Themes of healing among Squamish Nation members after the loss of a loved one to suicide

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Abstract

This research was a response to the disproportionately high suicide rates, risk for suicide clusters, and need for a suicide postvention plan in the Squamish Nation community. Using a community-based research approach and working collaboratively with Squamish Nation, I interviewed 8 community members who had lost a loved one to suicide within the past 1–10 years to understand what helped in their healing journey, as well as their recommendations for helping families after a loss to suicide. Findings indicate 5 themes of helpful postvention supports: healing self, social supports, formal community supports, wider world supports, and culture. Culture was found to aid healing across all levels. These themes do not exist in isolation, but are interrelated, both individually and communally helping community members in their healing journey. Recommendations for suicide postvention highlight the integration of healing supports from dominant mental health models and an Aboriginal wellness model. These findings should be considered with caution due to the small sample size; however, they are in line with the available Aboriginal suicide postvention literature and an Aboriginal worldview. Aboriginal communities across Canada are not homogenous, therefore generalizability to other communities is unknown.

Keywords: Aboriginal suicide, suicide survivors, Aboriginal healing, community-based research, CBR

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Chapter 1: Introduction

Suicide is a serious public health problem in Canada and is particularly pronounced within Aboriginal communities. In 2007, approximately 10 people died each day by suicide in Canada (Links, 2011). Aboriginal youth suicide rates are five times higher than non-Aboriginal rates (British Columbia Ministry of Healthy Living and Sport, 2007; Caldwell, 2008), and Inuit suicide rates are 11 times higher than the rest of Canada (Statistics Canada, 2015). Aboriginal suicide rates are highest among the youth population (ages 15–24; Health Canada, 2008). The suicide rate for Aboriginal male youth is 126 out of 100,000, compared to 24 out of 100,000 for non-Aboriginal male youth; the suicide rate for Aboriginal female youth is 35 out of 100,000, compared to 5 out of 100,000 for non-Aboriginal female youth (Health Canada, 2003). Aboriginal suicide rates also vary significantly among different communities, stressing the importance of identifying the risk and protective factors unique to each community (Chandler & Lalonde, 2013; First Nations Health Authority [FNHA], 2015; Health Canada, 2008).

What Causes Aboriginal Suicide?

The causes of the high Aboriginal suicide rates are "multi-faceted and multi-generational" (Health Canada, 2008, p. 25). According to Health Canada (2008), Aboriginal youth suicide rates are related to "the erosion of conditions that promote a strong sense of identity, colonization and rapid cultural change,

trans-generational grief associated with the residential school system and child welfare system, and being members of a marginalized and economically disadvantaged group" (p. 1). In 1995, the Royal Commission on Aboriginal Peoples released a report on suicide identifying four groups of risk factors related to Aboriginal suicide: psychobiological, situational, socioeconomic, and culture stress. Psychobiological factors that were identified are related to unresolved grief; colonization and ongoing oppression have prevented the opportunity to heal and without the opportunity to heal, grief experienced by Aboriginal peoples has been internalized and remains unresolved (Sherwood, 2015). Unresolved grief accumulates and compounds, having an intergenerational effect on the Aboriginal population (Sherwood, 2015).

Situational factors related to Aboriginal suicide include disruptions to family life (e.g., Indian residential school, forced adoption, long-term hospitalizations away from home) as well as substance misuse (Chenier, 1995). From 1892–1996, Aboriginal children in Canada were forcibly removed from their families and taken to Indian residential schools operated by the Roman Catholic Church, Church of England, United Church, or Presbyterian Church, and later by the Government of Canada (Elias et al., 2012). This was a lawful government practice, with the intention of eliminating the cultural identity of Aboriginal children (Elias et al., 2012; Kirmayer, Gone, & Moses, 2014). There were "alarming levels" of physical and sexual abuse within the residential

schools, as well as “staggeringly high” death rates (Kirmayer et al., 2014, p. 306). The trauma experienced within this system negatively affected the children, their families, and their communities for generations (Elias et al., 2012). Substance misuse has also caused suffering in Aboriginal communities (Duran, 2006; Mushquash, Stewart, Comeau, & McGrath, 2008). Colonization, ongoing oppression, and low socioeconomic status are all factors related to the onset and maintenance of alcohol misuse in Aboriginal communities (Reading, Kmetic, & Gideon, 2007).

According to the 2008–2010 First Nations Health Survey, First Nations people self-report that drug and alcohol misuse is the most common health risk in their communities (First Nations Information Governance Centre, 2012). This survey also found that First Nations people often drink alcohol less than non-First Nations people; however, excessive drinking is more common among First Nations people (First Nations Information Governance Centre, 2012). This escalated rate of excessive drinking in Aboriginal communities is a serious concern, as suicide in Aboriginal communities most often occurs with excessive alcohol consumption (Aboriginal Healing Foundation, 2007). Statistics indicate that 60% of all suicide attempts and suicides by Aboriginal people occur with acute alcohol use, compared to 24 per cent of suicide attempts for non-Aboriginal people (FNHA, 2015).

Socioeconomic factors related to Aboriginal suicide include poverty, lack of education, unemployment, poor housing, and poor water/sanitation (Chenier, 1995). In 2005, the median income for adults in First Nations communities was less than half than that of the general Canadian population (Health Canada, 2014). In 2006, half of the adults in First Nations communities had not finished high school, the unemployment rate was four times higher than that of the non-Aboriginal population, and half of the adults living in First Nations communities reported mould or mildew in their home (Health Canada, 2014). These socioeconomic factors are all determinants of health (Health Canada, 2014), and the ongoing inequities are clearly linked to the high rate of Aboriginal suicide.

Last, according to the Royal Commission on Aboriginal Peoples, cultural stress was found to be the most significant risk factor for Aboriginal suicide (Chenier, 1995). The Royal Commission on Aboriginal Peoples referred to culture stress as

> the loss of confidence in the ways of understanding life and living that have been taught within a particular culture. It comes about when the complex of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. (as cited in Chenier, 1995, p. 2)

Colonialism has resulted in culture stress for Aboriginal people; the loss of their land, language, and belief systems has significantly impacted confidence in their way of life (Chenier, 1995). Due to this cultural stress, colonialism is often viewed as the root of Aboriginal suicide (Elias et al., 2012; Kirmayer, Brass, & Tait, 2000; Kirmayer, Simpson, & Cargo, 2003; Lavallee & Poole, 2010). Since colonialism, suicide has become prevalent in Aboriginal communities, whereas historically it was a rare occurrence (Kirmayer et al., 2007). Colonialism is "the conquest and control of other people's land and goods . . . the takeover of territory, appropriation of material resources, exploitation of labor and interference with political and cultural structures of another territory or nation" (Loomba, 2005, p. 8). Colonialism has resulted in social, economic, cultural, and political inequities (Adelson, 2005; Kirmayer et al., 2000; Tester & McNicoll, 2003). The result of these inequities is a disruption in the balance of mental, physical, emotional, and spiritual health (Tester & McNicoll, 2003). The disruption in the balance of these four quadrants of health can result in suicide behaviour (MacNeil, 2008). Suicide is the "clearest indicator of the severity of social disruption in Aboriginal Canada and the rates are shockingly high by any standard" (Tester & McNicoll, 2003, p. 556).

Aboriginal people clearly face a number of distinct risk factors, many risk factors are faced concurrently, and the risk factors are more oppressive than those faced by the non-Aboriginal population (Health Canada, 2008; White, 2007).

Continued oppression makes recovery difficult (Kirmayer et al., 2000; Walls, Hautula, & Hurley, 2014). Therefore, it is important to understand what can be done to effectively reduce Aboriginal suicide.

Protective Factors

Kral (2012) contended that dominant mental health model suicide prevention strategies are not commonly accepted in Aboriginal communities and evidence-based prevention strategies, based on non-Aboriginal samples, are not effective when applied in Aboriginal settings. Researchers know that suicide prevention involves the development of strategies to promote protective factors and decrease risk factors related to suicide (FNHA, 2015; Health Canada, 2008). Therefore, it is imperative to consider the protective and risk factors for suicide unique to the Aboriginal population when considering how to decrease suicide. The previous section described the risk factors related to suicide; this section describes the protective factors.

According to Health Canada (2013), some protective factors related to suicide for Canada's Aboriginal youth are

> recreation/physical activity; positive cultural identity; self-esteem; family attention, support, and care; positive parental expectations; peer support; caring exhibited by other adults and community leaders; community self-determination; a high level of general problem solving skills/coping; good physical and mental health; access to appropriate housing; culturally

> relevant health care services; future orientation, direction, and determination; positive attitudes toward school; good school performance; learning ability; emotional stability or regulation; internal locus of control; sense of meaning or coherence; having many reasons for living; and religion or spirituality. (pp. 8–9)

Research has also found six community factors that have a significant role in decreasing Aboriginal suicide (Chandler & Lalonde, 2009). These six factors are self-government, successful land claims, education, health care, cultural services, and control over police and fire protection. Aboriginal communities with these six factors have a significantly lower rate of suicide (Chandler & Lalonde, 2009).

Prevention Strategies

Suicide behaviour in Aboriginal communities has been reframed as a problem with roots in colonialism and contemporary structures and systems, not an individual pathology (Lavallee & Poole, 2010; Walls et al., 2014). There is growing acknowledgement that prevention strategies need to focus on empowering communities (Kirmayer et al., 2014). They should be culturally relevant, include traditional teachings, and include Elders (Kral, 2012). Clearly, suicide prevention strategies cannot solely target mental health (Lavallee & Poole, 2010).

Each Aboriginal community will have its own view of the strategies needed for suicide prevention (Chandler & Lalonde, 2009; Cotton, Nadeau, & Kirmayer, 2014; Kral, 2012; Royal Commission on Aboriginal Peoples, 1995). The effectiveness of community-driven strategies in reducing suicide rates must not be overlooked. According to the Centre for Suicide Prevention (2013a, 2013b), suicide prevention strategies should be developed by the community and those who understand its social background. Programs developed within the communities have proven more effective than interventions that are implemented by government (Kral, 2012). Strategies should also target different levels: the community, the family, and the individual (Kirmayer, Boothroyd, Laliberte, & Simpson, 1999). Recent research has suggested that these programs not only result in a reduction of suicide but also empower the community and rebuild pride that has been destroyed by colonialism (Kral, 2012).

In the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS), Health Canada (2008) supported the empowerment of First Nations communities to develop their own suicide prevention strategies. Historically, Aboriginal wellness strategies have been viewed as "subservient and invalid" (Duran, 2006, p. 26) by the dominant mental health agencies, with clinical strategies rooted in Western ideology deemed superior. Conversely, dominant suicide prevention, intervention, and postvention (SPIP) strategies have not been commonly accepted in Aboriginal communities (Clifford, Doran, & Tsey, 2013; Kral, 2012). It is

argued that due to the Aboriginal collectivist orientation, the individual focus of dominant mental health models could be detrimental to British Columbia (BC) First Nations clients (McCormick, 1997).

The goal of NAYSPS was to reduce risk factors and increase protective factors against suicide (Health Canada, 2008). Rather than providing evidence-based strategies that have not proven effective in Aboriginal populations, the Canadian government provided funding for the communities to run their own programs (Kral, 2012). It was required that the programs developed must be "evidence based and recognize traditional and cultural knowledge, build on existing structures and processes, and respect federal, provincial and territorial mandates" (Health Canada, 2008, p. 3). The overall objectives of the NAYSPS were to

- increase awareness and understanding preventing suicide among first nations youth;
- strengthen key protective factors such as a strong sense of identity, meaning and purpose, and resilience;
- strengthen and help create collaborative approaches and links within and across governments, agencies, and organizations;
- improve and increase efforts to respond to crisis, and to intervene more effectively in preventing suicide and suicide clusters following a suicide related crisis in First Nations communities; and

- enhance the development of knowledge regarding what works in preventing suicide among First Nations youth. (Health Canada, 2008, p. 3)

In phase 1 of NAYSPS, 200 community-driven projects were implemented, each unique to the needs of the community it served (Health Canada, 2013). Evaluation of the NAYSPS community initiatives has been positive, suggesting "a decrease in youth delinquency and substance abuse, an increase in youth participation in school and community, community wide commitments to training in suicide awareness and intervention and general improvements in youth leadership skills" (Health Canada, 2013, p. 5). These findings support the argument for community-driven prevention initiatives, which are diverse and address the unique needs of each community. It is anticipated that in the long term NAYSPS will reduce suicide rates in Aboriginal communities (Health Canada, 2013). Research on the effectiveness of these programs is not available to date.

The Importance of Suicide Postvention

Suicide postvention is a term that describes support for those grieving from the loss of a loved one to suicide (FNHA, 2015). When a suicide occurs, many people are affected, including family members, friends, neighbours, and employers (Andriessen & Krysinska, 2012). Those affected are often referred to as survivors, as their life has been changed due to the loss of a significant other (Andriessen, 2009). For survivors, life may change in several ways, with mental

health issues and social difficulties being significant challenges (J. R. Jordan, 2001), and family relationships and routines being disrupted (McMenamy, Jordan, & Mitchell, 2008). Survivors may also experience a combination of grief and posttraumatic stress that significantly increases the risk for suicidal ideation and suicide attempts among survivors themselves (Cerel, Padgett, Conwell, & Reed, 2009). It remains unclear how many survivors are affected by a suicide. Research suggests that a single suicide has an average of 6 to 10 survivors (Andriessen & Krysinska, 2012). In contrast, survivors themselves suggest much higher estimates, ranging from 45–80 people affected by a suicide (Berman, 2011). Cleiren and Diekstra (1995) found that approximately 18–34 % of survivors report maladjustment up to four years after a loss.

Suicide postvention involves "addressing traumatic after-effects among survivors, grief and trauma recovery, and education to reduce the risk of more suicides" (FNHA, 2015, p. 49). Suicide postvention is an important response for Aboriginal communities for several reasons. First, suicides on reservations often occur in a cluster (Centre for Suicide Prevention, 2013b; Kirmayer et al., 2007). A suicide cluster is "a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community" (Centers for Disease Control and Prevention [CDC], 1988). Due to close familial relations and facing the same social challenges in a small community, an increased risk for a suicide cluster exists on a reservation (CDC,

1988; Centre for Suicide Prevention, 2013b). The impact of a suicide affects the whole community (CDC, 1988; Centre for Suicide Prevention, 2013b). Suicide postvention reduces the risk of survivors attempting and completing suicide. Because suicide postvention reduces the risk of suicide, it can also be viewed as a suicide prevention strategy. Another reason that postvention is important is that grieving families need support (Kirmayer et al., 1999). Those grieving after a suicide are at risk for heightened distress, psychiatric morbidity, and suicidal ideation (Kirmayer et al., 1999). Postvention helps survivors grieve and heal, reducing the risk of suicide (FNHA, 2015).

It is important to have postvention strategies in place to support the community in a timely manner after a loss (Kirmayer et al., 1999). In the past, "potential opportunities for prevention were often missed during the early stages of response as community leaders searched for information on how best to respond to suicide clusters" (CDC, 1988, Introduction section, para. 2). To allow for a timely response, the postvention plan must already be developed, agreed upon, and familiar to all responders before a crisis (CDC, 1988). A postvention plan can "build the self-esteem of the community as a whole: normalizing the bereavement process, ensuring that those that need support get it, and providing education" (FNHA, 2015, p. 125). In an effort to help communities develop SPIP plans, the FNHA (2015) developed *Hope, Help, and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide*.

This toolkit acknowledges the limited existing suicide postvention research and literature, particularly for Aboriginal communities, as well as the lack of best practice guidelines (FNHA, 2015). From the limited available research, the toolkit summarizes promising practices for SPIP planning. It provides guidance for Aboriginal communities to develop a SPIP plan that meets their own unique needs.

My Professional Experience

Below, I include information on my professional experience to illustrate the path I took that led me to conduct this research. I have an undergraduate degree in criminology, which had a strong focus on the overrepresentation of Aboriginal people in the Canadian criminal justice system. I also have a master's degree in counselling psychology, which included a course on multicultural counselling. Finally, I am a Doctor of Psychology (PsyD) student at Adler University. Most of my PsyD assignments have focused on Aboriginal suicide in Canada. One of these assignments ("Addressing Aboriginal Suicide: Integrating the Medical Model and the Aboriginal Wellness Model") was presented as a poster presentation at the Canadian Psychological Association convention in June 2016.

Since beginning my career in 1999, I have had the privilege of working with Aboriginal clients. First as a youth worker with nonprofit agencies, then as a mental health clinician with the Ministry of Children & Family Development

(MCFD), I offered support to Aboriginal youth involved in the child protection and criminal justice systems. While working at MCFD, I attended a three-day multicultural sensitivity training session facilitated by Squamish Nation Elders. I also had the opportunity to develop and manage ONYX, a program for sexually exploited youth. This position involved flying into remote Aboriginal communities (Powell River, Bella Bella, and Bella Coola) to work collaboratively with Aboriginal bands to support their youth.

Since May 2010, I have had the privilege of working closely with the Squamish Nation. I was hired as a mental health intake counsellor. It was a new position developed in conjunction with the development of the Community Health & Wellness Division of Yúustway Health Services (YHS). As the division grew, I transitioned to my current role of a registered clinical counsellor contracted by YHS. As a contracted counsellor, I provide individual and group counselling, crisis counselling, and consultation on mental health issues. I have developed and facilitated numerous groups per year in the community, including an Indian Residential School Survivors support group, a First Nations girls group, and groups on grief and loss, anger management, stress and coping, managing anxiety, and creating happiness. Since working in the community, I have learned about the culture, values, and beliefs of the Squamish Nation. My colleagues and clients have helped me integrate traditional healing with my Western training. I have

learned the importance of language, ceremony, song, and cedar, among many other teachings.

Unfortunately, I have also witnessed the high rate of suicide and its devastating effect on the community. Much of my time working on reserve has been focused on SPIP. I accessed funding to coordinate several suicide prevention initiatives within the community; a youth-driven suicide prevention documentary and music video (both on the Squamish Nation YouTube channel), a weaving for wellness group with Elders and at-risk youth, and a weaving for wellness group with isolated Elders. I have also conducted numerous suicide assessments and facilitated integrated case management with community services to ensure the safety of community members at risk. Finally, I have attended homes after families have lost a loved one to suicide, as well as funerals and a suicide drum walk, offering postvention support for survivors.

Recently, I was invited to sit on a new Squamish Nation community committee for SPIP planning. This committee's objective is to improve SPIP supports in the community, following recommendations in the *Hope, Help, and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide* (FNHA, 2015). This research proposal stems from a request YHS made to me, asking for help to develop a suicide postvention plan for the community. It will provide the knowledge sought to meet the

postvention needs identified at the committee meetings, specifically the need to understand how to help grieving families after the loss of a loved one to suicide.

Statement of Purpose and Research Questions

I took a community-based research (CBR) approach to seek to identify suicide postvention strategies for supporting grieving families in the Squamish Nation community; this research is in response to the community's concern about disproportionately high suicide rates, the risk for suicide clusters, and the current need for a suicide postvention plan. Squamish Nation members are descendants of Coast Salish Aboriginal peoples, who have lived in villages throughout the Greater Vancouver area, Gibson's Landing, and the Squamish River watershed "since beyond recorded history" (Squamish Nation, 2013d, para. 2). They have never ceded or surrendered their traditional land. The Squamish Nation has over 3,600 members, with 60% currently living on urban reserves in North Vancouver, West Vancouver, and Squamish Valley (Squamish Nation, 2013c).

I worked collaboratively with the Squamish Nation to understand how best to support survivors within the community after the loss of a loved one to suicide. Engaging the community is crucial and more effective than implementing untailored postvention plans developed by external sources (Centre for Suicide Prevention, 2013b; Chandler & Lalonde, 2009; Cotton et al., 2014; Kirmayer et al.,1999; Kral, 2012). Collaboration with the community has also been thought to reduce the risk of exploitation or oppression, which is a common concern when

conducting research with Aboriginal populations (Kirmayer et al., 1999). Historically, research in Aboriginal communities has been conducted by non-Aboriginal researchers, has not reflected Aboriginal world views, and has not always benefited Aboriginal communities, leaving a sense of mistrust of research and researchers (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada [Tri-Council], 2014). This historical dynamic underscores the importance of collaboration in any research activities with these communities.

The Squamish Nation YHS is currently working on the development of a SPIP plan for the community. To develop this plan, they are utilizing the *Hope, Help, and Healing Toolkit* developed by the FNHA (2015). This toolkit suggests seven areas of focus to include in a suicide postvention plan: cultural programs and interventions, managing the response, media reporting guidelines, postvention protocols, supporting grieving families, care for the worker, and grief programs (FNHA, 2015). For this research I used a CBR method, employing a qualitative interview and thematic analysis. The research focus is on one of the seven postvention areas—supporting grieving families. My main research question was, "What helps Squamish Nation members heal after the loss of a loved one to suicide?" I analyzed responses for key themes related to healing after a suicide. Increased awareness of these themes of healing will help to guide postvention

planning for the Squamish Nation community, specifically postvention planning for supporting grieving families.

Rationale for Chosen Terminology

The *International Journal of Indigenous Health* (IJIH) has recommended terminology for researchers to use, including both *Aboriginal* and *Indigenous*, to represent the original peoples of Canada (IJIH, n.d.). *Aboriginal* is a collective name that refers to all First Nations, Inuit, and Métis across Canada, whereas *Indigenous* is a term that historically has referred to Aboriginal peoples internationally (IJIH, n.d.). I was uncertain which term to employ for this research: *Aboriginal*, a government-directed term, commonly used in research in Canada, or *Indigenous*, a self-proclaimed term more commonly used internationally.

IJIH (n.d.) recommended that researchers follow the principle of self-identification when choosing terminology. Therefore, I asked the department head at YHS which term was preferred. The department head suggested that the researcher ask the participants which term they preferred. Four participants indicated a preference for *Aboriginal*, three indicated a preference for *Indigenous*, and one participant did not respond to the inquiry. Of note, one participant said he preferred the term "Native Canadian" over the suggested terms. Ultimately, I went with the majority preference and have used *Aboriginal* throughout the research when discussing the literature and statistics across Canada.

I have also used the term *First Nations* throughout this research. According to the IJIH (n.d.), *First Nations* became popular in the 1980s, replacing the terms *band* and *Indian*, which many found insulting. To date, there is no official definition of First Nations (IJIH, n.d.). First Nations differs from the term Aboriginal as it does not include Inuit or Métis (IJIH, n.d.). I have used *First Nations* when citing research specifically on First Nations. As well, when I discuss the Squamish Nation community, I use *First Nations*, as the Squamish Nation formally refers to itself as a First Nation.

Chapter 2: Literature Review

As noted in Chapter 1, the focus of this dissertation is to understand how Squamish Nation members heal after the loss of a loved one to suicide. Understanding this healing process will help guide the development of community suicide postvention supports. In considering suicide postvention supports for an Aboriginal community, one must understand the issues most commonly faced by survivors, as well as the context within which these issues are experienced. In this chapter I discuss the following issues commonly faced by survivors: grief, posttraumatic stress disorder (PTSD), and traumatic grief. Second, I review the literature related to reasons why survivors in Aboriginal communities are at high risk for traumatic grief. Last, I explore how the dominant mental health model and an Aboriginal wellness model in general have historically supported survivors.

Issues Faced by Survivors

Those who are impacted by a suicide are often referred to as survivors (Andriessen & Krysinska, 2012), a term I have used in this paper. For survivors, life may change in several ways, with mental health issues and social difficulties being significant challenges (J. R. Jordan, 2001). Understandably, survivors often view a loss by suicide as a stressful event and report negative mental health outcomes (Mitchell, Gale, Garand, & Wesner, 2003). Psychological distress, including high levels of depression, anxiety, and trauma, are common reactions

experienced by survivors (McMenamy et al., 2008), as is complicated grief (Cerel et al., 2009; McMenamy et al., 2008). Social difficulties often arise for survivors, with guilt, shame, stigma, and isolation being common experiences (Andriessen & Krysinska, 2012; McMenamy et al., 2008). Members of the survivor's social network may view them negatively (J. R. Jordan, 2001). Allen, Calhoun, Cann, and Tedeschi (1994) found that in comparison to other mourners, individuals bereaved by suicide tended to be viewed more harshly by others. For example, they are seen by others as "more psychologically disturbed, more ashamed, and more able to prevent the death than were survivors of natural or accidental deaths" (p. 44). Survivors can experience feelings of abandonment (Andriessen & Krysinska, 2012). Given these reactions, survivors may find it difficult to discuss the suicide with others (McMenamy et al., 2008).

Family relationships and routines may also be disrupted (McMenamy et al., 2008). Relationships with family members may become more distant (J. R. Jordan, 2001; McMenamy et al., 2008). J. R. Jordan, Kraus, and Ware (1993, as cited in J. R. Jordan, 2001) noted the family system may be affected by the "shutdown of open communication, disruption of the role functioning of family members, development of conflict around differences in bereavement coping styles, destabilization of family coalitions and intergenerational boundaries, and disruption in relationships between family and its larger social network" (p. 95).

These findings indicate that changes in social support and the family system can be difficult for survivors (J. R. Jordan, 2001).

Survivors may also experience *complicated grief*—referred to as *traumatic grief* by Prigerson, Shear, et al. (1999)—a combination of grief and posttraumatic stress. Historically, grief researchers and trauma researchers have worked independently of each other (Stroebe, Schut, & Finkenauer, 2001). However, in the 1990s, researchers began discussing the overlap among grief and trauma (Stroebe et al., 2001). Complicated grief includes symptoms of both depression and PTSD (Cerel et al., 2009). These symptoms in survivors significantly increase the risk for suicidal ideation and suicide attempts among survivors themselves (Cerel et al., 2009).

Grief. Grief is a "primary emotion reaction to the loss of a loved one through death" (Cantwell-Bartl, 2001, p. 1). The mourner may experience "shock, numbness, and disbelief, followed by a period of depression, anxiety, anger, pining, social and personal withdrawal and, for some, somatic symptoms" (Reed, 1998, p. 285). Although the mourner feels sad and misses the deceased, he or she is able to gradually adjust (Prigerson, Shear, et al., 1999). Grief symptoms can decrease rather quickly over time, with some symptoms decreasing faster than others (Cleiren & Diekstra, 1995). Social functioning improves as grief symptoms reduce and the mourner adapts to the loss (Reed, 1998).

Previous models of grief that refer to distinct stages or phases have not been supported by research (Cleiren & Diekstra, 1995). According to Prigerson, Shear, et al. (1999), depressive symptoms related to bereavement in the *Diagnostic Statistical Manual of Mental Disorders (DSM)-IV)*were the only symptoms that were "treatment-worthy" (p. 68). The next version of the manual, the *DSM-5* (American Psychiatric Association [APA], 2013), recognized that grief may precipitate a major depressive episode and have overlapping symptoms, yet continued to distinguish grief from mental illness. Therefore, grief continues to be considered a normal adaptive response to loss and not a mental illness in need of treatment.

A common question among researchers is whether grief after a suicide is different than grief after other types of loss (J. R. Jordan, 2001). Although survivors and clinicians argue that suicide bereavement is unique, many researchers have argued that there is no empirical evidence indicating that survivors react differently than others in bereavement (J. R. Jordan, 2001). J. R. Jordan (2001, p. 92) wrote a response to this argument, stating that "bereavement after suicide is sufficiently distinct to merit additional research and specialized clinical services for most suicide survivors" (p. 92). J. R. Jordan (2001) argued that bereavement after suicide has three key differences from other types of bereavement; namely, the struggle with these three questions: (1) Why did they do it? (2) Why did I not prevent it? and (3) How could they do this to me?

Although there is not enough research to definitively state that suicide bereavement is different than bereavement after other types of loss, there is enough indication of the difference to justify further research (J. R. Jordan, 2001).

Traumatic grief. Traumatic grief occurs when a person experiences both grief and traumatic stress because of death (Prigerson, Shear et al., 1999). The APA does not consider traumatic grief a mental illness; however, it is a serious mental health condition (Cerel et al., 2009). As noted above, traumatic grief increases the risk for suicide (Cerel et al., 2009; J. R. Jordan, 2001; Melhem et al., 2004; Prigerson et al., 1997; Prigerson, Bridge, et al., 1999) and long-term psychosocial and physical health problems (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Research has demonstrated that traumatic grief is an illness of its own, distinct from grief (Cantwell-Bartl, 2001), bereavement-related depression, anxiety (Boelen, van den Bout, & Keijser, 2003; Prigerson, Shear, et al., 1999), and PTSD (Melhem et al., 2004).

Prigerson et al. (1995) developed the Inventory for Complicated Grief (ICG) assessment tool to distinguish between uncomplicated grief and complicated grief. They intentionally created a tool that excluded common symptoms of depression and anxiety to ensure that complicated grief was a distinct illness (Prigerson et al., 1995). In 1999, a panel of loss and trauma experts replaced the term *complicated grief* with *traumatic grief*, to acknowledge that it is a stress response condition similar to PTSD (Prigerson, Shear, et al., 1999). The

ICG is a reliable and valid measure that accurately identifies people with high levels of maladaptive grief symptoms (Prigerson et al., 1995). It consists of 19 questions that measure "pre-occupation with thoughts of the deceased, searching and yearning for the deceased, disbelief about the death, crying, being stunned by the death, and not accepting the death" (Dyregrov, Nordanger, & Dyregrov, 2003, p. 147).

Prigerson, Shear, et al. (1999) proposed the following criteria for traumatic grief:

- the person experienced the death of a significant other;
- the person's reactions involve an intrusive, distressing set of core symptoms that include yearning, longing, and searching;
- in response to the death, four or more of the following symptoms are present: frequent attempts to avoid reminders of what has happened; feeling of purposelessness and a sense of futility about the future; subjective sense of numbness, detachment, or absence of an emotional response; difficulty acknowledging the death; feeling that life is empty or meaningless; difficulty imagining a fulfilling life; feeling that part of oneself has died; a shattered world view; symptoms of harmful behaviours related to the deceased person; and excessive irritability, bitterness, or anger related to the death;
- the duration of the disturbance or the symptoms is at least two months;

and

- the disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning. (p. 68)

Researchers have recommended that traumatic grief be included as a distinct mental illness in the *DSM-5*. Currently, the *DSM-5* includes adjustment disorder as an option for identifying that a survivor is experiencing a maladaptive grief response. The criteria for adjustment disorder include emotional or behavioural symptoms that occur within three months of a stressor, that cause more marked distress than is expected in consideration of context and cultural factors, that do not represent normal bereavement, and that impair social, occupational, or other key areas of functioning (APA, 2013, pp. 286–287). In addition, symptoms do not last more than six months after the stressor has been eliminated (APA, 2013, p. 287). Although these criteria encompass those of traumatic grief, they are much broader and fail to recognize symptoms unique to traumatic grief.

The *DSM-5* also includes a condition for further study titled persistent complex bereavement disorder, with the specifier "with traumatic bereavement" for "bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death" (APA, 2013, p. 790). This condition is similar to past research on traumatic grief and the criteria proposed by Prigerson, Shear, et al. (1999). However, the proposed criteria differ

from Prigerson, Shear, et al. (1999) in that the symptoms must have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children, and they must be inconsistent with cultural, religious, or age-appropriate norms (APA, 2013).

Posttraumatic stress disorder. Traumatic events "confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe" (Herman, 2015, p. 24). Survivors often state that the unexpectedness of the suicide, and the helplessness they experience, impair their functioning (Farberow, Gallagher, Gilewski, & Thompson, 1987). In response to the traumatic event, "when neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized" (Herman, 2015, p. 24). Survivors do not have any means of resistance or escape from the traumatic event; there is no action they can take to stop the traumatic event. Research has suggested that the traumatic nature of losing a loved one to suicide results in survivors experiencing symptoms of PTSD (Dyregrov et al., 2003; Poijula, Whalberg, & Dyregrov, 2001).

PTSD is a distinct mental health illness in the *DSM-5* (APA, 2013) that includes exposure to actual or threatened death, serious injury, or sexual violence; intrusion symptoms associated with the trauma; avoidance of stimuli associated with the trauma; negative cognitions and mood associated with the trauma; and

alterations in arousal and reactivity associated with the trauma, which have occurred for more than one month (pp. 271–272).

Comparing traumatic grief and post-traumatic stress disorder. Traumatic grief and PTSD overlap on symptoms and have several distinguishing criteria (Prigerson, Shear, et al., 1999). Traumatic grief and PTSD are similar as they are both stress responses (Melhem et al., 2004; Prigerson, Shear, et al., 1999). Both responses include "intrusive thoughts, emotional numbness, detachment from others, irritability, and anger" (Melhem et al., 2004, p. 1415), as well as "disbelief, anger, shock, avoidance, numbness, a sense of futility about the future, a fragmented sense of security, trust, control" (Prigerson, Shear, et al., 1999, p. 68). However, traumatic grief is distinguished from PTSD by separation distress related to the deceased (yearning, searching, and having recollections of the deceased), hyper vigilance related to searching for cues of the deceased, sadness as the primary emotion (not fear as with PTSD), and no hyperaroused sleep as seen in PTSD (Melhem et al., 2004).

Survivors and traumatic grief. The distress experienced by survivors often meets the criteria for traumatic grief (Cerel et al., 2009; McMenamy et al., 2008). Using the ICG, Dyregrov and Dyregrov (2005) found that 78% of parent survivors scored high for traumatic grief. The common symptoms included "preoccupation with thoughts of their child, searching and yearning for the child, experiencing disbelief about the death, and difficulties accepting the death"

(Dyregrov & Dyregrov, 2005, p. 718). Research has indicated that survivors with traumatic grief experience long-term difficulties with mental health, psychosocial functioning, and physical health (Melhem et al., 2004; Prigerson et al., 1997).

Survivors often view a loss by suicide as a stressful event with negative mental health outcomes (Mitchell et al., 2003). Psychological distress, including high levels of depression, anxiety, and trauma, are common reactions experienced by survivors (McMenamy et al., 2008). Allen et al. (1994, as cited in J. R. Jordan, 2001) found that in comparison to other mourners, "individuals bereaved by suicide tended to be viewed as more psychologically disturbed, less likeable, more blameworthy, more ashamed, more in need of professional mental health care, and more likely to remain sad and depressed longer" (p. 93). Due to these symptoms, there is a high risk of developing long-term depression and PTSD (Melhem et al., 2004).

Survivors experiencing traumatic grief also exhibit more long-term psychosocial impairment and physical health problems (Melhem et al., 2004; Prigerson et al., 1997). These difficulties exist even after control for comorbid conditions such as anxiety and depression (Melhem et al., 2004). The risk for long-term psychosocial and physical health problems, among survivors with traumatic grief, has been consistently found in research (Mitchell et al., 2004). Long-term impairments related to traumatic grief include problems with sleep, mood, and self-esteem (Prigerson et al., 1995). Higher rates of heart problems and

cancer have also been indicated (Prigerson et al., 1997). Finally, an increased risk of suicidal ideation has also been found among survivors with traumatic grief (Cerel et al., 2009; J. R. Jordan, 2001; Melhem et al., 2004; Prigerson et al., 1997).

Traumatic Grief in Aboriginal Communities

Aboriginal youth suicide rates are five times higher than non-Aboriginal rates (British Columbia Ministry of Healthy Living and Sport, 2007), and Inuit suicide rates are 11 times higher than the rest of Canada (Statistics Canada, 2012). These statistics suggest that there are a significant number of Aboriginal survivors. Not only are there many Aboriginal survivors, but identified risk factors also suggest that Aboriginal survivors are at greater risk for developing traumatic grief.

Reed (1998) studied risk factors for parents who lose a child to suicide. Reed found that parents who are older, more educated, and employed outside the home have a more adaptive grief response. Currently in Canada, most Aboriginal parents are young: approximately 24% Inuit, 26% First Nations, and 21% Métis girls have mothers between the ages of 15 and 24, compared to 8% of non-Aboriginal girls (Statistics Canada, 2015). Canadian Aboriginals also have less formal education than non-Aboriginals (Statistics Canada, 2015). In 2006, 35% of Aboriginal women over 25 years of age had not completed high school, compared to 20% of non-Aboriginal women and 39% among Aboriginal men (Statistics

Canada, 2015). Finally, this population is overrepresented in the unemployment statistics, with unemployment rates for Aboriginal women double that of non-Aboriginal women (Statistics Canada, 2015). In 2009, the unemployment rate for Aboriginal people was 13.9%, compared to 8.1% for non-Aboriginal people (Statistics Canada, 2015).

Reed (1998) also found that the older the deceased, the less risk for maladaptive grief among parent survivors. The majority of deaths by suicide in Canada are by young members of Aboriginal communities, mainly youth aged 15 to 24 (Health Canada, 2003). According to the Canadian Institute of Child Health (2003, as cited in Caldwell, 2008), 38% of all deaths of First Nations youth aged 10–19 years old are a result of suicide. In combination with Reed's findings, the young age of those who are dying by suicide may increase the risk for traumatic grief among parents in Aboriginal communities.

Prigerson et al. (1997) suggested that survivors who went through adversity in childhood and had a history of insecure attachments were at higher risk for traumatic grief after a suicide. The author argued that adversity in childhood is a common risk factor for traumatic grief among Aboriginal people, as it is directly related to colonialism. Colonialism has resulted in social, economic, cultural, and political inequities (Adelson, 2005; Tester & McNicoll, 2003). The result of these inequities is the disruption in the balance of mental, physical, emotional, and spiritual health (Tester & McNicoll, 2003). This

disruption in the balance of the four quadrants of health can be considered adverse circumstances that most Aboriginal children experience. Continued oppression makes recovery difficult (Walls et al., 2014). Therefore, colonialism and ongoing oppression leave Aboriginal children facing adversity.

A history of insecure attachments is also a result of colonialism. One aspect of colonialism was the implementation of the residential school system, which involved taking Aboriginal children from their homes against their will from 1879–1986 (Milloy, 1999; York, 1990). Many of these children experienced physical, emotional, and sexual abuse at residential school (Milloy, 1999; York, 1990). They were punished for speaking their language, talking to their siblings, or running back home to their family (Milloy, 1999; York, 1990). Speaking of her experience at residential school, Helen Cromarty, a former student, stated,

> As a residential school survivor, there were things taken away from us that we can never ever get back, doesn't matter how hard you work at it. I worked hard to get my culture back, my language. I still have to work at it. (as cited in The Canadian Press, 2016, para. 6)

According to Milloy (1999), the residential school system "produced thousands of individuals incapable of leading healthy lives or contributing positively to their communities" (p. xvii). Meeting the emotional needs of a child is important in the development of a secure attachment (Boyd, Johnson, & Bee, 2012). I submit that the residential school system resulted in a pattern of insecure

attachments for many Aboriginal people; therefore, Aboriginal survivors are likely more vulnerable to experiencing traumatic grief. In consideration of these risk factors (age of parent, education, employment, age of deceased, childhood adversity, and insecure attachments), it appears that the risk for traumatic grief is much higher for Aboriginal people in Canada (Spiwak et al., 2017).

Dominant Mental Health Treatment Models and an Aboriginal Wellness Model

Suicide postvention involves addressing the effect of the suicide on survivors (FNHA, 2015). Survivors need postvention supports after the loss of a loved one to suicide (Kirmayer et al., 1999). As noted above, survivors are at increased risk for traumatic grief and suicidal ideation, and this risk is much higher for Aboriginal people in Canada. In the following section I explore how suicide postvention for survivors have historically been applied using dominant mental health models and an Aboriginal wellness model.

Dominant mental health models and suicide postvention. I define dominant mental health models as the dominant approaches to assessment and treatment of mental health issues in Canada, administered for and by the dominant culture. Mental health treatment is administered by mental health clinicians (e.g., psychologists, psychiatrists, social workers, counsellors) to an individual or group of individuals (e.g., via individual therapy, group or family therapy, or support groups). Mental health clinicians also diagnose—the very use of diagnosis and

application of treatment is part of an emphasis on the individual, that person's "illness," and an individually based treatment focus that views the "pathology" as being located in the individual (Duran, 2006).

Mental health treatment is thought to be ideally focused upon the application of evidence-based treatment as the prescribed intervention, as it is short-term, solution focused, and result oriented (Prilleltensky & Nelson, 2002). Evidence-based treatment is a practice that has evolved from the medical model with a focus on using scientific research findings to determine effective suicide prevention and intervention strategies (White, 2007). Unfortunately, research on suicide postvention is limited, with most studies being descriptive rather than evaluative in nature (Kirmayer, Fraser, Fauras, & Whitley, 2009). Due to this gap in the literature, evidence-based interventions for suicide postvention are limited. This section examines how dominant mental health models address suicide postvention by treating two key issues faced by suicide survivors—traumatic grief and suicidal ideation.

Dominant mental health models: Treating traumatic grief among survivors. As noted previously, the distress experienced by survivors often meets the criteria for traumatic grief (Cerel et al., 2009; McMenamy et al., 2008). The dominant mental health models often provide support groups to treat traumatic grief among survivors. Postvention support groups are one of the most widely offered supports for suicide survivors in the United States, with over 400 groups

offered (Cerel et al., 2009). Support groups allow survivors to identify with one another, to assure themselves that they are not alone, and to feel a benefit from listening to one another's stories (Cerel et al., 2009). According to the World Health Organization (2008), "A support group can assist greatly, as a lack of communication can delay the healing process" (p. 4). Although research is limited, support groups for suicide survivors seem to be an effective postvention activity (Andriessen & Krysinska, 2012; J. R. Jordan & McMenamy, 2004). One may argue further that a support group that addresses the unique challenges facing survivors of suicide is a significantly powerful intervention. In this section, I present findings supporting postvention group for survivors.

Farberow (1992) researched 60 survivors (70% adult women; other descriptive statistics were not provided) who attended an eight-week semistructured survivors-after-suicide program. This program was led by a mental health professional and a survivor that previously completed the program, with the purpose of helping survivors work through their grief by sharing similar experiences and discussing books and articles. The participants were asked to rate their level of anger, grief, and other emotions at the time of death, preintervention, and postintervention. Farberow firmly concluded that survivors with high levels of distress showed significant improvement after attending the survivors-after-suicide program.

Renaud (1995) found that participants of a 10-week support group, with a focus on discussing suicide-related themes and homework assignments, showed a significant decrease in depression and anxiety related symptoms. Participants were callers to a suicide prevention centre who were invited to attend the group, and they completed self-report measures pre- and postintervention. There were eight adult participants who had lost a loved one to suicide within the previous year; statistics related to ethnicity were not provided (Renaud, 1995).

In a comparison study by Constantino, Faan, Sekula, and Rubinstein (2001), results indicated that both grieving support groups and social activity groups were effective for improving mood amongst widows of suicide. Participants were 47 adult women; 43 were White, 1 was Asian, and 3 were African American, and all had graduated high school or had post-secondary education. The groups ran eight weeks, with 90-minute sessions, and evaluation was based on self-report measures pre- and postintervention: The Beck Depression Inventory (Beck, Steer, & Brown, 1996), the Grief Experience Inventory (Sanders, Mauger, & Strong, 1985), and the Social Adjustment Rating Scale (Constantino et al., 2001; Holmes & Rahe, 1967). Findings indicated that blending both the grieving group and the social activity group might be the most effective model for survivors (Constantino et al., 2001).

A more recent study in 2003 found that an 8-week psychoeducational support group for survivors led to participants feeling an increase in well-being

and social support (Mitchell et al., 2003). The sample size was 10 adult participants; 7 participants attended more than four sessions, and 3 participants attended four sessions or fewer (Mitchell et al., 2003). Other descriptive statistics of participants were not provided. This model focused on participants discussing their loved one, watching presentations about suicide and research, and building coping skills (Mitchell et al., 2003). The purpose of the group was to help participants reach closure around their loss and increase their sense of well-being (Mitchell et al., 2003). The group process and themes that arose were examined using a narrative approach, and results suggest that helping survivors to create therapeutic narratives is an effective method of intervention (Mitchell et al., 2003).

Due to the limited research that is available in this area, it remains unclear which type of group treatment and which group format are the most effective for which survivors. Further research is needed to determine best practices for supporting survivors of suicide.

Dominant mental health models: Treating suicidal ideation among survivors. Traumatic grief among survivors significantly increases the risk for suicidal ideation and suicide attempts (Cerel et al., 2009). To prevent cluster suicides, it is essential that a postvention response address suicidal ideation among survivors as early as possible (FNHA, 2015). The treatment of suicidal ideation is one of the most difficult clinical issues to address (Kozlowski, 1997).

A universal theory of suicide does not exist, and no two populations are the same, making a single model for intervention and prevention difficult (Breton et al., 2002).

To date, there is little evidence-based practice for treating suicidal ideation, due to limited research in this area (Kirmayer et al., 2009). However, dominant mental health models do share four key assumptions regarding suicide (Wexler & Gone, 2012): (a) suicide indicates psychological problems, (b) suicide is a personal choice, (c) suicide prevention is best accomplished by mental health professionals, and (d) suicide prevention belongs within the formal mental health system. These key assumptions are reflected in dominant suicide intervention strategies that are developed and implemented, such as suicide risk assessment and cognitive therapies.

These treatments view suicidal ideation as a problem within the individual, with risk factors related to mental illness (Breton et al., 2002; Wexler & Gone, 2012). Treatment is focused on making changes within the individual, with a specific focus on building coping skills. Research has found that cognitive therapy is effective in reducing future suicide attempts (participants were 60% African American, 35% White, 1% Hispanic, 2.5% Native American, and 2% other; Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012). A meta-analysis and a literature review of research worldwide also found cognitive

behaviour therapy to be effective in reducing suicide behaviour (Daigle, Pouliot, Chagnon, Greenfield, & Mishara, 2011; Tarrier, Taylor, & Gooding, 2008).

It is important to point out that the research on dominant mental health postvention strategies has mostly included participants from the dominant culture. The research that I found indicated that these strategies have not been accepted or effective in Aboriginal populations (e.g., Kral, 2012), and could result in unintended harm (McCormick, 1997; Sareen et al., 2013). Research on effective postvention strategies for Aboriginal survivors is needed.

Aboriginal wellness models and suicide postvention. Due to the increased risk for traumatic grief and suicidal ideation among Aboriginal survivors, effective suicide postvention strategies for this population are essential. Researchers have strongly suggested that suicide postvention strategies be created from an Aboriginal view of wellness; though practices and beliefs vary widely across the total group of Aboriginal persons in Canada (British Columbia Ministry of Healthy Living and Sport, 2007; Chandler & Lalonde, 2013; Mussell, Cardiff, & White, 2004; Poonwassie & Charter, 2001), an overall understanding of wellness has been identified in the literature and has been described as having four domains or quadrants: mental, physical, emotional, and spiritual (Cotton et al., 2014; Poonwassie & Charter, 2001).

According to this overarching model, “it is the movement towards balance in all four quadrants of a person’s holistic health that is the underpinning of this

path forward towards the achievement of mental wellness and reduced problematic substance use" (Tripartite First Nations Health Plan, 2013, p. 5). One may achieve this mental, physical, emotional, and spiritual balance by following traditional practice (Lavallee & Poole, 2010; Poonwassie & Charter, 2001; Tripartite First Nations Health Plan, 2013). Traditional practice often includes participation in ceremony, connection with community, involvement of Elders, role modelling, and the revitalization of cultural traditions, and all are beneficial methods of healing for Aboriginal communities (McCormick, 1994; Poonwassie & Charter, 2001).

McCormick (1997) interviewed 50 BC First Nations members and found 10 themes that were important for healing: establishing a social connection and obtaining support/help from others, anchoring oneself in tradition, exercise and self-care, involvement in challenging activities and setting goals, expressing oneself, establishing a spiritual connection and participation in ceremony, helping others, gaining an understanding of the problem, learning from a role model, and establishing a connection with nature. McCormick's (1997) study highlighted the collectivist orientation of traditional practice and the power of interconnectedness of the individual, family, community, spirituality, and nature. Healing practices often included the client and the healer, as well as the family and community (McCormick, 1997). As noted by Mussell et al. (2004), "Aboriginal mental health is relational; strength and security are derived from family and community" (p. 4).

Historically, Aboriginal wellness models have been viewed as "subservient and invalid" (Duran, 2006, p. 26) by the dominant model, with strategies rooted in Western ideology deemed superior (Duran, 2006). Conversely, dominant SPIP strategies have not been commonly accepted in Aboriginal communities (Clifford et al., 2013; Kral, 2012). McCormick (1997) argued that due to BC First Nations clients' collective orientation, the individual focus of dominant mental health models could be detrimental to them.

The Suicide Prevention, Intervention, and Postvention (PIP) Initiative for British Columbia stated that "cultural safety and community renewal approaches should be emphasized when engaging in suicide prevention, intervention and postvention with aboriginal populations" (as cited in Joshi, Damstrom-Albach, Ross, & Hummel, 2009, p. 161). This initiative also identified the following recommendations for SPIP work in Aboriginal communities:

- appropriate practices for Aboriginal populations in suicide prevention, intervention and postvention involve a mix of Western and traditional practices;
- best practices should be developed by a community;
- suicide prevention, intervention and postvention among Aboriginal populations should have an across the lifespan approach; and
- communities would benefit most by being presented with a compilation of strategies that they can choose from to implement given the diversity that

exists across communities. (Joshi et al., 2009, p. 161)

The *Hope, Help, and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide* (FNHA, 2015), recommended the development and implementation of a SPIP protocol unique to each community. This toolkit recommended the following postvention programs and activities to address several individual and community needs: development of a crisis response team, grief programs, care for the worker, support for grieving families, postvention protocols to stabilize the crisis, media reporting guidelines, and cultural programs and interventions (FNHA, 2015).

According to the National Aboriginal Youth Suicide Prevention Strategy (2009), Health Canada also supports the empowerment of First Nations communities in developing their own SPIP strategies. Rather than providing evidence-based strategies that are not proven effective in Aboriginal populations, the Canadian government has begun providing funding for communities to develop their own programs (Kral, 2012). Findings from the initial evaluation of these community initiatives have indicated success in using strategies that are community driven and unique to Aboriginal communities; however, research on their effectiveness has not been published to date (Health Canada, 2013). It is anticipated that such initiatives will lead to a reduction in suicide rates in the long term (Health Canada, 2013).

A systematic review of SPIP strategies for Indigenous communities in Australia, New Zealand, the United States, and Canada found insufficient evidence for determining which strategies are most effective (Clifford et al., 2013). Clifford et al. (2013) recommended further research using methodologically rigorous designs in the evaluation of SPIP strategies targeting Aboriginal suicide, as without further research it is likely that effective programming will not be implemented and suicide rates will not decrease.

Although almost no empirical studies have been published in peer-reviewed academic journals in Canada, numerous SPIP programs have been implemented in Aboriginal communities across the country (Bennett et al., 2015; Clifford et al., 2013; Kirmayer et al., 2009). However, the effectiveness of most SPIP programs is unknown. A review of SPIP strategies in Canadian Aboriginal communities uncovered two initiatives that took place in response to the high rate of suicide. One initiative took place in an Inuit community. In response to the high suicide rate, this particular community held adult and youth committees that met regularly to discuss ways to prevent future suicides (Kral, 2012). They also removed the closet rods, the most common means of suicide, from every home in the community. These two strategies resulted in a shift from being the community with the highest rate of suicide to no suicides for a four-year span (Kral, 2012).

In a second Inuit community, a youth committee opened a youth centre with peer counsellors, games and activities, talks with Elders, and movies (Kral,

2012). Suicides stopped for two years while the youth centre was running, then began again when it shut down, with one or two suicides per year. Six years later, a youth centre was reopened in the community and suicide rates have significantly decreased (Kral, 2012). These SPIP initiatives were community driven, empowering, and effective. I found no studies discussing postvention support for Aboriginal survivors in Canada.

Although there is insufficient evidence to determine which Aboriginal wellness strategies are most effective, suicide risk assessment is an essential postvention strategy for reducing suicide risk among survivors. MacNeil and Guilmette (2004) proposed the use of a culturally sensitive suicide risk management tool for use with Aboriginal populations. They argued that an assessment and intervention tool that reflects culture and empowers clients would help to reduce Aboriginal suicide in Canada (MacNeil & Guilmette, 2004). Their argument is supported by findings that suggest that dominant assessment and intervention models (e.g., Applied Suicide Intervention Skills Training [ASIST]) have the potential to cause harm when used with Aboriginal populations (Sareen et al., 2013). Sareen et al. (2013) evaluated the effect of ASIST training on First Nations participants in Manitoba and found an increase in suicidal ideation among ASIST participants compared to participants who attended a two-day cultural resilience retreat. These findings suggest that the dominant mental health model for intervention with suicidal ideation has the potential to cause harm and

adaptations should be made to meet the needs of different populations. To date, the suicide risk management tool proposed by MacNeil and Guilmette has not been evaluated.

Graham and Thomas (2002) advocated for adjusting the Reasons for Living inventory (RFL) for use as a suicide risk assessment tool with Aboriginal youth. The RFL inventory, developed by Linehan, Goodstein, Nielson, and Chiles (1983), included 48 questions related to six key reasons for living: survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections. Graham and Thomas argued that with the addition of questions related to spirituality and nature, the RFL would fit well with an Aboriginal model of wellness focused on the interconnectedness of the individual, family, community, and world (Graham & Thomas, 2002). An adjusted RFL assessment tool could improve suicide assessment with Aboriginal youth by connecting dominant mental health professionals to an Aboriginal wellness model of healing (Graham & Thomas, 2002).

It is apparent that SPIP strategies that address healing for survivors in Aboriginal communities must be culturally sensitive and community driven to be effective. Currently, there is insufficient evidence to determine which strategies are most effective. Further evaluation and research in Aboriginal SPIP is needed.

Summary

Suicide rates are high in Canada, particularly in some Aboriginal communities, and are a serious concern. Dominant model efforts to date have not been successful in healing for survivors or lowering overall suicide rates. The dominant mental health models target healing at an individual level, with an individually based treatment focus that views the pathology as being located in the individual (Duran, 2006). The Aboriginal wellness model highlights the collectivist orientation of traditional practice for healing and the power of the interconnectedness of the individual, family, community, spirituality, and nature (McCormick, 1997; Mussell et al., 2004). As noted earlier, due to the Aboriginal collectivist orientation, the individual focus of dominant mental health models could be detrimental to BC First Nations clients (McCormick, 1997). Suicide postvention is a complex issue that needs to be addressed with a culturally sensitive approach.

Considering the high rate of suicide within Aboriginal communities in Canada and the risk factors related to traumatic grief, it is imperative that research be conducted to help in the prevention, intervention, and postvention of this serious health phenomenon. Further research on how Aboriginal families heal after the loss of a loved one to suicide could help guide the development of effective postvention strategies. Research should take into consideration the diversity among Aboriginal communities, recognizing that each community is

unique and has its own strengths and needs. Gaining a thorough understanding and appreciation for the values, beliefs, and practices of a specific Aboriginal community is imperative when developing healing supports for that community (Poonwassie & Charter, 2001).

This research explored supports that helped Squamish Nation survivors heal after the loss of a loved one to suicide. I anticipated that results would indicate that survivors in the Squamish Nation community integrated healing strategies from both dominant mental health models and an Aboriginal wellness model. However, the community's input was needed to fully and most appropriately understand and recommend a model for healing. Ultimately, all future postvention strategies should be developed and implemented in a fashion that empowers community and reduces oppression.

Chapter 3: Method

In this chapter I describe the methods I used to identify the supports that helped Squamish Nation members heal after the loss of a loved one to suicide. The chapter includes a rationale and description of the CBR process, as well as descriptions of the ethics process, participant recruitment, data analysis, the dissemination of findings, and ongoing journalling I conducted.

Rationale for Community-Based Research

I used a CBR design to identify themes of healing after the loss of a loved one to suicide. I chose this design because of its focus on seven principles defined by Boyd (2014): collaboration, community driven, power sharing, a social action and social justice orientation, capacity building, transformative, and innovative. This design meets the *Tri-Council Policy Statement* (*TCPS-2*) requirements of community engagement with Aboriginal populations (Tri-Council, 2014). CBR principles were an ideal fit for this research, as I explain below.

Collaboration between the researcher and the community to solve a community-identified, and defined, problem is a key principle of CBR (Boyd, 2014). Defining the problem, choosing the methodology, collecting and analyzing the data, sharing the findings, and evaluating the project all involve collaboration (Boyd, 2014). Involving the community in this process can lead to more cohesion amongst participants (Watters & Comeau, 2010). Cohesion and collaboration were important for this research, as working together to identify themes of healing

after a suicide can increase harmony in the advocacy of community needs (Watters & Comeau, 2010). My intention in this research, and in using CBR, was to empower the community to highlight the suicide postvention needs of grieving families.

I also chose a CBR design because it is community driven. Traditionally, researchers have chosen the topics studied in social science research (Boyd, 2014). Research was conducted for the interest and benefit of the researcher, and was often considered exploitive and oppressive (Boyd, 2014). In CBR, research should be community driven from start to finish, from the definition of the problem to the project evaluation (Boyd, 2014).

For this project, YHS identified the issue: a desire to understand how best to support survivors within the community after the loss of a loved one to suicide. According to its mission statement, YHS "strives to improve the health and wellness of Squamish Nation membership through the provision of community health services and the promotion and support for access to all health services" (Squamish Nation, 2013e, para. 2). YHS "provides members with the best possible public and preventative health services as well as advocacy and support to access government and community health programs and services" (Squamish Nation, 2013e, para. 3).

YHS includes the Community Health & Wellness Division, which "provides members with mental, emotional, physical and spiritual support and

health services. These include conventional mental health & addictions counselling, community nursing and a doctor's clinic as well as traditional, alternative and naturopathic healing and wellness" (Squamish Nation, 2013e, Community Health and Wellness Division section, para. 1). I made efforts to include YHS and participants throughout the entire research process. At a meeting with YHS, I presented the method of data collection and analysis for approval. It was also agreed that YHS would be updated bimonthly on my progress by email, noting the research steps I had completed. YHS agreed to be available by phone or email as questions arose throughout the research process.

Power sharing is another principle of CBR. Collaboration is highlighted in a CBR design, by power being shared between everyone involved (Boyd, 2014; Holkup, Tripp-Reimer, Salois, & Weinert, 2004). The sharing of power is aimed at eradicating the inequality that happens in a typical research design between researchers and participants (Watters & Comeau, 2010). This is important, as historically research in Aboriginal communities was often oppressive (Baum, MacDougall, & Smith, 2006; Centre for Suicide Prevention, 2013a). The aim is to make decisions collaboratively; each participant has distinct and equally important contributions that lead to mutual learning (Creswell, 2008; Holkup et al., 2004; Watters & Comeau, 2010). For example, survivors each have their own lived experience of losing a loved one to suicide. Survivors can share which community responses were helpful or unhelpful and may suggest others to be

developed. The contributions of all participants are equally important and will bear equal weight in the data analysis.

Last, in CBR the researcher needs to remain aware of his or her privilege and how it may impede power sharing (Boyd, 2014). “Knowledge, discussion, and reflection about power, power sharing, and power dynamics within the community are critical for successful partnerships. Engaged scholars and activists need to encourage, support, and foster a climate where all stakeholders and researchers share power” (Boyd, 2014, p. 15). In addition, the researcher must be open to surrendering power and be able to identify and challenge individuals and groups that have power in the community (Boyd, 2014).

I engaged in ongoing self-reflection via regular journalling and supervision with my dissertation chair to identify any concerns related to misuse of this privilege. Regular journalling allowed me to make my “experiences, opinions, thoughts, and feelings visible and an acknowledged part of the research design, data generation, analysis, and interpretation process” (Ortlipp, 2008, p. 703). Watt (2007) described the benefits of regular journalling in qualitative research in the following statement:

> Audiences should have the opportunity to see how the researcher goes about the process of knowledge construction during a particular study. By engaging in ongoing dialogue with themselves through journal writing, researchers may be able to better determine what they know and how they

> think they came to know it. An introspective record of a researcher's work potentially helps them to take stock of biases, feelings, and thoughts, so they can understand how these may be influencing the research. Making such information available to readers provides them with a means to better evaluate the findings. (p. 84)

I also chose a CBR design for its call for social action and social justice orientation. "Involving those most affected by issues and problems within their own communities in the research process is an act of social justice" (Boyd, 2014, p. 18). Participants are empowered through collaboration and power sharing (Boyd, 2014). Participants call attention to community needs that are not being met and highlight the needs to guide the way for solutions to be developed (Watters & Comeau, 2010). After the research is complete, it is important that the community decide what solutions are implemented as a result of (Boyd, 2014). Through CBR, this project highlighted themes related to supporting grieving families after the loss of a loved one to suicide, then provided recommendations for suicide postvention. The community will decide whether to implement all or some of the recommendations when developing suicide postvention supports for grieving families.

Capacity building is another principle of CBR. The researcher's role is to empower and strengthen communities (Boyd, 2014). "Through people's participation in the research process they are enabled to learn what has previously

been the domain of ‘expert’ or ‘professional’ knowledge, such as how to apply research techniques” (Bozalek, 2011, p. 471). Participants can learn about the research process and develop research skills (Watters & Comeau, 2010). They can also learn communication skills (Boyd, 2014). This transfer of knowledge empowers and strengthens the community. Potentially, participants may learn to design their own research to assess the effectiveness of suicide postvention supports.

The principle of transformation is also an important aspect of CBR (Boyd, 2014). Boyd (2014) defined transformation as “a multidirectional exchange of ideas, experiences, knowledge, and understanding where all stakeholders grow and where change happens as a result of partnership” (p. 19). The objective is not simply to empower the community, but to enable change to occur as a result of the partnership between researcher and community, with all those involved growing. This partnership in this project has, I hope, resulted in change for both myself and the participants. At the feedback sessions with participants, I asked them if their participation in this research, specifically telling the story of their loss and healing journey, affected them in any way. Most participants noted a positive benefit of participating, described in Chapter 4. I also tracked my own growth through journalling and reflecting on my journal entries throughout the research process.

The final principle for CBR is innovation (Boyd, 2014). "Multidisciplinary groups including academics, practitioners, and community members are better able to think creatively and strategize how to research complex issue and problems" (Boyd, 2014, p. 19). Having a diverse group of participants with different perspectives can result in the development of meaningful interventions for the community, rather than researchers developing interventions that are not meaningful to the community or are difficult to implement (Boyd, 2014). I expected that this project would result in identifying an inclusive range of themes that would guide the development of meaningful and applicable interventions for postvention as it would include survivors who constituted a diverse age group, and potentially different perspectives. Although participants constituted a diverse age group with varying perspectives, it is important to consider that the results may not be representative of the entire community due to the small sample size.

In conclusion, this CBR research design included consultation with YHS, a briefing note sent to Squamish Nation Chiefs and Council, an agreement of YHS support, a research agreement approved by Squamish Nation Chiefs and Council, and consultation with Squamish Nation Elders. These CBR procedures met the following *TCPS 2* (Tri-Council, 2014) requirements; working collaboratively (Articles 9.1 and 9.12), determining the nature and extent of collaboration (Article 9.2), ensuring the respect for community customs and codes

of practice (Article 9.8), delivering a formal research agreement as per Articles 9.10 and 9.11, and recognizing the role of Elders as per Article 9.15.

Ethics Process

It is imperative that research conducted in Aboriginal communities take steps that are in keeping with the principles of ownership, control, access, and possession (OCAP). These principles were developed by the First Nations Centre (2007) to ensure that First Nations control what research is conducted in their community, how it will be used, where the data are stored, and who can assess the data. In keeping with these principles, I met with the management of YHS to negotiate the proposed research terms. The meeting covered the following terms suggested by Macaulay, Commanda, Freeman, and Gibson (1999): the research goals and objectives, the methods and length of the project, the terms of the community–researcher partnership, the degree of confidentiality, data storage, future control and use of data, methods of resolving disagreements, and the dissemination of results. These terms were discussed and agreed upon, and are described in the research agreement.

Presenting the research proposal to the Squamish Nation Chiefs and Council was the next step in my effort to proceed with this research in a culturally sensitive and respectful manner. The Squamish Nation Chiefs and Council described their governance model in the following way (Squamish Nation, 2013b):

> As a Nation, our traditional custom was consensus-based decision making through the long house. This process was modified by the 1923 Amalgamation, which established the Squamish Nation Council of Hereditary Chiefs to conduct the affairs of the Squamish Nation.
>
> This governance structure was further modified following a membership working group, General Meetings and a referendum, which resulted in the election of sixteen (16) councillors for four-year terms (plus an elected Band Manager), since 1981. In turn, the sixteen councillors elect Co-Chairs of the Council instead of a Chief—as such, the Squamish Nation governance model is unique. (paras. 2–3)

The Squamish Nation Chiefs and Council have the following mandate (Squamish Nation, 2013a):

> To protect the Amalgamation and enhance the Uxwumixw cultural values and traditions through respect, equality and harmony for all. Chiefs and Council have a responsibility to govern the affairs of the Nation as a whole and uphold their fiduciary obligation for the wellbeing of the members of the Nation. Chiefs and Council are committed to providing exceptional service to our membership and providing leadership in intergovernmental relations. We believe in the core values of honesty, integrity, accountability and ownership, consistency and fairness, and

achieve this through positive attitude, teamwork and a strong work ethic. (para. 1)

On June 15, 2016, I attended a meeting with Squamish Nation Chiefs and Council and presented a briefing note which explained the research proposal. The purpose of the meeting was to explain the research proposal, answer any questions or concerns, seek input, and receive permission to conduct the research. The proposal was approved, the agreement was signed, and members of the council offered to assist as needed throughout the research process. For final ethics approval, I made an application to the Adler Research Ethics Board, which was approved after I completed the requested edits.

Conflict of Interest

For this research project, my role was a student researcher in the community, not a counsellor. Research participants requesting counselling services during the research process were referred to a YHS mental health intake worker for a referral to a counsellor other than myself, to avoid any dual relationships. Current clients of mine were not eligible to participate. I recognized that, having worked in the Squamish Nation community since May 2010, some participants may be prior clients of mine. Potential participants were advised that I could not act as a counsellor for any participants until data collection was complete.

In addition, I expected that I would continue to work in the community after this research project. Therefore, it was possible that research participants may become future clients. To avoid any potential conflicts of interest, participant requests for counselling after the research is complete will go through the mental health intake worker at YHS. The mental health intake worker will discuss concerns of dual relationships and offer an alternative counsellor. Ultimately, the participant may choose to work with me when my role as student researcher is complete and I return to the role of counsellor.

Participants

There were inclusionary and exclusionary criteria for participation. Participants had to be 19 years of age or older and be able to communicate in English. Participants also had to be Squamish Nation members, as the purpose of the research was to reflect Squamish Nation themes of healing. Most important, participants must have experienced the loss of a loved one to suicide no earlier than one year and no later than 10 years ago. “Loved one” referred to someone that the participant felt love for, and this is the definition I planned to provide had anyone asked, but no participants did.

Initially, criteria required that participants must not have lost a loved one to suicide within the last two years. My intention was to reduce the likelihood that participants would find the questions emotionally triggering. To increase recruitment, I applied to REB to reduce this time period to one year, and this

application was approved. A one-year period of mourning is traditional in the community, with all photos of the loved one put away for one year after the passing. The research team and the REB agreed that a period of one year was sufficient to be sensitive to the participants' well-being.

Finally, to reduce risk, participants were required to rate their current mental wellness as okay or better. If any individuals had not rated their current mental wellness as okay or better, I would have offered to connect them with the mental health intake worker at YHS and would have advised them that they were unable to participate in the research study. However, all participants rated their mental wellness as okay or better.

Exclusionary criteria included suicidality over the past six months or current crises. I assessed suicidality following the screening for participants form (see Appendix A; see also further description under Procedures). No potential participants were actively suicidal or experiencing any current crises that required immediate support.

From this point forward, potential participants are referred to as such, while those who participated in this study are referred to as community members. I chose this shift in terminology as *participant* felt too academic to me, whereas *community member* felt more culturally sensitive and appropriate. Eight Squamish Nation members living on the Capilano and Mission reserves in North and West Vancouver participated in this study. They included six women and two men,

ranging in age from 34 to 81 years old, and had all lost a loved one to suicide within the past 10 years. Four of them had lost two loved ones to suicide within this time frame, and one member had lost six loved ones. None of the community members had lost a loved one to suicide within the past year. Each of them rated their current mental wellness as okay or better.

It is important to note that I personally knew each of the community members prior to the study. Three of the members had attended more than one therapeutic group I had facilitated within the past seven years, three members were professional colleagues working on reserve, and three of the members had family members to whom I had provided or was providing mental health support. Although these dual relationships may be considered a conflict of interest, the familiarity may also be the reason why these community members felt comfortable volunteering to participate. It is common for persons working on reserve to have dual relationships, and it was my sense that my dual role as a counsellor and researcher was not seen as unusual, was culturally sensitive, and was appropriate. To protect participants from coercion related to dual relationships, I sought them indirectly through advertising and consistently reminded them that participation was voluntary and they could stop participating at any time. Without my familiarity and positive working relationship with the community, it is likely that this research may not have been considered or approved by the Squamish Nation.

Measures

Data were collected using two methods for descriptive purposes (a demographic measure and my own journal of the research process) and two methods for analytical purposes (semistructured interviews and feedback sessions). A demographic measure I developed was used to gather the following descriptive data (see Appendix B): name, age, address, gender, residential school survivor, Aboriginal band membership, length of time living in the community, number of loved ones lost to suicide over the past 2–10 years, relationship to the deceased, how old the loved ones were when they died by suicide, and when community members lost their loved one to suicide. This information helped ensure that community members met the inclusion criteria and helped to understand their history of losing loved ones to suicide prior to the interview. Community members were advised that they must answer all the demographic and interview questions, or their answers would not be included in the research.

I used semistructured interviews to gather data related to community members' experiences and opinions. This format used broad questions to provide the space for members to share without restriction (Creswell, 2008). The primary questions were as follows: (1) Can you tell me about your experience losing a loved one to suicide? (2) What was helpful in your healing journey? (3) What supports would you like to see offered to families in the Squamish Nation community after a suicide? Secondary questions included the following: (a) Did

you access any formal mental health or wellness supports? and (b) Did culture/religion play a role in your healing? I developed these interview questions, which were then reviewed and approved by YHS. I also used prompts as needed to ensure a thorough understanding of the community member's experience. Prompts included questions such as "Can you tell me more about that?" and "What else was helpful?"

Community members also attended feedback sessions to review the findings, clarify any misunderstandings, provide feedback, or request edits prior to the finalization of the results. They were also asked the following question suggested by YHS: Did the telling and recording of your healing journey change you in any way? During the feedback sessions, I used a feedback session script (see Appendix C). This met the requirements of Article 9.17 of the *TCPS 2* (Tri-Council, 2014).

Initially, I had planned to collect archival data to supplement the demographic data, including birth and death statistics and geographic regions of the survivors loved ones who had passed by suicide. I requested permission from YHS to contact the Squamish Nation Member Services to obtain these data. This information would provide an understanding of the prevalence of suicide in the Squamish Nation community and would not link to individual community members. Although statistical data would be included in the findings, names of community members participating in the study would be kept strictly confidential

(identifying information would be removed). YHS advised that these archival data were not available, as information related to cause of death is not recorded by the Squamish Nation. According to Health Canada (2003), First Nations communities across Canada typically under report, or do not report, suicide statistics.

Procedures

The procedures for the study included the following steps: consultation with YHS, presentation to Squamish Nation Chiefs and Council for approval, invitation to Elders to participate, application to the Adler University REB for approval, community member recruitment, face-to-face interviews with community members, data analysis and initial integration of findings, the dissemination of findings, and ongoing journalling by myself about the research process. I address the timeline and description of these procedures in this section.

Consultation with Yúustway Health Services. In April 2016, supervising faculty (Dr. Cindy Weisbart) and I met with YHS to discuss the research proposal, specifically the research purpose, the methodology, my roles and responsibilities as a student researcher, and those of Adler University, YHS, and the Squamish Nation Chiefs and Council. I presented the research proposal and YHS provided feedback and suggestions. YHS verbally approved the research proposal and offered its support in my application to Chiefs and Council for approval. YHS agreed to schedule a time for me to present to Chiefs and

Council in May 2016. I agreed to send copies of the proposed research agreement to YHS and Chiefs and Council within a week prior to the scheduled presentation.

The research proposal was then edited to incorporate the feedback from YHS, in the spirit of CBR and collaboration. This process met the following *TSPS 2* requirements: working collaboratively (Articles 9.1 and 9.12), determining the nature and extent of collaboration (Article 9.2), and ensuring the respect for community customs and codes of practice (Article 9.8; Tri-Council, 2014).

Presentation to Squamish Nation Chiefs and Council for approval. On June 15, 2016, I attended a meeting with Squamish Nation Chiefs and Council and presented a briefing note which explained the research proposal. At this meeting, Chiefs and Council members expressed strong support for the research proposal, advised the need to increase understanding of how to help survivors heal, and shared personal stories related to their loss of a loved one to suicide. The research proposal was approved, the research agreement was signed, and several members offered to assist in any way they could throughout the research process. This process meets the *TCPS 2* (Tri-Council, 2014) requirements of delivering a formal research agreement as per Articles 9.10 and 9.11.

Invitation for Elders to participate. On July 4, 2016, I met with two Squamish Nation Elders in their home to request their participation as consultants for this proposed research. I explained the purpose of the research, the expected timeline (October 2016 to August 2017), and the role and time commitment

expected of consultants. The Elders agreed to act as consultants. They agreed to meet with me on three occasions during the expected timeline to answer any questions I may have, or provide suggestions, regarding doing research in a culturally sensitive manner. This process met the *TCPS 2* requirements of recognizing the role of Elders as per Article 9.15 (Tri-Council, 2014). I met with the Elders for a second time in April 2017. I asked them for feedback on the amended Looking for Participants flyer, and they said it looked fine. I advised that recruitment had been difficult, and they told stories of their experience with people that were suicidal.

Application to the Adler University Research Ethics Board for approval. In fall 2016, I applied to the Adler University REB for approval. As anticipated, the REB requested edits and additional information. A REB application was resubmitted with edits and subsequently approved. Once I had obtained approval from YHS, Squamish Nation Band Council, and the Adler University REB, I began my semistructured face-to-face interviews for data collection.

Community member recruitment. In CBR, the researcher should attempt to include the most oppressed members of the community (Boyd, 2014). A purposive sampling approach is recommended for qualitative research (Creswell, 2008). Consultation with YHS yielded the suggestion of utilizing the Squamish Nation newsletter, delivered to every home on the Squamish Nation

reserves in Squamish, West Vancouver, and North Vancouver, BC, as a method of recruiting community members, increasing the likelihood that those marginalized in the community would be equally encouraged to participate (as per Article 9.6 of the *TCPS 2*; Tri-Council, 2014); the newsletter was also posted on the Squamish Nation Facebook page. It is a simple way to reach every home across all of the Squamish Nation reserves. I placed a letter of invitation (see Appendix D), approved by YHS, on the Squamish Nation Facebook page and the Squamish Nation newsletters for the North Shore and Squamish Valley. Community members interested in participating were asked to contact me by my business phone number or Adler University email address.

Unfortunately, recruitment of community members was slower than expected. In an effort to improve recruitment, I discussed changes in recruitment strategies with my supervising faculty and the department head at YHS. These changes in recruitment strategy were supported by Kim Brooks at YHS. With approval from my supervising faculty and Kim Brooks, I applied to the REB for amendments to the recruitment procedures. In March 2017, the REB approved my request for changes in recruitment: delivering flyers in person and using a new flyer. With this approval, I went in person to the Squamish Nation community offices, programs, and events to advertise the research study's purpose by handing out a new flyer entitled "Looking for Participants" (see Appendix E) to staff members and posting the flyer on bulletin boards, in hope of increasing

participation. I made this new flyer in response to community feedback that noted the letter of invitation that was placed in the Squamish Nation newsletter and Facebook page was too lengthy, too academic, and impersonal. This new flyer replaced the previous letter of invitation and was posted in the Squamish Nation newsletters and Facebook page.

I screened for appropriate participants by phone, refusing or accepting their participation, following the script for screening for participants. If suicidal ideation or need for support had been disclosed, I would have referred the community member to the YHS mental health intake worker, or a staff person covering their absence, who would have been available to conduct a suicide assessment, create a safety plan, and connect the community member with a registered clinical counsellor, registered social worker, or registered psychologist on interview days.

YHS hours were Monday–Friday, 8:30 am to 4:30 pm (closed for lunch 12:00–1:00 pm). Interviews took place during these hours, and YHS agreed that the mental health intake worker would free her schedule from 3:30–4:30 pm on days that interviews were scheduled to ensure support was available. If potential participants were actively suicidal, if there was concern of imminent and serious risk to self, or if they were not willing to connect with YHS staff, I would have contacted the Integrated First Nations Unit (IFNU) to gain police assistance. I would also have asked them if they were currently struggling with any personal

crises that required immediate support. If so, I would have offered to them with the mental health intake worker at YHS to be referred to the appropriate supports and would have advised that they could not be included to participate in the study at this time, following the script for screening participants. No potential participants were actively suicidal or experiencing any current crises that required immediate support.

Face-to-face interviews with community members. Once community members were deemed to have met all inclusion criteria to participate, I emailed or hand delivered an informed consent form to their home for their review (see Appendix F). This was distributed at least 24 hours prior to participating in the initial interview to prevent undue influence. It informed participants of what their participation would include, that the interview and feedback session would be audio-recorded, and how their identity and information would remain confidential. Information on mental health supports available in the community and off reserve was included on the informed consent form.

These community members were advised that interviews and feedback sessions would take place at the YHS office or their home, depending on their preference. At the YHS office, confidentiality of participation was not guaranteed, as staff of YHS may see participants arrive and/or leave, and most community members are familiar with one another. Participants could choose to meet in their home for reasons of confidentiality. If a community member preferred the

interview and/or feedback session in their home, I requested that a room in the home be available for privacy from other residents.

I also reviewed the steps taken to ensure confidentiality through the security of data—specifically, how the audio-recorded data would be immediately transferred to an encrypted and password-protected USB drive, which would be stored in a locked file cabinet when not in use, along with the signed informed consent forms and demographic forms. I reviewed the informed consent form in person, and it was signed by each participating community member and collected by myself prior to the initial interview. All community members were also asked if they had any questions.

At this time, I assessed for capacity for the purposes of informed consent. I began by reviewing the informed consent form, followed by the assessment for capacity form (see Appendix G), asking each community member one of the following clarifying questions to help determine understanding of the consent process: (1) Can you choose to stop participating after the interview has begun? (2) Do you have to give answers to all of my questions? or (3) Are there consequences if you choose not to participate? This assessment ensured that their participation was voluntary and provided sufficient understanding of whether there was any impaired capacity to provide voluntary consent.

According to the *TCPS-2*, those who can understand the information presented and the potential consequences are able to participate in research (Tri-

Council, 2014). Community members were asked if they had any questions and were asked to give consent verbally that they agreed to participate. Providing consent verbally and in writing further assured voluntariness. It was also a culturally sensitive approach to participation. During this process, I had further ability to assess each community member's capacity. If community members were found not to have the capacity for the purposes of informed consent, I would have advised them that they were unable to participate in the study, following the rejection script on the assessment for capacity form. Once informed consent was determined, the community member was given the demographic questionnaire, which was reviewed and completed before beginning the interview.

Community members committed to a 1.5- to 3-hour semistructured interview and a 1-hour feedback session. Semistructured interviews have both advantages and disadvantages. One advantage is that they provide the opportunity to gather comprehensive personal information from participants (Creswell, 2008). Another is that asking specific questions allows some control over the information gathered (Creswell, 2008). One disadvantage is that the information collected is the participant's views, filtered through their personal perspective (Creswell, 2008). Other disadvantages are that semistructured interviews take a lot of time, the researcher's presence may influence the participant's response, there can be recording equipment issues, the researcher may need to address emotional upset

of participants, and the researcher may need skills to prompt the participant to share ideas (Creswell, 2008).

Each community member was given a research number at the beginning of the interview. Only myself and supervising faculty know which number goes with which name. No one else knows the community member's name or answers to the different questions. Community members were advised that they could request the use of their real name to honour their story. No community member requested the use of their real name in the findings. At the semistructured interview, I asked open-ended questions and gathered information following the interview script (see Appendix H). Community members were advised that there were no right or wrong answers and all opinions and ideas were encouraged. Community members were also advised that the interview may cause emotional discomfort: They could decide not to answer a question, take a short break from answering questions, reschedule their interview, and/or withdraw from the research at any time. If any community members had chosen to withdraw from the study and requested that their data be withdrawn within two weeks of the interview, I would have shredded their consent form and excluded and/or electronically deleted any of their verbal comments from the audio-recording transcription. No community members withdrew from the study.

All interviews were audio-recorded and transcribed (by either myself or a transcriber), and all identifying information was removed. These data were

immediately transferred to an encrypted and password-protected USB drive. All data (i.e., audio files, transcripts, signed informed consent forms, demographic information forms, professional assistance confidentiality forms, and confidentiality agreement forms) were stored in a locked file cabinet when not in use, and will be kept for five years after the work is completed. After the five years have elapsed, all data will be destroyed by deleting all digital information and shredding all paper data. The supervising faculty, the transcriber, and myself had access to the information collected. The transcriber reviewed and signed a professional assistance confidentiality agreement (see Appendix I), and the supervising faculty and I reviewed and signed a confidentiality agreement (see Appendix J).

Data analysis. Data analysis began following REB approval in fall 2016, and incorporated data from both the interviews and the feedback sessions with community members. According to Guest, Bunce, and Johnson (2006), 12 is likely an adequate number of interviews for saturation to be achieved when the research purpose is to describe a shared belief or behaviour among a fairly homogeneous group. Data saturation is achieved when the researcher is no longer able to collect new information and when further coding is no longer feasible (Guest et al., 2006). Because the goal of this research was to describe a shared belief among a homogenous group, I anticipated that 12 interviews would be adequate for saturation. Data analysis and interviews took place concurrently,

with a goal of continuing until saturation was determined. If saturation had been reached prior to the 12th interview, I would have continued to interview all community members that were scheduled in respect for their time and interest.

I chose thematic analysis because it is flexible, easy to learn and implement, and fits well with CBR (Braun & Clarke, 2006). According to Braun and Clarke (2006), a theme identifies something in the data that stands out as significant in relation to the research question, and highlights patterns within the data set. Researchers may consider themes that run within data sets, across data sets, or both within and across data sets (Braun & Clarke, 2006). For this study, I included themes that ran across data sets, rather than within a data set. I chose this approach to increase the likelihood that findings represented the community, rather than an individual.

I sought a detailed description of the data, as in my study I attempted to answer three specific questions: (1) What was helpful in your healing journey? (2) What supports would you like to see offered to families in the Squamish Nation community after a suicide? and (3) Did the telling and recording of your healing journey change you in any way? Braun and Clarke (2006) named this method theoretical thematic analysis, as the researcher codes the data according to research questions, rather than utilizing an inductive approach which gathers rich predominant themes across participants. Semantic themes, which are explicit in

the data, were coded, rather than looking for underlying latent themes and meanings.

The data were then organized to illustrate patterns in semantic content and summarized. Next, I interpreted these themes and attempted to theorize patterns and their meaning. Theoretical thematic analysis requires the researcher to engage with the literature related to the topic prior to data analysis, to guide the interpretation of themes and their meanings. I had engaged intensively with the literature related to suicide postvention, both within the Western and Aboriginal frameworks, and used this knowledge throughout the thematic analysis.

Braun and Clarke (2006) identified six phases of theoretical thematic analysis, which I followed in this study: familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. In keeping with CBR, and the intention to represent community members' stories correctly, I inserted two steps after defining and naming themes and before producing the recommendations: feedback sessions and reintegration of findings in response to feedback from the community members.

The first phase of thematic analysis involved becoming familiar with the data. I engaged in this phase by transcribing the audio recordings of the interviews or checking the transcripts against the recordings of the interviews, rereading the

entire data set before coding, searching for meanings and patterns, and making a list of coding ideas.

The second phase involved generating initial codes. I decided that codes would be theory driven and be related to the research question. I initially coded as much as possible, keeping the data in context, and some codes fit into more than one theme.

Searching for themes was the third phase of this thematic analysis. I looked for relationships between codes and themes. The fourth phase required the reviewing of themes. I chose which themes to combine, which to separate, and which to discard, and developed subthemes. Themes that had a lot of similarity and overlap were combined, and themes that seemed too broad or diverse to successfully portray the voices of the community members were separated into more succinct themes. Other themes that did not appear to represent the codes well were discarded, and the codes were placed in other themes that were more appropriate or were discarded. Finally, I developed subthemes to highlight specific themes within a theme.

The fifth phase involved defining and naming themes. In doing so, I found that I collapsed more themes together, changed the names of some themes, and identified what was interesting about each theme and why. This approach was based on my knowledge of the literature.

The sixth phase involved feedback sessions with each community member. After defining and naming the themes, I met with each community member to ensure that the chosen themes represented their stories. Feedback sessions took place at YHS or at the community member's home, depending on their preference. At the beginning of each feedback session, I reviewed the informed consent form and the assessment for capacity form. If any community members had been found not to have the capacity for the purposes of informed consent, I would have advised them that they would be unable to participate further in the study, following the rejection script on the assessment for capacity form. All community members assessed were found to have capacity for the purposes of informed consent.

After capacity to consent was determined, I followed the feedback session script. The feedback session provided the opportunity for community members to provide clarifications, feedback, or revisions prior to the finalization of the results. First, I reviewed the themes I found in their story. All the community members agreed with the themes I chose to highlight their story of healing and the suggestions they had for suicide postvention in the community. Second, I asked permission to use specific quotes from their story to highlight themes in the findings. Community members were advised that because the Squamish Nation is a small community, it was possible that certain sentences used or certain kinds of information included may put them at risk of being identified by people they

know. Two community members requested minor edits to quotes that they approved for use in the findings; one was made to sound less blunt and the other was to identify a cultural piece with wording that felt more fitting.

At the feedback sessions, I also asked community members if their participation in this research, specifically telling the story of their loss and healing journey, had affected them in any way. This question was suggested by YHS, as the telling of one's story may traditionally be viewed as healing. Feedback meetings were recorded, and the data from the feedback sessions was analyzed and stored in an identical manner as the data from the interviews.

Phase seven focused on the reintegration of findings in response to feedback from community members. As noted above, all the members agreed with the themes I chose to highlight their story of healing and the suggestions they had for suicide postvention in the community. Therefore, I determined that revisions to the initial finding of themes was not needed. I made the requested minor changes to two quotes that were requested by two members. Finally, I transcribed answers to the last interview question asked at the feedback sessions ("Did your participation in this research, specifically the telling of your loss and healing journey, affect you in any way?"), and these new data were analyzed and shared in the findings.

I took several steps, suggested by Kazdin (2003), to minimize any influence my perspective may have on the findings. From the outset, I stated my

preconceived views and orientation related to suicide postvention for survivors in the community via a journal. I also told each community member at the start of the interview that my work supporting grieving families, and my academic studies, have led me to believe that the best support is often a blend of both dominant mental health supports (e.g., counselling) and the Aboriginal wellness model (e.g., house cleansing). I also shared with each community member my awareness that I represent the White population, which has been historically oppressive, and that my objective as a researcher was to understand their perspective on healing without oppression or the colonizing of their responses. In addition, I noted in the results section how my expectations were or were not met throughout the research process. Transparency regarding my views and reviewing the findings with community members increased the dependability and credibility of the findings.

Dissemination of findings. Finally, for phase eight of thematic analysis, I have produced a written report of the findings outlining themes related to healing after the loss of a loved one to suicide. In accordance with CBR, the findings should be shared with those who can promote change and enact planning within the community (Creswell, 2008). Therefore, in 2018 the report will be shared with YHS, the Squamish Nation Chiefs and Council, the community members who participated, and other recipients identified by the research team. I may make a

request to Squamish Nation Chiefs and Council for the findings to be published or shared elsewhere.

Ongoing journalling. I used ongoing self-reflection via regular journalling to identify any concerns related to misuse of privilege. Regular journalling allowed me to reflect on my thoughts and feelings about situations that arose throughout the research process. Much of my journalling was around ethical issues; specifically, how to walk in the academic world and Aboriginal world at the same time, ensuring that my needs as a researcher did not oppress the community in any way.

Chapter 4: Results

The purpose of this chapter is to present the results of this study; namely, "What helps Squamish Nation members heal after the loss of a loved one to suicide?" Themes and subthemes identified across the data are described. Quotes by community members are provided to further illustrate the themes and subthemes. It is important to note that these themes do not exist in isolation but are interrelated.

Before I describe the themes and subthemes that were found, I highlight three topics that may help the reader to contextualize the results: factors that may have influenced participation, journalling by the researcher, and a theme of multiple loss that arose among members' stories.

Factors That May Have Influenced Participation

Although I had hoped for a minimum of 12 participants, eight community members were interviewed for this study. All community members who participated lived on reserves in North and West Vancouver; there was no representation from the Squamish Valley.

Many factors may have influenced participation. First, the loss of a loved one to suicide is a difficult topic to discuss, and many may not want to share their story, especially with a White researcher who is not a community member. Second, three potential participants did not pass the inclusionary criteria, as they had lost their loved one to suicide more than 10 years ago. Third, most of my

work with the Squamish Nation has taken place in North and West Vancouver. I have stronger relationships and connections with members residing on reserves in North and West Vancouver than I do with Squamish Nation members living in the Squamish Valley, which may have influenced participation. A fourth consideration is there were several losses in the community during the data gathering stage by fentanyl overdose and natural causes, as well as suicide. Two booked interviews were cancelled due to these losses. As well, many community members no longer met the inclusionary criteria of not losing a loved one to suicide in the preceding 6 months. In respect for the community's loss and grieving, I decided that eight interviews were sufficient and stopped advertising for participants.

Journalling by the Researcher

As noted in Chapter 3, I journalled throughout the research process to help avoid misuse of privilege and to identify and address any ethical concerns that arose. At times my chair and I referred to this research process as an "ethical minefield," as questions consistently arose about how to manage walking in both the academic world and the First Nations world in an ethical manner. I have not shared all the concerns that arose, but I do share a few that stood out for me.

One of my first concerns occurred when I met with the Elders and did not provide a handshake (honorarium). This troubled me; as a professional working in the community, I had always given the Elders a handshake for their participation.

However, I did not have any funding for this study and was not in a financial position to offer handshakes. I contacted the department head of YHS to consult on this matter, and she advised that a handshake was appropriate in this situation. Therefore, I began to search for funding and asked YHS for a letter of support. YHS generously advised that they would offer funding to support the following research costs: handshakes (honorariums) for the Elders, transcription of interviews, and travel costs for me to visit Elders in Squamish Valley, attend interviews, and attend meetings with YHS or members of the research team.

I discussed the ethics of accepting funding from YHS with my supervising faculty. We agreed that accepting the funding was ethical, as it supported research costs and was not for my personal monetary gain. I applied to REB, which approved my acceptance of the funding. Receiving funding from YHS was very helpful and much appreciated. At the next meeting with the Elders, I provided them with a handshake for the previous meeting and the current meeting. I felt much better knowing I was approaching the research process in a traditional way.

Another concern that arose was related to recruitment of participants. Numerous times community members asked me if I had asked specific people to participate. I explained that I was not able to approach people to participate, as it could be viewed as coercion, and it was a REB requirement that people must approach me themselves. Typically, I would approach people directly to request their participation for an activity in the community, so this concern of coercion

felt awkward, and almost impolite, at times. I worried that some community members may be wondering why I did not ask them to participate, as I had been their support person after they had lost a loved one to suicide. Therefore, I was quite overt about the fact that I could not approach anyone directly to request their participation. My hope was that word would spread and no one would be offended that I did not approach them.

In addition to my concern for others' perceptions, I was also concerned about the low number of participants. I was often frustrated by the binds of research ethics that did not permit me to walk in the community the way I was used to and was potentially limiting my ability to recruit enough community members to make the findings valuable. Yet, I understood the purpose of this restriction and in no way wanted to coerce any community member to participate. In hindsight, perhaps the recruitment flyer should have explicitly stated that I could not approach anyone, easing my worries and any potential confusion in the community.

A third concern that arose was regarding the description of cultural practices. During interviews, several community members referred to cultural practices that helped in their healing. For example, they said they would go to the mountains, have a bath, or attend the longhouse. I struggled with whether a description of these practices was needed for the findings. Could I simply include these practices without explanation? Why should I provide explanations of

cultural practices that have been threatened by colonialism? By providing a description or explanation, I felt I would be sharing traditional knowledge without the permission of the community. I would be sharing information about practices they historically have had to hide to protect. Is it my position to share that information? I do not feel that it is, if it does not meet the purpose of the research.

During interviews, I wondered if I should interrupt and ask members to explain what these cultural practices are, to have the descriptions in their own words. I tried that approach and I felt exploitive. In the end, I do not believe that providing descriptions of traditional practices would help the community or meet the purpose of this study. The purpose of this study is to assist YHS in developing suicide postvention supports, and the staff at YHS understand what these traditional practices are. Therefore, I have chosen not to include descriptions of these practices in my findings in respect for the community.

The last ethical concern that arose was regarding recruitment. I advertised for participants from December 2016 to May 2017. During this period, a high number of deaths occurred due to fentanyl overdose, natural causes, and suicide. As the number of deaths increased, the effect on the community was palpable. The community was grieving as I was advertising for participants to discuss their grief and healing. As the number of deaths increased, I began to feel uncomfortable with advertising any further. I did not want to put my hope for more participants over the needs of the community. I did not want to be

insensitive to their grieving and need for support. Although I was researcher in the community, I was also a counsellor providing grief and loss support, and I could sense first-hand how the community was struggling. Therefore, I decided to stop advertising for participants.

Multiple Loss

The theme of multiple loss is separated from the other themes, as it does not answer the research question, but I considered it a prominent theme that was important to include for contextualizing the results. The experience of losing multiple loved ones stood out across the stories of six community members. Some members noted multiple loss of loved ones to suicide. Others noted losing a loved one while still in the process of grieving for another. Below are statements from three community members that describe the theme of multiple loss:

> And it said, ah, grief and loss counselling is now being offered to the Squamish Nation members. And that's when I knew, that I need this. I need this! And at that time when we lost four young people in the community, from suicide and they're all in their twenties, and um, I knew that I had to at least try. (Member 1)

> So, we average 32 losses a year, and there's ebbs and flows, ah, he told me at that meeting, every 10 years you're going to have 50 or more. So, it was almost like every week, and true to form, about every 10 years we have, ah, major losses. (Member 4)

> And I think she said there's about six, six give or take, males in our family that have committed suicide, and they're all around 30, and he was the most recent one. And you know, um, it started to make me wonder, you know, what's going on? (Member 6)

The experience of multiple loss, and the effect this has on mental health, should be taken into consideration when considering the findings and implementing suicide postvention supports.

Identified Themes and Subthemes

The first two interview questions were (1) Can you tell me about your experience losing a loved one to suicide? and (2) What was helpful in your healing journey? Reviewing community members' answers to these questions, I identified five themes of healing: healing self, social supports, formal community supports, wider world supports, and culture. In addition to identifying supports that helped in their healing journey, I asked community members a third question: What supports would you like to see offered to families in the Squamish Nation community after a suicide? Recommendations made by members are also included within the five themes of healing. Figure 1 illustrates the interplay within and between the themes, with each ring in the circle influencing the others. Each theme envelops three or more subthemes, as illustrated in Table 1.

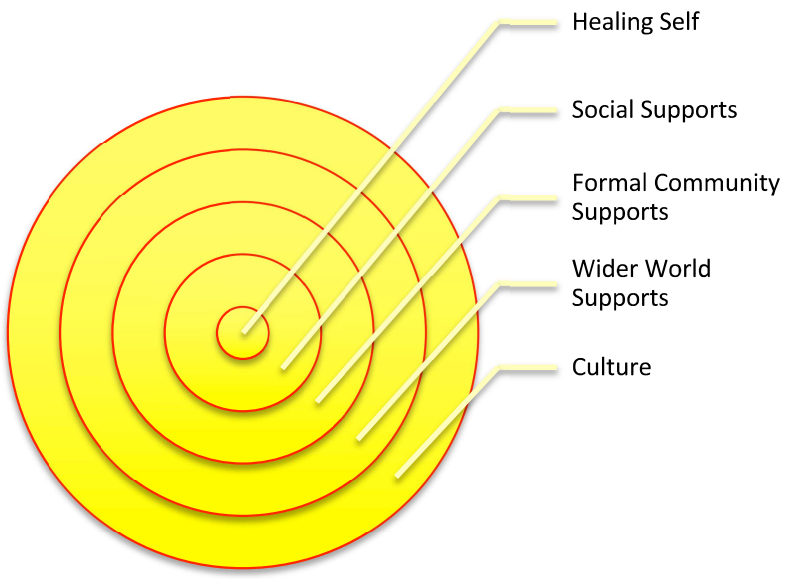

Figure 1. The interplay within and between the five themes of healing.

Table 1

Themes and Subthemes

Healing self	Social supports	Formal community supports	Wider world supports	Culture
Acceptance	Family stand together	Alternative healing	Off-reserve supports	Following the teachings
Day to day	Connecting with others	+ Counselling	Collaboration with service providers	Sharing the teachings
Sense of purpose	Help from community	Wellness centre		Get the tools back
Still with us		Ceremony		
Coping activities		Church		
* Helping others		Health workers' presence		
		Suicide prevention		
		Get the people involved		

* Noted by all community members as helping in their healing.

+ Recommended by every community member for future postvention planning.

Healing self. I identified healing self as a theme after noticing a pattern of intrapersonal processes that indicated healing. When community members described what helped in their healing process, there was reference to their

personal internal experience across all their stories. This theme refers to healing that took place within the self, rather than external supports that helped with the healing process. Several different intrapersonal factors formed the following subthemes: acceptance, day-to-day coping, sense of purpose, still with us, strategies, and helping others. Each subtheme is described below and quotes from interviews are provided to illustrate the subtheme.

Acceptance. Acceptance was a subtheme in the story of community members. How members perceived the loss played a large role in their healing journey. Arriving at the place of accepting that their loved one had died by suicide and was not coming back was noted by members as healing. Members often referred to acceptance as letting go of the loved one and being ready to move forward in their own lives. "And I think this is very important for your study. Is getting people to the point where they're willing to let go. And what I mean by that is to come to terms and accept" (Member 1). Member 2 also described the role of acceptance in the healing process:

> It's just accepting it. Figuring out how to move forward. . . . You wonder, there's always wonder left. There's always going to be, why? There's always going to be, what could I have done? Could I have done anything? Um, but on that healing journey, you really find out no, there isn't.

Day-to-day coping. Members referred to the idea of taking things "day to day." The overwhelming emotional pain and loss experienced throughout their

healing journey, the unpredictability of how they would feel each day, and the recognition that grief is a process and people take time to heal were also important. Community members shared how they took things day to day in their self-healing process. “It’s a day-to-day thing. Sometimes it’s hour to hour. Sometimes it’s wake up in the morning, ‘Good morning, Son.’ Other mornings it’s, ‘God I miss you, Son’” (Member 1). Member 5 said, “Um, it’s learning to live day by day without them, you know, learning to accept it.”

Sense of purpose. In addition, a personal sense of purpose was helpful for two community members. As described by Member 1, a sense of purpose was found by choosing to take steps towards healing, specifically when seeing grief and loss supports offered in the community (local newsletter). The choice to work on healing after the loss represented a choice to “get busy living,” offering a sense of purpose:

> I think the watershed moment was when, when after I read that ah newsletter, and thinking about it, sitting on my couch, looking around the room. And um, I’m either going to die in this room, or I can get out and do something. ’Cause it all came down to, you know, that particular moment where get busy or, get busy living or get busy dying. . . . Ah, and that’s the key point that I really wanna emphasize is, ah, um, getting out of the bubble, getting out of the comfort zone, the grief zone, you know where you’re, you know, you’re very protective of yourself, but taking that leap

> of faith. And um, yeah, it's gonna hurt. But you're hurt anyway! Right? You're hurt anyway! . . . I found that, cause once, once you join this healing journey, this, when you embark on it, um, it gives you purpose. (Member 1)

Still with us. A positive outlook on the journey of their loved one after they passed was also noted as being a part of community members' self-healing. Three members shared a belief that their loved ones were in a good place and were still with them. Below are statements made by two community members that support this subtheme:

> And I'd walk by the long house and, at that time the long house was open. So I could hear the drums, right, I could, you know it just oh my god. You know, so I'd walk by the first couple times and the third time I heard my son whisper, "Come in, Dad." (Member 1)

> And knowing they are still with us in spirit. They may not be physically, but they are always still with us. That keeps me going. . . . I just thank the Creator today they are not suffering for whatever it was, why they took their lives. That they're not suffering no more, that they're happy. (Member 5)

Coping activities. Coping activities was a subtheme in the story of five community members. This theme refers to activities that members used to help cope with their healing. Activities ranged from knitting, to walking, to the use of a

Facebook memorial page. These activities were self-developed, rather than discovered through professional supports. Statements from three community members describe the role of coping activities in their healing process. Member 8 commented, “I said we need to stop this! We need to focus and we need to start going for walks every day. So, we started going for walks every day.” Another member said,

> One of [loved one’s] friends generated a Facebook page. In memorial of [loved one]. So that’s what I’ve been using, you know, it’s not necessarily what, how I’m feeling about [loved one] is how I’m feeling in general. And in looking back every now and then you go back, and, you go yeah, yeah, I remember that day, ya know, it was tough. (Member 1)

Finally, Member 7 noted,

> I think that was the hardest part, was like healing my own self and making myself go to different like workshops, and oh I should go there, and oh I should take [friend] there, or just keep myself not thinking of him all the time.

Overall, community members indicated the use of different coping activities to help them through their grieving process. This information is helpful in highlighting that everyone is different and activities that help may be unique to the survivor.

Helping others. Helping others was a subtheme in the story of all eight community members. This was the only subtheme among the results that was identified in the story of every member interviewed as something that helped in their healing. This theme refers to the desire to help others, and how the act of helping others was seen as inherently self-healing. Below are statements from two community members that describe the role of helping others in their healing process.

> If I can help out one father, or change the mind of one kid, or a person, um, you know to fight through the day . . . 'Cause I swore on my son's grave, that if anybody, anybody reaches out to me for help in that way I will be there. And I have! And, um, you know, getting people to listen, or just listening! Right, just say, "Yeah man, I know exactly how you feel." . . . And ah, you know, walking away from stuff like that is um—. . . it strengthens my spirit. (Member 1)

> The Creator won't give you what you can't handle. Maybe down the road one day you'll be helping somebody out in this situation you are in today. Somebody said that to me and it really stuck because I've grown a long way, with my life period. From a lot of struggles and mentally, emotionally, and physically abusive situations where I have helped people be, helped people just by being there present, or shared my story with

> them, by, and help them get through the same situation I went through once before, right? (Member 5)

Member 1 also shared how since the loss of a loved one to suicide, other people who have lost a loved one to suicide have reached out for support:

> I've had friends of friends, or acquaintances, friends of acquaintances, that would Facebook me, or call me, and say, "Yeah, your buddy Jo Smith told me what happened and, ah, you know I've lost a loved one, um, do you mind, do you have a couple minutes"?

The theme of wanting to help others was also evident in the members' participation in this research. Members indicated hope that the sharing of their story of grief, loss, and healing would help others. Statements from community members that describe this hope of helping others by sharing their story include Member 5's comment: "I hope, you know, sharing my story will help other people, you know." As well, Member 2 said,

> And, so being able to talk about stuff like this even, is still my informal way of being able to tell my story and tell my kids that it's okay. It's okay to hurt, it's okay to grieve, it's okay to tell your story, and whatever arises from it, that there are ways to get through it in an adult way, in a healthy way, in a safe way, instead of letting the anger build up or, you know, having the outbursts.

Overall, healing self through themes of acceptance, day-to-day coping, sense of purpose, still with us, strategies, and helping others was helpful for suicide survivors.

Social supports. When I asked community members what helped during their healing journey, I found a theme of accessing social supports across all their stories. Three types of social supports stood out, which I separated into the following subthemes: family standing together, connecting with others, and getting help from the community.

Family standing together. Family standing together was a subtheme of social supports. This subtheme includes comments related to a focus on family, being together, and standing with your family by your side during the grieving process. Member 1 described how family standing together helped in the healing process: "Well, for me it was narrowing my focus on my life and, worrying about, um, [coughs], you know my grandson, my mother and father." Member 8 said,

> I says, we have to stand together as a family, and we have to sit there as a family, and we have to support one another as a family, and we have to be quiet as a family. This is no joking around, no talking, this is just be quiet, listen, learn, I says, and calm your spirit. I says, everybody needs to calm their spirit. I says, you know, there's a time to grieve and a time to let go of those feelings.

Leaning on family for support through the grieving process, rather than isolating oneself, was also noted as healing. Member 5 described the importance of remembering to lean on family for support when grieving: “You know, you’re not alone, right? There’s, you’re never alone, and that’s one thing I stress out, you know, you’re never alone, never feel alone. There is sources out there, there is family that love you.”

When asked why being with family was helpful during the grieving process, Member 6 highlighted the power of common experience:

> Just because everybody’s like grieving and going through the same thing. And has understanding and that love and support, you know. Um, and can under, can relate to, relate to each other, you know. It’s ah, I think it’s just a part of the healing process.

Connecting with others. Connecting with others was another subtheme across the stories of community members. This subtheme highlights how being with others and receiving their support and care is healing. Although similar to family standing together, this subtheme differs as it involves reaching out or accepting support from others outside of the family, rather than isolating oneself. It includes connecting with others who understand and others who have also lost someone to suicide. Therefore, it is considered a social support, as it is not a support from within oneself. Member 5 stated, “I talked. I talked. I didn’t hold it in. I talked to everybody. And how it affected me, just to release in my own

ways." Another statement from a community member that describes how connecting with others helped in the healing process came from Member 2:

> That's an interesting thing because I'm such an introvert, and I'm such a hermit that, um, I had to actually seek out people that understood my way of living, and that, I ended up finding a few people that . . . kinda, weren't going through the same thing but were going through stuff. That we could just sit there, and socialize, and know that we were going through stuff and be able to just blurt shit out and, and then just, you know, didn't have any expectations.

Connecting with others who have lost a loved one to suicide was also a form of social support for community members. This strategy refers to members seeking others who have experienced the loss of a loved one to suicide, and how talking together about that common experience was healing. Member 2 shared how this was important for healing:

> It's hard to talk to people that are going through it. I wanted to talk to people that went through it, but my peers were all going through it. So, it's okay to talk, like I tell my children, it's okay to talk to people that are going through it, but you need to talk to people who have gone through it. So that they can share their experience that helped them get through it, not to people who are still trying to figure out reasons or ways of getting through it.

Help from community. Help from community was also a theme among community members. This subtheme differs from family standing together and connecting with others as it involves a larger community response. Community members often gather after a loss to show support for the family. This community support may not involve direct interaction but simply gestures of support such as gathering together, bringing food, singing, and drumming. This subtheme included statements related to how acknowledgement and informal help from the community was beneficial to the healing process.

> The community was really scared for us at the time because it was the toughest, I swear the Creator gave us the biggest challenge . . . the community was totally helpful. And yeah . . . yeah, the community totally was. You never know how many people actually care about you until you're in a tough situation like that and the whole community is worried about you. That's a perfect example, showing that, you know, you are loved, in a situation when you're feeling that you're not loved. Yeah. Like that you're the only person, but you're actually not. (Member 5)

Member 8 shared how the help of the community was beneficial for a family member that was healing after the loss of a loved one to suicide. For confidentiality, the name of the community has been removed from this quote.

> The community of [XX] opened up the gym so people can go there and share a meal and be with [the loved one's family]. And what really helped

> her [loved one's family member] was the community getting together and eating together, and drumming and singing. She really, really liked the drumming and singing. And it helped calm everybody down. Um, incorporating the traditional songs, um, during the grieving process, sharing a meal with everybody and everybody just brought food. There was a constant flow of food and you know, beverages, juice, water. So the gym was always open. So that was a gathering place. (Member 8)

Formal community supports. When I asked community members what helped during their healing journey, and what supports they would like to see offered after a suicide, I identified a pattern of accessing and/or recommending formal community supports across all their stories. Formal community supports differ from social supports in that they are offered by workers whose role or job it is to provide the supportive service. In addition, these supports are typically available for all community members to access.

It is important to note that my prompts included questions such as "Did church or religion play a role in your healing," and "Did counselling play a role in your healing?" Formal community supports accessed were separated into the following subthemes: alternative healing, counselling, ceremony, and church. Formal community supports recommended include the following subthemes: alternative healing, counselling, wellness centre, health workers' presence, suicide prevention activities, and get the people involved.

Alternative healing. Alternative healing was a subtheme in the story of two community members. Alternative healing is a common term used in the community for non-Western ways of healing. For example, YHS offers referrals to the following alternative healing services: bio-mat, brushing off, massage, reiki, shamanic, and naturopathic. Member 2 described the role of alternative healing in the healing process:

> I do alternative healing myself. That is a culture in itself, because I utilize different modalities from different cultures. So, when you say culture to me, I don't refer to my own culture, I refer to other cultures that have helped me get through what I've been through in a different capacity. So I've used that alternative healing, of aromatherapy, Hawaiian healing, Japanese healing with reiki, the reflexology.

Two community members found alternative healing helpful in their healing journey, and two community members (one that indicated alternative healing as helpful and one that did not) recommended that this access be expanded in the community. Statements from community members described the array of alternative healing supports they would like to see offered to families in the community after a loss to suicide. Member 2 suggested offering "access to, ah naturopaths and um, different modalities of alternative healing like aromatherapy um, reflexology, massage, ah Reiki, all the different, there are so many different modalities that help people!" Member 4 commented, "Not only within our own

tradition, the broadest traditions in terms of acupuncture, whatever, um, worldly traditions there are out there that have their way in uh Mother Earth or spirituality." Overall, only 25% of the community members found alternative healing helpful or suggested it for future suicide postvention.

Counselling. Counselling was a subtheme in the story of six community members. This subtheme refers to mainstream models of individual or group counselling with a registered clinical counsellor, registered social worker, or registered psychologist. Member 2 stated, "I experienced some counselling after that because I, because I didn't know how to feel. And, I would get angry and then I would cry and, and then I would get angry." Another statement that described the role of one-to-one counselling in the healing process came from Member 4:

> I think back then I was going to therapy because of the multiple losses, I found a way to find support. And I knew we were in one of those peak years, so, so I found some support during that time.

Group counselling was identified as playing a role in the healing process of three community members. These members attended a 6- to 8-week grief and loss group based on cognitive behaviour therapy that I facilitated at YHS. I facilitated several grief and loss groups between 2011 and 2015. Over this time, each of these members attended two or more 6- to 8-week rounds of the grief and

loss group. Below are statements from two community members that describe the role of group counselling in their healing process:

> And ah, each session was about three hours, and um, that in itself was the Mount Everest. For me. And um, what it is, is uh, you know, and they tell you up front that um, this is gonna hurt, but this is gonna hurt in a way that's, you know, you're—you're wounded. So now is the time we, we can go as slow as you want or as fast as you want. That's up to you. Everybody's different. And I'm like, okay. [Clears throat.] And once I jumped in, I jumped in. And um, as time goes on, without it I don't know where I'd be right now. (Member 1)
>
> I did a lot of counselling here. Did suicide workshops to help me get through it. . . . Also thankful for the people that pushed me to. You know, they'll be like, this workshop's coming. Because at first when I was really weak and wasn't me, I was lost. You know, I had family and friends that pushed me to go to these workshops. You know. And I never thought that it would help, because I wasn't all there, right? But I took to it like a sponge and it, you know, it helped me. And it brought me to where I am today, and I'm really thankful. You know, not just for my culture, I'm thankful for these because it probably woulda, it saved my life, I really truly, dearly believe it saved my life. (Member 5)

Member 3 attended more than one 6- to 8-week group counselling session. When asked to explain, Member 3 said, “I think I attended four . . . six weeks . . . cause I picked up on something that I’d missed the first time going there.”

In addition to sharing which supports they accessed, community members made several recommendations for community supports that they would like to see offered for suicide postvention. Psychoeducational workshops and group counselling were recommended as a suicide postvention support by five community members. Community members described supports they would like to see offered to families in the community after a loss to suicide, including “more events, maybe? . . . I dunno, more events that work around depression and suicide” (Member 3). Member 6 said, “I like that idea that they did recently, when they had a workshop or something, and it was, it was some kind of grieving workshop. Where like, um, a part of a healing, ah, and moving forward workshop.”

Two community members made recommendations for family sessions as a suicide postvention strategy. They indicated that families could benefit from immediate professional support after a loss by suicide, suggesting support similar to a critical incident stress debriefing. Below are their statements describing the supports they would like to see offered to families in the community after a loss to suicide.

> It does come down to you, yourself and your grief. But if you have a family and you're in a household and people live with you, I highly recommend that they at least go to one session as a family, not separate. Where they can express their feelings, they can say, "You know what, Dad, my brother's gone. Why did you talk to him like that?" You know. I mean, all these feelings can come out in a safe place. And, ah, and not be violent. (Member 1)

Later in the interview, this same community member added,

> You know, most rational, most decent people, if you went to them and said, "Yeah, XX came to see us and, um, I'd like to ask if the family can come in and, or we can come to you." Right. And I think within our culture that's, that's important, to at least offer, right? (Member 1)

Member 4 also recommended family counselling sessions:

> And sometimes, I think it would be beneficial to have the core family almost have a debriefing among themselves. And that's gonna be, I know it's going to have its inherent challenges, knowing my families. Cause not everybody will come. Not all families get along. I think at the core, the core issue, even if it's just two or three people, to find a way to support them to begin that work, immediately.

Recommendations were also made for ongoing family sessions that include support for children:

> Whoever's doing this work, support work, can continue. Because things move very fast, and somebody needs to be there to follow up, on an ongoing basis, from the critical incident debriefing onward. And if people continue to go, as individuals or as family, then I think that would be an opportunity people could be afforded to, help them move on. Especially kids, you know. Especially the kids. (Member 4)

Ceremony. Ceremony was a subtheme in the story of five community members. This theme refers to community members attending ceremonies that occur after a loss, such as funerals, memorials, and burnings. The ceremonies referred to here are a support held by and for the community, not something one does alone. Traditional workers and other professionals assist in the implementation and facilitation of ceremony. Community members found that these community supports were helpful in accepting, letting go, and moving forward. Below are statements from three community members that describe the role of ceremony in their healing process. First, Member 4 discussed how funerals are for supporting those that are grieving: "Yeah, yeah, it's all about us that are left. That's what I found. Supporting the way to help people move on."

Another member discussed the difficulty of attending a memorial, as well as the role it played in healing:

> Yeah, it was, it was hard. It was, it was hard. It was like, it was hard at first. I was dreading it, I didn't want to do it. I was dodging my family left,

> right, and centre. But when the day actually came, I did it. Participated in it more, and um, it's a lot of planning to do a memorial. But it was, it helped me release a bit more and accept the fact that, you know, he's never coming back, obviously. But uh, best way to explain is a lot of the heaviness is gone and weight off my shoulders kinda thing. (Member 5)

Last, Member 8 explained why attending a burning was a healing experience: "The burning is healing because the traditional spiritual workers are able to speak to the spirits." I do not specifically detail this ceremony here in respect for protecting the traditional knowledge of the Squamish Nation people. This decision is in line with Article 9.8 of the *TCPS-2* (Tri-Council, 2014), which states that researchers must ensure the respect for community customs and codes of practice.

Church. Church was a subtheme in the story of four community members. This subtheme falls under community supports as churches are a formal community support offered by workers whose role or job it is to provide the supportive service. In addition, these supports are typically available for all community members to access. Community members indicated that churches both on and off reserve were a helpful support that they accessed. Members spoke of attending the Shaker Church, the Catholic Church, and the United Church, as well as attending random churches to feel a sense of healing. Statements from three community members mentioned churches when asked what helped in their

healing process. Member 3 mentioned “The Shaker Church. After . . . after being in my room . . . yeah.” Member 5 also mentioned the Shaker Church, noting that it “helped me, that’s helped me cry. And taught me how to pray. Prayer got me a looong way. Pray every day, pray every morning, for all my loved ones, for, to all my ancestors. Yeah.” Finally, Member 7 stated, “It was the church that helped me through.”

Wellness centre. In keeping with the themes of alternative healing and Western supports as helpful for healing, recommendations for the creation of a wellness centre in the community was a subtheme across three community members. This theme refers to the idea of a centre that offers both Western counselling supports and alternative healing supports on site. Statements from three community member participants described how they would like to see a wellness centre in the community for members to go to for healing after a loss to suicide. Member 4 stated, “Well, my dreamboater would be to go back to the Esemkwu Healing Centre. . . .The opportunity for the best of both worlds, science and culture and medicine and tradition.” Member 7 noted the benefits an onsite wellness centre provided: “Even if I talked about something else, it would let go of some of the hurt when I’d go down there [Unnamed Healing Centre].” Member 2 commented,

> You know [clears throat], I really appreciate, I truly believe in alternative healing, but I don’t believe that it can completely be done without Western

> medicine at the same time. I think they complement each other, um, in a healing path for people because each person needs a different path in order to get to their goal. So creating a centre where they have both, um, ways, being shown to them? Per se. Yes, we need our serotonin level to be a certain way in order for us to be able to learn how to feel good. But we also need that, um, different ways to look inwards to be able to project outwards. So, needing that alternative healing and different modalities help different people in different ways, again. So being able to offer different modalities to people and also being offered that Western way of life.

Health workers' presence. Recommendations for the presence of health workers from YHS was a subtheme across seven community members. This theme refers to the outreach response by health workers from YHS after a loss occurs; community members suggested improving YHS services by increasing the presence of health workers in the community. Below are statements from two community members that describe the supports they would like to see offered to families in the community after a loss to suicide.

> I think that they do outreach like in the event of, of a person dying, whether it be suicide or not. The, you know, afterhours mental health workers or someone will come and say, "We're here, here's our card," you know, give support to the family. I think um, ah, there should, I'm not sure

> how that works exactly, but I definitely think there should be people like on call like that during the weekend. . . . Just to say, "These are our services," or what the afterhours services are available to the nation members. Because um, you know, um, you never know when someone is going to pass away or anything like that. And I think prevention is the most important thing, . . . 'cause you can lose another one during that time, right? (Member 6)
>
> Well, if there's a suicide in the family, you know, I really like the fact that, you know, there's an open door for a clinical counsellor and a worker to go into the home and just be there. Just be present. The presence weighs a lot of value to families that are in grief. They may not want services at that time, but presence and being visible is really important to our Aboriginal culture, because it's acknowledged. You know, they acknowledge when somebody comes in the door and stands beside them. You know, it's all about standing beside the family, and it's not standing outside and looking in the door and saying, "Well, are you not going to ask me in the door?" It doesn't work that way. (Member 8)

Below are statements from two community members that describe the supports they would like to see offered by YHS to families in the community after a loss to suicide.

> You know, it's kind of like offering somebody half a sandwich. Right. You know, they're hungry, and you give them a half a sandwich. Yeah, you know, it gets you through the moment, but at the same time, you know, um, I'm not saying you gotta have a feast but uh, you just can't have your workers spread thin like that. So I think my highest recommendation is more staff. . . . I don't know if it's a booklet or some form of communication that can let someone know, right. Uh, having it on the world-wide web, you know, having a five-minute, um, not promotion but, showing the office space, showing the people, your success rate, you know, why you're here. Squamish Nation had lost a few native youth in the last little while, and uh, putting them at ease and they feel welcome before they even walk in the door. (Member 1)
>
> I think somebody should at least not be friends for now and then forget about you, you know. Like, we're here forever on this reserve and I think, with the ladies we're talking about, is that it would be nice for the Elders get to know the health workers. (Member 7)

Suicide prevention. Another recommendation for a community postvention support was the implementation of suicide prevention activities in the community. This desire for more suicide prevention activities was a theme across four community members. The theme of suicide prevention refers to any activities that were suggested to act as preventive measures, including suicide prevention

and intervention training and cultural events. Below are statements from two community members that describe the suicide prevention activities they would like to see offered in the community after a loss to suicide. Member 6 described a sense of helplessness that can occur when a loved one discloses feelings of suicidality:

> For a community member it's like, okay, what do you do? What do you actually do? You know, when they are opening up to you and saying that they're having this issue. You know, you wouldn't know what to do, right? . . . I think another good, um, support would be like suicide prevention workshops.

Another member described the implementation of cultural activities as a suicide prevention strategy:

> A lot of the, a lot of the cultural things, you know, are very strong. If, if the community can actually get together, I'm talking Squamish as the community, get together and start enforcing the traditional gathering . . . you know, and have that available all the time. Not only when somebody passes away. They always bring the people up to the centre at the funeral to do a song. I says get the people out to do the drumming and singing, you know, and get the people involved. (Member 8)

Get the people involved. Recommendations to get the people involved was a subtheme across four community members. Community members stressed the

desire for more community events—social, recreational, and cultural—to bring people together. As noted in the suicide prevention activities theme, Member 8 suggested to "get the people out to do the drumming and singing, you know, and get the people involved." Member 3 described "maybe more, like outings or, walking groups, or support groups" as supports that could be offered to families in the community after a loss to suicide.

Overall, alternative healing, counselling, a wellness centre, ceremony, church, health workers' presence, suicide prevention, and getting people involved are all strategies that community members recommended for future suicide postvention planning.

Wider world supports. Wider world supports refers to formal supports that are not based in Squamish Nation communities. When asked what helped in their healing, or what supports they would recommend for suicide postvention, five members indicated an openness to accessing supports that were outside the community. Their stories included an openness to both Western supports and traditional supports from other Nations. I identified two subthemes under this theme that encompass wider world supports that were helpful, as well as those recommended for future suicide postvention planning: off-reserve supports and collaboration with service providers.

Off-reserve supports. Off-reserve supports was a theme in the story of four community members. This theme refers to supports that members accessed

outside of the Squamish Nation community, as well as off-reserve supports that come into the community to provide support after a tragedy. This theme illustrates an openness to accessing supports offered by non-Nation members off reserve, as well as non-Nation members coming onto reserve. The supports often represent the dominant system that has been historically oppressive. In addition, this theme highlights an openness to accessing supports offered by other First Nations. Below are statements from three community members that describe the role of off reserve supports in their healing process. Member 1 referred to attending a grief and loss support group off reserve: "I went to a couple of sessions that wasn't Squamish Nation and, uh, you know, they've plugged into different areas that we never did."

Another member referred to the IFNU, an integrated off-reserve policing unit established between the West Vancouver Police and the Royal Canadian Mounted Police, that comes into the community to provide culturally sensitive support as needed, and the relationship that has been built with them.

> Yeah, and I think, um, we've some great strides with the integrated unit [police] culturally incorporating them I think has taken a long time. And I think they're, they are more sensitive to, to the cultural side of Squamish or Salish or whoever. Now many I have talked to who have moved on said they found it the best experience ever. (Member 4)

Finally, one member indicated that attending a church off reserve was helpful during the healing journey: “And I got to know another church, the United Church, that helped me through” (Member 7).

There were also recommendations for utilizing off-reserve supports for helping grieving families in the future. Below are statements from two community members that describe the off-reserve supports they would like to see offered to families in the community after a loss to suicide.

> I think some way, somewhere in this city, it doesn’t mean I have to go to Yúustway. It could be a drop-in place, where you can go, you, you—I’m sure there is, different little tiny hole-in-the-wall places around the city. (Member 1)

> You know, I’m really, really supportive of the Tsow-Tun Le Lum 6-week program on grief. Because that really gets people to focus directly on their grief and they even have a—what do they call it—psychotherapy, yeah, they have that person there. And that person really helped me when I was at Tsow-Tun Le Lum. (Member 8)

Collaboration with service providers. Recommendations for collaboration with service providers was a subtheme across two community members. This theme refers to the collaboration among service providers after a tragedy, and the desire for an improved connection between healers themselves, and between IFNU and the community. Below are statements from two

community members that describe how they would like to see collaboration with service providers occur in the community after a loss to suicide.

> And for me to be able to refer them out and saying, "Hey, you know, I think if you did this or if you just saw this person it would enhance what you are trying to do for yourself." And knowing that I have a really good circle of positive people that can help. (Member 2)

> Because 9-1-1 uh, our Integrated [IFNU] doesn't respond to 9-1-1. Even though uh, they're here. . . . No, no, they're not first responders. They'll, they'll probably show up. So I think there's, there's still that missing link between the community and the first responders. (Member 4)

Overall, 50% of the community members found wider world supports helpful, and 25% made recommendations for the inclusion of wider world supports in future suicide postvention planning.

Culture. I identified culture as a theme of healing or recommended support across the stories of six community members. This theme of culture encompasses three subthemes: following the teachings, sharing the teachings, and getting the tools back. Culture was seen across all themes: healing self, social supports, formal community supports, and wider world supports. Therefore, it can be considered a subtheme of all the themes. When referring to the power of culture for healing, community members spoke of culture as a support that often encompassed more than one theme at a time. With respect for the fluidity of

culture across all themes, and the interplay that occurs, I have chosen to list it as a theme of its own. As illustrated in Figure 1, culture wraps around all the themes.

Following the teachings. Below are statements from two community members that describe the role of following the teachings in their healing process. These members discussed the different traditional teachings and practices that helped on their healing journey. These traditional ways are not specifically detailed here in respect for protecting the traditional knowledge of the Squamish Nation people. This is in line with Article 9.8 of the *TCPS-2*, which states that researchers must ensure the respect for community customs and codes of practice (Tri-Council, 2014).

Member 4 said, "I would say I follow the teachings still. I, uh, continue to pray, continue with ceremony; I find that healing. Um, getting up in the mountain, in bath, letting go up there." Member 5 stated,

> Wow. I've come a long way since that day. Self-healing is a daily process. It doesn't happen with the snap of a finger or the blink of an eye, that's for sure. Going to the waters, brushing off, cedars boughs, cultural events, that's really, that's probably what saved me, is my culture. I really believe in my culture.

Sharing the teachings. Another member indicated that sharing traditional knowledge and teaching cultural practices to community members during their grieving was a part of self-healing: "[Loved one's mother] wasn't brought up in

traditional and cultural. So that was part of my healing journey as well, is to guide her through that whole process. She knows of it but has never practiced it" (Member 8).

Getting the tools back. Recommendations for using culture as a postvention strategy in the community was a subtheme across five community members, four of whom had indicated that culture played a role in their healing journey. Recommendations focus on getting the traditional tools back in the community, including people gathering to enjoy cultural activities together, such as drumming and singing, as well as teaching the young ones about culture in an effort of revitalization. Below are statements from three community members that describe how they would like to see cultural offered as a postvention support in the community.

Member 3 said, "The community needs to have a culture. I mean, they have culture nights and that, but, I dunno. I don't see much people going." Member 4 advised, "Get the tools back in the community . . . cause there's a whole generation that's just, uh, doesn't know, I think." In reference to teaching the young ones about culture, one member suggested,

> And get them, you now, get them interested. If they're not interested, have it available. You know, it doesn't have to be every week. It could be once a month, you know, as long as people are starting to learn. Because the

> culture, the drumming and singing and the language and that are all being revived, so a lot of people are just learning. (Member 8)

Overall, three community members stated that culture did not play a role in their healing. They stated that culture was not part of their upbringing, yet one of these members recommended culture be included in suicide postvention strategies.

Community Members' Experience of the Interview Process

During the initial research stage, my supervising faculty and I met with YHS to discuss the research methods. YHS suggested that I ask community members at the feedback stage if their participation in the research process had changed them in any way. The feedback stage was offered after the interviews were complete and the data were preliminarily analyzed so that community members could review the findings, clarify wording, give feedback, or make changes. It was decided that I would ask each community member the following question: Did the telling and recording of your healing journey change you in any way?

In response to this question, seven community members stated that participation had a positive effect on them, and one community member stated it had not had an impact one way or another. Member 2 said, "It was actually pretty empowering because hearing the responses that I had to the questions being asked were a lot stronger and more confident than I think I actually believe that I am."

Member 8 commented, “It just reassured me that, you know, what, what we do in our life and how we walk and how we carry ourselves will reflect on others.” Another statement that illustrated the effect of participation came from Member 6:

> For me, it feels a part of my wellness to be able to contribute that and share that, you know. . . . And for things to change, or to improve, if you don’t share your thoughts or feelings or suggestions, it’s—nothing’s going to change, right? So, I guess sorta in that way it would be, be towards my wellness, on my healing journey.

Summary of Findings

In conclusion, I interviewed eight community members, six females and two males, ranging from 32 to 81 years of age. Each of the community members had lost a loved one to suicide within the past 1 to 10 years. Overall, community members found that the research experience had a positive effect on them. Throughout the interviews, I noticed a theme of multiple loss, which is important to consider and provides context to the findings. I also identified five themes of healing across the stories of the community members: healing self, social supports, formal community supports, wider world supports, and culture. These themes include both the intrapersonal experience of healing as well as the benefits of external supports and culture. Culture was found to interplay among all the themes, often overlapping themes; therefore, I assigned it as a theme of its own.

Chapter 5: Discussion

This discussion is divided into five sections. The first section reviews the purpose of the study. The second section explores the relationship between the findings and the literature. The third section summarizes community members' experience of the research process. In the fourth section, I outline assumptions and limitations of this study. The fifth section discusses implications for practice and research, followed by recommendations for suicide postvention planning for the Squamish Nation. Finally, in the last section I offer recommendations for future research.

Purpose of the Study

This CBR study aimed to understand how best to support Squamish Nation survivors after the loss of a loved one to suicide. I conducted it in response to the high suicide rates, the risk for suicide clusters, and a request by YHS to help in the development of a suicide postvention plan within this community. Currently, dominant mental health models aimed at helping individuals to heal focus on the individual—that person's "illness"—with an individually based treatment approach that views the pathology as located in the individual (Duran, 2006). In these models, mental health treatment is concentrated upon evidence-based interventions (Prilleltensky & Nelson, 2002). In contrast, an Aboriginal wellness perspective highlights the collectivist orientation of traditional practice for healing and the power of the interconnectedness of the individual, family,

community, spirituality, and nature (McCormick, 1997; Mussell et al., 2004). Dominant mental health agencies have historically dismissed the Aboriginal wellness model, considering it inferior and invalid, and their individual-based treatment as the best approach (Duran, 2006).

Suicide postvention is a complex issue that needs to be addressed with a culturally sensitive approach. Historically, research in Aboriginal communities has been oppressive and exploitive, resulting in lack of trust of research and researchers (Tri-Council, 2014). Collaboration in any research activities with Aboriginal communities is imperative to build trust and to avoid further oppression or exploitation. Community engagement in postvention planning is also essential, as postvention plans tailored to the community are more effective than those developed by others unfamiliar with the community (Chandler & Lalonde, 2009; Cotton et al., 2014; Kirmayer et al., 1999; Kral, 2012).

In an effort to develop an effective suicide postvention plan for the community, and reduce risk of further exploitation and oppression, I employed a CBR design. A CBR design, as described in Chapter 3, focuses on seven principles defined by Boyd (2014): collaboration, community driven, power sharing, a social action and social justice orientation, capacity building, transformative, and innovative. These CBR principles support the *TCPS-2* (Tri-Council, 2014) framework for ethical conduct of research with First Nations People of Canada: working collaboratively (Articles 9.1 and 9.12), determining

the nature and extent of collaboration (Article 9.2), ensuring the respect for community customs and codes of practice (Article 9.8), delivering a formal research agreement (Articles 9.10 and 9.11), and recognizing the role of Elders (Article 9.15). It was my highest priority, as a non-Aboriginal researcher conducting research in a First Nations community, to ensure these CBR principles and the *TCPS-2* framework were followed. I aimed to work in a manner of utmost respect for the community's needs and interests, taking care to avoid acts of exploitation and/or oppression.

In collaboration with YHS, I conducted interviews with Squamish Nation members to increase understanding of themes of healing supports, which may help guide suicide postvention planning for the Squamish Nation community. I interviewed eight community members about their healing journey. Interviews revealed several common themes of healing supports, as well as a theme of multiple loss which provides context to the findings. Five major themes of healing supports were identified: healing self, social supports, formal community supports, wider world supports, and culture. These themes do not exist in isolation, but are interrelated, individually and communally helping community members in their healing journey (see Figure 1).

Relationship Between the Findings and the Literature

The research findings are consistent with previous research, most of which has been conducted among non-Aboriginal populations. Given the paucity of

research among Aboriginal survivors, several of these findings may be considered a unique addition to literature. In addition, most of these findings are in line with an Aboriginal worldview, recognizing the interrelatedness between the individual, family, community, and wider world (Castellano, 2008; Graham & Thomas, 2002; McCormick, 1997). However, these findings should be considered with caution, considering the small sample size and the focus on one specific community. In this section I explore the relationship between these findings and the literature for each theme of healing.

Multiple loss. A theme of multiple loss was identified across the stories of the community members who participated in this study. Most of the community members noted a loss of several loved ones to suicide, overdose, or natural causes, and at times indicated they were still grieving one loss when another occurred. Aboriginal communities in Canada have suffered loss for generations (Chenier, 1995; Elias et al., 2012; Health Canada, 2008). Loss of culture, language, and rights are a few examples. In addition, they experience a higher rate of loss to suicide than the non-Aboriginal population (British Columbia Ministry of Healthy Living and Sport, 2007; Caldwell, 2008; Statistics Canada, 2015). Given the higher rate of loss and other risk factors (age of parent, education, employment, age of deceased, childhood adversity, and insecure attachments) discussed in Chapter 2, the risk for traumatic grief among Aboriginal people in Canada is high (Spiwak et al., 2012).

Despite this increased risk for traumatic grief, the community members who participated reported their current mental wellness as "okay or better." They denied any suicidal ideation over the preceding 6 months, and they had not lost a loved one to suicide in the previous year. Therefore, one may cautiously surmise that the community members interviewed were not experiencing traumatic grief at the time of the interview. I asked community members the following question: What factors or supports protected them or helped them to heal after the loss of a loved one to suicide? I propose that understanding what helped these community members heal may help in understanding how to prevent or treat complicated grief for other survivors in the community.

Healing self. Community members identified healing self as a key theme in their healing journeys. This theme included six subthemes: acceptance, day-to-day coping, sense of purpose, still with us, coping activities, and helping others. This finding is in keeping with a First Nations perspective on wellness that assumes that the core of wellness involves "the human being taking responsibility for their own health and wellness with a strong sense of self-identity and self-esteem. Everything originates at the center, and it is with one's self, that the journey of wellness begins" (FNHA, 2015, p. 14).

This study is congruent with literature that suggests that acceptance, taking things day to day, and feeling a sense of purpose are a part of the healing process. Although community members felt sad and missed the deceased, they

gradually adjusted to their loss, which is described by Prigerson et al. (1999) as part of the grief process.

There is a lack of research available on the coping activities that survivors utilize on their own to cope (J. R. Jordan & McMenamy, 2004). Therefore, the finding that members' natural coping activities were seen as beneficial to healing is a unique contribution to research in this area. In addition, the information on the types of activities that community members used to cope is also a unique contribution. These findings are consistent with the Canadian Association for Suicide Prevention's (2017) website recommendation that "doing something active rather than just thinking to resolve emotions is healthy. Examples include journaling, writing letters, walking and exercising" (Coping with suicide loss section, para. 3).

An unanticipated finding was that 100% of the community members endorsed helping others as a method of healing. Helping others was not indicated as a healing strategy among the limited research on survivors. However, literature has indicated that helping others can lift the weight of the grief, as well as be a way to honour the loved one that passed (Weeks, 2004). This finding, that helping others was healing for community members, is consistent with literature that found helping others to be a healing practice among BC First Nations (McCormick, 1997). This suggests that helping others may be a powerful healing practice for Squamish Nation survivors. This finding is also consistent with

FNHA's (2005) recommendation that suicide survivors be included in the development of suicide postvention strategies for community, as well as research by McMenamy et al. (2008), which found that 100% of survivors (94% of whom were White) who accessed support from other survivors found it beneficial.

It is important to consider that the desire to help others may have played a role in the willingness of community members to participate in this research. Two members spoke overtly about how they wanted to help me with this research because I had helped them with their healing in the past. Perhaps their participation in the research was also a way to honour their loved one. This would have been an interesting question to have asked them.

Social supports. Community members identified social supports as playing a key role in their healing. Social supports included the subthemes of family standing together, connecting with others, and getting help from the community. This finding is consistent with the First Nations perspective on wellness, which views family as an essential support base (FNHA, 2015) and a source of healing (Graham & Thomas, 2002). It is also congruent with McCormick's (1997) research on healing among BC First Nations, which found that First Nations people of BC view family, friends, and community as natural supports to lean on in a time of need.

Research among dominant populations has led to similar findings. McMenamy et al. (2008) interviewed 63 adult survivors, most of whom indicated

that informal support from family, friends, and neighbours was helpful in their healing. This is important, as social difficulties often arise for survivors, with guilt, shame, stigma, and isolation being common experiences (Andriessen & Krysinska, 2012; McMenamy et al., 2008). Survivors can experience feelings of abandonment (Andriessen & Krysinska, 2012). The study by McMenamy et al. (2008) highlighted the power of survivors connecting with others, with 100% of survivors in their study indicating that connecting with another survivor for support was healing. Feigelman and Feigelman (2008) suggested that survivors may find peer support from other survivors more desirable than support from professionals, who represent the mental health system that failed to prevent the loss of their loved one. In addition, survivors often believe that only other survivors understand what they are going through and can provide beneficial support (Feigelman & Feigelman, 2008). Community members in this study also indicated that connecting with other survivors who shared their common experience was healing.

Formal community supports. Community members identified formal community supports as playing a key role in their healing and/or as a recommendation for future suicide postvention strategies. These supports included alternative healing, counselling, a wellness centre, ceremony, church, a health worker's presence, suicide prevention, and getting the people involved. Community members did not mention general practitioners or funeral directors as

helpful, which are two formal supports that have been indicated as beneficial in other research findings with non–First Nations participants (McMenamy et al., 2008).

Two community members found alternative healing helpful in their healing journey, and two community members recommended that it be included in future postvention supports. A thorough literature review of grief recovery among survivors did not mention alternative healing as a beneficial support. It is unclear if this is because most research was performed with the dominant culture; alternatively, this finding could be unique to the Squamish Nation community. It was surprising that more members (6/8) indicated counselling supports as playing a role in healing than alternative healing supports (2/8). Although one may speculate from the findings that alternative healing is not a popular choice in the community, with only two community members endorsing it as being helpful and two recommending it for future suicide postvention planning, I would highlight that I did not specifically ask community members if alternative healing played a role in their healing. I suspect this percentage may have been higher if that question had been included in the interview process.

Overall, 100% of the community members found individual and group counselling helpful in their healing journey and/or recommended that suicide postvention efforts include these types of supports. Even though all members thought counselling would be beneficial, only five members (62.5%) had accessed

counselling support. It is likely that this finding is inflated, as members who had accessed counselling, and specifically group counselling with me, may have been more likely to come forward to volunteer for this study. This finding, that more community members support counselling than accessed counselling, is congruent with the available literature. For example, a study by Provini, Everett, and Pfeffer (2000) suggested that although 13% of survivors desire formal support, only 11% receive formal support. This difference may be a result of the stigma of suicide and/or lack of familiarity with community resources available (Provini et al., 2000). A lack of access to counselling may also be an obstacle to survivors getting support in some communities.

Support groups for suicide survivors also seem to be an effective postvention activity (Andriessen & Krysinska, 2012; J. R. Jordan & McMenamy, 2004; McMenamy et al., 2008). Support groups offer an opportunity for survivors to hear one another's stories and realize they are not alone (Cerel et al., 2009). McMenamy et al. (2008) found that survivors rated a support group for suicide grief as much more helpful than one for grief in general. Feigelman and Feigelman (2008) studied support groups for survivors, finding the following benefit:

> No longer marginalized, survivors are able to offer each other important mutual aid, helping each other deal with the necessary life adjustments following a suicide loss. As survivors discover their similarities, they are

> drawn together to form a natural therapeutic environment. Between the successful models of coping behavior that survivors offer to each other, their mutually reassuring and supportive responses, survivors are able to move beyond the isolating sadness of loss and once again envision possibilities for hopeful and meaningful future actions. (p. 299)

The findings of this study also support group therapy as an intervention for suicide survivors. Therefore, the findings are consistent with the literature, as well as with FNHA's (2005) recommendations for implementing group therapy as an effective suicide postvention strategy.

Findings also support recommendations by FNHA (2005) to provide in-home family support after a suicide to address the family's loss and the grieving process. Community members indicated the need for a critical incident debrief to support family members in their time of loss, to help families process the loss and stand together. After a suicide, family relationships and routines may be disrupted (McMenamy et al., 2008), and relationships with family members may become more distant (J. R. Jordan, 2001; McMenamy et al., 2008). Provini et al. (2000) interviewed adult survivors and found that among those that identified concerns, 65% identified family relationship issues. The provision of in-home family support may help to minimize disconnection among family members, helping families to stand together. Families standing together was a theme in this study that was found to be helpful in members' healing journeys. McMenamy et al.

(2008) interviewed 63 suicide survivors and found that 69% of those who attended family therapy found it helpful in their healing.

FNHA (2005) indicated that communication within the family is a protective factor, as it can help a family member to feel understood and respected. FNHA recommended

> utilizing Critical Incident Stress Management (CISM) activities that can support healing following a traumatic incident, including but not limited to, formal and informal debriefings and response evaluation. Debriefings can be likened to a structured talking circle that provides education and a safe location for a group of individuals to address the facts, thoughts and feelings regarding a traumatic incident. (p. 51)

The effectiveness of psychological debriefing, such as critical incident stress management, has been highly debated in the literature and is still a contentious issue (Rose, Bisson, & Wessely, 2003; Wessely & Deahl, 2003). There are many advocates for this type of intervention, although some research has found few benefits and possible harm (Wessely & Deahl, 2003). After a systematic review of the literature, Rose et al. (2003) recommended that psychological debriefings not be routinely used. If a psychological debrief does take place, it should be offered with follow-up support, rather than as a stand-alone intervention (Wessely & Deahl, 2003). However, the effectiveness of

psychological debriefing within Aboriginal communities is unknown and may have different results.

Another unique finding in this study was the recommendation for a wellness centre that offers both counselling and alternative healing on site at a single location. Previously, there was a wellness centre in the Squamish Nation community that these community members referred to as helpful for the wellness of the community. The wellness centre that was referred to was closed several years ago. Currently, YHS offers intake onsite, then refers members to a variety of locations on and off reserve for counselling and alternative healing. The request for a wellness centre situated in the community has not been noted in previous research.

Most community members indicated that ceremony (e.g., funerals, burnings, and memorials) was helpful in their healing journey. According to Weeks (2004), death rituals (funerals, memorials, tributes of life, or celebrations of life) are an important and essential part of the healing process after a loss for North Americans. Weeks described the variety of death rituals across Jewish, Christian, and Native American communities in North America. These death rituals help mourners to accept the reality of the death, prepare to experience life without their loved one, and receive social support from others (Weeks, 2004). Therefore, this study supports the existing research on ceremony as healing, with these findings focused specifically on survivors. Church was another formal

support noted by community members as helpful in their healing journey. This is similar to findings by McMenamy et al. (2008), who interviewed adult survivors (94% White) and found that 66% who accessed church for support found it helpful.

Although community members did not indicate that the presence of health workers after a loss was helpful in their journey, seven members made recommendations regarding their presence. This finding may be unique to this study, but it is not unexpected. After a tragedy in the Squamish Nation community, it is a cultural norm for health workers to visit the home of the family to pay their respects and offer their support.

Suicide prevention was another theme noted in members' stories, referring to a desire for more suicide prevention strategies implemented within the community. Suicide prevention involves the development of strategies to promote protective factors and decrease risk factors related to suicide (FNHA, 2015; Health Canada, 2008). Community members specifically indicated a need to promote cultural activities as a method of suicide prevention.

Research has found that survivors' pain and grief often motivate them to become involved in suicide prevention to prevent others from experiencing a loss to suicide (Cerel et al., 2009). Being involved in advocacy for change, and seeing the change then occur, is healing for some survivors (Cerel et al., 2009). Community members who participated in this study also recommended suicide

risk assessment training for community members. Suicide risk assessment is an essential postvention strategy for reducing suicide risk among survivors. However, there is insufficient literature supporting the use of dominant mental health model suicide risk assessment. Some literature suggests that such training can be detrimental in Aboriginal communities (Sareen et al., 2013). Therefore, care should be taken to find a culturally sensitive suicide risk assessment model.

Community members in this study also stressed a desire for more community events—social, recreational, and cultural—to bring people together after a loss. McCormick (1997) found that being socially connected, going out with others, and having fun is healing for First Nations people. This power of social connection as healing highlights the collectivist orientation of many First Nations members (McCormick, 1997).

Wider world supports. Community members identified wider world supports as playing a key role in their healing and/or as a recommendation for future suicide postvention strategies. Subthemes include both off-reserve supports and collaboration with service providers. As anticipated, there was less endorsement for using wider world supports for healing (62.5%) than for healing self, social supports, and formal community supports (100%). The importance of wider world supports for suicide postvention is highlighted by FNHA (2015) in the following statement:

> It is through partnerships and collaborations among all groups, authorities, and agencies that we can improve the mental wellness outcomes for and with First Nations and Aboriginal people. Circles remind us of our accountability to each other in this work and how respectful interactions are key in addressing suicide, mental wellness and substance use among First Nations and Aboriginal People in BC. (p. 17)

Although there was a recommendation for improved collaboration with the INFU for suicide postvention response, there was no indication that the police were a helpful formal support for healing. McMenamy et al. (2008) interviewed adult survivors (71% female and 94% White) and found that 49% of participants that accessed police support found it helpful in their healing. This study did not specifically ask community members about their experience with the police. Perhaps if questions related to police support had been included in the study, a theme may have been identified.

Culture. Community members identified culture as playing a key role in their healing and/or as a recommendation for future suicide postvention strategies. This theme included subthemes of following the teachings, sharing the teachings, and getting the tools back. These findings support literature that identifies culture as key to Aboriginal wellness. For example, research has found that one may achieve mental, physical, emotional, and spiritual balance by following traditional practice (Lavallee & Poole, 2010; Poonwassie & Charter, 2001; Tripartite First

Nations Health Plan, 2013). In addition, FNHA (2005) stated that a connection to culture, traditional knowledge, and traditional practices are essential for suicide prevention, intervention, and postvention. This study also supports literature that views a strong cultural identity and affiliation as a protective factor:

> Cultural safety and community renewal approaches should also be emphasized when engaging in suicide prevention, intervention and postvention with First Nations and Aboriginal peoples. In communities where there is a strong sense of culture, community ownership, and other protective factors, there can be much lower rates of suicide, and sometimes none at all. (FNHA, 2005, p. 30)

Community members' experience of the research process. During the initial stages of the CBR process, my committee collaborated with YHS to develop appropriate interview questions. YHS suggested that I ask the following question at the feedback sessions: Did the telling and recording of your healing journey change you in any way? As anticipated, most community members (7/8) indicated that participating in this study had a positive effect on them. One member indicated neither any benefit nor detriment. This is in keeping with the finding that members found helping others to be healing. Participation in this study could be viewed as a way of helping others, such as the community and the researcher. Some community members said they volunteered to be interviewed because I had helped them in the past. They saw that I needed help getting

participants, and they wanted to help me. This speaks to the value of researchers having a prior relationship with the community. This is also consistent with research that indicates survivors are motivated to become involved in activities related to suicide prevention (Cerel et al., 2009). By participating in activities related to suicide prevention, they are actively helping to prevent others from experiencing a loss to suicide (Cerel et al., 2009).

Implications for Practice and Research

Implications for practice. A synthesis of the identified themes of healing supports led to implications for implementing suicide postvention practices in First Nations communities in Canada. First, participants perceived addressing suicide postvention from an Aboriginal wellness model as effective. An Aboriginal wellness model highlights the collectivist orientation of traditional practice and the power of interconnectedness (McCormick, 1997). Healing practices often include the client and the healer, as well as the family and community (McCormick, 1997). Previous research by McCormick (1997) found that a wellness perspective that highlights the collectivist orientation of healing practices is important for healing among BC First Nations. Findings from this research are congruent with previous research. These findings also go further to suggest that both the individual and communal impact of supports are perceived as being specifically helpful for healing after a loss to suicide, as the healing journeys of these Squamish Nation members involved an interconnectedness of

individual, social, formal community, wider world, and cultural supports. These findings are also in line with an Aboriginal worldview, as described below:

> A central teaching of First Nations Elders is that everything is related. This wisdom is sometimes represented visually by locating individuals at the centre of a set of concentric circles that ripple outward to include family, community, nation, and the natural world. The notion is not that human beings are at the centre of the universe but that our lives are nested in complex relationships. Our words, our actions, and even our thoughts have wide-reaching, timeless impacts that cannot be discerned by our physical senses. Conversely, our lives are impacted by forces and events in the larger world, whose origins and intentions are often beyond our knowledge or understanding (Castellano, 2008, p. 386).

Second, as anticipated, there is an implication that participants perceived the integration of both dominant mental health supports and culture as helpful for healing among First Nations survivors. This involves maintaining an Aboriginal wellness model while allowing space for dominant mental health supports. A popular quote by Sitting Bull highlights this idea: “Take what is good from the White Man and let’s make a better life for our children” (as cited in Duran & Duran, 2000, p. 94). Duran and Duran (2000) also believed that the dominant mental health system has some valuable ideas, and they encouraged integration with cultural practices in the pursuit of developing an effective wellness model for Native Americans and others.

Findings indicated that survivors integrated healing supports from both dominant mental health models and their culture. This practice may be due to the resources available in the Squamish Nation community. Over the past 10 years, YHS has made a significant effort to offer both dominant mental health supports and cultural supports to the community, including strategies such as workshops, counselling, alternative healing, groups, and community trainings. Most of the community members who participated in this study have accessed supports through YHS. They indicated that these supports have been helpful and recommended them for other suicide survivors in the community. These findings support recommendations that suicide prevention, intervention, and postvention strategies for Aboriginal populations involve both dominant mental health supports and traditional practices (Joshi et al., 2009). Therefore, while an Aboriginal wellness model is recommended as a framework for addressing suicide postvention, inviting valuable ideas from dominant mental health models is recommended.

Finally, the current research findings highlight the resiliency of the Squamish Nation members who were interviewed. Distress experienced by suicide survivors often meets the criteria for traumatic grief (Cerel et al., 2009; McMenamy et al., 2008). Dyregrov and Dyregrov (2005) found that 78% of parent survivors scored high for traumatic grief when administered the ICG. The typical symptoms included “preoccupation with thoughts of their child, searching

and yearning for the child, experiencing disbelief about the death, and difficulties accepting the death" (Dyregrov & Dyregrov, 2005, p. 718). Long-term difficulties with mental health, psychosocial functioning, and physical health are also commonly experienced by survivors (Melhem et al., 2004; Prigerson et al., 1997).

In consideration of the risk factors for traumatic grief (age of parent, education, employment, age of deceased, childhood adversity and insecure attachments), it appears that the risk for traumatic grief is high for Aboriginal people in Canada (Spiwak et al., 2017). In addition, community members indicated experiencing multiple loss, at times grieving one loss when another occurred. Despite the increased risk of traumatic grief and experiences of multiple loss, the journeys of these community members illustrate both individual and community resiliency. The individuals found healing within themselves, used a variety of different supports, and sought culture as medicine. The community came together to support the survivors after their loss. Therefore, I suggested that professionals involved in future SPIP work with the community recognize and promote both the individual and communal resiliency of the Squamish Nation.

Implications for research. Achievements and challenges faced during this study offer implications for conducting CBR within First Nations communities. First, collaboration and engagement with the community is helpful for avoiding research that is exploitative or oppressive. As noted in Chapter 3, I journalled throughout the research process to help avoid misuse of privilege and

to identify and address any ethical concerns that arose. Numerous ethical dilemmas were faced along the way, and collaboration with YHS played a major role in reducing the risk of unethical practice. As noted in Chapter 4, my journalling led me to ask YHS for guidance on cultural issues, helping to increase culturally sensitive practice.

Another implication for conducting CBR in First Nations communities is that collaboration and engagement inherently increase awareness of what is happening in the community. For example, during the recruitment process for this research, several deaths occurred in the community. It was important to stop recruitment and respect the community's need to grieve. When working in First Nations communities, awareness of what is happening in the community is essential to ensure ethical practice, and a CBR approach can help to increase this awareness.

Recommendations for the Squamish Nation

In this section I discuss the findings and provide recommendations for suicide postvention strategies for the Squamish Nation community. On one hand, these recommendations represent the opinions of a small number of Squamish Nation community members that reside in North and West Vancouver; therefore, they should be considered with a degree of caution as they may not be representative of all Squamish Nation survivors. On the other hand, it is important that suicide postvention strategies are community driven (Wexler & Gone, 2012).

To date, these are the only data gathered regarding Squamish Nation survivors' healing journeys after a loss to suicide. It is important to note that these findings are consistent with the available literature on suicide postvention, as well as an Aboriginal wellness model. I elaborate on limitations of the findings in the next section.

The Suicide Prevention, Intervention, and Postvention (PIP) Initiative for British Columbia (as cited in Joshi et al., 2009) suggested that "communities would benefit most by being presented with a compilation of strategies that they can choose from to implement given the diversity that exists across communities" (p. 191). A handout entitled "Suicide Postvention Recommendations for the Squamish Nation" will be provided to YHS, Squamish Nation Chiefs and Council, the community members who participated in this study, and any other recipient who may find it helpful. This handout will present a list of suicide postvention recommendations for the community to review and choose whether to implement.

Implementing recommendations. The implementation of suicide postvention strategies is likely best undertaken by the current SPIP committee, which includes members from various Squamish Nation departments as well as wider world supports. As the findings and literature suggest, a collective approach among individuals, families, community and wider world supports may best meet the needs of survivors. As well, findings suggest that not only were individual

supports helpful for healing, but the communal effect of supports from a variety of levels was beneficial. Therefore, it is important that postvention initiatives offer survivors support from all levels identified (healing self, social supports, formal community supports, wider world supports, and culture). Finally, the integration of both dominant mental health supports and culture was found to be beneficial. Therefore, it is important to offer both types of supports to survivors.

Recommendations for healing self. Implications for suicide postvention planning include strategies that involve survivors in suicide postvention. Considering the theme of helping others as healing, involving survivors in the planning and implementation of postvention supports is recommended. This may be a powerful source of healing for those providing the support as well as those receiving it.

Recommendations for social supports. Implications for suicide postvention planning include strategies that strengthen families, connections with others, and connections with community support. To help families stand together and connect with others, psychoeducational information should be provided to family and friends on how to support survivors after a loss to suicide. Considering the healing potential of survivors connecting with other survivors, a peer support program should be developed to train survivors to be peer support workers.

Recommendations for formal community supports. There are several implications for formal community supports for future suicide postvention

planning, specifically related to the subthemes identified: alternative healing, counselling, wellness centre, ceremony, church, health workers' presence, suicide prevention, and getting the people involved. First, I recommend that YHS provide a workshop for professionals who work with survivors in the community, sharing the findings of this research. These findings may help professionals with assessment and treatment planning for community members who have lost a loved one to suicide.

A second recommendation is to provide in-home family counselling after a loss to suicide. This support should be culturally sensitive and prompt, and it should include an assessment of how the children and youth in the family are coping. It should also include follow-up sessions. I suggest further exploration of critical incident stress management and effectiveness in First Nations communities, considering that research within dominant populations has suggested that this tool is not effective and has the potential to cause harm (Rose et al., 2003; Wessely & Deahl, 2003).

Considering the strong support for group counselling in this study and in the literature, a third recommendation is for group counselling to be offered to survivors. A culturally sensitive cognitive behavioural therapy approach is recommended, as that was the approach taken in the group that the community members referred to as having played a role in their healing journeys. As noted in the previous section, peer-led support groups were also highly rated by survivors.

Therefore, a peer-led support group should be made available, with a counsellor acting as cofacilitator, offering psychoeducation from a cognitive behavioural therapy approach.

A fourth recommendation is for the continued provision of alternative healing, and a fifth is the continued provision of counselling, as both supports were noted in the findings and literature as helpful for healing among survivors. I further recommend offering both alternative healing and counselling at one location on reserve, such as at a wellness centre.

A sixth recommendation for formal community supports is to assist survivors in holding ceremonies, such as funerals, memorials, and burnings. I recognize that there are traditional protocols and do not provide specifics in this recommendation. With respect, I have included this recommendation to highlight the benefit of ceremony for healing, rather than to suggest how it should take place. As I wrote this section, I noticed a flyer in the Squamish Nation newsletter inviting community members to the Shaker Church to hang an ornament on a Christmas tree in memory of a loved one who has passed. This event is an example of assisting survivors in holding ceremony.

A seventh recommendation is to provide survivors information about the location of churches on and off reserve and the times community members can attend. Results indicated that community members found attending church

beneficial for healing, and some survivors may not be familiar with the locations off reserve and the times of church ceremonies.

An eighth recommendation for formal community supports is the continued presence of health workers in the family home after a loss to suicide. Seven out of eight participating community members made recommendations for health workers to attend the family home to show their support. While attending the home, health workers could provide information, made in other recommendations, related to grief and loss supports on and off reserve.

Findings of this study also support recommendations for cultural activities for suicide prevention, as well as culturally sensitive suicide risk assessment training in the community. The implementation of cultural activities for suicide prevention also arose in the culture subtheme and is discussed in that section. I recommend that culturally sensitive suicide risk assessment training be offered to community members. The suicide prevention recommendations made by community members may be viewed as advocacy efforts. These community members are survivors advocating for suicide prevention activities to prevent others from experiencing a similar loss. Therefore, suicide prevention strategies that are implemented because of this study may add to the healing journey of those who made the recommendations.

Finally, social recreational programming is recommended for getting the people involved. Social recreational programs bring people together, reducing

social isolation. Community members recommended activities such as outings, walking groups, drumming, and singing groups. The development and implementation of social recreational programming, specifically to support survivors after a loss, could be linked with the peer support program mentioned previously.

Recommendations for wider world supports. Implications for future suicide postvention planning include recommendations for both off-reserve supports and for collaboration with service providers. One recommendation is to increase community awareness of off-reserve postvention supports. This could be done through the Squamish Nation newsletter and Facebook page. In addition, staff could have a list of supports to provide to survivors. A second recommendation is to continue to collaborate with IFNU on suicide postvention response. YHS has held several SPIP meetings to date, with IFNU in attendance; I recommend these meetings continue on a regular basis, with ongoing monitoring to evaluate the costs and benefits.

Recommendations for culture. Implications for suicide postvention supports include following the teachings, sharing the teachings, and getting the tools back. One recommendation is to offer culture activities as suicide prevention, intervention, and postvention strategies. Community members suggested including the youth and offering these activities to the community on a regular basis. A second recommendation is to offer cultural training that teaches

traditional tools. In my experience working in the community, when YHS has offered workshops in wool weaving, cedar weaving, and drum making, the community response has been significant. There was more interest than spaces available. These teachings can be costly due to handshakes for the teachers as well as materials. Yet, the benefit for wellness is highlighted in these findings as well as the literature.

Future Research Suggestions

Future research suggestions are typical in academia and are based on the researcher's interests and opinions. Offering future research suggestions brings me a sense of personal discomfort, as CBR is based on meeting the needs of the community rather than the interest of the researcher. Therefore, I offer these future research suggestions in a spirit of respect, acknowledging that any decision to pursue future research is the community's choice. In addition, I strongly recommend that any future suicide postvention research in Aboriginal communities employ a CBR design, ensuring ongoing collaboration and engagement with the community throughout the research process.

My first suggestion is to replicate this CBR study in this community. Adding the voices of more Squamish Nation survivors would increase the validity of the findings. Having more stories from more community members would also enrich the data and assist in understanding how best to support survivors after a

loss to suicide. However, as noted above, the decision to replicate the study and conduct further research is a decision for the community to make.

I anticipate that the Squamish Nation will consider this study's suicide postvention recommendations in future suicide postvention planning. Future research using a CBR design to evaluate the short- and long-term effects of the implementation of the recommendations is also suggested. Again, although future research may be helpful, this is a decision for the community to make. Considering the findings of this study and the current literature, a peer-led support group for survivors, with a counsellor as cofacilitator, sounds like a promising recommendation. The implementation and evaluation of a peer-led support group would provide an understanding of its effectiveness in this community.

It is unknown whether the identified themes of healing are specific to the Squamish Nation or transferable to other urban Aboriginal communities. Offering this CBR process to other communities in a way that recognizes their voice and meets their needs is suggested. Aboriginal suicide is a serious issue across Canada, and a CBR approach could identify recommendations for suicide postvention unique to each community, while avoiding further exploitation or oppression.

Assumptions and Limitations

Assumptions. In this section I discuss four assumptions I made during the research process: participant honesty, participant willingness, representativeness,

and the development of effective suicide postvention strategies. First, I assumed that the participants answered interview questions honestly and candidly. To increase this likelihood, I explained to each community member how anonymity and confidentiality would be maintained. Participants were given the option to be interviewed at their home rather than at YHS, and they were asked to approve any of their quotes used in the Results section.

A second assumption was that community members were willing participants, particularly those contacted by YHS staff. To increase the likelihood of this being the case, I informed participants that they may withdraw from the study at any time and with no ramifications, and I reminded them of this right throughout the research process.

A third assumption was that the views of community members in this study are representative of Squamish Nation survivors as a whole. Recommendations for future postvention planning were derived from these community members' stories, and it is important to note that they may not represent themes of healing among all survivors in the community.

A final assumption was that by employing a CBR design, I could use this research to guide the development of suicide postvention strategies that are more effective in helping survivors than past provincial or federal initiatives. Understanding themes of healing among Squamish Nation survivors may help guide the development of postvention strategies unique to the community.

Recommending a one-size-fits-all approach to Aboriginal suicide postvention is not the answer. It is my hope that results from this study, which are specific to the Squamish Nation community, are a step towards the development of suicide postvention strategies that will ultimately grow and lead to improved supports for survivors and a reduced rate of suicide in the community.

Limitations. I discuss several limitations of this research in this section: the qualitative nature of the study, the recruitment method, the exclusionary criteria, the interview method, the sample size, and the generalizability of the results. First, although the qualitative nature of the research was a strength in that it was highly appropriate for learning about individual lived experience, particularly within a marginalized group (S. Jordan, 2008), the potential exists for my individual biases to influence the results (Kazdin, 2003). For example, I knew all the participants before this study. I knew parts of their stories and saw their healing from my perspective. I had my ideas and opinions about what helped in their healing journeys and had to ensure that my impressions did not affect the results.

In addition, as a therapist in the dominant mental health system, I am biased toward incorporating dominant models of healing with traditional methods. This bias could affect the interpretative validity of the findings, which is the extent to which the participants' opinions and feelings were accurately interpreted (Kazdin, 2003). Validity can be particularly problematic when conducting

thematic analysis, which provides a lot of flexibility for researchers and is often criticized as an approach where researchers may do whatever they want (Braun & Clarke, 2006).

In Chapter 3, I described the steps I took to minimize any influence my perspective may have on the findings. These included journalling and directly telling each participating community member my preconceived views and orientation towards suicide postvention. I also shared with each community member my awareness that I represent the White population, which has been historically oppressive of Indigenous peoples, and that my objective as a researcher was to understand their perspective on healing without oppression or the colonizing of their responses.

To ensure rigour in the thematic analysis process, I followed the criteria set out by Braun and Clarke (2006) for transcription, coding, analysis, allocation of time, and written report. In Chapter 3, I provided clear and explicit information about the thematic analysis and decisions made throughout the process. I included themes that ran across data sets, rather than within a data set, to increase the likelihood that findings represented the community and not an individual. In addition, I conducted feedback sessions with community members to discuss the findings; all members agreed with the themes I had assigned to their story, and I used feedback from members to refine the quotes. Finally, in the Discussion section I noted how my expectations were or were not met throughout the

research process. Transparency regarding my views, the process of thematic analysis, and the review of findings with community members increased the dependability and credibility of the findings.

The recruitment method is a second possible limitation. Recruiting participants through the Squamish Nation newsletter may not have reached all members of the community, specifically members who were not literate. The Community Health and Wellness team at YHS helped to mitigate this issue by relaying the information verbally to members they thought may be interested in participating. As previously mentioned, this could raise a concern of community members feeling pressured to participate. I addressed this concern by informing potential participants that the study was voluntary and they could choose not to participate at any time.

The voluntary aspect of recruitment also led to a type of selection bias referred to as volunteer bias (Hernán, Hernández-Diaz, & Robins, 2004). Volunteer bias occurs when participants are all volunteers, rather than randomly assigned from a population (Hernán et al., 2004). This can threaten the validity of findings as volunteers may have different characteristics than a randomized sample. All participating community members in this research volunteered to participate.

Community members were also familiar with me as a clinical counsellor in the community prior to the research commencing. Three of the members had

attended more than one therapeutic group I had facilitated within the past seven years, three were professional colleagues working on reserve, and three had family members to whom I had provided or was providing mental health support. Our prior relationship and their volunteering to participate indicate an openness to dominant mental health service providers that may not be representative of the entire population and may influence the findings. However, although volunteer bias is a limitation, this method of recruitment was ethical and culturally sensitive, and it avoided exploitation and oppression.

A third limitation was the exclusionary criteria. I had to exclude several community members who expressed interest in participating as they had lost a loved one to suicide within the preceding year, or more than 10 years prior. Those with a recent loss were excluded as they may be still grieving. Two community members had arranged interviews that were cancelled due to a suicide in the community. Those with a loss more than 10 years prior were excluded as the length of time may have altered their recollection of the healing journey, and supports in the community have changed significantly over the past 10 years. This criterion resulted in three community members being thanked for their interest and support, but not being included in the study. Even though excluding community members from participating is contrary to the Squamish Nation cultural norm of inclusion, it was necessary to ensure that the process of participating did not cause harm. The exclusion of community members from the

study may have affected the results, as the data may have been richer with more participants.

A fourth limitation was the interview method, as the data gathered were the community members' views of how they had healed after the loss of a loved one to suicide, which may not represent an actual causal relationship between the activities of perceived benefit and the healing outcome (Kazdin, 2003). However, storytelling is a common teaching tool in the community, and I decided that the interview method was a culturally appropriate way of gathering data.

Sample size was a fifth limitation, as only eight community members participated in this study. Because the goal of this research was to describe a shared belief among a homogenous group, I had anticipated that 12 interviews would be adequate for saturation. I followed guidelines by Guest et al. (2006) that data saturation would be achieved when the researcher is no longer able to collect new information and when further coding is no longer feasible. My goal was to conduct data analysis and interviews concurrently until saturation was determined. I stopped recruitment at eight interviews, as the community was grieving a number of losses at that time. The collection of new information decreased significantly after the sixth interview, with only one new theme arising during the seventh and eighth interviews. However, it is not certain whether saturation was reached or more information may have been collected with a larger sample.

Finally, the literature is clear that suicide postvention plans for Aboriginal communities must be unique to the needs of each specific community (FNHA, 2015; Joshi et al., 2009; Poonwassie & Charter, 2001); therefore, the results of this study may not be generalizable to other communities. However, the purpose of the research was to assist the Squamish Nation community specifically. It is important to note that the findings represent the views of a sample of Squamish Nation members who live in North and West Vancouver. There were no participants from the Squamish Valley. Therefore, the findings may not be generalizable to the Squamish Nation members living in the Squamish Valley.

Considering these assumptions and limitations, readers should use caution when interpreting the findings. Although I took steps to minimize limitations, my bias may have influenced the findings, the findings may not be representative of all survivors in the community, and the suicide postvention recommendations may not represent all ways to support Squamish Nation survivors.

Conclusion

It has been my privilege to conduct this research with the Squamish Nation community. Suicide is a serious health issue across Aboriginal communities in Canada. Survivors are at high risk for traumatic grief, and providing support for their healing is imperative. The CBR design allowed me to collaborate and engage with the community in a culturally sensitive manner, reducing risk of exploitation or oppression, and to develop community-specific

postvention recommendations that are anticipated to be more effective than those developed externally. Interviews with Squamish Nation members suggested that approaching suicide postvention from an Aboriginal wellness model is beneficial. This model recognizes the benefits of the individual and communal impact of healing self, social supports, formal community supports, wider world supports, and culture.

In addition, when using an Aboriginal wellness model for postvention, there are benefits to integrating valuable Western supports. These findings are in line with the available literature among non-Aboriginal populations and an Aboriginal worldview. Several findings of this research are unique contributions as they relate to a First Nations population. However, findings should be interpreted with caution due to the limitations mentioned above. My hope is that these findings, and the suggested recommendations for suicide postvention, may offer some guidance on how to support Squamish Nation survivors on their healing journey.

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Appendix A: Script for Screening of Participants

Thank you for your interest in this research on how Squamish Nation members heal after the loss of a loved one to suicide. My name is Jennifer Campbell, and I have worked with the Squamish Nation since May 2010 as a counsellor. This study is part of my doctoral studies and my supervisor is Dr. Cindy Weisbart, a registered psychologist and a professor at Adler University. For this project I am a student researcher, not a counsellor. I am not able to provide counselling to any participants until my research is complete and the findings have been presented. If you would like to access counselling during the research process, counsellors are available by contacting Yúustway Health Services at [telephone number].

Before we start, it is important to make sure that you meet the requirements. May I confirm that:

- You are 19 years of age or older.
- You are a Squamish Nation member.
- You have lost a loved one to suicide within the past 1–10 years.
- You have not lost a loved one to suicide in the past year.
- You have not been suicidal for the past 6 months.
- You would rate your current mental wellness as okay or better.
- You can communicate in English.

(If potential participant answers “yes” to all of the above, continue with the script. If potential participant answers “no” to any of the above, student researcher says, “Unfortunately, you don’t meet the criteria necessary for this study. I appreciate you reaching out and showing interest. Would you be interested in any of the individual or group counselling offered in the community?” If callers answer “yes,” request their contact information and tell them you will have the Mental Health Intake Worker from Yúustway Health Services call them.)

First, you will be asked to attend a 1.5- to 3-hour interview. At the first interview I will ask you three questions: (1) Can you tell me about your experience losing a loved one to suicide? (2) What was helpful in your healing journey? and (3) What supports would you like to see offered to families in the Squamish Nation community after a suicide? I will ask you questions to understand your experience. The interview will be audiotaped and later written down. Myself, my supervising faculty, the transcriptionists, and a data analysis assistant will look at what is written down from your interview, and interviews with other community members, and put them together to look for themes of healing. Once we find themes, I will share them with you at a final 1-hour interview. I will then ask for your opinion. Your comments will be used to make any needed changes to the themes.

This study may be published, but to protect your confidentiality, no names will be used and information will be disguised so that you cannot be identified, unless you request your name be included to honour your story. Your involvement is entirely voluntary and you may leave the study at any time. Once data analysis has begun two weeks after the interview, your information and comments cannot be removed from the study.

Do you have any questions? Thank you very much for your time. If you would like to contact me with any questions or comments, please call me at: [telephone number] or email me at [email address].

Appendix B: Demographic Information

Thank you for your participation in this research. Before we start the interview, I am going to ask you some questions about yourself and the loved one(s) you have lost to suicide over the past 1–10 years. Please take your time and remember that you can

- decide not to answer a question (but if you do not answer any of the questions, your answers will not be included in the findings);
- take a short break from answering questions;
- reschedule your interview; or
- withdraw from the research at any time.

Government Name _____

Squamish Name _____

Date of Birth _____

Address _____

Gender _____ Residential School Survivor? Yes/No _____

Aboriginal Band Membership (Describe): _____

Length of time living in the Squamish Nation community?

How many loved ones have you lost to suicide over the past 1–10 years?

What was your relationship to them?

How old were they when they committed suicide?

When did you lose each loved one to suicide?

Appendix C: Feedback Session Script

Thank you for meeting with me today. First, let's review the forms we completed last time we met. (Review Informed Consent Form and Assessment for Capacity Form. If participant agrees to informed consent and is found to have capacity to provide informed consent, move to (2). If participant does not agree to informed consent or is found not to have capacity to provide informed consent, follow the rejection script on the Assessment for Capacity Form.)

This interview will be around 1 hour. I look forward to first sharing the findings with you. I will ask you:

(a) Do the findings tell your story?

(b) Would you like any of the words changed or removed?

I also look forward to learning if the interview had an effect on you. I will ask you:

(a) Did the telling and recording of your healing journey change you in any way?

I might ask you other questions to get more information and understand your experience better.

Like I said before, you might feel some stress when being asked and answering questions. If you feel stress, you can:

- decide not to answer a question (but if you do not answer any of the questions, your answers will not be included in the findings);

- take a short break from answering questions;
- reschedule your interview; or
- withdraw from the research at any time.

Appendix D: Letter of Invitation

Have you lost a loved one to suicide?

Would you like to share the story of your healing journey?

My name is Jennifer Campbell, and I have worked in the community since May 2010 as a mental health counsellor for Yúustway Health Services. I am now in school studying to become a psychologist and will be doing this as a student researcher for my doctoral studies at Adler University. This research has the support of Yúustway Health Services and Squamish Nation Band Council. We hope that what we can learn together will help guide a healing plan for the community.

You are invited to join and share your healing journey if you

- are 19 years of age or older;
- are a Squamish Nation member;
- have lost a loved one to suicide within the past 1–10 years;
- have not lost a loved one to suicide in the past year;
- have not been suicidal for the past 6 months;
- would rate your current mental wellness as okay or better; and.
- can communicate in English.

This research will help to understand how community members heal after the loss of a loved one to suicide. With this information, Yúustway Health Services will better understand how to support grieving families.

If you want to join, there will be a 1.5- to 3-hour interview for you to share your story, then later a 1-hour session to go over the research findings. Participation will be kept confidential, only Jennifer Campbell and her Research Team will know the names of participants.

If you would like to join this research study, or if you have any questions, please contact Jennifer Campbell at: [telephone number] or [email address].

Thank you very much!

Appendix E: Looking for Participants Flyer

Looking for Participants

Want to help grieving families in your community?

We would like to hear your story of healing after the loss of a loved one to suicide.

- Private interviews
- Participation is confidential and voluntary

My name is Jennifer Campbell and I have worked in the community since 2010 as a Counsellor for Yúustway Health Services. I am studying to become a psychologist and will be doing this as a student researcher for my doctoral studies at Adler University. This research has the support of Yúustway Health Services and Squamish Nation Band Council. We hope that what we can learn together will help guide a healing plan for the community.

[Item]
[Contact Info]

[Item]
[Contact Info]

[Item]
[Contact Info]

[Item]
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[Contact Info]

[Item]
[Contact Info]

Appendix F: Informed Consent

INFORMED CONSENT FORM

Research Title
Squamish Nation Members' Healing Journeys After the Loss of a Loved One to Suicide

The Researcher
My name is Jennifer Campbell and I am doing this research as part of my doctoral degree in the Clinical Psychology Program at Adler University (Vancouver Campus). You may also know me as a registered clinical counsellor from my work at Yúustway Health Services. For the purpose of this research, and throughout the research process, I will be in the role of a student researcher not a counsellor. I cannot provide counselling to participants during the research process.

If you have any questions about the research, you can contact me or my University Advisor. Our contact information is below:

Student Researcher:	Jennifer Campbell	E-mail: [email address] Phone #: [telephone number]
Research Advisor:	Dr. Cindy Weisbart	Program: PSYD Clinical Psychology Phone #: [telephone number] E-mail: [email address]

The research has been approved by Yúustway Health Services, the Squamish Nation Chiefs and Council, and the Adler University (Vancouver Campus) Research Ethics Board (REB).

This Research
The research focuses on gathering information to understand how to community members heal after the loss of a loved one to suicide.

My research advisor and I are working with Yúustway Health Services and Squamish Nation Elders.

You are eligible to participate if you are:

- 19 years of age or older.
- A Squamish Nation member.

- You have lost a loved one to suicide within the past 1–10 years
- You have not lost a loved one to suicide in the past year.
- You have not been suicidal for the past 6 months.
- You would rate your current mental wellness as okay or better.
- You can communicate in English.

As part of my research, I am asking you to do the following:
Attend two interviews. The first is a **1.5- to 3-hour interview.** At this interview you will be asked questions about your experience losing a loved one to suicide. Your answers, and answers from other community members, will be gathered together to identify themes related to healing. Once the interviews are complete and the themes have been identified, I will share them with you at a **1-hour feedback session** and ask for your feedback. I will also ask you questions about your experience in this study at the feedback session. The interview and feedback session will be recorded and later transcribed. This data will be immediately transferred to a password-protected USB drive, which will be stored in a locked file cabinet in the student researcher's office when not in use, along with the signed informed consent forms. The audio-recording will be transcribed, and all identifying information will be removed—this transcription will also be kept in the same locked cabinet. All data (i.e., audio files, transcripts, consent forms) will be kept in this locked file cabinet for five years after the work is presented. During this five-year timeframe, Yúustway Health Services and Squamish Nation Chiefs and Council may use data, that has been approved for use by each participant at each feedback session, with names removed and research numbers assigned instead, for other research purposes. After those five years, the data will be destroyed (i.e., professionally shredded and/or erased).
I am also asking you some questions about yourself, to be used for description and analysis—for example, your age, your education level, and how many loved ones you have lost to suicide.

We will meet somewhere private and quiet that works for both of us. For example, a Yúustway Health Services office or your own home would work.

The Research Is Voluntary
You can decide if you want to participate in the research. There will be no problem if you say "no." However, you must answer all of the demographic and interview questions for your answers to be included in the research. You may also withdraw from the research at any time for any reason. If you withdraw within 2 weeks of the interview, your data will not be included in the findings. If you withdraw more than 2 weeks after the interview, your data cannot be removed. In such a case, you will be passing on the opportunity to clarify any

misunderstandings, provide feedback, or request edits prior to the finalization of the results.

The Research Is Confidential
All the information you give us will be confidential to the best of our ability. Because the Squamish Nation is a small community, there is risk to confidentiality. To reduce this risk, we will give you a research number at the beginning of the interview. Only my supervising faculty, transcriptionists, data analysis assistant and myself will know which number goes with which name. No one else will know your name or what your answers are to the different questions. I will remove all identifiable information from any direct quotes I use. Again, because the Squamish Nation is a small community, it is possible that certain sentences you use or certain kinds of information you include may put you at more risk of being identified by people who know you. This is more likely if I use any long quotes of yours over 40 words. Also, if multiple quotes from you are used, that might increase the chances of someone putting the facts together and guessing who you are. You will have an opportunity to review extended quotes before the research is published. To honour and recognize your story, you may choose to have your name included in the research. If you choose to have your name included, it may be viewed by people internationally, and cannot be removed after the findings are shared.

Interviews and feedback sessions will take place at the YHS office or your home, depending on your preference. At the YHS office, confidentiality of participation is not guaranteed, as staff of YHS may see you arrive and/or leave, and as you know most community members are familiar with each other. You may choose to meet in your home for reasons of confidentiality. If you prefer to have the interview and feedback session in your home, I request that a room in the home be available for privacy from other residents.

Limits to What Is Confidential
We will need to tell someone if anyone is at risk of abuse or neglect or harm. This includes yourself or anyone else, including a child or Elder.

The Results of the Research
A report of findings will outline themes of healing. The report of findings will be shared with YHS, Squamish Nation Chiefs and Council, the participants, and any other recipients identified by the research team. I will also publish the report of findings in my dissertation. There may be requests from the student researcher to Squamish Nation Chiefs and Council for findings to be published or shared elsewhere.

I may also write or speak about the research. Your name or any other information that might identify you will NOT be included in any writing or presentation, unless you request to be acknowledged for your story.

For five years after the findings have been presented, Yúustway Health Services and Squamish Nation Chiefs and Council may use the written copy of your interview (with your name removed and a research number assigned instead) and the research findings, for other future research purposes.

If you want a summary of the results, you can ask for at this at the end of this form.

The Risks and Benefits
You might feel some stress when being asked and answering questions about your healing journey. If you feel too distressed you can:

1/ decide not to answer a particular question
2/ take a short break from answering questions
3/ re-schedule your interview
4/ withdraw from the research at any time

You may also feel you have learned something about yourself as a result of answering the questions, and you may find that telling your story is healing for you.

If you have any concerns about your treatment as a participant, you may contact the Chair of the Research Ethics Board. Her contact information is below:

REB Chair: Debbie Clelland PhD (604) 699.3570
E-mail: dclelland@adler.edu

If you would like counselling support or crisis support I can connect you with the mental health intake worker at Yúustway Health Services, or you may contact the services below.

Counselling
Mental Health Intake Worker
Yúustway Health Services, Squamish Nation
604-982-0332 (North Shore)
1-877-628-2288 (Squamish Valley)

Mental Health Counselling
First Nations Health Authority
1-800-317-7878

Crisis Support

SAFER (Suicide Crisis Line)
1-800-784-2433

Crisis Intervention Centre of BC
1-866-661-3311

Indian Residential School Crisis Line
1-866-925-4419

Consent for this Research:

- I understand my participation in this research is voluntary.
- I understand that signing this document does not impact my legal rights in any way.
- I know that if I refuse to answer any of the demographic and interview questions my answers will not be included in the research.
- I know I can withdraw from the research at any time.
- I know I can ask that all my information be removed until 2 weeks after the interview.
- I know that what I say will be audio-recorded.
- I understand that direct quotes may be used in the results, any information that will identify me will be removed, and my name will not my included unless I request it to be included.
- I further understand that at the feedback session I will have the opportunity to review the findings, clarify any misunderstandings, provide feedback, or request edits prior to the finalization of the results.
- I am giving my consent to participate in this study.
- I have received a copy of this Informed Consent signed by the researcher.

_____ _____
Participant Signature Date

_____
Participant Name (Print)

_____ _____
Researcher Signature Date

_____
Researcher Name (Print)

I would like to receive a report of findings.

Yes _____ e-mail address or home address.

Appendix G: Assessment for Capacity

In order for you to participate in the research, I must ensure that you are able to understand the information presented and the potential consequences. You have had 24 hours to review the Informed Consent Form on your own, and we also just reviewed the informed consent together. To ensure you understand the consent process and that your participation is voluntary, can you please tell me (choose one question to ask potential participant):

(1) Can you choose to stop participating after the interview has begun?

(2) Do you have to give answers to all of my questions?

(3) Are there consequences if you choose not to participate?

(If the participant answers correctly, follow the **acceptance script**. If the participant answers incorrectly, follow the **rejection script**.)

Acceptance Script

Thank you for your interest in this study. I look forward to hearing your story. Next, we will gather some demographic information, then we will start the interview.

Rejection Script

Thank you for your interest in this study.

I have put a lot of care and thought into who can participate in the study. I need to make sure everyone participating in this research understands the consent process and the potential consequences of participating. You may not understand

the consent process and/or the potential consequences. Therefore, out of respect, we cannot have you participate in this study.

If you have any questions, you can contact Dr. Weisbart. I can contact Dr. Weisbart with your questions if you are more comfortable with that. If you want to reach Dr. Weisbart or I, please see the poster in the newsletter for our contact information.

Appendix H: Interview Script

First, I want to thank you for your participation in this study. It is expected that your story will help guide planning for supporting grieving families after a suicide in the community. This interview will be around 1.5 to 3 hours.

I will ask you three key questions:

(1) Can you tell me about your experience losing a loved one to suicide?

(2) What was helpful in your healing journey?

(3) What supports would you like to see offered to families in the Squamish Nation community after a suicide?

Secondary questions I will ask are:

(a) Did you access any formal mental health or wellness supports?

(b) Did culture/religion play a role in your healing?

You may know me as a counsellor in the community, but in this situation I am a student researcher. My counselling experience and schooling have led me to believe that the best support is often a mix of counselling and cultural practices. I am aware that I am a White female and that White people have harmed your people for many years. My goal is to understand your story of healing, with both heart and mind, working in a good way. I want your voice to be heard.

I will ask questions to understand your experience. I may ask you other questions as we go along in order to gather more information and a good understanding of your experience. Other questions may include:

(1) Can you tell me more about that?

(2) What else was helpful?

There are no right or wrong answers. All opinions and ideas are encouraged. Again, you might feel some stress when being asked and answering questions about your healing journey. If you feel too distressed, you can:

- decide not to answer a question (but if you do not answer any of the questions, your answers will not be included in the findings);
- take a short break from answering questions;
- reschedule the interview; or
- withdraw from the research at any time.

(Student researcher now starts with the research questions.)

(1) Can you tell me about your experience losing a loved one to suicide?

(2) What was helpful in your healing journey?

(3) What supports would you like to see offered to families in the Squamish Nation community after a suicide?

Appendix I: Professional Assistance Confidentiality Agreement

Name of Researcher and Affiliation:

Jennifer Campbell, MEd, doctoral student at Adler University

I have agreed to assist Jennifer Campbell in her research study on understanding how Squamish Nation members heal after the loss of a loved one to suicide. I understand that my role is to transcribe interviews or assist with data analysis and interpretation. I understand that I must maintain the confidentiality of what research participants say and do, including that they are participants in the project. I further agree that no materials will remain in my possession beyond the operation of this research project and I further agree that I will make no independent use of any of the research materials from this project.

Even though I have signed this Confidentiality Agreement, I can discuss the research, including participation of individuals and the details of the research data, with other research team members who have also signed a Confidentiality Agreement.

A copy of this Confidentiality Agreement has been given to me for my records.

Signature _____ Date _____

Printed name _____ Title_____

Appendix J: Confidentiality Agreement by Research Team

RESEARCH PROJECT:
Squamish Nation Members' Healing Journeys After the Loss of a Loved One to Suicide

Student Researcher:
Jennifer Campbell, MEd
E-mail: [email address] Phone: [telephone number]

Supervising Researcher:
Dr. Cindy Weisbart, PSYD Core faculty, Adler University
E-mail: [email address] Phone: [telephone number]

CONFIDENTIALITY AGREEMENT: Student Researcher and Supervising Researcher. Through my work as a Student Researcher or Supervising Researcher with the above research, I understand my responsibilities concerning the confidentiality of any research data collected. I have reviewed the TCPS2 requirements for safeguarding the confidentiality of data for the duration of the project. I understand that I must maintain the confidentiality of what research participants say and do, including that they are participants in the project. Even though I have signed this Confidentiality Agreement, I can discuss the research, including participation of individuals and the details of the research data, with other research team members who have also signed a Confidentiality Agreement.

A copy of this Confidentiality Agreement has been given to me for my records.

_____ _____

Name Signature

_____
Date