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Circle of Strength: A Case Description of Culturally Integrated Suicide Prevention

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This article presents a case description of an American Indian female at high risk for suicide in effort to document the potential effectiveness of a college student suicide prevention program designed for Northern Plains American Indian students. The program is integrative and culturally grounded within the Medicine Wheel, stressing continuity of care through programming and ongoing communication across support systems. The composite case description presented illustrates the secondary prevention aspects of the model, and how utilizing the model within the framework of continuous care was helpful for a suicidal person and produced a successful outcome over the course of 6 months.

Keywords American Indian, college students, continuity of care, Native American, prevention, suicide

American Indians and Alaska Natives (AI/AN) have the highest suicide rate of any ethnic/racial minority group in the United States at 1.8 times the national average. Suicide represents the second leading cause of death for American Indians aged 15–24 years (Centers for Disease Control and Prevention, 2009). Unfortunately, Indian Health Services has less than one mental health professional for every 3,000 people served (IHS, 2009). Many AI/AN persons lack access to adequate mental health services and when services are obtained they can lack integration and coordination with other resources (Gone, 2004). Research within other populations has documented that a lack of follow-up and poorly integrated treatment services (e.g., continuity of care) are significantly associated with elevated risk for death by suicide (Apter & King, 2006; Desai, Dausey, & Rosenheck, 2005). Thus, there is a great need to attend to the development of programs and health delivery systems that integrate care across health modalities, and is culturally appropriate for AI/ANs. Given the holistic belief systems found within AI/AN groups, a continuity of care model that integrates this holistic world view that is adaptable to unique tribal practices and values is likely to be better received and potentially more effective (Gone, 2004).

As a result of the lack of access to mental health care, many AI/AN students' mental health concerns are not identified until they are in a college where mental health services are available. However, few tribal and 2-year colleges provide counseling services. According to the U.S.

Department of Education, there are over 190,000 AI/AN college students, with over half in 4-year colleges and universities (U.S. Department of Education, 2008). Among these AI/AN college students, approximately 15% (28,500) report seriously contemplating suicide over the past 12 months (American College Health Association, 2009). Among colleges and universities that do provide counseling services, rarely is there a mental health professional who is AI/AN or one with experience for working with this population's cultural and spiritual needs. The lack of AI/AN knowledge and representation among mental health professionals is one of the barriers for AI/AN students to seek help (Gone, 2004).

To date, there are few suicide intervention and prevention programs specifically created for AI/AN populations (see LaFromboise, 1995; LaFromboise & Lewis, 2008 for an exception). Nor are there any known culturally informed models emphasizing continuity of care across health systems and between the spiritual and physical realms of AI/AN life. In response to the high rates of suicide among AI/AN college students and the need for prevention models emphasizing culturally integrated care, a suicide prevention model based in Northern Plains Indian culture was designed for use at a public university (see Muehlenkamp, Marrone, Gray, & Brown, 2009). The suicide prevention program is consistent with Alcantara and Gone's (2007) transactional-ecological model that stresses the inclusion of traditional cultural factors intertwined with the developmental aspects significant to college students.

While full discussion of the model is beyond the scope of this article (see Muehlenkamp, Marrone, Gray et al., 2009), it is important to note that it is a multi-level program targeting primary and secondary prevention initiatives. The primary prevention component offers programming that focuses upon enhancing AI resilience through cultural and spiritual connections, reducing common risk factors for suicide, gatekeeper training, and reducing stigma around seeking help (see Figure 1). The secondary prevention component consists of an AI suicide prevention team, which is composed of faculty/staff dedicated to supporting the academic and mental health needs of AI students. Each member of the team is considered an AI support person who can be paired with a student identified at risk for suicide. The AI support person works with the student to help coordinate care and identify culturally sensitive resources to reduce the student's distress and suicide risk (see Figure 2). Across both prevention aspects, this model emphasizes a holistic worldview with the Medicine Wheel as its core, providing a framework for integrating the connections among (a) American Indian students, campus departments and health services, and tribal communities; (b) American Indian culture and spirituality; and (c) educational aspects designed to develop skills, strengthen relationships, and build resilience. Through the purposeful integration of these pieces, culturally sensitive continuity of care is modeled.

The medicine wheel and its underlying meanings are well known among many American Indian tribes, but the philosophy used in this model originated from the Lakota (commonly known as Sioux) tribe (Dapice, 2005). The medicine wheel (Figure 1) is sectioned into four multidimensional sacred parts that are believed to be strongly connected to and representative of the circle of life (Roberts, Harper, Tuttle-Eagle Bull et al., 1998). These four sacred parts represent many relationships that can be expressed in sets of four, such as the four sacred colors (red, yellow, black, white), the four parts of the spiritual and physical world (mental, physical, emotional, spiritual), the four primary values of the Lakota (respect, generosity, wisdom,

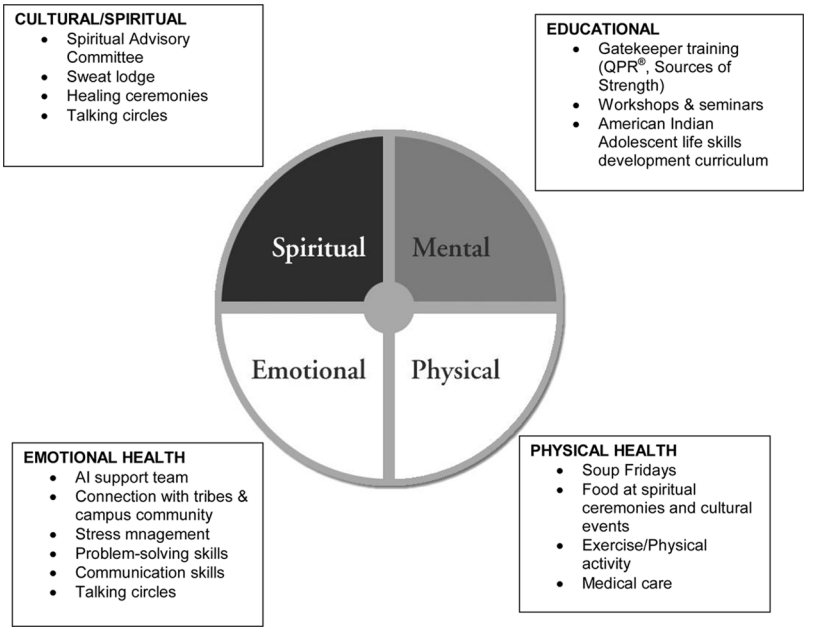

FIGURE 1. *Medicine wheel model of suicide prevention activities.*

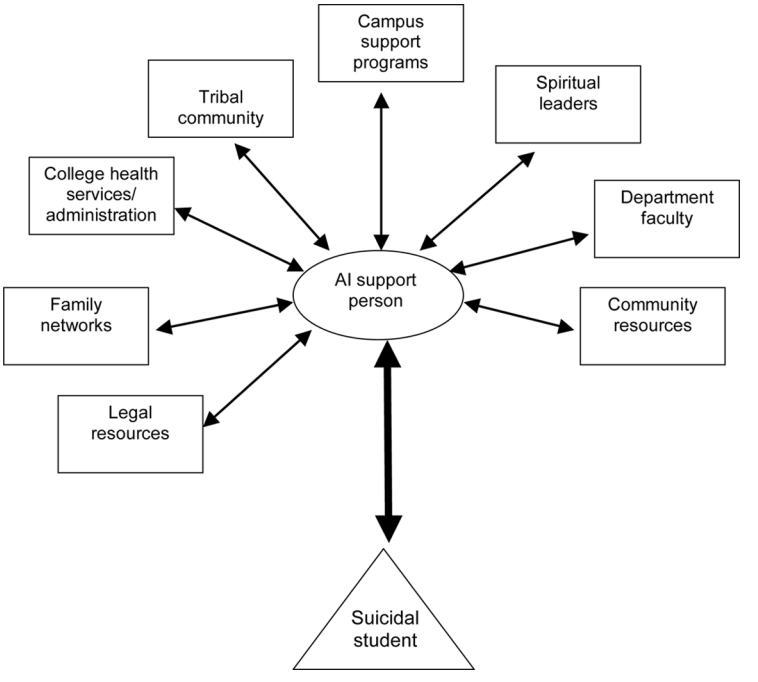

FIGURE 2. *American Indian support person integrative role.*

and courage). A key principle of the medicine wheel is interconnectedness, which emphasizes that all aspects of one's life influence the others (Coyhis & Simonelli, 2005). Healing in one area can be impacted by healing in another; representing the importance of continuity and integration of care across the four areas regardless of the health concern. The four sources of strength (quadrants) identified within the medicine wheel as mental (cognitive, psychoeducational, thinking processes), physical (food/nutrition, physical health, exercise, housing, physical wellbeing), emotional (counseling, social supports, interconnectedness, trust, encouragement), and spiritual (cultural, spiritual, ceremonial) provide the foundational structure for the current suicide prevention model. No quadrant of the wheel can be addressed alone, but a balance among the four quadrants helps the individual to proceed into wellness. This model is comprehensive in addressing the overall wellness and balance of all aspects of the individual. Preliminary outcome data suggest the primary prevention components of this model are potentially effective in reducing suicide risk among AI college students (Muehlenkamp, Marrone, Gray et al., 2009). Presented below is a case example of the secondary prevention component that successfully helped a suicidal student because of the interconnected care it supported.

CASE DESCRIPTION: JANE

Background

This case involves a female, American Indian (AI) graduate student in her mid-twenties whom we will call "Jane." Prior to the events that connected Jane with the AI Suicide Prevention program, she was a successful graduate student, advancing through her program of study in a timely fashion, and she worked as a graduate assistant on campus. Jane had a large network of friends both at school and back home in her American Indian community, with whom she frequently socialized, and she was connected to her spiritual beliefs through religious activities in her home community. Jane was also physically active, maintaining a frequent exercise routine as she was a person dedicated to promoting physical and emotional health. She had no prior legal history, no prior emotional problems, and no known prior suicide attempts. Jane was known to have a strong, positive relationship with her cousin with whom she lived as well as with her immediate family.

Jane was involved in a car accident while under the influence of alcohol. She and her three passengers, including a minor, were thrown from the car. Jane was taken to the hospital with head trauma and other minor injuries. Other passengers had scrapes and bruises, but no injuries. Jane's cousin contacted her on-campus employer (who was a member of the AI suicide prevention team and a mentor) to say she had an accident and was in the hospital for physical injuries and would not be in to work that day. The local newspaper reported that Jane was cited by the police for driving under the influence of alcohol (a misdemeanor) and reckless endangerment of a minor (a felony). Jane did not show up for work for over a week and had not contacted her employer, even after being discharged from the hospital. Jane was not in contact with her department of study nor her graduate advisor. She was not answering the telephone, attending classes, going to work, or maintaining any personal relationships other than her cousin with whom she shared an apartment off campus.

Jane's employer informed the AI Suicide Prevention Team of the situation and as she had an established relationship with Jane, the employer was assigned to be Jane's AI support person. The AI support

person contacted Jane by registered letter to schedule an appointment for her to come in and discuss her absences. During that meeting, Jane did not discuss the alcohol use at the time of the accident or the potential legal issues she was facing. The AI support person brought up the information that had been in the newspaper. Jane remained very quiet, would not make eye contact, and seemed surprised the AI support person knew about the legal issues. During their 90-minute meeting, the AI support person and Jane outlined a number of issues that required immediate action or Jane could suffer major negative consequences to her job, her future career, and her freedom. During this conversation, Jane demonstrated significant levels of hopelessness and helplessness. She also endorsed high levels of shame. The AI support person inquired about suicidal thoughts, their intensity, and whether she had a plan. Jane indicated that she had strong, frequent thoughts about suicide but did not endorse having any plans, or having the means for an attempt. While Jane did not present with active self-harming behaviors, she did describe incidents in which she was placing herself at increased risk for injury (e.g., noncompliance with medical regimens, failure to use physical supports causing a fall down stairs). Jane's status at that time, based within the Medicine Wheel, is presented in Table 1. After leaving this initial meeting, Jane returned home where she was arrested and taken to jail. She did not contact anyone to arrange for bail or let them know what happened until Monday (3 days later) after she was released.

At a meeting with her AI support person a few days after being released from jail, Jane acknowledged a high level of distress and persistent thoughts of suicide. However, she refused to access general student support programs that were in place on campus (e.g., counseling services) because she perceived them as adversarial, punitive (i.e., mandatory sessions or be suspended), and reflective of how the White culture attempts to rigidly control American Indians (Coyhis & Simonelli, 2005). She was also fearful of the potential stigma around using mental health services, particularly because she feared that using such systems would somehow be relayed to the director of her departmental program of study. In addition, Jane was confronted with comments by university administrative staff that students must deal with the consequences of their actions rather than being "coddled." Faculty in her department of study took a "hands off" approach rather than checking in to determine if supports were needed, so she felt relatively un-supported. Therefore, there were a number of obstacles inherent in the policies and traditional model of care on Jane's campus which impeded her willingness to acquire assistance. Consequently, Jane's AI support person worked closely with Jane to develop an integrative intervention plan that would assist Jane with accessing the necessary resources to support her and move her from a point of desperation to one of action.

Circle of Strength Coordination of Care

Jane represented an "at risk" student and so was entered into the secondary prevention component of the AI Suicide Prevention Program, which has the goal of reducing suicide risk by alleviating stressors contributing to the suicidality and improving overall functioning. This aspect of the prevention program embodies continuity of care by ensuring that students are connected to and utilize resources available to them after they have been identified as "at risk." In order to do this, a student is assigned an AI support person who remains as a primary contact and continuous support person for the student, following up as required. All AI support persons

TABLE 1. **Jane's Health Status Across the Four Medicine Wheel Strengths**

Strength	1st contact and assessment	Outcome—6 months later
Mental	Strong, persistent suicidal ideations	No reported thoughts of death
	Poor concentration	Sustained concentration
	Excessive sleeping	Attending classes & passing
	Not attending classes (at risk for failing)	Completing research
	Not working on her research	Making progress on her degree
	Neglecting graduate assistantship duties	Performing assistantship duties
	Stalled progress on her degree	
Physical	Severe headaches	Decreased headaches
	Decreased mobility due to injuries	Improved physical mobility
	Head injuries impairing mental activities	Engaged in regular exercise/sports
	Increased physical accidents/injury	Eating regularly (healthier foods)
	Not eating or eating only junk food	Regular sleep schedule
	Excessive sleeping	
Emotional/Social	Depressed mood	Happier mood
	High hopelessness/helplessness	Reported being able to manage tasks
	Feeling overwhelmed & ashamed	Utilizing positive coping model to minimize experience of shame
	Fear of being an embarrassment to family	
	Withdrawal from all social interactions	Engaged with peers, family
	Did not disclose accident or legal issues to anyone (including family) except her sister	Continues counseling for substance abuse issues
Spiritual	Withdrawal from spiritual activities	Participated in AI spiritual ceremonies
	No contact with spiritual leader	
	Did not attend spiritual ceremonies frequently attended in past	Active involvement in spiritual events and ceremonies in home community
	No communication with other members of her	Maintains communication with spiritual leader
	American Indian community	
Suicide risk*	High	Low
	Strong, persistent suicidal ideations	Denied suicidal thoughts
	Increased rates of accidental injuries	No accidental or intentional injuries

Note: *Suicide risk level was assessed by the American Indian Support Person coordinating Jane's care via face to face interview.

are trained in suicide risk assessment and referral by the Director of the AI Suicide Prevention Program who is a faculty person on campus and licensed mental health provider. The AI support person is available to students during the work week and occasionally on weekends depending upon the agreement established between the student and AI support person. The role of the AI support person is to act as a consultant, linking and empowering students to use available university, community, and AI-specific resources. In essence, the AI support person resembles a role similar to that of a case manager or treatment coordinator within traditional medical settings.

The resources and interventions utilized are individually tailored to the specific needs of the at-risk student, depending on their situation and risk factors. The student's AI support person may assist with basic problem-solving and solution generation but they do not provide individual therapy and instead act as a resource and liaison for the student. The AI support person remains the same for the student until it is mutually agreed upon that the student no longer requires the support person.

After obtaining the appropriate verbal consents from Jane, her AI support person was able to begin to facilitate Jane's access to her necessary resources (described below). The AI support person checked-in with Jane weekly (via phone, email, or in person) for the first 5 weeks always inquiring about suicidal thoughts, then bi-weekly for another 2 months, and then monthly to ensure that Jane was continuing treatments and using the resources available to her. In addition, Jane's AI support person facilitated communication between Jane, faculty of her academic department, and tribal spiritual leaders from Jane's home community. The specific interventions facilitated via the AI support person, consistent with the Medicine Wheel model, are described below.

Mental

Interventions within this category focused on aspects of Jane's functioning that related to mental and cognitive tasks such as deciding what to do about her legal problems, academic standing/progress, and daily living tasks. Jane was referred to an American Indian attorney who helped her navigate the legal process and minimize the immediate and long term consequences of her actions. Jane also worked with her AI support person to prioritize daily tasks and create a manageable academic and work schedule. She was also coached in communicating with her academic advisor to create a new plan for finishing her research and classes and return to making adequate progress on her degree.

Physical

Interventions in this domain tend to focus on improving physical health and addressing physical disabilities in a way that promote student functioning. After receiving notification from the University that continued absence from her assistantship would result in termination and a graduate record of a "failed placement," Jane was referred to University disability services and was able to obtain accommodations (e.g., was provided resources to complete some work at home) for her physical injuries that prevented the termination. Jane was visited by different AI program staff with food to encourage regular, healthy eating as well as to provide social support. In addition, Jane was encouraged to and attended the program's weekly "Soup Fridays" for nutrition and social interaction. She was also encouraged to attend her physician appointments and would check-in with her AI support person regarding her attendance and health status.

Emotional and Social. Interventions within this domain frequently focus on improving emotional and social functioning, managing emotional disorders/symptoms, and enhancing coping skills. Jane was referred to the mental health counselor associated with the AI Suicide Prevention Program on campus who provided initial emotional support and basic counseling resources. Through this contact, Jane was connected with a culturally informed therapist in the community for her substance abuse and depression. The AI Suicide Prevention Program counselor continued to follow-up with Jane periodically to encourage her to adhere to her recovery plans and to offer

continued on-campus counseling support. Jane was also supported in talking with her family and identifying agreeable social activities to engage in with close friends.

Spiritual. Interventions within this domain focus on connecting students to traditional spiritual practices and alternative healing methods consistent with their particular American Indian beliefs. The spiritual advisor in the local community for American Indian ceremonies was notified and visited Jane. Together they planned some ceremonies to promote Jane's healing and wellness, which she participated in. She was also urged to visit the spiritual advisor of her home community, who (with Jane's permission) was contacted and informed of the events that had occurred by her AI support person. Jane followed through and began to have regular contact with her spiritual leader.

Outcome

The primary outcomes that are strived for when using the secondary prevention aspects of the AI Suicide Prevention Program are to reduce suicide risk by alleviating distress and enhancing healthy functioning by providing a consistent support base that coordinates and links the student to the different types of care required. As a result of the integrative efforts of the program and the attention to the holistic, culturally appropriate domains affected in Jane's life, a successful outcome was obtained approximately 6 months following Jane's initial contact with her AI support person (see Table 1). Specifically, Jane had returned to a pre-morbid level of functioning and no longer expressed suicidal wishes. While it is impossible to know if Jane would have attempted suicide, it is strongly believed that the program's ability to reach out to Jane, connect her to appropriate medical and legal resources, follow-up to ensure she was utilizing the resources available, and the ability surround her with culturally relevant and spiritual interventions returned her to a healthier, more successful student. When asked about her experience with the AI prevention program, Jane stated that having a consistent, supportive person to consult with who respected and worked within her AI cultural needs was a critical factor in actually seeking and using help resulting in her eventual return to healthy functioning.

CONCLUSION

This case description documents how having an integrative program and methods for responding to suicidal risk among minority, or marginalized, students that incorporate their unique cultural needs may reduce suicide risk. Consistent with the larger suicide literature, models of care that work to ensure a patient's treatment is coordinated across multiple systems and actually utilized by the patient, tend to be effective in returning the patient to a healthier, non-suicidal state (Mann, Apter, Bertolote et al., 2005). The model described in this case description provides a strong safety net for AI students who may be suicidal that focuses upon continuity of care by assigning a single support person for the student to use as a resource and liaison among different care systems and modalities. Having a single point of support that helps the student identify the types of interventions and resources needed may ease the burden on the student of creating an appropriate holistic system of intervention. The case description also highlights how having a personal supportive resource on campus that attends to cultural needs may be particularly salient in breaking down barriers to help-seeking for minority students.

Despite these apparent strengths of the program developed, a potential weakness is that it can be time-intensive for the faculty

member acting as a support person since they are responsible for linking the student to appropriate resources and maintaining regular follow-up with the student. Furthermore, the success of the program is dependent upon someone identifying the at-risk student and referring them to the AI Suicide Prevention Team. Thus, a larger university system for promoting effective, regular communication and monitoring of students who may be at-risk is essential. Without the individual buy-in of faculty and administrators this program could be less effective because students at risk would not come to the attention of the program.

In summary, it is important for suicide prevention programs, particularly those on college campuses, to have the freedom to reach out to those who may be having a difficult time and provide support without appearing punitive or uncaring. Students who are at risk for suicidal behavior may be less able to reach out themselves because of feeling overwhelmed by their situation. Having a model that promotes access to culturally integrated resources and encourages an ongoing relationship with the student is at the heart of a continuity of care model. The program described offers one model for utilizing continuity of care for the prevention of suicide among AI students within a college or university setting.

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