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Michelle C. Sarche, Paul Spicer, Patricia Farrell,
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Chapter 16

AMERICAN INDIAN LIFE SKILLS: A COMMUNITY-BASED INTERVENTION FOR INDIGENOUS MENTAL HEALTH

Teresa D. LaFromboise and Azadeh S. Fatemi

Although suicide was infrequent among North American Indigenous tribes prior to colonization (Pine, 1981), their suicide and suicide-related behaviors (e.g., ideation, suicide planning, and suicide attempts) have become a major public health concern (Centers for Disease Control, 2006). Completed suicide is 72% more common among North American Indigenous people than among the general U.S. population (Indian Health Service, 2002). Suicide is increasingly becoming a dramatic problem in a number of North American Indigenous communities, signaling intensified distress (U.S. Commission on Civil Rights, 2004). Troublingly, suicidal behavior emerges early in the life span. When collapsing data across 562 American Indian tribes or nations, suicide is the third leading cause of death among North American Indigenous children and adolescents in the ten to fourteen-year-old age group, and the second leading cause of death in the fifteen to twenty-four-year-old age group (National Center for Health Statistics, 2002).

Despite the fact that mood disorders and poor social adjustment are frequently cited as the strongest predictors of suicidal behavior in childhood (Foley et al., 2006), many Indigenous[1] children are also disproportionately exposed to substance abuse (Galliher, Evans, & Weiser, 2007). During the Senate Select Committee on Indian Affairs' hearings on American Indian youth suicide in 2009, Sen. Byron Dorgan spoke passionately (with permission from the family) about a fourteen-year-old girl residing

on a Northern Plains reservation who laid in bed in a fetal position for some ninety days and nobody asked about her. Senator Dorgan went on to say that "her sister had committed suicide. Her mother was a drug abuser. Father had taken his own life. And somehow she just fell through the cracks." Eventually, the young woman took her life (see http://www.indian.senate.gov/hearings/hearing.cfm?hearingID=3681).

In addition to behavioral maneuvers, a youth's style of reasoning and beliefs shape the suicidal act (Jobes & Nelson, 2006). Suicidal adolescents often believe that suicide will bring about a solution to their problems. The attempt will help them get away from their troubles for a time; suicide will make others better understand their intolerable psychic pain; or, they will be dead.

The purpose of this chapter is to describe the development and evaluation of the American Indian Life Skills (AILS) intervention for mental health with Indigenous adolescents. Prior to this undertaking, an Indigenist stress-coping model and a social-cognitive model of health will be introduced. Then selected ecological, social, and individual risk factors that influence Indigenous adolescent suicide will be enumerated. Finally, a pathway to resilient adaptation that features the approach-coping strategies addressed in the AILS intervention will be recommended.

THEORIES OF INDIGENOUS SUICIDE

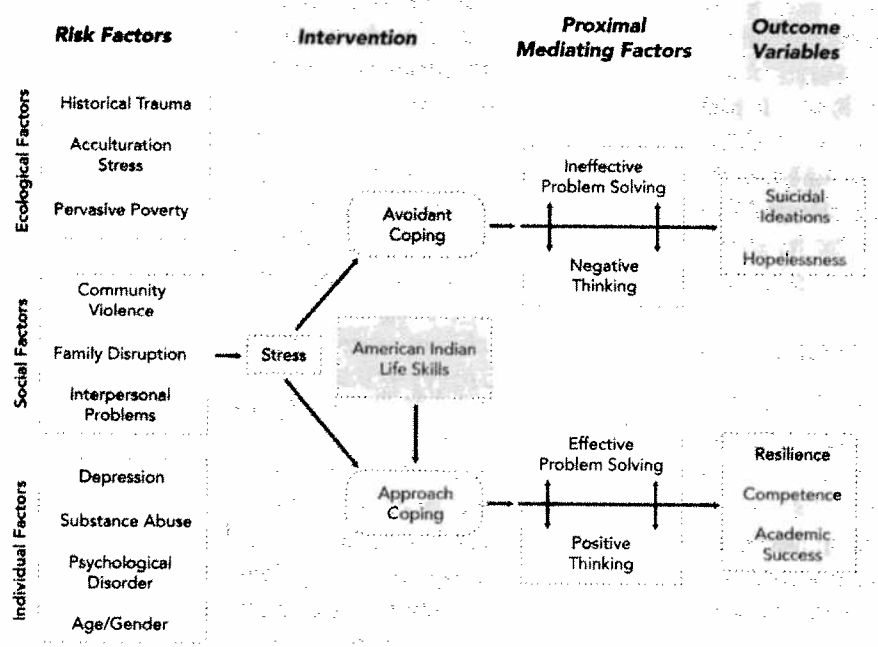
The AILS interventions has been guided by both stress-coping (Lazarus, 1966) and social-cognitive (Bandura, 1986) theories. According to the stress-coping paradigm, suicide is a deadly behavior that manifests itself after chronic and cumulative exposure to stress (Bechtold, Manson, & Shore, 1994; Clum & Febbraro, 1994; Dinges & Duong-Tran, 1993). Suicide is often associated with an overload of a number of ecological, social, and individual risk factors. The AILS intervention complements the Indigenist stress-coping theory base put forth by Karina Walters and her colleagues (2002). According to these researchers, historical trauma is a salient, almost ever-present stressor that impacts contemporary Indigenous behavior and psychological well-being.

In our application of the Indigenist stress-coping paradigm to the problem of youth suicide, we suggest that multigenerational trauma based upon genocidal practices and resultant cultural loss negatively affects cognitive functioning. In stressful situations Indigenous adolescents are unlikely to confront problems with volition, owing to feelings of helplessness and hopelessness associated with historical trauma. Instead of taking direct action, seeking social support, monitoring emotional arousal, or discussing

problems with others, Indigenous adolescents often practice avoidant coping. They may withdraw from a negatively arousing situation or selectively attend to the threatening aspects of that situation, thus failing to heed other important information that may be relevant to the struggle associated with coping. The AILS intervention encourages an active role in coping through acquiring life skills, including suicide prevention skills.

From a social-cognitive perspective, suicidal behavior is attributed to direct learning or modeling influences (e.g., death by suicide on the part of an extended family member) in conjunction with certain environmental influences (e.g., normative support for substance abuse) and individual characteristics (e.g., hopelessness or anxiety) that mediate decisions related to suicidal behavior. Social-cognitive skills developed through life skills training should act to lessen the impact of these influences. The following review of select risk factors for Indigenous youth suicide and suicide-related behaviors displayed in figure 16.1 features ecological and social factors in addition to individual risk factors that converge in a chain of events at a critical point to create a lethal act (Linehan, 1993).

Figure 16.1.
Indigenist Stress-Coping Model for Youth Suicide Prevention



RISK FACTORS FOR INDIGENOUS YOUTH SUICIDE

Ecological Factors

Historical Trauma

Indigenous youth often navigate a multigenerational legacy of traumatic experiences defined as historical trauma. This type of trauma results from successive, compounding events perpetrated on a community over generations to eradicate cultural identity and challenge a culture's right to exist (Yellow Horse Brave Heart & DeBruyan, 1998). Historical trauma, although most often associated with past events shared by a community, need not be directly experienced to have a profound impact.

Using a variety of methods, Whitbeck and colleagues (2009) hypothesized that growing up in a context of constant reminders of loss associated with colonization may contribute to adolescent depression and demoralization, which can lead to negative developmental outcomes such as early onset of alcohol and drug use, school leaving, and high suicide rates. They found that loss stemming from historical trauma is often on the minds of one-fifth of Indigenous adolescents in the eleven to thirteen-year-old age group. In their study, daily thoughts of historical loss in adolescents were similar but sometimes exceeded those of their adult caretakers who presumably would be closer to the impact of the trauma. Many adolescents (20.5%) reported daily or more thoughts about their tribe's loss of land (and the consequent loss of cultural traditions and natural resources), compared with 12.4% of their adult female caretakers. Research with First Nations communities in Canada by Michael Chandler supports contentions concerning the erosion of self- or cultural-continuity owing to the demoralizing effects of attacks on the psyche, such as colonialism (Chandler & Lalonde, 1998; Chandler et al., 2003; Hallett, Chandler, & Lalonde, 2007). According to Chandler, incursions such as historical trauma and colonialism put individuals and whole communities at risk for suicide.

Acculturation Stress

Emile Durkheim (1897–1951) tied life during periods of societal transition to psychological distress and, for some, eventual death by suicide. Acculturation stress is a unique form of stress linked to individuals or groups undergoing change. Many Indigenous people experience pressure to engage in activities within the U.S. mainstream society. Adolescents often encounter bicultural conflict when they realize that they have to consider leaving home for further training to advance their employability and eventually help improve living conditions within their community.

For some, this includes fear over eventually making a complete transition away from ongoing contact with their tribal communities. Acculturation stress has been shown to make individuals vulnerable to negative mental health outcomes, including anxiety, depression, feelings of marginality or alienation, heightened psychosomatic symptom levels, and identity confusion (Berry & Annis, 1974; Boggs, 1953; Lefley, 1976; see also Choney, Berryhill-Paapke, & Robbins, 1995, for a health model conceptualization of Indigenous acculturation).

The relationship of acculturation stress to suicide was established in a study of suicide patterns in New Mexico between 1957 and 1979. Van Winkle and May (1986) found that tribal members from more acculturated Pueblos in the Southwest had the highest rates of suicide, followed by tribal members from transitional and then traditional Pueblos. The veracity of this relationship was supported in a follow-up study by the same researchers using 1980–1987 data (Van Winkle & May, 1993; see also Levy, 1965, for similar results) and was further buttressed by Lester's (1999) finding that suicide rates were positively associated with acculturation stress and negatively associated with traditional integration in eighteen Indigenous tribes.

Pervasive Poverty

Poverty has a deleterious impact on cognitive functioning, physical health, academic achievement, and social-emotional development in early childhood (Burton, 2007; McLoyd, 1998). North American Indigenous people have the highest poverty rate of any ethnic group in the United States (Dalaker, 2001; Sarche & Spicer, 2008; U.S. Commission on Civil Rights, 2004). For Cherokee youth living in poverty, Costello and colleagues (2003) found that their socioemotional development was impeded and their mental illness was exacerbated. In a national survey of adolescent health (Blum et al., 1992), handling economic survival issues of their families was one of the major areas over which Indigenous adolescents expressed anxiety. Furthermore, poverty both increases the likelihood of violence occurring and severely curtails a victim's ability to effectively respond to violence once it has occurred (Cazenave & Straus, 1990).

Social Factors

Invalidating contexts lead to self-invalidation which, according to Brown, "develops when individuals learn to disregard, criticize or punish themselves (and their emotions) from observing others who have invalidated them in these ways" (Brown, 2006, p.101). When punishment from

others (e.g., child neglect, sexual abuse, social ostracism, discrimination) appears to be inevitable, self-punishment may be the lesser of two evils. The following social risk factors for suicide emphasize the role of context in the development of cognitions.

Family Disruption and Family Dysfunction

Individuals are known to acquire negative emotional responses, dysfunctional thought patterns, and ineffective behavioral repertoires from adverse childhood circumstances. The forced removal of Indigenous children from their families for boarding school education and their wholesale adoption into non-Indigenous families, until passage of the Indian Child Welfare Act (U.S. Public Law 95-608) in 1978, almost destroyed Indigenous family functioning (Blanchard, 1988). "The consistent threat of losing one's child created a sense of hopelessness and powerlessness that made it difficult for the adults to function well as parents" (Graham, 1998/1999, p. 17). Perceived negative parenting styles have been associated with adolescent death by suicide in non-Indigenous groups (Ruchkin et al., 2003). Walls, Chapple, and Johnson (2007) have called for further research on aversive parenting in the study of Indigenous youth suicide.

Community Violence

The statistics on violence within Indigenous communities are staggering. The homicide rate for Indigenous people is 70% higher than for Whites (Robin et al., 1997). The lifetime estimates of domestic violence victimization among Indigenous women range from 50% to 80% (Weaver, 2008). Indigenous youth are two times more likely than their non-Indigenous peers to experience violent victimization (U.S. Department of Justice, 2004) or physical attack (Manson et al., 2005).

Indigenous youth have the highest rate of placement in federal and state correctional facilities (79%) of any group of young people (Federal Bureau of Prisons, 2008). While incarcerated in federal facilities, they are much more likely than non-Indigenous youth to receive harsh punishment (i.e., pepper spray, restraints, isolation) (Pavkov et al., 2010). Many of the multiple problems associated with exposure to community violence—like anxiety and PTSD, depressive symptoms, aggression, antisocial behavior, social withdrawal, substance use, and academic problems—are also associated with Indigenous youth suicide (Buka et al., 2001; Cooley-Quille et al., 2001; Lambert, Copeland-Linder, & Ialongo, 2008; Lynch, 2003).

In 2002 Donald Meichenbaum, noted cognitive psychologist, consulted with the Society of Northern Renewal concerning the psychological needs of Inuit people in the Canadian province of Nunavit. Beyond negative reactions to acculturation stress, Meichenbaum noted that the people of this village also experienced social isolation, poverty, and the demoralizing effects of a number of social factors, including community violence. Over a six-year period in the 1980s, a self-confessed male pedophile school teacher sexually abused eighty-five male Inuit youth. One of the consequences of this insidious violence was an extremely high rate of suicide within the community. The suicide rate of female Inuit was 32 per 100,000 per year, and the suicide rate of male Inuit (not affected by this particular pedophile) was 119 per 100,000 per year. Among the cohort of sexually abused male Inuit youth, the suicide rate was 200 per 100,000 per year. Note that the base rate of suicide in the United States is 12 per 100,000 per year (Meichenbaum, 2006).

Interpersonal Problems

Poor coping abilities are associated with difficulty interacting and establishing, and maintaining satisfying relationships (Segrin, 2009). Interpersonal problems have been shown to be a critical link to suicide-related behaviors among Indigenous adolescents (Howard-Pitney et al., 1992). This concept is especially important for adolescents living on reservations or in remote villages, since differences in geographical context and cultural beliefs affect social functioning. However, even those living in urban areas can become prey to social isolation or peer victimization owing to their minority status, as interpersonal expectations may differ across groups defined by race, ethnicity, or culture.

Hawton, Fagg, and Simkin (1996) reported that 36.7% of suicide attempters in the general population under the age of sixteen list friendship difficulties as a main precipitant to their suicidal behavior; 10% of young U.S. teens report that social isolation directly led to their suicide attempt; and 11% attempted suicide following a conflict with a boyfriend or girlfriend. Bearman and Moody (2004) examined the National Longitudinal Study on Adolescent Health data and found that social isolation from peers and transitory friendships significantly increased the odds of suicidal ideation, but found this to be only true for girls. However, they also found that being a part of a tightly networked school community with a high relative density of friendship ties was a protective factor against suicide attempts for boys. Without available

and responsive networks of friends or family owing to interpersonal problems or community malaise, a youth's suicidal crisis may not be recognized.

Individual Factors

Depression

Depression and other forms of negative affect such as anger may be a reaction to adverse social and ecological circumstances. According to Shaffer and colleagues (2001), the presence of major depression is the most significant risk factor for suicide. A mood disorder alone or alongside a conduct disorder and/or substance abuse disorder characterized most deaths by suicide among an ethnically diverse sample of youth under the age of twenty (Shaffer et al., 1996). Depression and low self-esteem are particularly prevalent among Indigenous adolescents (Jackson & Lassiter, 2001; Twenge & Crocker, 2002; Walls et al., 2007). In a study comparing a variety of racial and ethnic adolescent groups, Saluja and colleagues (2004) found that Indigenous youth and Latina/o youth had higher levels of depressive symptoms than Caucasian youth, with African American and Asian American youth having the lowest prevalence rates. In most suicide risk-factor studies with this population, there has been a personal history of depression present at the time of suicidal behavior (Dinges & Duong-Tran, 1993; Howard-Pitney et al., 1992; LaFromboise et al., 2007; Manson et al., 1989).

Anxiety

One of the symptoms of internalizing disorders is anxiety, which is a major risk factor for suicide (Conrad et al., 2010). Literature on suicide also demonstrates that one of the important correlates of adolescent suicide attempts is trait anxiety (Wolfsdorf et al., 2003). Costello and colleagues (1996) examined 323 American Indian children aged nine, eleven, and thirteen years for the prevalence of DSM-III-R disorders. Their results demonstrated that one of the most common diagnoses for the Indigenous population was anxiety disorders (5.7% +/- 1.0%). Examining data from the Methods for the Epidemiology of Child and Adolescent Mental Disorder, Gould and colleagues (1998) found that an anxiety disorder increases the risk of suicide attempt. In addition, in a study of Native Hawaiian adolescents, Yuen and colleagues (1996) found that anxiety is one of the significant risk factors correlated with suicide attempts. Although evidence related to the correlation between anxiety and suicide is not as strong as the relationship between

depression and suicide among Indigenous adolescents, it is important to consider the role of anxiety in adolescent suicide.

Substance Abuse

Adolescents who are severely depressed or have severe emotional problems may be more inclined to engage in substance abuse. A drug- or alcohol-induced predisposition to impulsivity and emotional volatility can enhance a depressed youth's predisposition to suicidal behavior (Brent et al., 1999; Gould et al., 1998; Shaffer et al., 1996). Ninety percent of suicides in the United States are characterized by both substance abuse and a psychiatric disorder (Goldsmith et al., 2002).

Unfortunately, many Indigenous communities include households where people engage in substance abuse (Walters, Simoni, & Evans-Campbell, 2002). Of the ten leading causes of death among Indigenous adolescents, at least three are related to heavy alcohol use: accidents, suicide, and homicide (Indian Health Service, 2002). A number of substance abuse trends are disturbing in terms of their developmental impact. When compared with White youth, Indigenous youth come into contact with both legal and illegal drugs at an earlier age; they tend to drink more frequently; and when they drink they often consume alcohol in larger quantities (Hawkins, Cummins, & Marlatt, 2004). Roski and colleagues (1997) found that among Indigenous eighth graders, drinking rates surpassed those of all other ethnic populations within their cohort, exceeding the rates of White students by 50% to 100%.

Psychiatric Disorder

A key individual risk factor for suicide common to all ethnic and cultural groups that transcends cultural contexts is a preexisting psychiatric disorder (Spirito & Overholser, 2003). Since this chapter focuses primarily upon the AILS intervention, we emphasize psychological processes that may influence suicidal behaviors more so than psychiatric disorders. Given that caveat, the variable rates of psychiatric disorders among Indigenous adolescents cannot be ignored.

According to a study by Beals and colleagues (1997), 29% of Indigenous youth met the diagnostic criteria for at least one psychiatric disorder. Whitbeck and colleagues (2008) gathered data on psychiatric disorders and substance abuse from 651 Indigenous adolescents representing a single tribe in the northern Midwest of the United States and Canada. They found that 44.8% of the adolescents aged thirteen to fifteen had a lifetime psychological disorder, and 26.6% had a twelve-month disorder. These

rates are similar to prevalence rates of adults from the American Indian Service Utilization, Psychiatric Epidemiology, Risk, and Protective Factors Project (AI-SUPERPFP). However, the Great Smoky Mountains Study, which compared 323 Cherokee children aged nine, eleven, and thirteen to 933 similarly aged Caucasian children, found that Cherokee children had a lower overall prevalence of psychiatric disorders compared to Caucasian children (Costello et al., 2003).

One particular psychiatric disorder associated with historical trauma is PTSD. This disorder was more common in the two Indigenous reservation populations sampled in the AI-SUPERPEP study than in other populations using comparable measures (Beals et al., 2005). A recent study of Indigenous adolescents indicated rates of PTSD within the sample as high as 22% (Yellow Horse Brave Heart, 2003); whereas another study of Indigenous adolescents being treated for substance abuse reported that 10% of the sample had developed full PTSD and another 14% met the criteria for sub-threshold PTSD (Deters et al., 2006).

Age

Adolescence is characterized by physical maturation of the brain and body, giving rise to intense psychological and physiological change, particularly in terms of the intensification of emotional experiences. From a risk perspective, rapid change influencing emotionality during this developmental stage may lead to suicidal behavior (Casey et al., 2010). Children who have difficulty with emotional and social problem solving and poor reality testing appear to be more prone to suicide than those who are facile in these areas. For example, LaFromboise and colleagues (2007) found that among youth who had attempted suicide, some misjudged the repercussions of an event or crisis. They offered the following reasons for why they had tried to kill themselves: "I was mad," (sixth-grade male); "I thought no one would notice if I was gone," (seventh-grade female); "I thought my mom would be happier if I were dead and they'd all cheer," (eighth-grade female); "I got in a fight and I thought I was going to be picked on," (sixth-grade male). Given that cognitive immaturity and age-related impulsivity play a large role in early adolescent suicidal behavior, intervention efforts with this population need to be in place prior to the transition to high school.

Gender

Risk factors for suicide often differ along gender lines, suggesting that girls and boys could be reacting in different ways to similar environmental

factors and biological vulnerabilities. Rubenstein and colleagues (1998) found that female adolescents were significantly more likely than males to report suicidal behavior in the past year. Death by suicide in boys is more likely to be associated with antisocial or aggressive behavior, whereas death by suicide in girls is more likely to be associated with depression (Shaffer et al., 1996). For female adolescents, mood and anxiety disorders were independently associated with increased risk of suicide attempts; for males, both substance abuse disorders and mood and anxiety disorders were independently associated with increased risk of suicide attempt (Gould et al., 1998).

Stress

Stress, which often precedes suicidal behavior (Shaffer et al., 2001), involves changes from a steady state that require adjustment to reestablish a homeostatic balance (Coddington, 1972). Excessive negative change requires readjustment that may exceed an adolescent's adaptive capacity and thus lead to health and mental health problems. Stress and stressful life events (e.g., pressure to perform under standardized test conditions, sudden illness of a parent) have been found to predict suicidal ideation (Howard-Pitney et al., 1992) and other negative outcomes, such as physical health problems (e.g., risky sexual behavior) and self-reported anxiety among Indigenous adolescents (DeCoteau, Hope, & Anderson, 2003; Kaufman et al., 2004).

The impact of stress and stressful life events on adolescent functioning is cumulative. Adolescents are at greatest risk when they experience multiple stressors simultaneously. Dinges and Duong-Tran (1993) found that two stressful life events predicted Indigenous youth depression and suicidal ideation, while three stressful life events predicted Indigenous youth depression with actual non-fatal suicide attempts. Finally, given extensive exposure to uncontrollable negative life events, Indigenous adolescents may perceive stressful life events as more stressful or report greater psychological distress from stressful experiences than adolescents within the general population (Beals et al., 2002).

As indigenous children develop into adolescents their coping repertoire is expected to expand, owing to increased life experiences. The literature on children and coping report their increased engagement in an array of distinct methods of coping, such as asking others who have had similar experiences what they did (support for action), humor, problem solving, planning, positive thinking, acceptance, spiritual coping, and distancing actions (Sandler et al., 2000). Stressors encountered

in daily living are multifaceted and may require both approach- and avoidant-coping strategies (Sandler et al., 1997).

Avoidant Coping

Adams and Adams (1996) found that highly depressed adolescents in both clinical and nonclinical populations were much more likely to try to deal with negative life events by engaging in an overly rigid avoidant or disengaged style of coping. Within the general adolescent population, this style is associated with greater depression (Seiffge-Krenke & Klessinger, 2000) and substance use (Eftekhari, Turner, & Larimer, 2004). Piquet and Wagner (2003) found that suicidal youth in stressful situations were unlikely to make responses that required a volitional approach (e.g., taking direct action, seeking social support, or discussing the problem). Instead they were likely to use a form of coping that is featured by withdrawal from potentially negatively arousing situations. Adolescents who use avoidant coping tend to see problems as beyond their control and consequently they experience ongoing distress and physiological arousal (Derryberry & Reed, 1994). According to Meichenbaum (2006), avoidant copers often fail to appreciate the role of spirituality as a means of coping. They also try to avoid reminders of past trauma situations, use alcohol or drugs to control anxiety, abandon normal activities, engage in wishful thinking, and keep secrets. Among adolescents within the general population, their use of avoidant coping has been related to persistent emotional and behavioral difficulties (Dempsey, Overstreet, & Moely, 2000).

Youth who face recurrent violence exposure and who use fewer approach strategies have been found to exhibit more PTSD symptoms (Kliewer et al., 1998). In one study, suicidal youth were able to generate as many adaptive strategies in order to cope with their own most severe life stressor as non-suicidal controls, yet they were more likely than the controls to identify maladaptive behaviors (e.g., attempting suicide, violence against others, and extreme social withdrawal) as effective ways of coping. They also demonstrated little correspondence between their perceptions of the controllability of stressful events and the types of coping strategies they generated (Wilson et al., 1996).

Negative Cognitions

Ed Shneidman, one of the first scholars to explore the thought processes of suicidal individuals, contended that suicide is a transient psychological constriction of affect and intellect, not a psychological disorder. Negative thoughts often include devaluation of the self (Teasdale & Rezin, 1978).

Aaron Beck (1967, 1970) observed that depressed individuals frequently engage in a negative cognitive triad, viewing themselves, the world, and the future in bleak terms. Based on the cognitive model of depression, certain negative thoughts can produce and maintain a state of depression. Conversely, depression enhances the probability of negative thinking, which further exacerbates depression (Teasdale, 1983).

A unique type of negative cognition that accompanies depression is hopelessness. This type of thinking involves lowered expectations of positive future experiences, the ability to obtain certain goals, or to find success (Melges & Bowlby, 1969). Hopelessness, along with substance use, depression, and friend and family history of suicide, has been associated with suicidal ideation among early adolescents (Howard-Pitney et al., 1992; LaFromboise et al., 2007). Suicidal ideation has been defined as the domain of ideas about death, suicide, and serious self-injurious behaviors that include thoughts about the planning, conduct, and outcome of suicidal behavior (Kienhorst et al., 1990; Overholser & Spirito, 2003; Reynolds, 1988).

Ineffective Problem Solving

Suicide is more likely to be selected as a viable option when one is faced with multiple recurring problems and a scarcity of solutions. Research with adolescents from the general population who have attempted suicide indicates that many of them have particular deficits in problem solving (Speckens & Hawton, 2005). Rather than employ a generalized cognitive-affective-behavioral response set that problem solvers bring to a problem (D'Zurilla & Nezu, 1990), suicide attempters tend to think about problems in a less accurate fashion. Even though suicide attempters are able to gather relevant factual information about problems and to identify problem-solving goals, many have difficulty identifying solutions, selecting the best solutions, or actually implementing the solutions they generate (Sadowski & Kelley, 1993). They adopt more avoidant responses to problems by either putting off dealing with them or looking to others for assistance.

AMERICAN INDIAN LIFE SKILLS INTERVENTION

The AILS intervention is an intensive, multicomponent intervention consisting of psycho-education, coping skills enhancement, and life-style changing activities (LaFromboise, 1995). It was designed to focus upon key classes of stressful episodes, including risk-taking behaviors associated with substance abuse, sexual activity, bullying, and suicide attempts. This intervention incorporates experiences relevant to Indigenous

adolescent life into seven major units that focus upon life skills as follows: (1) building self-esteem; (2) identifying emotions and stress; (3) increasing communication and problem-solving skills; (4) recognizing and eliminating self-destructive behavior; (5) advancing knowledge about the variability in rates of suicide across tribes and risk factors for Indigenous adolescent suicidal behavior; (6) practicing how to ask for help for themselves or for their friends when suicide becomes an issue; and (7) engaging in individual and collectivistic goal-setting. The AILS emphasizes approach coping and strives to enhance youth awareness of their personal power to make a difference in other's lives.

APPROACH COPING

Approach coping, which involves cognitive and emotional activity oriented toward a threat, is related to positive emotional and behavioral functioning (Berman, Jobes, & Silverman, 2007). People who use approach coping strategies generally tend to see obstacles as challenges (or opportunities) (Snyder et al., 1999). They may use more overall coping strategies and thus are more flexible in and have a wider repertoire of ways of dealing with stress. The risk of suicidal behavior is lessened when children and adolescents have available both internal (e.g., cognitive) and external (e.g., interpersonal) resources for coping successfully with stress and conflict. However, findings such as this imply that children should be taught multiple coping strategies to manage both controllable and uncontrollable situations.

Positive Thinking

The ability to anticipate positive future experiences and think positively has a strong link with psychological well-being (Vincent, Boddana, & MacLeod, 2004). Positive thinking casts a problem situation as changeable and a desirable outcome goal as achievable. It promotes not only optimistic but realistic attributions for positive and negative life events. Positive thinking encourages the development of a sense of control over one's behavior, thoughts, feelings, and environment. It also supports the development of flexible thinking that is necessary for creative breakthroughs. Casey, Oei, and Newcombe (2004) argued that in situations of danger, the presence of positive cognitions concerning coping or control enables individuals to tolerate thoughts concerning imminent danger and thus perform more adequately. Interventions designed to prevent depression often focus on changing underlying thoughts and beliefs in a more positive and realistic direction. Skills that aid in the habitual use of positive thinking can be absorbed by children from a very early age (Reivich & Shatté, 2002; Seligman et al., 1995).

Effective Problem Solving

A self-directed, cognitive behavioral process in which an individual attempts to identify or discover adaptive solutions for specific situations that emerge in the course of everyday living defines effective problem solving (D'Zurilla, Nezu, & Maydeu-Olivares, 2002). During this purposive process, coping efforts are directed toward altering the problematic situation itself, altering a person's outlook about the situation, or both. Effective problem-solving strategies can help adolescents respond to events in their environments in a timely fashion, make better choices, reduce the negative impact of adverse life circumstances, and become better agents of change in their own lives (Conger et al., 2009; Nezu, Nezu, & D'Zurilla, 2000). In addition, effective problem solving decreases the risk of developing depression (Spence, Sheffield, & Donovan, 2003) and increases the likelihood that one can successfully negotiate the challenges of adolescence (HermanStahl, Stemmler, & Petersen, 1995).

The AILS intervention employs a social-skills training approach whereby interventionists follow the format of information giving, modeling, behavior rehearsal, and feedback for skills development. The AILS training manual contains fifty-six lessons that can be delivered over a thirty-week period of time. The AILS intervention is most often delivered by classroom teachers. However, community members who work in behavioral health and positive youth development programs (e.g., Indian Boys and Girls Clubs, church camps, tribal juvenile services) have also delivered the intervention. In the current climate of educational policy, based upon No Child Left Behind legislation and limited resources, essential lessons that are critical to developing life skills and suicide prevention skills within the AILS intervention have been identified. (The list of essential AILS lessons is available upon request from the first author.)

Based on our review of the literature, the AILS intervention is the only evidence-based suicide prevention intervention that is tailored for cultural sensitivity in Indigenous communities (see the 2007 review of the treatment-outcome literature for mental health interventions focused upon alleviating Indigenous psychological distress by Gone and Alcantara for an enunciation of the state-of-the-art limitations in this area). An effectiveness study following a quasi-experimental design found that the AILS intervention reduced Indigenous youths' hopelessness, increased their confidence to manage anger, and increased their problem-solving

and suicide-intervention ability (LaFromboise & Howard-Pitney, 1995). The second source of evidence supporting the effectiveness of the AILS intervention in reducing suicidal behavior is based upon a longitudinal study of the mental health status of students attending Indian boarding schools, conducted by the National Center for American Indian Alaska Native Health Research (Manson et al., 1989; Manson, 1987–1992). This study verified the reduction of a twenty-year suicide rate among students at Sequoyah High School in Tahlequah, Oklahoma, with no deaths by suicide noted since implementation of the AILS intervention in the early 1990s (see Goldsmith et al., 2002).

The AILS intervention strongly relies upon social validation from the target community in its estimation of intervention effectiveness. Thus, the degree of acculturation among adolescents who participate in the AILS intervention must be taken into account during intervention delivery. For example, when the AILS intervention is offered by an interventionist from the local tribe who is fluent in the language of the community, the interventionist is encouraged to speak with adolescent participants in the tribal language during intervention sessions (as deemed appropriate). This gives youth the opportunity to talk more privately about difficult issues with fellow tribal members when also in the presence of staff who are non-tribal members. It also facilitates the process of transposing examples of local tribal values, traditions, and mores onto those presented in the AILS intervention printed material.

When the AILS intervention is offered in an urban area with youth from diverse tribes, interventionists are encouraged to infuse examples pertaining to the participants' cultures into the intervention content. Surface-level cultural modifications such as inserting local place names into vignettes, replacing tribally specific proverbs with frequent sayings found in the participants' communities, and mentioning upcoming community events instead of the less immediate events referred to in the text can be accommodated without compromising intervention fidelity. Handling deeper-level cultural modifications, such as infusing information about tribal-specific beliefs concerning appropriate ways to handle conflict or grief, may be more challenging in terms of fidelity.

Consensus within the training group is easily formed around common experiences with acculturation stress (e.g., being followed in stores, being stopped by police for an invalid reason, low expectations on the part of teachers, etc.). An atmosphere of mutual support and trust gradually develops as participants engage in frequent role plays and feedback sessions in the course of the intervention. Issues of confidentiality spilling out into the school milieu have seldom been a problem.

Since suicidal behavior can start very early in life, an early adolescent version of the AILS intervention is being refined and evaluated at this time. The aim of the middle school version (AILS-M) is to prevent the onset of self-destructive and suicide-related behavior and impart life skills at an early age. The AILS-M intervention consists of thirty half-hour-long lessons that can easily be delivered within one academic semester. Results of the effectiveness studies of the AILS-M intervention currently being conducted will be available from the first author by the end of the 2010–2011 academic year.

AILS INTERVENTION OUTCOME: RESILIENT ADAPTATION

Resilience includes the capacity to face challenges and to somehow become more capable despite adverse experiences. Ann Masten (2001) posits that resilience is a process influenced by everyday decisions, rather than a fixed constitutional attribute. Given that many Indigenous people live under adverse circumstances, we believe that resilience is an appropriate construct for both the process and the desired outcome of the AILS intervention, especially in light of its Indigenist stress-coping model theoretical underpinnings. We have coined the term "adaptive resilience" as the ultimate desired outcome of Indigenous youth coping with stress, since we believe that is what occurs when an individual embraces life and uses a wide repertoire of coping skills to deal with adversity rather than engages in hopelessness and suicidal behavior.

People who display resilient adaptation become stronger by learning new skills, developing creative ways of coping, and effectively overcoming life's challenges. All Indigenous youths' experiences are viewed as educational, since they contribute to their growth in ability to deal with future problems. Furthermore, exposure to multiple protective factors during AILS intervention training increases their chance of competent social adjustment because, as Rutter (1990) has stated, it indirectly moderates the effects of risk exposure. Scholarship on Indigenous resilience (Cross, 1998; Goodluck & Willeto, 2004; Graham, 2001; Heavy Runner & Marshall, 2003; LaFromboise et al., 2006) suggests the importance of Indigenous community, family, and personal values as critical to the development of resilience among youth.

SUMMARY AND FUTURE DIRECTIONS

Suicide is one of the leading causes of death among Indigenous adolescents and one of the main concerns in the field of Indigenous mental health. Indigenous adolescents face numerous risk factors (e.g., historical

trauma, pervasive poverty, acculturation stress, community violence, family disruption, interpersonal problems, depression, substance abuse, age/gender, psychological disorders) that could lead them toward suicidal ideation, suicidal behavior, or the act of suicide itself. Inappropriate or nonexistent coping strategies play an important role in Indigenous suicide. Suicidal youth tend to negate life and engage in avoidant coping, ineffective problem solving, and negative thinking strategies. Suicidal ideation and hopelessness are common risk factors for suicide among Indigenous youth.

The AILS and the AILS-M interventions were developed with cultural components in mind (emphasizing those of Indigenous adolescents). They incorporate school-based suicide prevention practices and skills development while following the principles of social-cognitive intervention. The AILS intervention empowers adolescents to use approach coping, positive thinking, and problem solving; helps them reduce their negative thoughts and hopelessness; while increasing their resilient adaptation to stress and stressful life events.

Indigenous youth face particular developmental challenges during the middle school years that may make them vulnerable to suicide (e.g., early onset of puberty, substance use, and risky sexual engagement). It is thought that by developing the middle school version of the AILS intervention, interventionists can assist Indigenous early adolescents in acquiring age-appropriate coping strategies, such as accepting the reality of death, learning to tolerate sustained thoughts or memories of a deceased loved one, and learning to commit to new relationships with other adults, such as stepparents.

Currently, the AILS intervention for middle school youth (AILS-M) is being implemented and evaluated. This version is based on extant knowledge of the cognitive development of early adolescents and addresses the risk factors related to this particular developmental period.

O'Connell, Boat, and Warner (2009) have argued that interactive school-based interventions that emphasize a community component appear to be more effective than school-based interventions alone. If an Indigenous community is open to parental and other adult community member involvement (which research has demonstrated to be beneficial), we suggest increasing the role of families and extended families in the AILS intervention. Once the intervention is launched, information sessions would be offered where questions about suicide risk and community resources for suicide prevention are answered. Parents and other adult family members would be asked to review AILS intervention materials with their child, in order to know what they are learning. They would be encouraged to go through suicide prevention training. Family and interested community members would be invited to celebrate the beginning and the completion of the program through an event such as a celebration or feast. Some

communities have held an awards ceremony at the completion of the AILS intervention. Parents and other adult family members would also receive information about the importance of an emotionally supportive and nurturing home environment, effective guidance, healthy future orientation, parental (village) monitoring of children, and such, in separate, concurrent training sessions for parents and children (see Brody et al., 2008; Kratochwill et al., 2009 for examples of this process).

Increasingly, Indigenous communities are becoming more willing to participate in comprehensive interventions that modify target behaviors (May et al., 2005), and to offer information about essential cultural elements that should be considered in the content and delivery of these interventions (BigFoot & Schmidt, 2006). The main outcome of this integrative work is for parents and other adult family members, community leaders, school staff, and Indigenous youth to work together to create a community of support for Indigenous resilient adaptation.

NOTE

1. Due to space limitations the term *Indigenous*, which refers to American Indian, Alaska Native, Native American people, will be used to replace the term *North American Indigenous* from this section of the chapter to the end.

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