clinical work through an evaluation and feedback process (component G: Hearing from the patient if what we are doing is working). Building on Peterson's original conceptualization,[12] we have included all stakeholders in these components whenever possible. The process is decidedly dialogical and conversational.

We also included as part of the assessment component the Northwestern University Life Story Interview of Dan P McAdams of the Foley Center at Northwestern University.[14] This interview asks people about high points of life, low points, turning points, times of overcoming obstacles, relevant stories that they would not want to leave out of their life story, and more. McAdams' interview asks people to imagine that their lives are a novel. This population related better to imagining their lives as movies. Movies are time-limited and contain a finite number of scenes or vignettes carefully chosen to tell the desired story. We asked people for the important scenes that we must see to understand them as human beings. We also asked about the soundtrack to the movie, the lighting, and similar cinematographic details. What music would we hear during each scene? What are the identifiable challenges, obstacles, helpers, villains, and lovers in the movie?

With suicide attempters, we were primarily interested in their theories about death and what happens after death, and how their beliefs (stories) about how their departure from this world would affect others. If suicide is a strategy, then what is the need that it is meant to fulfill? What is the purpose of this behavior within the social hierarchy in which the attempter finds himself/herself?

Investigations in indigenous contexts using indigenous knowledge methods proceed similarly to Peterson's qualitative methods.[12] These approaches are sometimes seen as anecdotal by evidence-based medicine. Kirmayer et al[8] commented on the problems presented by this cross-cultural distrust:

> Evidence-based practice (EBP) and cultural competence (CC) aim to improve the effectiveness of mental health care for diverse populations. However, there are basic tensions between these approaches. The evidence that purports to ground EBP is limited, often in ways that are biased by specific disciplinary, economic or political interests and cultural

> assumptions. In particular, the paucity of evidence regarding cultural minorities results in standard practices based on data from the majority population that have uncertain relevance for specific cultural groups. As well, research evidence about intervention outcomes tends to focus on individual symptoms and behaviors and may not reflect culturally relevant outcomes … . [C]onsideration of culture raises two deeper problems for EBP: 1) The diagnostic and conceptual frameworks used to pose questions, devise interventions, and determine outcomes in EBP are themselves culturally determined and therefore potentially biased or inappropriate; and 2) Cultural communities may have "ways of knowing" that do not rely on the kinds of observational and experimental measures and methods that characterize EBP.

Fishman[13] describes how Peterson's model could be used to build theory in psychotherapy, exemplified by him in the work of Gray and Stiles[15]; Schielke, Stiles, et al[16]; and Stiles.[17] They say, "A central tenet of theory building case study research is that observations about rich material from individual cases—both the commonalities and differences—can be combined to inform and support theories about complex underlying psychological phenomena … ."[16p532] This approach is compatible with indigenous knowledge methods.

A modified grounded theory method[18] was used to review the life stories of indigenous suicide attempters, using constant comparison methods[19] to find the common themes stated by respondents in the areas of interest. This same method was used to review psychotherapy case notes from indigenous suicide attempters to determine the commonalities and differences among the interventions used. The constant comparative method[20] was again used to iteratively review the material to select what was common and to delete what was not.

Analytic Procedure

The analytic process began with open coding.[21] We read each life story interview and the clinical case notes several times and worked through them in detail, reading line by line and breaking the data down into individual meaning units. We then labeled segments of the text with initial codes, indicating the idea or concept contained in that data fragment. We made an attempt where possible to embed action in the codes, following universal modified grounded theory principles.[22,23] We pursued a flexible analytic stance to the material through microanalysis of the data fragments, being mindful of assumptions about the data and asking what else it might mean.[21]

After completing open coding for the first 9 cases (stage 1), we conducted a detailed process of comparing codes. We clustered initial codes with similar meanings to develop lower-level theoretical concepts. While continuing with open coding of the remainder of the interviews, informed from our category and concept formations, we repeated this process of comparing codes iteratively to develop higher-level theoretical concepts. We conducted this process of constant comparison throughout the research until the highest-level theoretical categories were constructed. As the analysis proceeded and higher-order concepts and categories were constructed, the lower-order concepts became the properties that defined each category and its dimensions.[21]

Once some initial concepts were constructed, we introduced axial coding[24] in parallel with the above clustering process to explore the links among different concepts. We attempted to engage in constant questioning and thinking about potential linkages (explicit or implicit) between concepts and categories.[25] This process involves distinguishing among conditions, actions and interactions, and consequences to sort and arrange the concepts during the process of analysis. We documented these linkages in memos throughout the research process. Once half of the cases had been read, we engaged in focused coding[22] in which we selectively focused our subsequent coding activities on the concepts and categories constructed from the first half of the sample to further elaborate and saturate these categories.

In the final stage of analysis, we focused on selective coding,[21] which is the process of integrating and refining the categories to construct the theory. The goal is to locate a superordinate category to represent the major theme of the research and pull all the other categories together into a coherent framework. This core concept should be abstract enough to integrate all the other categories and should capture the essence of the research.[26] We used the range of approaches recommended by Strauss[24] and Corbin[25] to facilitate the process of integration, including writing the storyline, rewriting the storyline in terms of categories, use of diagramming, memo reviewing, and memo sorting.

As recommended by Charmaz,[22] throughout the study, we wrote memos to capture the emerging analytic process. The nature and quality of the memos evolved as the analysis proceeded. Earlier memos captured thoughts and reflections on codes that stood out and documented hypothesized links between lower-level concepts and questions about these links to shape the process of forming basic categories. As the study proceeded, the memos increased in their level of theoretical abstraction, documenting higher-level linkages among categories and their properties.

We met regularly to discuss ongoing analytic ideas and kept an audit trail of how our concepts emerged. We also kept a reflective journal to capture our own influence on the research process and to provide space for bracketing our own reactions to the data.[27] We also engaged in member checking in which we gave copies of our draft results to as many patients as we could reach to inquire if the analysis fit their experience.[28]

Philosophy of the Analysis

We followed the approach described by Charmaz,[22] which has been called social constructivism.[29] Social constructionism views all knowledge as created by human beings through language, discourse, and culture. Social constructivism acknowledges that knowledge may exist independently of human beings and that the physical constraints of the world impose constraints of the knowledge that human beings can produce. Both theories acknowledge that all perspectives are to some degree biased and fallible and that our conclusions or knowledge is always

provisional. The researchers' preexisting perspectives inevitably shape emerging knowledge. The researchers' professional discipline, theoretical proclivities, and familiarity with the literature affect theoretical sensitivity. Dey writes that "there is a difference between an open mind and an empty head."[30p251] Strauss[24] also believed that preexisting knowledge could facilitate data collection. The analysis focused on what the therapist did and how the patient responded.

RESULTS

We identified 9 types of interventions. The first intervention type was designed to get attention or to pique curiosity. The therapist asked novel questions. For example, in one vignette, he asked the patient to imagine for a moment that she was wrong about what happens after death. He told her about one of the local elders who claimed to have been in contact with people who had committed suicide. He reported the elder as having said that the people told him that suicide had not changed anything. They had all the same problems and now a new one—they were dead! What if, he wondered, the nothingness you expect turns out to be something like that. He proposed that it is harder to work on relationships with the living when you are dead. This led to a spirited discussion about nothingness vs somethingness, but the patient appeared engaged.

Another variant used to get people's attention was the reincarnation theme. The therapist asked, "What if reincarnation is correct and you just have to come back again with all these same people and do it all over until you get it right?" Then he further explored the ultimate futility of suicide if reincarnation is correct. He buttressed these ideas with reference to North American indigenous reincarnation beliefs.[31]

The therapist challenged (humorously when possible) whatever idea the patient held about death with a counter idea that was different. He elicited the story that led to the conclusion the patient had made and then offered a counternarrative that led to a different conclusion.

The second intervention type was eliciting the suicide story (in which suicide makes sense) and then posing the counternarrative, which makes suicide seem pointless or meaningless. These first 2 themes are highly related, but in our coding process they also emerged as worthy of being distinguished. Other methods could be used to gain attention or pique curiosity, so the presentation of counternarratives to the suicide story seemed robust.

The third intervention type was addressing stories about relationship. Given the common theme of suicide in the context of managing difficult relationships, another robust theme appeared to be that of addressing stories about relationships in which attempting suicide is a management strategy. Examples of questions that did this included "What if you kill yourself and no one cares?" "What if you go to your funeral as a ghost (spirit) and discover that no one noticed how much they hurt you; they're just angry with you for killing yourself." The approach of presenting a counternarrative to the currently accepted narrative was also operative. The general principle appeared to be to propose that the patient's current relationship story does not work and that another story might be better. The broader organizing principle in these first 3 themes is the offering of counternarratives. For example, the therapist would tell stories about times when people killed themselves and their friends and relatives did not react in the ways the story predicted.

A subtheme within the interpersonal realm relates to strategies of communicating how hurt one feels. For example, in one vignette, the therapist posed the question, "What are some ways that people have communicated to you that you have hurt their feelings?" "What are other ways that you have communicated to people that you are deeply hurt?" "What if you kill yourself and your ex-girlfriend doesn't realize you did it because you were so hurt? What if it just confirms her opinion that you're a stupid jerk?"

The fourth intervention was teaching communication skills. The therapist remarked on the poor communication strategies of his patients, described teaching recognition and expression of emotions. In one vignette, he remarked to a patient who said she was feeling suicidal, "Suicidal is not a feeling. It is a strategy. You could feel hurt, angry, wounded, betrayed, disappointed, and many other things, but not that." He used Linehan's[32p53-60] handouts for recognizing and describing feelings. He used the nonviolent communication techniques of Rosenberg[33] to help the patients express themselves more effectively to the people in their lives, to be able to directly and verbally communicate their hurt, and to speak more directly about what need was not being met by the other person, instead of communicating indirectly through a suicide attempt.

When revenge was the motive for a suicide attempt, the therapist presented alternate ways to seek revenge. In one vignette, he told the patient, "Success is the best revenge." To another, he suggested that the best way to get back at a partner who has dumped you is by finding someone new and becoming happier than you were before. To some of the more pessimistic patients who argued against this, the therapist maintained a list of popular romantic comedies for them to watch in which people are dumped by their romantic partner and end up with a better relationship than before. His goal was to develop a plausible personal story about finding love after a breakup or succeeding after a failure.

The fifth intervention was finding a positive future. The therapist aimed to assist the patient in developing possible positive futures. Imagining a positive future can be quite tricky for many indigenous patients who have experienced cultural and social breakdown and the epigenetic contribution from their parents' residential school experience. The therapist invited them to imagine something positive that could happen in the future. In one vignette, the patient was invited to remember times in the past when she had fallen in love. She was invited to consider how many times this had happened and then to imagine that it could happen again. In another vignette, he invited a patient to imagine buying a winning lottery ticket because this patient knew someone who had bought a winning lottery ticket. In another vignette, he invited a patient to imagine getting a job. In another, the patient was asked to imagine getting a better job.

The sixth intervention was exploring what a good life is and how we know when we are happy. The therapist frequently asked,

"What is a 'good life'?" "How would you know that you had a good life?" "How would you know that you were happy?" He frequently noted that people want to be happy without knowing how they would know they were happy. He frequently prescribed a Canadian film that addressed this question called *Hector in Search of Happiness*. In this film, Hector, a psychiatrist, realizes he does not know if he's happy and he does not know what makes people happy. He goes on a search around the world to find out what makes people happy. The movie provokes discussion about what happiness and a good life are.

The seventh intervention was to encourage patients to find humor. Despite the serious nature of suicide, the therapist clearly sought to bring humor into all these discussions. Humor is central to indigenous cultures. The Canadian indigenous novelist Thomas King[34] remarked in his Massey lectures that whatever you think about Indians in Canada, add more humor and more dogs. The therapist was noted to seek opportunities to bring humor into the discussion, and the patients responded well when this happened. A therapy dog also attended the sessions whenever he was available.

The eighth intervention was to invoke culture. The therapist frequently told patients that suicide was not part of traditional indigenous culture. He related that people only considered suicide when shamed to the point of banishment. He said that traditional culture emphasized an ongoing dialogue with spirits, both incorporeal beings and the essence of beings in nature (trees, animals, rocks, rivers, mountains, the sun, the moon, and more). Within that context, he talked about suicide making less sense because the dialogue continued whether one was dead or alive. He said that the ancestors did not envision suicide as a solution because problems continued into the spirit world. He talked about the emphasis on solving problems in the present world so people could enter the spirit world more freely.

The therapist also emphasized the potential role of elders as helpers. He spoke about their importance and how we often defer to what they say. He spoke about how elders emphasized the continuity of the mind independent of the body. Equally importantly, he said, was the capacity of elders to bring people into the folds of the community, which happens through the participation of the person in ceremony or just through the interactions that occur around an elder in his/her community. He spoke about elders being at the center of a circle of people who help each other.

The therapist coordinated patients meeting with elders and attending ceremonies as part of the therapeutic process. Importantly, patients often disagreed with the therapist, at which point he turned the process into a humorous debate, never directly confrontive.

The ninth intervention was creating and rehearsing counternarratives. The therapist used the template of the heroic journey for inventing with the patient a story in which the suicide attempt represented the "dark night of the soul in which the hero shivers alone, cold on a mountainside" and then proceeds to find helpers and allies to overcome the obstacles and the enemy (suicide) to triumphantly prevail in a positive future. Multiple plausible versions of this story were created and rehearsed, including selectively choosing audience members from the patient's external world and trying elements of the story with them. The goal was to perform an altered identity narrative in which suicide was not even considered. The overarching organizing concept of the themes we recognized can be stated as "replacing bad stories with better stories."

In meta-commenting, we note that the psychotherapy overall had a decidedly indigenous flavor. The therapist was indigenous, as were the patients. The approach appeared to be primarily narrative, although informed by mindfulness practices and dialectical behavior therapy, along with body-centered and experiential practice from a trauma-informed perspective. The common indigenous practice of smudging, in which one burns sage or cedar and waves the smoke around the person, who covers himself/herself with it as a cleansing and a blessing, was frequently used. (Even the Roman Catholic Church has adopted this practice in indigenous settings, as during the canonization of the first indigenous saint[35]). Then, often the therapist sang a song to honor the ancestors and the spirits. Interestingly, almost everyone welcomed smudging and singing, even if they ascribed to Christian or atheist beliefs. These procedures set a cultural tone of respect for tradition and ancestors.

For the life story, a modification of the Northwestern University Life Story Interview was used. Then, after hearing the life story, the Adverse Childhood Events Scale was used so that people could appreciate the level of trauma they actually experienced. Patients were given a copy of the story so that they could continually expand and revise it. In exploring problematic relationships, a genogram was frequently used to clarify the conflictual relationships. For talking circles, an invitation was always made to the patient to bring everyone s/he knew to a talking circle. Twenty percent accepted that invitation. The acceptors tended to be more culturally connected and accepting of the idea that everyone we know plays a role in our mental health. Another 17% brought their immediate family to a talking circle. Another 15% brought one or both parents.

Therapy usually began with a focused interview about the proximal conditions surrounding the suicide attempt and resulted in a story about the suicide that revealed the patient as a central character with beliefs, desires, and intent. The story made clear what the person intended to accomplish by suicide and what s/he believed would happen if s/he died, both to him/her and the other people in the story. The therapeutic interventions that arose from that story moved toward a revised story that would decrease the likelihood of further attempts at suicide. The main character needed to change beliefs, intent, or strategy for this to happen.

Relation building and listening are vital elements of any psychotherapy. The psychotherapist also being indigenous and being understanding and respectful of some aspects of the patient's culture helped but was not as universal as one might naively assume. Fifty-one percent of the patients reported no cultural connection, which we hypothesized made suicide more acceptable to them. These patients did not know any of the stories of their people; they knew no songs, no ceremonies, and initially rejected any efforts to connect them with their culture.

The remainder had some cultural connection and identity but not in a way that one could say was strong or played a substantial role in their lives. We found it notable that none of the patients was strongly culturally connected, also pointing to the idea that culture and language protect against suicide. Only 12% of the patients grew up in association with cultural traditions. Roman Catholicism played an influential role followed by other Christian traditions.

DISCUSSION

The systematic review of interviews and case notes from successful psychotherapies (as defined by no further suicide attempts) can help us understand how to work therapeutically with this population. Although there are certainly other approaches, this narrative approach was accepted by most of the patients. The purpose of psychotherapy was to change the stories people held about death, about what happens when people die, about the effect of completed suicide on the people who are left alive, and about how one can best communicate hurt and achieve revenge. Counternarratives assisted participants in developing richer stories on these topics, which led to different, more positive outcomes. This was not a study to compare methods of psychotherapy but rather to observe what interventions were used and appeared to be appealing and successful.

The generally positive results found among this cohort might not be seen among patients with long-term issues, older populations, and those who had more medication exposure, more hospitalizations, and more suicide attempts. More intensive treatment involving dialectal behavior therapy groups and more frequent individual psychotherapy might be necessary to produce a change in that population.

The idea of personal and cultural continuity is essential to understanding suicide among First Nations youth. Identity narratives resolve the question of what it means to have or be a self and to consider oneself as continuous in time. Those whose identity narratives are undermined by radical personal and cultural change are at risk for suicide related to loss of a sense of continuity and a future with commitments that are necessary to guarantee appropriate care and concern for one's well-being. Adolescents and young adults living through dramatic change are a high-risk group for suicide. When communities lack a sense of cultural continuity, the risk increases further. Narrative therapy of the kind described in this article appears to help patients build an identity narrative with more personal continuity and the projection of the person into a positive future. These can offset risk factors for suicide. Future research could compare conventional cognitive behavior therapy approaches to preventing repeated suicide attempts to the currently reviewed narrative approach for indigenous and nonindigenous patients.

CONCLUSION

Working in culturally syntonic ways with indigenous people who have attempted suicide can prevent future suicide attempts. We present a narrative approach that acknowledges suicide as a response to historical and intergenerational trauma while posing it as a nonindigenous response. Our goal is to identify the stories in which suicide makes sense, to label these stories as colonizing and nonindigenous, and to find alternative stories for solving life's problems that do not lead to suicide. Although common themes emerged in our population, the stories can be quite individual. The goal is to work together to find and to perform stories of personal empowerment and cultural resistance. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgments

Laura King, ELS, performed a primary copy edit.

How to Cite this Article

Mehl-Madrona L, Mainguy B. Narrative approaches to North American indigenous people who attempt suicide. Perm J 2020;24:19.032. DOI: https://doi.org/10.7812/TPP/19.032

References

1. DeMont J. Northern showdown. Macleans 1994 Sep;107:14-6.
2. Wexler L, Chandler M, Gone JP, et al. Advancing suicide prevention research with rural American Indian and Alaska Native populations. Am J Public Health 2015 May;105(5):891-9. DOI: https://doi.org/10.2105/AJPH.2014.302517.
3. Wexler L, White J, Trainor B. Why an alternative to suicide prevention gatekeeper training is needed for rural indigenous communities: Presenting an empowering community storytelling approach. Crit Public Health 2015 Mar;25(2):205-17. DOI: https://doi.org/10.1080/09581596.2014.904039.
4. Kirmayer L. Suicide among aboriginal people in Canada. Ottawa, Ontario, Canada: Aboriginal Healing Foundation; 2007.
5. Recollet C, Rego C, Partridge C, Manitowabi S. Health status profile and environmental scan: Aboriginal, first nations, & metis. Toronto, Ontario, Canada.: North East Local Integration Network; 2010.
6. Danto D, Walsh R. Mental health perceptions and practices of a cree community in northern ontario: A qualitative study. Int J Mental Health Addict 2017 Jul;15(4):725-37. DOI: https://doi.org/10.1007/s11469-017-9791-6.
7. Tingey L, Cwik MF, Goklish N, et al. Risk pathways for suicide among Native American adolescents. Qual Health Res 2014 Nov; 24(11):1518-26. DOI: https://doi.org/10.1177/1049732314548688.
8. Kirmayer LJ, Brass GM, Tait CL. The mental health of Aboriginal peoples: Transformations of identity and community. Can J Psychiatry 2000 Sep;45:607-16. DOI: https://doi.org/10.1177/070674370004500702.
9. McCormick R. Aboriginal approaches to counselling. In: Kirmayer L, Valaskakis G, editors. Healing traditions: The mental health of aboriginal peoples in Canada. Vancouver, British Columbia, Canada: UBC Press. 2009; p 337-54.
10. Bowden A, Caine V, Yohani S. A narrative inquiry into the experiences of two non-aboriginal counsellors working with aboriginal people. Can J Counsel and Psychother 2017 Jan;51(1):40-60.
11. Mehl-Madrona L. Indigenous knowledge and aboriginal suicide attempers. Can J Psychiatry 2016 Nov; 61(11): 696-9. DOI: https://doi.org/10.1177/0706743716659247.
12. Peterson DR. Connection and disconnection of research and practice in the education of professional psychologists. Am Psychologist 1991 Apr; 46(4):422-9. DOI: https://doi.org/10.1037/0003-066X.46.4.422.
13. Fishman DB. Editor's introduction: Combining pragmatic case studies within a single case experimental design. Pragmatic Case Studies Psychother 2012;8(4):245-54. DOI: http://doi.org/10.14713/pcsp.v8i4.1797.
14. McAdams DP. The life story interview [Internet]. Evanston, IL: Foley Center for the Study of Lives; 2008 [cited 2019 Jul 11]. Available from: www.sesp.northwestern.edu/foley/instruments/interview.
15. Gray MA, Stiles WB. Employing a case study in building an assimilation theory account of generalized anxiety disorder and its treatment with cognitive-behavioral therapy. Pragmatic Case Studies Psychother 2011;74(4):529-57. DOI: http://doi.org/10.14713/pcsp.v7i4.1115.
16. Schielke HJ, Stiles WB, Cuellar RE, et al. A case study investigating whether the process of resolving Interpersonal problems in couple therapy is isomorphic to the process of resolving problems in individual therapy. Pragmatic Case Studies Psychother 2011;7(4):477-528. DOI: http://dx.doi.org/10.14713/pcsp.v7i4.1114.
17. Stiles WB. Logical operations in theory-building case studies. Pragmatic Case Studies Psychother 2009;5(3):9-22. DOI: http://doi.org/10.14713/pcsp.v5i3.973.

18. Ruppel PS, Mey G. Grounded theory methodology—narrativity revisited. Integrative Psychological Behav Sci 2015 Mar; 49(2):174-86. DOI: https://doi.org/10.1007/s12124-015-9301-y.
19. Olson JD, McAllister C, Grinnell LD, Gehrke Walters K, Appunn F. Applying constant comparative method with multiple investigators and inter-coder reliability. Qual Rep 2016;21(1):26-42.
20. Fram SM. The constant comparative analysis method outside of grounded theory. Qual Rep 2013;18:1-25.
21. Strauss A, Corbin J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2nd ed. Thousand Oaks, CA: Sage Publications Inc; 1998.
22. Charmaz K. Constructing grounded theory: A practical guide through qualitative analysis. Thousand Oaks, CA: Sage Publications; 2006.
23. Glaser BG. Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociological Press; 1978.
24. Strauss AL. Qualitative analysis for social scientists. Cambridge, UK: Cambridge University Press; 1987.
25. Corbin J, Strauss A. Basics of qualitative research: Techniques and procedures for developing grounded theory. 4th ed. Los Angeles, CA: Sage Publications Inc; 2015.
26. Bartlett D, Payne. Grounded theory: Its basis, rationale, and procedures. In: McKenzie G, Powell J, Usher R. Understanding social research: Perspectives on methodology and practice. London, UK: Falmer Press; 1997. p 173-95.
27. Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory, method and research. London, UK: Sage Publications; 2009.
28. Creswell JW. Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage Publications; 1998.
29. Berger P, Luckmann T. The social construction of knowledge: A treatise in the sociology of knowledge. New York, NY: Open Road Media; 1966.
30. Dey I. Grounding grounded theory: Guidelines for qualitative enquiry. London, UK: Academic Press; 1999.
31. Mills A, Slobodin R, editors. Amerindian rebirth: Reincarnation belief among North American Indians and Inuit. 2nd ed. Toronto, Ontario, Canada: University of Toronto Press Scholarly Publishing Division; 2009.
32. Linehan M. DBT® skills training handouts and worksheets. 2nd ed. New York, NY: The Guilford Press; 2014.
33. Rosenberg MB. We can work it out: Resolving conflicts peacefully and powerfully. Encinitas, CA: PuddleDancer Press; 2005.
34. Salaita S. Humor and Resistance in Modern Native Nonfiction. Alif: Journal of Comparative Poetics 2011;31:133.
35. Kateri Tekakwitha becomes Canada's first aboriginal saint [Internet]. Toronto, Ontario, Canada: CTV News; 2012 Oct 21 [cited 2019 Apr 15]. Available from: www.ctvnews.ca/canada/kateri-tekakwitha-becomes-canada-s-first-aboriginal-saint-1.1004239.