

CRITICAL SUICIDLOGY

Transforming Suicide Research and Prevention for the 21st Century

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12

Indigenous Best Practices

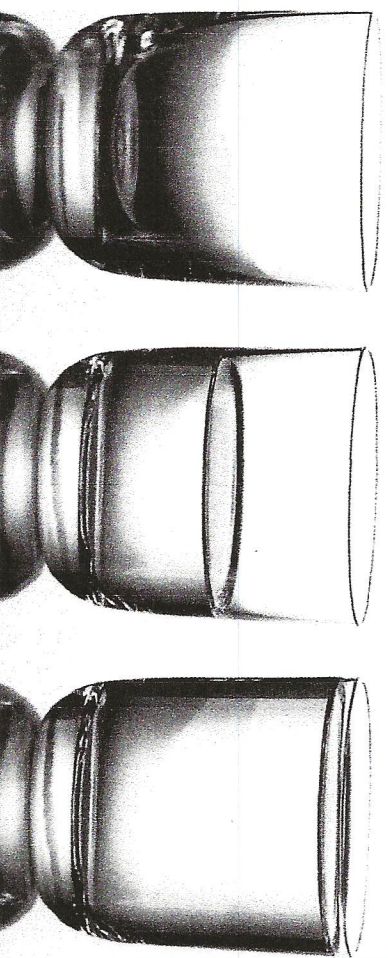
Community-Based Suicide Prevention in
Nunavut, Canada

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A critical perspective in suicidology follows Harvey's (1990) idea of "deconstructing taken-for-granted concepts and theoretical relationships" and digging "beneath the surface of ostensive appearances through direct analysis of social phenomena." The goal is to develop an alternative account through "a process of conceptual shuttling back and forth between the particular phenomena under investigation and the wider structure and history to which it relates; between the taken-for-granted and the deconstructed concepts; and between the theoretical deconstruction and the reconstructed social totality" (p. 32). It includes asking penetrating questions, challenging structures of power, discovering appropriate research methodologies, and contextualizing data and ideas (Green and Labonté, 2008). In suicidology, it goes beyond positivistic scientific methods, beyond the quantitative, and into qualitative, ethnographic, and mixed methods of investigations (Kral, Links, and Bergmans, 2012). It involves looking at the historical, social, cultural, and political contexts behind suicide and suicide prevention, and into community realities where suicide takes place and where it can be prevented. A critical suicidology asks new questions, seeks new methods, and pursues alternative avenues for thinking about suicide and suicide prevention.

Culture Change

Rather than taking the usual approach in suicidology – which is to examine risk factors such as depression and alcohol abuse – this chapter will examine



Inuit suicide by taking a historical and cultural approach, arriving later at the interpersonal and psychological. Good and colleagues (2008) have proposed the concept of postcolonial disorders, where a disordering of the cultural/social system creates disorder in individuals. Suicide among Inuit will be examined as a postcolonial social disorder stemming in part from imperial/colonial government intervention. Inuit culture and lifestyles were dramatically altered, leading to negative experiences.

Inuit have lived in the Canadian Arctic for about 1,000 years. They were preceded by the Dorset/Tunit culture, who had lived there for the previous 3,000 years. Indigenous Arctic peoples originated in Siberia and are genealogically related across Siberia, Alaska, Nunavut, and Greenland. Canadian Inuit had European visitors sporadically between the 1500s and 1800s. Many were taken captive to Europe (Sturtevant and Quinn, 1989). The first significant outside visitors, from the mid-1800s to the early 1900s, were whalers from Scotland and later America. Whalers had Inuit move in the summer to be near the whaling ships, which would employ them in exchange for flour, tobacco, guns, and other supplies. Disease brought by the whalers took many lives, but Inuit culture did not change. Inuit lived in family camps on the land, moving at least twice a year based on hunting and animal migration patterns. Winter residences in the snow houses saw more Inuit living together. Men were the hunters; women sewed skin clothing, prepared food, and took care of the home. Young girls helped their mothers and learned from them, while young boys were with their fathers hunting and learning to be men. Parents and elders were the teachers. Gender relations were reciprocal and interdependent. Indigenous social structures are based on kinship (DeMallie, 1998), and this was true for Inuit (Briggs, 1995). Family is the central component of Inuit well-being (Kral, Idlout, Minore, Dyck, and Kirmayer, 2011), and that is true to this day. Food sharing or *minigig* was central, and this collectivist culture had strong laws of behaviour and social interaction. Marriages were arranged prior to or shortly after birth, and across the Arctic, couples engaged in sexual spouse exchange. Hunting was a collective endeavour, and shamans or *angakkuit* mediated between humans and the spiritual world, helping with weather, hunting, and healing.

Between the 1920s and 1940s, what is known as the trinity arrived in Nunavut and the Canadian Arctic: the RCMP, Anglican and Catholic missionaries, and the Hudson's Bay Company. Christian conversion was swift in the context of epidemic disease brought by the foreigners (Laugrand and Oosten, 2010). Many practices such as shamanism, spousal exchange, and

facial tattooing became prohibited and were severely disciplined if practised. These resulted in shamans going underground and in spouse exchange, polygamy, and women's facial tattoos disappearing. Also, dependency was created on the Hudson's Bay Company, a fur trading company, through a barter exchange program. Yet Inuit families still lived on the land as they had before, living traditional lifestyles.

All of this changed dramatically when the Canadian government took over Inuit lives after 1957, during a major tuberculosis epidemic. Wenzel (1991) has called this the "government era" for Inuit. Inuit moved off the land into crowded settlements run by white or Qallunaat (White) Northern Service Officers. An alien electoral system was established, children were taken from their families and sent to day or residential schools, small houses broke up the extended families that had long lived together, and a wage economy was started that, because there were few jobs, led to poverty (Damas, 1996). Roles and responsibilities changed. Hunting over time became more sporadic, and because that was men's responsibility, men had a more difficult time with acculturation.

The most negative effect of colonialism on Indigenous peoples has been on their family and interpersonal relations (DeMallie, 1998; Royal Commission on Aboriginal Peoples, 1996). Economic cooperation among kin networks began to decrease when settlements were established in the 1960s (Damas, 1963; Graburn, 1964). Intergenerational segregation began, and by the early 1980s there was much conflict between parents and their children (Condon, 1988). Drinking among adults became a problem, and a youth culture developed because so many children were growing up together (Condon and Stern, 1993). Kral (2012) has noted that the key relational components among Inuit – *naalaktug* (respect, obedience) and *unguiq* (affection, closeness) – decreased during the government era. *Naalaktug* meant respect for someone older than oneself, part of cross-generational attachment and cooperation, and it together with *unguiq* formed essential integrated relational bonds among Inuit. The removal of respect in hunter-gatherer societies is highly disruptive (Brody, 2000). Parenting has changed, with many youth relying on peer rather than parental support. Many children and their parents avoid one another. Inuit are concerned about this change in parenting (Kral, 2012).

Another significant change for Inuit relates to marriage and romantic relationships. Arranged marriages began to decrease once children were sent to schools in the 1960s and 1970s, and by the 1990s they had almost vanished. In the 1980s, sexual relations between young women and men

were troubled, with young people not knowing what to do and having no role models (Graburn, 1964, 1969; Brody, 1991; Burch, 1975; O'Neil, 1983). An individualist model of love and romance was entering Inuit lives (Swidler, 2001). Many romantic relationships today among Inuit youth are troubled (Kral and Idlout, 2009).

Inuit Suicide

Indigenous youth suicide, primarily among males, is high globally (Kral, 2012). In 2009, the suicide rate for Canada was 11.7 per 100,000 while for Nunavut it was 83.9 (Nunavut Bureau of Statistics, 2012; Statistics Canada, 2012). The suicide rate is even higher in Nunavik, northern Quebec (Hirsch, 2006). In Nunavut, suicides began to escalate in the mid-1980s. By the late 1990s, the federal government was spending a great deal of money on suicide prevention from a Western perspective, yet suicide rates continued to climb. Wexler and Gone (2012) have shown that the Western perspective includes seeing suicide as psychological, individual, private, and associated with psychopathology and psychiatric disorders. Also, suicide prevention means, for Westerners, seeking professional help. In Indigenous communities, the self is relationally defined and suicide is seen as a social and spiritual problem tied to family, community, and the cultural context. It follows that community projects are more valuable than health services.

In Nunavut, Inuit report that suicide is based on romantic and family problems among youth, and suicide attempters also indicate this (Kral, 2003). Suicidal youth are seen as lonely and angry and as feeling rejected. Family problems included parents drinking and fighting. Penny and colleagues (2008) found that Inuit youth suicide was mostly related to poor family ties and also to not spending time on the land and not attending school. Given that most suicides are related to romantic and family relationships, it is clear that the greatest social perturbation experienced by the Inuit involves these relationships. It is important to understand the perturbation preceding suicide (Shneidman, 1993). Dramatic changes in kin and romantic relations have affected Inuit negatively, and these changes have stemmed from the colonial government era. They include changes in *naaluktuq* and *ungajuq*, where respect and affection are not as tied together as they once were, and poor communication across generations has left many feeling alone. A feeling of belonging or *ilagijauittinniq* is a key protective factor for suicide (Joiner, 2005), and many Inuit youth are not experiencing this. This is what Durkheim (1951) postulated as a societal cause of suicide,

in his concepts of anomie and egoistic suicide, where the life path is lost and people are disconnected from one another. Yet some of this has been changing for the better in the Canadian North. When efforts are made to bring Inuit together, suicide can be prevented.

Prevention from the Inside

We have been witnessing a movement towards evidence-based prevention and intervention programs in mental health (e.g., Goodheart, Kazdin, and Sternberg, 2006; Kazdin, 2008; Norcross, Beutler, and Levant, 2001; Norcross, Hogan, and Koocher, 2008; Sturmen and Hersen, 2012). At the core of these programs is empirical evidence that they work. How they work is based on program fidelity; put another way, how these programs are organized and integrated is based on the outcome evidence (Botvin, 2004). When such programs are used with the populations on which the evidence is based, many are successful (Chambliss and Ollendick, 2001; Cook, 2001; Lambert and Archer, 2006).

There is a problem, however: We in North America live in a rather heterogeneous society made up of people from a multitude of cultures, backgrounds, education levels, and values. Experiences of mental health and disorder differ among groups. It is difficult to adapt evidence-based mental health programs to particular cultures. When programs are applied to minority populations, they do not work as well (Castro, Barrera, and Martinez, 2004; Castro, Barrera, and Holleran, 2010). This is true for Native American on reservations, where twelve-step and related programs are not well accepted by the people living there (Gone, 2008; Prussing, 2008). Often, traditional cultural practices of healing are undertaken in these Native communities but are not brought into mainstream treatment venues. This has been the case for suicide prevention in Aboriginal communities in Canada. Suicide prevention programs and training introduced in the 1990s by the Canadian government did not lower the suicide rate; indeed, that rate kept climbing in Inuit communities. One program brought Inuit from many communities together for suicide prevention training, but there was no follow-up, and no documented action took place. Yet when Inuit communities have taken it upon themselves to decrease suicide, positive outcomes have been seen (Kral and Idlout, 2009).

In the 1990s, when we were beginning a study on Inuit suicide and well-being, Inuit from the study's steering committee indicated that one of the communities involved in the study, which had the highest suicide rate in

the Canadian Arctic, had not had a suicide for several years. These Inuit told us that the suicides stopped not because of some outside program, but because Inuit in the community had done something themselves. They suggested that we investigate what had been done so that other communities could learn from them. When one of us, Kral, was in that community conducting the study, he asked about the suicides stopping. There had not been a suicide in almost four years. It was discovered that the deputy mayor and the community's Hamlet Council had organized weekly gatherings of community members to talk about suicide. They had talked about why it was happening and what they could do about it. They had agreed to watch for Inuit who were looking sad, staying to themselves, and to engage with them. A youth committee organized the same thing for other youth in the community. The minister of the Protestant church also did this in the church. The local housing committee decided to remove the number one suicide method from every house: the closet rod. Most suicides had taken place by hanging from this rod. The message for suicide prevention in the community was very loud: the Inuit were taking care of one another, and it worked. Some suicides had taken place since then; even so, this was a powerful lesson in collective efficacy and agency, in community empowerment, and in community-driven suicide prevention.

During this study, we collected data in a second Inuit community. The youth committee there was very involved in the research. That committee was not well organized, however, so its president decided after we left to bring together new members who were committed to youth suicide prevention. New members were found, and this new committee together with the Igloodik film company Isuma opened a youth centre. This centre was a place for youth to come together; it provided games and movies as well as elders teaching about traditional culture. This youth committee also organized peer counsellors in the community; for a while, it even had a crisis line. There had been many suicides over the previous several years, but after the youth centre opened there were no suicides for about two years. In the second year the community celebrated the youth centre and that no suicides had taken place. Community members acknowledged that this youth centre had had very positive effects on youth. We also found that high school attendance increased and that break-and-enter crimes had almost stopped. After two years the centre had financial problems and had to close. The tragic suicides resumed. Six years later, Kral was living in the community and working with the new youth committee, who were dedicated to reopening the centre. The committee applied for and received a few government

grants; the Hamlet Council also provided support for reopening the centre. The day it opened was a community celebration. Youth committee members were on the roof of the centre throwing candy to children. Since this centre reopened eight years ago, suicides have decreased by 67 percent.

There have been other accounts of Aboriginal communities being successful at designing and running their own mental health programs and activities (Gone, 2011; Wieman, 2009). Noting this, in 2005, the First Nations and Inuit Health Branch of Health Canada launched the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). Unlike previous interventions, where programs were introduced to Aboriginal communities with no positive outcomes, the new NAYSPS is funding Aboriginal communities to design their own suicide prevention programs (Kral et al., 2009). Program evaluations are part of this, so outcomes will be reported. This goes well beyond applying evidence-based programs to Aboriginal communities. These community-based programs are Indigenous best practices – at least, they are based on the actions taken by communities known to have decreased suicide (Kral and Idlout, 2009).

One means of conducting research and implementing prevention is by applying participatory and collaborative methods. With Indigenous communities, this has been identified as an ethical principle (NAHO, 2007; Royal Commission on Aboriginal Peoples, 1993; Smith, 2011). Methods such as participatory action research (PAR) and community-based participatory research (CBPR) are on the increase: people in the communities are being engaged as co-researchers, involved from the very beginning – developing research questions, designing the method, collecting the data, interpreting the findings, and disseminating the results. Our research has followed this model (Kral and Idlout, 2006). This has included helping community youth organizations develop their own programs, helping them apply for grants, and so on. This is action research. As seen in the community examples above, community-driven action can prevent suicide. Inuit community action for suicide prevention, often by youth, has been successful.

This success of PAR/CBPR methods is being seen in public health, community psychology, social work, nursing, and other disciplines (Minkler, Vasquez, and Shepard, 2006; Cook, 2007; Flicker, Savan, McGrath, Kolenda, and Mildemberger, 2008; Healy, 2001; Koch, Selim, and Kralik, 2002; MacQueen et al., 2001; Nguyen et al., 2006; Rhodes, Hergenrather, Wilkin, Alegria-Ortega, and Montano, 2006; Shalowitz et al., 2009; Taylor, Braveman, and Hammel, 2004). PAR/CBPR is being practised in Indigenous communities, and many of these communities welcome this form of research and

action (Jernigan, 2010; Christopher, Gidley, Letteeg, Smith, and McCormick, 2007; Cummins et al., 2010; Fisher and Ball, 2002, 2003; Grimwood, Doubleday, Ljubicic, Donaldson, and Blangy, 2012; Kostel, Baccan, and Lemelin, 2012; Kwiatkowski, 2011; Minor, Boone, Kalt, Kinch, and Birch, 2004). Beydon-Miller and colleagues (2012, p. 387) have argued that PAR is like jazz, in the sense that it is "built upon the notion that knowledge generation is a collaborative process in which each participant's diverse experiences and skills are critical to the outcome of the work. PAR combines theory and practice in cycles of action and reflection that are aimed toward solving concrete community problems while deepening understanding of the broader social, economic, and political forces that shape these issues." There is respect for local knowledge and a commitment to social justice and trust in a democratic process; there is also the development of trusting and respectful relationships between community members and outside researchers (Kral, in press). All of this reflects a reconsideration of research ethics. In our experience, PAR has been a powerful tool for learning, and through it we have participated in and documented successful, community-based suicide prevention. Bringing Inuit communities together for suicide prevention and youth well-being has also begun. A relatively new organization in Nunavut called the Embrace Life Council has been doing this. Through the council, communities share their success stories with one another and together develop programs and activities for youth and families. There is a movement towards not only suicide prevention but also the reclamation of control over lives. This has also been seen in Alaska, where Indigenous community wellness teams have been building their own programs (Statewide Suicide Prevention Council, 2002). When communities take responsibility for themselves, collective efficacy develops (Bandura, 1997).

Rethinking Suicide and Suicide Prevention

We hope we have demonstrated that suicide can be understood from social, cultural, and political perspectives and that suicide prevention can go beyond evidence-based Western programs. Most people with an accumulation of the well-known suicide risk factors will never commit suicide. Risk factors bring perturbation to individuals; however, perturbation rarely leads to suicide. For suicide to take place, there must first be the *idea* of suicide, the belief that suicide is the answer to the perturbation, and there must also be a willingness to act towards that end. This is called lethality (Kral, 1994). Like a great many ideas, in keeping with how humans learn through imitation (Hurley and

Chater, 2005), suicide is contagious (de Leo and Heller, 2008; Gould, 2001). The attitude that suicide is acceptable has been correlated with suicide (Stack and Kposowa, 2008). We believe that Indigenous youth suicide, including in Nunavut, is a contagious phenomenon whereby youth copy one another. We have found that many Inuit, including youth, agree with this (Kral 2012). Suicide has become a cultural idiom of distress among Inuit youth in the context of the perturbation of disturbed family and interpersonal relationships, which has arisen following the colonial disruption of Inuit life.

Much has been learned about suicide and suicide prevention from psychology and psychiatry, the disciplines that dominate suicidology. The emphasis in these, however, is on the individual and on pathology. It is clear that depression and hopelessness are linked to suicide. Yet as stated above, these are perturbations rather than lethality. As Marsh (2010) argues, rather than looking at universals in suicide, we need to look at local, contextualized understandings of suicide, as well as historical and cultural features. We are calling for an Indigenous psychology and suicidology, one that goes beyond universal and individualistic analysis. This will require a redefinition of the subject matter under consideration – in this case, suicide and suicide prevention – as well as a changing of disciplinary norms, boundaries, and primary affiliations (Danziger, 2006). Regarding suicide prevention, little still is known. Empirical evidence for suicide prevention is lacking (De Leo, 2002; Thompson, 2005). There are thus no evidence-based suicide prevention programs. Yet from what we have seen in some Inuit communities, and given increasing evidence for the success of community-based participatory projects, there is reason to believe that community-based programs might work. This is a direction for suicide prevention, in keeping with the growth of PAR/CBPR in public health and community psychology. When given agency, collective efficacy becomes active. It is time for an alternative approach.

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