PROMOTING CULTURE AS A PROTECTIVE FACTOR AMONG AI/AN YOUTH IN KLAMATH COUNTY

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DISSERTATION ABSTRACT

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Youth suicide continues to be a growing public health tragedy in the United States. In particular, AI/AN youth are at disproportionate risk for suicide. The present study takes place in Klamath County, Oregon where the suicide rate is more than triple the national average. To address the issue of AI/AN youth suicide in Klamath County, a research-practice partnership (RPP) between the University of Oregon Suicide Prevention Lab and the Klamath Tribal Youth and Family Guidance Center Prevention Department was established. The aim of the RPP was to better understand the various protective factors that can be harnessed as part of youth suicide prevention initiatives in Klamath County. As part of a larger research agenda, the RPP hosted a tribal youth Gathering of Native Americans (GONA) to promote culture as a protective factor. In particular, the RPP aimed to better understand the role of culture as a protective factor by examining data collected at a youth GONA. For the present study, the research element consists of the secondary analysis of two existing datasets: The Klamath Cultural Connectedness Survey- Female Youth GONA and QPR (Question, Persuade, Refer) Pre/Post survey. The study sample was comprised of 10 AI/AN females, aged 12-18 who lived in Klamath County. The results of the analysis provide initial support that the youth GONA successfully blended Western and Indigenous ways of knowing, serving as a potentially

effective youth suicide prevention initiative for the Klamath Tribes. Further, participants' cultural connectedness increased after attending the GONA. The present study also provided initial evidence that QPR, which was nested within the GONA, was feasible, acceptable, and was associated with an increase in participants' knowledge and self-efficacy about suicide prevention and intervention.

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To those that we’ve lost to broken hearts, carrying burdens that weren't yours to bear. You are loved and missed. We’ll see you on the other side.

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CHAPTER I: INTRODUCTION

The first chapter of this dissertation presents the context for the present study, including the problems to be addressed and the type of research used to address them. The first section of the introduction will discuss rising suicidal behavior, ideation, and depression facing youth today. The second section provides context for American Indian/Alaska Natives (AI/AN), including an overview of AI/AN health challenges and youth suicide rates, followed by a discussion of tribal sovereignty, historical trauma, and the federally mandated boarding school era. The next section provides context for AI/ANs living in Oregon, specifically in Klamath County. The chapter begins by reviewing mental health challenges faced by AI/AN youth, and youth suicide rates in Klamath County, before moving into a description of the Klamath Tribes Historical Trauma Genogram, a brief history of the Klamath Tribes, and a discussion about intergenerational resilience.

The intervention and data collection from the present study occurred on Klamath homelands. However, most of my writing, data analysis, and remote meetings took place in Eugene, Oregon which was traditionally known as Kalapuya Ilihi. I would like to give thanks to the original stewards of this land, the Kalapuya, for the opportunity to live, learn, and be in community on this land. The Kalapuya have occupied this land since time immemorial. Today, many are now citizens of the Confederated Tribe of Grand Ronde, and the Confederated Tribes of the Siletz Indians whose relation to the land continues today. Sepkeec'a.

Many terms, including Native American, American Indian, Indian, and Indigenous, are used to represent this population. For this paper, AI/AN will be used to remain consistent with the language used by governmental agencies (i.e., Centers for Disease Control and Prevention [CDC], U.S. Census, public education, Bureau of Indian Education, etc.). At times, "tribal" and

"Indigenous" will also be used interchangeably. Also, throughout this paper, a degree of generalizability is made when referring to AI/ANs. It is important to note that each tribe is unique with its own languages, belief and value systems, culture, and history. It is not my intention to produce work or knowledge that is generalizable to AI/AN people.

Additionally, I received written consent from the 2018-2022 Klamath Tribal Council to complete this study, with the agreement of periodically updating the Tribal Council on the research progress. Although I am a Klamath Tribal member, I speak only for myself as an individual and do not represent AI/AN or the Klamath people as a whole.

As a final note, the topic of youth suicide can be a deeply emotionally triggering topic. Throughout this process, I have kept medicine at my desk (e.g., cedar, sage, sweetgrass, sage, and tobacco), made offerings, sat in prayer, walked, learned yoga, cried, watched funny YouTube shorts to laugh, baked a lot of muffins, and took extended breaks from the work. I encourage folks to take notice of sensations within your mind, body, and spirit as you read this content. Please tend to your heart as needed.

1.1 Mental Health Challenges in Youth: Rising Suicidal Behavior, Ideation, and Depression

Youth suicide is a growing public health tragedy in the United States. Rates of youth suicide increased by almost 60% between 2007 and 2018 (Curtin, 2020), making it the second leading cause of death among youth aged 10 to 19. Tragically, 2,744 youth aged 10 to 19 died by suicide in 2019. In 2020, suicide rates were three to four times higher for males aged 15-24 (Garnett et al., 2022). Suicide rates for females ages 15-24 were 5.8 per 100,000. Among males aged 15-24, the suicide rate was 22.4 per 100,000 (CDC, 2022). The public health significance of

youth suicide becomes even more apparent when examining the high rates of suicidal ideation (i.e., thoughts, ideas, or seriously considering suicide) and suicidal behavior (i.e., making a suicidal plan or attempted suicide).

Rates of suicidal behavior have also increased in recent years. Plemmons and colleagues (2018) explored the hospitalization rates for suicidal attempts or behavior among American children ages 5 to 17 years. They found that rates steadily increased from 2008 to 2015, with almost 15,000 hospitalizations per year. Females aged 10-24 are at particularly high risk for emergency department (ED) visits for self-harm with a rate of 487.9 per 100,000, twice the rate of ED visits for males in the same age range (203.3 per 100,000) (CDC, 2022). According to the CDC (2022), females attempt suicide one and a half to two times more often than men and boys. Suicidal attempts happen ten times more often than suicide in females (Chaudron & Caine, 2004).

During the COVID-19 pandemic in 2020, the proportion of mental health-related ED visits among youth aged 12-17 increased by 31% compared with that during 2019. From February 2020 through March 2021, emergency room visits for suspected suicide attempts were 50.6% higher for females aged 12-17 than during the same period in 2019. Among boys of the same age range, the increase was 3.7% (Yard et al., 2021).

Suicidal ideation is another public health concern for American youth. According to a review of data from the 2019 CDC Youth Risk Behavior Survey, approximately one in five (18.1%) high school-aged youth aged (14-17) had seriously considered attempting suicide, and one in six (15.7%) had made a suicide plan. This study also found that females had elevated rates of suicidal ideation, suicide plans, and suicide attempts than males of the same age (Ivey-Stephenson et al., 2020).

Depression, a significant antecedent to suicidal ideation, is also increasing amongst American youth. The number of teenagers experiencing depression increased by 59% between 2007 and 2017 (Geiger & Davis, 2019). An estimated 3.2 million American adolescents aged 12 to 17 years old experienced at least one major depressive episode in 2017, representing 13.3% of the entire population in that age group (National Institute for Mental Health [NIMH], 2021). Depression disproportionally affects females. In 2017, teenage girls were three times as likely as teen boys to have had recent experiences with depression. One-in-five teenage girls (20%) and 7% of teenage boys experienced at least one major depressive episode that year (Geiger & Davis, 2019).

Furthermore, COVID-19 exacerbated mental health challenges. In March 2020, the government closed schools across the country to prevent the spread of COVID-19. These restrictions were particularly difficult for youth since they rely heavily on peer connections for emotional support. As a result, students were negatively affected by social distancing and stay-at-home orders, which often led to loneliness and isolation (known risk factors for anxiety and depression) (Panchal et al., 2021).

In a study that examined mental health, suicidality, and connectedness among high school students during the COVID-19 pandemic, Jones and colleagues (2022) found that 37.1% of students who didn't feel close to people at school experienced poor mental health, 44.2% experienced persistent feelings of sadness or hopelessness, 19.9% had seriously considered attempting suicide, and 9.0% had attempted suicide. On the other hand, poor mental health, persistent feelings of sadness or hopelessness, and suicidal thoughts and behaviors were less prevalent among students who felt close to people at school and virtually connected with others

during the pandemic (Jones et al., 2022). Compared to all races, 49.5% of AI/AN students felt sad or hopeless, 23.3% seriously considered suicide, and 20.1% attempted suicide (CDC, 2022).

While suicide is a public health concern across the country, suicide disproportionately affects AI/ANs (Leavitt et al., 2018). Health disparities experienced by AI/ANs, particularly those living in rural areas, can be attributed to inequities in the social detriments to health, such as inadequate access to health care, poverty, race-based discrimination, disregard for cultural beliefs, traumatic stress, and historical trauma (*Disparities*, 2019; Skewes et al., 2020; Whitsell et al., 2012). The following section will discuss the context of higher rates of suicide among AI/AN youth.

1.2 The AI/AN Context

The second part of this introduction will introduce the AI/AN context, including a discussion of tribal sovereignty, historical trauma, and the federally mandated boarding school era. An understanding of the accurate historical context is essential when considering mental health issues faced by AI/ANs today. Next, an overview of AI/AN health disparities will be provided, followed by a summary of youth suicide rates for AI/AN youth in Oregon and Klamath County, Oregon.

According to the 2020 U.S. Census, 3.7 million people identified as AI/AN alone, and 5.9 million people identified as AI/AN combined with one or more other races (U.S. Census Bureau, 2020). This is more than 9.6 million people, comprising 2.9% of the U.S. population.

The AI/AN identity encompasses many tribes, nations, bands, pueblos, communities, and Native villages throughout the geographic borders of the U.S. In total, there are 574 federally recognized, sovereign tribal nations with a formal government-to-government relationship with

the U.S. Government (Bureau of Indian Affairs [BIA], 2021; Kelley et al., 2018; National Congress of American Indians [NCAI], 2020). In addition, there are more than 100 state-recognized tribes and hundreds of unrecognized tribes throughout the country (many of which are within the state of Oregon), which includes tens of thousands of people (O'Neill, 2021; Department of Health and Human Services Office of Minority Health, 2021; Sanez, 2020). Despite a common misconception of homogeneity within the AI/AN population, marked variations exist, with distinct histories, cultures, customs, languages, land bases, treaties, and governments, spanning 35 states and 326 land areas (i.e., reservations, pueblos, rancherias, missions, and villages) (Alćantara & Gone, 2007; BIA, 2021; NCAI, 2020).

Historically, research has presented a one-dimensional framing of AI/ANs as broken, unhealthy, impoverished individuals, communities, and tribes that need "fixing." This "damage-centered" research is historically and socially situated to explain contemporary issues, such as high rates of suicide in tribal nations (Tuck, 2009). Damage-based research seeks to document pain and loss within an individual, community, or tribe (Tuck, 2009), aiming to leverage reparations, resources, and sympathy for communities of color (Tuck, 2009; Wood et al., 2018).

However, while historical factors do contribute to contemporary issues, this type of research tends to perpetuate a one-dimensional and flawed narrative of abuse, addiction, poverty, and illness, in which tribal nations and communities are portrayed as irrevocably broken, damaged, and hopeless, which can reinforce stereotypes and unequal power relationships (O'Keefe et al., 2013; Roundtree & Smith, 2016; Tuck, 2009; Wood et al., 2018). It has contributed to the situation in which, even today, AI/AN youth are bombarded with negative narratives in schools, health centers, and the media (Wood et al., 2018). Importantly, deficit-based approaches fail to incorporate indigenous-led narratives of community and well-being

(Wood et al., 2018). These narratives forget that tribal nations are also brimming with strengths, connectedness, culture, language, tradition, abilities, connection to land, spirituality, opportunities, and resilience (Goodluck & Willeto, 2009).

Further, most suicide prevention research has been deficit-based, and prevailing prevention models focus on reducing risk factors (Allen et al., 2021; FitzGerald et al., 2017; Tingey et al., 2016). However, protection, resilience, and culture have been central to recent AI/AN prevention science research (Allen et al., 2021). More recently, researchers have called for a paradigm shift in mental health promotion and suicide prevention in AI/AN communities, moving from the traditional problem- or deficit-based approaches to strength-based approaches (Allen et al., 2019; Henson et al., 2017; LaFramboise et al., 2006; Mackin et al., 2012 Tingey et al., 2016). A strength-based approach shifts the focus away from the deficits or risk-focus of the person or community and focuses on their strengths, capabilities, and resources (Xie, 2013).

1.2.1 Tribal Sovereignty

Today, there are three sovereign entities within the United States: tribes, state governments, and federal governments. Tribal sovereignty has been described as the "life-blood" of tribal nations and encompasses the legal, cultural, and historical matters that grant tribes the right to self-govern (Kault & Singer, 2004; NCAI, 2020). Between 1778 and 1871, the federal government entered into more than 370 treaties with tribal nations (NCAI, 2020). Under the U.S. Constitution, treaties are the "supreme law of the land," are considered to be binding, legal documents with no expiration date, and have established a unique set of rights and conditions for tribal nations who ceded millions of acres of homelands to the U.S. government (Rodman, 2016). The U.S. government recognizes AI/AN tribes as distinct governments with similar powers as

state and federal governments to regulate their internal affairs. In essence, tribal sovereignty is the inherent authority of AI/AN tribes to govern within tribal territories.

Only tribal governments have the authority to "speak for" the tribe as an entity. When conducting research in AI/AN communities, it is essential to work with the tribe to identify appropriate avenues, protocols, and contacts (Harding et al., 2012). Further, indigenous data sovereignty is the right of a tribal nation to govern the collection, ownership, and application of its data. This refers to all data gathered by the tribal nation themselves or by any other external data agents (Carroll et al., 2019). AI/ANs should have authority over AI/AN data. Therefore, it is vital to respect and honor indigenous data sovereignty when working with tribal nations.

1.2.2 Historical Trauma and the Boarding School Era

European colonization nearly eradicated the Indigenous population of North America through waves of disease, war, expansionist policies, and genocide (Yellow Horse Brave Heart, 2003; Yellow Horse Brave Heart & DeBruyn, 1998). In a 400-year timeframe, approximately 90% of the continental Indigenous population were killed, and those remaining were spiritually, physically, mentally, and emotionally traumatized by profound, unresolved grief and trauma. Research has shown that the effects of these tragic events are transmitted intergenerationally as descendants continue to experience the impact of ancestral suffering (Warne & Lajimodiere, 2015).

Historical trauma is often attributed to treaties and governmental assimilation policies, which resulted in the forced removal of homelands; mandated boarding schools; forced adoption and sterilization programs; and the loss of traditional lifeways (Denham, 2008; Yellow Horse Brave Heart, 2003). Yellow Horse Brave Heart (2003) defines historical trauma as "a cumulative

emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (p. 7). The impact of traumatic history, specifically regarding boarding schools, still widely affects many AI/AN communities.

In his book *Healing the Soul Wound* (2019), Dr. Eduardo Duran, calls attention to how traumatic events inflict a "wounding on the soul". This is referred to as the "soul wound". Trauma, or soul wounding is transmitted across generations, and it's also cumulative (Duran et al., 2005). When trauma isn't healed in previous generations, it has to be dealt with in subsequent generations (Duran, 2019). For example, if an ancestor experienced trauma three generations ago, and another two generations ago, then another one, and trauma happening right now, this means a child born today is bringing in multiple points of trauma from across the generations (Duran et al., 2005). According to Duran (2019), this happens in "the spirit way". If the spiritual wound isn't healed, people, along with their descendants are likely to face various forms of mental, physical, and spiritual suffering in the future (Duran et al., 2008). As such, there is a spiritual component of trauma that must be addressed if one is to heal and find relief from their suffering.

The boarding school era (1860's to 1970's) was particularly devastating for AI/AN families and communities. Federally operated boarding schools were seen as part of a solution to the "Indian problem" by the assimilation and acculturation of AI/AN children into the dominant society (Warne & Lajimodiere, 2015; Yellow Horse Brave Heart, 2003). AI/AN children, some as young as three years old were forcibly taken from their families and sent to boarding schools. Children were often sent far from their homes for as long as 12 years, many never returning due to disease, abuse, and unknown deaths (Warne & Lajimodiere, 2015). When a child died at boarding school without "money on the books," the child was buried at the school, preventing

the child from receiving proper traditional burials and denying the family members the opportunity to properly grieve and send their kin off in a good way (Ball & O'Nell, 2016).

Heartbreakingly, children were deprived of traditional parenting role models and the intergenerational transmission of culture, language, and lifeways (Yellow Horse Brave Heart, 2003; Yellow Horse Brave Heart & DeBruyn, 1998; Whitesell et al., 2012). Instead, children experienced a lack of nurturing and rampant abuse, resulting in uninvolved, neglectful, punitive, authoritarian parenting styles (Yellow Horse Brave Heart, 2003). Children were taught to have shame and despise every part of their culture, language, religion, and lifeways (Connolly et al., 2022).

Warne & Lajimodiere (2015) suggest that "the damage from boarding school abuse, loneliness and lack of love, and lack of parenting is seen as a key factor in illnesses that plague tribes today" (p. 571). Boarding school experiences negated protective factors such as bonding and sense of belonging to family and community, parental competence, availability, support, and involvement in schooling, and culturally traditional role models (Yellow Horse Brave Heart, 2003; Yellow Horse Brave Heart & DeBruyn, 1998).

In 2018, I attended a community-wide Gathering of Native Americans (GONA) hosted by Klamath Tribal Youth and Family Guidance Center (YFGC). In a room full of tribal members, I asked, "how many of you had a parent or grandparent that was sent to boarding school?" Every tribal member raised their hand. The widespread effects of federal boarding school policies are still present in our homes and communities. Boarding schools were just one of many federal policies intended to assimilate AI/ANs, but perhaps one of the most devastating because of the extensive impact on connectedness, culture, family structures.

Historical trauma has been shown to negatively impact mental health among AI/AN populations (Skewes et al., 2020). However, research and discussion about the sustained impact of colonialism often omit the strengths of individuals, families, and communities (Denham, 2008). These unspoken stories of resilience and survivance are often present behind the realities of trauma and inequities (Denham, 2008). Although trauma can be intergenerational, resilience can also be intergenerationally transmitted (Braga et al., 2012; Denham, 2008). A study by Denhem (2008) found that resilience is transmitted by "a strong circle of oral traditions contributed by each family member to the larger family circle [which] generates and connects a cycle of listening and learning that culminates in the sharing of their wisdom with others" (p. 393).

Acknowledging the traumatic history *and* the natural resilience of tribal nations can be beneficial for developing intervention and prevention programs that build upon individual, family, community, and cultural strengths to promote positive outcomes for AI/ANs (Whitesell et al., 2012). Further, Gone and Trimble (2012) suggest an alternative pathway of healing and empowerment that is grounded in local AI/AN knowledge, community, and cultural reclamation. Therefore, youth suicide prevention initiatives should be grounded in local knowledge, community connection, and cultural reclamation. These strength-based initiatives should consider the broader context of historical trauma while also imparting the legacy of resilience amongst their people and communities.

1.2.3 Overview of AI/AN Health Disparities

AI/AN communities continue to experience significant health disparities compared to other racial and ethnic groups (Rey et al., 2022; Xu et al., 2018). Compared with other ethnic

groups, AI/AN community members have a lower life expectancy (78.5 years to 73.0 years, respectively) (*Disparities*, 2019) and are disproportionately affected by a more significant number of chronic physical and mental health problems (Arias et al., 2014; Cobb et al., 2014; Gone & Trimble, 2021). Disproportionate death rates for many, often preventable causes include infant mortality (Wong et al., 2014), diabetes mellitus (Cho et al., 2014), alcohol-attributed deaths (Landen et al., 2014), heart disease (Veazie et al., 2014), and unintentional injuries (Murphy et al., 2014; as cited in Warne & Lajimodiere, 2015).

From 2009 to 2011, diseases of the heart, malignant neoplasm (cancer), unintentional injuries, and diabetes were the leading causes of AI/AN deaths. Ratios of age-adjusted mortality rates for AI/ANs compared to all races in the U.S. are alcohol-induced (6.6), chronic liver disease (4.6), diabetes mellitus (3.2), unintentional injuries (2.5), and homicide (2.1) (*Disparities*, 2019). This also translates to higher rates of suicide in the AI/AN community than in any other ethnic group in the United States (Leavitt et al., 2018).

The recent COVID-19 pandemic has exacerbated these problems; AI/AN community members have suffered a hospitalization rate of four times the general population and a mortality rate of double the general population (Hill et al., 2021), worsening existing health inequalities and economic concerns (Empey et al., 2021). Jim and colleagues (2014) found that this population's health and morality status assessments are often hampered because of a lack of complete and accurate data on race and ethnicity in surveillance and vital statistics systems. Often, AI/ANs are misclassified as another race (i.e., on a death certificate). As a result, mortality estimates for this population have been historically underestimated (Jim et al., 2014).

1.2.4 Higher Rates of Suicide Amongst AI/AN Youth

Youth suicide is a significant public health priority nationally and statewide. The loss of youth to suicide is devastating and traumatic to friends, families, and entire communities. In particular, AI/AN youth are at disproportionate risk for suicide (Cwik et al., 2015). In Oregon and the U.S., the CDC identified suicide as the second leading cause of death among AI/AN aged 15 to 34 years old (2019). AI/AN young men are particularly vulnerable. At the national level for all races, suicide rates are highest among middle-aged male individuals 45 to 64 years (20 per 100,000) (CDC, 2019); however, among AI/AN males, suicide rates are highest among those aged 15 to 24 years old (60 per 100,000) (CDC, 2019).

In addition to age-related differences, research also establishes gender differences in suicide ideation, attempts, and completions in AI/AN communities (Kelley et al., 2018). In a 1999 study of more than 13,000 AI/AN youth, Browosky and colleagues (1999) found that 22% of females and 12% of males attending reservation-based schools had reported attempting suicide. While AI/AN girls experience suicide-related hospitalizations more frequently than boys (LaFromboise et al., 2006), the CDC (2019) reports that AI/AN males aged 15 to 24 are more than three times more likely to die by suicide. This could be due to males using more lethal means such as firearms (Balis & Postolache, 2008).

The risk of suicide is also affected by geographical location. The CDC (2018) reports that suicide rates are higher in rural America than in urban America and have been steadily growing since 1999. In particular, AI/AN youth have the highest rates of suicide in rural America (CDC, 2018). Rural areas have distinct barriers to accessing mental health services and implementing suicide prevention programs. Reservation communities, which are typically geographically isolated, are often underserved with limited access to treatment, are understaffed, under-

resourced, and struggle to meet the treatment needs of the community (Skewes et al., 2020; Zuckerman et al., 2004).

These barriers areas usually fall into three categories: not available (i.e., lack of providers and programs), not accessible (i.e., geographic and social isolation, lack of transportation, lack of finances), and not acceptable (i.e., high stigma, low privacy in tight-knit communities) (Owens et al., 2008; Taylor et al., 2014). Moreover, these rates may be underestimated for ethnic misclassification, jurisdictional overlap for reporting, and distrust of data collection processes resulting in underreporting (O'Keefe et al., 2019). For example, race and ethnicity misclassification rates in AI/AN communities range from 1% to 30%, depending on the region (Alćantara & Gone, 2007).

1.3 The Oregon AI/AN Context

The third part of the introduction will discuss the Oregon AI/AN context. The research within this dissertation takes place in rural Southern Oregon, located in the Pacific North-Western region of the U.S. Currently, there are nine federally recognized tribal nations and many more unrecognized tribes situated in Oregon. This section includes an overview of mental health challenges AI/AN youth face in Oregon. Then, a summary of suicide rates in Klamath County, and in particular, Klamath Tribal youth, followed by a brief overview of some notable moments of Klamath Tribal history, will be provided.

While suicide is a severe public health problem, the issue is worse in some locations than others. In Oregon, the suicide rate is 20.4 deaths by suicide per 100,000 people (CDC, 2021b), which is considerably higher than the nationwide average of 13.9 per 100,000 people (NIMH, 2021b). In Oregon, suicide is the leading cause of death among youth aged 10 to 24. The most

recent data shows an annual toll of 129 deaths by suicide and 900 hospitalizations due to self-inflicted injury or attempted suicide in this group (Oregon Health Authority [OHA], 2019). It has been shown that AI/AN youth in Oregon are 2.8 times more likely to die by suicide than White youth (Northwest Tribal Epidemiology Center, 2014).

1.3.1 Mental Health Challenges in Oregon AI/AN Youth

Rates of youth suicide in Oregon have been increasing since 2011 (OHA, 2019), with suicide as the second leading cause of death for young people aged 10 to 24 (Klamath Basin Behavioral Health, n.d.). Oregon's AI/AN population is at particular risk of poorer morbidity, mortality, health outcomes, and access to care compared with non-Hispanic, White populations (OHA, 2019). Concerning suicide, in particular, a 2014 study by the Northwest Tribal Epidemiology Center found that in Oregon, deaths from suicide were higher for AI/AN people (2.8%) than non-Hispanic, White people (1.9%). While the majority of Oregon AI/AN suicides occurred between 20–39 years of age, the most significant disparity in suicide rates was for AI/AN youth aged 10-19, at 2.8 times higher than rates among non-Hispanic, White youth in the same age group (Oregon American, 2014).

1.3.2 High Suicide Rates in Klamath County

Specifically, the research within this dissertation takes place in Klamath County, which is located in central southern Oregon along the California border. According to the 2021 U.S. Census, approximately 69,413 people live in Klamath County. The county seat is Klamath Falls, with an estimated population of roughly 21,813 residents (83.1% White alone and 3.0% AI/AN alone) (U.S. Census Bureau, 2021).

Reflecting the general pattern in Oregon, these disparities are also visible among the AI/AN youth of rural Klamath County. Suicide rates in this county (47 per 100,000) are more than double the rate of Oregon (19 per 100,000) and more than triple the rate of the U.S. (14 per 100,000) (Klamath Basin Behavioral Health, n.d.). In a secondary analysis of the 2018 Oregon Student Wellness Survey, the OHA and the Klamath Tribes found high rates of suicide attempts in the past 12 months amongst 6th Grade students (24.3%), 8th Grade students (27.3%), and 11th Grade students (9.4%), all of which are significantly higher than the state as a whole (Ngo, 2018). The same survey also found that risk factors such as mental health concerns, substance use, experiencing harassment based on race, and Adverse Childhood Experiences (ACEs) were significantly higher amongst the Klamath Tribal youth than the state average (Ngo, 2018).

1.3.3 Klamath Tribes Genogram

Today, the Klamath Tribes consist of three distinct groups: The Klamath, Modoc, and Yahooksin Band of Snake Indians (Paiute), with approximately 5,776 enrolled members (1,243 under 18 years old, 3,570 between 18-59 years old, 963 elders at least 60 years old). The Klamath Tribes Administration is located in Chiloquin, Oregon, about 30 minutes north of Klamath Falls on Highway 97. Within the city limits, the population in 2022 is 779 people, and nearly half of the residents are tribal members (50.2% White and 46.7% AI/AN) (Chiloquin, Oregon Population, n.d).

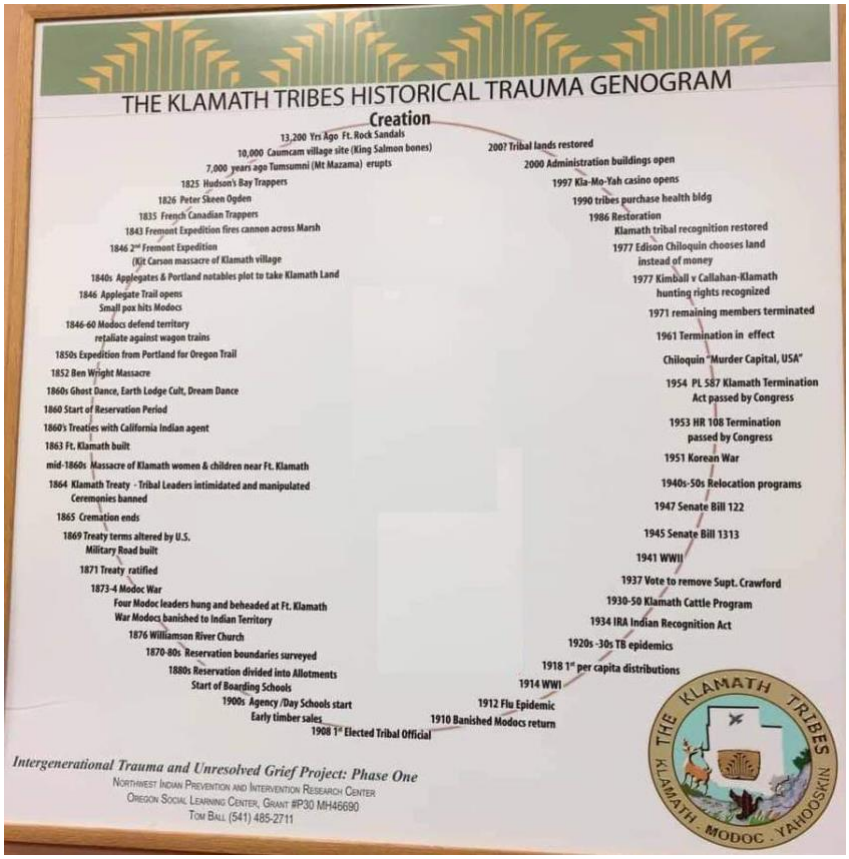
The Klamath Tribes' Genogram (as shown in Figure 1) hangs on the wall of the Klamath Tribal Council chambers. Ball and O'Nell (2016) produced the genogram with a panel of tribal elders. A genogram is a visually compelling tool that uses oral histories to document the intergenerational, community, historical, and spiritual aspects of AI/AN experiences of trauma

(Ball & O'Nell, 2016). At the request of tribal elders, the Klamath Tribes Genogram is cyclical instead of a typical western, linear approach to history. It begins with Creation, as creation stories, shared through countless generations of oral tradition, place the Klamath Tribal people here from time beyond memory. Instead of using written accounts to document history, AI/AN people often rely on verbal language to share information passed on. Oral tradition can be defined as the oral transmission of cultural knowledge and beliefs from one generation to the next.

The Klamath Genogram makes a full circle through thousands of years from creation through current events, presenting the shameful acts of the U.S. government, while still capturing the continued strength, pride, resilience, and survivance of the people. According to the elders, historical traumas are infused within the larger story of the tribes. As a result, the Klamath people transmuted from naturally resilient to trauma resilient (Barney & YellowOwl, 2022). The Klamath story is centered around their ancient relationship with the land, its near ruin, and the imperative return of stewardship to the people. Many events recorded on the genogram are associated with loss, including land, life, lifeways, and culture. Specifically, the genogram includes the continued attempts by dominant society to dispossess the Klamath of their natural resources, federal boarding school policy, the complete loss of their land base, and the traumatic aftermath of termination (Ball & O'Nell, 2016). The following section will briefly discuss some of these events.

Figure 1

The Klamath Tribes Genogram



1.3.4 Klamath Tribal History

The Creator provided the Klamath people (?ewksiknii) with all that was needed to live in abundance. The people had a sacred responsibility to be good stewards of the land and to give thanks for these gifts in ceremony, and in turn, the land would care for them. The homelands were rich in forests, rivers, lakes, marshlands, and meadows that fed the people, provided medicines, clothed them, and protected them. Their work ethic made them resilient, always preparing themselves for the next thing by hunting, fishing, and gathering (Barney & YellowOwl, 2022).

The people, organized in six bands, lived along the Klamath Marsh, on the banks of the Klamath Lake, the mouth of the lower Williamson River, Pelican Bay, on the banks of the Link River, and in the Sprague River Valley (The Klamath Tribes, n.d.). Located in a basin, surrounded by soaring mountains with harsh winters, they were some of the last tribes to be colonized (YellowOwl, 2021). They subsisted on roots, berries, medicine, waterfowl, fish, wocus (water lily that was a main staple of the diet), and wild game. The people were renowned for intricate basketry, using cattail and tule for various products, including clothing, shelter, cooking utensils, and toys (Ball & O'Nell, 2016; Connolly et al., 2022). Women were viewed as highly valued members of Klamath society (Hancock, 2016).

It wasn't until 1826 that the first non-natives, Hudson Bay fur trappers, arrived on Klamath land. It has only been 196 years since white settler contact on Klamath land. In the spring of 1846, during Manifest Destiny, John Freemont and Kit Carson made their third expedition west. The Freemont Expeditions marked the first documented cases of sexual violence toward Klamath women (YellowOwl, 2021). Later, in 1864, the Klamath, Modoc, and Yahooskin people signed the Klamath Treaty with the U.S. government, ceding almost 22 million acres to the United States. The remaining 1.5 million acres became the Klamath Indian Reservation. When the Modocs heard there would be treaty negotiations, they were told they would not get a treaty. They went into treaty negotiations knowing they would be removed from their homelands (Barney & YellowOwl, 2022). Once the treaty was signed, the Modoc and Yahooskins were forcibly removed from their homelands and placed on the Klamath Reservation while continually making pleas to return to their land.

In 1872, Captain Jack and a band of Modocs left the Klamath Reservation and returned to their homelands to build a winter camp on the Lost River. Soldiers from Fort Klamath were sent

to move the Modoc by force back to the Klamath reservation. The Modoc people resisted, and thus, the Modoc War began. For months, Captain Jack and fewer than 60 Modoc warriors fought off more than 1,000 soldiers at what is now the Lava Beds National Monument in Northern California. Captain Jack shot and killed General Edward Canby during a peace commission meeting.

Eventually, in July, the Modocs either surrendered or were captured and taken back to Fort Klamath. The leaders were put in a jail cell, and the rest of the people were put into a stockade. Modoc warriors, including Captain Jack, Schonchin John, Black Jim, and Boston Charley, were held in the jail cell from July until October. Held in an 8x8 cell, they were denied basic needs and not allowed to bathe for three months. Gallows were built before the trial began. Without a legitimate council, the men were tried and found guilty of war crimes and sentenced to death at Fort Klamath (Ball, 1998; Barney & YellowOwl, 2022; James, 2008; YellowOwl, 2021;).

On October 3, 1873, the men walked up 20-foot-high gallows as 2,000 spectators, and 300 military men eagerly looked on. The government required all local Indians and every remaining member Modoc tribal member, including the men's families, women, children, and elders, to attend. They were forced to witness the hangings of their leaders and family members. After the men dropped to their deaths, their bodies hung from the gallows for 30 minutes while the crowd scavenged for souvenirs such as pieces of the gallows, hair, and noose rope (James, 2008). Reporters in attendance described a visual and audible wave of grief that swept over the entire tribal population. They wailed and wept into exhaustion, collapsing onto the ground. This experience caused a collective emotional break and mass trauma, experienced by an entire nation of tribal people. The warrior's heads were taken and shipped to Washington D.C. The remaining

Modoc survivors were put on a wagon to Redding and then on a freight train, forcibly relocated to Oklahoma Territory.

This was when the first suicides were documented among the people. Gunshot and hanging were the two documented methods of suicide and were the only two words recorded in the tribal language for suicide (Barney & YellowOwl, 2022). Dr. Tom Ball (1998), a Klamath Tribal member, wrote, “atrocities of this war are recalled, clearly, and remain indelibly imprinted in the present consciousness of the Indian people and contribute to evoke strong emotions” (p.55).

Despite this devastating loss, the Klamath Tribes (Klamath, Modoc, and Yahooskin) were resilient and persevered through the decades creating a thriving timber, ranching, and farming economy. The reservation was rich in water resources and timber, boasting one of the world's most vast Ponderosa pine stands. They became entirely self-sufficient and one of the wealthiest tribes in the nation by using the natural gifts the creator gave them (Ball, 1998; Chiu, n.d.; YellowOwl, 2021). The U.S government recognized the value in the immense bounty of the Klamath’s natural resources.

As a result, in 1954, Congress passed Public Law (PL) 587, The Klamath Termination Act. Although 109 tribes were terminated, the Klamath Tribes received their own termination bill because of their wealth of natural resources (YellowOwl, 2021). The Klamath Tribal Council strongly opposed termination; however, they were never allowed a vote (Hancock, 2016). Nonetheless, in 1954 the Klamath Tribes were terminated, stripping them of a land base and the legal right to self-govern (Ball & O’Nell, 2016).

Termination led to the liquidation of the Tribes’ assets, and the land was purchased by the U.S. Forest Service and private investors. With the stroke of a pen, the Klamaths went from

being entirely self-sufficient to having no land or identity. They lost their inherent rights to hunt, fish, gather, and subsist as they had since time immemorial. Once a collective society receives a soul wound of that magnitude, severe consequences manifest through the victims. Duran (2019) suggests that this suffering cannot be resolved without healing the wound that underlies suffering at the soul level. Soul wounding can be manifested in many ways such as domestic violence, substance abuse, depression, and suicide (Duran, 2019).

With the loss of land, identity, community, and economic stability came increased illness, depression, self-medication, substance abuse, violence, lateral violence, domestic violence, a decrease in spiritual practices, and premature death. (Chiu, n.d.; Hancock, 2016). Elders reported family infighting and blaming each other for losing their land, being cast aside by other tribes, feeling lost, and having trust for no one (Ball & O'Nell, 2016). Also, tribal members lost access to health care for three decades until the 1980s (YellowOwl, 2021).

The health, welfare, and overall well-being of the people declined dramatically. Notably, termination produced a hazardous environment for Klamath women. With the increase in alcohol abuse came a dramatic rise in domestic violence. Likewise, termination had a devastating effect on the cultural continuity, including significant pregnancy and childbirth practices of Klamath women (Hancock, 2016).

By 1963, government officials began to admit the obvious: termination had been an unjust and immoral action (Hancock, 2016). Four decades later, a study randomly surveyed a large sample of Klamath Tribal members to examine the degree of association between PTSD and termination. Results indicated that 72% of the sample had a PTSD diagnosis due to the historical trauma of termination (Ball, 1998).

In the 1970s, tribal leaders and allies organized to advocate for the restoration of their status as a tribal nation. In 1986, three decades after termination, PL 99-398, The Klamath Indian Tribe Restoration Act, was signed unanimously in the House and the Senate (Hancock, 2016). Although federal recognition was restored, the Tribes did not recover their original reservation or any of the $500 million in revenue the government generated from what was originally Klamath lands (Ball & O'Nell, 2016; Chiu, n.d.).

While the Klamath Tribes successfully regained the restoration of federal recognition, there is still a long road to restoring land and wellness after the devastation of termination and other federal policies. Today, the Klamath people, including the Klamath Tribal Council (10 elected members), General Council (all tribal members over 18 years old), Klamath Tribal Youth Council are the embodiment of resilience. They work to maintain and restore culture, homelands, and lifeways through political activism, self-determination, and self-advocacy. Projects include forest and ecosystem restoration through modern science and traditional knowledge, economic self-sufficiency, promoting cultural healing practices, and language revitalization.

The profound effects of colonization and forced assimilation of the original inhabitants of this land continue to have a deep impact on the people. This unresolved trauma is intergenerationally cumulative and continues to cause suffering in the present. Many of our ancestors were unable to grieve and heal from the ongoing wounding. That energy of pain was passed on down and is now experienced as fear and sadness, or as Western medicine defines it, anxiety and depression (Duran et al, 2005).

As a sovereign nation, The Klamath Tribes can be sovereign about the way they heal. This includes remembering ancestral knowledge, reclaiming stewardship of the land, and reconnecting to culture, identity, and to each other. The healing process should include and

validate ancestral trauma with the understanding that healing not only involves the individual but also previous and future generations. When we heal ourselves, we also heal those who came before us and those who have yet to be born. We can heal our great-grandparents, our parents, and all the way up the line. We can also heal our children, and their children by healing ourselves (Duran, 2019).

The unique histories of AI/AN people aren't the same as we learn in history class or popular culture. Two centuries of collective trauma and soul wounding at the hands of the federal government undoubtedly contribute to the mental health challenges of the Klamath people today. I included this history, hoping to give the reader a different perspective and deeper understanding of what's behind the grim statistics. I also wanted to illuminate the importance of shifting from deficit-based to strength-based frameworks that promote culture and connectedness. My duty as a tribal member includes service to the people. In doing this study, I hope to contribute to the healing of our people.

1.4 Purpose of the Dissertation

The present study came from recognizing that AI/AN youth in Klamath County, Oregon, are at exceptionally high risk for suicide. The main objective of the present study was to develop insight to support youth suicide prevention initiatives, with a particular focus on harnessing culture as a protective factor for AI/AN youth. This work was one of many projects completed within a research-practice partnership (RPP) between the University of Oregon Suicide Prevention Lab, and The Klamath Tribes Youth and Family Guidance Center Prevention Department (discussed further in Section 3.1). The present study was a secondary analysis of data that was collected at a weekend-long culturally-based youth intervention. The research

component of this study aimed to survey the perceptions of female AI/AN youth living in Klamath County. Specifically, the RPP requested a secondary analysis of the data to examine the acceptability of the intervention model, participants' cultural connectedness, as well as participants' knowledge and self-efficacy skills regarding suicide prevention.

CHAPTER II: LITERATURE REVIEW

Chapter 2 provides an in-depth review of the literature starting with the Interpersonal-Psychological Theory of Suicide. Next, the role of connectedness will be discussed, along with a discussion of Western and Indigenous concepts of health. Additionally, the Social-Ecological Model (SEM) will be discussed. Then, protective factors for AI/AN youth, which have been situated within the SEM framework (e.g., individual, relational, community, and multi-level) with be described in detail. The importance of cultural connectedness for AI/AN youth will be explained, followed by an overview of the risk factors for this population. Then, the Gathering of Native Americans (GONAs), a culturally-based intervention will be discussed along with evidence supporting the use of GONAs. Next, a summary of the literature review is provided. Finally, the broad research questions that guide the present study will be shared.

2.1 The Interpersonal-Psychological Theory of Suicide (IPTS)

The first part of this literature review describes the IPTS, a well-known theoretical framework that attempts to explain why individuals engage in suicidal behavior and identify those at risk. First, the IPTS is outlined and described in detail. Then, general evidence supporting the theory is discussed. Finally, youth-specific evidence for the IPTS is explored.

2.1.1 Outlining the IPTS

The IPTS was first introduced by Joiner (2005) and elaborated on by Van Orden et al. (2010). The IPTS was developed to provide a theoretical framework for suicidal behavior and to better understand why the vast majority of individuals who think about suicide do not go on to make an attempt (Chu et al., 2017). This ideation-to-action framework suggests that an

individual will not die by suicide unless they have both the desire to die by suicide (suicidal ideation) and the ability to do so (acquired capability) (Chu et al., 2017).

The first core construct of IPTS is *thwarted belongingness*, a psychologically-painful mental state that happens when the fundamental human need for connectedness is unmet. The two dimensions of thwarted belongingness include loneliness (i.e., wanting human contact but feeling disconnected) and an absence of reciprocal care (i.e., "I have nobody to turn to, and nobody turns to me"). Risk factors that predict the development of thwarted belongingness include self-reported loneliness, living alone, fewer friends, family conflict, non-intact family, social withdrawal, having few social supports in one's network, and the tendency to view the behaviors of others as rejection (Chu et al., 2017; Van Orden et al., 2010).

Another core construct of IPTS, *perceived burdensomeness*, refers to social disconnection and the perception that one's existence has become a burden to others. The two dimensions of perceived burdensomeness include perceptions of liability (i.e., "It is better for others that I die than if I live") and self-hate (i.e., I hate myself). Risk factors for the development of perceived burdensomeness include unemployment, homelessness, illness, and low self-esteem (Van Orden et al., 2010). A critical prediction of IPTS is that the hopelessness of both thwarted belongingness and perceived burdensomeness, simultaneously, is a risk factor for the desire for suicide and suicide risk (Chu et al., 2017).

The third construct of IPTS, *acquired capability* (i.e. "I am not at all afraid to die"), refers to suicidal intent that develops into active suicidal desire when the individual has lost the innate drive for self-preservation and feels capable of engaging in lethal self-injury. IPTS recognizes that suicidal ideations are difficult to enact because they defy our basic biological survival instinct (Chu et al., 2017). A diminished fear of pain, injury, and death can be acquired through

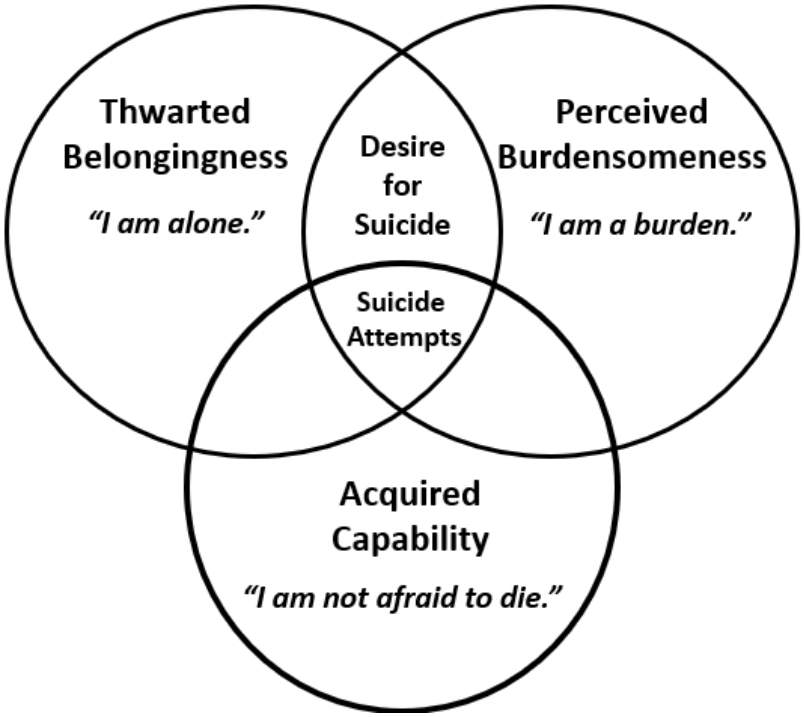
repeated exposure to painful events and experiences, allowing habitation and increased pain tolerance to develop over time. Risk factors for the development of hopelessness include a family history of suicide, previous suicide attempt(s), exposure to physical violence, combat, and a history of childhood maltreatment (Van Orden et al., 2010).

IPTS proposes that when an individual simultaneously holds the psychological states of thwarted belongingness (i.e., "I am alone") and perceived burdensomeness (i.e., "I am a burden"), they can develop suicidal desire. That desire can translate into lethal or near-lethal behavior only with the presence of acquired capability (Van Orden et al., 2010). IPTS includes the assumption that thwarted belongingness and perceived burdensomeness are dynamic cognitive-affect states influenced by interpersonal and intrapersonal factors and associated with various risk factors. When these two states are concurrent, along with a general feeling of hopelessness (i.e., the thwarted belongingness and perceived burdensomeness will never change), suicidal ideation can develop (Van Orden et al., 2010).

To summarize, the IPTS (shown in Figure 2) proposes the following about individuals most at risk for suicide: those who score highly on all three constructs (thwarted belongingness, perceived burdensomeness, and acquired capability) are at most risk of suicidal behavior (Orden et al., 2010).

Figure 2

The Interpersonal-Psychological Theory of Suicidal Behavior (Joiner, 2005)



2.1.2 General Evidence for the IPTS

Since the development of IPTS (Joiner, 2005), the core predictions of the theory have been relatively supported in the research literature. Ma and colleagues (2016) conducted a systematic review to identify support for IPTS and critical gaps in the evidence by reviewing 58 research articles representing 66 individual studies. The effect of perceived burdensomeness on suicide ideation was the most tested and supported relationship, with more than three-quarters of studies suggesting the association was statistically significant. However, evidence for other theory predictions, particularly critical interaction effects, was more mixed (Ma et al., 2016).

In a 2017 meta-analysis of 122 published and unpublished studies, Chu and colleagues confirmed the predictions of IPTS but with modest effect sizes. Specifically, their analysis

confirmed that the interaction between thwarted belongingness, perceived burdensomeness, and acquired capability for suicide was significantly related to a more significant number of prior suicide attempts. The interaction between thwarted belongingness and perceived burdensomeness was significantly associated with suicidal ideation.

2.1.3 Youth-Specific Evidence for the IPTS

Although IPTS has a growing body of evidence from adult samples, findings from data from adults might not be equally applicable to youth. As a result, Steward and colleagues (2017) reviewed the evidence for the applicability of IPTS in youth. Seventeen studies were identified for the review. Overall, the authors concluded that IPTS is a promising theoretical framework for understanding suicidal ideation in adolescents.

The predicted associations between perceived burdensomeness thwarted belongingness, and suicidal ideation was supported in many studies. Loneliness, which was used as a proxy for thwarted belongingness, was associated with suicidal ideation (Lasgarrd et al., 2011). However, family, school, and peer relationships were protective against suicide ideation. Similarly, social support, which reflects lower perceived burdensomeness and higher feelings of belongingness, was protective against suicidal ideation (Wong and Maffini, 2011).

Support was also found for the predicted role of acquired capability and increasing the risk of suicide attempts. Klonsky et al. (2013) reported that youth with a history of non-suicidal self-injuries (over time leads to the development of acquired capability) and suicidal ideations were the unique predictors of a suicide attempt when tested with other suicide risk factors including depression, anxiety, impulsivity, and borderline personality disorder. Likewise, Nock and colleagues (2006) found that adolescent inpatients who reported experiencing no pain during

non-suicidal self-injury (demonstrating acquired capability) made almost twice as many suicide attempts as those who reported pain.

Overall, the literature supports the IPTS in youth, particularly the association between acquired capability and suicide attempt, and is a promising theoretical framework for understanding suicidal ideation and behavior in adolescents. Therefore, for the present study, the IPTS will be used as the theoretical lens to better understand the factors associated with suicide among youth in Klamath County.

2.2 Defining Connectedness

The second part of this literature review summarizes the construct of youth connectedness. In 2008, the CDC stated that "connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance to prevention" (p. 3). Mohatt et al. (2011) describe connectedness as the "interrelated welfare of the individual, one's family, one's community, and the natural environment" (p. 444). Research with AI/AN populations have identified a holistic sense of connectedness between an individual and their family, community, and natural environment as an important element of the circular AI/AN worldview, and a protective factor against suicide (Mohatt et al., 2011).

Connectedness is particularly relevant in youth suicide prevention because it is positively associated with resilience (Abubakar & Dimitrova, 2016; Howard Sharp et al., 2015) and negatively associated with perceived burdensomeness (Opperman et al., 2015). Therefore, it can be predicted that interventions that successfully develop connectedness can also be expected to reduce the risk of AI/AN youth suicidal behaviors.

Connectedness reflects an individual's actions and attitudes, perception of their engagement with, and affection for other people, activities, and organizations (Karcher, 2008). Actions can be increased or decreased with intervention, and attitudes can be developed through intervention (Karcher, 2011). With this definition, connectedness is measurable and can be used as an indicator for program outcomes (Karcher, 2008).

Karcher's (2011) theory of adolescence connectedness was framed around developmental principles, ecological structures, and prevention research. According to this theory, connectedness can be expressed across various social ecologies. Microsystems of connectedness include important relationships in adolescents' lives including parents, siblings, peers, friends, and teachers (Karcher, 2008). Macrosystems of connectedness are the larger institutions, such as family, neighborhood, school, religion, and cultural groups, in which macrosystemic relationships and activities occur (Nakkula & Selman, 1991). Mesosystems are the processes of connection that link micro- and macrosystems (Karcher, 2008). Existing literature emphasizes the importance of ecological models using multiple levels of analysis to research the sources of protection for AI/AN youth (Allen et al., 2014a). The following section will discuss protective factors for AI/AN youth that are situated within the Social-Ecological Model.

2.3 Western and Indigenous Concepts of Health

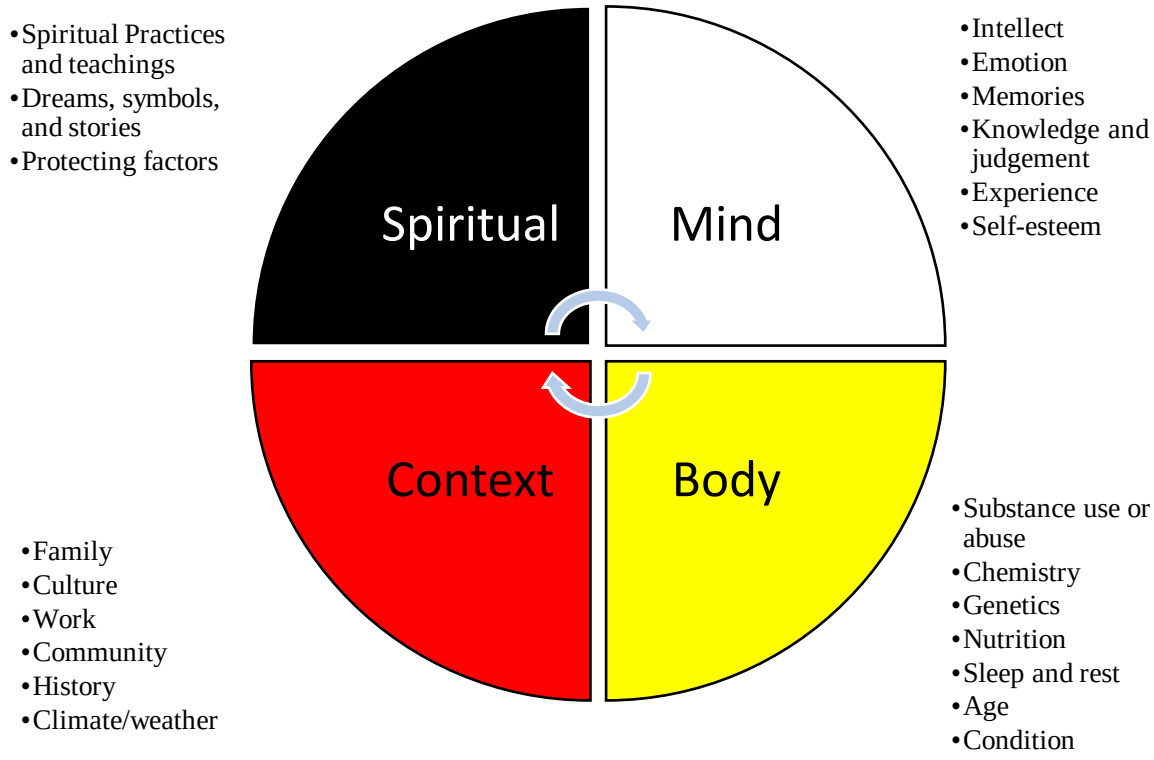
The strengths-based, culture-based approach is critical in rural AI/AN communities because it enables researchers and practitioners to combine tribal best practices with evidence-based practices (EBP). EBPs are based on scientific evidence, while tribal best practices are based on oral traditions and generations of teachings. EBPs in isolation impose a linear approach to research, which is logical and systematic, with a beginning and an end (Cross, 1997). This is

aligned with the Western view of understanding the world in terms of cause-and-effect relationships, where interventions aim to provide a diagnosis and treat a specific cause or symptom of concern (Cruz & Spence, 2005). This worldview may not be well received in specific communities because it profoundly conflicts with the circular worldview held by most AI/AN populations (Cross, 1997). In many cases, the Western medical model responses to AI/AN health have been ineffective and harmful. This can be attributed to the dominant culture's lack of understanding or regard for the robust, interdependent relationships between wellness, culture, traditions, and spirituality (Masotti et al., 2020).

In many AI/AN worldviews, healthy human development is achieved with harmonious mind-body-spirit connections (Duran et al., 2005). Many AI/AN cultures embrace the relational, circular worldview in which wellness only exists when there in balance in all dimensions of life (i.e., mental, emotional, physical, and spiritual) (Cross, 1997). The Relational Worldview Model (shown in Figure 3) is a framework developed by Cross (1997) and is a reflection of the AI/AN concept of balance as the basis for wellness. Within a relational worldview, helpers and healers provide interventions based on restoring balance to self, family, and community. As a result, interventions aren’t targeted to a specific symptom or cause but focused on returning the individual’s balance (Grandbois, 2005).

Figure 3

Relational Worldview Model (Cross, 1997)



This traditional way of knowing highlights the need to address how traumatic events disrupt a person's mental, physical, and spiritual well-being. Duran and colleagues (2005) suggest that when a person is hurt, it's usually in three places: the body, the mind, and the spirit. Issues such as sadness (depression), fear (anxiety), and suicidal ideation exist because of some recent and/or historical event that has disrupted the harmonious balance between the mind, body, and spirit. While the body can generally repair itself, the spirit remains injured because it needs spirit medicine to heal. In this worldview, the spirit is eternal (Duran et al., 2005). Spirit can move from place to place and through time across generations (Duran, 2019). In this way, when

ancestors' souls have been wounded without the chance to heal, this hurt is passed on to the next generation (Duran et al., 2005).

The Spirit of Suicide. Many AI/AN traditions believe that everything is living and has a spirit. This worldview also includes the spirit of sadness, the spirit of fear, and the spirit of suicide (Duran et al., 2008). In many AI/AN communities, suicide is considered to be a spiritual entity. Within Duran's soul wound theory, the spirit of suicide comes with the intention of helping, trying to show the individual something (e.g., how previous trauma has wounded their soul/spirit). The suicidal images have transforming energy that can turn suffering from personal and intergenerational trauma into the healing of the soul. The spirit of suicide asks the individual to have a spiritual death and rebirth, to heal the wounded soul. Unfortunately, the idea of wanting to die is a misinterpretation of the soul's desire to transform. The ego misinterprets transformation as a physical death instead of the soul's quest for fulfillment. (Duran 2019). Instead of being fearful of these spirits, Duran suggests leaving an offering (e.g., sage, tobacco, cedar) for the spirit of suicide as an expression of gratitude. Once the individual has made contact with a spirit, it changes the relationship. In making an offering, it is possible to have a relationship with the spirit (Duran, 2019).

Medicine Wheel. While there are many similarities among AI/AN philosophies, it would be inaccurate to assume that all AI/AN cultures are the same (Grandbois, 2005; Little Bear, 2000). A common paradigm within many (but not all) AI/AN cultures is the medicine wheel (Richmond et al., 2007). The medicine wheel is a visual representation of an Indigenous philosophical outlook. It often includes the four cardinal directions (i.e., north, east, south, west) and the four dimensions of wellness (i.e., mental, emotional, physical, and spiritual) (Dapice, 2006; Pomerville & Gone, 2019). Richmond and colleagues (2007) suggest that medicine wheels

are a symbol of wholeness and "encompass a conceptual understanding of life and the interrelatedness of all its functions" (p. 3). Each of the four dimensions are interrelated. If one dimension becomes out of balance, they lack wholeness in all aspects (Dapice, 2006). The medicine wheel is widespread in Indigenous North America and is often used in treatment settings, interventions, and approaches (Pomerville & Gone, 2019). The medicine wheel is used as a visual aid throughout the preset study.

While there are vast differences in Western and Indigenous approaches to wellness, there can be two or more ways of knowing, which can be a harmonious process (Duran, 2019). When implementing AI/AN youth suicide prevention initiatives, we must consider blending Western approaches and evidence-based practices with traditional Indigenous ways of knowing and tribal best practices.

2.4 Understanding Protective Factors for AI/AN Youth

This section will present a synthesis of the substantive findings regarding protective factors for AI/AN youth. Research evidence shows that promoting protective factors can be more beneficial than reducing risk factors for AI/AN youth (Allen et al., 2018; Borowsky et al., 1999; Henson et al., 2017; LaFramboise et al., 2006; Mackin et al., 2012; Rasmus et al., 2019). One study among Oregon AI/AN youth showed that protective factors contribute independently to fewer self-reported suicide attempts, can help reduce the effect of cumulative risk, and buffer the impact of risk factors (Mackin et al., 2012). Researchers also found that adding at least one protective factor to existing risk factors reduced the likelihood of past AI/AN youth suicide attempts (Borosky et al., 1999; Pettingell et al., 2008)

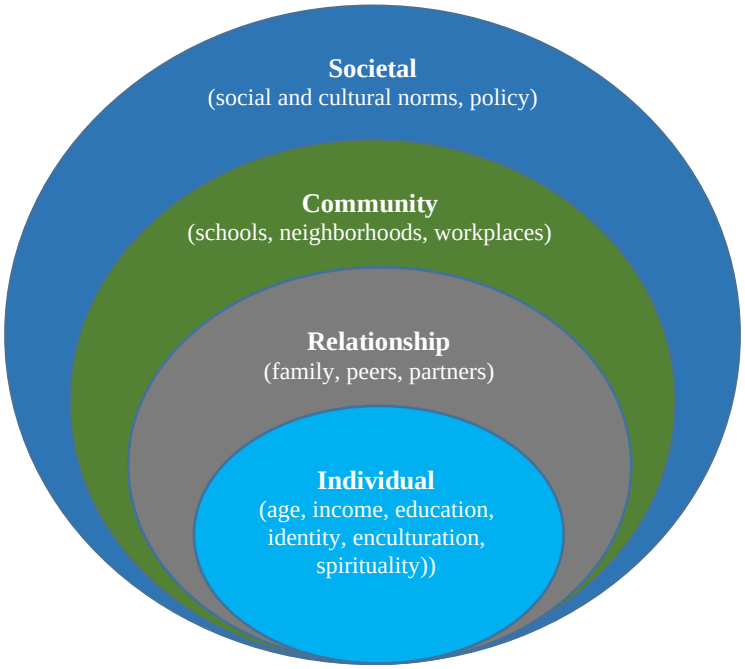
Identifying these protective factors has important implications for practitioners working in youth suicide prevention. They can be used to guide strength-based suicide prevention programming for AI/AN youth living on reservations (Henson et al., 2017). Indeed, when protective factors are enhanced, their positive health effects can reach beyond the target population to affect the entire community (Mackin et al., 2012). The following sections will discuss protective factors at multi-socioecological levels including the individual, relational, community, and multi-levels (Allen et al., 2021).

2.4.1 The Social-Ecological Model (SEM)

The following section draws on the Social-Ecological Model (SEM) to organize risk and protective factors for AI/AN youth. The CDC (2021) developed the SEM as a framework for holistically addressing health outcomes. The SEM is a four-tiered framework for organizing risk and protective factors and informing multi-level prevention strategies. From micro to macro, the four levels of the SEM (shown in Figure 4) are (a) individual; (b) relational; (c) community; and (d) societal.

Figure 4

The Social-Ecological Model



First, the individual level includes biological factors, personal characteristics, and past experiences (e.g., age, education, income, substance abuse, history of abuse). This level also includes an individual's culture (e.g., identity, enculturation, spirituality). Second, the relational level examines close relationships and interactions between two or more people, including close peers, partners, and family members. Third, the community level explores the culture and practices of the settings and institutions in which relationships occur (e.g., schools, workplaces, neighborhoods). Finally, the societal level examines the factors that create acceptance or intolerance for specific health outcomes and create and sustain inequities between groups in society, including health, economics, education, and public policy (CDC, 2021).

For AI/AN youth, both risk factors and protective factors span across multiple domains of the SEM (Allen et al., 2014; Alcantara & Gone, 2007; Borowsky et al., 1999; Henson et al.,

2017; O'Keefe et al., 2019; Tingey et al., 2016). Therefore, it is crucial for practitioners developing youth suicide prevention strategies to consider factors across each level.

2.4.2 Individual Level Factors

Within the SEM framework, individual-level factors include characteristics that youth possess (e.g., health conditions, personal history, biological characteristics) (CDC, 2021; Henson et al., 2017). Analyzing data from a sample of 11,666 AI/AN youth from reservations across the continental U.S., Borowsky et al. (1999) identified good emotional health as a protective factor for both male and female youth. In a sample of 690 AI/AN youth living on reservations in New Mexico, Chino and Fullerton-Gleason (2006) identified optimism about the future as a significant protective factor against suicide attempts. In a sample of 2,794 AI/AN youth living on reservations in New Mexico, FitzGerald et al. (2017) identified getting good grades as a significantly protective against suicide attempt among girls.

2.4.3 Relational Level Factors

The relational level of the SEM includes direct person-to-person interactions, particularly influential relationships with others (e.g., peers, family, elders, school staff, and neighbors) (CDC, 2021; Henson et al., 2017). The protective factors identified at the relational level include non-familial and family connectedness.

Non-Familial Connectedness. Non-familial connectedness is defined as youth having positive relationships or interactions with individuals who are not members of their families, such as peers and teachers at school, or people they know within their neighborhoods (Henson et al., 2017). Non-familial connectedness was identified as protective against suicide attempts for

AI/AN youth in three studies, with different factors identified in each. In the study by Borowsky et al. (1999), it was demonstrated that discussing problems with friends markedly reduced the risk of suicide attempt for male and female youth. Chino and Fullerton-Gleason (2006) identified three significant non-familial protective factors: avoiding people that could get them in trouble, feeling like many people in their neighborhood care about them, and having friends that do well in school. Finally, FitzGerald et al. (2017) identified two significant non-familial protective factors for girls: positive relationships with adults at school and teachers' listening. Together, these studies suggest that relationships beyond the immediate family are essential for the development and well-being of AI/AN youth and can help protect against suicide.

Family Connectedness. Henson et al. (2017) define family connectedness as a youth having positive relationships or interactions with their family members. The role of family connectedness has been well documented as an essential role in protecting AI/AN youth from suicide (Allen et al., 2014a). In Whitlock and colleague's (2014) review of the literature, the most frequently studied social ecology was the family, where indicators of adolescent connectedness were associated with a decrease in suicide risk.

In Alcantara and Gone's (2007) literature review, family connectedness and social supports were identified as protective factors from suicide among AI/AN people. Borowsky et al. (1999) identified discussing problems with family and a sense of connectedness with family as significant protective factors against suicide attempts. Chino and Fullerton-Gleason (2006) identified three significant familial protective factors: eating together as a family, being able to talk to parents about essential concerns, and positive relationships with adults in the home. Similarly, in a study with 2,218 AI/AN youth in New Mexico, Fullerton et al. (2019) identified positive relationships with adults in the home and having a parent/guardian at home who believes

in their success to be significant protective factors in reducing suicide attempts. FitzGerald et al. (2017) also identified having a parent/guardian at home who believes in their success and a parent/guardian knowing their whereabouts as significant protective factors against suicide attempts for both males and females. Additionally, Pharris et al. (1997) found family caring and connectedness protective for suicidal thoughts and behaviors amongst AI/AN youth who were sexually abused.

Overall, there is good evidence to suggest that family connectedness serves as a protective factor for reducing the risk of suicide for AI/AN youth. The findings of these studies indicate substantial consistencies in associations between indicators of adolescents' connectedness to family and decreased risk of suicide. Likewise, the findings of these studies indicate the need for incorporating family as an important strategy for AI/AN youth suicide prevention programming.

2.4.4 Community Level Factors

The community level of the SEM includes the conditions and variables present in the settings and institutions where youth spend time, including schools, neighborhoods, cultural events and ceremonies, and health care facilities (CDC, 2021; Henson et al., 2017).

Community Connectedness. Community-level protective factors identified include community connectedness, defined as a youth having positive connections, engagement, or interactions with community members (Henson et al., 2017). Chino and Fullerton-Gleason (2006) found that feeling like they mattered to the community was significantly protective for AI/AN youth. Additionally, FitzGerald et al. (2017) found that for girls, in particular, significant protective factors included adults in the community telling them they did a good job and having

positive relationships within the community. Further, Borowsky et al. (1999) found that having a nurse or clinic at their school was significantly protective for girls. This provided the opportunity to seek adequate mental health support as needed, reducing the likelihood of a mental health condition becoming more severe.

School Connectedness. The role of school connectedness has shown to be particularly important in the context of youth suicide prevention. There is a wealth of research that supports the association between school connectedness and reduced suicidal thoughts and behaviors. Perceived closeness, sense of belonging, and engagement with peers and teachers predict lower likelihood of suicide among AI/AN youth (Tingey et al., 2016; O'Keefe et al., 2018; Whitlock et al., 2014). Other studies have found that school completion and a positive outlook toward education are protective against suicide for AI/AN youth (Alcantara & Gone, 2007; Tingey et al., 2016; Whitbeck et al., 2001).

Waters and Cross (2010) describe school connectedness as "the belief by students that adults in the school community care about their learning and about them as individuals" (p. 165). Sources of connectedness at school have been shown to consist of three elements: connectedness to adults, connectedness to peers, and connectedness to the school (Karcher & Lee, 2002). Youth become connected by engaging with and valuing the people, activities, and worlds within their social ecologies (Karcher & Lee, 2002).

Whitlock and colleagues (2014) build upon this conceptualization and suggest that school connectedness is an attitude that has four distinct components: (1) social affiliations, (2) school belonging, (3) attitude about school importance, and (4) a supportive learning environment. Within this conceptualization, the researchers suggest that school connectedness has an inverse relationship between youth and suicidal ideation (Whitlock et al., 2014). A 2017 meta-analysis

by Marraccini & Brier confirms this assumption. They investigated the literature exploring associations between school connectedness and suicidal ideation across general and subpopulations (ie., high-risk and sexual minorities) using a random-effects model. Results confirmed that higher school connectedness is associated with reduced reports of suicidal thoughts and behaviors across general, high-risk, and sexual minority youth.

Whitlock and colleagues' (2014) propose three mechanisms by which connectedness protects against suicidal thoughts and behaviors. Their framework suggests three broad pathways that connectedness may protect against suicidal ideation: (1) interpersonal responses and processes (ie., believing one is valued and cared for); (2) collective responsibility and action, and (3) positive norms and expectations. According to Whitlock et al., (2014), school connectedness can reduce thwarted belongingness and perceived burdensomeness, protecting youth against suicidal ideation.

Together, these studies suggest that connectedness beyond the immediate family and in multiple ecological domains is important for the development and well-being of AI/AN youth and can help to protect against suicide. While school connectedness is an important strategy in youth suicide prevention initiatives, School settings are situated to serve the vast majority of youth and are a strategic entry point for prevention efforts (GIH, 2018). Schools are natural sites for suicide prevention and may have the greatest potential to moderate the occurrence of risk factors (Berman et al., 2006; Kalafat, 2003).

2.4.5 Multi-Level Factors

Multi-level factors are those that span over multiple levels of the SEM framework. The literature review identified one such multi-level protective factor: cultural connectedness.

Henson and colleagues (2017) define cultural connectedness as any aspect of a youth's life influenced by their connection and engagement with their tribal culture.

Cultural Connectedness. Research with AI/AN communities have identified a holistic sense of connectedness of the individual with their family, community, ancestors, spirituality, culture, land, and natural environments (Bowen, 2005; Hazel & Mohatt, 2001; Hill, 2006; Hill, 2009; Mohatt et al., 2011). This critical element of connectedness within the AI/AN worldview is a culturally-based protective factor against substance abuse and suicidal ideation (Hazel & Mohatt, 2001; Mohatt et al., 2011). Specifically, there has been growing recognition of cultural connectedness as a protective factor for AI/AN youth.

The term *cultural connectedness* refers to how an AI/AN individual is integrated within their AI/AN culture (Mohatt et al., 2011) and reflects a shift from a deficit-based approach to one of resiliency and strength (Snowshoe et al., 2015). Mainly, strength-based, culture-based approaches are beneficial in AI/AN settings because they allow AI/AN people to reclaim their traditional ways of knowing and being (Snowshoe et al., 2015). Further, cultural connectedness may help explain why many youth thrive despite significant adversity stemming from the legacies of colonization, federal policies, land loss, and assimilation discussed in Chapter 1 (Hawkins et al., 2004; Snowshoe et al., 2017). Long-term impacts of colonization have impacted access to systems of traditional knowledge. As a result, many AI/AN communities have created culture and revitalization programs (Pu et al., 2013). The present study is in partnership with the Klamath Tribes Youth and Family Guidance Center Prevention Department, which seeks to support youth in accessing their traditional ways of knowing and being. The following will review the potential benefits of cultural connectedness for AI/AN youth.

LaFromboise and colleagues (2006) examined resilience (i.e., the capacity to face challenges despite adversity) and pro-social behaviors (e.g., helping, sharing, comforting) among a sample of 212 AI/AN youth living in the upper Midwest. The researchers found that enculturation (i.e., participation and identification with traditional cultural elements) was associated with an increased likelihood of pro-social outcomes. This study found enculturation to be the strongest predictor of higher levels of resilience. For each increment of enculturation, youth were 1.8 times more likely to be resilient. In a cross-sectional study of 196 AI/AN youth in the upper Midwest, Whitbeck and colleagues (2001) found enculturation to be a protective factor associated with school success. Allen et al. (2006) found the transmission of cultural expectations and values and the concept of interconnectedness to be protective against youth alcohol abuse.

Pu and colleagues (2013) found that youth interest in their tribe's culture had a strong positive, indirect relationship with violent behavior. This study surveyed 630 AI/AN youth in the Midwest. Path analysis was used to identify the direct and indirect association of three potential protective factors (parental monitoring, youth self-efficacy, cultural connectedness) with reduced violence behavior (Pu et al., 2013). Further, Mmari and colleagues (2010) conducted focus groups with 172 AI/AN youth and adults to examine protective factors associated with low-delinquent behavior. Results indicated that tribal language, involvement in ceremonies and pow wows, and a sense of spirituality were protective against delinquent behaviors (Mmari et al., 2010).

Strickland and Cooper (2011) held focus groups and observations with 30 AI/AN youth aged 14 to 19 in a Pacific Northwest tribe. The purpose of the study was to gain a better understanding of youth perspectives on risk and protective factors for suicide. Youth reported

intertribal events, prayer, going to the mountains (i.e., connection to the land), and talking with elders as sources of strength. In a cross-sectional study of 71 White Mountain Apache youth aged 10 to 19, Cwik and colleagues (2015) found that the risk of suicide was decreased if their family lived a traditional lifestyle, which included activities such as the practice of sacred ceremonies and events, the preparation of traditional foods, consultation with tribal elders, and speaking the tribal language. Similarly, Pharris et al. (1997) examined data from the National American Indian Adolescent Health Survey that included 991 females and 166 males who reported a history of sexual abuse. Chi-square analysis was used to identify significant protective factors for hopelessness and suicidality. Results indicated that involvement in traditional activities to be protective for boys (Pharris et al., 1997).

A study by Garroutte and colleagues (2003) examined the association of different types of spirituality on the lifetime prevalence of self-reported suicide in an AI/AN population. Their findings indicate a strong and persistent protective association between cultural spiritual orientations (forms of spirituality deriving from traditions that predate colonization) and suicide attempts. Personal interviews with 1456 AI/AN tribal members revealed that those with a high level of cultural spiritual orientation had a reduced prevalence of suicide, as compared to those with a low level of cultural spiritual orientation (Garroutte et al., 2003). Commitment to cultural spirituality, as measured by an index of spiritual orientations, was significantly associated with a reduction in attempted suicide (p=0.01). The reduction in lifetime suicide attempts paired with a high level of cultural spiritual orientation suggests the importance of including indicators of cultural spirituality in studies of the well-being of AI/AN's. These findings support AI/AN suicide prevention programs that use cultural connectedness as a corner-stone (Garroutte et al., 2003).

Protective factors for AI/AN youth span across multiple levels of the SEM. Specifically, research confirms the prediction that connectedness serves as a protective factor for AI/AN youth. In particular, non-familial, familial, school, community, and cultural connectedness have been identified in the literature. When implementing youth suicide prevention initiatives, tribal communities, agencies, and schools should explicitly seek to foster youth connectedness.

2.5 Understanding Risk Factors for Youth Suicide

While promoting protective factors through strength-based frameworks can be impactful for AI/AN youth, it is also essential to be aware of risk factors affecting this population. The following identifies suicide risk factors for AI/AN youth living on reservations, which span across the individual, relational, community, and societal levels of the SEM framework.

Individual-level risk factors include mental health issues (sadness, depression, and hopelessness) (Chino & Fullerton-Gleason, 2006), as well as somatic symptoms (e.g., headaches and stomach aches), health concerns, and a history of being treated for emotional problems (Borowsky et al., 1999). Substance abuse is also a significant risk factor amongst AI/AN youth living on reservations (Borowsky et al., 1999; Chino & Fullerton-Gleason, 2006; Cwik et al., 2015). Chino and Fullerton-Gleason (2006) identified drug and alcohol use as the most powerful predictor of a suicide attempt. Similarly, in a study using self-report surveys of AI/AN youth who made a suicide attempt, Cwik et al. (2015) found substance abuse to act as a risk factor for a suicide attempt, likely because it led to increased impulsivity. In addition, Mackin and colleagues (2012) reported prior suicide attempts, tobacco use, violence perpetration, early sexual activity, high-risk sex, violence victimization, and gun availability as individual-level risk factors for

AI/AN youth. Mackin and colleagues (2012) also reported that two-spirit (i.e., the embodiment of both a masculine and feminine spirit) youth have elevated reports of suicide attempts.

Numerous relational risk factors for suicide attempts in AI/AN youth have also been identified. In the study by Chino and Fullerton-Gleason (2006), a higher risk of suicide attempts was associated with spending unstructured time with friends in the evening, a history of experiencing sexual or physical violence, and knowing adults who do wrong or dangerous things. Borowsky et al. (1999) reported a having history of sexual or physical violence and a history of a family member attempt or die by suicide as risk factors. They also found that the risk factor with the strongest association with suicide attempts was having a friend attempt or complete suicide (odds ratio, 3.80 for boys; 4.53 for girls) and that an additional risk factor for boys was being involved in gangs. Cwik et al. (2015) found having caregivers with substance abuse problems and suicidal behavior among peers and family as risk factors. In addition, Mohatt and colleagues (2012) reported family conflict or violence, family drug and alcohol use, and a lack of friends as relational risk factors for suicide.

Little research was found regarding community and societal risk factors. Community risk factors include living in an impoverished neighborhood and living in an area characterized by crime (Mohatt et al., 2012). Perceived discrimination, the impact of colonization, poverty, relationships with agencies surrounding reservations, and conflicts with law enforcement have been identified as societal risk factors for AI/AN youth (Alcantara & Gone, 2007; Chino & Fullerton-Gleason, 2006; Freedenthal & Stiffman, 2004; Strickland & Cooper, 2011; Whitbeck et al., 2001).

All things considered, the RPP agreed that a strength-based approach to suicide prevention would best meet the needs of the local tribal youth. The RPP collaborated to leverage

local knowledge and culture while navigating the COVID-19 pandemic to help ensure that interventions could be tailored to the local context. The following section discusses a strength-based, culture-based intervention that was utilized for the present study.

2.6 Gathering of Native Americans (GONA)

Gathering of Native Americans (GONA) are strength-based, culture-based events that are typically one to four days in duration. The Substance Abuse and Mental Health Service Administration (SAMHSA) Tribal Technical Training and Assistance Center conducts GONAs as an integral component of their technical assistance to tribes (SAMHSA, 2015). Within the Klamath Tribal community, GONAs have been held for various purposes including strengthening education, suicide prevention, and community wellness planning.

The technical approach to GONAs are built upon an indigenous theoretical framework of vision, circles of relationship, and a sense of hope (SAMHSA, 2016). GONAs provide essential pathways for this framework to unfold.

GONAs are explicitly structured to reflect the cultural values, traditions, and spiritual practices of the local tribal community. These events seek to enhance feelings of belongingness, mastery, interdependence, and generosity amongst attendees. GONAs often take place in community settings and content is specifically tailored for the local tribal community in which the event takes place. In Indian country, community healing is crucial to prevention efforts as each community member is of value in empowering the community. GONAs are intended to be a safe place to share, heal, and plan for action (Neumann, n.d.).

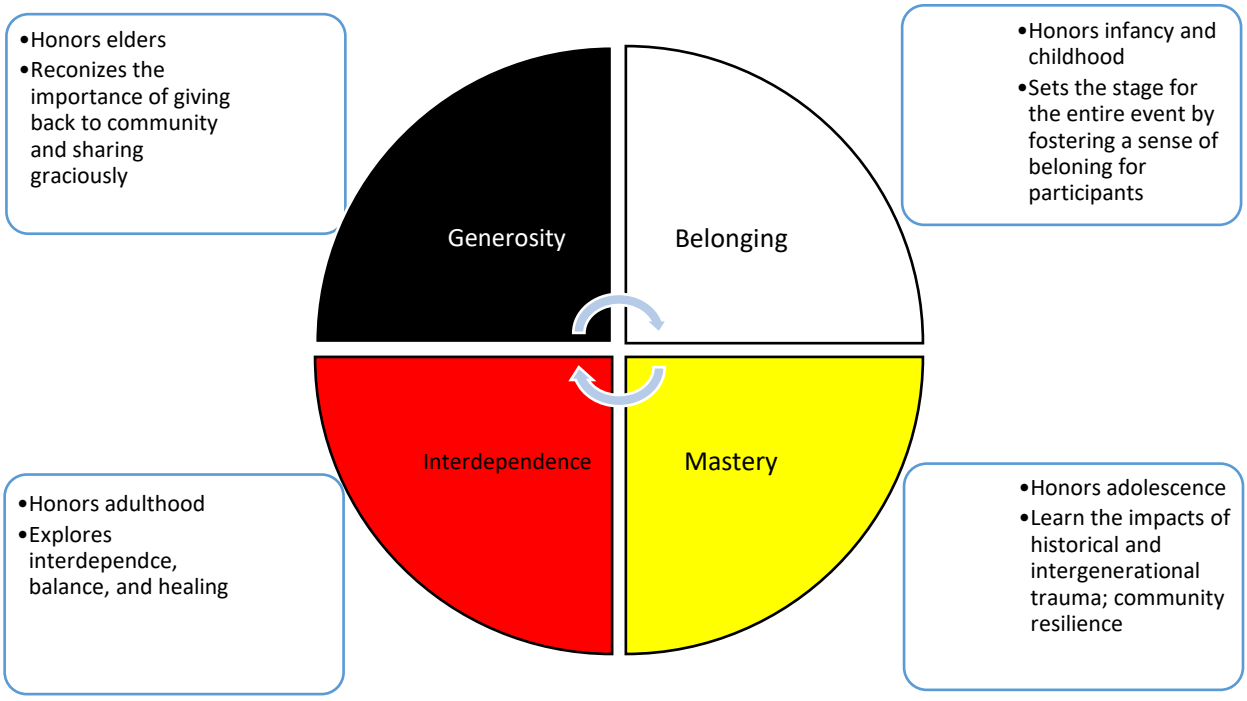
The GONA framework is often used to facilitate a culture-based planning process, where community members come together to address community-identified issues (SAMHSA, 2016).

In addition to community planning, GONAs are also utilized as holistic, strength-based interventions that provide culturally appropriate ways of understanding wellness. GONAs focus on AI/AN values, traditions, and spiritual practices and promote balance, well-being, and resiliency among AI/AN communities (Kraus et al., 2017).

The four guiding principles of GONAs (shown in Figure 5) incorporate each level of human growth and responsibility in many AI/AN cultures: Belonging, mastery, interdependence, and generosity (Neumann, n.d.) *Belonging* represents infancy and childhood. Typically, belonging is the first session of the GONA. The purpose of the belonging element of the GONA is to create an open, safe, and trusting environment grounded in connection so participants can begin the work of coming together as a team to address common goals. During this session, participants acknowledge the protective factors associated with belonging and participate in activities that help each person fully realize that they belong (SAMHSA, 2015).

Figure 5

The GONA Medicine Wheel



Mastery represents empowerment for individuals and the community, and honors adolescence as a time of vision and mastery. This second session of the GONA defines tribal-specific historical and intergenerational trauma and discusses how it resulted in the loss of culture, language, and traditions. Participants discuss the resulting legacy of mental health and substance abuse disorders, and suicide and also review community-specific data. The discussion then shifts from historical trauma and colonization to the community's revitalization and participants' vision for a healthy self and community (SAMHSA, 2015).

Interdependence honors adults, who are integral parts of families and communities, and is typically the third session of the event. The purpose of the interdependence element of the GONA is to explore the interdependent roles and responsibilities that facilitate healing, to re-establish the balance needed to solve common problems, celebrate community achievements, and develop a common vision necessary to promote wellness (SAMHSA, 2015).

Finally, the GONA concludes with *generosity.* Generosity honors elders who share their knowledge and teachings to future generations. The purpose of the generosity element is to recognize the importance of giving back as one of the highest values in many AI/AN cultures and to recognize the many resources within the community that contributes to the overall community well-being (SAMHSA, 2015). These concepts are situated within a medicine wheel and allow participants to engage and participate in forming their own identity. This process creates connections to family, culture, and community, which colonization and assimilation attempted to eliminate from the AI/AN family structure (Aguilera & Plasencia, 2005).

A youth-specific GONA focuses on issues that directly affect youth (e.g., bullying, suicide prevention). Within this framework, facilitators are trained to recognize that some youth

are out of balance instead of being labeled as sick, or mentally ill (Aguilera & Plasencia, 2005). A youth GONA is a valuable setting to implement youth suicide initiatives because it provides a safe learning environment that is enriched with culture.

According to the SAMHSA GONA Toolkit (King & Guillory, 2015), GONAs incorporate youth and bring together relevant stakeholders concerning suicide prevention and intervention, including AI/AN youth and elders, educational leaders, those who serve in gatekeeper roles, tribal departments, tribal government, and community mental health practitioners. Each stakeholder can benefit from participating. Youth are able to develop and deepen their connection to the community and receive leadership formation and training. In addition, adult stakeholders can better understand youth concerns and benefit from the enhanced resource base of youth leadership.

Additionally, the community as a whole may acquire (King & Guillory, 2015): (a) the development of future leaders who feel ownership of the culture and community they will grow to inherit; (b) a new pool of adult volunteers who want to serve the community; (c) the ripple effect of youth lending energy and spirit to community efforts and inspiring other youth to participate in the community in positive ways; and (d) youth who are more likely to get positively involved in the community when provided an increased sense of empowerment and community engagement.

Further, qualitative and quantitative data, including pre-post surveys, interviews, and observations, may be collected at GONAs, and subsequently analyzed to strengthen the evidence base and improve future implementation efforts. In this way, GONAs may be useful as an AI/AN community implementation model to address suicide prevention efforts, mental health promotion, and stigma reduction. The implementation of youth GONAs should be considered to

address suicide prevention, mental health promotion, and the stigma related to mental health and suicide on AI/AN reservations and communities.

2.6.1 Evidence Supporting the Use of GONAs

GONAs are considered to be a tribal best practice and have a long history of use. However, there is limited academic research into their effects, although early studies are promising. For example, one study among AI/AN youth living in Fresno and Oakland, California, indicated that attending a GONA led to an increase in youth resilience, in particular, due to the intervention's effects on hope, family connection, and connection to community (Kraus et al., 2017). Pre- and post-surveys were administered to 241 11- to 17-year-old participants. Researchers investigated the change in hope, family connection, and community in three cohorts (i.e., 2012, 2013, 2014) by using paired t-tests (effect size was not mentioned). Hope ($p< 0.05$) and family connection ($p< 0.05$) increased significantly in each cohort, while community connection increased very modestly ($p< 0.05$ in 2012 and 2013, and $p=0.057$ in 2014). Qualitative data analysis included the following themes: increased sense of interdependence, increased interest in connecting with community, finding purpose, and an increase in happiness. These findings suggest that GONAs may be correlated with an increase in youth resilience as measured by the intervention's effects on hope, family connection, and connection to community (Kraus et al., 2017).

Similarly, Aguilera and Plascencia (2005) examined HIV/AIDS and substance abuse prevention for AI/AN youth in Oakland. Twenty-nine youth participated in the GONA. Eighty-three percent reported they had learned more about AI/AN culture, 79% felt more connected to the AI/AN community, 79% thought they would become more involved in the community, 69%

thought their communication skills improved, and 55% felt that their drug refusal skills improve. The researchers suggested that GONAs can help AI/AN youth learn and access valuable tools that can help reduce their HIV/AIDS risk and increase their substance abuse refusal skills (Aguilera and Plascencia, 2005).

Furthermore, Nelson and Tom (2011) extended the previous findings by conducting a mixed-methods outcome evaluation of an HIV/AIDS, hepatitis, and substance abuse prevention GONA for 100 AI/AN youth aged 13 to 18 in the San Francisco Bay Area. The outcome measures of interest were knowledge, perception of risk, sexual self-efficacy, ethnic identity, and sexual risk behavior. A sequential explanatory strategy was used to guide analyses, and findings indicated that knowledge, perception of risk, and sexual self-efficacy increased. At the same time, no changes were found in measures of ethnic identity and sexual risk behavior. Increased knowledge scores suggest that the GONA successfully remedied misconceptions and lack of knowledge among youth that lasted over the four to six-month follow-up period. Similarly, the GONA skill development and knowledge-building components increased sexual self-efficacy. However, despite these positive gains in knowledge, participant behavior did not significantly change.

2.7 Summary of Literature Review

This chapter has summarized some key theoretical and practical considerations for suicide prevention for AI/AN youth. In the first section, the IPTS was shown to be a valid framework for understanding suicidality in adults and in youth. This theory suggests that an individual will not die by suicide unless they have both the desire to die by suicide and the ability to do so. It proposes that when an individual simultaneously holds the psychological states of

thwarted belongingness and perceived burdensomeness, they can develop suicidal desire. Further, the risk of lethal or near-lethal behavior is heightened with the presence of acquired capability. Therefore, when planning and implementing youth suicide prevention initiatives, it is important to consider strategies that might be used to address feelings of perceived burdensomeness and thwarted belongingness.

In the second section, the role of youth connectedness was reviewed. The construct of connectedness is essential in suicide prevention as it is positively associated with resilience and negatively associated with perceived burdensomeness. In addition, research has identified connectedness as a protective factor for AI/AN populations. As a result, interventions that target connectedness may reduce the risk of AI/AN youth suicidal behaviors. Moreover, connectedness is measurable and can be used as an indicator for program outcomes. Therefore, it was concluded that AI/AN youth suicide prevention initiatives should seek to foster connectedness.

The third section discussed differences between Western and Indigenous approaches to wellness. The Western view of medicine is systematic and based on scientific evidence, and understands the world in terms of cause-and-effect relationships. In contrast, Indigenous worldviews embrace the relational, circular worldview in which wellness exists when there is balance in all dimensions of life (i.e., mental, physical, emotional, and spiritual). In many AI/AN cultures, the spirit is eternal and can move from generation to generation. In this way, when ancestors' souls have been wounded without the chance to heal, the hurt and pain are passed on to the next generation. Further, many AI/AN cultures believe that everything has a spirit, including suicide. Duran's (2019) soul wound theory suggests that the spirit of suicide comes with the intention of helping, not hurting. Unfortunately, the ego misinterprets this as the desire for physical death, rather than a spiritual transformation. In this way of knowing, it is possible to

have a relationship with the spirit of suicide. While this worldview differs from theories such as Joiner's (2005) IPTS, there can be two or more ways of knowing, which can be harmonious. Researchers should consider blending Western and Indigenous ways of knowing when implementing AI/AN youth suicide prevention initiatives.

Section four reviewed the protective factors for AI/AN youth, which were situated within the Social-Ecological Model. Researchers have found that many protective factors related to family, school, community, and culture are unique for AI/AN populations (Alcantara & Gone, 2007; Borowsky et al., 1999). In the AI/AN population, strength-based intervention strategies that increase cultural connectedness (Allen et al., 2018; Rasmus et al., 2019) and network factors (e.g., connectedness with adults and elders in the community) are protective for youth at risk of suicide (Philip et al., 2016). Strength-based intervention efforts that leverage local protective factors and create environments rich in protective factors are vital to improving the well-being of AI/AN youth (Henson et al., 2017).

The fourth section introduced the various risk factors for AI/AN youth, which spanned across the individual (e.g., mental health issues, substance abuse, prior suicide attempt), relational (e.g., having a friend attempt or die by suicide, family conflict, lack of friends), community (e.g., crime), and societal levels (e.g., perceived discrimination, the impact of colonization, conflicts with law enforcement) of the SEM. While strength-based approaches to suicide prevention are essential, it's still important to be aware of the risk factors affecting this population.

Offering a potential intervention to address the issue, the final section turned to the use of the Gathering of Native Americans (GONA), a strength-based, culture-based theoretical framework. GONAs are often used as holistic interventions that focus on AI/AN values,

traditions, and values. The four guiding principles of GONAs are belonging, mastery, interdependence, and generosity. The events seek to promote balance, well-being, and resiliency while providing participants with a safe place to heal and belong. Therefore, it was concluded that GONAs should be considered a valuable intervention to address suicide prevention on AI/AN reservations and communities.

2.8 The Present Study

The implications that emerged from this literature review were used to shape the focus of the present study. Specifically, to address the issue of AI/AN youth suicide in Klamath county, an RPP between the University of Oregon Suicide Prevention Lab and the Klamath Tribal Youth and Family Guidance Center Prevention Department was established in January 2020 (discussed in Section 3.1). As part of a larger research agenda, the RPP hosted a tribal youth GONA to promote culture as a protective factor. The aim of the RPP was to better understand the various protective factors that can be harnessed as part of youth suicide prevention initiatives in Klamath County. In particular, the study aimed to better understand the role of culture as a protective factor by examining data collected at the youth GONA. At the request of the RPP, the present study is a secondary analysis of two data sets collected at the tribal youth GONA.

2.8.1 Research Questions

The present study was guided by four main research questions:

1. Was the GONA model feasible and acceptable to the participants?
2. Did the participants' cultural connectedness increase after participating in the GONA?

3. Did the participants' self-perceived knowledge regarding suicide awareness increase after the QPR training?
4. Did the participants' self-efficacy about applying the QPR skills increase after the training?

CHAPTER III: METHODS

In Chapter 3, the methodology used for the present study, including methods used to collect the research data will be described in detail. First, a description of the RPP and current study will be provided, along with the purpose of the research in question. Next, the Klamath Tribal Youth GONA will be described in detail, including an overview of activities, intended outcomes, and participants. In addition, a description of the overall research design will be provided. Also, survey research will be examined, including the development of questionnaires, the procedure for collecting data, and the approach to analyzing and evaluating the data. Finally, the ethical procedures that were adhered to throughout the study will be discussed.

3.1 The RPP and the Current Study

The present study is situated within an RPP that was developed between the University of Oregon Suicide Prevention Lab (a research group within the College of Education, whose primary purpose is to implement and evaluate a state-wide suicide prevention initiative), the Klamath County Suicide Prevention Coalition (a community-led coalition of practitioners engaged in a variety of suicide prevention work in Klamath County), and The Klamath Tribal Youth and Family Guidance Center- Prevention Department (YFGC).

For this particular project, the research element consists of the secondary analysis of two existing datasets: The Klamath Cultural Connectedness Survey- Female Youth GONA and QPR (Question, Persuade, Refer) Pre/Post survey. Data was collected by YFGC staff at a 3-day female Tribal youth GONA event. The event's purpose was to promote tribal culture as a protective factor for suicide prevention and overall wellbeing.

3.1.1 Purpose of the Research

The present study aims to better understand the various protective factors that can be harnessed as part of youth suicide prevention initiatives in the county. In the past, research with this population was often limited to analyzing large, publicly available data sets (Rey et al., 2021) and had little engagement with practice. Therefore, the present study was aimed at examining the role of culture as a protective factor for female AI/AN youth living in Klamath County, while using the RPP to situate the research and implementation plan in collaboration with researchers and practitioners.

The YFGC entered into a technical assistance partnership with SAMHSA to develop and implement a suicide prevention community plan within the Klamath Tribes and local community. The project included the following goals: Increase youth engagement, increase youth and service providers' knowledge of suicide signs and symptoms, and increase the number of YFGC youth referrals by 10%. The broad research questions for the present study are related to the overall YFGC goals. They include examining the increase in youth knowledge of suicide signs and symptoms, and the rise of youth cultural connectedness after attending a GONA intervention. While the research questions aren't directly related to increasing youth engagement and improving the overall number of YFGC referrals, data from the present study will be used to inform YFCG reporting requirements.

3.1.2 Overall Research Design

The research design refers to the overall strategy used for answering the research questions listed in Section 2.8.1. Essentially, it is the blueprint for collecting, measuring, and

analyzing the data, which provides a solid foundation for the research. A substantial research design ensures that conclusions are valid and justified.

The RPP agreed that quantitative data collection and analysis methods should be employed to address the research questions. Further, the team decided that quantitative methods were appropriate because the critical social phenomena in question were quantifiable and could be assessed through descriptive statistical methods. A quasi-experimental single-group pre-posttest design was used to evaluate the GONA and embedded QPR training, in which the outcome was measured once before and once after the intervention.

3.2 Establishing the RPP

To address these research questions, to help facilitate the implementation of youth suicide prevention programs in Klamath County, and to dismantle silos between research and practice, an RPP was formed between the University of Oregon Suicide Prevention Lab, the Klamath County Suicide Prevention Coalition, and the YFGC Prevention Department. This section will describe the formation and purpose of the RPP and stakeholder engagement situated within the RPP.

3.2.1 The Formation of the RPP

In 13 years as a special educator, I have witnessed the loss of 12 former students; 4 died by suicide. Consequently, I left the classroom to pursue a doctorate at the University of Oregon in search of solutions. During spring term of my first year, a tribal youth from my community died by suicide. That day I walked through campus, processing the grief with another tribal doctoral student. The following day he asked if I would be interested in pursuing a partnership

between the Klamath Tribes and the University of Oregon Suicide Prevention Lab. I agreed and immediately reached out to a former colleague who worked at YFGC. He agreed to meet with the University of Oregon Suicide Prevention Lab to discuss a potential collaboration. I organized a meeting using a network of contacts that included members of the Klamath Suicide Coalition and practitioners primarily focused on AI/AN community work. Attendees included University of Oregon doctoral students and professor, local school administrators, YFGC Prevention staff, tribal court and probation staff, county mental health supervisors, Department of Human Services caseworkers and supervisors, and Klamath County Public Health.

Members of the Klamath Tribal Council were also invited to discuss their role in the partnership, to help mitigate a long-standing distrust for research, discuss the potential benefits of the project, and their concerns, and answer any questions. The Chairman and Vice-Chairwoman attended and expressed an interest in strengthening their network and improving relationships with surrounding agencies, which historically have been strained. Since receiving tribal approval is an important step in working within a collaborative research partnership (Rey et al., 2021), I agreed to provide periodic updates on research and progress to the Tribal Council (the Klamath Tribes does not have an IRB).

At the initial meeting, the group expressed the need to better understand the context of youth suicide in the county and a desire for a more comprehensive action plan to address the issue. The group agreed that while the work should be focused on AI/AN youth, other youth should not be excluded from the research since the community and schools are approximately 50% non-native. Fortunately, the group unanimously agreed to form a collaborative research-practice partnership (RPP).

3.2.2 The Purpose of the RPP

Once the RPP was formed, the first agenda item was to clearly define the purpose and goals of the RPP. The team agreed that the purpose of the RPP would be to identify and address gaps in suicide prevention services, prevention, intervention, postvention, and mental health promotion at the school level within the county. Once gaps were identified, a fundamental goal of the RPP was developing an action plan to support a more coordinated implementation of youth suicide prevention services within the county. In turn, the present study could be used to directly inform the Youth Suicide Intervention & Prevention Plan (YSIPP) and improve the capacity of community partners to support AI/AN youth suicide prevention throughout the state.

A key priority of the RPP was to tailor interventions to meet the unique needs of the local AI/AN population. Allen and colleagues (2014) noted the importance of using local knowledge and theory to frame and guide the work (as cited in Wexler et al., 2015). Thus, the RPP committed to working closely with community partners to co-develop and refine locally-tailored services and strategies while ensuring transparency and mutual beneficence. The following section will provide an overview of RPP activities to clarify how the youth GONA and the present study are situated within the larger study.

3.2.3 RPP Timeline

Once the RPP was formed in January 2020, the team worked to develop the Klamath County Needs Analysis (discussed further in Section 3.3). The need analysis went live in March 2020, coincidently the same week the state was shut down for the COVID-19 pandemic. Despite the circumstances, more than 360 community members and professionals responded to the survey. At this time, the RPP (and the rest of the world) was put on pause. However, by the

beginning of 2021, the RPP began meeting remotely. The Klamath County Youth Survey (discussed further in Section 3.3), was completed in April 2021. Next, to address results from the youth survey, the RPP decided to facilitate two youth GONAs: a GONA for those who identify as female in the summer, and a GONA for those who identify as male in the winter. During the summer of 2021, the RPP began setting the groundwork for the female youth GONA. Unfortunately, because of COVID-19, staff turnover, and tragedy within the small community, the female youth GONA was postponed until the fall, and the boy's GONA was postponed indefinitely.

In July 2021, a content analysis of the meeting minutes and agendas from the RPP was conducted. The purpose of this qualitative analysis was to determine the extent to which best practices for effective RPPs had been followed across the course of the project and to identify any opportunities for improvement in future work (Thomas, 2021). In September 2021, at the request of the RPP, Richie Thomas conducted a secondary analysis of the Klamath County Need Analysis, Klamath County Youth Survey, and RPP Content Analysis for his dissertation: *Fostering a Research Practice Partnership to Understand the Community Needs for Addressing Suicide Prevention among Youth in Klamath County*.

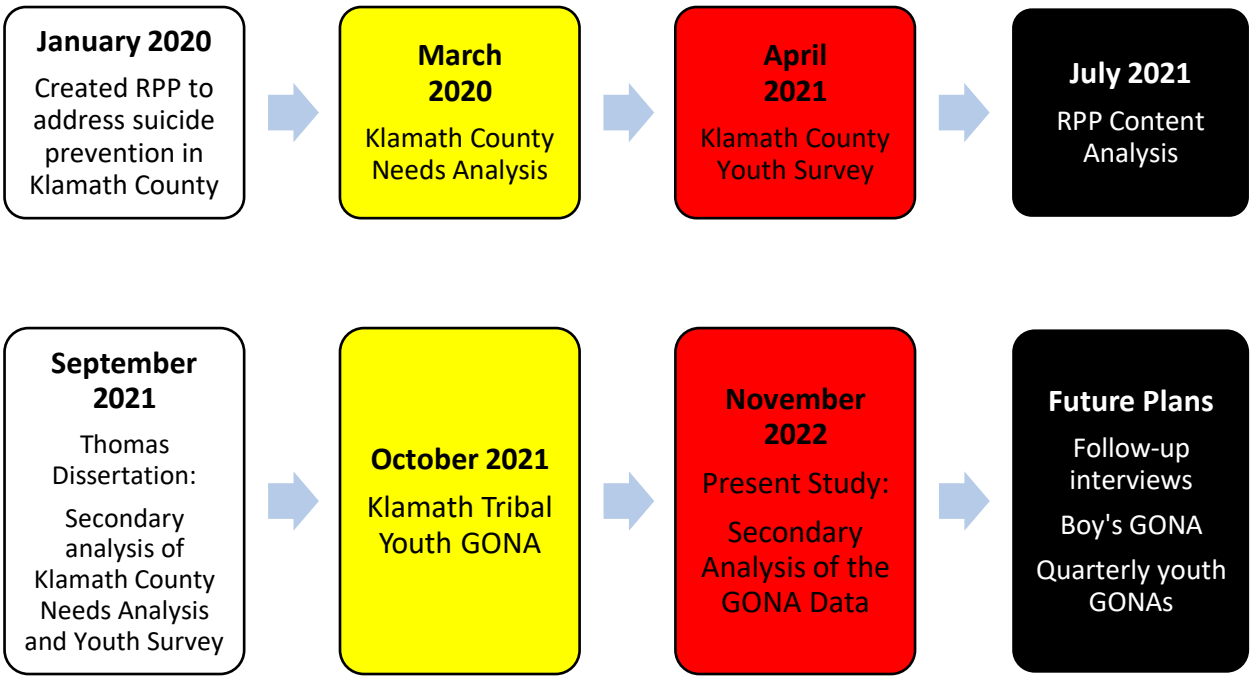
Originally scheduled for July 2021, the female youth GONA was finally held in October 2021. Following the event, the RPP requested a secondary analysis of the data collected at the GONA. In response, the present study was developed. The RPP also requested three to six-month follow-up interviews with the participants. Further, the RPP planned to hold the boy's GONA in December 2021. Unfortunately, the winter of 2021-2022 was difficult for the small tribal community. COVID-19 significantly impacted the community. In addition, there were several unexpected deaths, often in quick succession. When tragedy strikes in a small community

it affects everyone. In particularly difficult times, such as the winter of 2021-2022, tragedy is so frequent that the community is in perpetual grief.

It is important to practice what we preach, especially when times are tough. If we teach youth the importance of living in balance and tending to our mind, body, and spirit, we must honor those teachings. In times of widespread grief and loss, prioritizing the well-being of ourselves and our loved ones is of the utmost importance. As a result, the RPP paused so that team members could tend to more immediate needs. Figure 6 shows a timeline of RPP events, including plans for the future. The follow-up interviews, boy's GONA, and quarterly youth GONAs will happen in time.

Figure 6

Research Practice Partnership (RPP) Collaborations Between University of Oregon Suicide Prevention Lab and Klamath Tribal Youth and Family Guidance Center Prevention Department



3.2.4 Incorporating Best Practices for RPPs

To ensure a dynamic relationship between research and practice, the University of Oregon Suicide Lab reviewed, discussed, and incorporated the three principles for successful RPPs: mutual beneficence, commitment to long-term collaboration, and enduring efforts to build and maintain trusting relationships (Tseng et al., 2017).

Mutual beneficence was promoted by jointly defining the research agenda. Further, continuous efforts were made to ensure that any feedback was well-received and that the planned research would benefit the local organizations. Intentional conversations were held to discuss mutual beneficence to ensure that each party felt heard and satisfied with the investigation. Further, explicit conversations were held periodically to discuss mutual beneficence. In this way, the team ensured that voices were being heard and needs were being met. When mutual beneficence is honored, the result is shared ownership and opportunities to learn from others (Coburn et al., 2013).

Next, researchers and practitioners committed to maintaining a *long-term working collaboration* by co-creating a plan of research, which is described in the following section. Specifically, the project aimed to address persistent problems of practice and uncover critical drivers for improvement. The commitment to long-term collaboration allowed for greater flexibility and stability, enabling the team to navigate challenges including COVID-19, staff turnover, and grief and loss experienced by many RPP members. Consequently, long-term collaboration, as well as open and explicit communication helped foster trust and a positive working relationship between RPP members.

Finally, as a tribal and community member, it was critical that I adhered to the aforementioned principles. Being a member of a tribe does not make a person an expert on tribal

affairs. In this way, I always tried to position myself as a learner, to know when to speak and when to listen, to stay curious, and to ask questions.

3.3 The Youth GONA: t'at'aksni stintatk

The main objective of the RPP was to support the implementation of youth suicide prevention initiatives in the county. An initial task of the RPP was to survey key stakeholders within Klamath County better to understand the context of youth suicide prevention services. While the county-wide survey provided valuable practitioner and community input, the RPP determined that youth voice was absent in the survey results. As a result, the RPP surveyed a sample of 5th to 12th-grade youth in Klamath County (n=156) to elicit an understanding of the youth voice to capture their perceptions about mental health and mental health services. Notably, 52.6% of respondents self-identified as AI/AN. The youth survey indicated that 59% of youth are aware of mental health services, but only 22% had ever accessed the services.

Further, 44% of youth reported barriers to seeking help for mental health issues. A free-response question indicated stigma as a barrier to seeking help for mental health issues. Markedly, males were more likely to feel confident their voice was being heard on mental health issues and more comfortable talking to peers about mental health issues than females were (Thomas, 2021).

Following the survey completion, the RPP agreed that a GONA would be one of the principal strategies for translating the research findings into practice. The GONA framework had been successfully implemented in the community for adult, youth, and community-wide events. In addition, many members of the RPP had previously attended a GONA and reported satisfaction with the events.

As discussed previously in Section 1.2.4, there are gender differences in suicide ideation, attempts, and completions in AI/AN communities (Kelley et al., 2018). AI/AN girls tend to have more internalized behaviors, experience suicide-related hospitalizations more frequently than boys (LaFromboise et al., 2006), and report more suicide attempts than males (Borowsky et al., 1999). Further, considering the historical context of Klamath women, the RPP decided to host the initial GONA for tribal youth that identifies as female.

The GONA took place over three days in October 2021. The event was facilitated by members of the RPP who were experienced in youth prevention work, and some who were trained as GONA facilitators. The gathering was attended by ten young women (aged 12-18) from the Klamath, Modoc, and Paiute Tribes. The GONA sought to raise awareness about the worsening youth mental health issues in Klamath County whilst fostering cultural connectedness as a protective factor against those issues, and increasing youth knowledge of suicide signs and symptoms. For example, activities that were conducted as part of the youth GONA included discussions about cultural awareness (e.g., Klamath Tribal history, Klamath and Modoc creation stories) and culturally-focused activities (e.g., Klamath language, cooking traditional meals, making hand drums and necklaces, intergenerational learning), as well as culturally-based suicide prevention and postvention training.

In addition to culture-based learning, the RPP agreed to include activities centered around suicide prevention. A team member mentioned the “Big Six”, which are suicide prevention programs recognized by the Oregon Health Authority. Programs include QPR (“Question, Persuade, Refer”), Sources of Strength, Youth Mental Health First Aid (YMHFA), Applied Suicide Intervention Skills Training (ASIST), safeTALK, and Connect Postvention.

After reviewing each of the six programs, we agreed on three. Specifically, QPR, Sources of Strength, and Connect Postvention were integrated throughout the weekend. The QPR and Connect sessions were conducted in partnership with expert facilitators from Klamath Basin Behavioral Health (KBBH), ensuring that the attendees had access to the best possible advice and support.

3.3.1 Setting up the GONA

We began planning the female youth GONA in May 2021. The event was initially scheduled for summer 2021, however, the event was postponed because of numerous deaths in the community, a turnover in staff, and a COVID-19 surge. Also at this time, the youth were attending school remotely. The team agreed that an in-person, overnight GONA would be ideal to facilitate connectedness and to provide an opportunity for in-person learning. In August 2021, a member of the RPP, a public health employee, shared COVID-19 data modeling and suggested that October would be ideal for an in-person event. The team agreed to limit adult participation to abide by the COVID-19 protocol. However, it was also agreed upon to ensure a clinical provider would be on-site and available for participants to access.

Once a date was determined, the team selected a 10-bedroom home located at the Running Y Resort. The Running Y is located in southwestern Klamath County. This particular home is located on the shores of Klamath Lake and adjacent to Buck Island (i.e., w'quatwas in the Klamath language). The house is an ideal site for promoting culture as a protective factor. It is situated on traditional hunting, fishing, gathering grounds, and seasonal camps for the Klamath people. In particular, Buck Island was used as a traditional fishing village, cremation, and burial site. Remnants of burial and cremation mounds and depressions in the ground where traditional

pit houses stood are visible from the back porch of the house. Near the fishing village, fishing calendars are drawn on rocks that explain when and where to fish. Further, the peninsula where the home is located was a traditional hunting place to harvest deer for the winter. The men would corral deer to the end of the peninsula while the women would wait in canoes on the lake to watch for deer swimming away (Hess, 2021). It was powerful having a culture-based youth event at a location where their ancestors once lived and thrived. As a final task, the RPP agreed to name the GONA *t'at'aksni stintatk* (i.e., children are sacred in the Klamath language).

3.3.2 Aims and Intended Outcomes of the GONA

As the literature review revealed, connectedness on multiple levels of the SEM serves as a protective factor for AI/AN youth. Specifically, cultural connectedness is a distinctive protective factor that The Klamath Tribes Prevention Department is uniquely situated to teach. The overall hope of the RPP was that youth connection to culture and knowledge of suicide signs and symptoms would increase after attending a GONA.

Throughout the planning process, the RPP discussed other intended outcomes of the event. Specifically, strengthening the partnership between YFGC and KBBH was a desired outcome. Historically, relationships between tribal and non-tribal agencies have been strained. While professional relationships had developed and flourished throughout the RPP, the GONA was the first opportunity to collaborate in person. KBBH offered to provide clinical staff, to help cook, and run errands for the event. Further, they agreed to co-present QPR and Connect Postvention presentations to provide participants with a combination of western and indigenous perspectives.

Other intended outcomes were related to the goals of YFGC program, including increasing YFGC referrals by 10% and increasing youth engagement. First, the RPP predicted that youth participation in QPR training could lead to an overall increase in youth referring peers in crisis for YFGC services. Next, the RPP anticipated that overall youth engagement in YFGC activities would increase due to word of mouth and GONA attendees promoting future events. Last, the RPP was hopeful that a successful in-person event would set the precedence for hosting future in-person youth events (at this point, in-person events were paused because of COVID-19).

3.3.3 Participants

The RPP chose to recruit tribal youth who identified as female and living in Klamath County. Expressly, the sample was limited to youth attending middle school (aged 12-14) and high school (aged 14-18). Children in grade 5 and below were excluded because the subject matter was deemed inappropriate for younger children. Since the event was indoors and overnight, the sample was limited to 10 participants to follow Klamath Tribal Incident Management Team COVID-19 regulations.

Every Klamath Tribal household was sent a GONA event notice in the U.S. mail. In addition, the Tribal Communications Department sent a recruitment email to all Klamath Tribal members. YFGC staff also posted the event flier on Facebook. In total, 10 AI/AN female youth aged 12-18 (M = 14.7) participated in the event and completed the surveys. Two participants responded to the mass mail out, four responded to Facebook, and four by word of mouth.

3.3.4 Activities of the GONA

RPP members arrived at the venue an hour early on Friday to assemble supplies, set up technology, put away groceries, and hold an informal staff meeting. By 6:00 p.m., six staff and ten participants settled into the common area for dinner, an introduction ice breaker, and a review of the agenda. The group also co-created a unique list of expectations and norms that included “practice sisterhood and lateral love”, “practice culture”, “take a healthy risk”, “mach’a’daak” (listen up), “respect that we all belong and are meant to be here”, and “respect each other’s voices and lived experiences”.

Next, participants completed the Klamath Tribal Cultural Connectedness pre-survey on their mobile devices. Then, a positive affirmation activity was introduced. This activity encouraged participants and staff to provide specific, kind, and thoughtful affirmations in writing to each other throughout the weekend. Further, Klamath language was infused throughout the weekend with words, names, places, and phrases. Additionally, participants were provided with journals and prompted throughout the weekend to make entries with the purpose of self-reflection, mindfulness, and stress relief.

Throughout the weekend, the youngest guest was six-years-old, and the oldest was a tribal elder. Intergenerational events are an important element and a community norm in many AI/AN cultures. This is important to note because network factors, such as connectedness with adults and elders in the community are a protective factor for AI/AN youth (Philip et al., 2016). In addition, non-familial and familial connectedness are protective for this population. While many GONA participants and staff were related, an important group norm for the weekend was to foster connectedness and treat each other like family.

Before eating dinner, a tribal elder prayed over the food, explained to the youth why “our people” pray, and stated that traditionally “our people prayed over everything, always.” She

explained that although she prayed over the first meal, she hoped that participants would take a "healthy risk" and volunteer to pray before the remaining meals throughout the weekend. Throughout the weekend participants stepped up to offer a prayer before meals. At one point a participant asked if the prayer had to be about a God or creator, which provided an opportunity for a great teachable moment. Staff talked about spirituality and how it isn't singular and doesn't have to be about any certain God, belief, or religion. They assured the participant that something as simple as kind and uplifting words could be offered.

RPP staff shared cooking and kitchen clean-up duties. Participants were asked to help with clean-up and were invited to help in the kitchen. The youth often joined us in the kitchen; multiple generations honoring the responsibility of putting nothing but love and good feelings into the food we made for the group. It was moving to spend time in the kitchen with these young women as I had taught most of them throughout elementary school.

After dinner, the YFGC Behavioral Health Manager arrived to present the Klamath Tribal History, Historical Trauma, and Resilience training. She came with her niece, both dusty and tired after a day of cooking at a traditional wedding ceremony, but radiating love and contentment. The presentation began with creation and wove through decades of tribal history and collective trauma while highlighting the people's continued resilience. The main purpose of the presentation was not only to educate about historical trauma and resilience but also about connectedness and belongingness. Next, participants transitioned to journal writing with the intention of bringing awareness to the balance of all four dimensions (i.e., mental, physical, spiritual, and emotional) and connection to spirit, land, and ancestors. Prompts included, "Think about your spirit; how well are you tending to it?", "How is your prayer?", "How is your connection to the land?", "How do you think your ancestors felt throughout the traumatic events

we've just discussed?". The presentation concluded with, "Do stuff that will make your ancestors proud. We are all ancestral prayers coming to life". Although the presentation was almost three hours long, the participants intently and actively listened without interruption.

Saturday commenced with a prayer, breakfast, ice breakers, review of norms and expectations, adjustments to the agenda, and reinforcement of the positive affirmation activity. Afterward, the group assembled on the back patio to discuss Buck Island (discussed in Section 3.3.1) and the cultural significance of the event location. Additionally, participants and facilitators discussed the importance of connection to the land, which is a unique protective factor for this population. The immense sense of pride and curiosity when learning about their ancestors was evident.

Later, the group transitioned to the common area for the morning session. YFGC staff shared the Klamath and Modoc creation stories and concluded by sharing the following statement: "the land was created for us; we were not an afterthought. It wasn't until every single hill and valley were created and ready for us that we were created. Our creator created this place specifically for us. Our creation story tells us that we always have a place to come back to, and that we were created for a purpose. Our ancestors prayed for our existence. This creation story tells us that we were created purposefully, which means we are here for a purpose. Once we know our purpose, we can wake up each day with intent." This session aimed to teach belonging, connection, and that we are all here for a purpose.

The afternoon session included a Sources of Strength activity centered around positive values including generosity, belonging, hope, and resilience. Participants discussed the meaning of these values and identified people who exemplified these values in their own lives. Most all participants listed a mother or grandmother ad their source of strength. Sources of Strength is a

school-based, peer-led prevention program that seeks to prevent suicide, bullying, and substance abuse by increasing help-seeking behavior and connectedness within a strength-based model (Sources of Strength, n.d.). The program is one of OHA's Big Six suicide prevention training initiatives.

Saturday night concluded with the GONA theme of "generosity" and hands-on activities. First, YFGC staff reviewed traditional Klamath and Modoc values of generosity. Further, they explained that wealth was traditionally measured by how much one gave away, not by how much one owned. Additionally, staff discussed the importance of giveaways in that when you give, you receive. Next, participants made hand drums and bone hairpipe necklaces. Afterward, YFGC staff encouraged participants to consider a recipient for their giveaway item.

QPR Gatekeeper Training. Sunday began with a prayer, breakfast, a review of norms and the agenda, and quickly transitioned into QPR. QPR is an hour-long gatekeeper training that increases knowledge and dispels myths about suicide and suicidal behaviors. Gatekeeper training is a common approach to increasing mental health help-seeking behaviors and suicide awareness. A gatekeeper is someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. QPR participants are trained to recognize the early warning signs of a suicide crisis, know how to offer hope, and be informed about community resources. The program also aims to increase self-efficacy by strengthening the participants' capacity to ask individuals about their suicidal thoughts and/or intentions directly, persuade them to ask for help, and accompany them to an appropriate service provider (QPR Institute, n.d.).

First, participants took the QPR pre-survey on their mobile devices. Next, YFGC and KBBH co-presented QPR with material with some additions including AI/AN specific statistics, visuals, videos, and resources. At the end of the presentation, participants asked questions and

shared personal life experiences. Many were thankful to learn gatekeeper skills to use in the future, but others were expressed sadness for not having the skills during times of need. Finally, participants took the QPR post-survey on their mobile devices.

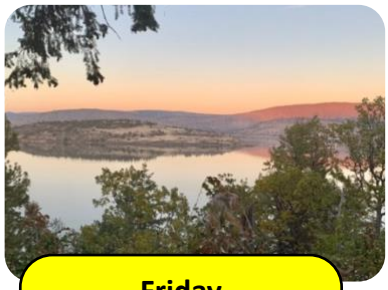
Connect Postvention. The group quickly transitioned into Connect Postvention, where the attendees were taught best practices for responding adaptively in the aftermath of a suicide in their community. Connect provides postvention protocols that are tailored for specific audiences. Content includes reviewing suicide-related grief, recommendations for funerals and memorials, best practices for safe messaging on social media, and identifying local resources. The RPP agreed that a collaborative approach to postvention would be beneficial, combining western postvention with tribal cultural components. KBBH and YFCG staff collaborated to adapt and co-present Connect.

YFGC staff began by sharing that postvention has always been a large part of Klamath culture. KBBH staff shared clinical information such as the emotions when we face during a tragedy, while the YFGC staff cross-referenced with traditional beliefs and traditional forms of postvention. Further, they shared that the Klamath come from a ceremonial culture that includes ways of grieving that allow their people to heal. The group discussed ways their families cope with grief, such as sweat lodge, time with family, giveaways, wrapping each other with support, traditional medicines, and funerals. This included a conversation about social norms that have been adopted (i.e., healthy and unhealthy) and encouraging youth to lean into their culture, especially when they feel like they want to go down an unhealthy path. I could sense validation in participants as they each realized their families have a culturally unique way of grieving loved ones.

GONA Conclusion. The giveaway was the final activity of the weekend. Giveaways are common ceremonies in many AI/AN communities with different formats, but often with a similar purpose: to honor the reciprocity of giving and receiving. The giveaway at the GONA was intended to keep the "generosity" theme. Participants gifted their handmade items to another attendee. After the giveaway, participants completed the Klamath Cultural Connectedness post-survey on their mobile devices. Finally, YFGC staff asked participants to share a word to describe their weekend. In conclusion, here are their responses: enlightened, new, hopeful, inspired, connected, thankful, proud, grateful, belonging, and useful. Figure 7 provides an overview of GONA activities.

Figure 7

Activities of the Klamath Tribal Youth GONA



Friday (Belonging)

- Introductions
- Group norms
- Group definition of "belonging"
- Positive affirmation activity
- Klamath Tribes cultural awareness, history, and resiliency presentation

Saturday (Generosity)

- Invocation/ prayer
- Review of norms
- Group definition of "generosity"
- Traditional Klamath values of generosity
- Sources of Strength
- Belonging and Klamath/Modoc creation stories
- Detour to participants' volleyball game
- Hand drums and hairpipe bone necklaces

Sunday (QPR & Connect)

- Invocation/ prayer
- QPR
- Connect Postvention (blending western and traditional knowledge)
- Giveaway

Note. Photographs were taken by Author at the GONA. The first photo was taken from the GONA venue and shows Klamath Lake and Buck Island, a traditional Klamath fishing village. The second photo shows hand drums participants made for the giveaway. The third photo shows participants and staff at the QPR training.

3.4 Measures

Questionnaires are one of the most common data collection methods in survey research. They can be self-administered or given by a professional, either individually or in a group, and include questions reflecting the research aims (Ponto, 2015). Surveys can be administered in numerous formats, but online surveys have a minimal cost, are quick, offer more candid responses, and lack interviewer biases. Disadvantages of online surveys include technology issues, including access to a device and the internet. A good survey will be apparent, relevant, attractive, easy to read, and should take no more than 10 minutes to answer to enhance the response rate. Some surveys measure knowledge, while others measure constructs, practices, or behaviors. Researchers should use items validated in previous research (Story, 2019).

The Klamath Cultural Connectedness Survey (KCCS) (pre/post) and QPR Survey (pre/post) are existing surveys that have already been carried out as part of the RPP between the University of Oregon and YFGC Prevention Department. Each survey can be classified as an exploratory cross-sectional questionnaire, in which quantitative data was collected. The RPP agreed that survey research would be appropriate because it's quick and convenient but can provide answers to the questions that have been raised. For this study, a single group pre-and post-intervention design was used to examine the impact of the GONA on female tribal youth aged 12-18 living in Klamath County.

The KCCS aimed to capture pre- and post-information about the cultural connectedness of participants. The questionnaire was designed to evaluate the overall impact of the GONA by

assessing participants' perceptions of changes in their connection to culture. Seven survey questions were formulated to examine the change in participants' cultural connectedness and two questions to examine the overall satisfaction of the event.

The QPR Survey aimed to capture pre and post-information on the suicide awareness of participants. The questionnaire was designed to examine the program's effectiveness in dispelling myths about suicidal behaviors, increasing participants' knowledge about warning signs of a suicidal crisis, and increasing participants' self-efficacy skills.

3.4.1 Measuring the Acceptability of the GONA Model

An overall goal of the RPP was to measure the acceptability of the GONA model. After discussion, the RPP agreed to use the two same acceptability questions for the KCCS and the QPR survey. The team agreed to use the two acceptability items from the original QPR survey. The first item, "Would you recommend this training to others?" included a 5-point scale ranging from 1 = "Definitely no" to 5 = "Definitely yes". Item two, "Please indicate your overall rating of this training" included a 5-point scale ranging from 1 = "Poor" to 5 = "Excellent".

In addition to acceptability, the RPP agreed to include feasibility indicators of participant recruitment and retention, as well as activity engagement. To measure these indicators, I took detailed field notes during each GONA activity.

3.4.2 Measuring Cultural Connectedness

While researchers generally agree about the importance of culture for AI/AN mental health and well-being, operational models are often based on belief rather than a tested theoretical framework (Snowshoe et al., 2015). Snowshoe and colleagues (2015) developed the

Cultural Connectedness Scale (CCS) to recognize the need to conceptualize and operationalize cultural connectedness. The main objective of developing the CCS was to create a tool that aids in predicting positive health outcomes for First Nation (FN) youth. A sample of 319 FN, Métis, and Inuit youth in 8th through 12th grades participated in the study. A combination of rational expert judgments and empirical data were used to refine a pool of 64 cultural connectedness indicators. Next, exploratory factor analysis (EFA) was used to examine the latent structure of the items. Then a confirmatory factor analysis (CFA) was used to test the fit of a more parsimonious version of the final EFA model. The three subscales demonstrated adequate score reliabilities with Cronbach's alpha values (0.872 for identity, 0.808 for spirituality, and 0.791 for traditions). The criterion validity was assessed against proxy measures of well-being and mental health outcomes (i.e., life satisfaction, sense of self) (King et al., 2019). The final product was a 29-item inventory that included three dimensions: identity, traditions, and spirituality (Snowshoe et al., 2015).

While this study determined that cultural connectedness was positively related to indicators of mental wellness, the results were correlational (Snowshoe et al., 2017). As a result, Snowshoe and colleagues (2017) conducted a study using a brief version of the CCS to examine further the association between the components of cultural connectedness (i.e., identity, traditions, spirituality) and positive mental health for FN youth. The study included 290 FN, Métis, and Inuit youth in 7th through 12th grades. Using the 29-item CCS, the team selected ten items to comprise the Cultural Connectedness Scale-Short Version (CCS-S). The selection of the ten items was heavily informed by collaboration with FN traditional elders. Four items belonged to the identity subscale, three on the traditions subscale and three on the spirituality subscale. Five items on the CCS-S had a dichotomous response scale of "no" or "yes", four items had a 5-

point Likert scale ranging from “never” to “every day”, and one had a 5-point Likert scale ranging from “strongly disagree” to “strongly agree" (Snowshoe et al., 2017).

CFA was used to investigate the factor stability of the construct in the sample. The researchers also used hierarchical multiple linear regression analysis to establish the validity of the abbreviated measure. Fit indices for the final CCS-S indicated a good model fit, $X^2(21) = 746.939$, $p < .001$; CFI = .967; TLI = .970; RMSEA = .060; WRMR = .784. Further, the CCS-S demonstrated good scale score reliability (Cronbach’s a=.70, 95% CI .641-.752). This study provided justification for the use of the shortened version of the scale, and confirmed the findings of the 2015 study by further illuminating the importance of the three cultural connectedness components (i.e., identity, traditions, and spirituality) (Snowshoe et al., 2017).

For the present study, the RPP agreed to use the Klamath Cultural Connectedness Scale (KCCS), which was a modified version of the CCS. The following section describes the development of questionnaires that were utilized at the GONA.

3.4.3 Development of Questionnaires

The Klamath Connectedness Survey. The KCCS was modified from Snowshoe and colleagues’ (2015) CCS during a co-design process between RPP members. An RPP member who had previous experience using the CCS and the CCS-S suggested using the CCS-S to measure cultural connectedness amongst GONA participants. After reviewing the CCS-S the team agreed that some items were not a fit for the population in question and that ten items were too many. We learned that the selection of the ten CCS-S items was centered on community-based knowledge obtained from collaborating with elders. As a result, the RPP decided to use rational expert judgments to select items from the CCS that would best fit the population in

question. The team agreed to select less than ten, but more than five items, to ensure that necessary data was collected without overwhelming participants. Further, the team agreed to use questions with the same subscale to avoid confusing participants. Eventually, we selected seven items from the CCS. Each item selected was from the identity subgroup. The RPP agreed to revisit the KCCS items after the GONA to determine if any adjustments would be needed for subsequent events. Figure 8 lists the 29 items of the CCS, and the items for CCS-S and KCCS.

The purpose of the KCCS was to gather information from participants using pre-and post-surveys. Specifically, the surveys were given Friday evening at the beginning of the GONA and Sunday after the event. The purpose of the KCCS was to capture information about the cultural connectedness of the participants.

The pre-survey included one binary question (yes/no), “Have you attended a Gathering of Native Americans (GONA) in the past two years?”. Next, the survey listed seven statements and gave respondents a mix of Likert-style responses. This was scored on a five-point rating scale, ranging from 1= (“Strongly disagree”) to 5 (“Strongly agree”).

The post-survey included three additional questions. The first question asked, “Please indicate your overall rating of this training.” This was scored on a five-point rating scale, ranging from 1= (“Poor”) to 5 (“Excellent”). Next, respondents were asked, “Would you recommend this training to others?”. This was also scored on a five-point rating scale, ranging from 1= (“Definitely no”) to 5 (“Definitely yes”). Finally, one additional question asked respondents, “Please provide any additional comments about the training,” with space for open-ended responses.

Figure 8

Items of the 29-item Cultural Connectedness Scale (CCS) (Snowshoe et al., 2015), Cultural Connectedness Scale-Short (CCS-S) (Snowshoe et al., 2017), and Klamath Cultural Connectedness Survey (KCCS)

	CCS Items	CCS-S Items	KCCS Items
Identity			
1.	I plan on trying to find out more about my [Aboriginal/FNMI] culture, such as its history, traditions, and customs.	X	X
2.	I have spent time trying to find out more about being [Aboriginal/FNMI], such as its history, traditions and customs.	X	X
3.	I have a strong sense of belonging to my [Aboriginal/FNMI] community or Nation.	X	X
4.	I have done things that will help me understand my [Aboriginal/FNMI] background better.		
5.	I have talked to other people in order to learn more about being [Aboriginal/FNMI].		X
6.	When I learn something about my [Aboriginal/FNMI culture], I will ask someone more about it later.		X
7.	I feel a strong attachment towards my [Aboriginal/FNMI] community or Nation.	X	
8.	If a traditional person, Elder, or Clan Mother spoke to me about being [Aboriginal/FNMI], I would listen to them carefully.		X
9.	I feel a strong connection to my ancestors.		X
10.	Being [Aboriginal/FNMI] means I sometimes have a different way of looking at the world.		
Traditions			
11.	It is important to me that I know my [Aboriginal/FNMI] language.		
12.	I use tobacco for guidance.	X	
13.	I have participated in a cultural ceremony (examples: Sweatlodge, Moon Ceremony, Sundance, Longhouse, Feast or Giveaway).		
14.	I have offered food or feasted someone/something for a cultural reason.		
15.	Someone in my family or someone I am close with attends cultural ceremonies (examples: Sweatlodge, Moon Ceremony, Sundance, Longhouse, Feast or Giveaway.		
16.	I plan on attending a cultural ceremony in the future (examples: Sweatlodge, Moon Ceremony, Sundance, Longhouse, Feast or Giveaway).		
17.	I have a traditional person, Elder or Clan Mother who I talk to.	X	
18.	How often do you make tobacco offerings for cultural purposes?		
19.	How often do you use sage, sweetgrass, or cedar in any way or form?		
20.	How often does someone in your family or someone you are close with use sage, sweetgrass, or cedar in any way or form?	X	
Spirituality			
21.	I know my cultural/spirit name.	X	
22.	In certain situations, I believe things like animals and rocks have a spirit like [Aboriginal/FNMI] people.	X	
23.	The eagle feather has a lot of meaning to me.	X	
24.	When I am physically ill, I look to my [Aboriginal/FNMI] culture for help.		
25.	When I am overwhelmed with my emotions, I look to my [Aboriginal/FNMI] culture for help.		
26.	When I need to make a decision about something, I look to my [Aboriginal/FNMI] culture for help.		
27.	When I am feeling spiritually disconnected, I look to my [Aboriginal/FNMI] culture for help.		

The QPR Survey. The QPR Survey was developed in collaboration between Lines for Life (a regional non-profit focusing on suicide prevention) and the University of Oregon Suicide Prevention Lab to improve the training quality of the program. The RPP reviewed the QPR Survey and agreed to use the survey as-is, with the addition and the local crisis line and NATIVE 741741 within the survey. The QPR Survey aimed to collect information from participants on pre-and post-surveys. Specifically, the survey was given Sunday morning, before the QPR training and directly after the training. The purpose was to capture information on respondents' changes in knowledge, self-efficacy, and help-giving behaviors.

The first set of questions on the pre-survey measured demographic characteristics. Respondents were asked, "Which ethnicity do you most identify with (check all that apply)?" and "Are you a Klamath Tribal member?". Next, respondents were asked "What is your age?" with a space for free text entry to write their age. Additionally, they were asked, "Please indicate if you had any of the following suicide prevention training in the past two years (check all that apply)" (e.g., "Mental Health First Aid," "Sources of Strength," "QPR," etc.), with a free-response option to write other training not included on the list.

The second set of questions on the pre-and post-survey was designed to examine the program's effectiveness in dispelling myths about suicidal behaviors and increasing participants' knowledge about warning signs of a suicidal crisis. The survey listed seven statements and provided respondents with a mix of Likert-style responses. This was scored on a five-point rating scale, ranging from 1= ("Very low knowledge") to 5 ("Very high knowledge"). The survey asked, "How would you rate your knowledge of the following topics:"

1. Facts concerning suicide prevention.

2. Warning signs of suicide.
3. Persuading someone to get help.
4. How to get help for someone.
5. Information about local resources for help with suicide.
6. Understanding about suicide and suicide prevention.
7. How to ask about suicide.

Since QPR was designed to introduce skills that are needed to talk directly with individuals in a suicidal crisis and to help them access services, the third set of questions on the pre-and post-survey was designed to capture information on participants' self-efficacy skills. The survey listed eight statements and provided respondents with a mix of Likert-style responses. This was scored on a five-point rating scale, ranging from 1= ("Not confident at all") to 5 ("Very confident"). The survey asked, "Please rate how confident you are in regard to the following skills or abilities commonly used to support mental wellness and prevent suicide:"

1. Identify signs and symptoms of mental health distress in others.
2. Provide support without judging or giving advice.
3. Address misinformation and educate others about suicide.
4. Ask someone you know well if they are thinking of suicide.
5. Ask someone you do NOT know if they are thinking of suicide.
6. Be prepared with the necessary phone numbers and contacts for mental health services.
7. Collaborate with a person of concern to determine what type of help they will accept.
8. Be present and supportive when connecting with others' pain and intense emotion.

Finally, the fourth set of questions was designed to capture respondents' attitudes about suicide. The survey listed three statements and provided respondents with a mix of Likert-style

responses. This was scored on a five-point rating scale, ranging from 1= ("Strongly disagree") to 5 ("Strongly agree"). The survey asked, "Please rate your level of agreement with the following statements:"

1. Suicide is a major issue among students and school personnel.
2. I would seek mental health services for myself if I were in a crisis.
3. People in my community see suicide as a sign of personal weakness.

3.4.4 Procedure for Data Collection

The KCCS survey was assessed pre- and post-GONA retreat (i.e., Friday and Sunday). The QPR survey was assessed pre- and post-QPR training and was embedded within the GONA (i.e., Sunday). Potential respondents were contacted through email, social media, and U.S. mail with an invitation to participate. For each survey, the study information was provided in the correspondence with families, and on the survey page. Each survey was hosted online, using Qualtrics. YFGC Staff provided the survey URL link to participants for use on their mobile devices. Once each participant had the survey open, information about the study (on the survey page) was read aloud by YFGC staff before participants began the survey. The surveys were intentionally kept as short as possible to ensure that the necessary data were collected, leading to an expected survey completion time of 10-15 minutes. Survey participation was optional and entirely conducted during the prevention event.

In addition to the surveys, I recorded my observations from the GONA in detailed field notes, which I returned to when analyzing data. Specifically, during each activity, I took notes on participant engagement, comments, questions, and feedback.

3.4.5 Data Analysis

For this study, the data were initially analyzed by the University of Oregon Suicide Prevention Lab, which was asked to perform simple descriptive analyses of critical variables and report summary data back to the RPP. Therefore, the data were already deidentified and "cleaned" (e.g, Likert responses re-coded numerically, renaming columns with simpler variable names). The present study went beyond the initial analysis by calculating more detailed descriptive statistics. For the quantitative analysis for the present study, statistical analyses were conducted in SPSS version 26 and effect sizes were calculated in Excel 2019.

The KCCS included seven questions that aimed to examine the changes in participants' cultural connectedness and two questions to examine the GONA's acceptability. The survey was administered at the beginning of the event on Friday and at the conclusion of the event on Sunday. The QPR survey included seven items to example participants' knowledge, eight items to examine self-efficacy skills, and two questions to examine QPR's acceptability.

The study was underpowered by design, so *p*-values were not used for hypothesis testing and effect sizes were interpreted instead. To address each of the research questions associated with the survey data, SPSS was used to produce descriptive statistics to summarize the results of each question across the sample as a whole. Specifically, descriptive statistics were calculated for each response variable, using statistics such as means, standard deviations, frequencies, and percentages, to summarize the results of each question across the sample as a whole (e.g., levels of agreement, levels of confidence). I created scale scores based on each of the research questions (e.g., mean score of the cultural connectedness items, mean score of QPR knowledge items). Next, paired t-tests were used to calculate the effect size for the pre-post change scores. With 10 subjects, the power is only .17 to detect a small- to medium-size effects (g=.35).

Therefore, instead of *p*-value, I used Hedge's g (Hedges et al., 2014) effect size to gauge meaningful differences ($g > .35$). For a small sample size (<50), Cohen's *d* tends to over-inflate the results. Hedge's *g* reduces effect sizes for small samples by a few percentage points (Hedges & Olkin 1985). Benchmarks suggested by Cohen (1988) will be used to interpret the study findings: 0.2 = small, 0.5= medium, 0.8 = large. These benchmarks refer to effect sizes as small ($d = 0.2$), medium ($d = 0.5$), and large ($d = 0.8$) (Cohen, 1988). Finally, total mean scaled scores were calculated.

3.5 Ethical Procedure

The ethical review process is a meaningful way to ensure that research is conducted under sound scientific principles and that possible risks have been considered, minimized, and deemed acceptable. Overall, the RPP (including the GONA) was conducted as part of a contract with OHA to inform on implementation of the YSIPP within Klamath County. I applied for ethical approval for this study from the University of Oregon's Institutional Review Board (IRB). Since the project involved the secondary analysis of existing, deidentified datasets, it was anticipated that I would not require ongoing institutional review board oversight. Therefore, I applied for IRB approval for exempt research under Exemption 4 of the 45 Code of Federal Regulations Part 46: "involves the collection or study of data or specimens if publicly available or recorded such that subjects cannot be identified."

In May 2022, the University of Oregon's IRB approved the study for an exemption. Once I received written approval verification, I began the actual data review process and frequently referred to the IRB research plan throughout the process to ensure my adherence to ethical research practice.

Although the research plan involves the secondary analysis of an existing data source, I am aware of the need to ensure that participants' responses are kept private at all times during any of the present study, ensuring that not only are the participants' right to confidentiality is respected, but also that the Tribes' inherent right to data sovereignty is honored.

The data has been stored securely, further minimizing the risk of potential breaches which could affect participant privacy. Specifically, I've saved the spreadsheets on my university laptop's secure and password-protected cloud-based storage drive. This minimizes the risk of privacy breaches due to human error (e.g., losing a portable USB drive that others can subsequently access).

Any publications will avoid giving any descriptive information about participants beyond the description of the target population (i.e., "school-aged Tribal youth in Klamath County"). In this way, it is not conceivable that participants' right to anonymity would be compromised by the re-analysis of the datasets.

After the study has been complete, the de-identified datasets used for analysis will be retained for two years to support the work of the RPP and enable future researchers or practitioners aligned with the RPP to re-analyze the responses. If researchers or practitioners not aligned with the RPP wish to re-analyze the data, they can request access to it by e-mailing me with their rationale. I will then consult with the YFGC and tribal council. If it is deemed that they have a significant justification for using the data, I will e-mail them the anonymized dataset to use in their research.

CHAPTER IV: RESULTS

This chapter discusses the data analysis methods used for investigating the research questions posed in Chapter 2. This study was a secondary analysis of data collected at the Klamath Tribal female youth GONA in October 2021, conducted as part of the RPP.

First, the results of the KCCS are presented, showing participant perceptions of changes in connection to their culture. Then, participant ratings of overall satisfaction with the GONA event are presented. Next, the results of the QPR pre and post-tests are presented, showing the changes in participants' knowledge, self-efficacy skills, and attitudes regarding suicide prevention. Additionally, participant ratings of overall satisfaction with the QPR training are presented. Finally, a summary of the results is provided.

4.1 The Klamath Cultural Connectedness Survey

4.1.1 Research Question 1: Was the GONA Model Feasible and Acceptable to the Participants?

The KCCS and QPR survey each included two questions that examined the effectiveness of the training. First, the KCCS will be reviewed, and then the QPR survey. The first KCCS acceptability question asked participants if they would recommend the GONA training to others. A 5-point scale ranging from 1 = Definitely no to 5 = Definitely yes was used in the response. Figure 9 shows that participants chose either “definitely yes” (80%), “probably yes” (10%), or “might or might not” (10%).

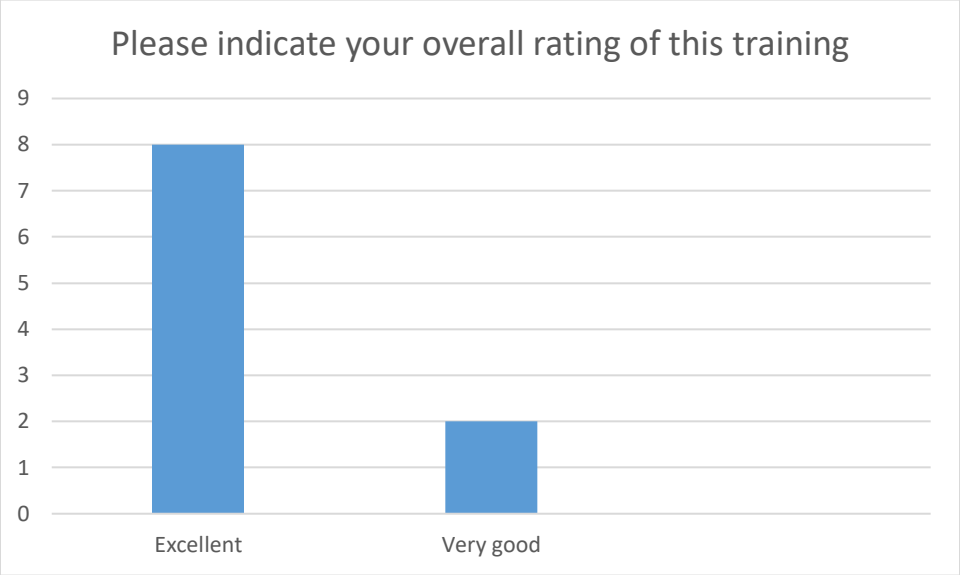
Figure 9

Ratings on Recommending the GONA to Others

This question asked participants for their overall rating of the GONA training. A 5-point scale ranging from 1 = “Poor” to 5 = “Excellent” was used in the response. As shown in Figure 10, participants chose either “excellent” (80%), or “very good” (20%). The mean average score across the sample was 4.8 (*SD* = 1.27).

Figure 10

Overall GONA Rating



The QPR survey included two questions that examined the effectiveness of the training. The first question asked participants if they would recommend the QPR training to others. A 5-point scale ranging from 1 = Definitely no to 5 = Definitely yes was used in the response. Figure 11 shows that participants chose either “definitely yes” (60%) or “probably yes” (30%).

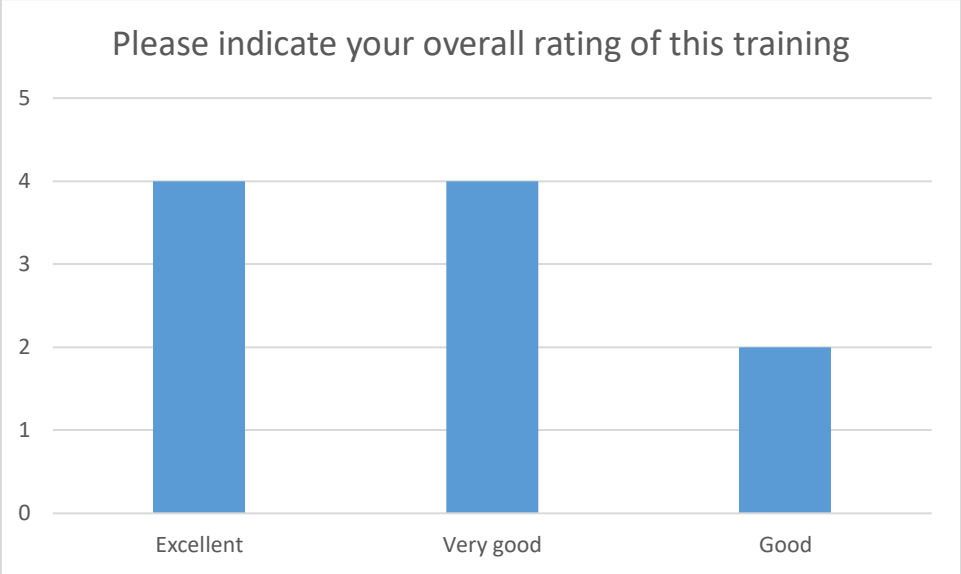
Figure 11

Ratings on Recommending QPR to Others

The second question asked participants for their overall rating of the QPR training. A 5-point scale ranging from 1 = "Poor" to 5 = "Excellent" was used in the response. As shown in Figure 12, participants chose either "excellent" (40%), "very good" (40%), or "good" (20%). The mean average score across the sample was 4.2 (*SD* = 0.71).

Figure 12

Overall QPR Rating



Throughout the weekend I took field notes as informal qualitative data. One purpose was to examine the feasibility of the GONA. For example, ten participants were recruited for the event, and each participant stayed for the duration of the event. In addition to the successful recruitment and retention of participants, there was a high level of engagement amongst participants. Many participants stated how thankful they were for the opportunity to learn about their culture in a safe environment. When I asked what a safe environment meant to them, they explained that learning in public schools often feels unsafe because of perceived racism. Examples included micro and macroaggressions from non-native peers and staff, staff relying on them as "native experts" in content areas such as history, and having subpar facilities, curriculum, and inexperienced staff as compared to schools with predominantly white populations. They explained that feeling safe meant having clean and well-kept facilities, content that was relevant and approachable, peers they could relate to, and staff who genuinely cared

about them. Some explained the sense of pride they felt learning about their people and their culture. Two participants talked about how they enjoyed learning about their culture from someone other than their family members. When I asked what they meant by this, they shared that although they respect their family, it was nice to "shake it up" and learn different perspectives from other tribal members.

Adequate resources and training, another component of feasibility, were also documented in my notes. Participants expressed relief over learning the QPR content, which included inputting local crisis lines into their phones. Multiple participants stated they had been with peers or adults in a time of crisis and did not know what to do. They indicated that after receiving the QPR training, they felt confident in knowing how to connect people in crisis with the help they need. Some participants voiced gratitude for having constant access to healthy food throughout the weekend. Finally, most participants expressed interest in participating in additional GONAs. Some mentioned the desire for longer events, such as five days. They shared that one full day and two half days were not enough time to learn and make connections with their peers. Some participants expressed interest in more frequent GONAs, while others would like GONAs with more than ten participants so they could attend with their friends and family.

4.1.2 Research Question 2: Did the Participants' Cultural Connectedness Increase After Participating in the GONA?

The KCCS included seven questions that examined participants' connection to their culture. For each question, a 5-point scale ranging from 1 = "Strongly disagree" to 5 = "Strongly agree" was used in the response. For the first question, as shown in Table 1, participants' pre- and posttest ratings on how their tribe's history, traditions, and customs had shaped them were

compared before and after the GONA. On average, participants scored lower before (M = 4.5, SD = 0.97) than after the GONA (M = 4.8, SD = 0.42). This improvement, 0.3, was not statistically significant $t(9) = -0.90$, $p = .394$, although a small-to-medium effect size was found ($g = 0.40$).

For the second question, participants' pre- and posttest ratings on sense of connectedness to their tribe were compared. On average, participants scored lower before (M = 4.4, SD = 0.70) than after the GONA (M = 4.8, SD = 0.42). This improvement, 0.4, was not statistically significant $t(9) = -1.81$, $p = .104$, although a medium effect size was found ($g = 0.69$).

Then for the third question, participants' pre- and posttest ratings on connection to their ancestors were compared. On average, participants scored lower before (M = 4.5, SD = 0.71) than after the GONA (M = 4.9, SD = 0.32). This improvement, 0.40, was not statistically significant $t(9) = -1.81$, $p = .104$, although a medium-to-large effect size was found ($g = 0.73$).

With respect to the fourth KCCS item, participants' pre- and posttest ratings on having talked to other people to learn more about being a member of my tribe. On average, participants scored the same before (M = 4.7, SD = 0.48) and after the GONA (M = 4.7, SD = 0.48); $t(9) = 0.00$, $p = 1.00$. Given the high baseline scores on this item (i.e., a ceiling effect), there was no meaningful change detected.

For the fifth question, participants' pre- and posttest ratings on learning more about being a member of their tribe were compared. On average, there was a ceiling effect at baseline (M = 5.0, SD = 0.00) that limited the ability to detect meaningful change.

For question six, participants' pre- and posttest ratings on learning more about their tribe's history, traditions, and customs were compared. On average, similar to the previous

question, there was a ceiling effect at baseline (M = 5.0, SD = 0.00) that limited the ability to detect meaningful change.

For question seven, participants' pre- and posttest ratings on listening to elders were compared. On average, similar to the previous two questions, there was a ceiling effect at baseline (M = 5.0, SD = 0.00) that limited the ability to detect meaningful change.

Finally, a total scale score was calculated for the KCCS. Because the internal consistency of the 7 items was not calculable given the lack of variability on two of the seven items, further item analysis was conducted to derive the KCCS scale score. From the remaining five items, an iterative process was used to identify the best set of items to be included in the scale score based on Cronbach's alpha. Because the Cronbach's alpha was less than .70 for both 5-item and 4-item scale scores, a 3-item scale score was calculated based on the mean of the first three KCCS items (Cronbach's alpha = .88). On average, participants scored lower before (M = 4.5, SD = 0.72) than after the GONA (M = 4.8, SD = 0.36). This improvement, 0.37, was not statistically significant $t(9) = -1.56$, $p = .154$, although a medium effect size was found (g = 0.58).

Table 1

Pre-Post Test Change on Cultural Connectedness Scale

Variable	*Pre-test* *M (SD)*	*Post-test* *M (SD)*	*t*	*p*	Hedge's *g*
I have a strong sense of how my tribe's history, traditions, and customs have shaped me	4.5 (.97)	4.8 (.42)	-0.90	.394	.40
I have a strong sense of belonging or connectedness to my tribe	4.4 (.70)	4.8 (.42)	-1.81	.104	.69
I feel a strong connection to my ancestors	4.5 (.71)	4.9 (.32)	-1.81	.104	.73
I have talked to other people to learn more about being a member of my tribe	4.7 (.48)	4.7 (.48)	-0.00	1.00	.00
I plan to spend time learning more about my tribe's history, traditions, and customs	5.0 (.00)	4.8 (.42)	1.50	.168	NC
When I learn something new about my tribal culture, I will ask someone more about it later	4.7 (.48)	4.7 (.48)	0.00	1.00	.00
If a leader or Elder spoke to me about being (my tribe), I would listen to them carefully	5.0 (.00)	5.0 (.00)	NC	NC	NC
KCCS scale score	4.5 (.72)	4.8 (.36)	1.56	.154	.58

Note. $N = 10$; M = mean; SD = standard deviation; NC = not calculable.

4.2 The QPR Survey

The QPR Survey aimed to capture pre- and posttest information on the suicide awareness of participants. The questionnaire consisted of three sets of questions examining self-perceived

knowledge regarding suicide awareness, self-efficacy about applying QPR skills, and attitudes regarding suicide, followed by two questions that examined the QPR training effectiveness. The survey was administered at the beginning and end of the QPR training. For this study, QPR pre and post-test scores were compared using paired sample t-tests. Hedges *g* was used to calculate effect size. Finally, a total mean scaled score was calculated.

4.2.1 Research Question 3: Did the Participants' Self-Perceived Knowledge Regarding Suicide Increase After the Training?

The QPR survey included seven questions that examined participants' self-perceived knowledge regarding suicide. For each question, a 5-point scale ranging from 1 = "Very low" to 5 = "Very high" was used in the response. For the first question, as shown in Table 2, participants' pre- and posttest ratings on self-perceived knowledge regarding facts about suicide prevention were compared. On average, participants scored lower before (M = 3.4, SD = 0.97) than after the QPR (M = 4.0, SD = 0.67). This improvement, 0.6, was not statistically significant $t(9) = -2.25$, $p = .051$, although a medium-to-large effect size was found (g = 0.72).

Next for question two, participants' pre- and post-test ratings on self-perceived knowledge regarding warning sides of suicide were compared. On average, participants scored lower before (M = 3.8, SD = 0.63) than after the QPR (M = 4.0, SD = 0.82). This improvement, 0.2, was not statistically significant $t(9) = -0.80$, $p = .443$, although a small effect size was found (g = 0.27).

Then for question three, participants' pre- and post-test ratings on self-perceived knowledge regarding persuading someone in crisis to get help were compared. On average, participants scored lower before (M = 3.8, SD = 0.92) than after the QPR (M = 4.2, SD = 0.63).

This improvement, 0.4, was not statistically significant $t(9) = -1.50$, $p = .168$, although a medium effect size was found ($g = 0.51$).

Additionally, for question four, participants' pre- and post-test ratings on self-perceived knowledge regarding how to get help for someone in crisis were compared. On average, participants scored lower before ($M = 3.4$, $SD = 1.27$) than after the QPR ($M = 4.1$, $SD = 0.74$). This improvement, 0.7, was not statistically significant $t(9) = -1.77$, $p = .111$, although a medium effect size was found ($g = 0.68$).

Moreover, for the fifth question, participants' pre- and post-test ratings on self-perceived knowledge regarding information about local resources were compared. On average, participants scored lower before ($M = 2.8$, $SD = 1.34$) than after the QPR ($M = 4.1$, $SD = 0.57$). This improvement, 1.3, was statistically significant $t(9) = -3.88$, $p = .004$, and a large effect size was found ($g = 1.45$).

Further, for question six, participants' pre- and post-test ratings on self-perceived knowledge regarding suicide and suicide prevention were compared. On average, participants scored the same before ($M = 4.1$, $SD = 0.57$) and after the QPR ($M = 4.1$, $SD = 0.57$). This was not statistically significant $t(9) = -0.00$, $p = 1.000$, and no meaningful effect was found ($g = 0.00$).

For question seven, participants' pre- and post-test ratings on self-perceived knowledge regarding how to ask if someone is considering suicide were compared. On average, participants scored lower before ($M = 3.2$, $SD = 0.79$) than after the QPR ($M = 4.1$, $SD = 0.57$). This improvement, 0.9, was statistically significant $t(9) = -3.86$, $p = .004$, and a large effect size was found ($g = 1.31$).

Finally, a total mean scaled score for the pretest (M = 3.5, SD = .90) and posttest (M = 4.1, SD = .68) was calculated. This improvement, 0.6, was statistically significant t(9) = -2.77, p = .022, and a medium-to-large effect size was found (g = 0.70).

Table 2

Pre-Post Test Change on QPR Scale: Self-Perceived Knowledge Regarding Suicide Awareness

Variable	*Pre-test*	*Post-test*			
	M (SD)	*M (SD)*	*t*	*p*	Hedge's *g*
Facts concerning suicide prevention	3.4 (.97)	4.0 (.67)	-2.25	.051	0.72
Warning signs of suicide	3.8 (.63)	4.0 (.82)	-0.80	.443	0.27
Persuading someone to get help	3.8 (.92)	4.2 (.63)	-1.50	.168	0.51
How to get help for someone	3.4 (1.27)	4.1 (.74)	-1.77	.111	0.68
Information about local resources for help with suicide	2.8 (1.34)	4.1 (.57)	-3.88	.004	1.45
Understanding about suicide and suicide prevention	4.1 (.57)	4.1 (.74)	0.00	1.000	0.00
How to ask about suicide	3.2 (.79)	4.1 (.57)	-3.86	.004	1.31
Total scaled score	3.5 (.90)	4.1 (.68)	-2.77	.022	0.70

Note. N = 10; M = mean; SD = standard deviation.

4.2.2 Research Question 4: Did the Participants' Self-Efficacy About Applying the QPR Skills Increase After the Training?

The QPR survey also included eight questions that examined participants' self-efficacy about applying QPR skills. For each question, a 5-point scale ranging from 1 = "Not at all

confident" to 5 = "Very confident" was used in the response. For question one, as shown in Table 3, participants' pre- and posttest ratings on self-efficacy about identifying signs and symptoms of mental health distress in others were compared. On average, participants scored lower before (M = 3.0, SD = 0.82) than after the QPR (M = 3.9, SD = 0.88). This improvement, 0.9, was not statistically significant $t(9) = -2.21$, $p = .054$, although a large effect size was found ($g = 1.06$).

Next for question two, participants' pre- and post-test ratings on self-efficacy about providing support without being judgmental or giving advice were compared. On average, participants scored lower before (M = 3.8, SD = 1.03) than after the QPR (M = 3.9, SD = 0.88). This improvement, 0.1, was not statistically significant $t(9) = -0.20$, $p = .840$, with a small effect size. No meaningful effect was found ($g = 0.10$).

Then for question three, participants' pre- and post-test ratings on self-efficacy about addressing misinformation and educating others about suicide were compared. On average, participants scored lower before (M = 3.5, SD = 0.85) than after the QPR (M = 3.8, SD = 0.63). This improvement, 0.3, was not statistically significant $t(9) = -1.15$, $p = .279$, although a small-to-medium effect size was found ($g = 0.40$).

Also, for the fourth question, participants' pre- and post-test ratings on self-efficacy about asking someone they know well if they are thinking of suicide were compared. On average, participants scored lower before (M = 3.5, SD = 0.85) than after the QPR (M = 4.1, SD = 0.74). This improvement, 0.6, was not statistically significant $t(9) = -2.25$, $p = .051$, although a medium-to-large effect size was found ($g = 0.75$).

Further for question five, participants' pre- and post-test ratings on self-efficacy about asking someone they do not know if they are thinking of suicide were compared. On average,

participants scored lower before (M = 2.7, SD = 1.06) than after the QPR (M = 3.7, SD = 1.06). This improvement, 1.0, was statistically significant $t(9) = -2.53$, $p = .032$, and a large effect size was found ($g = 0.94$).

Additionally, for question six, participants' pre- and post-test ratings on self-efficacy about being prepared with the necessary contacts for mental health services were compared. On average, participants scored lower before (M = 2.9, SD = 0.88) than after the QPR (M = 4.2, SD = 0.63). This improvement, 1.3, was statistically significant $t(9) = -3.88$, $p = .004$, and a large effect size was found ($g = 1.70$).

Again, for question seven, participants' pre- and post-test ratings on self-efficacy collaborating with a person of concern to determine what type of help they will accept were compared. On average, participants scored lower before (M = 3.1, SD = 0.88) than after the QPR (M = 3.8, SD = 0.79). This improvement, 0.7, was statistically significant $t(9) = -2.69$, $p = .025$, and a large effect size was found ($g = 0.84$).

Moreover, for the eighth question, participants' pre- and post-test ratings on being present and supportive when connecting with others' pain and intense emotion were compared. On average, participants scored lower before (M = 3.1, SD = 0.99) than after the QPR (M = 4.2, SD = 0.63). This improvement, 1.1, was statistically significant $t(9) = -3.16$, $p = .012$, and a large effect size was found ($g = 1.32$).

Finally, a total mean scaled score for the pretest (M = 3.5, SD = .92) and posttest (M = 4.0, SD = .78) was calculated. This improvement, 0.5, was statistically significant $t(9) = -2.714$, $p = .024$, and a large effect size was found ($g = 0.85$).

Table 3

Pre-Post Test Change on QPR Scale: Self-Efficacy About Applying QPR Skills

Variable	*Pre-test* *M (SD)*	*Post-test* *M (SD)*	*t*	*p*	Hedge's *g*
Identify signs and symptoms of mental health distress in others	3.0 (.82)	3.9 (.88)	-2.21	.054	1.06
Provide support without judging or giving advice	3.8 (1.03)	3.9 (.88)	-0.20	.840	0.10
Address misinformation and educate others about suicide	3.5 (.85)	3.8 (.63)	-1.15	.279	0.40
Ask someone you know well if they are thinking of suicide	3.5 (.85)	4.1 (.74)	-2.25	.051	0.75
Ask someone you do NOT know if they are thinking of suicide	2.7 (1.06)	3.7 (1.06)	-2.53	.032	0.94
Be prepared with the necessary phone numbers and contacts for mental health services	2.9 (.88)	4.2 (.63)	-3.88	.004	1.70
Collaborate with a person of concern to determine what type of help they will accept	3.1 (.88)	3.8 (.79)	-2.69	.025	0.84
Be present and supportive when connecting with others' pain and intense emotion	3.1 (.99)	4.2 (.63)	-3.16	.012	1.32
Total scaled score	3.2 (.92)	4.0 (.78)	-2.714	.024	0.85

Note. $N = 10$; M = mean; SD = standard deviation.

4.3 Summary

The KCCS and QPR acceptability items examined the effectiveness of the GONA model. Results indicate that the event was both feasible and acceptable to the participants. The posttest

revealed that all participants reported high overall satisfaction and would recommend the training GONA and QPR to others.

The KCCS examined participants' changes in cultural connectedness over a weekend-long GONA event. Although the paired sample t-tests did not show significance due to the small sample size, results indicate that while participants came in with a high level of cultural connectedness, there was still growth with a medium-to-large effect size on the following items: having a sense of how their tribal history, traditions, and culture have shaped them (g = .40), having a sense of connectedness to their tribe (g = .60), and feeling a strong connection to their ancestors (g = .73), as well as the KCCS scale score (g = .58)

The first set of QPR items examined participants' self-perceived knowledge regarding suicide. Paired sample t-tests showed significance, on the following two items: information about local resources for help with suicide (p = .004), and how to ask about suicide (p = .004). Hedges' g showed medium-to-large effects on most items. Results show meaningful effect sizes in most areas including facts about suicide prevention, warning signs of suicide, persuading someone to get help, how to get help for someone, and information about local resources, and how to ask about suicide.

The second set of QPR items examined participants' self-efficacy about applying QPR skills. The paired sample t-tests showed significance on the following items: ask someone you know well if they are thinking of suicide (p = .032); be prepared with the necessary phone numbers and contacts for mental health services (p = .004); collaborate with a person of concern to determine what type of help they will accept (p = .025), and be present and supportive when connecting with others' intense pain (p = .012). Hedges' g showed medium-to-large effects on most items. The QPR training had medium to large effects in most areas of participants' self-

efficacy skills including identifying signs and symptoms of mental health distress in others, asking someone they know if they are thinking of suicide, asking someone they do not know if they are thinking of suicide, being prepared with the necessary contacts for mental health services, collaborating with a person of concern to determine what type of help they will accept, and being present and supportive with others' pain and intense emotion.

Overall, the results of each group of analyses show favorable results. Participants reported that the GONA model is favorable and worth recommending to others. Additionally, participants showed an increase in cultural connectedness, knowledge regarding suicide, and self-efficacy about applying QPR skills. The results of these analyses are very valuable in terms of providing valuable support that can be used as part of the RPP to evaluate the effectiveness of training and interventions, and to highlight opportunities for future improvement.

CHAPTER V: DISCUSSION

In the fifth and final chapter, the secondary analysis of the Klamath Cultural Connectedness Scale (KCCS) and the Question, Persuade, Refer (QPR) survey will be discussed. The results of each survey will be examined in relation to previous research and theory. Next, the limitations of the present study will be stated, and then implications for future research will be considered. In addition, the research-practice partnership's (RPP) future work plans will be shared. Finally, the chapter will conclude with a brief conclusion.

5.1 The Results in Relation to Previous Research and Theory

The present study was one of many projects completed within the RPP between the University of Oregon Suicide Prevention Lab and the Klamath Tribes Youth and Family Guidance Center Prevention Department. It is the research component of the Klamath Tribal Youth GONA, which was held to increase participants' cultural connectedness and knowledge and self-efficacy skills regarding suicide prevention. GONAs are cultural-based interventions that provide culturally appropriate ways of understanding wellness. QPR as a gatekeeper training that aims to teach participants how to recognize a person in crisis and the warning signs that someone may be contemplating suicide. Although QPR is not cultural-based, the RPP sought to make the training acceptable by nesting it within the GONA.

Specifically, the present study was a secondary analysis of data collected at the GONA. The KCCS aimed to measure increases in participant cultural connectedness and was given before and after the weekend-long GONA. The QPR survey measured participants' knowledge and self-efficacy of suicide prevention, which was administered before and after the QPR

training. The following sections will discuss the results of the analysis in relation to previous research and theory; and are organized by research questions of the present study.

5.1.1 Was the GONA Model Feasible and Acceptable to the Participants?

The first research question asked if the GONA model was feasible and acceptable to the participants. This includes the GONA overall as well as the QPR training that was embedded within the GONA. Overall, the results of the Klamath Cultural Connectedness Scale and QPR survey show high acceptability of the GONA and the embedded QPR training. For example, participants reported high satisfaction with the GONA and QPR. Further, most participants would recommend the GONA and QPR to others. Detailed field notes documented the feasibility of the GONA. This included the successful recruitment and retention of participants, a high level of engagement, and adequate resources and training for implementation. In this way, the GONA framework may be considered a promising tribal practice for promoting culture and increasing suicide prevention knowledge and self-efficacy for Klamath Tribal youth. The results suggest that blending cultural events with evidence-based suicide prevention practices could also be an effective approach to youth suicide prevention for other Indigenous communities.

A core tenet of the GONA is that when participants do healing work for themselves, bringing balance to their self, family, and community, they also help to heal their ancestors and future generations (Duran, 2019). Healing begins to happen when youth know who they are and where they come from (Ullrich, 2020). In this way, the GONA framework could also be recognized as a pathway of intergenerational healing through connectedness to ancestral knowledge, culture, mind, body, spirit, and to each other.

5.1.2 Did the Participants' Cultural Connectedness Increase After Participating in the GONA?

The second research question of the present study examined if participants' cultural connectedness increased after participating in the GONA. The results confirm that overall, participants' cultural connectedness did increase. Specifically, the analysis showed that there were post-GONA increases in participants' sense of belongingness and connection to their tribe and their ancestors.

Connectedness is particularly relevant in youth suicide prevention because it is the opposite of thwarted belongingness, which is one of the main psychological antecedents of suicide identified in the interpersonal-psychological theory of suicide (IPTS; Joiner, 2004; Van Orden et al., 2010). Thwarted belongingness is characterized by loneliness and the absence of reciprocal care, both of which are addressed by improving the individual's connectedness with others. Moreover, it has also been found that connectedness is also negatively associated with the other main psychological antecedent of suicide, perceived burdensomeness (Opperman et al., 2015). The IPTS holds that when a person simultaneously experiences thwarted belongingness and perceived burdensomeness, they will develop the desire for death. Increasing connectedness diminishes thwarted belongingness and perceived burdensomeness, thereby reducing the desire for death and the likelihood of suicidal behavior.

Connectedness to culture specifically can also play a major role in youth suicide prevention, particularly in the American Indian and Alaska Native (AI/AN) communities (Wexler et al., 2022). Past research has shown that a holistic sense of connectedness to family, community, ancestors, spirituality, and culture serves as a protective factor against suicide for AI/AN youth (Alcantara & Gone, 2007; Allen et al., 2014a; Chino & Fullerton-Gleason, 2006;

Hazel & Mohatt, 2001; Mohatt et al., 2011; Whitlock et al., 2014). Further, youth connectedness to family, community, and spiritual connectedness may contribute to a synergistic outcome of collective well-being (Ullrich, 2019). In this way, helping to cultivate a strong cultural identity may also help to reduce the risk of AI/AN youth suicidal behaviors.

For these reasons, it can be expected that the youth GONA may help to reduce the risk of youth suicide, through the mediating pathway of increasing cultural connectedness. Indeed, the GONA framework is grounded in connectedness, helping participants to instill an overall sense of belonging and restore balance to the self, family, and community (Duran, 2019). The analysis shows that these ambitions are met, and provides support for the suitability of the GONA as part of a youth suicide prevention strategy for AI/AN groups.

5.1.3 Did the Participants' Self-Perceived Knowledge and Self-Efficacy Regarding Suicide Increase after the Training?

The third research question examined if participants' self-perceived knowledge regarding suicide increased after the QPR training. QPR is a gatekeeper training that targets the domains of knowledge and self-efficacy toward suicide prevention. This program seeks to increase an individual's willingness and comfort of intervening with individuals who appear at risk for suicide by referring them to a mental health professional. Increasing knowledge is a core component of gatekeeper training (Hagwood et al., 2021). Overall, the analysis showed that there was a marked increase in participants' knowledge regarding suicide. Participants reported meaningful increases in knowledge about facts concerning suicide prevention, warning signs of suicide, persuading someone in crisis to get help, and how to get help for someone in crisis.

Further, participants reported the largest increase in knowledge about information regarding local suicide prevention resources and how to ask someone about suicide.

Burnette and colleagues (2015) developed a theoretical model that describes gatekeeper training competencies (i.e., knowledge and self-efficacy) and the pathways that lead to changes in suicide intervention behavior. They found that the intervention actions of gatekeepers, such as discussion of mental health concerns and suicidality, and referral to mental health services are considered to be a main mechanism for the reduction of suicidal behavior within a community (Burnette et al., 2015). However, little research exists on whether the effects of gatekeeper training are maintained over the long term (Holmes et al., 2021).

Research question four asked if participants' self-efficacy about applying QPR skills increased after the training. Self-efficacy refers to a gatekeeper's comfortability and confidence to intervene with an individual experiencing suicidal thoughts (Burnette et al., 2015). Participants reported an increase on all items, with the largest increases in identifying signs and symptoms of mental health distress in others, asking someone they do not know if they are thinking of suicide, being prepared with the necessary phone numbers and contacts for mental health services and being present and supportive when connecting with other's pain and intense emotion.

A recent systematic review of 16 studies found that self-efficacy may be the most long-lasting outcome of gatekeeper training (Holmes et al., 2021). Holmes and colleagues (2015) found that each study reported an increase in self-efficacy at post-training measurement, and most studies reported that self-efficacy was maintained above baseline levels at follow-up time points.

The present study has shown that nesting QPR within a GONA is feasible and acceptable and that participants' knowledge and self-efficacy skills increased after participating in the training. Future research may consider follow-up interviews at multiple time points to examine the long-term efficacy of QPR as well as the impact on suicide intervention behaviors.

5.1.4 Summary

The literature review in Chapter 2 discussed the importance of blending Western approaches with traditional ways of knowing when implementing youth suicide prevention initiatives. While Western medicine focuses on pathology, sickness, and how traumatic events effect an individual's mental and physical state of being, in many AI/AN worldviews, healthy human development is achieved with harmonious mind-body-spirit connections (Duran, 2019). Because suicide is deeply connected to local, historical and relational contexts, effective suicide prevention initiatives must consider evidence-based practices, while adapting for the unique needs of tribal communities (Wexler et al., 2022).

The results of the analysis provide support that the youth GONA successfully blended Western and Indigenous ways of knowing, serving as an effective youth suicide prevention initiative for the Klamath Tribes. Further, participants' cultural connectedness increased after attending the GONA. The present study also provide support that QPR, which was nested within the GONA, was feasible, acceptable, and successfully increased participants' knowledge and self-efficacy about suicide prevention and intervention. The formation of the RPP, which brought together university scholars, tribal agencies, schools, mental health practitioners, and community members, was critical for bridging the understanding between these two ways of knowing and developing an effective intervention (Wexler et al., 2022). Indeed, it is recognized

that research that is done by and for the community can contribute to healing (Duran, 2019), and the RPP helped to facilitate this process.

5.2 Limitations

This section describes limitations that may have affected this study, how these were mitigated where possible, and what impact they may have in the interpretation and use of the data. In particular, it considers the impact of the coronavirus (COVID-19) pandemic, sampling limitations, and potential measurement issues.

5.2.1 The Impact of COVID-19

The foremost limitation of the study was the impact that the ongoing COVID-19 pandemic had on recruitment and the timing of the event. The study was originally intended to take place in July 2021 while participants were on summer break. However, the GONA had to be rescheduled multiple times because of COVID restrictions and COVID-related occurrences within the community (e.g., staff turnover, grief, and loss). It took place in October 2021 instead, meaning that it was more difficult to recruit participants as they were no longer on summer break. Additionally, the event was limited to 10 participants because of the COVID protocol for tribal-sponsored in-person events. As a result, the study had a small sample size that was underpowered to detect clinically meaningful effects. This limitation is discussed in more detail in the following section.

In addition, postponing the event until October condensed the timeline for completing follow-up interviews and the boy's GONA. The work of the RPP had a fixed-end point for the research due to funding. If additional time were available, the RPP would have hosted the boy's

GONA and conducted 6-month and 12-month follow-up interviews. Follow-up interviews may have provided more youth voice and richer qualitative data. Future plans for the RPP include 12-month GONA follow-up interviews, and hosting a boy's GONA.

5.2.2 Sampling Limitations

The small sample for this study (N = 10) was under-powered to detect clinically meaningful effects . Due to the low sample size, I cannot rule out the possibility that the findings emerged due to chance, so the results are interpreted as tentative early findings which will need to be confirmed in future research. While feasibility and acceptability of the approach was established, further validation with an adequately powered study and a larger sample size is needed to establish the efficacy of this approach.

Other sampling limitations concern sampling bias and the impact it has on the generalizability of the research findings. The GONA used open recruitment and was limited to tribal youth who identify as female. The finding that participants reported high levels of baseline cultural connectedness suggests that there may have been self-selection bias, with the sample limited to youth who were already engaged with the tribal community. Furthermore, it should also be noted that the results are specific to Klamath Tribal youth residing within Klamath County and that the results may not necessarily generalize to other AI/AN communities and other Indigenous groups worldwide.

For these reasons, caution should be taken not to over-generalize the findings beyond the sample. Future researchers and practitioners may consider drawing a larger sample size, purposefully recruiting youth who are less culturally connected, and holding GONAs that are not gender-specific.

5.2.3 Measurement Limitations

Other limitations to the present study concern measurement. Each survey consisted of self-reported data, which raises concerns about the validity of participant responses. The scale items on each assessment were on a 5-point Likert scale, and answers to the questions were chosen subjectively, based on participants' self-perception. Additionally, social desirability bias may have affected the accuracy of participants' responses. For example, I've known many participants since they were infants. The participants may have responded to questions in a manner that would be viewed favorably by myself or other facilitators.

In addition, four of the seven items on the KCCS were subject to ceiling effects. In particular, the results showed that many participants arrived at the GONA with a high level of cultural connectedness, meaning that any further improvements in cultural connectedness were difficult to detect through the analysis (although there were still small improvements evident in the post-intervention data). Larger overall sample sizes and purposefully recruiting a more diverse range of participants (e.g., seeking out participants who are more likely to have low cultural connectedness) would be an effective way to address this limitation in future research.

Finally, some KCCS items were not practical for measuring pre-post gains during a weekend-long event. For example, one question asked participants if they had talked to other people to learn more about being a member of their tribe. It is unlikely that participants would have the opportunity to talk to someone about their tribe and report a meaningful change in two days. Future researchers and practitioners should consider revising the KCCS, including more objective items and items that are sensitive to change over time (e.g., testing knowledge).

While there are limitations, self-reported data are still a valuable way of measuring psychological phenomena. In the future, it would be most useful to combine self-reported data with objective data (e.g., skill application), where possible, for the most holistic understanding of intervention effectiveness.

5.3 Implications for Future Research and Practice

The results of this study provide opportunities for improving youth suicide prevention initiatives in Klamath County. Overall, the results indicate that participants' cultural connectedness and knowledge, and self-efficacy skills about suicide increased after attending the GONA. The following sections will first describe future directions for research and then future directions for practice. Finally, future work with the RPP will be reviewed.

5.3.1 Future Research

Sample Size. This event was limited to 10 tribal youth. In the future, researchers and practitioners may consider drawing a larger sample size of participants to increase the power of the study. This may include larger samples of AI/AN youth, but may also be extended to other groups as well (e.g., non-natives, school and district staff, LQBTQ+, and families). Other settings may also be considered (e.g., healthcare and schools). Drawing a larger sample size from other groups would provide the opportunity to test whether the same approach used here could be used to blend Western and Indigenous knowledge for other communities. In addition, continuing to sample more of the population during repeated GONAs should be considered. Further, recruitment based on gender may exclude two-spirit or non-binary youth. When

considering recruitment for future events, it is important to consider inclusivity and gender-based recruitment in consultation with an RPP and tribal elders.

Measurement. Results demonstrate the need to refine the KCCS, such as increasing the sensitivity of measures to change. Researchers and practitioners may consider eliminating redundant or poorly functioning items that measure the same level of the latent construct, as these can increase measurement error and reduce power in detecting true prevention effects (Fok & Henry, 2015). The item response theory model (IRT) can be used to detect redundant and poorly functioning items (Samejima, 1969). In addition, consider including items that measure the full range of the latent construct being measured. Item response theory analysis can assist with this, which will make it possible to detect change regardless of where in the latent construct it occurs (Fok & Henry, 2015).

Experimental design. In addition, more rigorous experimental designs are needed to establish the youth GONA as an evidence-based practice, including randomized controlled trials including comparative effectiveness designs or staggered implementation designs (e.g., stepped wedge designs). Without controlled experimentation, such as the current quasi-experimental study, the causal associations cannot be firmly established

5.3.2 Future Practice

Future Youth Suicide Prevention Initiatives. The RPP was integral for setting up the GONA and conducting the present study. It is important to consider the implications of the present research in terms of recommendations for future RPPs in the context of suicide prevention. Most notably, results from the present research indicate that the GONA and QPR were feasible and acceptable. Future practice may consider building on this model to further

advance the suicide prevention work within Klamath Tribes, in Klamath County, and in other AI/AN communities. This may include leveraging strength-based approaches to suicide prevention. For example, RPPs may promote culture as prevention and utilize strength-based activities to promote cultural connectedness. RPPs may also consider follow-up GONAs with the same sample, and more frequent GONAs with larger sample sizes and demographics (e.g., boys, all-inclusive, LGBTQ+, non-natives, families). Additionally, RPPs may consider other settings for GONAs. Schools provide a setting where students spend most of their week and are a natural entry point to reaching larger audiences of youth. One thing to consider with school settings is the wretched past of boarding schools and the distrust for educational institutions. However, healing the wounds of boarding schools may be addressed within the GONA curriculum.

Other RPPs may adopt a similar approach to implementing effective youth suicide prevention initiatives by tailoring interventions to the needs, priorities, culture, and available resources for their specific context. It is important to customize the program to fit the community's culture (Wexler et al., 2022). Initial steps may include identifying a target audience, refining the KCCS, and determining local tribal history and culture to be shared within the GONA framework. The planning process should engage many voices and diverse expertise to foster trusting relationships and ongoing engagement (Wexler et al., 2022). Further, RPPs may consider incorporating youth voice in the development and evaluation work. For example, formative interviews or focus groups with the youth may provide richer qualitative data on the acceptability of the GONA and themes regarding cultural connectedness. In addition, members of the Tribal Youth Council or youth leadership could be part of the development and planning work.

Cultural Competence of the QPR Training. The KCCS (the GONA pre-post survey) and QPR Survey showed high overall acceptability ratings. However, the GONA acceptability was slightly higher than the QPR, likely because the GONA was more culturally acceptable to the participants. In the future, researchers and practitioners may consider improving the cultural adaptations of the QPR training material. For example, videos and graphics in the QPR training were dated and unrelatable. Updated PowerPoints, videos, and handouts would be ideal and have higher acceptability for tribal youth.

Data Sovereignty. As sovereign nations, tribes should have the authority to govern the collection, ownership, and application of their data. This refers to all data gathered by the tribal nation themselves or by any other external data agents. For future studies, researchers and practitioners may consider explicit conversations about data storage and ownership. Further, the Klamath Tribes, as well as many other tribal nations, do not have an IRB or formal research approval process. For the benefit and protection of the people, tribes may consider developing procedures and protocols for research requests.

5.4 Concluding Comments

The present study contributed towards the purpose of reducing the prevalence of youth suicide within Klamath County. It was conducted as part of the RPP which included specialists from UO Suicide Prevention Lab, community members, and practitioners from the Klamath County Suicide Prevention Coalition, and contributed to a body of research and practice. Specifically, the present study consisted of a secondary analysis of the Klamath Cultural Connectedness Survey and the QPR Survey. The results provide support that GONAs are feasible and acceptable, and were associated with increases in participants' cultural

connectedness. Results also indicate that QPR trainings, when embedded within GONAs, are feasible and acceptable, and were associated with increases participants' knowledge and self-efficacy skills around suicide prevention. In this way, it can be expected that the Klamath Tribal youth GONA helped to reduce the risk of youth suicide, through the mediating pathway of increasing cultural connectedness, and by increasing gatekeeper intervention behaviors. It is our hope that the RPP will play a crucial role in reducing the prevalence of youth suicidality in Klamath County so that fewer families and communities will be affected by losing a child in this way.

APPENDIX A

Youth GONA Pre-Training Survey

Thank you for participating in the Teen Girls Retreat GONA! As a part of this retreat, the Klamath Tribal Health Youth & Family Guidance Center wants to learn more about how future programs can serve Indigenous youth. To that extent, we are asking you to complete a brief survey both before and after the retreat, so we can learn how to improve the next one.

We are asking you to do this because you have insights and opinions that matter to our organization in promoting the success of Indigenous youth. It is extremely important to us that youth voices are accounted for and heard.

Please understand that all information shared with us is confidential and your personal identity and responses will not be shared with anyone. You can skip any questions that you do not wish to answer. If you have any questions, you can reach out to:

NICOLE BARNEY(she/her/hers)
DOCTORAL CANDIDATE SPECIAL EDUCATION AND CLINICAL SCIENCES
COLLEGE OF EDUCATION, UNIVERSITY OF OREGON
nbarney@uoregon.edu
(541) 880-6207

Q1 **Please enter the last 4 digits of your cellphone number.** This will only be used to link your pre- and post-training surveys.

Q2 **Please enter the year you were born.** This will only be used to link your pre- and post-training surveys.
Birth year (1)

▼ 2012 (1) ... 1940 (73)

Q3 **Have you attended a Gathering of Native Americans (GONA) in the past two years?**

- ○ Yes (1)
- ○ No (2)

Q4 **Please rate your level of agreement with the following statement:** (Select one for each)

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have a strong sense of how my tribe's history, traditions, and customs have shaped me. (6)	○	○	○	○	○
I have a strong sense of belonging or connectedness to my (tribe) community or Nation. (7)	○	○	○	○	○
I feel a strong connection to my ancestors. (8)	○	○	○	○	○
I have talked to other people to learn more about being a member of my (tribe) community or Nation. (9)	○	○	○	○	○
I plan to spend time learning more about my (tribe) community's history, traditions, and customs. (10)	○	○	○	○	○

When I learn something new about my (tribal culture), I will ask someone more about it later. (11)	○	○	○	○	○
If a leader or Elder spoke to me about being (my tribe), I would listen to them carefully. (12)	○	○	○	○	○

APPENDIX B

Youth GONA Post-Training Survey

Thank you for participating in the Teen Girls Retreat GONA! As a part of this retreat, the Klamath Tribal Health Youth & Family Guidance Center wants to learn more about how future programs can serve Indigenous youth. To that extent, we are asking you to complete a brief survey both before and after the retreat, so we can learn how to improve the next one.

We are asking you to do this because you have insights and opinions that matter to our organization in promoting the success of Indigenous youth. It is extremely important to us that youth voices are accounted for and heard.

Please understand that all information shared with us is confidential and your personal identity and responses will not be shared with anyone. You can skip any questions that you do not wish to answer. If you have any questions, you can reach out to:

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Q1 **Please enter the last 4 digits of your cellphone number.** This will only be used to link your pre- and post-training surveys.

Q2 **Please enter the year you were born.** This will only be used to link your pre- and post-training surveys.
Birth year (1)

▼ 2012 (1) ... 1940 (73)

Q3 **Please rate your level of agreement with the following statement:** (Select one for each)

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have a strong sense of how my tribe's history, traditions, and customs have shaped me. (6)	○	○	○	○	○
I have a strong sense of belonging or connectedness to my (tribe) community or Nation. (7)	○	○	○	○	○
I feel a strong connection to my ancestors. (8)	○	○	○	○	○
I have talked to other people to learn more about being a member of my (tribe) community or Nation. (9)	○	○	○	○	○
I plan to spend time learning more about my (tribe) community's history, traditions, and customs. (10)	○	○	○	○	○

When I learn something new about my (tribal culture), I will ask someone more about it later. (11)	○	○	○	○	○
If a leader or Elder spoke to me about being (my tribe), I would listen to them carefully. (12)	○	○	○	○	○

Q4 **Please indicate your overall rating of this training.**

- ○ Excellent (1)
- ○ Very good (2)
- ○ Good (4)
- ○ Fair (5)
- ○ Poor (6)

Q5 **Would you recommend this training to others?**

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably no (4)
- ○ Definitely no (5)

Q6 **Please provide any additional comments about the training.**

APPENDIX C

GONA QPR Gatekeeper Pre-Training Survey

Lines for Life, in collaboration with the University of Oregon, is evaluating the QPR (Question, Persuade, Refer) gatekeeper training by asking participants to complete a short survey before and after the training. The intent of this survey is to collect information that will assist the quality improvement of the program. Your participation is voluntary, and all of your responses will be kept confidential. We appreciate your participation and cooperation.

Please enter the last 4 digits of your cellphone number. This will only be used to link your pre- and post-training surveys.*

_____

Please enter the year you were born. This will only be used to link your pre- and post-training surveys.*
Birth year (4)

▼ 2012 (1) ... 1940 (73)

Which ethnicity do you most identify with? (Check all that apply)

- ☐ Hispanic and LatinX (1)
- ☐ Native Hawaiian and Pacific Islander (2)
- ☐ Middle Eastern and North African (3)
- ☐ White (4)
- ☐ American Indian and Alaska Native (5)
- ☐ African American or Black (6)
- ☐ Asian (7)
- ☐ Prefer not to answer (9)
- ☐ Other (please describe): (8) _____

Display This Question:

If Which ethnicity do you most identify with? (Check all that apply) = American Indian and Alaska Native

What Tribes/Nations are you from?

_____

What is your age?
Age (4)

▼ 11 (1) ... Over 65 (13)

How would you identify yourself?

- ○ Male (1)
- ○ Female (2)
- ○ Transgender male (3)
- ○ Transgender female (4)
- ○ Gender Variant/Non-Conforming (5)
- ○ Prefer Not to Answer (6)

How would you rate your knowledge of the following topics? (Select one for each)

	Very low Knowledge (1)	Low Knowledge (2)	Medium knowledge (3)	High knowledge (4)	Very high Knowledge (5)
Facts concerning suicide prevention (know1_1)	○	○	○	○	○
Warning signs of suicide (know1_2)	○	○	○	○	○
Persuading someone to get help (know1_3)	○	○	○	○	○
How to get help for someone (know1_4)	○	○	○	○	○
Information about local resources for help with suicide (know1_5)	○	○	○	○	○
Understanding about suicide and suicide prevention (know1_6)	○	○	○	○	○
How to ask about suicide (know1_7)	○	○	○	○	○

Please rate how confident you are in regard to the following skills or abilities commonly used to support mental wellness and prevent suicide. (Select one for each)

	Not at all confident (1)	A little confident (2)	Somewhat confident (3)	Confident (4)	Very Confident (5)
Identify signs and symptoms of mental health distress in others (1)	○	○	○	○	○
Provide support without judging or giving advice (2)	○	○	○	○	○
Address misinformation and educate others about suicide (3)	○	○	○	○	○
Ask someone you know well if they are thinking of suicide (4)	○	○	○	○	○
Ask someone you do NOT know if they are thinking of suicide (5)	○	○	○	○	○
Be prepared with the necessary phone numbers and contacts for mental health services (6)	○	○	○	○	○

Collaborate with a person of concern to determine what type of help they will accept (7)	○	○	○	○	○
Be present and supportive when connecting with others' pain and intense emotion (8)	○	○	○	○	○

Support Services

If you need emotional support or are in crisis, please contact:

National Suicide Prevention Lifeline: 1-800-273-8255

Klamath Basin Behavioral Health: 541-883-1030

Text **NATIVE** to 741741

Klamath Tribal Health and Family Guidance Center: 541-882-1487

APPENDIX D

GONA QPR Gatekeeper Post-Training Survey

Lines for Life, in collaboration with the University of Oregon, is evaluating the QPR (Question, Persuade, Refer) gatekeeper training by asking participants to complete a short survey before and after the training. The intent of this survey is to collect information that will assist the quality improvement of the program. Your participation is voluntary, and all of your responses will be kept confidential. We appreciate your participation and cooperation.

Please enter the last 4 digits of your cellphone number. This will only be used to link your pre- and post-training surveys.

Please enter the year you were born. This will only be used to link your pre- and post-training surveys.
Birth year (4)

▼ 2012 (1) ... 1940 (73)

How would you rate your knowledge of the following topics? (Select one for each):

	Very low Knowledge (1)	Low Knowledge (2)	Medium knowledge (3)	High knowledge (4)	Very high Knowledge (5)
Facts concerning suicide prevention (know2_1)	○	○	○	○	○
Warning signs of suicide (know2_2)	○	○	○	○	○
Persuading someone to get help (know2_3)	○	○	○	○	○
How to get help for someone (know2_4)	○	○	○	○	○
Information about local resources for help with suicide (know2_5)	○	○	○	○	○
Understanding about suicide and suicide prevention (know2_6)	○	○	○	○	○
How to ask about suicide (know2_7)	○	○	○	○	○

Please rate how confident you are in regard to the following skills or abilities that are commonly used to support mental wellness and prevent suicide. (Select one for each):

	Not at all confident (1)	A little confident (2)	Somewhat confident (3)	Confident (4)	Very Confident (5)
Identify signs and symptoms of mental health distress in others (1)	○	○	○	○	○
Provide support without judging or giving advice (2)	○	○	○	○	○
Address misinformation and educate others about suicide (3)	○	○	○	○	○
Ask someone you know well if they are thinking of suicide (4)	○	○	○	○	○
Ask someone you do NOT know if they are thinking of suicide (5)	○	○	○	○	○
Be prepared with the necessary phone numbers and contacts for mental health services (6)	○	○	○	○	○

Collaborate with a person of concern to determine what type of help they will accept (7)	○	○	○	○	○
Be present and supportive when connecting with others' pain and intense emotion (8)	○	○	○	○	○

Please indicate your overall rating of this training.

- ○ Excellent (1)
- ○ Very good (2)
- ○ Good (3)
- ○ Fair (4)
- ○ Poor (5)

Would you recommend this training to others?

- ○ Definitely yes (9)
- ○ Probably yes (10)
- ○ Might or might not (11)
- ○ Probably no (12)
- ○ Definitely no (13)

Would you be willing to be contacted by phone for follow up survey? (if yes please provide it)

- ○ No (1)
- ○ Yes (2) _____

Please provide any additional comments about the training.

_____

_____

_____

_____

_____

Support Services

If you need emotional support or are in crisis, please contact:

National Suicide Prevention Lifeline: 1-800-273-8255

Klamath Basin Behavioral Health: 541-883-1030

Text **NATIVE** to 741741

Klamath Tribal Health and Family Guidance Center: 541-882-1487

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