American Journal of Neurology Research

Review Article

Cultural Adaptations to Suicide Screening among American Indians/Alaska Natives

Mark Standing Eagle Baez*

Assistant Professor of Clinical and Counselling Program at Bemidji State University, Bemidji, Minnesota, USA.

Corresponding Author Information

Mark Standing Eagle Baez

Assistant Professor of Clinical and Counselling Program at Bemidji State University, Bemidji, Minnesota, USA.

Received: February 14, 2025; **Accepted:** March 26, 2025; **Published:** April 02, 2025

Citation: Eagle Baez MS. Cultural Adaptations to Suicide Screening among American Indians/Alaska Natives. American J Neurol Res. 2025; 4(2):1-6.

ABSTRACT

American Indian/Alaska Native (AI/AN) populations experience disproportionately high rates of suicide, and understanding the neurological and mental health factors, as well as the historical and cultural context, is crucial for effective prevention and intervention strategies. Intergenerational trauma, stemming from past biases and cultural disruption, significantly contributes to the higher rates of suicide among AI/ANs, affecting mental health and leading to substance abuse and other adverse outcomes. In 2021, suicide rates were highest among American Indian/Alaska Native (AI/AN) persons, and AI/AN youths had the highest rates of suicide compared to their same-aged peers from other racial and ethnic groups [1]. The ongoing challenge of AI/AN youth suicide is a public health crisis of relatively recent historical origin that is inadequately addressed by contemporary prevention science [2]. However, when selecting screening tools for AI/ANs, it is critical to consider that they are primarily developed for non-Native communities, may have intrinsic biases, and may originate from a colonial perspective along with their applications. Indigenous people are not the same as other groups; their unique cultural factors, such as traditions, family, and historical trauma, should be among the most critical justifications to consider for behavioral health screenings and services promoting suicide care in Indigenous communities. Literature suggests little to no suicide screening tools explicitly tailored for Indigenous people. This article will highlight preventive and protective factors incorporated into a screening tool called Indigenous S.A.F.E. Screening (ISS), which uses a culturally sensitive, relevant, and appropriate language method. A pilot study on the ISS is currently being conducted. The current study will gather data on the tool's face and construct validity among experts in the behavioral health field.

Introduction

Indigenous communities have significantly higher rates of suicide than non-Native communities in North America. AI/AN young adults are at the most significant risk for thinking about and attempting suicide [3]. Additionally, in contrast to the general population, rates of suicide among AI/AN people peak between the ages of 20 and 29, after which they decrease with age [2]. These statistics question whether longstanding mental health treatments have effectively addressed suicide among AI/AN communities. Prevention and intervention efforts have been unsuccessful in repairing this disparity. One clarification is that these efforts are culturally unequal for AI/AN communities. Suicide disproportionately affects the American Indian population in the United States. Among AI/ANs, suicide is the second leading cause of death [4]. A study conducted by Stone et al. [5] found higher odds of suicide among AI/AN persons across a range of connection problems related to family, interpersonal violence victimization and perpetration, and death of friends or family members by suicide. When Indigenous people do receive treatment, their care may be culturally inappropriate because of the individualistic and clinic-based intervention offered by primarily non-Native counselors [6]. While it is important to acknowledge

these statistics, which tell part of the story of Indigenous families, research that only focuses on adverse outcomes misses the inherent strengths, resilience, and hope present in Indigenous communities and cultures. Neurological conditions most closely linked to suicidal thoughts include hopelessness, depression, and social isolation. Although these are psychological states, they often intertwine with neurological dysfunctions, significantly increasing the risk of suicidal ideation. Nevertheless, culturally adapted research and assessment evaluations can help shift narratives to reflect current community conditions and highlight local strengths. To conduct culturally adapted research and assessments, it is essential to customize evidence-based interventions to practice-based evidence that considers Indigenous languages, cultures, and contexts, ensuring alignment with their values and traditions. The ISS tool, which will be discussed briefly below, is designed explicitly for Indigenous peoples and was developed based on the insights of a selected panel of Indigenous and non-Indigenous experts who have worked with Indigenous populations, encompassing both direct and indirect services. The data used to create the ISS tool was collected using the Delphi method. This structured group communication technique utilized iterative rounds of anonymous questionnaires and controlled feedback from the primary investigator to achieve consensus on complex issues, such as suicide.

Literature Review

Underserved cultural and racial groups face barriers to effective mental health care, making it critical for practitioners to be equipped to integrate cultural considerations for suicide prevention and intervention [7]. It would be valuable to know specific ways to improve suicide screening services for Indigenous people. Although the total suicide proportion in the U.S. has heightened in recent years, identifiable populations and individualities encounter inconsistent risks. The second leading cause of death is suicide among AI/AN youth ages 8 to 24, and AI/AN youth from 10-24 years of age have the highest rate of suicide of all demographic groups. Culture can also be an obstacle to services, although this seems to be progressing since the extreme increase in suicide deaths and suicide deaths [8]. Mental health stigmatization is widespread everywhere, but there can be more stigma of suicide in Indigenous communities. Some groups will not reach out to mental health services because of the perception of suicide associated with services [9]. Others may decline mental health services when they are identified as at-risk, related to the association and perception of suicide [10].

It has been shown that cultural stigma exists pertaining to mental health services because of a lack of validated, culturally tailored measures in Indigenous communities. Stigma can impact how Indigenous people respond to suicide questionnaires, including not being honest about questions related to suicide and the risk for suicide [9]. Western approaches to suicide prevention involving individual-level efforts for behavioral change via mental health professional intervention by themselves have failed mainly at addressing suicide in Indigenous populations, possibly due to cultural misalignment with Indigenous paradigms [11]. Evidence suggests that for mental health treatment, Indigenous people prefer culturally informed care that respects Native perspectives on health and well-being [12]. LaFromboise and Lewis [13] suggest that Tribal stakeholders generally prioritize strengths-based strategies that harness Native ways of knowing and being, integrate local and cultural resources, and promote Tribal nations' self-determination. Preventative strategies that emphasize holistic and relational perspectives and strong connections with land, spirituality, cultural traditions, and Elders are shared across many Tribal settings [14]. Many mental health screening tools lack cultural sensitivity, which can make it difficult for Indigenous people to feel safe about disclosing personal information and or seeking help from mental health professionals. Current Western traditional models for screening suicide are often based on a Western perspective, which may not align with Indigenous people's worldviews. Some American AI/AN populations have distinctive patterns of risk and protective factors for suicide [15]. While screening tools are fairly standard, we have seen from other literature and reports from community partners that these tools can be culturally insensitive and challenging to implement.

Neurological Disorders

Neurological disorders are associated with suicide, and AI/ANs experience high rates of suicide and substance use disorders. However, risk factors like trauma and socioeconomic status can help explain these disparities. Ehlers et al. [16] suggest that suicide and neurological disorders may present the flowing among AI/AN:

- A study of over 7.3 million people found that people with neurological disorders had a higher risk of suicide.
- The risk of suicide varied depending on the type of neurological disorder and how long someone had had it.

Suicide and risk factors for AI/AN

- AI/AN experience high rates of suicide and substance use disorders.
- Risk factors for suicide among AI include historical trauma, discrimination, unstable family relationships, unemployment, and alcoholism.
- Some studies have found that accounting for risk factors reduces the likelihood of mental health disorders.

Research on suicide and AI/AN

- Research has focused on developing community programs to reduce the risk of suicide among AI.
- Clinical neuroscience techniques may help identify risk and protective factors for mental health disorders in AI populations.
- A study of AI found that people with no reported suicidal thoughts had more significant activity in executive control regions during a stop-signal task.

Genetic factors

- A study of an AI/AN population found that rare genetic mutations are associated with suicidal behaviors.

There is increasing interest in culturally responsive suicide prevention approaches for migrant and minority communities [17-20]. Current research shows that culturally sensitive and responsive approaches are a promising direction for preventing suicide among migrant and non-Western cultural groups [11,21]. Practitioners and professionals should not generalize about the experiences of marginalized groups; researchers have found that there is an association between historical and racialized trauma and suicide risk. The expert panel comprises psychologists, mental health practitioners, nurse practitioners, social workers, and researchers. The panel of experts provided sound recommendations for the ISS instrument to be more culturally aligned and sensitive. It ultimately reached a consensus on the screening questions developed by the author.

Instrument

The Indigenous S.A.F.E. Screening (ISS) tool is a suicide screening tool for all ages in clinical settings, behavioral health, and community-based settings. The acronym S.A.F.E. stands for Suicide-Assessing-Factors of Event. The Indigenous S.A.F.E. Screening tool (ISS) is a screening tool that was developed by an Indigenous practitioner for Indigenous people and can be administered by native and non-Native clinicians and professionals. The study provided guiding steps to ensure thorough contingency planning for practitioners to ensure the validity of this screening tool. This does not suggest that we are against empirically supported analyses. However, Duran, Fierhammer, and Gonzalez described it brilliantly by stating:

> 'Just because a mental health approach has undergone empirical testing does not make a particular helping theory of choice for all or even most clients whom practitioners are called upon to serve. Indeed, clinical trials and empirical testing support the efficacy of many mental health theories.

However, if an empirically validated approach to helping is not culturally relevant to clients from different groups, using that particular theoretical approach is likely to be ineffective or beneficial for those individuals.

The initial development was conducted by the author, an Indigenous practitioner for Indigenous clients, utilizing a Delphi method that incorporated the assistance of 21 expert panels comprising both Native and non-Native practitioners. The study provided guiding steps to ensure thorough contingency planning for practitioners, thereby ensuring the validity of this screening tool. The ISS comprises 9 questions. The tool is a one-page document designed to be administered in approximately 9 minutes. The ISS will identify individuals who require further mental health/suicide safety assessment as well as identify risk factors and protective factors.

- *Tell us what you like about life or living: being on your good path*
- *Can you imagine a beautiful story or moment when you felt happy with life? If so, when did this happen, and what was the memory?*
- *Are you willing/able to speak with family, friends,' a medicine person, or others you trust in your circle of support about emotional problems?*
- *When challenges arise, people may resort to unhealthy coping, such as substance use. When you feel sad, angry, or emotionally distressed, describe how you cope and whether you use alcohol or drugs.*
- *In the last seven days, have you had thoughts/dreams about ending your life?*
- *In the past week, month, or year, have you had thoughts of you no longer living? If so, when?*
- *Have you experienced thoughts of ending your life by self-injury? Please share your thoughts and feelings about the experience and what stopped you.*
- *At this moment (or right now), do you have thoughts or feelings about ending your life? If yes, what emotions are you feeling, and why do you feel this way?*
- *What gives you hope?*

Administration of ISS and Significance of the Screener

A central principle in administering this screening should be to use it only with appropriate training, without any deviation from cultural responsivity. The qualification level refers to trained personnel, including those with a PhD. The ISS was developed to enable Native and non-Native clinicians, therapists, support staff, and professionals to administer the tool to Indigenous clients. The ISS will take 9 minutes to complete. Routine screening is a crucial component for identifying and providing appropriate care for individuals at risk of suicide. Screening can be conducted in various settings by trained individuals. In rural or urban communities, screening settings may include mental health and primary care clinics, substance use disorder treatment clinics, emergency departments, schools, or community-based settings. Whether screening is done initially, on every visit, for everyone, or only for specific individuals depends on the setting and the expected level of risk among the individuals within that setting.

Indigenous and Western perspectives also have epistemological differences regarding what is knowable and, more specifically, how suicide should be studied [17]. Practitioners, mental health professionals, and educators must acknowledge the demographic and socioeconomic factors contributing to these health inequalities and prioritize further understanding, flexibility, and efforts to address these disparities. Additionally, it is essential to understand the role of cultural issues and other risk factors in the high prevalence of mental health disorders among Indigenous populations. Indigenous and non-Indigenous practitioners and mental health professionals will be able to administer this screening tool, including its cultural applicability and steps for assisting with the cultural screening process. Utilizing a culturally responsive approach when administering the ISS is recommended.

Table 1:

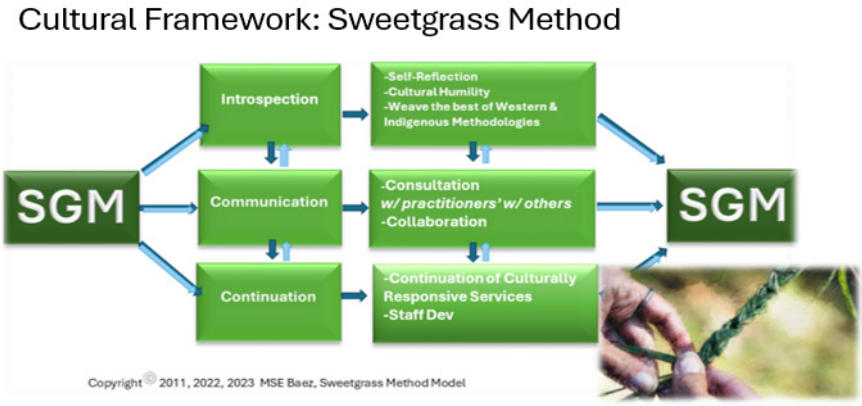

Table 2: Cultural Approach to Administering the ISS: Sweetgrass Method (*adapted from the Sweetgrass Method to Bullying 2023*).

INTROSPECTION	
• Understand your limits with AI/AN & First Nations culture. • Reflect on how you approach AI/AN people. What do you know? What assumptions might you hold? • Be open to improving your skills. Ultimately, you want to enhance your learning to promote better outcomes among AI/AN and First Nations peoples.	• Consult with other practitioners with experience working with AI/AN, First Nations clients, or particular Tribes. This may include networking with Tribal/village communities and Elders. • Assess self-care. Can you respond to the situation with cultural humility, calmness, and professionalism? Or are you overstressed and lacking patience?
COMMUNICATION	
• It is often best to immediately work with Indigenous clients with cultural sensitivity and cultural relevance. • Approach the client calmly and with a soft but assertive tone. • Practice cultural humility to build trust. Ask questions and approach the person with sincere curiosity. Be upfront with the AI/AN or First Nations person if you do not know about their culture and ways, but stress that you are open to learning to provide the support that honors their growth and the relationship between the two of you. • Ask, "Do you prefer AI/AN, First Nations, or Indigenous?" and inquire about the Tribal name.	• Recognize that different cultures have different attitudes regarding personal space and eye contact. • Address the concern without a fixed stare (i.e., pan around the room). • Clearly state that you care about who they are, their culture, and where they come from, which is why you want to address the possible thoughts of ending life. • Listen to the client and check your cultural understanding of them and their situation. • Collaborate with the client's family; listen to their story and learn who they are and where they come from. Moreover, they understand their family customs.
CONTINUATION	
• Show up and follow through. The client and their family must believe you will do what you say. • Recognize the value of AI/AN or First Nations clients' talents, abilities, skills, and experiences that honor who they are as AI/AN and First Nations people.	• Maintain healthy partnerships with the AI/AN or First Nations client, their family, and the community (e.g., Tribal/Village healers). • Provide ongoing support and suicide prevention/intervention strategies that are culturally responsive for both clients/students and caregivers. • Incorporate practice-based evidence (i.e., what works for that Tribal/Village community).
THREE STEPS: Apply the SGM to your screening	
• Educate Yourself: Take the time to learn about the history, culture, and rights of Indigenous peoples in your area. Understanding their experiences and perspectives is crucial.	• Build Trust: Approach Indigenous communities respectfully and openly. Establishing trust is essential for meaningful relationships (layout intentions, no secrets).
• Engage Respectfully: Initiate conversations with Indigenous individuals and groups, ensuring you listen actively. Building a relationship requires mutual respect and understanding. Seek introductions through trusted community members and demonstrate respect by following proper protocols.	

The Sweetgrass Method (SGM) (see Table 1), grounded in this tradition, is a culturally responsive framework that looks at the best of Western evidence-based approaches and the best of Indigenous practice-based evidence for the clients serviced [22-24]. The SGM emerged from frustration over the barriers to services for AI/AN people. The author began incorporating the best ways to serve his clients by combining Indigenous and Western approaches, as other Indigenous colleagues had done. In 2008, the author implemented this Indigenized methodology by weaving in the best of Traditional healing methods with the Western approaches. The SGM weaves together three strands: (a) introspection, a life-long commitment to self-reflection, cultural humility, and weaving in the best of Western evidence-based practices and the best of Indigenous practice-based evidence; (b) communication, communicating/networking in a culturally appropriate manner; and (c) continuation, ongoing cultural support for Indigenous clients. Applying the SGM (Table 2) to the ISS tool, clinicians and mental health professionals would initiate this screening

dialogue through introspection [25]. This would include thinking through what practitioners know and need to learn about their client's Indigenous culture and reflecting on where there may be similarities and differences between their client's traditions and their own.

Reflection

Suicide is preventable. It disproportionately affects American Indian or Alaska Native (AI/AN) persons. Previous studies have examined suicide characteristics and circumstances among non-Hispanic AI/AN only in a limited number of states [5]. Despite significant ongoing systemic challenges Indigenous people face in the United States, they continue to demonstrate remarkable resilience, often drawing strength from their deep connection to land, culture, community, and spiritual practices, even while reporting high rates of psychological distress due to the impacts of colonization and dispossession; this resilience is evident in their ability to maintain cultural identity, adapt to changing environments, and advocate for their communities despite adversity [26]. Despite efforts by Western methodology to treat and support Indigenous people, health disparities and inequities are desperately tricky, with little progress made over the last few decades. Most mental health professionals have some understanding of the historical challenges that Indigenous Americans have faced related to colonialism but often do not connect the dots between those circumstances and the presentation and treatment today [27]. Studies that have examined cultural relationships have found that higher levels of hope were associated with lower levels of suicidal ideation in American Indian youth [28].

The Western approach to screening suicide among Indigenous people has been from one perspective. However, incorporating traditional Indigenous methods is crucial to addressing the mental health needs of marginalized Indigenous communities effectively. The ISS aims to capture significant information, incorporate cultural relevance and sensitivity, and deliver services centered on Indigenous perspectives. Current research on the ISS is seeking a promising instrument that is culturally appropriate, relevant, and sensitive to the Indigenous clients being screened. This study aims to draw on the same local culture, knowledge, needs, and priorities by adopting a similar approach and incorporating Indigenous perspectives when developing a screening tool.

References

1. Stone DM, Mack KA, Qualters J. Notes from the Field: Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group United States, 2021. MMWR Morb Mortal Wkly Rep. 2023; 72: 160-162.
2. CDC. Suicide prevention resource for action. Atlanta, GA: US Department of Health and Human Services. 2022.
3. McCance-Katz EF. The Substance Abuse and Mental Health Services Administration (SAMHSA): New Directions. Psychiatr Serv. 2018; 69: 1046-1048.
4. Gray JS, McCullagh JA. Suicide in Indian country: The continuing epidemic in rural Native American communities. Journal of Rural Mental Healt. 2014; 38: 79-86.
5. Stone D, Trinh E, Zhou H, Welder L, End Of Horn P, et al. Suicides Among American Indian or Alaska Native Persons - National Violent Death Reporting System, United States, 2015-2020. MMWR Morb Mortal Wkly Rep. 2022; 71: 1161-1168.
6. Wexler L, Chandler M, Gone JP, Cwik M, Kirmayer LJ, et al. We are advancing suicide prevention research with rural American Indian and Alaska Native populations. Am J Public Health. 2015; 105: 891-899.
7. Cruz MA. Cultural Considerations in Suicide Prevention and Intervention. American Psychological Association Communiqué. 2024; 52: 12-16.
8. Cwik M, Barlow A, Tingey L, Goklish N, Larzelere-Hinton F, et al. Exploring risk and protective factors with a community sample of American Indian adolescents who attempted suicide. Archives of Suicide Research. 2015; 19: 172-189.
9. Shaw JL, Beans JA, Comtois KA, Hiratsuka VY. Lived Experiences of Suicide Risk and Resilience among Alaska Native and American Indian People. Int J Environ Res Public Health. 2019; 16: 3953.
10. Allen LR, Watson LB, Egan AM, Moser CN. Well-being and suicidality among transgender youth after gender-affirming hormones. Clinical Practice in Pediatric Psychology. 2019; 7: 302-311.
11. Sjoblom E, Ghidei W, Leslie M, James A, Bartel R, et al. Centering Indigenous knowledge in suicide prevention: a critical scoping review. BMC Public Health. 2000; 22: 2377.
12. Wilson DH, German D, Ricker A, Gourneau H, Hanson GC, et al. Feasibility, acceptability, and effectiveness of a culturally informed intervention to decrease stress and promote well-being in reservation-based Native American Head Start teachers. BMC public health. 2023; 23: 2088.
13. LaFromboise TD, Lewis HA. The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. Suicide and Life-Threatening Behavior. 2008; 38: 343-353.
14. LaFromboise TD, Malik SS. A culturally informed approach to American Indian/Alaska Native youth suicide prevention. In N. Zane, G. Bernal, F. T. L. Leong Eds. Evidence-based psychological practice with ethnic minorities: Culturally informed research and clinical strategies. American Psychological Association. 2016; 223-245.
15. Adams RJ, Haroz EE, Rebman P, Suttle R, Grosvenor L, et al. Developing a suicide risk model for use in the Indian Health Service. Npj Mental Health Research. 2024; 3.

16. Ehlers CL, Yehuda R, Gilder DA, Bernert R, Karriker-Jaffe KJ. Trauma, historical trauma, PTSD and suicide in an American Indian community sample. J Psychiatr Res. 2022.

17. Wexler LM, Gone JP. Culturally responsive suicide prevention in Indigenous communities: unexamined assumptions and new possibilities. Am J Public Health. 2012; 102: 800-806.

18. Na S, Ryder AG, Kirmayer LJ. Toward a culturally responsive model of mental health literacy: facilitating help-seeking among East Asian immigrants to North America. Am J Community Psychol. 2016; 58: 211-225.

19. Allen J, Wexler L, Rasmus S. Protective factors as a unifying framework for strength-based intervention and culturally responsive American Indian and Alaska Native suicide prevention. Prev Sci. 2022; 23: 59-72.

20. Meza JI, Bath E. One size does not fit all: making suicide prevention and interventions equitable for our increasingly diverse communities. J Am Acad Child Adolesc Psychiatry. 2022; 60: 209-212.

21. Villarreal-Otálora T, Jennings P, Mowbray O. Clinical interventions to reduce suicidal behaviors in Hispanic adolescents: a scoping review. Res Soc Work Pract. 2019; 29: 924-938.

22. Baez MSE. Significant Partnerships with Native American Students, Parents, and Schools: A Sweetgrass Method. National Association of School Psychologists. 2011; 39: 34.

23. Baez MSE, Isaac P. Sweetgrass Method to Bullying Prevention for Native American Youth. Journal of Indigenous Research. 2013; 3: 1-15.

24. Baez MSE, Baez CA, Lavallie B, Spears W. Sweetgrass Method: A Culturally Responsive Approach to Mental Health. Journal of Indigenous Research. 2022; 10: 1-22.

25. Baez MSE. Weaving Indigenous Perspective into Bullying Prevention/Intervention: Sweetgrass Method. National Association of School Psychologists. 2023.

26. Baez MSE. Indigenous Spirituality: Resilience in Decolonizing Mental Health. Crushing Colonialism magazine. 2025.

27. Blume AW. An Indigenous American conceptualization of substance abuse and its treatment. Alcoholism Treatment Quarterly. 2021; 39: 135-153.

28. O'Keefe VM, Wingate LR. The role of hope and optimism in suicide risk for American Indians/Alaska Natives. Suicide life-threatening behavior. 2013; 43: 621-633.