Perspectives on Suicide Prevention among American Indian and Alaska Native Children and Adolescents: A Call for Help

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Abstract

Suicide rates among American Indian Alaska Native (AIAN) children and adolescents are the highest in the United States. Risk factors for suicide among AIAN youth include: strained interpersonal relationships, family instability, depression, low self-esteem, and alcohol use or substance abuse. Protective factors include: caring family relationships, supportive tribal leaders, and positive school experiences. Carefully planned, culturally sensitive, comprehensive programs that address the social determinants of health outcomes such as poverty, school failure, familial conflicts, and limited access to health care, should be the focus of blueprints for change for these vulnerable children. Moreover, culturally competent providers are key elements associated with reducing the suicide rates among AIAN children and adolescents.

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Purpose

Mental health problems among children and adolescents can be conceptualized along the lines of a continuum. Examples of problems include developmental delays, substance use and abuse, and anxieties. Others, though serious mental health conditions, are more likely to be subliminal and not easily discernible. Behaviors such as school failure, runaway episodes, and sexually acting out could mask other psychological dysfunctions, but youth might not receive the needed mental health services (Barlow & Walkup, 1998; Bussing, Gary, Mills, & Garvan, 2003; Fisher et al., 2002; Hoza, 2001; Rieckmann, 2001). In both instances, stress and other social determinants could add to the existing vulnerabilities and risks that the American Indian (AI) child will probably confront. Social disintegration and acculturation are examples of phenomena used to explain suicide among American Indians and Alaska Natives (AIAN) (Garcia Coll et al., 1996; Marmot & Wilkinson, 1999). Cultural conflict and identity formation problems are thought to help create chronic dysphoria and anomie that influence their vulnerability to suicide (Novins, Beals, Roberts, & Manson, 1999).

The purpose of this article is to assist the nurse and other health professionals to gain additional knowledge and skills that are necessary to deliver culturally competent mental health services to AIAN children and adolescents. The article embraces the assumption that nurses and other health professionals can and must provide essential mental health services to AIAN individuals and communities. These services may include direct clinical care, advocacy for more culturally appropriate mental health care, and integrating the essential components of AIAN culture and traditions into all aspects of prevention and treatment. Consultation with tribal nations and local, state, and national organizations in the service of providing quality and cost-effective services and collaborating with AIAN communities is an area that should be recognized.
and strengthened. Implementing community-based culturally competent research that includes service as a domain where nursing can make a significant contribution could make a difference. This article highlights theories and epidemiological data about suicide and discusses risk factors within the context of a case study about Billy Joe, a young American Indian youth. It presents what in mental health care is called the "Psychological Autopsy;" however, in this article, it is referred to as "Life Reflections." The article concludes with a blueprint for change.

The search strategy for this review used the following databases from 1990 to 2003:

Biological Abstracts (BIOSIS Previews), CINAHL, MEDLINE, Native Health History Database, Native Health Research Database, PsycINFO, and Social Work Abstracts. Key search terms included: Native Americans, North American Indians, Alaskan Native, Eskimos, substance abuse, psychological stress, depression, and suicide. This review references individual research reports, reviews, government statistics, books, and dissertations.

Theories of Suicide

Baechler’s Theory

There are five domains for explaining suicide as suggested by Baechler (1979). First, the escapist, which employs a problem solving approach that allows the person to take leave or escape from the conflict or frustration at hand. Second, aggression is experienced when the suicidal person wishes to provoke extreme guilt in the survivor. Third, ablative, which is sacrificial suicide that promises to provide a heightened state for the suicidal person, and fourth, ludic, which is associated with the desire to prove something. Gaming with one’s life is its fifth domain (Baechler). The first three domains of suicide are entrenched in conflict, fueled by anger and resentment, and have elements of retribution. Manipulation is typically present in the interpersonal relationships (Baechler; Gary, Yarandi, & Scruggs, 2003; Maris, 1969, 1992). Ludic suicide is related to the desire to attain pleasure through risk taking. However, the first four domains of suicide are life threatening and could result in death (Maris, 1969, 1992). The fifth, gaming, is demonstrative of risk taking that brings pleasure, but is deadly.

Shneidman’s Theory

Shneidman’s theory suggests that suicide is a social phenomenon (Shneidman, 1993), a dynamic process that includes relationships with others in three patterns: egotic, dyadic, and ageneratic. Egotic suicide is derived from an intrapsychiatric source, the person expresses misery and carries his or her own misery index (Gary et al., 2003; Maris, 1969, 1992). The misery index typically only helps to increase the person’s misery. That is to say, individuals who are feeling downtrodden and dejected view the world from a perspective of pessimism and hopelessness. This worldview is typically reinforced by his or her prevailing mood and cognitive states. Feelings of loneliness, aloneness, and alienation are dominant in this type of suicide. Dyadic suicide arises when there is a plethora of unmet needs and wishes linked to another person, who potentially could satisfy these needs, but fails. This person typically has a dominant role in the suicidal individual’s life (Shneidman). Suicide, then, is a dynamic process where two people are engaged in the act; one who commits suicide and the significant other. Dyadic suicide represents a relationship failure. Ageneratic suicide occurs when the individual disconnects from significant others and also alienates or separates from history, including ancestors, culture, and folklore (Gary et al.; Kettl, 1998; Maris, 1969, 1992; Shneidman). This type of suicide can be used to explain the plight of AIAN children and adolescents (Shneidman; Gary et al.).

Durkheim’s Theory
Durkheim ([Durkheim, 1897/1951]; Maris, 1969, 1992) suggested that there are basically four types of suicide. Egoistic suicide occurs when a person is extremely individuated and has little or no linkages to family and community. Altruistic suicide presents when the person is not adequately individuated and is dominated by the values and behaviors of a certain group such as peers or a religious following. Anomic suicide is thought to be present when there is alienation and the purpose for living is believed to have escaped the person's reality. Finally, fatalistic suicide is manifest when the individual experiences overregulation, restraints and thwarted opportunity, consistent unattainable goals, and dreams that explode. Durkeim and others (Poussaint & Alexander, 2000) suggest that members of oppressed ethnic groups were associated with this type of suicide. Hence, it could be useful in exploring the plight of an American Indian youth, Billy Joe.

For lack of an AIAN framework, this article embraces Durkheim's (1897/1951) theory as a perspective for understanding suicide among AIAN children and adolescents. The theory suggests that 'fatalistic suicide' (Durkheim) occurs among persons experiencing excessive regulation, whose futures are systematically obstructed, and whose dreams and passions are violently choked by oppressive and harsh discipline (Barbee, 1994a, 1994b; Byrd & Clayton, 2002; Durkheim; Gary et al., 2003; Maris, 1969, 1992; Poussaint & Alexander, 2000). American Indians have had to endure many losses including the trouncing of ownership of their own land; extreme exploitation of their food and natural resources such as the buffalo; and other social determinants of health including poverty, poor education, high unemployment, and lifestyles that are unhealthy. Forced geographical relocation and cultural assimilation have been prominent challenges in their tempestuous histories (Brave Heart & De Bruyn, 1998; Garrouette et al., 2003; Joe, 2001). There have been too few safety nets in place for AIAN people that facilitate healthy lifestyles and educational attainment. Over the centuries, feelings of hopelessness and despair have occurred and changes in cultural beliefs have been thrust upon them, leading to thoughts about a blighted future and too often suicide. For AIAN people, suicide can be perceived as a way out because there are hardly any attainable options (Brave Heart & DeBruyn; Gibbs, 1997; Joe & Kaplan, 2001; Jones, G. D., 1997; Jones, J., 1997; Lester, 1995, 1997b; Poussaint & Alexander; Rieckmann, 2001; Shervington, 2000; Wissow, Walkup, Barlow, Reid, & Kane, 2001). Harsh and debilitating living conditions are evident in their health, education, and economic statuses, with inadequate opportunities for solace and healing (LaFromboise & Howard-Pitney, 1995b; Seligman, 1975; Smith, 1999; United States Department of Health and Human Services [USDHHS], 2000).

In the mental health sector, misdiagnoses are apparent, and few providers are AIAN (Smedley, Stith, & Nelson, 2003) who are trained to provide culturally appropriate diagnoses and interventions. Once in the mental health system, barriers exist, including the clinician’s culture that is typically different from AIAN cultural beliefs and practices, resulting in inappropriate labeling and victim blaming. These cultural differences may not even be recognized by majority (Caucasian) clinicians because they are lacking in educational preparation about AIAN culture (Joe, 2001; Johnson & Cameron, 2001).

**Epidemiology**

In the United States, between 1952 and 1995, the incidence of suicide among adolescents and young adults was tripled. Currently, every day about 80 Americans take their own lives and over 1,900 emergency department visits are made for self-inflicted injury. Moreover, every 18 minutes a person dies because of a successful suicide, and for every two victims of homicide, three persons take their own lives. Thousands of teens commit suicide each year. It is the third leading cause of death among 15-24 year olds, and the sixth leading cause of death among 5-14 year olds. Among youth between the ages of 15-19, firearm-related suicides account for more than 60% of their deaths. Teenagers in American culture experience overwhelming amounts of stress, confusion, self-doubt, uncertainty about the future, peer pressure, and the strains for wanting to be successful. American Indian youth experience the highest rates of suicide in the nation.
highest rates of suicide in the nation. Suicide is considered as the most tragic of all mental disorders evident among American Indian youth (Brave Heart & DeBruyn, 1998).

Death from injury and injury rate among AIAN children are twice that of other racial and ethnic minority populations in the United States, accounting for 75% of all deaths in youth. Although some death rates among AIAN children have decreased ---drowning and fire-related traumas--- others such as homicide and suicide have remained unchanged (Centers for Disease Control [CDC], 2003b). The Centers for Disease Control's Mortality Morbidity Weekly Report suggests that health professionals working with AIAN populations should concentrate on the specific injury-related death and disability in each AIAN community. That is to say, in some communities the focus could be on motor vehicle crashes, while in other communities the emphasis would be on suicides or homicides (CDC, 2003b). Table 1 presents the injury-death rates that occur among youth ages 19 or younger, by year, cause, and gender, as adapted from the Centers for Disease Control, for periods between 1989 and 1998. It compares the outcomes from AIAN, Caucasian, and Black youth (CDC, 2003b) as they relate to high risk events.

From Table 1, it is clear that the motor vehicle death and suicide rates for every time period between 1989 and 1998 were greater for AIAN youth than for Caucasian and Black youth (males and females). Although the motor vehicle mortality rates were improved across the decade, they remain at least two times greater for AIAN youth than for Caucasian males and females. The AIAN male suicide rate increased slightly at the end of the decade, and was three times greater than their Caucasian and Black counterparts. Female AIAN youth suicide increased over the decade and was three times greater than their Caucasian and Black counterparts. Firearms-related deaths increased over time, and were lower than Black males, but higher than Caucasian males. Table 1 also shows that homicide rates increased for AIAN males, which are greater than Caucasian males, but lower than Black males. In addition, drowning as a cause of death increased among AIAN females. Mortality and morbidity vary by region throughout Indian Country. For instance, motor vehicle related deaths in the Aberdeen (Dakotas, Nebraska, Iowa) and Billings (Montana and Wyoming) regions were three times higher than the national rates. The highest suicide rates were in Tucson (Arizona), Aberdeen, and Alaska areas (CDC, 2003b). These regions are described through agencies in areas of Indian Country reporting to the Indian Health Service; reports do not include urban areas where one-half of the AIAN population now reside (CDC, 2003b). In summary, AIANs are dying prematurely from preventable injuries; some are intentional.

Community-based and grassroots-generated intervention programs are needed to address these life-denying injuries in AIAN youth. Particular attention should be given to the causes or sources of these injuries that result in death. For instance, vehicle deaths in AIAN communities must be understood within the context of some basic facts. When examining the domain of safety, AIAN children have not benefited to the same extent as their Caucasian counterparts. Briefly, some reasons might be (a) lack of safety belt use, (b) alcohol-impaired driving, (c) limited enforcement of occupant restraint violation, (d) traffic and safety laws that are developed and enforced as the particular tribes determine, and are defined within the context of their rights as sovereign nations, and (e) high alcohol related motor vehicle death rates that could be life threatening to children who are at-risk passengers in these vehicles (CDC, 2003b). In addition, cars owned by AIANs may not have functioning seatbelts; due to poverty and poor roads, AIAN-owned vehicles deteriorate rapidly without proper maintenance. Among the population that live on reservations, most suicides, homicides, and motor vehicle related deaths involve alcohol consumption (CDC, 2003b; Grossman, Milligan, & Deyo, 1991).

Risk Factors for Suicide among American Indian Youth

American Indian youth frequently experience strained interpersonal relationships (Range et al., 1999), live with consistent family instability (Nelson, McCoy, Stelter, & Vanderwagen, 1992), depression (Cameron
and use or abuse alcohol or substances (May et al., 2002). Thus, they are more likely to exhibit risky behaviors. Multiple home placements (Manson, Beals, Dick, & Duclos, 1989), or involvement in the juvenile justice system also increase the risks for a compromised life (May & Moran, 1995).

Other sources report additional suicide-related risk factors in the general population. Included are the suicide of a close friend or relative (Wagner, Cole, & Schwartzman, 1995), a history of a suicide attempt (Lewinsohn, Rohde, & Seeley, 1994), hopelessness (Joiner & Rudd, 1996), low self-esteem (Lewinsohn et al.), deficit coping and problem-solving skills (Wilson et al., 1995), and negative life events such as school problems, family conflict, pregnancy, and contracting sexually transmitted diseases (Wagner et al.). These factors could be included in risk identification in AIAN youth. Assessment and treatment protocols should reflect culturally relevant tools that are designed to address the specific risks that are evident in the various AIAN communities.

Focused and sustained approaches to culturally competent suicide prevention programs ought to be a high priority (USDHHS, 1999). Davidson (1990) identified risk factors associated with adolescent suicide. These could be applied to AIAN suicide prevention programs that address the following situations:

- Psychiatric disorders, especially depression, anxiety, and post traumatic stress syndrome
- Substance use and abuse
- Family loss, separation, and disruption
- Family member of a suicide victim
- Homosexuality
- Rapid social change and devastating economic conditions
- Impulsivity and aggression
- Access to lethal methods

Grossman et al. (1991) conducted a study to investigate suicide risk factors among Navajo adolescents, with a sample consisting of 7,254 students in grades 6-12. Results indicated that almost 15% (1,088) had been suicidal at sometime in the past. The behaviors and experiences that were associated with suicidal thoughts included a history of mental health problems, feelings of alienation from family and community, having a friend who had experienced a suicide attempt, and weekly liquor consumption. Other significant factors included a family history of suicide or suicide attempt, poor self-perception of health status, a familial history of physical abuse and violence, and female gender. Sexual abuse exposure, especially among the females, was an important risk factor.

Among 13,923 sexually abused adolescents in reservation-based AIAN communities, the protective factors varied. For girls, family attention, positive feelings toward school, parental expectations, and caring, as exhibited by family and adults, were reported as protective factors. Tribal leaders were perceived as protective mechanisms against hopelessness and suicidality. Tribal leadership that is demonstrative of caring and the instillation of hope is helpful for females. On the other hand, boys identified protective barriers as positive experiences at school, participation in traditional activities, affirmative academic performance, and caring, as expressed by family members and other adults on the reservation. Support from tribal leaders was also important. Hence, connectedness and support from family, school, and community were the essential elements for protection in both groups (Pharris, Resnick, & Blum, 1997). In another study of American Indian youth between the ages of 15 and 17 years, living on or near the Northern Plains reservations, researchers reported that a commitment to cultural spirituality was associated with suicide reduction. That is to say, those individuals with high levels of a culturally-based spiritual orientation evidenced reduced prevalence of suicide when compared with those with low levels of cultural and spiritual orientation. These results are not unlike historical reports that suggest that American Indian suicide-prevention programs should focus on cultural spirituality (Garrouette et al., 2003).

A Young American Indian Male
To better illustrate the psycho-social-cultural dynamics of suicide, the case of 15-year old Billy Joe will be presented (name changed to protect patient privacy). It details his struggles with school, familial conflicts, and exposure to drugs and alcohol, his grief over the loss of his father and uncle, and other issues in his life.

**Name:** Billy Joe Light Feather  
**Age:** 15  
**Home:** Southwestern United States

**Brief Social and Health History**

Billy Joe had a history of truancy from school, and he was experiencing frequent conflicts with his stepfather who thought that he was not attentive enough to traditional Indian values and folklore. Billy Joe, instead, was more concerned about being accepted by his peers, and he wanted to fit in and be like the other guys, many of whom were not Indian, but definitely "cool" and "hip." He also stated that the conflict between him and his stepfather resulted in him being beaten because of his "defiance and rejection" of his culture, as perceived by his stepfather. Billy Joe had begun to drink with his friends on the "Res" and to have fun away from his home and out of the watchful eyes of his family. He indicated that he had begun to drink like his father would drink, "lots of it, but quiet and out of the house." He was also "expelled" from one boarding school because of fighting and not following the rules. He further stated that he had a deep dislike for boarding schools, and did not enjoy being away from his home, even though he did not get along with his stepfather.

Billy Joe is a healthy young man, who is about 6 feet tall (like his biological father, he proudly stated) and weighs 200 pounds. He loves the outdoors and often spends his time in the woods admiring the beautiful trees and bird watching. He has no remarkable illnesses or other types of disabilities. He does have a scar on his right arm that is the result of a conflict with another young man who attacked him while at one of the boarding schools. The physical examination was complete, without any documented health concern; there were no other remarkable findings.

**Current Health Status**

This 15 year old American Indian male presented to the emergency room after having been involved in a vehicle accident where he ran off the road and into a deep trench and demolished his car. He suffered a broken leg, fractured collar bone, and multiple bruises throughout his body. He thinks he might have been unconscious for a period of time because he does not recall any events immediately following the accident. When he awakened, he was in the emergency department of a small hospital near his reservation, about 50 miles from his home. Billy Joe stated that he did not think he would live to be an old man, and he indicated that he felt lonely and alone, alienated from his family and others on the reservations. At the end of the conversation, Billy Joe told the nurse that he had been at some other emergency room before because of a similar vehicular accident but he would not share details, nor did he remember the name of the hospital. Since Billy Joe presented with alcohol scents over his body, and several beer bottles were confiscated from the scene of the accident [indicated in the accident report], a blood alcohol test was performed. The result revealed a blood alcohol level (BAL) of .08. This is considered a very high level.

**Risk Factors Evidenced in the Billy Joe Case Study**

The identification of adolescent suicide risk factors ([Davidson, 1990](#)) are applied to Billy Joe:

- Male Gender
- Middle Adolescence, Age 15
Substance use
Family disruption
Feelings of alienation
History of motor vehicle accident
History of suicide in family

**Contributing Factors**

*Psychiatric disorder.* It is not certain that Billy Joe has had a previous psychiatric diagnosis, and the nurse will need to rule out this possibility once more information is forthcoming from Billy Joe and his parents.

*Drug and alcohol use.* Obvious alcohol use was evidenced by BAL, and the scent on his body. There were cans of beer in and around the vehicle. Billy Joe did not discuss his alcohol use with the nurse. Instead, he simply stated, "I am not talking about that."

*Sexual identity issues.* There is no evidence for the support of sexual identity problems with Billy Joe.

*Environmental factors.* Billy Joe’s father left the family several years ago, when he was very young. Billy Joe recalled that there was lots of tension in the home at times, and at other times, the family got along very well. He did not know what caused the fighting between his mother and biological father, but now he thinks it was related to his father drinking too much at times. He currently lives with his biological mother and his stepfather, a strict disciplinarian.

Change in school environments may have also affected Billy Joe. He has attended three different schools, and did not like any of them. He shared with the nurse his experiences with boarding schools and the dominant themes were loneliness, feelings of isolation, and sometimes a sense that things would never change. The invalidating and non-facilitating environment on the "Res", that helps to create and maintain low self-esteem and a lack of hope about his life and future is a major concern for him.

*Problems with peer relationships.* Billy Joe reported getting in fights with other guys about his own age and at other times guys who were older. He thought that because of his height and well built frame, people sometimes thought he was older than his actual age. But this did not concern Billy Joe most of the time. He did have a tendency to "shy" away from guys because he "did not want trouble." Overall, Billy Joe did not think he had a good friend on the "Res", and no one that he could talk with.

*Social isolation.* At times, Billy Joe stated that he felt alone and too lonely. He would isolate himself when he felt this way, but that would only increase his aloneness and sometimes make him very angry. He spent hours in the nearby woods, walking, thinking, and sometimes crying.

*Firearms present on the reservation.* Many AIANs are subsistence hunters, thus firearms are present in homes; Billy Joe knows where his stepfather keeps his guns. He has not taken a gun to the boarding school, but sometimes he "slips" a gun when he is going out for the night, and thinks he might end up with a few drinks to chase away the loneliness associated with his father’s absence and his uncle’s death.

*Prior suicidal histories in family.* An uncle who lived on the "Res", in the same area where Billy Joe lives, committed suicide about two years ago. This uncle was Billy Joe's mother's favorite brother. Billy Joe was very fond of his uncle, and after his death Billy Joe would go into the woods and cry. He did not ever want
his mother to be burdened with his sorrows, so he never talked with her about his sadness. He commented, "Indian guys are like that, you know." "I need to look out for my mother."

Lethal attempts that occurred earlier. Billy Joe was unclear about previous suicide attempts. He did, however, state-- "I don't know." He would not discuss the topic any further.

Exposure to information about near lethal attempts among other family members. Billy Joe stated that his mother and her family talked about relatives who had committed suicide, but that was always "grown folks talk"... he did hear them and listened. He is, however, well aware of the fact that people say that Indians kill themselves for some reason.

Evidenced-Based Interventions for AIAN Youth

There are few evidence-based studies about AIAN youth and suicide and little is known about risk factors for suicide despite the high rates of self-destructive behaviors (Grossman et al., 1991). Perhaps one reason for this scenario is the fact that there are few AIAN mental health providers, limited mental health resources, and inadequate empirically tested culturally competent interventions that are known to make a difference with AIAN children and youth.

The Healing Circle

One intervention, however, is the healing circle that addresses traditional Indian and Native values. This cultural approach to health care is being empirically tested and studied (Lowe & Struthers, 2001). Its findings will inform the scientific and clinical literature. Lowe and Struthers conceptualized an AIAN nursing framework that provides a structure to guide nurses and other health professional in their work with AIANs. The framework is derived from focus groups held at Summit IV of the National Alaska Native American Indian Nurses Association (NANAINA). AIAN nurses suggested that the essence of nursing come from seven dimensions: caring, tradition, respect, connectedness, holism, trust, and spirituality that should be evident in all nurse-patient interactions. Caring was identified by AIAN nurses as having the characteristics of health, relationships, holism, and knowledge. Tradition is an important dimension in the framework, and was considered a core component in all aspects of nursing. The third dimension, respect, is the base for all relationships and provides honor, identity, and strength to communications and behaviors. Fourth, connection, the past, present and future of the person’s life should be acknowledged and accepted as a component of the relationship. AIAN nurses rely heavily on relationships that help to form connections; the person’s life experiences are entwined with events and interactions with others. Holism is the fifth dimension of the framework, which means that the whole is greater than the sum of the parts. The holistic approach is an important component of nursing as a profession, and addresses the vital need to respond to the entire human being. Balance, culture, and relationships are characteristics of holism. In addition, trust is another dimension of the framework. Lack of trust is a barrier in building a relationship with patients and other health providers. Trust in the framework is based on three characteristics: relationship, presence, and respect. Furthermore, spirituality represents a bond with the "Great Mystery," or the Creator, the source and sustainer of all life. Spirituality is characterized by relationships, unity, honor, balance, and healing. AIAN people, according to Lowe and Struthers, respond best to prevention, treatment, and healing, when culturally competent care is provided. The traditional Healing Circle as described by Brave Heart & DeBruyn (1998) is an approach that was developed by AIAN people to provide culturally competent care for AIANs. Its components embrace many of those in Lowe and Struthers' framework.
The Medicine Wheel

According to Brave Heart & DeBruyn (1998), AIAN people have experienced devastating results from European contact, resulting in the colonization of AIAN people. A history of chronic trauma and unresolved psychological grief across generations and throughout the centuries is omnipresent. They refer to this dynamic as historical unresolved grief and suggest that it is at the core of the high rates of a multitude of social pathologies such as suicide, homicide, domestic violence, child abuse, alcoholism, and other health and social disparities that AIANs confront on a daily basis. There also exists a multitude of social and political forces that help to maintain and perpetuate these conditions that would be difficult for the majority of people in other societies to momentarily tolerate. Because there is little research or theoretical information about unresolved grief and AIANs, they suggest that literature about the Jewish Holocaust survivors and their children could be used to explain the intergenerational transmission of trauma and grief as expressed by this oppressed group of Americans, who are the nation’s original people.

Culturally appropriate interventions ought to be based on traditional AIAN ceremonies integrated with western treatment modalities for grieving and healing that are adapted to the AIAN culture and beliefs (Brave Heart & DeBruyn, 1998; Gray & Nye, 2001; Johnson & Cameron, 2001; Rieckmann, 2001). The Medicine Wheel is a traditional American Indian modality that has been used to treat loss, depression, despair, and other conditions that interfere with social competence, coping and productivity. The Medicine Wheel represents a circular pattern of balancing matters, such as life and death; health and illness; and coping and distress. It provides the balance that AIAN people seek, including physical, mental, social, emotional, and spiritual dimensions as basic approaches to health (Barlow & Walkup, 1998; Brave Heart & DeBruyn; Byrd & Clayton, 2001; USDHHS, 2000).

Mental Health Interventions

There is evidence from the Indian Health Service suggesting that over the past 40 years, AIAN people have embraced various aspects of western medicine in the areas of emergency care, antibiotics, dialysis treatment, and obstetrics. However, in the domains of mental health, AIAN approaches have remained strongly grounded in Traditional Indian Medicine (TIM). Two basic explanations are possible: First, western medicine has not explored ways for integrating the two approaches, but has instead belittled TIM.
Secondly, mental health issues and treatment may be considered by AIANs as out of the realm of western medicine. That is, western medicine and AIAN approaches could produce tension and little therapeutic benefits. Nevertheless, too few culturally competent mental health resources exist for AIAN people, precluding their access to care, and "equal treatment" for a plethora of diseases and disorders (Smedley et al., 2003).

AIAN people tend to conceptualize the etiology of mental illness as an imbalance that is caused more by external forces such as a curse, witching the attachment of a spirit, or a lack of harmony with nature. On the other hand, western medicine focuses on internal factors such as genetics, DNA, or some other biologically based or western notion of social determinants of health (Barlow & Walkup, 1998; Manson et al., 1989; Marmot & Wilkinson, 1999). All health professionals should be well informed about how to address their salient beliefs and practices with respect and honor (Lowe & Struthers, 2001). AIAN people frequently seek mental health care from traditional practitioners to alleviate the cause of the imbalance. Contrarily, western medicine tends to pressure AIAN patients to confront internal forces of insecurity, aggression, and depression, through counseling, diagnosing, and prescribing medications. The latter tends to leave patients feeling guiltier and victimized (Lowe & Struthers; Brave Heart & DeBruyn, 1998).

**American Indian/Alaska Native and Western Approaches to Suicide Intervention**

The Traditional Indian view of illness relates to an imbalance among a multiple and interlinking social, economic, genetic, environmental, and spiritual factors (Barlow & Walkup, 1998). These factors also influence help-seeking behaviors among individuals and families. Conceptually, help seeking is more than simply access to health services. Life is considered a sacred gift from the Creator. TIM teaches individuals to purify themselves and to seek balance through acts such as sweats, smudge, and offering of sacred objects, e.g., tobacco, corn pollen, sage, and cedar. Ceremonies are presented and families, clan members, and community members participate. The following brief description of how services might occur for Billy Joe from the perspective of American Indian cultural approaches and then Western approaches is demonstrable (Barlow & Walkup; Blanchard, Blanchard, & Roll, 1976; Brave Heart & DeBruyn, 1998; Manson et al., 1989).

**Billy Joe and American Indian Mental Health Care**

Culturally competent mental health care grounded in AIAN beliefs would look something like this:

1. The treatment team will consist of traditional healers and indigenous outreach workers who are lifetime members of the community and on call 24 hours of the day.
2. The local police may be the point of contact for the call for help which is immediate.
3. The entire family is consulted including extended family members; communications occur in the language of the Indian people.
4. All family members are included in treatment and prayer; spiritual ceremonies and rituals are core components of the treatment, none of which are dictated by time, insurance eligibility, and other similar constraints associated with western medicine in the nation.
5. The specific aim of the treatment plan is to bring harmony and balance to the family, and to Billy Joe. Being the center of attention, Billy Joe receives support from family, the medicine person, and the community. He is respected, honored, and revered as having spiritual connections and hope for the future.
6. The healers could remain with the family for several hours or days and beyond in the service of restoring the harmony and balance. Again, time is not a factor; nor is family concerned about hourly or daily charges and method of payment.
7. Adhering to a comprehensive system of cultural practices is treated as the "best practice" for the protection from physical and mental diseases. Proper health and social competence practices are
learned through ceremonies, instructions from parents and elders, traditional healers, and tribal leaders. The elders are always important agents in Billy Joe’s care.

8. Sacred and private ceremonies and other segments of the treatment are not open to public display or discussion, but must be allowed to manifest themselves as dictated by the elders, spiritual leaders, and other Indian people.

9. Billy Joe is given time to absorb all the blessings that he is experiencing and thus may have to miss school during this time. The support and caring will continue.

Billy Joe and Western Mental Health Care

To contrast TIM and western approaches, here is a description of typical mental health care offered to AIANs:

1. Mental health providers are seldom Indian people, and as a rule, they do not live on the "Res"
2. Treatment is provided off the reservation, it takes place in a mental health clinic (stigma is attached); the hours are predetermined and not negotiable
3. The counseling sessions are individualized and confidential.
4. Confidentiality is a major consideration during all treatment and especially for mental health care. Family members may not be included in some aspects of the treatment. Others, such as traditional healers and elders would have a limited, if any, role in the overall management of suicide prevention.
5. If family therapy or counseling is needed, this service is frequently rendered by other non-Indian providers or a group of non-Indian providers who may not be culturally competent. Typically, they do not live on the "Res" and know little about the life experiences that help to shape Billy Joe’s worldview.
6. Numerous clinics for AIAN people are seldom in good physical condition, are in need of repair, and are overused for the treatment of conditions such as alcoholism and detoxification. Youth would rather not be in these types of environments.
7. Clinics, because of their physical presentation, the lack of Indian providers along with the potential for stigma related to mental illness---- "Mental Health Clinic" ---makes a child’s or adolescent’s visit difficult and perhaps a stigmatizing event that could follow him or her for years to come.
8. Much debate continues to exist about mental disorders and behavioral problems among AIAN children and adolescents being directly linked to multigenerational historical trauma and cultural mayhem over the past several centuries. Nevertheless, whatever position emerges as authentic, responsible health professionals must quickly move to provide a higher level of quality health care to AIAN people (Borowsky, Resnick, Ireland, & Blum, 1999; CDC, 2003a, 2003b; Coleman, Charles, & Collins, 2001; Dinges, Atlis, & Ragan, 2000; Duclos, LeBeau, & Elias, 1994; Edmonson, 2000; National Institutes of Mental Health [NIMH], 2001).

Life Reflections (Psychological Autopsy)

In order to better understand the dynamics of suicide and successfully prevent its occurrence, the nurse can examine the suicidal act from the perspective of the person's phenomenological experiences (Cross, Gust-Brey, & Ball, 2002; Dinges & Duong-Tran, 1994). "Life Reflections" or "psychological autopsy" is a method developed to elicit information from others about the deceased person during the weeks before and up to the suicidal act. Sometimes the psychological autopsy can be extended over the duration of the person’s life (Cross et al.). A basic purpose of the psychological autopsy is to gain an in-depth understanding of the psychological events that the person experienced before death (Clark & Horton-Deutsch, 1992; Kettl, 1998; USDHHS, 1999).

The term "psychological autopsy" may not be considered as culturally sensitive. We propose a phrase such as "Life Reflections" or "Life Review" which suggests a more acceptable approach to the intent of unraveling the complexities related to suicide as experienced by AIAN people.
Clinicians and researchers should be sensitive to the lack of culturally appropriate and scientifically tested theories and methods associated with the identification, prevention, and management of suicide among AIAN people.

Among AIAN people, death is linked to spirituality; the body is sacred and should be respected by all people. While the actual method might remain similar to the proposed outline as suggested by Shneidman, its terminology is altered in this discussion. One additional comment: The term "Psychological Autopsy" has not been tested in AIAN populations to determine its acceptability or appropriateness. Importantly, neither has the alternative proposed nomenclature, "Life Reflections." Thus, the use of either of these terms should be applied with caution until they have been tested with and accepted across the various AIAN cultures. Clinicians and researchers should be sensitive to the lack of culturally appropriate and scientifically tested theories and methods associated with the identification, prevention, and management of suicide among AIAN people.

The essential components of Life Reflections are (a) face-to-face interviews with informants (family, friends, neighbors) who are knowledgeable about the dead person’s thoughts, patterns, behaviors, aspirations, failings, and overall feelings, (b) a review of the person’s clinical records including data about physical illnesses, mental disorders, recent losses, and future plans, and (c) the assimilation of these data by an experienced mental health professional, someone who is an expert in death studies and child and adolescent growth and development --- including the participation of tribal chiefs and spiritual healers, community-based informants, and professional experts in specific cultures is also essential (Berger & Tobeluk, 1991; Kulis, Napoli, & Marsiglia, 2002; Pescosolido & Georgianna, 1989; Rieckmann, 2001; Rodgers, 1991; Sack, Beiser, Baker-Brown, & Redshirt, 1994). This approach could be a highly valued method for unraveling the phenomenon of suicide among AIAN. Diverse cultural practices, the social determinants of health and mental health outcomes, and the contextual variables that continue to affect their lives, should be considered during the life review process. As a convenience to the reader, and, for lack of a better term, an "outline" of the Psychological Autopsy is presented in Table 2.

Table 2. Outline of a Psychological Autopsy

| 1.     | Identifying information about the deceased person (name, age, address, marital status, religious preference, occupation). |
| 2.     | Description of the details surrounding the death including the perceived cause, method, and other details. |
| 3.     | Outline of the deceased person’s history including siblings, marriage, medical illnesses, medical treatment and psychotherapy, previous suicide attempts, previous acts of aggression, history of acts of aggression directed against the deceased person, and expressed thoughts of aggression. |
| 4.     | Death history of deceased person’s family including suicides, homicides, cancer, fatal illnesses, accidents, ages at time of death, and other pertinent details. |
| 5.     | Description of the lifestyle of the deceased person; a detailed accounting of a typical 24-hour day. Descriptions of hunting episodes and habits, and the use of guns and other potentially lethal weapons should be included. |
| 6.     | Deceased person’s usual response to crises, stress, disequilibrium, and periods of emotional upsetness. |
| 7.     | Any recent (past 7 days to 12 months) upsets, pressures, disappointments, failures, conflicts in relationships, losses, and so forth. |
| 8.     | Substance use and abuse throughout life and just before death. |
| 9.     | Description of the person’s interpersonal relationships with family, friends, mental health professionals, and others. |
| 10.    | Dreams, fantasies, thoughts, fears, and anxieties related to risk-taking and death, accidents, suicide, homicide, and other acts of aggression. |
| 11.    | Changes in deceased person’s habits before death (eating, sleeping, sexual patterns, routines, family relationships, legal concerns, and other life routines). |
| 12.    | Nature and characteristics of the deceased person’s despair as detailed by community leaders, elders, traditional healers, school personnel, family members, and friends. |
| 13.    | Description of the person’s level of comfort with self and with ethnic and racial identity. |
| 14.    | Information about the person’s perceptions of his/her role in the family and community and... |
15. Description of the level of the person's sense of integration into the larger community, the "Res," and the Caucasian society and level of sense of comfort when in these environments.

16. Information regarding the deceased person's successes, upswings, types of humor, recreational preferences, and choice of music (preferred lyrics).

17. Assessment of intention of the person's role in his or her own death by suicide.

18. Rating of lethality. For a detailed discussion see Hatton et al. (1977).

19. Reactions of informants to the person's death. Include the TIM people, elders, family, teachers, friends, and other individuals who live on the "Res."

20. Comments, special features.

Adapted from Shneidman (1993), p.179.

Some people who are in extreme psychological pain may manage to disguise the emotional upheaval and mask their lethal intentions (Shneidman, 1993). Family members might make statements such as, "She was okay when the bus came to take her to school this morning," or "He went to the dance last night and he talked about his motorcycle with much fondness." These individuals have been able to keep their secret about suicide, and clandestinely plan for the lethal event while functioning through masks and false personae (Gary et al., 2003; Shneidman). That is, the youth has been able to evidence social competence in the areas of home, school, and community, and structure two parallel lives that address different phenomena. Individuals who have these experiences also have tremendous ego strengths and have learned to compartmentalize emotions and life events, though the outcome could be detrimental. For AIAN people, the nurse should remember the importance of balance, holism, and spirituality in their lives (Borowsky et al., 1999; Gary et al; LaFromboise & Howard-Pitney, 1995b; Red Horse, 1992; Shneidman).

Blueprint for Change

AIAN children and adolescents confront devastating circumstances that have a high potential of robbing them of a productive and healthy adulthood. They live in the poorest communities, have the lowest educational attainments, and live in massive pockets of poverty, surrounded by a wealth of opportunity and privilege that is the expected norm of their more privileged Caucasian counterparts (Barlow & Walkup, 1998; Johnson & Cameron, 2001; Labun, 2002; LaFromboise & Howard-Pitney, 1995a; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Stryer, Weinick, & Clancy, 2002).

According to the National Institute for Mental Health's (NIMH) Blueprint for Change Research on Child and Adolescent Mental Health (2001), mental health problems continue to proliferate despite recent research findings related to etiology and treatment. Several reasons exist that prevent this burden from becoming lighter for children in general and AIAN children and adolescents in particular. Some of these reasons, including stigma, prejudice, fragmentation of services, and health disparities, are delineated below.

Stigma

Stigma about mental health services continue to grip most Americans, potentially interfering with help seeking behaviors, admission to academic institutions, employment, and even familial relationships (Jones, A., 1998; Link et al., 2001). In the general public, stigma affects the youth and their parents, creating an atmosphere of shame, guilt, discrimination, fear about some behaviors, and blaming. Mental health care does not have adequate insurance coverage for treatment and lags behind other disease conditions and health disabilities, though there is no scientific justification for the differences in coverage for adequate treatment (NIMH, 2001). Too many AIAN people who live on reservations and urban areas do not have health insurance and will most likely get their care from the Indian Health Service (IHS) system. This policy issue helps to maintain the stigma that has a long and disturbing history that works against positive health outcomes.
**Prejudice in Society**

According to J. Jones (1997), prejudice is more likely to occur when individuals are categorized into certain groups and specific characteristics are ascribed to them. Rationale is developed to support differential treatment. AIAN people fit this category which has led to detrimental outcomes with regard to mortality and morbidity patterns. AIAN people have specific health beliefs and behaviors that may not be congruent with western medicine. The level of dissonance between AIAN people and western-oriented health has caused tension and poor health. One remedy for such a dilemma includes decategorization of people and the removal of stereotypes. Public policy, institutional monitoring, accountability, and consequences of one's actions must be the centerpiece for change.

Because of the special government-to-government relationship between AIAN and the U.S. government, AIAN people are thought and expected to have health coverage by the Indian Health Service. This could be a false perception. Thus, they may suffer from prejudicial health care practices. Many AIAN people have few resources and cannot purchase the necessary goods and services.

**Fragmentation of Services**

The institutions that are responsible for providing health care for children and adolescents have been and remain fragmented. The schools, boarding schools, mental health clinics, emergency care, hospitals, and AIAN human and material resources are embedded in models which do not match the realities of AIAN conditions, and which often disregard their cultural beliefs and practices. Culture and tradition are not well understood by the predominately-Caucasian mental health workforce, who are typically trained from the western health models and funded accordingly. Significantly, AIAN people reside in geographical locations that are sometimes separated and distanced from the existing core of mental health services. Most mental health services are rendered in clinics, not in homes, and they are "westernized" rather than family and community centered. Treatment, as a rule, is steeped in western values and not always easily adaptable to TIM. The potential that a "sick" child would be sent away to a hospital for treatment creates hesitancy for help seeking among family members and the ill child. These thoughts are quickly associated with boarding school experiences that could provoke negative images and emotions (Andrew & Krouse, 1995; Barlow & Walkup, 1998; Bechtold, Manson, & Shore, 1994; Begay & Maryboy, 2000; Berger & Tobeluk, 1991; Blum, Harmon, Harris, Bergeisen, & Resnick, 1992; Dinges et al., 2000; Frank, Moore, & Ames, 2000).

**Health Disparities**

For years, there has been evidence that ethnic minority people receive less care and a poorer quality of care than Caucasians (Brave Heart & DeBruyn, 1998; Byrd & Clayton, 2002; Smedley et al., 2003). Children who live in chronic poverty conditions are at greater risk for anxiety (Yates, 1987), depression (Dyer, 1994), and antisocial behaviors (Costello, Compton, Keeler, & Angold, 2003) in addition to poor physical health and learning disabilities. Yet, AIAN children and adolescents have had to confront these realities for more than three centuries. Recall that they experience higher rates of morbidity and mortality, a poorer quality of life (Barlow & Walkup, 1998; Garcia Coll & Garrido, 2000; Garroutte et al., 2003), and shorter life expectancies than many other ethnic/racial groups.
Fortunately, Billy Joe survived this "accident"—though some would refer to it as a suicide attempt. It is useful, however, for nurses to be familiar with the utility of methods such as the "Life Reflections" or the "Psychological Autopsy." Its strengths and liabilities, when applied to AIAN people, must be empirically determined, and should be investigated by AIAN people. Knowing about and adapting the components of the strengths of the existing life reflections or autopsy process is one way to gain more knowledge about the phenomenon of suicide among AIAN people and their various cultural practices. Unique histories of the different AIAN peoples are additional realities that should be integrated into the reflective methodology. But there is more. Developing culturally competent programs for suicide prevention, treatment, and health literacy is the natural next step. These programs must be created and designed within the context of the lived experiences of AIAN people. Moreover, they must be conceptualized and implemented by AIAN people.

**Emerging Evidence-Based Treatment**

Evidenced-based programs for prevention and treatment of mental health services for AIAN children and adolescents are beginning to occur. However, the use of such scientific evidence is only beginning to occur in mental health care systems that address common childhood and adolescent disorders ([Lowe & Struther, 2001](#)). This predicament is not unlike the lack of evidence-based prevention and treatment programs for numerous disorders that are common among other ethnic minority groups ([Bagley, 1991](#); [Baker, 2001](#); [Barlow & Walkup, 1998](#); [Bechtold et al., 1994](#); [Berkanovic & Telesky, 1985](#); [Berlin & Fowkes, 1983](#); [Betancourt, Green, & Carrillo, 2002](#); [Bolton et al., 2001](#); [Bussing, Schoenber, Rogers, Zima, & Angus, 1998](#); [Bussing, Zima, Gary, & Garvan, 2003](#); [Byrd & Clayton, 2001](#); [Gary & Yarandi, 2004](#); [Gazmararian et al., 1999](#)). For AIAN children and adolescents, certain questions must first be addressed: (a) Do prevention and treatment programs match with or are they culturally congruent with their specific ethnic group culture? How is this outcome determined? (b) Is the mental health workforce culturally competent to provide the necessary health care for a certain AIAN community? Ethnic group? (c) Is there a national commitment to educate and train AIAN researchers, clinicians, and educators? (d) Is the community involved with the decision makers regarding the allocation of scarce resources, and do they have the authority to address the social determinants known to be related to better health outcomes ([NIMH, 2001](#))? The list goes on, and on.

**Conclusion**

Suicide rates among AIAN children are the highest in the United States. A blighted future, a sense of hopelessness, and failed expectations grip the lives of AIAN youth. Carefully planned, culturally sensitive, comprehensive programs that address the social determinants of health outcomes such as poverty, school failure, familial conflicts, and limited access to health care, should be the focus of blueprints for change for these vulnerable populations. Moreover, culturally competent providers are key elements associated with reducing the suicide rates among AIAN children and adolescents. A major concern associated with cultural competence is linked to the lack of a culturally diverse workforce, or, more importantly, a workforce that includes AIAN people in mental health and substance abuse disorders treatment, research, and public policy promulgation. Leadership to reduce and eliminate suicide among AIAN children and adolescents will require assistance from federal, state, local, and AIAN governments ([LaFromboise & Howard-Pitney, 1995a, 1995b](#); [Lester, 1995, 1997a, 1999](#); [Manson et al., 1989](#); [May et al., 2001](#); [NIMH, 2001](#); [LaFromboise & Howard-Pitney, 1995a, 1995b](#); [Lester, 1995, 1997a, 1999](#); [Manson et al., 1989](#); [May et al., 2001](#); [LaFromboise & Howard-Pitney, 1995a, 1995b](#); [Lester, 1995, 1997a, 1999](#); [Manson et al., 1989](#); [May et al., 2001](#); [LaFromboise & Howard-Pitney, 1995a, 1995b](#); [Lester, 1995, 1997a, 1999](#); [Manson et al., 1989](#); [May et al., 2001](#)).
Honoring the AIAN traditions and practices such that they are openly applied to complement modern mental health practices is another next step. AIAN families and communities need to be involved in planning and implementing all aspects of their lives, among which are parenting education in school-based health and social programs, youth programs that embrace traditional cultural and ethnic values. Regardless of the approach, the sacredness of all life, and connections with the “mighty spirit” as determined by AIAN people, must permeate all conceptualizations and actions associated with them.

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References


Cameron, . (1999). Need this ref from authors.


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