UNDERSTANDING SUICIDE IN THE NAVAJO POPULATION

by

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Abstract

Suicide is the second leading cause of death for American Indians and Alaskan Natives. The suicide rate for the Navajo population is more than double the national rate, which indicates suicide is a significant problem on the Navajo Reservation. The objective of this qualitative research was to glean insight about suicide in the Navajo population. This study used a convenience purposive sampling method. After approval from the university human subjects review board, eight informants who previously lived or worked on the Navajo Reservation were interviewed. Informants are individuals with exposure and/or experience with suicide on the Navajo reservation. The approximate length of interviews was thirty minutes. Narrative data from the interviews was transcribed and analyzed using a content analysis technique to identify emerging themes pertaining to perceptions about Navajo suicide. The researcher and the faculty mentor individually, and together reviewed the data for key words, phrases, and then themes. Data was then additionally reviewed by a doctorally prepared reviewer with a final comparison as a cross check. Themes noted were hopelessness, social issues, and culture. Findings from this research project will improve understanding about perception of the problem, knowledge of existing mental health services, and cultural aspects important to the Navajo population that should be considered in interventions and education about suicide prevention.
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Chapter 1
Introduction

Every thirteen minutes, an American individual loses his or her life to suicide. The Centers for Disease Control and Prevention [CDC] reported 41,149 suicides in the United States in 2013 or 12.9 suicides for every 100,000 people (2015). Suicide is the tenth leading cause of death among all age groups (Stanhope & Lancaster, 2014). However, for American Indians and Alaskan Natives [AI/AN], the suicide rate is 1.5 times higher than the national rate, or 19.5 suicides for every 100,000 people. Suicide is the second leading cause of death for AI/AN individuals ages 15 to 34 (CDC, 2015).

Native American communities in North America have considerably higher rates of suicide than non-native people. Current suicide prevention initiatives have been unsuccessful at addressing the needs of Native Americans, and these initiatives are proving to be culturally incongruent. In the United States, rates of suicide in American Indian/Alaska Native (AI/AN) are significantly disproportionate with other groups. On some Native American reservations, the adolescent suicide rates are nearly seventeen times higher than the United States average (Wexler & Gone, 2012). American Indians and Alaska Natives are twice as likely to attempt suicide, and nearly 30% of deaths are unreported (Jiang, Mitran, Miniño, & Ni, 2015). Furthermore, 31.7% of deaths of AI/AN aged 15-24 years old are to suicide (Heron, 2016).

Many Native American communities exhibit a need for a broader, community-based approach to suicide prevention. Suicide is a collective community loss, and it is associated with the disorganization of society and culture loss. Conversely, lower suicide rates can be attributed to cultural empowerment, connectedness of the community, and family unity (Wexler & Gone, 2012). Although spiritual, cultural and social factors are large components of suicide prevention, prevention and intervention initiatives often focus on the individual and are clinically based.
Consequently, mental health services on Native American reservations are often not culturally congruent, and thus are infrequently utilized (Wexler & Gone, 2012). A greater understanding of Native American culture and suicide among the Navajo people may help to improve the cultural quality of care provided.

Understanding the unique perceptions of professionals living and working with the Navajo has potential to help healthcare providers offer more culturally congruent care. Enhanced understanding may also guide leaders in the healthcare profession and the government to create suicide prevention programs specifically tailored to the Navajo culture. Additionally, this study may increase suicide awareness and spark interest in suicide prevention. Thus, the immediate goal of this study was to enhance the understanding of suicide in the Navajo population, access to mental health services, and cultural aspects important to the Navajo people.
Chapter 2
Review of Literature

This review of literature focuses on several areas pertinent to this study such as Navajo culture, history of Navajo suicide, suicide assessment, and suicide prevention programs. There is little research on the Navajo population. Few research studies have been conducted on suicide in the Navajo population. The majority of information available about the Navajo comes from statistics released by government agencies.

Traditional Navajo Culture

The Navajo are the largest Native American tribe, originating in the 1500s. Today, the Navajo people (Diné) live on a 28,000 square mile reservation designated by the federal government in parts of Arizona, New Mexico, and Utah (Locke, 2001). The Navajo land is sacred, and the Navajo rely on it for food and shelter. Navajo culture is centered around maintaining Hózhó, which is the Diné word for beauty, balance, peace, wellness, and harmony (Kahn-John, 2010). Hózhó is a state of wellness that the Diné strive to attain. Hóchzó, or disharmony, occurs when physiological and psychosocial states are disrupted. Increasing rates of chronic diseases, mental illnesses, violence, and substance abuse are results of Hóchzó, or a disruption of Hózhó (Kahn-John, 2010).

Navajo spirituality centers on restoring Hózhó, which means keeping a balance between beauty, harmony, and health. Ceremonies performed by medicine men are used to heal illnesses, to strengthen the weak, and to give energy to the sick. There are around sixty sacred ceremonies, averaging four days each. All ceremonies must be performed in the same precise way or else they may not be effective. Legend says that the Diné had to pass through three worlds into the present, which is the fourth world. The Holy People put down four mountains to form the boundaries of the Navajo land. There is Mount Blanca to the east, Mount Taylor to the south,
Mount Hesperus to the north, and San Francisco Peak to the west. The four mountains represent the four different colors, the four directions, the four seasons, and the first four clans (Locke, 2001).

Navajo children are taught to live in harmony with Mother Earth. The Holy People have the power to help or harm the Earth People. The Navajo believe that illnesses and misfortunes occur due to wrongdoings against the Holy People (Locke, 2001). The Navajo traditionally use natural herbs, prayers, songs, and ceremonies to treat and cure illnesses. The medicine man is a qualified, unique person with supernatural powers that allow him or her to diagnose and heal people. The Navajo believe that they remain an Indian Nation because of their strong faith in the Great Spirit (Giger, 2013).

Navajo culture strongly emphasizes traditional healing practices. Maintaining a constant balance, or homeostasis, is highly valued. Navajo people like to stay in harmony with their surrounding environment. Traditional medicine includes seeing a medicine man and the use of homeopathic remedies such as the use of herbs. Healing ceremonies performed by a medicine man combine traditional Navajo medicine with native healing practices (Giger, 2013).

The Navajo language is complex and very difficult to learn. Many Navajo, especially younger generations, speak both Navajo and English. Many elderly only speak Navajo. An interpreter is needed in most settings to ensure that information relayed is correct. The Navajo are a quiet and reserved people. The Navajo are comfortable with long periods of silence, and talking loudly is considered rude. Privacy is highly valued among Navajo, who rarely share their personal thoughts and feeling with people outside of their clan. Direct eye contact is rare and may be seen as disrespectful and sometimes confrontational (Giger, 2013).
Navajo family structure is matriarchal-oriented (Locke, 2001). Traditionally, Navajo families lived together in a hogan or groups of hogans. Hogans are sacred Navajo dwellings. Most modern Navajo families live in trailers or houses, although hogans are still used for ceremonial purposes (Locke, 2001). Extended families live in close proximity to one another. The clan is traced through the mother’s lineage. Children are born into their mother’s clan. The clan functions as a network and serves as a sense of belonging for its members. Many Navajo call each other “brother” or “sister” even though they may not be blood relatives. People from the same clan are forbidden to marry (Giger, 2013).

**Views of Death**

**Cultural Perspectives**

Death is a taboo topic in both traditional and modern Navajo culture. The Navajo are extremely afraid of death. Death is rarely a subject of conversation. The dead are buried quickly with no public ceremony (Locke, 2001). An ancient Diné legend about death says that if an animal hide placed in water did not sink, there would be no death. If the hide sank, then death would be a part of life. The Diné did not watch. Meanwhile, a coyote threw rocks on the animal hide so that it would sink because if no one died, there would be no more land for the coyote to live. The Diné saw that the hide sank, and now they believe that death eventually happens to everyone. The Diné want death to remain in the underworld, so looking at a dead body and interacting with dead bodies is limited. A Navajo believes that if an individual touches a dead body, the spirit may contaminate him or her (Giger, 2013).

Dying people are taken out of the home to die. Often, temporary hogans are built. If a sick person dies in the home, it is believed that his or her ghost may return to haunt the home. Homes where people have died are destroyed. A medicine man and close family members may stay with
a dying person until a few moments before death, but leave before death occurs (Locke, 2001). Two men are chosen to bury the body. They wear no clothes and coat their bodies in ash to protect themselves from evil spirits. The burial process must be done in a specific order or else the body may return to earth. The tools used to bury the body are immediately destroyed, and no footprints are left near the grave (Giger, 2013, Locke, 2001).

The afterlife is not well described by Navajo culture (Locke, 2001). If an individual commits suicide, it is believed that they carry the object with which they completed suicide with them into the afterlife (Giger, 2013).

It is important as a healthcare provider to respect Navajo death rituals. A common practice of the Navajo is to spread cornmeal around the dying person (even if they are in the hospital) as a curative measure. Respecting cultural practices and allowing the individual and family to engage in cultural activities is important (Giger, 2013).

Phrasing information when speaking to the Navajo has an effect on how the information is interpreted. Positive-oriented statements are preferred over negative-oriented statements. Negative information, such as with informed consent, truth in telling of terminal illness, and advanced directives when speaking of future illnesses, must be framed in a positive manner for the most effective response from the Navajo people (Giger, 2013). For example, “If you do not wash your foot, your foot will fall off,” is a negative statement. It would be better to say “Washing your foot will benefit your foot.”

**Historical Trauma and Culture Loss**

The United States Federal Government and the Navajo population were at odds for many years in the 1800s and early 1900s. Many attempts to eliminate Native Americans and/or to “Americanize” them were made. One attempt was called the Long Walk. The Long Walk was
the federal government’s first “Indian Removal” attempt. As many as 8,500 Navajo were forced to leave their native lands and walk nearly 300 miles in harsh winter conditions to Bosque Redondo in New Mexico. Bosque Redondo was the new holding area for the Navajo and was patrolled by the U.S. Army. Nearly 2,000 Navajo people died from hypothermia and starvation. The Navajo stayed at Bosque Redondo for three years with poor water and food supplies. In 1868, the federal government allowed the Navajo to return to a small portion of their original native lands (Locke, 2001).

Another attempt to “Americanize” the Navajo population was made beginning in 1860 with the opening of the first Indian boarding school. Boarding schools for Navajo children were used by the federal government to assimilate Navajo into the American way of life. The federal government thought that forcing Navajo children to attend white boarding schools would civilize the Navajo people and force them to accept white men’s beliefs and values. If parents refused to send their children to the boarding schools, police officers went into the Navajo communities and seized the children. While at the boarding schools, Navajo children had to live with white families. The Navajo’s traditional long hair was cut off, each child was given a new “white” name and new “white clothing.” Children were forbidden to speak the Navajo language and were often rewarded for only speaking English. Additionally, children were not allowed to eat native foods, and were taught Christianity (Locke, 2001).

Hundreds of years of historical trauma to the Navajo peoples has led to culture loss. Many generations of Navajo that are currently living have either experienced the trauma or have listened to their families pass down stories of traumatic events. As a result, many Navajos are ashamed of their culture. A qualitative study performed by Evangeline Parsons-Yazzie (1995) explored Navajo-speaking parents’ perceptions of reasons for Navajo language attrition. The
study found that many people do not speak or know the Navajo language because they are ashamed of their culture; have attended an English school where the Navajo language was not taught; have one parent who does not speak Navajo; or have spent a significant amount of time away from their Navajo-speaking families.

Today, a generation gap between the older and younger generations of Navajo is becoming more apparent. Many of the Diné youth are not familiar with the Navajo language or traditional teaching and lifeways. Cultural loss may make it more difficult for the Navajo people to deal with everyday challenges. Losing connection with Hózhó may be detrimental to the overall health and well-being of the Navajo culture. As culture loss continues to occur, younger generations may have a harder time accessing the important cultural knowledge that has sustained the Navajo population for years (Kahn-John, 2010).

**Modern Reservation Life**

**Living Conditions**

Living conditions are poor across the Navajo Nation. Poverty is widespread. The 2010 United States Census stated the poverty rate in Apache County, Arizona, an area where many Navajo live, was 36.6%. Poverty rates in the deep rural areas of the reservation, such as the Wide Ruins community, are as high as 65.1% (Tséhootsooí Medical Center [TMC], 2013). Poverty causes a wide range of problems such as poor living conditions and poor health. Many Navajo live in dilapidated hogans or homes. Often several members of an extended family may live in one house to pool resources and save money (Navajo Relief Fund, 2017). Fifteen percent of Navajo homes lack water and/or electricity. Ninety thousand Navajo families are homeless or live in crowded living spaces (Navajo Relief Fund, 2017). According the U.S. Census (2010),
16.9% of Navajo homes in Apache County, Arizona lack plumbing, and 10.4% of homes have no telephone.

**Employment**

Unemployment is a prevalent issue affecting the Navajo people. The unemployment rate in 2010 for Apache County, Arizona was 57.8% (U.S. Census, 2010). The high unemployment rate may be attributed to the rurality of the reservation. Many available jobs are seasonal and have few benefits. The rough terrain makes it difficult to travel to and from work. Many Navajo do not have transportation to get to work. Another barrier to obtaining a job on the reservation is language differences. Some employers require workers to be fluent in both English and Navajo. Skilled worker positions are most frequently available on the reservation. High schools value vocational education over academics because that is where jobs can be obtained. Thus, high schools often do not prepare students for college (Giger, 2013). The U.S. Census (2010) stated that 49.4% of the Navajo in Apache County, Arizona have not earned a high school diploma. Only 10.4% have a Bachelor’s degree or higher (U.S. Census, 2010).

**Transportation**

Lack of transportation is another pressing issue of the Navajo Nation. Many Navajo people do not own a car. Since poverty is widespread, many families do not have money to pay for gas, vehicle expenses, or traveling. Walking and hitch-hiking are two common modes of transportation. The Navajo Transit System (NTS) was established to help individuals travel from community to community. The NTS provides limited daily shuttle service to and from communities such as Fort Defiance, Kayenta, Gallup, Shiprock, Sanders, Tuba City, and Chinle (NTS, 2017). The demand for NTS shuttle services far exceeds the number of busses and routes available. The substantial land area of the reservation, long driving times, and large population
may contribute to increased demand. Additionally, many Navajo are not able to get to the bus stops. Bus stops are located on major highways that may be a considerable distance away from where people live. The NTS charges a $2.00 fare for each shuttle ride. Individuals may not be able to afford this fare. The NTS operates from 0500 to 1900 Monday through Friday, and is not operational on the weekends (NTS, 2017).

**Lifestyle Choices**

**Tobacco**

Poor lifestyle choices are common among many Navajo individuals. Cigarette smoking and tobacco use are prevalent on the reservation. Men are more likely to smoke than women. Tobacco use can lead to health problems such as chronic obstructive pulmonary disease and lung cancer (Giger, 2013).

**Physical Activity**

Many Navajo live a sedentary lifestyle. Physical activity other than what is required for work is rare. Men are less active than women (Giger, 2013). Only 4% of Navajos living in Apache County live within one-half mile of a park or recreational facility (TMC, 2013).

**Alcoholism**

Slightly over 11% of Navajos in Apache County heavily consume alcohol (TMC, 2013). Although the reservation is dry (no alcohol sold within its boundaries), people find ways to make alcohol. Products containing alcohol, such as hand sanitizer, hairspray, and mouthwash, are sold behind grocery store counters because people will use these to make alcohol. An individual must be eighteen years or older, with photo identification, to buy products that contain alcohol. Additionally, many people go to towns outside the reservation to buy alcohol.
Alcohol use leads to a variety of health problems such as depression and liver disease. It increases the likelihood of other risky behaviors such as drinking and driving and engaging in unprotected sex (Giger, 2013). Bootleggers are people who sell alcohol out of their homes or on the streets. If someone is caught with alcohol, there are minimal consequences. The individual may be given a court date, but many flee the area. Due to minimal police presence in rural areas, it is easy to relocate and escape consequences (TMC, 2013).

**Nutrition**

Many Navajo have poor nutrition. High fat diets and processed foods are common and can lead to obesity (BMI > 30). About 33% of Navajos in Apache County are obese (TMC, 2013). Obesity can cause other health problems such as diabetes and heart disease. Dietary intake of fruits and vegetables are low, but fat intake is high. Homemade foods are less common with the intake of processed foods rising. Intake of fat, sodium, and calories is increasing, while the intake of vitamins and minerals in decreasing (Giger, 2013).

The foods that Navajo people choose to eat largely depend on the geographical area, and the availability and affordability of healthy foods. In areas where fish and game are plentiful, these become important dietary sources. Fruits and vegetables are scarce on many federally defined Indian reservations. Many people do not have access to healthy foods like fruits and vegetables, and if they do, they do not have access to proper food storage. Since fruits and vegetables have short shelf lives and often require refrigeration, many Navajo just buy processed foods instead. Many foods, especially corn, hold both nutritional and ceremonial values. Corn is used in many dishes and ceremonies. Sheep meat, blue corn meal, frybread, beans, and squash are primary staples of the Navajo diet. However, processed foods are more frequently taking place of these healthier foods (Giger, 2013).
Healthcare

Healthcare is not available in all parts of the reservation. For example, dental facilities are sparsely located across the reservation. Many Navajo cannot access healthcare due to lack of transportation. Some Navajo walk, ride a bicycle, or hitchhike their way to a medical facility (Giger, 2013). To adapt to transportation obstacles and reduce costs, some Navajo schedule all individual appointments at a medical center in the same day, or all appointments for family members at the same time. Additionally, many Navajo cannot afford medical care. Nearly 27% of Apache County residents do not have health insurance (TMC, 2013). Given the rate of poverty and unemployment on the reservation, some may not seek medical care because they cannot afford it.

Healthcare Providers

There are two main types of healthcare providers on the reservation: traditional healers and biomedical physicians. In the past, their practices were not well blended. However, today, these two fields are being blended together. Traditional healers are also called medicine men. There are three types of traditional healers. Diagnosticians specialize in diagnosing illness or the cause of harm. Singers perform complex healing ceremonies. Herbalists use herbs to treat ailments. It is not uncommon for any one medicine man to be trained in more than one of these areas.

Today, medicine men and physicians work together in hospitals. It is not uncommon to see them talking with one another in the hospital. Sometimes, the physician will agree to allow a patient to leave the hospital temporarily so that the patient can participate in a healing ceremony outside of the hospital. Some Navajo may not feel welcomed by healthcare professionals, especially if traditional healing practices are not respected. Many Navajo are also afraid of the hospital because that is where people go to die. So, they avoid the hospital at all costs.
Navajo are more likely to seek healthcare if their provider incorporates traditional medicine into their treatment plan. Many healthcare providers will incorporate traditional singing and rituals into their practice to create passionate care that truly makes a difference in total healing time. It also helps the Navajo patient to respect and trust their provider easier. In 2009, the Community Outreach and Patient Empowerment (COPE) Project was formed. They collaborate with the Indian Health Service and Partners in Health to provide continuing education, resources, and training materials to healthcare providers on the reservation to allow for the best care possible. Today, a larger shift has been towards utilizing hospital services in conjunction with traditional practices (Giger, 2013).

**Mental Health Services**

Mental healthcare is an issue for the Navajo. Collaboration is needed to create crucial programming that will maximize the effectiveness of available mental health resources and protect persons from suicide risk. It is important for any medical or mental healthcare to be culturally sensitive, and meet the needs of a specific population. The TMC Needs Assessment (2013) identified this as a problem. The federal government allows Native Americans to use the National Suicide Prevention Hotline, but due to the incidence of poverty, many Navajo do not have access to the phone or the internet regularly. Without regular phone and internet service, their ability to utilize the Hotline may be limited. The TMC Needs Assessment (2013) also indicated that many Navajo get health information by word of mouth or by listening to the radio. TMC does offer counseling services, and traditional healers are employed. Many Navajo report difficulty accessing a healthcare provider due to lack of access to rural transportation (TMC, 2013). A culturally-specific suicide prevention program is needed for the Navajo so that risks of suicide can be decreased.
Mental Health Resources

Mental health services are scarce on the Navajo Reservation. The Navajo Nation Department of Behavioral Health Services is located in Window Rock, Arizona and focuses on treatment of alcohol and substance abuse rather than psychiatric care (Navajo Nation Department of Health, 2016). Native Americans for Community Action (NACA) is located in Flagstaff, Arizona. NACA has many mental health and suicide prevention programs, but it is a significant distance from several parts of the reservation. NACA has a wide variety of counseling techniques to restore Navajo cultural beliefs and restore Hózhó (Native Americans for Community Action, 2017). The Navajo Chapter of the Indian Health Service (IHS) is located in Window Rock, Arizona. The AI/AN National Suicide Prevention Strategic Plan is directed by the IHS, and offers online resources and suicide prevention information. The goals of the IHS are to use community level cultural approaches, increase access to mental health services, and promote collaboration between community and government agencies (IHS, 2017). Tsehootsooi Medical Center in Fort Defiance, Arizona has a 14 inpatient bed adolescent psychiatric unit and a Methamphetamine and Suicide Prevention Initiative Chapter.

Suicide Statistics

Grund and Yearwood (2014) described suicide as “an intentional act of killing oneself by any means” (p. 481). Many individuals who are thinking about suicide often feel pain, hopelessness, social isolation, guilt, and self-loathing. He or she may feel like there are no solutions to his or her problems and that there is no hope for improvement.

Every thirteen minutes, an American individual loses his or her life to suicide. Among these individuals, suicide is the second leading cause of death for American Indian/Alaska Native
(AI/AN) adolescents and young adults ages 15-34 (Centers for Disease Control and Prevention [CDC], 2015). Only 20% of individuals who complete suicide had contact with a mental healthcare provider in the month prior to the suicide (Schrieber, Culpepper, & Fife, 2011). Thus, healthcare providers must be advocates for mental health services to prevent suicide and reduce risk factors.

**Risk Factors**

Many factors place an individual at high risk for suicide. Approximately 90% of individuals who complete suicide were also suffering from psychiatric disorders including but not limited to depression, bipolar disorder, and schizophrenia (Grund & Yearwood, 2014). It is important to note that the U.S. Federal Drug Administration (FDA) issued a Black Box Warning for antidepressant medications for children and young adults. Sometimes, antidepressants cause feelings of mania, which has an especially high risk of suicide. Thus, the FDA recommends that careful monitoring of patients occur during the beginning of treatment and during dosing changes (Grund & Yearwood, 2014).

Nationally, males are four times more likely to commit suicide. Nearly half of all individuals who complete suicide have one or more chronic illnesses. Individuals with a history of previous suicide attempts are at high risk for attempting suicide again in the next 24 months. An evidence-based study performed by James Fowler (2012) showed that a history of suicide attempts was the strongest predictor that an individual will attempt suicide again. Individuals who are suffering from alcohol and substance abuse disorders also have a higher risk of suicide. Nearly 50% of individuals who complete suicide have alcohol in his or her bloodstream at the time of death (Grund & Yearwood, 2014).
In addition, having history of domestic and sexual abuse, lack of social support, social isolation, unemployment, and access to weapons also raises one’s risk of suicide (American Psychiatric Association, 2003). Copycat suicides are suicides that occur after a public figure, idol, or peer commits a highly-publicized suicide. Adolescents are most at risk for copycat suicide because the prefrontal cortex of the brain (responsible for judgment, frustration, tolerance, and impulse control), is immature (Grund & Yearwood, 2014, Fowler, 2012).

Reducing Risks

Protective factors reduce the risk of suicide. Having a religious affiliation has been correlated to reduced rates of suicide (Grund & Yearwood, 2014). Marriage, except for abusive or violent relationships, along with having children, has been associated with reduced rates of suicide. Strong, supportive social networks such as religious, educational, recreational, and familial groups also significantly reduces the risk of suicide (Fowler, 2012). Sufficient access to healthcare and effective coping skills are other protective factors (American Psychiatric Association, 2003).

The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) tool was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to aid clinicians in identifying suicide risk in individuals and developing a treatment plan (Grund & Yearwood, 2014). Nurses have a vital role in determining suicide risks of patients. Nurses can use the SAFE-T tool to aid in developing the best possible plan of care to keep patients safe. It is the responsibility of nurses to assess every patient for risk and protective factors for suicide by showing care and concern while forming a therapeutic nurse-patient relationship (Grund & Yearwood, 2014).
**Warning Signs**

Generally, when an individual is struggling and thinking about suicide, he or she shows warning signs of suicide. Individuals may communicate their thoughts by using overt (“I’m going to kill myself”) and covert (“I can’t do this anymore”) statements. The individual may talk about being a burden, feeling trapped, having unbearable pain, having no reason to live, and thoughts about killing or harming oneself. The individual may have mood changes such as depression, rage, loss of interest in others and activities, irritability, anxiety, and humiliation. Additionally, the individual may have the following behavior changes: increased alcohol and substance abuse, searching the internet for information and materials, acting recklessly, isolating oneself, changes in sleep patterns, visiting or calling others to say goodbye, and giving away possessions. Contrary to common belief, asking an individual about suicide does not put the idea of suicide into his or her head (Grund & Yearwood, 2014). Most often, patients find relief in talking about suicidal thoughts. Additionally, talking about suicide with someone lessens feelings of social isolation and despair, and increases problem-solving activities. Thus, asking an individual about suicidal feelings may prevent a suicide (Grund & Yearwood, 2014).

**Levels of Suicide Prevention**

There are three levels of suicide prevention: primary, secondary, and tertiary. Primary prevention involves providing education and support to patients and communities (Grund & Yearwood, 2014). The United States Department of Health and Human Services (2001) outlined goals for the National Strategy for Suicide Prevention. Goals include promote suicide awareness; developing support for suicide prevention; and eliminating the stigma associated with mental health. The organization seeks to implement suicide prevention programs and promote superior clinical and professional mental health practices.
Secondary prevention is treating the suicidal crisis itself. Secondary prevention may occur in acute care settings, mental health clinics, jails, and on telephone hotlines (Grund & Yearwood, 2014). Nurses help patients overcome the suicidal crisis by enhancing coping skills, building self-esteem, and mobilizing the patient’s support systems (Bulechek, Butcher, Dochterman, & Wagner, 2013). In the acute hospital setting, the patient is placed under suicide precautions (e.g. removing harmful objects and continuous monitoring) to prevent patient harm (Grund & Yearwood, 2014).

Tertiary prevention, often called “postvention” occurs after a suicide. The goal of tertiary prevention is to provide support the survivors of a person who has completed suicide. After a suicide, survivors may feel guilt or shame. Survivors are 4.5 times more likely to contemplate suicide themselves, yet only 25% of survivors are seeking mental health treatment (Grund & Yearwood, 2014). Postvention provides grief and loss counseling to reduce the traumatic aftermath and issues that survivors face, and it is helpful in preventing copycat suicides (Grund & Yearwood, 2014).

**Suicide in the Navajo Population**

TMC in Fort Defiance, Arizona aims to serve its community through several health programs and initiatives designed to stimulate a long term behavior change by influencing cultural norms of health and educating the community. The 2013 TMC Community Health Needs Assessment was developed to guide the organization in developing a health plan for the community. Much information can be gleaned from the Needs Assessment. The assessment analyzes the demographics of the Fort Defiance area, health status, health disparities, and gaps in healthcare, and determinants of health among the Navajo community.
Statistics from the 2013 TMC Community Health Needs Assessment support that suicide is a serious problem in the Navajo population. 30.51 out of every 100,000 people in Apache County, AZ, an area where many Navajo live, will commit suicide. In comparison, the national rate of suicide is 11.57 out of every 100,000 people (TMC, 2013). The suicide rate for the Navajo is more than double the national rate, which indicates that suicide is a drastic problem on the reservation. The assessment also identifies that intentional self-harm is the number two killer of youth in the TMC service area. These statistics imply the need for better mental healthcare on the reservation. Also identified in the TMC Needs Assessment, 42.17% of the Navajo said that mental health services are needed in the community (TMC, 2013). The Navajo themselves have identified the need. Additionally, the TMC Needs Assessment (2013) reported that 36.7 out of every 100,000 people are without adequate social and emotional support in Apache County. In comparison, the national rate for lack of social and emotional support is 20.93 out of every 100,000 people (TMC, 2013). With limited behavioral health services available on the reservation, many people do not know where to turn when they need help. The statistics and the identified and desired need would likely support an educational intervention for suicide prevention.

American Indian suicide can be traced back to historical trauma. Predisposing factors are social and family disruption, cultural conflicts, and social disorganization. Many Navajo still feel the effects of the Long Walk from 1864 to 1868. The federal government was prepared to take control of the Navajo population. It has led to a legacy of suffering, colonial oppression, and poor mental health (Goodkind, Hess, Gorman, & Parker, 2012). Additionally, TMC in Ft. Defiance, AZ used to be under the direction of the Indian Health Service. Many Navajo were
reluctant to utilize healthcare services because they viewed the government as dangerous and untrustworthy (TMC, 2015).

Adolescents are often challenged by their self-identity and accepting their minority status. Adolescent suicide among the Navajo is over double the national rate. Furthermore, many youth have been exposed to suicidal behaviors among their own families. Social and emotional support is essential for good mental health, economic stability, and educational success. Lack of support leads to higher incidences of suicide and other negative coping factors such as increased alcohol consumption (TMC, 2013).

**Culturally Congruent Care**

**Background**

Dr. Madeleine Leininger pioneered transcultural nursing theory. Leininger stated caring is the essence of nursing, and culturally congruent care creates beneficial meanings of nursing care and better health outcomes for patients. Leininger defined culturally congruent care as “the culturally based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death” (Leininger & McFarland, 2005). Each patient has different beliefs surrounding health, healing, wellness, illness, disease, and healthcare delivery. Being knowledgeable and respectful of cultural beliefs has a positive effect on healthcare delivery because it allows healthcare providers to deliver services that are responsive to the cultural needs of a widely diverse patient population (National Institutes of Health, 2017).
**Disconnect Between Cultures**

Many Western health models have been applied to Native American communities without considering modifying the model to fit local cultural context. Cultural differences have been acknowledged, but these differences are widely overlooked. Culture can be described as a framework through which communities model their beliefs and practices. Culture determines the roles of the individual, family, and community. Thus, it is important to consider these roles when assessing a cultural meaning of a health issue in order to develop the most useful health service. To date, this has not yet been established for suicide prevention or intervention practices among Native American communities in the United States (Wexler & Gone, 2012).

In the Western world, suicidal ideation is often attributed to psychological illness and is best treated by a mental health professional capable of dealing with a rapid crisis. The alignment of this assumption with Native American practice is essential to developing culturally appropriate healthcare. The Institute of Medicine (2002) claims suicide is not always a psychosocial disease, but a solution to certain cultural situations. Thus, suicide prevention attempts entail understanding how suicide varies among cultures and relates to the community. According to the American Foundation for Suicide Prevention (2017), “The most effective way to prevent a friend or loved one from taking his or her life is to recognize the factors that put people at risk for suicide, take warning signs seriously, and know how to respond.” The first step to suicide prevention is to identify at-risk individuals, and the next step is the recommendation to seek professional help. Therefore, Western suicide prevention includes identifying suicidal individuals and increasing the access and acceptance of seeking mental health treatments (Wexler & Gone, 2012).
Suicide is assumed to be a response to psychological pain that is rooted in the individual. It is frequently considered symptomatic to a psychosocial illness, and thus best treated by a mental health expert. It is understood that committing suicide is a personal response to one’s individual situation (Wexler & Gone, 2012). However, this view of suicide does not align with Native American views. Many Native Americans identify suicide as a result of years of historical oppression and ongoing social injustice and suffering. Most Native Americans focus on relationships rather than defining individual characteristics. For example, the Navajo often describe themselves through their kin rather than themselves. Native Americans understand suicide as a method of expressing despair related to culture loss linked with historical trauma. Without resolving ongoing social oppression, Native Americans may assume their struggles are personal rather than a result of an oppressive system. Personal struggles may lead them to feel like they have no future, which is a factor that is strongly attributed to a higher suicide risk (Wexler & Gone, 2012).

Most Western mental health professionals believe that suicide is a personal choice. However, many American Indian tribes consider suicide a tragic dilemma that is related to family and community suffering. When a tribe member feels like their community is bringing them down or their dead ancestors are calling to them, suicide may not be a choice, but a requirement which is especially true when there is culture loss. Culture is a protective factor against suicide (Fowler, 2012). Communities with a lower sense of connectedness with their culture experience higher suicide rates than communities that are empowering their culture (Wexler & Gone, 2012).

Western medicine traditionally suggests that suicide is psychologically significant. In contrast, Native Americans suggest that suicide is socially significant rather than psychologically significant. Suicide prevention, as a social problem, may be best taken care of by someone who
has a positive relationship with the individual and can act as a counselor. The most effective suicide interventions on a Native American reservation may be best performed by friends, family, and community members who have established relationships with the suicidal person. Approaching suicide as a social problem may create a sense of belonging among family and the community, which has been linked to lower suicide rates (Wexler & Gone, 2012).

**Suicide Prevention for Navajo People**

Some Native Americans may reject the clinical idea that suicide is a result of a mental illness. Native Americans may believe that suicide is a result of a long history of injustice that leads to detrimental circumstances. The clinical practice of “locking someone up” in a psychiatric ward to prevent suicide extends colonialism, evidenced by the Long Walk, for many American Indians. Inpatient psychiatric admissions may cause individuals to feel like they have lost their freedom. Wexler & Gone (2012) state, “It is not uncommon to hear tribal members express to mental health workers such sentiments such as ‘You people always come in here and tell us what’s wrong’ or that workers are ‘shoving programs down local people’s throats.’” If a mental health professional believes that a person is at risk for harming themselves, that person can be held against will and without family consent for up to seventy-two hours in an inpatient treatment facility. Involuntary psychiatric admissions may outrage many locals because it made them relive traumatic historical experiences such as when the federal government forcibly sent Navajo children away from their families to boarding schools or the forced relocation of the Navajo during the Long Walk. Suicide may also be considered a postcolonial disorder, and suicide prevention initiatives that maximize local community control may be the most successful (Wexler & Gone, 2012).
In summary, there are large gaps between Western suicide understanding and practices and Native American suicide understandings and practices. To create a successful suicide prevention initiative, addressing the gaps and tailoring the interventions to be culturally congruent is necessary. Interventions should consider local cultural meanings and practices along with family and community members’ thoughts. Collaboration between Western and local parties can help strengthen tribal communities and build resources that are congruent with cultural beliefs and practices (Wexler & Gone, 2012).

**Research Needed**

There is a minimal research about suicide in the Navajo population. Most existing research is outdated. This review of literature substantiates the need for further understanding of Navajo suicide to inform care of the Navajo population. While there are many suicide prevention programs, more research is needed to determine success in preventing suicide in the Navajo population.

**Research Question**

The impetus for this study is the extremely high rates of suicide in the Navajo population. A problem identified was the current lack of knowledge about perceptions of suicide in the Navajo population. The specific research question for this study asked: What are the community members’ perceptions of suicide in the Navajo population? Knowledge of current perceptions may help improve understanding about Navajo suicide, knowledge of existing mental health services on the Reservation, and cultural aspects important to the Navajo population that should be considered in interventions and education about suicide prevention.
Chapter 3
Methods

Overview of Methods/Design

This qualitative study explored perceptions of suicide in the Navajo population. The objective of this qualitative research was to glean insight about suicide in the Navajo population. A convenience, purposive sampling method was used. Data was collected through informant interviews. Data included audiotapes and field notes of the conversations between the researcher and the informants. After the interviews, theme analysis using Schreiber’s (2001) constant comparative method was performed to compare data using two levels of coding. The informants in this study shared the interest of suicide in the Navajo population. New perspectives about Navajo suicide were desired with this research study. This section will discuss specifics of the study methods.

Strategies to gain entrée. The location of this study was communities bordering the Navajo Reservation in Arizona and New Mexico. The researcher visited the Navajo Reservation twice and gained contacts in the medical facilities, schools, youth centers, and churches. Entrée was facilitated by learning about the Navajo culture, accessing the proper chain of command, and having flexibility. Mutual benefits to both the researcher and the Navajo population were identified.

Population and sample. The target population for this study was individuals who have previously lived or worked on the Navajo reservation. The sample size (n=8) was eight informants over the age of 18, from different races (may or may not be Navajo), ethnic backgrounds, genders, and occupations. All eight informants had knowledge and/or experience with suicide in the Navajo population through work or exposure to the Navajo population. The
sample and setting of this study were chosen because of proximity to the Navajo Reservation and expertise of the informants. Table 1 illustrates the demographics of the sample.

**Table 1. Demographics (n=8)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>5 female, 3 male</td>
</tr>
<tr>
<td>Age</td>
<td>20-65</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>6 Caucasian, 1 Mexican American, 1 American Indian</td>
</tr>
<tr>
<td>Marital Status</td>
<td>7 married, 1 divorced</td>
</tr>
<tr>
<td>Annual Income</td>
<td>$20,000-$100,000</td>
</tr>
<tr>
<td>Education</td>
<td>5 Bachelor’s, 5 Master’s, 1 Doctorate</td>
</tr>
<tr>
<td>Employment Status</td>
<td>7 employed, 1 retired</td>
</tr>
<tr>
<td>Occupation</td>
<td>3 youth workers, 1 teacher, 1 nurse, 1 social worker, 1 strategic planner, 1 office worker</td>
</tr>
<tr>
<td>Years lived on the Reservation</td>
<td>2.5-40 years (n=7)</td>
</tr>
<tr>
<td>Years worked on the Reservation</td>
<td>2.5-16 years (n=7)</td>
</tr>
</tbody>
</table>

**Participant recruitment.** Informants were recruited based on the recommendations of a contact who is a doctorally prepared Psychiatric Nurse Practitioner. The recommendations were considered appropriate based on the following criteria of the contact: previously lived and practiced on the Navajo Reservation; currently residence in Arizona; previous and current research experience with the Navajo Population and the Navajo Nation Institutional Review Board; member of the Navajo Tribe; and access to individuals with experience with the Navajo population. Approval from Ashland University Human Subjects Review Board was obtained prior to recruiting informants (Appendix A).

The informants chosen were individuals who no longer live or work on the Navajo Reservation, but had knowledge regarding suicide among persons living on the Navajo Reservation. All informants were aged 18 or over. No specific inclusion or exclusion criteria were used to reduce bias, and to obtain a variety of perspectives. Potential informants were contacted by email or phone using the script in Appendix B prior to the interview to determine
interest in participation. During the initial introduction, demographic information was obtained using the form in Appendix C to enable the researcher to ask about experience with the Navajo population. The informant could be excluded at that point if desired.

**Human subjects protection.** Permission to conduct this study was requested from Ashland University Human Subjects Review Board (HSRB). Upon approval, an introductory letter (Appendix D) from the researcher was sent out to potential informants. This letter included a detailed explanation of the study purpose, procedures, and researcher contact information. If the informant agreed to participate, they were provided an informed consent form (Appendix E). All interviews were conducted by phone. The informed consent form was read aloud to each informant prior to proceeding with the interview. The informant was asked to state, “I, ‘Participant’s Name’, agree to participate in this study.” This was considered verbal assent, and interview questions were provided. A hard copy was emailed to informants to keep for their records.

Risks to the informants of this study were minimal. Some question topics may have been sensitive to the informant. However, informants were free to decline to answer any questions they did not wish to answer or withdraw their participation from this study at any time. Informants were not pressured into participating in this study, and were informed that participation is voluntary. Participants were provided with referral information for mental health services if requested (Appendix F). Each interview was audio-taped, and all audio tapes and informant information were kept in a locked drawer in the faculty mentor’s locked office. Only the principal investigator and faculty mentors had access to the identifiable records of informants.
**Data collection.** This study used semi-structured informant interviews as the data collection method to gain insight into the informants’ perceptions of suicide in the Navajo population. Interviews lasted approximately thirty minutes. Oral communication is suitable for adults of varying ages, educational levels, and skill levels, and deemed appropriate for this study. The researcher did not assume that the informant would know what the researcher wanted to know. Time was taken at the beginning of the interview to clarify the purpose of the study, reassure confidentiality of responses, and answer informant questions about the study. An intentional effort was made to establish rapport with the informant to create a respectful, comfortable atmosphere to voice opinions.

Interview questions included information about perception of suicide in the Navajo population, knowledge of suicide prevention programs, services that are needed on the Reservation that are not currently provided, Navajo cultural aspects pertinent to talking about suicide, and supportive resources currently in the Navajo community. The questions were open-ended to allow for free recall and truly elicit the informant’s perspectives. The purpose of the interviews was to provide foundational information and enhance understanding of suicide in the Navajo population.

**Audio and field notes.** All informant interviews were openly audiotaped for transcription and analysis purposes. A digital voice recorder was used. Field notes taken by the researcher during the interview included who was speaking, key discussion points and sequences, notable quotes, tone of voice, willingness to talk, and striking themes. Immediately following each interview, the researcher recorded thoughts and concerns related to the content of the interview, and then debriefed with the faculty mentor. After the interviews were completed, the principal
investigator typed the narrative data from the audiotape to ensure the transcript that was kept anonymous.

**Trustworthiness of data.** This study followed Lincoln and Guba’s (1985) guidelines for establishing trustworthiness in qualitative studies. These guidelines include addressing credibility, dependability and confirmability, and transferability. Credibility is the truth value of the findings. Dependability refers to the consistency of the data findings. Confirmability reflects the objectivity of the study. Transferability is the determination that the study findings might be applied to other settings or situations. This section will discuss how these aspects of trustworthiness were addressed by this research study.

**Credibility.** Credibility was established by using member checks and peer debriefing. Member checks were performed by the researcher at the end of every informant interview. The informant responses were summarized, and the informant was asked to verify the summary. Peer debriefing occurred after each interview. Immediately following each interview, the researcher recorded thoughts and concerns related to the content of the interview, and then debriefed with the faculty mentor.

**Dependability and confirmability.** Raw data included information gleaned from interview transcripts and field notes. A consistency check of data was performed by comparing field notes to the audiotaped interview transcripts. A detailed audit trail of the data collection and analysis process was maintained. Content analysis of the narrative data was performed to identify emerging themes. The researcher, the faculty mentor, and the doctorally-prepared additional reader with qualitative research experience all reviewed the themes identified from data analysis. Discussion of themes resulted in new categorizations. Conducting more than one informant
interview also served to increase dependability. Earlier interview findings were confirmed in later interview findings, helping to establish consensus of themes.

**Transferability.** Researchers are often cautioned against generalizability in qualitative research. However, Lincoln and Guba (1985) discuss that some transferability between contexts may occur if the two contexts are similar. Research gleaned from this research study can be beneficial to others when thoughtfully considered for appropriateness in other contexts. The analysis and discussion of this study (Chapters 4 and 5) consider the extent to which this study might be otherwise applicable.
Chapter 4  
Data Analysis and Findings

The overall problem prompting this research study was the high rate of suicide in the Navajo population and the lack of information about current perceptions of Navajo suicide. The research question this study asked was: What are the community members’ perceptions of suicide in the Navajo population? To answer this question, the following five questions were discussed with the eight informants who participated:

1. Tell me about suicide in the Navajo Nation.
2. Describe any suicide prevention programs implemented. Tell me about any program data/results.
3. How should the culture of the Navajo be integrated into a suicide prevention program?
4. What Navajo cultural aspects should we consider including?
5. What supportive resources are present in the Navajo community that could be utilized?

This study used the Schrieber’s (2001) constant comparative method to analyze data. Data analysis was initiated during the planning stage. Data analysis continued throughout data collection during the informant interviews. The five questions that guided the interview discussion were modified as needed to allow for more specific responses.

Data Analysis

Data for this research study included the informant interview transcripts and field notes taken during and after the informant interviews. This section describes the analysis process, which is described in first person by the researcher to help the reader fully understand the analysis and decision-making processes that are utilized in a constant comparative analysis.
Transcripts. Transcript analysis was based on verbatim scripts from each informant interview. Step one of the analysis was First Level Coding (Schrieber, 2001). I studied the data for a long period of time, read each informant interview several times, and divided the transcripts into sections based upon informant responses. Utilizing the constant comparative analysis method, I identified key words, phrases, and repeated words and phrases. Step two of the analysis was Second Level Coding (Schrieber, 2001). I studied these words and phrases until themes emerged. The faculty mentor and the additional reader also performed First and Second Level Coding. We then compared analyses to identify new key words, categorizations, and themes.

Field notes. Field notes were openly collected by the researcher during the informant interviews. Field notes included who was speaking, key discussion points and sequences, notable quotes, tone of voice, willingness to talk, and striking themes. Immediately following each interview, I recorded thoughts and concerns related to the content of the interview, and then debriefed with my faculty mentor. Suggestions made during the debriefing sessions helped guide future informant interviews.

Findings from transcript data. This section discusses the data analysis of each of the five questions asked to the informants during interview sessions:

1. Tell me about suicide in the Navajo Nation.
2. Describe any suicide prevention programs implemented. Tell me about any program data/results.
3. How should the culture of the Navajo be integrated into a suicide prevention program?
4. What Navajo cultural aspects should we consider including?
5. What supportive resources are present in the Navajo community that could be utilized?
Table 2 summarizes the findings from questions 1 through 5, and lists the themes and sub themes identified from data analysis. Analysis from questions 1 through 5 are also discussed individually.

**Table 2. Summary of Findings: Themes and Sub Themes**

- **Social Issues**
  - Historical trauma
  - Quick staff turnover
  - Unstable family life

- **Hopelessness**
  - Lack of access to mental health services
  - Lack of transportation
  - Widespread poverty
  - Poor living conditions
  - Isolation
  - Mainstream disconnect

- **Culture**
  - Taboos surrounding death
  - Culture as a protective factor

**Question 1.** The purpose of Question 1, “Tell me about suicide in the Navajo Nation,” was an open-ended question to begin the flow of conversation and to allow true recall of responses. It was hoped that the informants would truly elicit their perspective of suicide in the Navajo
population in order to decrease the probability that the informants would give responses intended to please the researcher (social desirability) rather than share their honest opinions.

**Question 2.** The purpose of Question 2, “Describe any suicide prevention programs implemented. Tell me about any program data/results,” was an open-ended question to allow for true recall about suicide prevention interventions currently happening on the Navajo Reservation. It was hoped that this question would lead to the identification of suicide prevention efforts or lack of suicide prevention efforts.

**Question 3 and 4.** The purpose of Question 3, “How should the culture of the Navajo be integrated into a suicide prevention program?” and Question 4, “What Navajo cultural aspects should we consider including?” was to elicit informant ideas about using Navajo cultural aspects in suicide prevention efforts. It was hoped that informants would identify specific Navajo cultural factors that are protective against suicide or a risk for suicide.

**Question 5.** The purpose of Question 5, “What supportive resources are present in the Navajo community that could be utilized?” was to generate a list of resources in the Navajo community that could be used in a suicide prevention effort. It was hoped that the informants would have sufficient knowledge of resources in the Navajo communities to be able to determine if the resources would be beneficial in including in a suicide prevention effort.

**Levels of coding.** During First Level Coding, individual informant responses to interview questions were noted. Key words and phrases were identified, which led to overall themes. The similarities and differences between the key words and phrases was noted. During Second Level Coding, categories for each theme were identified.

**Findings from field notes.** Additional findings were noted from field notes and debriefing sessions with the faculty mentor. Each of the eight informants were open to discussion about
Navajo suicide and willing to offer their perspectives of the problem. All informants voluntarily chose to offer their insight about the problem. Each informant was actively involved in the interview. They each conveyed a passionate, devoted, and supportive attitude towards this research study. Additionally, a consensus that suicide is a massive problem for the Navajo people was conveyed by all informants.

**Summary of findings.** First Level Coding in the analysis of Questions 1 through 5 led to the identification of three themes. Second Level Coding identified subthemes. Chapter 5 will discuss each of the three themes and various subthemes. Critical thinking dimensions and implications for research and nursing practice will also be discussed in Chapter 5.
Chapter 5
Discussion and Implications

The purpose of this research study was to explore the perceptions of suicide in the Navajo population held by informants who have lived or worked on the Navajo Reservation in the past. The expectation was that these findings might be used to help improve understanding about Navajo suicide, knowledge of existing mental health services on the reservation, and cultural aspects important to the Navajo population that should be considered to develop interventions and education about suicide prevention. This chapter discusses the findings of this research study as they relate to the review of literature. In addition, limitations of the study, along with implications for research and nursing practice are discussed.

Discussion of Findings Related to Social Issues

As discussed in Chapter 4, one dominant theme that emerged was social issues. This section discusses social issues based upon the subthemes identified. Social issues as they relate to the review of literature will also be discussed.

Historical trauma. A widespread reason for high rates of suicide in the Navajo considered by the informants was historical trauma. The subtheme of historical trauma is supported by the research findings of Navajo survival, historical trauma, and healing. In regard to historical trauma, Goodkind et al. (2012) identified that forced relocation of the Navajo peoples by the federal government during the Long Walk has led to a legacy of suffering for the population resulting from colonial oppression and its negative impact on the population’s mental health.

An informant pointed out, “They’re a colonized group of people. … For 500 years there has been attempts to destroy them entirely, there’s been attempts to relocate them, to remove them from their parents and put them in other schools, … and stripping them of their culture, identity, and meaning to the world.” This response supports the findings of Goodkind et al. (2012).
Staff turnover. Another dominant subtheme from informant interviews was the high rates of staff turnover, especially in the hospitals and schools. One informant mentioned, “It’s very typical that you see people here for six months and then they’re gone. Or two to three years and they’re out. It’s very rare that you have people working in those positions that stay here long term.” Another informant emphasized the turnover rate affecting the mental health of Navajo youth stating, “Teachers, most are here to pay their loans and go, but they don’t realize that can be devastating to the kids over the years and over the generations. … The kids take it personally because they can’t leave [the reservation]. …When they see that nobody cares about them, they won’t try.” The findings from the informant interviews support the assertion by Grund and Yearwood (2014) that a lack of support system can damage one’s mental health and increase one’s risk for suicide. Formal research studies and data on turnover rates on the Navajo Reservation could not be located, but it was clear from the interviews that this is a concern.

Unstable families. A prevalent reason for high rates of suicide in the Navajo population considered by the informants was unstable family situations. The findings from informant interviews lend additional support to Grund and Yearwood’s (2014) statement that a lack of support system can damage one’s mental health and increase one’s risk for suicide. One informant stated, “There are other problems like parents and families not being stable.” Another informant elaborated, “All of a sudden by seventh grade or eighth grade, they’ve [the youth] have realized that oh my gosh, my family is totally messed up. And now it starts to bother them. That’s the age that needs the positive role models.” These responses align with literature indicating that strong, supportive social networks (e.g. religious, educational, recreational, and familial groups) significantly reduces the risk of suicide (Fowler, 2012).
Discussion of Findings Related to Hopelessness

Another dominant theme that emerged from data analysis was hopelessness. This section discusses the theme hopelessness and the subthemes identified. This section also discusses hopelessness as it relates to the review of literature.

Lack of access to mental health services. One subtheme identified by several informants was lack of access to mental health services. An informant mentioned, “Mental health services is really hard to get into. Because they are overbooked, understaffed, and underqualified.” Another informant stated “When a school teenager passed away, there was nobody really available to come speak to us. Unless someone readily volunteers their services, the school can’t really react the way they should to a suicide.” The findings from informant interviews support the need for mental health services also identified by TMC that 42.17% of individuals said mental health services were needed in their community (TMC, 2013). The interview responses also support Wexler and Gone’s (2012) assertion that a culturally congruent suicide prevention initiative may be the most successful for the Navajo population. Additionally, the responses from informant interviews identify the scarce amount of mental health services available on the Navajo Reservation as outlined in the review of literature.

Lack of access to transportation. Lack of transportation was another reason that may lead to increased numbers of suicide. Mental healthcare services may become more difficult to access. Many families do not own cars, especially those who live in poverty. Without transportation, people cannot access healthcare. An informant stated, “The biggest problem getting kids involved is transportation. … Transportation is the number one reason for kids being isolated.” Another informant pointed out that the reason that mental health services are not utilized enough was because “They don’t have a car and that ten minute drive seems too far
away now because they don’t have a way to get there.” The findings from informant interviews support TMC’s (2013) data that many families do not have the financial resources to pay for gas or a car to leave home. Many healthcare facilities are a half-hour or longer from rural communities. Informant responses also support the NTS (2017) data that the demand for transportation on the Navajo Reservation far exceeds the busses and resources that are available on the reservation.

**Hopelessness subthemes.** Three subthemes related to hopelessness were widespread poverty, poor living conditions, and isolation. The informant data largely supports the data collected by TMC (2013). One informant said, “There’s a broad sense of hopelessness here. Suicide happens a lot. ….Drugs and alcohol are everywhere. People live in poverty and don’t have jobs. … There’s also this feeling that there’s nothing to do. … Nothing to do to get paid for and nothing to do for fun. And so, that’s a pretty devastating feeling.” This informant’s perception supports the existence of widespread poverty, unemployment, and isolation as evidenced by the U.S. Census (2010). Another informant addressed the poor living conditions on the Reservation by stating, “The deeper you go into the reservation, the less [resources] they have. Many have no water or electricity in their homes. …. They live in hogans. They don’t work. Alcohol and drugs are prevalent. There’s nothing for them to do,” which further supports the evidence from TMC (2013) and Navajo Relief Fund (2017).

**Mainstream disconnect.** Another subtheme identified from analysis was mainstream disconnect. There is a sense that the Navajo Reservation is isolated, or separate from, the rest of the United States, causing disconnect between cultures. An informant stated, “Many Navajo look at what the Caucasian people have, and realize it’s not what they have. They don’t understand why Caucasian people live like we do, when they can’t get benefits.” Another informant said,
“You know, messages they’re [the youth] are getting from the broader culture. Maybe it’s bad to be a native person. Maybe it’s more desirable to be white, or to be rich, or to live in a city, or to drive a fancy car. Whatever it is, we all get a lot of messages that we aren’t good enough and we’d prefer something else.” The mainstream disconnect could be contributing to the increased numbers of suicides. Connectedness to one’s own culture is a protective factor against suicide (Grund & Yearwood, 2014). The informant responses also reinforce Kahn-John’s (2010) thoughts that losing connection with Hózhó can cause detrimental effects on the health and well-being of the Navajo people. Additionally, the informant responses also support that decades of historical trauma and culture loss may be continuing to have negative effects on today’s youth (Kahn-John, 2010).

**Discussion of Findings Related to Culture**

As discussed in Chapter 4, one dominant theme that emerged was culture. This section discusses culture and the subthemes identified. Culture as it relates to the previous review of literature is also identified.

**Taboos surrounding death.** As mentioned in the review of literature, there is a taboo surrounding death in the Navajo culture (Giger, 2013, Locke, 2001). A subtheme noted from informant interviews was taboos surrounding death. Taboos surrounding death (e.g. forbiddance of touching or looking at a dead person and not talking about death) may hinder the grieving process after a suicide or prevent someone who is thinking about suicide from talking about it. One informant said, “I need to be culturally respectful and culturally sensitive here. Keeping that in mind and the thought that death is a hard topic to discuss with Navajo. If you speak of the negative, there’s the belief that you bring about the negative, you bring it into reality.” Another informant said, “Mostly the taboos focus on death, and there’s a lot of things you can and cannot
do. If it’s a family member or somebody dies in your house, there’s different ceremonies and things that have to be done.” These research findings illustrate Giger’s (2013) and Locke’s (2001) writings about taboos surrounding death in the Navajo culture.

**Culture as a protective factor.** A dominant subtheme that emerged from data analysis was Navajo culture being a protective factor against suicide. Research by Goodkind et al. (2012) suggested that Navajo culture is fading away from the Navajo people, especially the youth. One informant illustrated this by stating, “Most individuals I work with are so far removed from their culture and society, that they really just don’t have a sense of belonging or hope.” Another stated, “Culture in itself has a protective feature for individuals and families. They tend to be a bit more resilient if they are grounded in some sort of cultural activity.” A third informant said, “Navajo culture is about life and living in beautiful ways together with your family, your community, your land. And if those things are emphasized more, I think that a lot of people would have a better well-being.” These informant responses support the literature that strong, supportive social networks such as religious, educational, recreational, and familial groups significantly reduces the risk of suicide (Fowler, 2012, Grund & Yearwood, 2014). The informant responses also support Kahn-John’s (2010) research that having a strong connection to Hózhó is associated with better overall health and well-being.

**Limitations of Study**

**Potential biases.** In this qualitative study, the researcher was most interested in identifying individuals’ perceptions of suicide in the Navajo population. However, the researcher has the potential to impact the process of data collection and analysis despite measures (as discussed previously) to minimize biases. Potential biases of this research study include: personal perceptions of suicide in the Navajo population, personal perceptions of the Navajo culture, and
ideas about others’ perceptions of suicide in the Navajo population. These perceptions have been influenced by the researcher’s status as a student nurse, and a visitor of the Navajo Nation. As discussed in this report, steps were taken (e.g. intentional listing and reflection of potential bias) to prevent these biases from influencing informant responses. However, it is possible that the researcher’s opinions may have influenced informant responses.

**Research method.** For this undergraduate research study, feasibility of scholarly research was considered over the rigor of scholarly research. Additionally, because a self-report method was chosen, the informants might have not shared their true opinions of suicide in the Navajo population.

**Factors specific to the Navajo Nation.** To conduct research directly on the Navajo Reservation, the researcher must obtain approval by the Navajo Nation Internal Review Board. This is a lengthy, expensive process that would have required multiple trips to the Navajo Reservation. For this undergraduate research study, feasibility of scholarly research had to be considered over rigor of scholarly research. The researcher and faculty mentor made the decision to only include individuals who do not currently work or live on the Navajo Reservation to circumvent the need for Navajo Nation Internal Review Board approval. Our sample was limited due to the inability to use informants currently living and working on the reservation. As a result, only one of our informants was a Navajo individual. However, every effort was made to interview informants with sufficient and appropriate background knowledge to contribute in-depth, rich descriptions on the topic of suicide in the Navajo population.

**Implications for Future Research**

There is a need for more studies regarding suicide in the Navajo population. This research study identified themes to guide future research about concerns of individuals living on the
Navajo reservation. Further research to learn about perceptions of individuals who live and work on the Navajo reservation would be helpful to build a body of current knowledge on topics of concern, such as suicide. Obtaining the Navajo Nation Internal Review Board approval would be helpful to increase the number of Navajo informants.

**Implications for Nursing Practice**

Perceptions of suicide in the Navajo population may change over time. Perceptions from this research study may soon become outdated as times and people change. The findings from this research study suggested several implications for nursing practice to address the high rates of suicide in the Navajo population. These implications for nursing practice suggested the importance of cultural competency, preserving Navajo culture between older and younger Navajo, and raising suicide awareness.

**Cultural competency.** Cultural competency in nursing practice is important to ensuring the best possible care for patients. Leininger stated caring is the essence of nursing and identified that culturally congruent care creates beneficial meanings of nursing care and better health outcomes for patients (Leininger & McFarland, 2005). Knowledge of the Navajo culture and being respectful of cultural practices may be important to reducing suicide. Knowledge and respect of cultural beliefs has a positive effect on healthcare delivery because it allows healthcare providers to deliver services responsive to cultural needs of a widely diverse patient population (National Institutes of Health, 2017). Enhanced cultural competency might help future suicide prevention initiatives be more tailored to Navajo culture, thus increasing effectiveness.

**Preserving Navajo culture.** Restoring Navajo culture in the youth might help reduce the suicide rate because cultural connectedness is a protective factor against suicide. Decades of historical trauma have led to the loss of rich cultural knowledge (Kahn-John, 2010). Cultural
knowledge may not be currently well communicated from elders to younger generations of Navajo people. A strong connection with Hózhó is associated with better health and well-being (Kahn-John, 2010). Ensuring cultural knowledge and the Navajo language is passed down from elders to youth is essential to survival of Navajo culture. Additionally, culturally congruent care creates beneficial meanings of nursing care and better health outcomes for patients (Leininger & McFarland, 2005).

**Raising suicide awareness.** Informants identified the need to raise awareness of suicide on the Navajo Reservation. Raising awareness might allow individuals to better serve as active listeners to those who are considering suicide. Educating the public about resources available in the community and how to reduce risk factors of suicide is an important first step. Validating suicidal feelings and actively listening to an individual considering suicide might be a therapeutic tool and intervention for suicide.
Conclusion

Understanding individuals’ perceptions about suicide in the Navajo population can guide efforts to implementing effective suicide prevention initiatives. The purpose of this qualitative study was to glean insight about suicide in the Navajo population. Eight informants who have previously lived or worked on the Navajo reservation volunteered to participate in individual informant interviews with the researcher. Five questions were used to explore what the informants thought about suicide in the Navajo population. Analysis using the constant comparative method identified three key themes that emerged during First Level Coding: social issues, hopelessness, and culture. Second Level coding identified several sub themes.

Findings from this research study might be used to help improve understanding about Navajo suicide, knowledge of existing mental health services on the Reservation, and cultural aspects important to the Navajo population that should be considered in interventions and education about suicide prevention. An understanding of the unique perceptions of professionals living and working with the Navajo has the potential to help healthcare providers offer more culturally congruent care. This study may increase suicide awareness and spark interest in suicide prevention. Thus, the immediate goal of this study was to enhance understanding of suicide in the Navajo population.
References


http://www.nativepartnership.org/site/PageServer?pagename=nrf_livingconditions

http://www.navajotransit.com/about-us.html


Tsehootsooi Medical Center. (2013). *Tsehootsooi medical center community health needs assessment.* Retrieved from

https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#


TO: Emily Donahue and Professor Sharon See  
FROM: Chris Chartier, HSRB Chair  
DATE: April 7\textsuperscript{th}, 2016  
SUBJECT: Human Subjects Review Board Approval  
PROJECT TITLE: Understanding suicide in the Navajo Population  
HSRB SUBMISSION #: 3-15-16-#077  

The Human Subjects Review Board has approved your research study. You may proceed with the study as you have outlined in your proposal. The approval is granted for one calendar year. Research participant interaction and/or data collection is to cease at this time, unless application for extension has been submitted and approval for continuance is obtained.

The primary role of the HSRB is to ensure the protection of human research participants. As a result of this mandate, we ask that you adhere to the ethical principles of autonomy, justice, and beneficence. We would also like to remind you of your responsibility to report any violation to participant protections immediately upon discovery. Likewise, we would like to remind you that any alteration to the research proposal as it was approved cannot move forward. Any amendment to the application must be submitted for approval before the project can resume.

We wish you success in your discoveries,

[Signature]

Doctor Chris Chartier  
Ashland University  
Chair Human Subjects Review Board
Appendix B

Script for Obtaining Informed Consent

For Face to Face Interviews:
In order to proceed with the interview, your informed consent must be obtained. Here is the written informed consent form for you to read. If you have any questions, please ask me. When you are finished reading the form, and if you agree to the terms of this study, please sign the form. A copy will be given to you.

IF PARTICIPANT AGREES: A signature will be obtained.

This will be considered informed consent, and interview questions will be asked.

For Interviews by Phone:
In order to proceed with the interview, I need to read you the terms of informed consent. When I am finished, if you agree to the terms of this study, please state, “I, “Participant’s Name”, agree to participate in this study.” If you would like a written copy of the informed consent, I will email or mail it to you.

Principal Investigator reads the Informed Consent Form (Appendix E) aloud.

IF PARTICIPANT AGREES: “I, “Participant’s name”, agree to participate in this study.”

This will be considered verbal assent, and interview questions will be asked.

For Interviews by Email:
An email will be sent to participant stating:

In order to proceed with the interview, your informed consent must be obtained. I have attached the written informed consent form for you to read. If you have any questions, please contact me. When you are finished reading the form, and if you agree to the terms of this study, please reply to my email stating, “I, “Participant’s Name”, agree to participate in this study.”

IF PARTICIPANT AGREES: He or she will email “I, “Participant’s name”, agree to participate in this study.”

This will be considered verbal assent, and interview questions will be asked.
Appendix C

DEMOGRAPHICS SHEET

“Understanding Suicide in the Navajo Population”

Please do not write your name on this form. It will be stored separately from any other information that you complete during this study and will not be linked to any of your responses in any way. This information is being collected for demographic purposes, and it will be kept confidential. This information will allow us to provide an accurate description of our population sample and will be reported on an aggregate basis only.

For the following items, please circle the response that is most descriptive of you, or fill in the blank as appropriate. If you feel uncomfortable answering a question, you may decline to answer that question.

**Gender:**  Male    Female    Prefer Not to Answer
**Age:**  18-29 years    30-49 years    50-64 years    65+ years    Prefer Not to Answer

**Ethnicity:**  *What race or ethnicity do you most identify? _______________________________
Prefer Not to Answer

**Marital Status:**  Single    Married or Domestic Partnership    Divorced    Widowed    Separated
Prefer Not to Answer

**Annual Income Level:**
- Up to $20,000
- $20,001 to $39,999
- $40,000 to $59,999
- $60,000 to $99,999
- $100,000 to $149,999
- $150,000+
Prefer Not to Answer
Education: What is the highest degree or level of school that you have completed?

No schooling completed
Some high school completed, no diploma received
High School Diploma or GED
Some college completed, no degree received
Vocational/Trade/Technical training
Associate’s Degree
Bachelor’s Degree
Master’s Degree
Professional Degree
Doctoral Degree
Prefer Not to Answer

Employment Status:

Employed Unemployed Retired Military Student Unable to Work
Prefer Not To Answer

Occupation: ________________
Prefer Not to Answer

How many years did you live on the Navajo Reservation? ________________
How many years did you work on the Navajo Reservation? ________________
Appendix D

Dear Informant,

My name is Emily Donahue, a junior Honors nursing student from Ashland University in Ashland, Ohio. I am currently working on my undergraduate Honors Capstone project, and the topic I chose was understanding suicide in the Navajo population. I began learning about the Navajo culture during my coursework which concluded when I visited the Navajo Reservation for a week in May 2015. I selected my Capstone topic because I was moved by the Navajo culture and desire to expand my learning, and potentially contribute to the understanding about suicide in the Navajo. I will be returning to the reservation May 2016. I am seeking participants for my study. I hope this letter provides you with some detailed information on my project and you are interested in participating in my project.

I have conducted an extensive literature review and compared suicide prevention programs. I believe that to have an impactful project voices of the people must be heard and integrated. It is vital my project be a collaborative effort with local people who are knowledgeable about Navajo suicide. I would like to interview approximately 10 participants (ex. healthcare professionals, nurses, social workers, teachers, and youth center staff) who do not currently live or work on the Reservation. I have created a few questions to provide foundational information and enhance understanding of the problem:

- Perception of the problem
- Knowing what programs are/have been done
- Services or practices that are needed but not currently provided
- Navajo cultural aspects to consider including
- Supportive resources currently in the Navajo community

My preference would be to do the interviews face to face when I visit in May. If this does not fit in your timeframe, the interviews could be done via phone or email. I am happy to answer any questions you might have.

Thank you for considering participating in my project and contributing information from your expertise on the topic of Navajo suicide. If you are interested in participating, please contact me at 419-689-0347 or email me at edonahue@ashland.edu.

Sincerely,
Emily Donahue, Student Nurse
Sharon See MSN, RNC-OB
Clinical Assistant Professor, Faculty Advisor
Appendix E

INFORMED CONSENT FORM

“Understanding Suicide in the Navajo Population”

You are being asked to participate in research. To make an informed decision about whether you want to participate, you should understand the purpose and the possible risks and benefits of this research. This process is known as informed consent. This form describes the purpose, procedures, benefits and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about this study have been answered, you will be asked to agree, which will allow your participation in this study. You should receive a copy of this document for your records.

A. PURPOSE AND BACKGROUND
Principal investigator Emily Donahue, nursing student, and Research Advisor Sharon See, MSN, RNC-OB from Ashland University’s Dwight Schar College of Nursing and Health Sciences are conducting a research study to help understand the incidence of suicide among Navajo individuals.

B. PROCEDURES
If you agree to participate in this study, the following will occur:
• A list of interview discussion topics pertaining to your views of suicide in your community will be given to you.
• After reading and thinking about the survey questions, you will be asked to share your responses via phone or in-person interview or email with the principal investigator and research advisor. This interview is expected to last approximately thirty minutes.
These procedures will take a total time of approximately thirty to forty minutes to complete. Data obtained from this research will be handled with as much confidentiality as possible.

C. RISKS/DISCOMFORTS
Risks and discomforts associated with this research are minimal. Some discussion topics may be sensitive to you, but you are free to decline to answer any questions you do not wish to answer or withdraw your participation from this study at any time.

D. BENEFITS
There will be no direct benefit to you from participating in this study. However, the information you provide may help health professionals better understand suicide in the Navajo community. Your participation may help secure federal, state, and local grant money for suicide prevention programs to be implemented in your community.

E. COSTS
There will be no costs to you as a result of taking part in this study.
F. PAYMENT
You will receive no compensation for your participation in this study.

G. CONFIDENTIALITY
Your identity will remain anonymous at all times throughout this study. Only the principal investigator and the research advisor will have access to your identity, and your name will not be shared with anyone. No names or identifying information will be included in any publications or presentations based on this data.

H. QUESTIONS
If you have comments or concerns about participating in this study, you may contact the principal investigator Emily Donahue via phone at 419-689-0347 or via email at edonahue@ashland.edu. You may contact the research advisor Sharon See, MSN, RNC-OB via phone at 419-521-6828 or via email at ssee@ashland.edu.

If you have any questions regarding your rights as a research participant, please contact Dr. Christopher Chartier, Chair of the Human Subjects Review Board, Ashland University at 419-289-4142 or via email at cchartie@ashland.edu.

I. CONSENT
I certify that I have been given a copy of this consent form to keep, and my participation in this research is voluntary. I certify that I have read and understood this consent form, and I understand that no compensation will be given to me for participating. I understand the risks, benefits of this research. I certify that I am 18 years of age or older. I understand that my participation in this study may be withdrawn at any time without penalty. By signing below, I affirm that I understand this paragraph and agree to participate as a subject in the research described.

_______________________          ________________________________________________
Date                                                 Signature of study participant
________________________________________________
Printed Name of study participant

_______________________          _______________________________________________
Date                                                 Signature of Person Obtaining Consent
Appendix F

Referrals for Mental Health Services

1. Tsehootsooi Medical Center, Ft. Defiance, Arizona
   
   928-729-3750

2. Navajo Treatment Center for Children and their Families, Window Rock, Arizona
   
   Counseling and Mental Health Services
   
   928-871-7679

3. Western New Mexico Medical Group Behavioral Health, Gallup, New Mexico
   
   Crisis Intervention and Mental Health Services
   
   505-863-3828
Appendix G

Questions for Participants

Primary Questions:
1. Tell me about suicide in the Navajo Nation.
2. Describe any suicide prevention programs implemented. Tell me about any program data/results.
3. How should the culture of the Navajo be integrated into a suicide prevention program?
4. What Navajo cultural aspects should we consider including?
5. What supportive resources are present in the Navajo community that could be utilized?

Follow-up Questions:
1. What do you believe are aspects of successful suicide prevention programs?
2. How would you recommend evaluating a culturally specific suicide prevention program in the Navajo community?
Author Biography

Emily Donahue was born in Mansfield, Ohio on August 17, 1995. She grew up in the Mansfield area, graduating from Shelby Senior High School in 2013. At Ashland University, Emily is an honors baccalaureate nursing student at the Dwight Schar College of Nursing and Health Sciences. She is a member of Sigma Theta Tau International and Alpha Lambda Delta. Emily was a participant of the Navajo Cultural Immersion course and has traveled to the Navajo Reservation in Arizona twice for a week long immersion. This experience broadened her intellectual and social horizons, and expanded her knowledge of working with diverse populations. Most recently, Emily has disseminated her Honors Capstone research findings at a regional scholarly meeting, and a national nursing conference. Additionally, Emily serves as a peer mentor for both the Honors Program and Nursing Program. Emily works part-time as an academic tutor and a patient care assistant. She has been on the Dean’s List for seven semesters. Upon graduation, Emily plans to work as a registered nurse, pursuing a career in critical care nursing. Emily also plans to attend graduate school in the future.