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Themes of Healing Among Squamish Nation Members After the Loss of a Loved One to Suicide

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Abstract
This research was a response to the disproportionately high suicide rates, risk for suicide clusters, and need for a suicide postvention plan in the Squamish Nation community. Using a community-based research approach and working collaboratively with Squamish Nation, 8 community members who had lost a loved one to suicide within the past 1–10 years were interviewed, to understand what helped in their healing journey, as well as their recommendations for helping families after a loss to suicide. Findings indicate 5 themes of helpful postvention supports: healing self, social supports, formal community supports, wider world supports, and culture. Culture was found to aid healing across all levels. These themes do not exist in isolation, but are interrelated, both individually and communally helping community members in their healing journey. Recommendations for suicide postvention highlight the integration of healing supports from dominant mental health models and an Aboriginal wellness model. These findings should be considered with caution due to the small sample size; however, they are in line with the available Aboriginal suicide postvention literature and an Aboriginal worldview. Aboriginal communities across Canada are not homogenous, therefore generalizability to other communities is unknown.

Author's Relationship with the Squamish Nation

Since May 2010, I (Jennifer Campbell) have worked closely with Yúustway Health Services (YHS), the Squamish Nation health department. Initially, I was hired as a Mental Health Intake Counsellor. It was a new position developed in conjunction with the development of the Community Health & Wellness Division. As the division grew, I transitioned to my current role

as a contracted professional. As a contracted professional, I provide a number of supports to YHS and community members: individual counselling, group counselling, crisis response, and clinical consultation. I have also had the privilege of coordinating a number of successful suicide prevention initiatives within the community, attaining funding from Health Canada and First Nations Health Authority. These initiatives include the making of a youth suicide prevention documentary and music video (both on the Squamish Nation YouTube channel), a Weaving for Wellness group with elders and youth, and a Weaving for Wellness group with isolated elders. I continue to work alongside staff and community members, coordinating the Suicide Prevention Committee and the Suicide Response Team. It is an honour and a privilege to be a part of this work.

Introduction

Suicide is a serious health concern across Canada. Aboriginal suicide rates are five times higher than the non-Aboriginal population (British Columbia Ministry of Healthy Living and Sport, 2007; Caldwell, 2008). The Squamish Nation, whose traditional territory is in the Lower Mainland of British Columbia, has lost many members to suicide. The community health department, Yúustway Health Services (YHS), has a Community Health and Wellness team that responds after a suicide, supporting grieving family members and the community with both traditional and Western healing practices. However, which supports are most effective and what additional supports may be needed is unclear. The community health department wanted to fully understand what helps grieving families heal after the loss of a loved one to suicide.

In 2016, YHS received funding from the First Nations Health Authority to develop a suicide prevention, intervention, and postvention (SPIP) plan for the community. Planning has followed the steps suggested in *Hope, Help, and Healing* (First Nations Health Authority, 2015), a toolkit designed to help First Nation and Aboriginal communities prevent and respond to suicide. The SPIP planning is extensive and will take time and resources. This research addressed one part of the SPIP plan; specifically, the suicide postvention supports called Support for Grieving Families.

Consistent with the principles of community-based and culturally sensitive research, the authors seek to honour and amplify the participant voices wherever possible. The term Aboriginal

will be used in this article when referring to the broad and diverse group of First Nation, Inuit, and Métis peoples because it was the term preferred by the majority of participants of this study

Aboriginal Suicide

Colonialism is often viewed as the root of suicide in Aboriginal communities (Elias et al., 2012; Kirmayer et al., 2003; Kirmayer et al., 2009; Lavallee & Poole, 2010). Since colonialism began, suicide has become prevalent in Aboriginal communities, even though historically it was a rare occurrence (Kirmayer et al., 2007). Colonialism is "the conquest and control of other people's land and goods . . . the takeover of territory, appropriation of material resources, exploitation of labor and interference with political and cultural structures of another territory or nation" (Loomba, 2005, p. 8). Colonialism has resulted in social, economic, cultural, and political inequities (Adelson, 2005; Tester & McNicoll, 2003). The result of these inequities is a disruption in the balance of mental, physical, emotional, and spiritual health (Tester & McNicoll, 2003). The disruption in the balance of these four quadrants of health can result in suicide behaviour (MacNeil, 2008). Suicide is the "clearest indicator of the severity of social disruption in Aboriginal Canada and the rates are shockingly high by any standard" (Tester & McNicoll, 2003, p. 556). Continued oppression makes recovery difficult (Walls et al., 2014).

From 1950 to 2000, the Canadian government established many prevention and intervention programs with little success in reducing Aboriginal suicide rates (Breton et al., 2002). Dominant mental health model prevention strategies are not commonly accepted in Aboriginal communities, and evidence-based prevention strategies, based on non-Aboriginal samples, are not effective when applied in Aboriginal communities (Kral, 2012). According to the Centre for Suicide Prevention (2013a, 2013b), suicide prevention strategies should be developed by the community and those who understand its social background. Each Aboriginal community will have its own view of the strategies needed for suicide prevention (Royal Commission on Aboriginal Peoples, 1995). The effectiveness of community-driven strategies in reducing suicide rates must not be overlooked. Programs developed within communities have proven more effective than interventions that are implemented by government (Kral, 2012). These programs not only result in a reduction of suicide, but also empower the community and rebuild pride that has been destroyed by colonialism.

In 2004, Health Canada (2008) supported the empowerment of First Nation communities to develop their own suicide prevention strategies, establishing the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). The goal of NAYSPS was to reduce risk factors and increase protective factors against suicide over a span of 5 years (Health Canada, 2008). Rather than providing evidence-based strategies that have not proven effective in Aboriginal populations, the Canadian government provided funding for the communities to run their own programs (Kral, 2012). It was required that the programs developed must be "evidence based and recognize traditional and cultural knowledge, build on existing structures and processes, and respect federal, provincial and territorial mandates" (Health Canada, 2008, p. 3). The overall objectives of the NAYSPS were to

- Increase awareness and understanding preventing suicide among First Nations youth,
- Strengthen key protective factors such as a strong sense of identity, meaning and purpose, and resilience,
- Strengthen and help create collaborative approaches and links within and across governments, agencies, and organizations,
- Improve and increase efforts to respond to crisis, and to intervene more effectively in preventing suicide and suicide clusters following a suicide related crisis in First Nations communities; and
- Enhance the development of knowledge regarding what works in preventing suicide among First Nations youth. (Health Canada, 2008, p. 3)

In phase 1 of NAYSPS, 200 community-driven projects were implemented, each unique to the needs of the community it served (Health Canada, 2013). Evaluation of the NAYSPS community initiatives has been positive, suggesting "a decrease in youth delinquency and substance abuse, an increase in youth participation in school and community, community wide commitments to training in suicide awareness and intervention and general improvements in youth leadership skills" (Health Canada, 2013, p. 5). These findings support the argument for community-driven prevention initiatives, which are diverse and address the unique needs of each community. It is anticipated that in the long term NAYSPS will reduce suicide rates in Aboriginal communities (Health Canada, 2013).

Suicide Postvention

Suicide postvention involves "addressing traumatic after-effects among survivors, grief and trauma recovery, and education to reduce the risk of more suicides" (First Nations Health

Authority, 2015, p. 49). Suicide postvention is an important response for Aboriginal communities for several reasons. First, suicides on reservations often occur in a cluster (Kirmayer et al., 2007) due to everyone being closely related and facing the same social challenges (Centers for Disease Control and Prevention, 1988). As well, the impact of a suicide affects the whole community (Centers for Disease Control and Prevention, 1988). Suicide postvention reduces the risk of survivors dying by suicide, and thus it can also be viewed as a suicide prevention strategy. A third reason that postvention is important is that grieving families need support. Those grieving after a suicide are at risk for heightened distress, psychiatric morbidity, and suicidal ideation (Kirmayer et al., 1999). Postvention helps survivors grieve and heal, reducing the risk of suicide (First Nations Health Authority, 2015). The purpose of this research was to understand what helped Squamish Nation members heal after the loss of a loved one to suicide. Findings may guide postvention planning specific to the community that would be more effective than generic attempts stemming from the dominant mental health model.

Research Design and Method

A community-based research (CBR) design was chosen because it is collaborative, community driven, shares power, is oriented to social action and social justice, builds capacity, and is transformative and innovative (Boyd, 2014). This design met the *Tri-Council Policy Statement* (TCPS2) requirements of community engagement with Aboriginal populations (Canadian Institutes of Health Research et al., 2018). The procedures also met the TCPS2 requirements of working collaboratively (articles 9.1 and 9.12), determining the nature and extent of collaboration (article 9.2), ensuring respect for community customs and codes of practice (article 9.8), delivering a formal research agreement (articles 9.10 and 9.11), and recognizing the role of Elders as per article 9.15 (Canadian Institutes of Health Research et al., 2018).

For sampling, a purposive approach was utilized, which is recommended for qualitative research (Creswell, 2008). A letter of invitation was posted in the Squamish Nation newsletter and on the Squamish Nation Facebook page to increase the likelihood of reaching all members of the community, as per article 9.6 of the TCPS2 (Canadian Institutes of Health Research et al., 2018). Potential participants contacted the interviewer by phone or email for screening. To be eligible to participate in the research, participants had to be 19 years of age or older, able to communicate in English, and Squamish Nation members who had experienced the loss of a loved one to suicide 1–

10 years prior to the research. Anyone who did not meet all three criteria were excluded. Squamish Nation membership was important as the purpose was to understand Squamish Nation themes of healing. Participants must not have lost a loved one to suicide within the preceding year to reduce the likelihood that they would find the questions emotionally triggering. To reduce risk of possible harm, participants had to rate their current mental wellness as okay or better. As well, prospective participants were excluded if they had been suicidal over the preceding 6 months. In total, eight community members participated in this research, two men and six women, ranging in age from 34–81 years old. They resided on Capilano and Mission reserves. Each of these participants had a prior relationship with the first author as a colleague, counselling client, or family member of a counselling client.

After reviewing the informed consent form and assessing for capacity, participants completed a demographic measure which asked their name, age, address, gender, First Nation membership, length of time living in the community, and whether they were a residential school survivor. Four key questions pertained to suicide: How many loved ones have you lost to suicide over the past 1–10 years? What was your relationship to them? How old were they when they died by suicide? When did you lose each loved one to suicide? This information helped to understand their history of losing loved ones to suicide prior to the interviews. Participants were interviewed one on one following a script. A YHS mental health intake worker was available on interview days to conduct a suicide assessment, create a safety plan, and connect the participant with a registered clinical counsellor, registered social worker, or registered psychologist as needed. Participants were advised that they must answer all demographic and interview questions, or their answers would not be included in the research.

After defining and naming the themes, participants attended a feedback session to review the findings, clarify any misunderstandings, provide feedback, or request edits prior to the finalization of the results. Participants were also asked if their participation in this research, specifically telling the story of their loss and healing journey, had affected them in any way. This question was suggested by YHS, as the telling of one's story may traditionally be viewed as healing. Data analysis included data from the interviews and feedback sessions. Thematic analysis was chosen because this method is flexible, easy to learn and implement, and fits well with CBR (Braun & Clarke, 2006). We attempted to answer three specific questions: (1) What was helpful in your healing journey? (2) What supports would you like to see offered to families in the

Squamish Nation community after a suicide? and (3) Did the telling and recording of your healing journey change you in any way? With theoretical thematic analysis, the researcher codes the data according to research questions, rather than utilizing an inductive approach which gathers rich predominant themes across participants (Braun & Clarke, 2006). Semantic themes, which were explicit in the data, were coded, rather than looking for underlying latent themes and meanings.

The data were then organized to illustrate patterns in semantic content and summarized. Next, we interpreted these themes and attempted to theorize patterns and their meaning. Theoretical thematic analysis requires the researcher to engage with the literature related to the topic prior to data analysis, to guide the interpretation of themes and their meanings. The first author had engaged intensively with the literature related to suicide postvention, both within the Western and Aboriginal frameworks, and used this knowledge throughout the thematic analysis.

Findings

Five themes of healing were identified using thematic analysis, each with a number of subthemes (see Table 1): healing self, social supports, formal community supports, wider world supports, and culture.

Table 1

Themes and Subthemes

Themes	Subthemes
Healing self	Acceptance
	Day to day
	Sense of purpose
	Still with us
	Coping activities
	* Helping others
Social supports	Family stands together
	Connecting with others
	Help from community

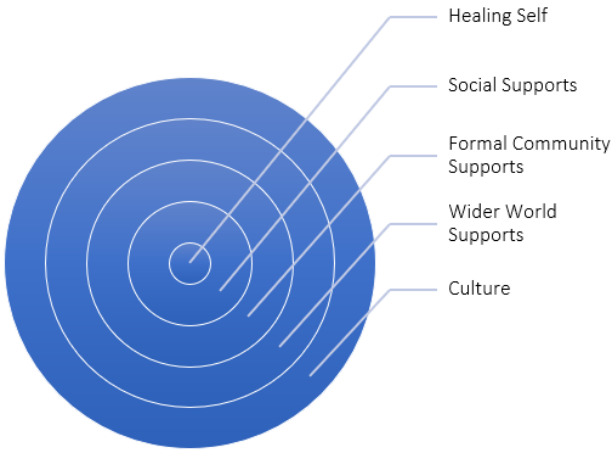
Formal community supports	Alternative healing
	+ Counselling
	Wellness Centre
	Ceremony
	Church
	Health workers' presence
	Suicide prevention
	Get the people involved
Wider world supports	Off-reserve supports
	Collaboration with service providers
Culture	Following the teachings
	Sharing the teachings
	Get the tools back

Note. * = Noted by all community members as helping in their healing. + = Recommended by every community member for future postvention planning.

As illustrated in Figure 1, culture wraps around all the themes. With respect for the fluidity of culture across all themes, and the interplay that occurs, culture is listed as a theme of its own. In addition, a theme of multiple loss was noted as important as it provides context to the findings.

Figure 1

The Interplay Within and Between the Five Themes of Healing



Multiple Loss

The theme of multiple loss is separated from the other themes: It does not answer the research question, but it was considered a prominent theme that was important to include for contextualizing the results. The experience of losing multiple loved ones stood out across the stories of six participants. Some participants noted multiple loss of loved ones to suicide. Others noted losing a loved one while still in the process of grieving for another. This statement by Participant 4 describes the theme of multiple loss:

> We average 32 losses a year, and there's ebbs and flows. He [a mentor] told me at that meeting, every 10 years you're going to have 50 or more. So, it was almost like every week. And true to form, about every 10 years we have major losses.

As well, Participant 6 said,

> There's about six, six give or take, males in our family that have committed suicide, and they're all around 30, and he was the most recent one. And you know, it started to make me wonder, you know, what's going on?

Participant 1 also stated,

> And it [community newsletter] said, grief and loss counselling is now being offered to the Squamish Nation members. And that's when I knew, that I need this. I need this! And at that time, when we lost four young people in the community from suicide, and they're all in their twenties, I knew that I had to at least try.

Healing Self

This theme refers to healing that took place within the self, rather than external supports that helped with the healing process. Several different intrapersonal factors formed the following subthemes: acceptance, day-to-day coping, sense of purpose, still with us, strategies, and helping others. The subtheme of helping others was endorsed by all participants as helpful in their healing. Participant 1's statement described the theme of healing self, specifically the subtheme of helping others:

> If I can help out one father, or change the mind of one kid, or a person, you know, to fight through the day. . . cause I swore on my son's grave, that if anybody—anybody—reaches out to me for help in that way, I will be there. And I have [been]!

Participant 7 stated,

> I think that was the hardest part, was healing my own self and making myself go to different workshops. And, "Oh, I should go there," and "Oh, I should take [friend] there," or just keep myself not thinking of him all the time.

As well, Participant 5 shared,

> And knowing they are still with us in spirit. They may not be physically, but they are always still with us. That keeps me going. . . I just thank the Creator today they are not suffering for whatever it was, why they took their lives. That they're not suffering no more, that they're happy.

Social Supports

When participants were asked what helped during their healing journey, a theme of accessing social supports emerged across all their stories. Three types of social supports stood out, which were separated into the following subthemes: family standing together, connecting with others, and getting help from the community. Statements from two participants described the theme of social supports. Participant 8 said,

> We have to stand together as a family, and we have to sit there as a family, and we have to support one another as a family, and we have to be quiet as a family. This is no joking around, no talking, this is just be quiet. Listen, learn, I says, and calm your spirit. I says, everybody needs to calm their spirit. I says, you know, there's a time to grieve and a time to let go of those feelings.

As well, Participant 5 commented,

> The community was really scared for us at the time because it was the toughest, I swear, the Creator gave us the biggest challenge. . . The community was totally helpful. . . the community totally was. You never know how many people actually care about you until you're in a tough situation like that, and the whole community is worried about you.

Formal Community Supports

When participants were asked what helped during their healing journey, and what supports they would like to see offered after a suicide, a pattern of accessing and/or recommending formal community supports was identified across all their stories. Formal community supports differ from social supports in that they are offered by workers whose role or job it is to provide the supportive service. In addition, these supports were typically available for all community members to access.

Prompts included questions such as "Did church or religion play a role in your healing" and "Did counselling play a role in your healing?" Formal community supports accessed included

alternative healing, counselling, ceremony, and church. Formal community supports participants recommended comprised the following subthemes: alternative healing, counselling, Wellness Centre, ceremony, church, health workers' presence, suicide prevention activities, and get the people involved. Many participants mentioned more than one support. For example, Participant 2 stated,

> I truly believe in alternative healing, but I don't believe that it can completely be done without Western medicine at the same time. I think they complement each other in a healing path for people, because each person needs a different path in order to get to their goal. So, creating a centre where they have both ways being shown to them [may be beneficial].

Formal community supports were noted to be important and powerful:

> You know, I had family and friends that pushed me to go to these workshops, you know. And I never thought that it would help, because I wasn't all there, right? But I took to it like a sponge and it, you know, it helped me. And it brought me to where I am today, and I'm really thankful. You know, not just for my culture. I'm thankful for these [grief and loss groups] because it probably . . . saved my life. I really, truly, dearly believed it saved my life. (Participant 5)

Similarly, Participant 8 commented,

> Well, if there's a suicide in the family you know I really like the fact that, you know, there's an open door for a clinical counsellor and a worker to go into the home and just be there. Just be present. The presence weighs a lot of value to families that are in grief. They may not want services at that time, but presence and being visible is really important to our Aboriginal culture, because it's acknowledged.

Participant 5 also mentioned the Shaker Church, noting that it "helped me, that's helped me cry. And taught me how to pray. Prayer got me a long way. Pray every day, pray every morning, for all my loved ones, for all my ancestors."

Wider World Supports

Wider world supports refers to formal supports, both Western and traditional, that are not based in Squamish Nation communities. When asked what helped in their healing, or what supports they would recommend for suicide postvention, participants indicated an openness to accessing supports that were outside the community. Two subthemes identified as helpful were to access off-reserve supports and collaborate with service providers. One statement from Participant 7 that described the theme of off-reserve supports was, "And I got to know another church, the United Church. That helped me through." Participant 8 also shared,

> You know, I'm really, really supportive of the Tsow-Tun Le Lum 6-week program on grief. Because that really gets people to focus directly on their grief. And they even have a—what do they call it—psychotherapy, yeah, they have that person there. And that person really helped me when I was at Tsow-Tun Le Lum.

In reference to collaborating with service providers, Participant 4 stated, "I think we've [made] some great strides with the integrated [police] unit. Culturally incorporating them, I think, has taken a long time. And I think they're more sensitive to the cultural side of Squamish or Salish or whoever."

Culture

Culture was identified as a theme of healing or recommended support across the stories of all eight participants. This theme encompassed three subthemes: following the teachings, sharing the teachings, and getting the tools back. Culture was seen across all other themes—healing self, social supports, formal community supports, and wider world supports—and therefore could be considered a meta subtheme (see Figure 1). When referring to the power of culture for healing, participants spoke of it as a support that often encompassed more than one theme at a time. An example of a statement from a participant that described the theme of culture was, "Get the tools back in the community . . . cause there's a whole generation that just doesn't know, I think" (Participant 4). Participant 4 further shared that "I follow the teachings still. I continue to pray, continue with ceremony; I find that healing. Getting up in the mountain, in bath, letting go up there."

Another participant said:

> Wow. I've come a long way since that day. Self-healing is a daily process. It doesn't happen with the snap of a finger or the blink of an eye, that's for sure. Going to the waters, brushing off, cedar boughs, cultural events—that's really, that's probably what saved me, is my culture. I really believe in my culture. (Participant 5)

In reference to teaching the young ones about culture, Participant 8 suggested,

> And get them, you know, get them interested. If they're not interested, have it available. You know, it doesn't have to be every week. It could be once a month, you know, as long as people are starting to learn. Because the culture, the drumming and singing and the language and that are all being revived, so a lot of people are just learning.

Participant 8 also indicated that sharing traditional knowledge and teaching cultural practices to community members during their grieving was a part of self-healing: "[Loved one's mother]

wasn't brought up in traditional and cultural. So that was part of my healing journey as well, to guide her through that whole process. She knows of it but has never practiced it."

Community Members' Experience

After the interviews were complete, participants were invited to a feedback session to review the findings, clarify wording, or suggest changes. At that time, participants were asked if the telling and recording of their healing journey had changed them in any way. Seven stated that participation had had a positive effect on them, and one stated it had not had an impact one way or another. Participant 2 commented, "It was actually pretty empowering because hearing the responses that I had to the questions being asked were a lot stronger and more confident than I think I actually believe that I am." Another participant described,

> For me, it feels a part of my wellness to be able to contribute that and share that, you know. And for things to change, or to improve, if you don't share your thoughts or feelings or suggestions, it's nothing's going to change, right? So. So, I guess sorta in that way it would be, be towards my wellness, on my healing journey. (Participant 6)

Discussion

Participants perceived that addressing suicide postvention from an Aboriginal wellness model was effective in their healing journeys. This finding is congruent with previous research. An Aboriginal wellness model highlights the collectivist orientation of traditional practice and the power of interconnectedness (McCormick, 1997). Healing practices often include the client and the healer, as well as the family and community. Previous research by McCormick (1997) found that a wellness perspective that highlighted the collectivist orientation of healing practices was important for healing among British Columbia First Nations. The current findings further suggest that both the individual and communal impact of supports were perceived as being specifically helpful for healing after a loss to suicide. The healing journeys of these Squamish Nation members involved an interconnectedness of individual, social, formal community, wider world, and cultural supports. These findings are also in line with an Aboriginal worldview:

> A central teaching of First Nations elders is that everything is related. This wisdom is sometimes represented visually by locating individuals at the centre of a set of concentric circles that ripple outward to include family, community, nation, and the natural world. The notion is not that human beings are at the centre of the universe but that our lives are nested in complex relationships. Our words, our actions, and even our thoughts have wide-reaching, timeless impacts that cannot be discerned by our physical senses. Conversely,

> our lives are impacted by forces and events in the larger world, whose origins and intentions are often beyond our knowledge or understanding. (Castellano, 2008, p. 386)

Second, as anticipated, participants perceived the integration of both dominant mental health supports and culture as helpful for healing among First Nations survivors. This approach involved maintaining an Aboriginal wellness model while allowing space for dominant mental health supports. A popular quote by Sitting Bull highlights this idea: "Take what is good from the White Man and let's make a better life for our children" (as cited in Duran & Duran, 2000, p. 94). Duran and Duran (2000) corroborated that the dominant mental health system has some valuable ideas, and they encouraged integration with cultural practices in the pursuit of developing an effective wellness model for Native Americans and others.

Findings indicated that survivors integrated healing supports from both dominant mental health models and their culture. This practice may be due to the resources available in the Squamish Nation community. Over the past 10 years, YHS has made a significant effort to offer both dominant mental health supports and cultural supports to the community, including strategies such as workshops, counselling, alternative healing, support groups, and community training sessions. Most of the community members who participated in this study have accessed supports through YHS. They indicated that these supports were helpful and recommended them for other suicide survivors in the community. These findings support recommendations that suicide prevention, intervention, and postvention strategies for Aboriginal populations involve both dominant mental health supports and traditional practices (Joshi et al., 2009). Therefore, although an Aboriginal wellness model is recommended as a framework for addressing suicide postvention, inviting valuable ideas from dominant mental health models is recommended and was supported by the participants.

Finally, the current research findings highlight the resiliency of the Squamish Nation members who were interviewed. Distress experienced by suicide survivors often meets the criteria for traumatic grief (Cerel et al., 2009; McMenamy et al., 2008). Dyregrov and Dyregrov (2005) found that 78% of parent survivors scored high for traumatic grief when administered the Inventory of Complicated Grief. The typical symptoms included "preoccupation with thoughts of their child, searching and yearning for the child, experiencing disbelief about the death, and difficulties accepting the death" (Dyregrov & Dyregrov, 2005, p. 718). Long-term difficulties with

mental health, psychosocial functioning, and physical health are also commonly experienced by survivors (Melhem et al., 2004; Prigerson et al., 1997).

In consideration of the risk factors for traumatic grief (age of parent, education, employment, age of deceased, childhood adversity, and insecure attachments), it appears that the risk is high for Aboriginal people in Canada (Spiwak et al., 2012). In addition, participants indicated experiencing multiple loss, at times grieving one loss when another occurred. Despite the increased risk of traumatic grief and experiences of multiple loss, the journeys of these participants illustrate both individual and community resiliency. The individuals found healing within themselves, used a variety of different supports, and sought culture as medicine. The community came together to support the survivors after their loss. Therefore, it is suggested that professionals involved in future SPIP work with the community recognize and promote both the individual and communal resiliency of the Squamish Nation.

Limitations of the Research

This research has several limitations: the qualitative nature of the study, the recruitment method, the exclusionary criteria, the interview method, the sample size, and the generalizability of the results. First, although the qualitative nature of the research was a strength in that it was appropriate for learning about individual lived experience, particularly within a marginalized group (Jordan, 2008), the potential exists for my individual biases to influence the results (Kazdin, 2003). The first author knew all the participants before this study. She knew parts of their stories and had to ensure that her impressions of their healing, from her perspective, did not affect the results. In addition, as a therapist in the dominant mental health system, she is biased toward incorporating dominant models of healing with traditional methods. This bias could affect the interpretative validity of the findings, which is the extent to which the participants' opinions and feelings were accurately interpreted (Kazdin, 2003).

The recruitment method is a second possible limitation. Recruiting participants through the Squamish Nation newsletter and Facebook page may not have reached all members of the community. The Community Health and Wellness team at YHS helped to mitigate this issue by relaying the information verbally to members they thought may be interested in participating.
The voluntary aspect of recruitment also led to a type of selection bias referred to as volunteer bias (Hernán et al., 2004). Participants were familiar with the first author in the community prior to the

research commencing. The prior relationship and their volunteering to participate indicate an openness to dominant mental health service providers that may not be representative of the entire population and may have influenced the findings.

A third limitation was the exclusionary criteria. Several community members who expressed interest in participating were excluded as they had lost a loved one to suicide within the preceding year or more than 10 years prior. Even though excluding community members from participating is contrary to the Squamish Nation cultural norm of inclusion, it was necessary to ensure that the process of participating did not cause harm (less than 1 year) and the limitations of memory and relevance of current supports were considered (more than 10 years).

A fourth limitation was the interview method, as the data gathered were the participants' views of how they had healed after the loss of a loved one to suicide, which may not represent an actual causal relationship between the activities of perceived benefit and the healing outcome (Kazdin, 2003). However, storytelling is a common teaching tool in the community, and it was decided that the interview method was a culturally appropriate way of gathering data.

Sample size was a fifth limitation, as only eight community members participated in this study. Recruitment stopped at eight interviews, as the community was grieving a number of losses at that time. The collection of new information decreased significantly after the sixth interview, with only one new theme arising during the seventh and eighth interviews. However, it is not certain whether saturation was reached or more information may have been collected with a larger sample.

Finally, the literature is clear that suicide postvention plans for Aboriginal communities must be unique to the needs of each specific community (First Nations Health Authority, 2015; Joshi et al., 2009; Poonwassie & Charter, 2001). Therefore, the results of this study may not be generalizable to other communities.

Recommendations and Implications

Joshi et al. (2009, p. 191) suggest that Aboriginal "communities would benefit most by being presented with a compilation of strategies that they can choose from to implement given the diversity that exists across communities", in order to allow them to choose the interventions that are right for their communities. In keeping with this spirit, 20 recommendations stemming from this research have been compiled in a handout entitled Suicide Postvention Recommendations for

the Squamish Nation (see the Appendix 1). It lists suicide postvention recommendations for the community to review and choose whether to implement.

On the one hand, these recommendations represent the opinions of a small number of Squamish Nation community members who reside in North and West Vancouver; therefore, they should be considered with a degree of caution as they may not be representative of all Squamish Nation survivors. On the other hand, it is important that suicide postvention strategies are community driven (Wexler & Gone, 2012). To date, these are the only data gathered on Squamish Nation survivors' healing journeys after a loss to suicide. They are consistent with the available literature on suicide postvention and with an Aboriginal wellness model.

The implementation of the suicide postvention strategies is likely best undertaken at the local, community level. In the case of Squamish Nation, the current SPIP committee, which includes members from various Squamish Nation departments as well as wider world supports is an example of a group positioned to consider and implement such strategies. As the findings and literature suggest, a collective approach among individuals, families, community, and wider world supports may best meet the needs of survivors. As well, findings suggest that not only were individual supports helpful for healing, but the cumulative effect of supports from a variety of levels was beneficial. Therefore, it is important that postvention initiatives offer survivors support from all levels identified (healing self, social supports, formal community supports, wider world supports, and culture). Finally, the integration of both dominant mental health supports, and culture was found to be beneficial. Therefore, it is important to offer both types of supports to survivors.

Achievements and challenges faced during this study offer implications for conducting CBR within First Nations communities. First, collaboration and engagement with the community are pivotal for avoiding engagement in research in a manner that is exploitative or oppressive. Numerous ethical dilemmas were faced along the way, and collaboration with YHS played a major role in reducing the risk of unethical practice.

Another implication for conducting CBR in First Nation communities is that collaboration and engagement inherently increased awareness of what is happening in the community. For example, during the research recruitment process, several deaths occurred in the community. It was important to stop recruitment and respect the community's need to grieve. When working in First Nation communities, awareness of what is happening in the community is essential to ensure ethical practice, and a CBR approach can help to increase this awareness.

For future research, replicating this CBR study in the Squamish Nation community is recommended, gathering the voices of a larger portion of the community, and including members in the Squamish Valley. A study could be conducted to evaluate the short- and long-term effects of the implementation of the recommendations, using the data as an iterative feedback loop to inform further refinements and improvements.

Conclusion

It has been our privilege to conduct this research with the Squamish Nation community. Suicide is a serious health issue across Aboriginal communities in Canada. Survivors are at high risk for traumatic grief and providing support for their healing is imperative. The CBR design allowed us to collaborate and engage with the community in a culturally sensitive manner, reducing risk of exploitation or oppression, and to develop community-specific postvention recommendations that are anticipated to be more effective than those developed externally. Interviews with Squamish Nation members suggested that approaching suicide postvention from an Aboriginal wellness model is beneficial. This model recognizes the benefits of the individual and communal impact of healing self, social supports, formal community supports, wider world supports, and culture. In addition, when using an Aboriginal wellness model for postvention, there are benefits to integrating valuable Western supports, particularly when such integration is guided by the Aboriginal communities being served. We hope that these findings, and the suggested recommendations for suicide postvention, offer some guidance on how to support Squamish Nation survivors on their healing journey.

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Appendix 1
Suicide Postvention Recommendations for the Squamish Nation

These are community-driven recommendations, based on findings from the interviews of Squamish Nation members who participated in this study. These recommendations may not be generalizable to other communities.

Recommendations for Healing Self

1. Train helping professionals: Provide a workshop for professionals in the community who work with survivors, sharing the findings of this research.
2. Involve survivors: Invite survivors to participate in the planning and implementation of any suicide prevention, intervention, and postvention activities.

Recommendations for Social Supports

1. Raise awareness in community. Provide culturally informed, community-relevant information to family and friends on how to support survivors after a loss to suicide.

Recommendations for Formal Community Supports

1. Have a counsellor and health worker at the family home after a loss to suicide: A registered clinical counsellor or psychologist with experience working in First Nations communities along with a member of the Community Health and Wellness Team should visit the family home within 48 hours after a loss. Survivors suggest that simply having their presence in the home is important. These helpers would also hand out information about supports available on and off reserve and offer referrals for counselling and alternative healing to those in need.
2. Offer debriefing or counselling for families: The registered clinical counsellor or psychologist who visits the family home should offer a voluntary debriefing for family members, providing education on trauma and loss, and assessing for safety of all

members who attend. Ongoing family counselling sessions should be offered as needed. *If a Critical Incident Stress Debriefing model is utilized, it should be monitored closely and evaluated consistently.

3. Provide childcare for those accessing counselling: Childcare or funding for childcare should be available to community members while they attend counselling or alternative healing appointments for grief and loss.
4. Organize social recreation programming for survivors: Encourage survivors to come together for prosocial activities such as sports, walking, and games.
5. Add Community Health and Wellness staff: Hire additional staff to provide support, reduce wait times, increase services offered, and bolster outreach to build relationships with community members.
6. Provide suicide prevention training for community members: Offer free, culturally sensitive suicide prevention training open to all members of the community.
7. Create a wellness centre: Open a wellness centre within the community that offers both Western and alternative healing supports.
8. Offer a culturally informed, CBT-based grief and loss support group.
9. Offer individual counselling: Continue to offer referrals to individual counselling.
10. Offer alternative healing: Continue to offer referrals to alternative healing.
11. Involve survivors: Train survivors to offer postvention support to families after a loss. Once trained, the survivors may attend the family home with other YHS staff, cofacilitate the grief and loss support group alongside a mental health professional, and attend any social recreation programing offered.

12. Conduct ceremonies: Continue to facilitate and/or support funerals, memorials, burnings, and other ceremonies that foster healing.
13. Share information about churches on and off reserve.

Recommendations for Wider World Supports

1. Increase community awareness of off-reserve postvention supports: After a loss to suicide, place information about off-reserve supports in the newsletter.
2. Collaborate with the Integrated First Nations Unit: Continue to improve collaboration with this unit. Invite the unit to attend scheduled SPIP meetings and other SPIP initiatives.

Recommendations for Cultural Supports

1. Offer cultural activities: Such activities can be used as prevention, intervention, and postvention strategies.
2. Offer cultural training: Teach traditional tools and other cultural practices that may promote healing and wellness.