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The Role of School Counsellors in the National Aboriginal Youth Suicide Prevention Strategy: An Illustration

Le rôle des conseillers et conseillères scolaires dans le cadre de la Stratégie nationale de prévention du suicide chez les jeunes Autochtones : une illustration

Noorfarah Merali
University of Alberta

ABSTRACT

Suicide clusters among Aboriginal communities have been attributed to shared family, social, and environmental adversities linked to their history of colonization and residential schooling. Aboriginal leaders often request mental health support from outside their communities to manage these crises. Health Canada's National Aboriginal Youth Suicide Prevention Strategy outlines evidence-based activities to be implemented by, or in collaboration with, community members. This article situates school counsellors working in schools on or near Aboriginal reserves within Health Canada's framework, and describes through an illustration how they can create sustainable partnerships with community members to augment the work of external crisis teams.

RÉSUMÉ

Les épidémies de suicides au sein des collectivités autochtones ont été attribuées aux difficultés communes sur le plan familial, social et environnemental, le tout étant lié à l'historique de la colonisation et aux pensionnats. Les leaders autochtones réclament souvent de l'aide en santé mentale provenant de l'extérieur de leurs communautés pour gérer les crises. La Stratégie nationale de prévention du suicide chez les jeunes Autochtones souligne des activités fondées sur des faits probants qui doivent être mises en place par les membres de la communauté et en collaboration avec ceux-ci. Cet article précise la place des conseillers et conseillères travaillant dans des écoles situées dans les réserves ou près de celles-ci, dans le cadre régi par Santé Canada, et on y illustre la manière d'établir des partenariats durables avec les membres de la communauté afin de bonifier le travail des équipes externes de gestion de crise.

The vulnerability of youth to commit suicide is a growing societal concern. In a seminal report about mental health and illness among the Canadian population, the Government of Canada (2006) identified suicide as the second leading cause of death among adolescents and young adults, right after motor vehicle accidents. Data specific to Aboriginal people in this report indicated that the Aboriginal youth suicide rate is five-fold greater for boys and seven-fold greater for girls than the rate for non-Aboriginals, making suicide the leading

cause of death for this cohort. Aboriginal peoples are the original inhabitants of Canada who were colonized by Europeans in their own land, and who were subsequently subjected to decades of racist government policies involving forced assimilation through residential schools and segregation onto remote reservations (Blue, Darou, & Ruano, 2010; Kirmayer et al., 2007; Waldram, 1997). The total Aboriginal population in Canada is approximately 1.5 million, including individuals who identify as First Nations, Metis (mixed European and Aboriginal ancestry), and Inuit, together encompassing over 634 different bands (Statistics Canada, 2015), scattered across the provinces and territories. Approximately 50% of the Aboriginal population in Canada is under the age of 25 (Statistics Canada, 2015). Health Canada's (2004) statistical profile of Aboriginal Canadians, which also included detailed information pertaining to suicide, highlighted that suicide accounts for 22% of all deaths among youth ages 10 to 19, and 16% of all deaths during early adulthood.

Even more alarming is the fact that when suicide happens among youth and young adults, it often happens in clusters, with one completed suicide being followed by several other attempted and completed suicides (Joiner, 1999; Scherr & Reinemann, 2011; Zenere, 2009). Cluster suicides that have occurred among Aboriginal communities in Canada have followed a suicide pattern referred to as a *point cluster*, with multiple completed suicides or suicide attempts taking place within the same geographic space and/or time period (Isaak et al., 2010; Kirmayer et al., 2007; Tousignant, Morin, Vitenti, De Serres, & Laliberte, 2014). These point cluster suicides often occur within institutional settings such as schools, hospitals, or specific communities and are most often due to adverse familial, social, and environmental conditions shared by youth in a particular Aboriginal community or reserve. These adverse conditions also contribute to a sense of hopelessness and helplessness among Aboriginal youth (Kirmayer et al., 2007).

Family and community-level trauma from a history of colonization and residential schooling has also been found to be a contributing factor to a higher than average suicide rate in Aboriginal youth (Elias et al., 2012; Kirmayer et al., 2007). Consistent with this finding, cluster suicides among Aboriginal communities often occur among biological relatives or next of kin with collective trauma experiences, and show a trend of spreading from youth to adult family and community members (Isaak et al., 2010; Kirmayer et al., 2007).

Elias et al. (2012) empirically demonstrated the multigenerational effects of being a residential school survivor on suicidal tendencies in a sample of close to 3,000 First Nations Canadians in Manitoba. These researchers found that children and grandchildren of residential school survivors, who also experienced familial abuse, were 17 times more likely to have a history of suicide attempts than those without multigenerational exposure to residential schooling. Ongoing struggles with grief about the loss of identity, culture, land, and family/community connections, as well as limited emotion regulation strategies among children and grandchildren of residential school survivors, may lead some youth to view suicide as their only option (Masecar, 2007).

This article describes contributing factors for cluster suicides and challenges in suicide prevention and intervention within Aboriginal communities. Subsequently, two frameworks for Aboriginal suicide prevention are presented, with an emphasis on the most recent one, which is Health Canada's (2013) suicide prevention strategy. The role of school counsellors in implementing this strategy is discussed. Specific actions school counsellors can take to address suicide crises are illustrated by sharing the author's story of assisting a school counsellor working in a school near an Aboriginal reserve to collaborate with community members and mental health crisis teams to contain and manage the crisis.

Life Adversity and Cluster Suicides

Statistics Canada (2015) shed light on some of the adverse familial, social, and environmental conditions shared by Aboriginal youth and young adults. Fifty percent of Aboriginal children and youth across Canada live in single-parent households, live with grandparents with no parent present, or are part of stepfamilies or foster families. Additionally, it was reported that more than 14,000 Aboriginal children under the age of 14 are in foster care, which is 10 times the number of non-Aboriginal children in this age group.

In a study funded by the Canadian Institutes of Health Research of family factors related to vulnerability for suicide among Aboriginal youth living on and off reserves, Tousignant et al. (2014) had cultural anthropologists and two psychology students conduct informal, semistructured interviews with family members about the childrearing process, family life, daily activities and structure, coping strategies for life difficulties, and support for children's involvement in their school and community activities. Content analysis was used to analyze the data both qualitatively for themes as well as quantitatively.

On-reserve families reported significantly higher rates of parental negligence of children in their families of origin and in their present families than did off-reserve families (Tousignant et al., 2014). Families residing on reserves also reported higher rates of various types of family violence, including domestic and sexual violence and completed suicides. Families living on reserves spontaneously reported problems with lack of parental supervision of youth and insecurity of their life situation as major problem areas. Parental addiction problems involving alcohol and drugs were identified among families living both on and off reserves. Similarly, Kirmayer et al. (2007) identified child abuse and neglect, domestic violence, parental psychopathology, and substance abuse as some of the contributing familial factors for cluster suicides among Canadian Aboriginal youth.

Additionally, when compared with non-Aboriginals, Aboriginal people are much more likely to experience poverty, live in overcrowded conditions, and experience financial and other barriers to completing their education, resulting in lower literacy and numeracy rates (Statistics Canada, 2015). However, Statistics Canada has never specifically calculated or examined poverty rates for the close to 50% of Aboriginal Canadians who live on reserves (mostly First Nations people).

Macdonald and Wilson (2016) identified this as a major omission that keeps the Canadian public in the dark about the true living conditions of Canadian Aboriginals. In calculating reserve poverty rates, these researchers found that 60% of First Nations children living on reserves live in poverty as a national average, with some regions like Manitoba and Saskatchewan having child poverty rates on reserves edging upwards of 70% and 80%. Furthermore, the employment rate of Aboriginal peoples in Canada is 62.5%, compared to an employment rate of 75.8% among non-Aboriginals, with much higher levels of poverty, poor quality housing requiring major repairs, and unemployment on remote reserves (Statistics Canada, 2015). Aboriginal peoples also have significantly higher rates of being victimized by crime in their communities (12% versus only 5% when compared with non-Aboriginals), with the most frequent types of crime occurring outside the family being assault and sexual assault (Statistics Canada, 2015).

The Role of Colonization and Residential Schooling

The challenging familial, social, and environmental conditions facing Aboriginal peoples in Canada are attributed to the colonization process and the residential schooling experience (Blue et al., 2010; Kirmayer et al., 2007; Waldram, 1997). The current problems with domestic and community violence, addictions, and physical and mental health were limited prior to the European insurgency (Blue et al., 2010; Kirmayer et al., 2007; Waldram, 1997). The separation of children from their families paired with the long-term suppression of Aboriginal culture and language in residential schools (where some children were subjected to repeated emotional, physical, and sexual abuse) led to individual and collective psychological trauma, community disintegration, and too many of today's adults not having effective parental role models or alternative coping strategies to support their children's positive development (Blue et al., 2010; Kirmayer et al., 2007; Waldram, 1997).

The remarkable resilience of the Aboriginal population is evident in the interpretation of the Statistics Canada (2015) report, which is based on the 2011 national census. For example, even though many Aboriginal people experience life difficulties, mental health problems, and suicide crises, approximately half of the Aboriginal people over the age of 12 reported that their health is excellent. Moreover, slightly more than half of those over the age of 18 reported that their mental health status was very good or excellent. Similarly, despite facing barriers to completion of their education, 48% of Aboriginal people in Canada now have a postsecondary qualification such as a certificate, diploma, or degree (Statistics Canada, 2015).

Also, there are some Aboriginal subgroups, such as the Mohawk, who have low suicide rates compared to the overall Aboriginal suicide rates for Canada (Tousignant et al., 2014). Also, the self-reported health and mental health status of Metis people parallels that of the non-Aboriginal population (Statistics Canada, 2015). Furthermore, results from the 2008–2010 Ontario First Nations Regional

Health Survey indicated that 83.5% of First Nations youth from age 12 to 17 have not considered suicide and 94.1% have never attempted suicide in their lifetime.

"Nonetheless, First Nations and Inuit Youth still suffer from suicide rates much higher than the Canadian population and it is important that investments in youth suicide prevention programs continue" (First Nations Information Governance Centre, 2012, para 4). In addition, although segregation on reserves may be viewed negatively by outsiders, there are some key strengths of reserve living that should be taken into account in suicide prevention efforts, including freedom to maintain traditional ways of life and development of social connections among Aboriginal youth (Tousignant et al., 2014).

Chandler and Lalonde (2008) conducted a large-scale study of more than 200 First Nations Bands and Tribal Councils in British Columbia over two time periods (1987–1992 and 1993–2000) in order to better understand why some communities had dramatically high suicide rates (800 times the provincial average) while others had few or no suicides. These researchers found that although suicide rates among Aboriginal communities drop slightly with increasing socioeconomic status (SES) and increase when reserves are in direct proximity to large urban centres, neither SES nor rurality account for the variance in suicide rates. In contrast, six key factors that address the degree to which each band or tribe has been able to establish what Chandler and Lalonde refer to as cultural continuity—the ability to affirm their cultural identity and carry their cultural practices into the future of their communities—fully explained the variance in suicide rates:

> Suicide rates are lower within communities that have succeeded in their efforts to attain self-government, or have a history of pursuing land claims, or have gained control over education, health, police, and fire services, or have marshalled the resources needed to construct cultural facilities within the community…. Communities in which women form the majority within local government are marked by lower suicide rates, as are those who have managed to gain a considerable degree of control over child and family services. (Chandler & Lalonde, 2008, pp. 239–240)

Remarkably, in communities that had all of these factors in place, the suicide rates were near zero (Chandler & Lalonde, 2008). These findings suggest that when Aboriginal people are given the opportunity to address the harmful effects of colonization by gaining back power over their lives and communities to reinstate their cultural identities and ways of life, they are able to sustain positive mental and physical health.

Leenaars (2006) explained what Aboriginal people in Canada, as well as those living elsewhere in the Arctic, Australia, New Zealand, and Brazil have been through, as part of a global phenomenon of attempted genocide of Indigenous peoples by colonizing groups. Leenars reviewed evidence that the treatment of Indigenous peoples around the world meets all the criteria in the definition in the United Nations Convention on the Prevention and Punishment of the Crime of Genocide, including (a) attempts to destroy an entire cultural, ethnic, or racial

group; (b) causing group members bodily and mental harm; (c) forcibly transferring children of the group to members of another group for cultural or religious indoctrination; (d) imposing measures to prevent births among members of the targeted group; and (e) inflicting conditions of life that bring about physical and cultural destruction.

In response to this lived reality among Aboriginal people, the Truth and Reconciliation Commission of Canada (TRC; 2015) has called for the official adoption of the United Nations Declaration on the Rights of Indigenous Peoples at all levels of government, as well as in all sectors of service delivery (health care, education, social and child protective services, and law). The TRC outlines a multilevel process whereby the desire of Canadian Aboriginals to regain self-determination with respect to their physical spaces and land, their children and families, and the practice of their religion, culture, and Indigenous traditions can be achieved. The process involves various activities, including issuing public apologies for the atrocities of residential schooling; partnering with communities and leaders to renegotiate various treaties and land claims; educating civil servants, educators, and mental health service providers about the history and culture of Aboriginal Canadians; and supporting, as well as enabling, community-initiated healing and recovery efforts.

Intervention Challenges with Respect to Aboriginal Cluster Suicides

In line with the recommendations of the TRC (2015), responses and solutions to the suicide problem among Aboriginal communities where point clusters occur should come from community members (Canadian Medical Association [CMA], 2015; Kirmayer et al., 2007; McCaslin & Boyer, 2009). However, since community members on reserves sometimes feel they do not have the skills, supports, or resources in place to manage a suicide crisis, community leaders and chiefs often directly request the help of mental health and counselling professionals from outside their communities (Baum, 2016; CMA, 2015; CBC News, 2016; Kirmayer et al., 2007). An example of a community calling for help of this nature was recently witnessed in relation to the 2016 suicide crisis in the Northern Ontario reserve of Attawapiskat, as well as in reserves in Manitoba. The call led to federal and provincial government support in sending mental health professionals to the reserves, mainly social workers, psychologists, and psychiatrists (Baum, 2016; CBC News, 2016).

The intervention strategies for suicide that most mental health professionals are trained to implement are individual rather than communal. With respect to point cluster suicides, individual interventions may simply address symptoms without addressing collective root causes or contributing family factors (CMA, 2015; Kirmayer et al., 2007; Tousignant et al., 2014). Also, mental health professionals coming from various parts of Canada, who simply enter and exit Aboriginal communities to provide temporary help during periods of crisis without planning for ongoing follow-up or partnership with community members, may leave people

feeling abandoned and at ongoing risk of relapse (CMA, 2015; Kirmayer et al., 2007). This risk will be more apparent because of strong Aboriginal cultural values surrounding the maintenance of social ties and relations, which stand in stark contrast to North American individualistic values (Blue et al., 2010; Brant, 1990; Restoule, 1997). Furthermore, mental health professionals with limited exposure to working with Aboriginal communities may not understand how to implement suicide prevention, intervention, risk management, and bereavement strategies in culturally appropriate ways (Caldwell, 2008; Isaak et al., 2010).

Caldwell (2008) initiated a 5-year participatory action project to culturally adapt suicide prevention and intervention strategies for Aboriginal people through consultation and collaboration with leaders, Elders, and youth from two Aboriginal communities in Atlantic Canada. The emerging suicide prevention and intervention continuum was a precursor to the National Aboriginal Youth Suicide Prevention Strategy put forward by Health Canada (2013). There are three parallels between these two frameworks for addressing suicide. First, both of them include activities directed at primary, secondary, and tertiary prevention. Second, within each of these areas, both frameworks emphasize knowledge development or capacity building among community members to empower them to recognize and address issues related to suicide and support their ability to self-govern and culturally revitalize, consistent with the objectives of the TRC (2015). Third, both are guided by evidence-based strategies to reduce risk factors for suicide among Aboriginal people while simultaneously increasing protective factors, and doing so in direct partnership with First Nations communities.

Primary prevention involves activities that target the whole community to enhance quality of life by building protective factors and attempting to reduce or address personal, familial, cultural, and environmental factors that contribute to suicide risk (Caldwell, 2008; Health Canada, 2013). Some key protective factors identified in the Health Canada (2013) strategy include positive cultural identity, self-esteem, positive parenting and family relationships/caregiving, strong peer relationships, community connections, community self-determination, emotion regulation and coping skills, good mental and physical health, good school performance, access to adequate housing, culturally appropriate health care, and religion and spirituality. Key risk factors for suicide include breakdown of cultural values and belief systems, dislocation from land, multigenerational traumas due to residential school experiences, racism and social isolation, poverty and homelessness, abuse and neglect, poor school performance, mental illness, addictions, and lack of access to health care (Health Canada, 2013). Activities listed under primary prevention in Caldwell's (2008) framework to address the protective factors and risk factors above include positive parenting programs to improve family communication and conflict resolution and reduce exposure to family violence; substance abuse programs; life skills courses for youth to increase self-esteem, emotion regulation, coping skills, and mastery; and social or group programs to promote friendships and help strengthen community ties between youth, adults, and Elders.

Health Canada's (2013) strategy makes several important additions. They emphasize (a) activities that promote cultural continuity, such as those involving traditional culture, arts, or recreation; (b) educational efforts to build community awareness about suicide; (c) youth leadership development programs; and (d) building partnerships between community leaders/members and critical resources in the areas of physical and mental health care, housing, education, employment (e.g., industry partnerships), recreation, justice (e.g., policing and legal systems), and various government departments (e.g., land claims). Both Caldwell (2008) and Health Canada (2013) identify Elders in the community, other community gatekeepers—such as leaders and chiefs, teachers, helping professionals, and other service providers—and youth and their families as the appropriate targets for primary prevention activities.

In terms of building life skills among Aboriginal youth, LaFromboise (1996) and LaFromboise and Howard-Pitney (1995) developed a school-based life skills curriculum specifically for Native Americans between the ages of 14 and 19 involving multiple interactive lessons and experiential exercises that can be collaboratively delivered by community leaders and teachers or teacher-counsellors in the classroom over the period of a few months. The curriculum covers topics such as building self-esteem, leadership skills, managing emotions and stress (including suicidal thoughts and feelings), effective communication and problem-solving, and recognizing and reorienting self-destructive behaviours. The curriculum includes vignettes and activities very relevant to Canadian Aboriginals, such as dealing with low teacher expectations of Aboriginal students' classroom performance, responding to instances of racism and acculturative stress, and dealing with family difficulties. The curriculum can also be culturally adapted for any specific American or Canadian Aboriginal subgroup. Evaluation research found that youth who received the program reported lower levels of hopelessness and better problem-solving and personal crisis management skills (LaFromboise & Howard-Pitney, 1996).

Secondary prevention involves intervening when risk factors for suicide are activated in the lives of youth or other community members to prevent suicide attempts (Caldwell, 2008; Health Canada, 2013). Secondary prevention activities identified in Caldwell's community action project included community education to increase recognition of symptoms of depression and suicide risk in self and others to encourage help-seeking, yellow ribbon suicide stigma reduction campaigns, and facilitating timely access to community or external resources for those who need help.

Health Canada's (2013) strategy for secondary prevention includes psychoeducation regarding the causes and consequences of self-destructive behaviour, as well as alternative self-management strategies. Health Canada also emphasized training community members in mental health first aid so they possess the skills to de-escalate youth in crisis while they try to connect them to mental health support. The curriculum developed by LaFromboise (1996) also addressed some of these areas, including direct instruction on how to help others who are thinking about committing suicide and understanding the reasons for wanting to end

one's life. Finally, Health Canada's framework recommended the development of community-driven crisis response protocols for suicide, in addition to engaging any external crisis response teams. Adolescents at risk for suicide, helping professionals, parents, and community members were identified as the most appropriate targets of secondary prevention activities (Caldwell, 2008; Health Canada, 2013).

Tertiary prevention concerns intervention for individuals who are currently suicidal and for families and communities of those who have committed suicide or who are contemplating suicide (Caldwell, 2008; Health Canada, 2013). Health Canada suggested that tertiary prevention activities should help Aboriginal communities deal with the aftermath of suicide and the related experiences of loss and grief. They also suggested that a key priority for tertiary prevention is to minimize contagion of suicide by engaging a network of mental health professionals, natural helpers or healers, grief counsellors, and trained community members who have assisted with secondary prevention activities to support those in distress. The Aboriginal community members who participated in Caldwell's (2008) project identified the following activities as those that would be most helpful in moving the communities to a pre-crisis level of functioning after youth suicides: support groups, individual and family counselling, training of health professionals to monitor survivors for any signs of suicidal behaviour, and improved coordination among various community supports such as those for emergency care of acutely suicidal individuals.

The Potential Contributions of School Counsellors to the Resolution of Suicide Crises

School counsellors, working in schools on or most proximal to Aboriginal reserves, can play an important role in suicide prevention and containment of suicide crises. School counsellors are experienced educators who have acquired advanced graduate training including coverage of (a) child and adolescent learning and development, (b) basic assessment, (c) individual and group counselling, (d) communication skills, (e) program development, (f) crisis management, and (g) multicultural counselling (Gladding & Alderson, 2012). The work activities of school counsellors are very broad and include engaging in individual or group counselling, classroom lessons, and community outreach. Through these activities, school counsellors (a) promote students' personal and social development; (b) enhance students' academic achievement; (c) facilitate students' career decision-making; (d) engage in school-based crisis management; (e) coordinate linkages between families, the school, and the community; and (f) identify at-risk students and their families for program development or referral purposes (Gladding & Alderson, 2012). In crisis situations, school counsellors are often supported by school-based or regional crisis teams, which consist of other school counsellors, teachers, administrative personnel, and mental health professionals (James & Gilliland, 2013).

The teaching backgrounds of school counsellors would enable them to effectively deliver educational lessons to Aboriginal youth, other teachers, and community leaders in the areas of life skills, communication and conflict resolution skills, and coping skills mentioned in the primary prevention category of both Caldwell's (2008) and Health Canada's (2013) suicide prevention frameworks. In fact, LaFromboise and Howard-Pitney (1995) and LaFromboise (1996) have identified school counsellors as one of the most appropriate facilitator groups for their American Indian Life Skills Curriculum described earlier. School counsellors' teaching background would also position them to deliver the education about signs and symptoms of depression and suicide risk to the above groups and also to parents, as well as to implement anti-stigma campaigns. Their knowledge of child and adolescent development and mental health would also enable them to help identify at-risk students for direct referral or mental health service connection. Moreover, school counsellors usually provide services that involve basic support, resource identification and referral, rather than intensive mental health services. All of these activities were part of the secondary prevention activities and capacity-building activities listed in the two frameworks described.

Under the tertiary prevention activities of Caldwell's (2008) and Health Canada's (2013) frameworks, school counsellors can facilitate the positive coping and bereavement among peers of deceased students, and help generate accurate understandings of suicide to minimize contagion. Their role as a family, school, and community liaison would also enable them to communicate with families whose children have already completed suicide or whose children are actively suicidal. The role of liaison is to ensure that the families are connected to appropriate supports within or outside their communities, and to advocate for them. They could also assist with monitoring of survivors of suicide on a regular or periodic basis to help prevent the risk of relapse by establishing long-term partnerships with Aboriginal communities. School counsellors could also take the leadership role on development of peer and community helper programs in partnership with Aboriginal communities.

In a review of the research on school-based suicide prevention related to Aboriginal communities, Kirmayer et al. (2007) emphasized that schools are one of the most widely used resources for youth suicide prevention due to their access to youth at risk and the ease of delivering programming to large groups of youth with limited additional expense. They highlighted three main findings in their review. First, they noted that school-based mental health and life skills education has been found to be effective in reducing student levels of depression, hopelessness, stress, and anxiety, and improving their emotion regulation skills. Second, they noted that identification of at-risk students and connection of those students to appropriate supports have been found to reduce student suicide attempts by up to 40%. Third, connection of youth to their families and communities can build their social and cultural capital, and promote resilience (Kirmayer et al., 2007).

Because the majority of school counsellors are White, it is of critical importance that any involvement in assisting with suicide prevention and managing suicide

crises occurs in direct collaboration and consultation with the affected Aboriginal communities, as recommended by Caldwell (2008), Health Canada (2013), and the TRC (2015). Initiating a partnership with community Elders, leaders, and members helps to ensure that their perceptions of the causes and consequences of suicide crises in their specific community are respected, as they are the experts on their own experiences. Partnerships with community members can also facilitate incorporation of Indigenous knowledge and traditional healing practices into the crisis response process, respecting Aboriginal people's cultural rights and self-determination (TRC, 2015).

Although there are opportunities for school counsellors to assist with suicide crises, existing research suggests that working with suicidal students and their families can lead to professional burnout (Christianson & Everall, 2009). Christianson and Everall's (2009) interviews with seven school counsellors across four Canadian provinces, who had lost a student due to suicide, highlighted the personal grief and loss of control participants experienced in the event of client death. This grief and loss of control occurred regardless of their levels of school counselling experience, which ranged from 15 to 31 years. In reflecting upon and learning from their experiences, the counsellors emphasized the importance of diligent self-care in working with suicide cases. Specific self-care strategies described as helpful included prayer and spirituality, healthy eating and exercise, massage, and access of personal and professional support networks for both consolation and consultation. The importance of building strong connections with various community resources for responding to the needs of suicidal students and their families was also addressed by the counsellors, as this would distribute the responsibility for assisting suicidal students across various service providers (Christianson & Everall, 2009).

An Illustration

In this section, I will share my story of assisting a school counsellor to respond to a suicide crisis on an Aboriginal reserve to illustrate the role school counsellors can play within Health Canada's (2013) framework and the process of relationship-building with community members. My choice of a story-telling approach is informed by the works of Bigum and Rowan (2009) and Dion (2004). Bigum and Rowan argued that the failure of many schools to recognize and respond to the unique experiences and needs of specific groups of culturally different students, such as Indigenous students, can be remedied through a knowledge-sharing process, involving various forms of story-telling that contribute to "educated hope." *Educated hope* is described as a recognition that regardless of one's beginnings in life and one's individual and social struggles, an alternative and positive future is possible (Bigum & Rowan, 2009).

Dion (2004) explained that story-telling is consistent with the oral tradition in Aboriginal communities. She also highlighted the fact that story-telling can be a means of challenging and disrupting the prior learning of educators/counsellors, which often leads them to take the problems faced by Aboriginal Canadians

for granted, and to believe that, as non-Indigenous people, there is nothing they can do to help. It is my hope that, in reading the story that follows, other school counsellors and counsellor educators will be able to identify specific ways that they can actively participate in the development of a positive future for Aboriginal youth affected by suicide in their communities.

In terms of my own positioning, I am a doctoral-level registered counselling psychologist and counsellor educator at a large Canadian university, with over 15 years of cross-cultural counselling experience. I am an immigrant from an African country that shares the Aboriginal peoples of Canada's long and troubled colonial past. I teach the full-year practicum course in my university's master's program in school counselling. Overseeing the practicum involves serving as the university supervisor for the work the students do in schools, in collaboration with school-based supervisors. The program serves both local students and those who commute into the city from various remote regions for classes on alternate weekends, with a number of students coming from schools on or nearby Aboriginal reserves.

A few years ago, a former practicum student who had completed her master's degree and was working as a full-time school counsellor in a junior high school near an Aboriginal reserve contacted me for ongoing consultation and supervision when faced with the initial onset of a point cluster suicide. Many of the children from the reserve attended this school due to its close proximity to their community. The counsellor was Caucasian and Canadian-born. Consultation and supervision was provided through Skype sessions twice a week over several months. The counsellor's activities under my guidance contributed to suicide containment and positive resolution of the crisis, in that there were no known suicide attempts or completed suicides in the year following the initial cluster of suicide attempts as per community member and school counsellor reports.

The reserve community did not speak to or inform the media or the public about the suicide problem they faced. They just asked for the help of school and mental health professionals on and outside of the school's crisis team once they became aware of the crisis situation. As the school counsellor still works on the school near the reserve, inclusion of the name of the former student in this article would lead to identification of both the school and the reserve. Therefore, for maintenance of the confidentiality of the reserve community, myself, and the school counsellor, the school counsellor agreed that this story would be provided from my perspective as the consultant for managing the crisis. Cluster suicides emerging across Aboriginal communities in Canada share similar characteristics (Kirmayer et al., 1997). Therefore, the situation the school counsellor was confronted with is described in general terms so it is not likely to be distinguishable from other cluster situations; the story focuses on describing specific interventions implemented and crisis responses, rather than client or community characteristics. The story was reconstructed by reviewing the contents of the counsellor's case notes and my own case consultation notes regarding the suicide crisis, including my own reflections.

In the initial Skype meeting, the school counsellor shared the following sequence of events that occurred among Aboriginal students from the same reserve community within a 1-week period, and the reactions of their parents, peers, and community members: An Aboriginal male student at the junior high school had just committed suicide. The case involved an intentional drug overdose, with the student's desire for life to end communicated to a non-Aboriginal friend a few days before the suicide, which the friend did not take seriously. The deceased student was the child of residential school survivors, who were both struggling emotionally from the traumas they endured. In the 3 days following the first suicide, there were discoveries by Aboriginal and some non-Aboriginal peers of four suicide notes written by other Aboriginal students within the same school from the same reserve. The notes were left in places where they could be easily found, such as on students' desks, in their rooms, or sticking out of their jean back pockets or side jacket pockets.

The school counsellor's observations were that the events in this situation caused widespread alarm, fear, and despair among (a) the peer groups of the suicidal students, (b) the entire student body, (c) parents of the student who completed suicide and of those whose suicide notes were discovered, and (d) the students' Aboriginal reserve community. Luckily, all the students for whom suicide notes were discovered were still alive at the moment their respective notes were reported to teachers and the school counsellor by their peers. The fact that these students were alive allowed for interruption of their suicide attempts, which will be described shortly.

During that initial Skype session, which took place at the end of the week in which all these events occurred and exactly one day after the fourth student suicide note was found, the school counsellor requested assistance in discerning how to manage the multiple simultaneous tasks of assisting with grieving, managing, and preventing suicide contagion, and how to engage all levels of the school and community in an urgent manner to respond to the crises. Upon hearing of the situation, I first checked in about the school counsellor's own emotional reaction to the crisis, and we discussed self-care strategies she could implement to support her well-being as she worked through the situation.

I reflected upon what could be done to help all the individuals affected by this situation, and the most helpful sequence of interventions. In my judgement, it seemed most urgent and appropriate to simultaneously focus on the bereavement process for the peers and family of the student who died and suicide risk management and resiliency-building for those who expressed a desire and intention to end their lives. Therefore, I helped the school counsellor to develop a communication plan for informing the school principal, school crisis outreach team, the parents concerned about their children's welfare, and Aboriginal community leaders about the nature of the situation. I was mindful that informing community leaders is critical in facilitating collaborative problem-resolution, which is the best practice outlined by Caldwell (2008), Health Canada (2013), and the TRC (2015).

In our supervision and consultation meetings, we discussed how the first suicide could be communicated to other students at the school in a developmentally appropriate way and how grieving could be facilitated in a manner that provides positive coping strategies and does not lead to spreading despair and helplessness. I suggested that the school counsellor could collaborate with other counsellors at the school and with teachers to directly communicate the death of their classmate to students in class. The teachers, with the school counsellor(s) present, were then involved in facilitating guided classroom discussions with students. These discussions were held in a circle desk arrangement and included (a) their best memories of the student who died, (b) what they are going to miss most about him, (c) how they want to keep those memories alive, (d) and what they would like to do with the now missing student's desk. The missing student's desk was left in its place and not arranged into the circle during these dialogues to mark, recognize, and acknowledge the loss. Teachers and school counsellors participated in these class dialogues by also sharing what they will miss most about the student.

According to the school counsellor's case notes, during the brainstorming session on what to do with the student's desk, the students generated several possibilities. These possibilities included decorating it with pictures taken with the student, placing flowers on it, each student placing a personal note in the desk drawer about what they wish they could tell the student about how they feel, and other such activities. The class of the deceased student decided on implementing both the first and third options. They also decided that they wanted to keep the desk as it is, without any other student being allowed to sit in it for the remainder of the school year, because they were not yet ready to let the student go. The chosen activities gave the youth a chance to directly express their emotions around the loss of their classmate in a safe and caring space, while also taking some action toward emotional healing. Prochaska and Norcross (2014) suggested that activities that provide opportunities for catharsis after being confronted with grief and loss can facilitate resilience and effective coping.

I encouraged the school counsellor to give the students the opportunity to ask any questions they had about suicide such as "What is it? Why might the student have done it?" I also encouraged the school counsellor to answer questions factually with the intention to educate, and recommended that she draw on related experiential lessons and activities about suicide from LaFromboise's (1996) evidence-based American Indian Life Skills Development Curriculum for this purpose. For example, the counsellor explained to students that suicide is taking one's own life before the age or stage when life naturally ends, and that there is no one reason a person decides to do this, but it most often relates to feeling hopeless and helpless. The students were told that suicide is not a reversible act and that a person cannot ever have a chance to change their mind if they use lethal means. The class was also educated about other ways to respond to feelings of hopelessness and helplessness, such as various coping strategies, people they could tell who could connect them with help such as teachers and school counsellors, and information

about various counselling and healing resources that they could be connected to within the Aboriginal and non-Aboriginal community.

When the first suicide had occurred, the school counsellor appropriately informed her school principal. In the following few days when other students' suicide notes were being discovered, the principal was updated about the emerging crisis situation, but had not yet engaged the school crisis outreach team. In the initial Skype consultation, the school counsellor was encouraged to immediately follow up with her principal for support in informing and urgently engaging the school crisis outreach team, and in mobilizing teachers and other school staff to assist with responding to and managing the situation as required. This contact with the principal and engagement of the crisis team occurred over the weekend after the week of the crisis events—so there were only a few days in between the discovery of the student suicide notes and the engagement of the school crisis team.

The school counsellor, in collaboration with a few other school counsellors and teachers, located the students who wrote the suicide notes to assess each one's current status and needs as each note was found. The students were located through contact with their parents or through the specific peers, siblings, or friends in the school who had found and reported the existence of the suicide notes. All the students were found and were provided with mental health support through psychologists and psychiatrists who were quickly brought in from other school districts and mobilized by the school's crisis outreach team. These services were provided while the students were being transported to intensive mental health support in a hospital outside their reserve. Two were in the midst of suicide attempts when found. Both students were found early enough to get them life-saving medical attention.

The parents of the student who completed suicide and the parents of the students who left suicide notes were in contact with each other and were sharing grief and fear among themselves, as well as among others in their Aboriginal communities. One of the parents also went on to commit suicide a few weeks later. As a first step toward building a partnership with the community, I advised the school counsellor to encourage the affected students' parents to reach out to the leaders and Elders of their community to provide them with firsthand community feedback about the developing problem. Both Health Canada (2013) and the TRC (2015) encourage community self-determination. I believed that having parents provide insider input to leaders of their own community to engage them in problem resolution would be more appropriate than having the White school counsellor point out that she has identified a problem affecting their community. The latter approach would repeat the interactions between White people and Indigenous communities in Canada's history of colonization.

After speaking with their community leaders, parents connected the school counsellor and school crisis team to the community. Together, they held a community meeting with the affected parents, other concerned parents in the community, and community leaders to listen to their perspectives on reasons this might be happening and learn from the contributing factors. The school counsellor and

crisis team also wanted to let the community know what the school is currently doing to respond to the crisis and to ask for the community's help.

Community members were also invited to provide input on any other intervention that they think needs to be done. Inviting community member input about helpful interventions was something I identified as critical in the consultation meetings with the school counsellor, recognizing that there may be ways that the community can introduce various forms of cultural continuity (Chandler & Lalonde, 2008) into the lives of the youth and families to promote healing and resilience.

Community members, including parents, and leaders discussed how the community has been impacted by residential schooling, relaying the facts that all the youth involved were children of residential school survivors and all their families were struggling emotionally. Community leaders also identified other contributing factors such as deep poverty, child abuse and neglect, substance abuse problems, and a lack of resources and supports in the community for both youth and adults. They also suggested that Indigenous healing traditions may be helpful to alleviate distress and to facilitate the effective grieving process of the affected parents in a culturally appropriate way.

Wilson, Rosenberg, and Abonyi (2011) found Aboriginal Canadian youth and young adults are twice as likely to seek out traditional healing for mental and physical health problems than their older counterparts, attesting to the value and relevance of Indigenous ceremonies and rituals in facilitating youth well-being. Such healing methods are means of connecting youth to their cultural identity and heritage, as well as building support among youth, Elders, and other community members (Chandler & Lalonde, 2008). For these reasons, traditional healing is recommended by Caldwell (2008), Health Canada (2013), and the TRC (2015).

As I continued my consultation with the school counsellor, I emphasized the importance of another aspect of working with the community: removal of the means for suicide. Kirmayer et al. (2007) identified removal of the means for suicide as a critical activity for primary, secondary, and tertiary prevention of suicide clusters among Aboriginal communities. In response to the crisis, community leaders and members collaborated with the school in creating a plan to remove any means for suicide from the homes of the affected youth and from the homes of other youth in the community, and to call upon healers within the community to initiate traditional ceremonies and rituals for the families involved who wanted this culturally congruent support. The introduction of these healing traditions and ceremonies for those who had not previously accessed them would serve as an important form of primary prevention for future suicide crises by further strengthening youth connection to their culture, identity, and community.

With the assistance of the mental health professionals brought in from other school districts to help with the crisis, the youth and families concerned also had their needs assessed and were provided direct counselling and bereavement support. Furthermore, they were directly connected to several community resources on or off the reserve (e.g., addictions treatment services in nearby towns, social services,

and employment supports) for quality of life enhancement for them and the other children and youth in their families. The school counsellor was encouraged by community leaders to write letters to the government or to support community lobbying efforts for more resources as part of the solution to the problem, and to support them taking on more control over child and family services in their community. The school counsellor followed through with supporting these efforts, which are in line with Chandler and Lalonde's (2008) work that suggested control over resources and child and family services among Aboriginal communities is a major protective factor against suicide risk. Engaging in this lobbying would represent an important primary prevention activity in Health Canada's framework.

I suggested that the counsellor and her colleagues on the school crisis team train all teachers in the school about how to recognize signs of depression, hopelessness, and suicidal ideation among children and youth, what to do to provide some basic support, and how to refer affected students for help. A school-wide anti-stigma campaign was also initiated. Education about depression and suicide was also delivered at a second community meeting with parents, community leaders, and Elders to promote early identification and response for at-risk youth and to empower the community to help itself through mental health first aid, in line with Health Canada's (2013) framework.

Community leaders and members were encouraged to consider taking on teaching roles in educating the youth in the community about life skills for future community-wide primary prevention efforts. Keeping in mind that Chandler and Lalonde's (2008) work emphasized that active participation of women in leadership activities in Aboriginal communities is a key aspect of cultural continuity that mitigates suicide risk, the counsellor was advised to work with the community to identify both men and women to serve as life skills educators and internal crisis responders for the reserve.

Since suicidal intentions and notes were most often found by siblings or peers, in this case illustration it was also important to equip other resilient youth as peer helpers. When I raised this issue with the school counsellor, she reported that the cultural value of noninterference (Blue et al., 2010) led to reluctance among the youth who reported the discovery of suicide notes to intervene in any way beyond just noting what they had found or observed. I encouraged the school counsellor to appeal to peers to help through activation of another critical Aboriginal community value—the value of sharing (Blue et al., 2010; Brant, 1990; Restoule, 1997). Among Aboriginal peoples, individual accumulation of knowledge, resources, wealth, or social ties at the expense of others in one's community network is considered against cultural dictates. Sharing of one's strengths, resources, whether monetary or nonmonetary, and social ties reflects most highly on a person's character and status, and is believed to be essential for community well-being (Blue et al., 2010; Brant, 1990).

Along with another school counsellor at the school, and in collaboration with community leaders and members, the school counsellor approached youth who were identified as resilient by others and asked if they would be willing to help.

The role of peer helper was framed as a "student sharer" of knowledge, skills, and resources to help improve other students' well-being. Classroom-based lessons were also drawn from LaFromboise's (1996) curriculum about what to do to help when someone expresses that he/she is thinking about suicide or is planning a suicide attempt. In addition, youth were engaged in a discussion about direct ways in which peers can share to improve their suffering classmates' quality of life—such as sharing clothing and food, given the lack of resources among people on the reserve. Classrooms were even guided in what they wanted to share or offer to the students whose suicide notes were discovered, and these items were taken as gifts to those students during the intensive counselling process.

SUMMARY AND CONCLUSION

This article illustrates how school counsellors working on or near Aboriginal communities can build sustainable partnerships with community leaders and members to engage in primary, secondary, and tertiary prevention activities described in leading frameworks for youth suicide prevention. The reserve described in the illustration was adjacent to an urban area. Although community members may have been able to access services in the surrounding area more easily than members of more remote reservations, Chandler and Lalonde's (2008) analysis found that suicide rates are actually higher in reserves that are most proximal to urban metropolitan centres.

Nevertheless, there may be some differences in how various interventions and supports are activated or received when working with more isolated communities. Regardless of the location of the reserves, school counsellors can represent the common thread between affected individuals, their parents, the school, crisis responders, and reserve communities. In this way, school counsellors can contribute to effective problem-solving and long-term community empowerment, in line with the recommendations of both Health Canada (2013) and the TRC (2015).

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About the Author

Noorfarah Merali is an associate professor of counselling psychology at the University of Alberta. Her main interests are in cross-cultural adaptation and cross-cultural counselling.

Address correspondence to: Noorfarah Merali, 6-102 Education Centre North, University of Alberta, Edmonton, Alberta, Canada, T6G 2G5. Email: noorfarah.merali@ualberta.ca