# Culture, Care & Suicide Prevention:

**Perspectives to Develop Reflective Practices and Cultural Humility**

## Session Aims

**1) Identify key elements of successful prevention and health promotion practices, particularly in cross-cultural settings**

**2) Describe conditions that support successful and culturally humble practices**

**3) Develop ideas and strategies for maximizing respectful and effective prevention work in participants' life/work lives**

# Introductions

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The road we take shapes our journey…

Please share a short story that helps us understand what brought you to your current work and to this session.

# What is suicide? What are the implications of this/these understanding?

- Act
- State of mind
- Evidence of a mental illness
- Social problem
- Commitment to a cause
- Health disparity
- Reflective of economic issues
- A consequence of historical and on-going trauma
- Communication
- A way out
- Psychological problem
- An honorable end….

# Suicide is an act, but what does it mean and for whom?

- Variability in demographics, correlates and rates across countries, ethnic groups & even communities.
- Different rates and etiology suggest that suicide holds different meanings and is associated with different practices for diverse groups (and for persons within).
- Prevention efforts should vary accordingly.

Example: Alaska Native and Western perspectives offer various points of contrast.

# Cultural and Culturally-specific Understandings and Practices

Exploring how we make sense of suicide can illuminate both the limitations of that perspective and the possibilities that can be created outside or in relation to it.

# Public Health Lens
# Suicide in the United States*

Old and Young people at highest risk

- Americans ages 65 and older are disproportionately more likely than other age groups to die by suicide
- Suicide was the third leading cause of death for young people ages 15 to 24

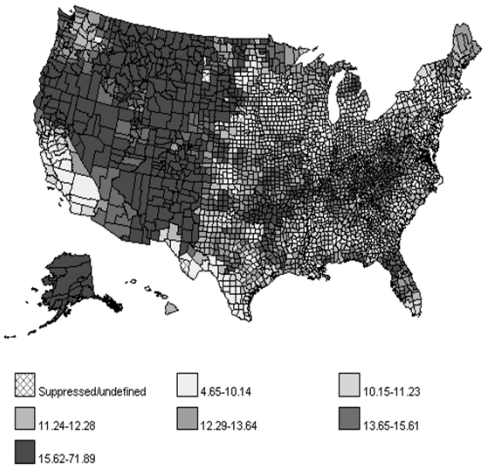
Men are at highest risk

- More than six times as many males as females ages 20 to 24 died by suicide

American Indian and Alaska Natives are the highest risk ethnic group

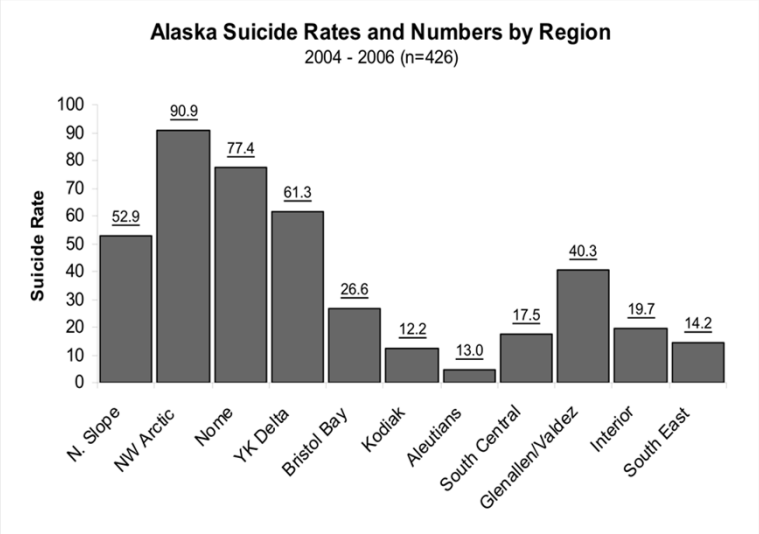
*Centers for Disease Control and Prevention, 2006

# Suicide Rates Across the U.S.




Centers for Disease Control and Prevention, National Injury Mortality Data, 2012

# Differences in Suicide Rates



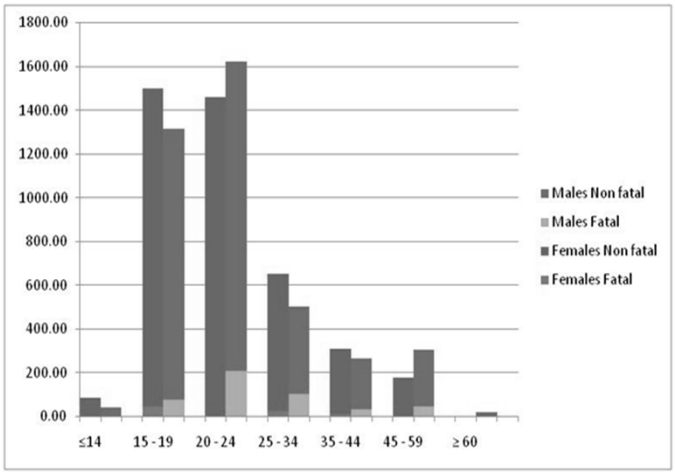

Allen, J., & Butler, J. Epidemiology of Suicide in Alaska, 2009

# What do we know about suicide in the Northwest Alaska?

- Numbers: Attempts?

  Deaths
- Age/Gender
- Method
- Situational factors
- Substance use
- Counseling experience

## Suicide Behavior in Northwest Alaska per 100,000 1990-2012




Wexler, L., Silveira, M.L., Bertone-Johnson, E. (2012). Factors Associated with Alaska Native Fatal and Nonfatal Suicidal Behaviors 2001-2009: Considering Trends and Discussing Implications for Prevention. Archives of Suicide Research, 16(4): 273-286.

## Normative Assumptions Underpinning Western Suicide Intervention

Suicide is a response to individual, psychological distress or disorder.

Mental health system has the expertise and resources to assesses psychological risk and keep the person safe.

Mental health services are required to diagnose the root, psychological disorder and to treat it.

## Consider how the standard (Western) suicide intervention protocol is experienced by some community members we talked to.

1. Refer to a mental health counselor/psychologist

*Tell a stranger—a therapist from somewhere else who "doesn't know what it is like around here"*

*Takes responsibility (and authority) away from parents, friends, family, community members "they [therapists] never listen to me [his mom]"*

## …Standard Suicide Intervention (continued)

2. If the clinician considers the suicidal person to be a danger to themselves or others, s/he is taken (sometimes against his/her will and that of the family) from their home, isolated, and watched by strangers.

*"They never ask(ed), they just took junior…"*

## …Standard Suicide Intervention (continued)

3. Based on surveillance and assessments (normed on a different population), a clinician is given the authority to determine level of risk

…If determined to be in imminent risk, s/he is:

→ Sent to a longer-term, institution (far from family & friends)

…If not, s/he is:

→ Sent back to their village feeling more isolated—

*"I was sent to jail." "He never trusts me anymore."*

Despite the connection between personal and community health in Native communities, suicide prevention interventions are often <u>individually-focused</u> and <u>clinically-based</u>.

Suicide prevention (as it is typically done in AI/AN communities) is incongruent with local beliefs and practices.

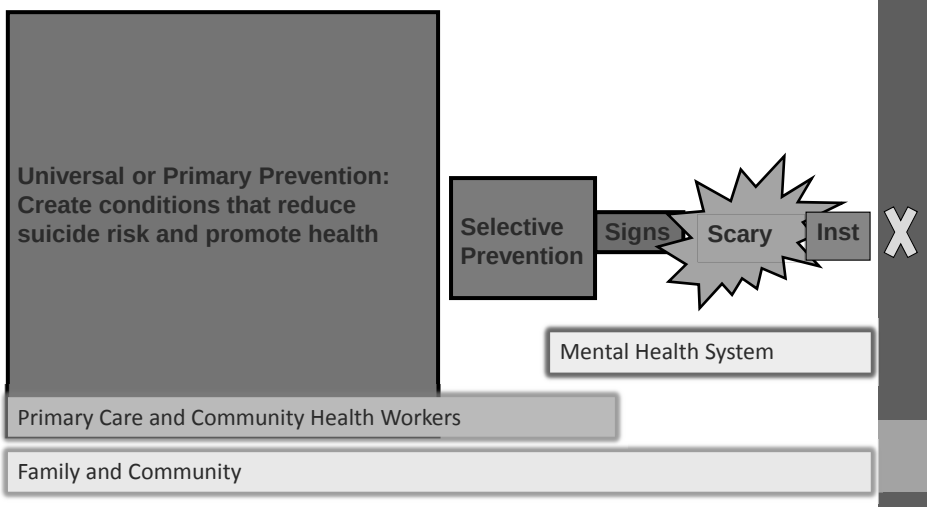
Danger of "neocolonial violence"

# Standard intervention protocols are built upon ideas of selfhood, health and suicide that are NOT necessarily shared by Alaska Natives*

**WESTERN-Medical**
**Autonomous / compartmental / technical / secular…**

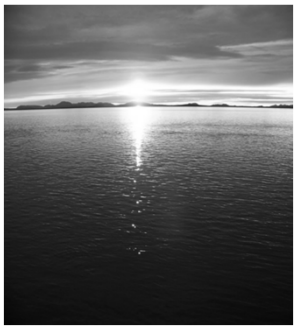
**INDIGENOUS-Cultural**
**Relational / interactional / contingent / spiritual…**

# Continuum of Suicide Prevention



The wide range of suicide rates among indigenous communities has been associated with community and cultural drivers*:

High rates are associated with cultural and community disruptions
--social disorganization,
--culture loss and
--historical trauma



Lower suicide rates are linked to:
--community empowerment,
--social connectedness,
--family cohesion, and
--cultural affinity or identity

# PC-CARES: Professional-Community Collaborations for At-Risk Engagement and Support

Uses popular education strategies to:

→Build a 'community of practice' among service providers, friends and families

→Foster personal and collective learning about suicide prevention, and

→Spur practical action to prevent suicide and promote health.

# Theoretical Foundations

- Social learning theory => Community of practice
  - sense of community
  - exchange of information
  - mutual learning
- Adult learning theory
  - Adults are internally motivated and self-directed
  - Adults bring life experiences and knowledge to learning experiences
  - Adults are goal oriented
  - Adults are relevancy oriented
  - Adults are practical
  - Adult learners like to be respected
- Storytelling: Accessible and translatable
- Empowering
  - Developing collective and personal efficacy
  - Critical consciousness (Freire)

# Let's begin…

- Think about a time when…
  - you felt like you really made a positive difference through your suicide prevention or other relevant work…
  - You learned something about your job, role, practice…
  - You learned something about yourself that has helped you do a better job working toward prevention, healing and wellness
  - Jot down your thoughts

## Share your story…

- Share your story with a partner
- What resonated about the story you heard?
- What did you notice about the story you told?

## What themes come up?

## How can we apply some of what we heard to our own practice?

## Session Reflections

(Informed by your insights and stories)

**What seem to be important aspects or elements of successful prevention and health promotion practices, particularly in cross-cultural settings?**

**What conditions seem to support meaningful and culturally humble/reflective practices?**

**How might we work in ways that maximize respect, dignity and positive changes in the lives of the people with whom we work?**

# Thank You & Acknowledgements

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