UiT The Arctic University of Norway

Faculty of Health Sciences, Department of Community Medicine

# Suicide among Sámi

Cultural meanings of suicide and interventions for suicide prevention in Nordic parts of Sápmi

Jon Petter A. Stoor

A dissertation for the degree of Philosophiae Doctor. October 2020

# Suicide among Sámi

Cultural meanings of suicide and interventions for suicide prevention in Nordic parts of Sápmi

Jon Petter A. Stoor

Department of Community Medicine

Faculty of Health Sciences

UiT – the Arctic University of Norway

Tromsø 2020

Front page photo: Marie Enoksson, Sámidiggi/Sámi parliament of Sweden, 2016

*'We are Sámi and we want to be Sámi, without therefore being neither more nor less than other peoples of the world'*

*Sámiid kulturpolitiikalaš prográm'ma: dåk'kehuvvun Davviriikaid VII sábmelaš-konferænsas Váččiris 11-14.8.1971 = Samernas kulturpolitiska program = Saamelaisten kulttuuripoliittinen ohjelma* (1974)

# Table of Contents

# List of Tables



# List of Figures

# Acknowledgements

I would like to begin with thanking the participants in the studies, and all those involved in suicide prevention among Sámi. It has been a privilege to learn from you and all your hard work, and I am convinced that your engagement has saved lives and will continue to do so. Duhat giitu!

Anne, I really was lucky in meeting you! You supervised me into becoming a clinical psychologist, and now you have guided me to become a researcher. What is more, you have been a true friend all the while! There would not have been a thesis if it were not for you! Thank you so much for everything.

Lars, I met you in what feels like a lifetime ago and you have had a great impact on my journey since. Always supportive—even when critical. Always pragmatic and with your priorities straight, ready to share from your vast experience, or sharing a laugh. I really could not have asked for a better mentor. Thank you so much!

To my friends during my years at Várdduo: Moa, Kristina, Charlotta, Åsa, Görel, Per, Tobias, Erik, Maria, Isabell, Peter, Lena Maria, Nina, Krister, Maja, Ina, Lenita, Christina, Lis-Marie and Patrik! Oh, the endless amounts of coffee and chats about all the big and small wonders of life!

And to all colleagues and new friends at EpiGH! Ida, Mazen, Osvaldo, Isabel, Masoud, Julia, Marie, Klasse, Anne, Kaspar, Sara, Angelika, Faustine, Micke, Lena, Arjan, Anna Karin, Linda, Sun, Kristina, Barbara, Annelie, Raman, Frida, Jenny, Susanne & Susanne & Ulrika & Ulrika, Chama, Karin, Anni Maria, Camilla, Eva, Fredrik, Göran, Hanna, Kerstin, Edy, Klara, Per Sara, Solveig, Paul and Yerzin!

To people and collaborators in the Sámi world over the years: Ella Carin, Jenny, Niila, Totte, Britten and others at Sámiid Riikasearvi (of course also including my former brother-in-law, Stefan)! Åsa, Áile, Katarina, Jannie, Gunn-Britt and others at the Saami council! Isak, Per Jonas, Sanna and all you young (and not so young!) rascals presently and formerly at Sáminuorra! Reindeer herders fighting for their livelihood, promoting mental health all the while: Lars-Ánte, Margret, Simon-Issát and Piere! Former colleagues at the Sámi parliament in Sweden, and collaborators in Norway: Marie, Nils-Anders, Anja, Lisbeth, Sofia, Lotta, Laila, Lena, Anette, and others who I have fought for Sámi rights alongside—including Kerstin, who was not part of the Sámi world but kept an open mind and paved the way.

To my co-authors, who have more than once been forced into lengthy discussions, and taught me much! Gro, Ellinor, Niclas and Heidi—and you who are mentioned elsewhere!

To my Arctic Fulbright brothers and sisters, especially you Nicole, Christina, Sean, Beth, Joseé, Gwen and Katie! To other friends and colleagues from Arctic health research, including my friend and co-supervisor Eduardo and Stacy; my generous host in Fairbanks, and Susan—who always found a way to open a door for me! Yury, Arja, Heidi, Solfrid, Rhonda, Jack, Siv, Ketil, Allison, Lisa, Jim, Peter—and Maria (yes, I'm talking about you, Dr. Furberg)! I look forward to many years of friendship and research to the benefit of our peoples!

The great institutions I have had the fortune to work for and at, not only during my formal PhD student years, but before that as well, at SANKS, the Centre for Sámi Health Research (UiT), Sámediggi, Várdduo—the Centre for Sámi Research (UmU) and the Department of Epidemiology and Global Health (UmU). While all the people who have helped me along in their capacities within those institutions are far too numerous for me to mention, there are a few super women I want to single out. Gunn, Cecilie and Ann Ragnhild: your leadership will always inspire me to continue to be of service to our people.

I also want to thank Miguel. Thank you for taking me under your wing and helping me along. I am sure your genuine interest in Sámi health and your skills as a researcher will be a great asset for the Sámi in Sweden. When this journey ends another begins - let's get to work!

My friends (of whom some have been mentioned already!). You have stood by me through the roller coaster that included most of these PhD-student years. No doubt the toughest years of my life, and you stood by me. Per Anders, Lars Henrik, Moa – and others! I hope I will be able to pay you back when you need me.

My brother Markus and my sister Inga Maria. We have shared many years together and it is a joy in my life to see you grow, and your families too. I think we all share a passionate will to contribute to our society, and leave this place a better one. I am very proud of you and I hope you are of me too!

Father, whenever I doubt if I am making it I can think of you. When I grew up I did not have to think about the things you must have gone through, because you did not let anyone else carry your burden. Now, wherever I go, I meet someone who knew you and remembers you for the rock you were, and for your cheeky jokes! I could lean on you as a child, and I still do.

Mother, thank you for always supporting me - no matter what. Emotionally, financially and in every other way. Although you live 600 km away you have still found a way to come help me when I needed you. I was born under a lucky star, by the greatest of mums. Tack!

Elsa, you most of all know the bumps and twists on this ride, but I hope you also know the spectacular views and the thrill of taking this ride together. I would not have pulled through without you, and the strength it gives me to build a future together. With you I feel understood and loved, with all my flaws. It is the greatest feeling! I hope you will want to share many more years with me. Mazel tov to us!

Sonja and Sigrid. I did not ask your opinion before embarking on this PhD-journey, and I know that you more than others have paid the price for my ticket. I have been away more often than I should, but I also hope that working for the inclusion of Sámi perspectives in this field will serve you as much as all young Sámi, and contribute to your Sámi identities being a source for joy and pride!

# Abbreviations

| | |
|---|---|
| AI/AN | American Indian/Alaska Native |
| ASIST | Applied Suicide Intervention Skills Training |
| FGD | Focus Group Discussion |
| LGBTQ | Lesbian, Gay, Bisexual, Transgender and Queer |
| MHFA | Mental Health First Aid |
| NGO | Non-Governmental Organisation |
| PSPS | Plan for Suicide Prevention among the Sámi people in Norway, Sweden and Finland |
| R&D | Research and Development |
| RHC | Reindeer Herding Community |
| SANKS | Sámi Norwegian National Advisory Unit on Mental Health and Substance Use |
| SSHF | Centre for Sámi Health Research |
| UiT | University in Tromsø – the Arctic University of Norway |
| UmU | Umeå University |
| WHO | World Health Organization |
| WPR | 'What is the problem represented to be?'-approach |

# List of Papers

**Paper I**

Stoor, J. P. A., Kaiser, N., Jacobsson, L., Salander Renberg, E., & Silviken, A. (2015).
'We are like lemmings': making sense of the cultural meaning(s) of suicide among the Indigenous Sami in Sweden. *International Journal of Circumpolar Health*, 74. doi:10.3402/ijch.v74.27669

**Paper II**

Stoor, J. P.A., Berntsen, G., Hjelmeland, H., & Silviken, A. (2019).
'If you do not birget [manage] then you don't belong here': a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway. *International Journal of Circumpolar Health*, 78(1). doi:10.1080/22423982.2019.1565861

**Paper III**

Stoor, J. P. A., Eriksen, H., & Silviken, A.
'Mapping of suicide prevention initiatives among Sámi in Norway, Sweden and Finland'
Submitted manuscript

# Overview of Papers

| Paper | Aim | Method | Material | Results | My work | Reference |
|---|---|---|---|---|---|---|
| I | To explore and make sense of the cultural meaning(s) of suicide among Sámi in Sweden | Qualitative focus group discussions (FGDs) with participants recruited through use of snow-ball method. Recorded FGDs were transcribed and qualitative content analysis was performed on the dataset. | Five recorded and transcribed FGDs with 22 participants in Sápmi on the Swedish side; data collected in 2012 | Four themes emerged from analysis: ''The Sámi are fighting for their culture and the herders are in the middle of the fight', ''Suicide as a consequence of Sámi losing (or having lost) their identity', 'A wildfire in the Sámi world' and 'Difficult to get help as a Sámi' | First author: lead in design, data collection, analysis and writing process | Stoor, J. P. A., Kaiser, N., Jacobsson, L., Salander Renberg, E., & Silviken, A. (2015). ''We are like lemmings'': making sense of the cultural meaning(s) of suicide among the Indigenous Sami in Sweden. *International Journal of Circumpolar Health*, 74. doi:10.3402/ijch.v74.27669 |
| II | To explore and describe cultural meanings of suicide among Sámi in Norway | Qualitative focus group discussions (FGDs) with participants recruited through use of snow-ball method. Recorded FGDs were transcribed and reflexive thematic analysis was performed on the dataset. | Five recorded and transcribed FGDs with 22 participants in Sápmi on the Norwegian side; data collected in 2014 | Six themes were developed from the data: 'Sámi are treated negatively by the majority society', 'Some Sámi face negative treatment from other Sámi', 'The historic losses of the Sámi have turned into a void', 'Sámi are not provided with equal mental health care', 'The strong Sámi networks have both positive and negative impacts' and ''Birgetkultuvvra' might be a problem' | First author: lead in design, data collection, analysis and writing process. | Stoor, J. P. A., Berntsen, G., Hjelmeland, H., & Silviken, A. (2019). 'If you do not birget [manage] then you don't belong here': a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway. *International Journal of Circumpolar Health*, 78(1). doi:10.1080/22423982.2019.1565861 |
| III | To identify, describe and analyse suicide prevention initiatives targeting Sámi, in Norway, Sweden and Finland during 2005-2019. | A pragmatic mapping method was used. Prevention initiatives were identified and described based on the authors experiences, professional networks, and project reports. Initiatives were analysed with the first step of the 'what is the problem represented to be?'-approach (WPR). | Project reports and documentation of initiatives, emails and first-hand experiences were used to describe and analyse suicide prevention initiatives among Sámi; data collected 2019 | Seventeen initiatives were identified during 2005-2019, in Sweden (9), Norway (5), Finland (1), and internationally, border-crossing (2). Analysis with the WPR-approach yielded 40 problematizations regarding how to prevent suicide among Sámi, pertaining to shortcomings on individual (5), relational (15), community/cultural (3), societal (14) and health systems levels (3). Initiatives generally lacked evaluation components. | First author: lead in design, data collection, analysis and writing process. | Stoor, J. P. A., Eriksen, H. A., & Silviken, A. C. (Submitted manuscript) 'Mapping suicide prevention initiatives targeting Indigenous Sámi in Nordic countries' |

# Abstract

**Background**: In suicidological research, it is well known that suicide rates differ, sometimes to a great extent, between countries, sexes, religious and ethnic populations. It has been suggested that in-depth exploration of social, cultural, contextual and historical perspectives on suicide is needed to explain this, and increase efficacy of prevention efforts.

Sámi are the Indigenous people who traditionally live in northern parts of Norway, Sweden, Finland and north-western Russia (the Kola Peninsula). Generally, Sámi seem to enjoy good health along with the majority populations, at least in jurisdictions where some data is available (no Russian data is available). However, suicide is considered a major public health issue among Sámi, as it is globally. Sámi men have died more often by suicide than the majority populations in Nordic countries, ranging from 17% excess in Sweden (1961–2000), to 150% excess in Finland (1997–2005). An increased focus on the importance of reducing suicide among Sámi has led to creation of a 'Plan for suicide prevention among Sámi in Norway, Sweden and Finland' in 2017. However, research on this issue is still very limited and mainly includes cohort studies on suicide mortality and cross-sectional studies on suicidal behaviour. There are no studies that have evaluated suicide prevention programs among Sámi.

**Objective**: The overarching aim of this thesis was to explore and elucidate how suicide is understood among Sámi and what specific actions have been taken to prevent suicide among Sámi in Nordic parts of Sápmi.

**Methods**: This thesis is composed of three studies. Studies I and II utilized qualitative focus group discussions (FGDs) to explore and describe cultural meanings of suicide among Sámi, in Sweden and Norway, respectively. Study III identified, described and analysed suicide prevention initiatives targeting Sámi in Nordic countries (Norway, Sweden and Finland), during 2005 – 2019.

**Results**: Studies I and II found that specific cultural meanings were attached to suicide among Sámi, focussing on how suicide is understood to occur when Sámi are unable to maintain their Sámi identity. Contextual issues that enable such interpretations to make sense included perceptions of shortcomings in mental health services for Sámi, strong Sámi networks that increase the impacts of suicide among Sámi, and internal as well as external threats that lead to Sámi struggling. Study III identified seventeen initiatives in Sweden (9), Norway (5), Finland (1), and internationally (2). Analysis of initiatives yielded 40 problematizations regarding how initiatives aimed to prevent suicide among Sámi, addressing shortcomings on individual, relational, community/cultural, societal and health systems levels. Initiatives generally lacked evaluation components.

**Conclusions**: The findings in studies I and II show that there are ways of investigating culture-specific understandings of suicide among Sámi, and that suicide among Sámi is currently understood to be linked to the difficulties of maintaining Sámi identities. As regards prevention, it is suggested that the dominant rationales for suicide prevention were addressing shortcomings on individual and relational levels, and raising awareness in the general public. This threatens to obscure more critical approaches such as broadening perspectives in prevention planning, improving health systems for Sámi, and promoting cultural empowerment among Sámi. To improve evaluation and identify most promising practices, increased support regarding development of plans and implementation for evaluation components is needed.

# Preface

I choose to begin this thesis by presenting myself: who I am, where I come from, and how I have come to do research on suicide among Sámi. I do this for two reasons. Firstly, thoroughly presenting oneself, beyond what is practice in Swedish or Norwegian societies, is 'the way we do it' among Sámi. I grew up presenting myself in this way within the Sámi world, but not outside it. Doing it here fulfils the purpose of clarifying not only who I am, but also who my relations are, and—when this is a mutual transaction—it provides an opportunity for all parties to better understand who we are in relation to each other. One could call it a Sámi tradition or a part of Sámi culture. Since this work very much concerns the Sámi and our society, it is natural for me to respect this tradition, and in doing so I also acknowledge the continued importance and relevance of our relations and the relational worldview that simultaneously shape who we are and how we understand our place with regard to others. Secondly, critical scholars both within social and medical sciences have acknowledged that positionality matters and that no production of knowledge is truly neutral or 'objective'. I agree with this perspective and ascertain that trustworthy research clearly states where it is coming from. The following presentation is of course very focused on myself—who I am and how I became who I am—but it serves the above purposes well.

I am Jon Petter Stoor, *Nilsa Ande Biehtár*, my grandfather being *Pikku-Nilsá* (Nils Petter Stoor) and my father being Anders Stoor. My mother Gunvor, born Eriksson, grew up in a farming family in Hemmingsmåla in the southern Swedish county of Blekinge. She met my father as a student of ecology in northern Sweden and together they had three kids, of whom I was born second. My father comes from Orusjohka (Årosjokk), west of Giron (Kiruna) within the Laeváš čearru (Laevas reindeer herding community), in the northernmost part of Sweden. My father was the second youngest, with seven siblings, in a Sámi family. They had to relocate from the Talma reindeer herding community after the closure of the Swedish-Norwegian border in early 20$^{th}$ century, and the resulting loss of their traditional reindeer grazing lands on the Norwegian coast. My grandmother Brita, born Partapuoli, passed away giving birth in 1949, and my grandfather, Nilsa, struggled with both poverty and mental health issues that periodically removed him from home. These struggles made him unable to take care of and support his family. Luckily, my eldest aunt Elle Karin managed to get custodianship of her younger siblings and thus kept the family together. However, growing up was probably not easy for my father as he attended the residential school in Čohkkiras (Jukkasjärvi). At Nomadskolan ('school for nomads'), speaking the Sámi language was not allowed, and interpersonal violence, such as bullying, occurred among the kids. In comparison, my own upbringing was privileged. I grew up with my older brother Nils Markus, and younger sister Inga Maria. We enjoyed safety and economic stability because both my parents worked and were able to support us, with my father working as an employment officer specialising in re-training programmes for Sámi. Even though my father would not speak Sámi with me or my siblings, other aspects of Sámi culture were more present in the family life, centred around weekends in the family cottage in Orusjohka, where my father had lived his first years of life in a goahti (turf hut).

I attended the Giron Sameskuvla (Kiruna Sámi School) until third grade, when the school started a research project on Sámi language immersion. The project provided Sámi language immersion training for those kids who were fluent in north Sámi. As I was not, due to Swedish being the language at home, I became separated from my classmates. This separation happened with very short notice and struck me hard because I was the only one in a former class of four who did not speak Sámi fluently.

I remember that time as very painful and have later in life understood that I pleaded to be allowed to stay with my classmates, promising to stay silent until I managed to speak Sámi. It is weird and frustrating to think of the parallels between my father's and my experiences in school: him not being allowed to speak his mother tongue, and me promising to stay silent until I could.

However, after a few months of conflict, the other non-Sámi speaking kids (including my sister, who had just started school) and I were taken out of the Sámi school and placed in the ordinary Swedish municipality schools. I settled in there and became well adapted. However, the experience had strongly influenced my Sámi identity, and I remember thinking of myself as an outcast, my identity too weak to be wanted by my Sámi community. This belief probably contributed to why I refused taking Sámi language classes and generally tried to hide my Sámi identity in the new school setting.

Many years later, as an undergraduate in psychology, I heard about young Sámi taking their own lives, and that others understood this phenomenon as associated with Sámi youth having difficulties in maintaining their ethnic identity. This description resonated with me on a personal level and made me think that my particular background, in combination with my professional training, might position me to be of service to the Sámi community. Furthermore, there were many changes during this time for me, with my two daughters borne within a year and me realising that it was my responsibility if they were to grow up with a strong and healthy Sámi identity. My father, perhaps aware of the difficulties I had endured as a Sámi who could not speak my language, said he would help and make sure to speak Sámi with his grandchildren. However, just six months after my first daughter was borne, my father was caught in a snowstorm while riding his snowmobile from Orusjohka towards Alisjávri, where the Laeváš reindeer herding community's summer encampment is located. On a mountainside, his snow mobile rolled over, with him stuck underneath it. He died there.

An accidental death—like my father's—can be similar to suicide in some regards, as it might leave the bereaved trying to cope with the experience of losing a loved one to a sudden and 'unnecessary' death. Losing my father in this way was indeed very shocking and traumatic and affected me in profound ways. Not in the least, my father was a very social person and, to some extent, losing him also meant losing strength and bonds to the social networks of which he was part.

Although I have very little recollection of the months following my father's death, it is easy to imagine the tumultuous time it was: mourning my father while far removed from my family, with one baby daughter, and another one soon to be born. When the strongest grief wore off, I went back to the university, but I found it difficult to engage with subjects other than those closest to my heart. In this way, choosing to focus my master's thesis on suicide and identity among Sámi was more out of necessity than free choice. It provided me with a sense of meaning in my work and led me to engage with my father's Sámi network (I still find great joy when I meet people who knew him, and in listening to their stories about him).

After graduation from university, a research group led by my co-supervisor Lars Jacobsson and I failed to secure research grants to study the connections between the conflict-ridden life of reindeer herders and their increased risk of suicidality and mental health issues. Instead, I relocated to the small town of Kárášjohka (Karasjok) in the Sámi core areas of Northern Norway, were Sámi and non-Sámi had been successful in creating the Sámi Norwegian National Advisory Unit on Mental Health and Substance Use (SANKS/SÁNAG). SANKS is a very special place where Sámi and non-Sámi therapists are trying to deliver specialised psychiatric services that fit the cultural and linguistic needs

of Sámi, and non-Sámi, patients. For a year and a half, I worked as a clinical psychologist at the in-patient youth psychiatric ward, earning my authorisation to practice as an independent psychologist. Meanwhile, my daughters attended the kindergarten for reindeer herding Sámi, and they were immersed in our culture and language. However, as I was very much aware of the continued lack of attention and resources to deal with the mental health and suicide-related issues in Sweden, I continued to search for ways that I could address those needs. The solution came in 2013/2014, when my main supervisor, Anne Silviken, and I received research grants to collect data for study II of this thesis and develop a full PhD project proposal. Conducting those projects led to writing new project grants, lobbying the Swedish government for an increased focus on Sámi psychosocial health and increasingly engaging myself in international Arctic Indigenous research and development projects under the Arctic council Sustainable Development Working Group. This endeavour, in turn, led to me work for a year at the Sámidiggi (Sámi parliament) in Sweden, conducting a series of scoping reviews on psychosocial health among Sámi in Sweden (Stoor, 2016), and then leading development of the 'Plan for suicide prevention among Sámi in Norway, Sweden and Finland', on behalf of SANKS and the Saami Council (2017). In December 2016, I started as a full time PhD student.

My original PhD plan was reliant on the 'Stories about Life and Death' project (funded as a PhD project for me), which aims to identify cases of suicide in young Sámi men in Norway and Sweden, and conduct interviews with several of the bereaved in each case (5–10 interviews per case). However, while that project was perhaps too ambitious from the start, data collection was also slower than expected, and hence the structure and content of this thesis was reshaped several times. Due to the flexibility of my employer (SANKS), the Arctic University of Norway (UiT), our main funders at Northern Norway Regional Health Authority and other involved stakeholders afforded my colleagues, Anne Silviken and Gro Berntsen, and I the possibility to continue interviewing the bereaved while I was simultaneously developing the present thesis. This final iteration focuses on the cultural meanings of suicide among Sámi in Sweden (study I) and Norway (study II) and examines what suicide preventive initiatives have been undertaken among Sámi in Nordic parts of Sápmi (study III).

For me, finishing this thesis represents one of the most meaningful activities that I can think of, other than raising my daughters and being with my loved ones. It is my contribution to the Sámi community, which I am proud to serve to the best of my ability.

# 1 Introduction

According to the latest global statistics from the World Health Organization (WHO, 2019b), suicide has been decreasing since the year 2000. Still, close to 800 000 persons take their own life each year, making suicide one of the 20 most common causes of death worldwide. Indeed, suicide is more common than homicide, and it is the second leading cause of death among 15–29-year-old individuals in the world. The WHO (2014) calls suicide prevention 'a global imperative', urging all countries to develop and implement suicide prevention plans (about 40 have done so). The Nordic countries have been very respondent to such calls, with Finland being the first country in the world to develop a nationwide approach to reduce suicide. Suicide has been decreasing continuously in the Nordic countries after a peak during the 1980s. Today, as seen from an international perspective, suicide rates are considered moderate in the Nordic countries. However, suicide is still a major public health problem, and far more people die by suicide than automobile accidents in Norway, Sweden and Finland every year.

Globally, suicide has disproportionately affected Indigenous populations (Pollock, Naicker, Loro, Mulay, & Colman, 2018). The burden of suicides among Indigenous peoples in the Arctic has risen drastically during the 21st century, to a point where northern regions of western countries, such as the United States, Canada and Denmark (Greenland), report the highest suicide rates in the world (Young, Revich, & Soininen, 2015). In comparison, the situation among the Sámi is considerably better. Still, studies on mortality have shown Sámi men have also been disproportionally affected (Hassler, Johansson, Sjolander, Gronberg, & Damber, 2005; Jacobsson, Stoor, & Eriksson, 2020; Silviken, Haldorsen, & Kvernmo, 2006; Soininen & Pukkola, 2008; Young et al., 2015), and the need to prevent suicide among Sámi has been increasingly highlighted by health care authorities, Sámi parliaments and non-governmental organisations (NGOs) (Norrbottens läns landsting, Region Jämtland Härjedalen, & Västerbottens läns landsting, 2015; Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse & Saami Council, 2017; Stoor, 2016). The last chairmanships of the Arctic Council (except for the Swedish chairmanship in 2011–2013) have also included political prioritization of suicide prevention, especially among Indigenous peoples, in the Arctic (Arctic Council Sustainable Development Working Group, 2015; Collins et al., 2019; Larsen, Pedersen, Berthelsen, & Chew, 2010). However, useful scientific evidence for suicide prevention among Sámi is scarce (Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse & Saami Council, 2017; Stoor, 2016), and a review on suicide prevention initiatives for Indigenous peoples in the Arctic found no such studies from Sápmi (Redvers et al., 2015).

While mainstream suicidology has strongly emphasized suicide as associated with mental health issues, critics—including those studying suicide among Indigenous peoples—have argued that this approach is reductionist and universalistic (Boldt, 1988) and neglects the impacts of culture and context. Instead, they have proposed that one must understand suicide as a phenomenon embedded within the specific culture and context where it happens in order to develop better suicide prevention in general (Hjelmeland, 2011; Hjelmeland & Knizek, 2017), and especially for Indigenous peoples (Chandler & Proulx, 2006; Kral et al., 2009; Tatz, 2017; Wexler, Chandler, et al., 2015).

This thesis represents both a general and a specific response to the calls for renewed research action, as per the above statement. In general, it seeks to understand suicide as a sociocultural phenomenon, thus expanding the body of research on sociocultural understandings of suicide. Specifically, it seeks

to elucidate aspects of how suicide is understood in the Sámi context in Norway and Sweden. Furthermore, this thesis maps suicide prevention initiatives that target Sámi in Norway, Sweden and Finland. Taken together, the hope is that this knowledge might inform improved suicide prevention among Sámi.

## 1.1 Overview of the thesis

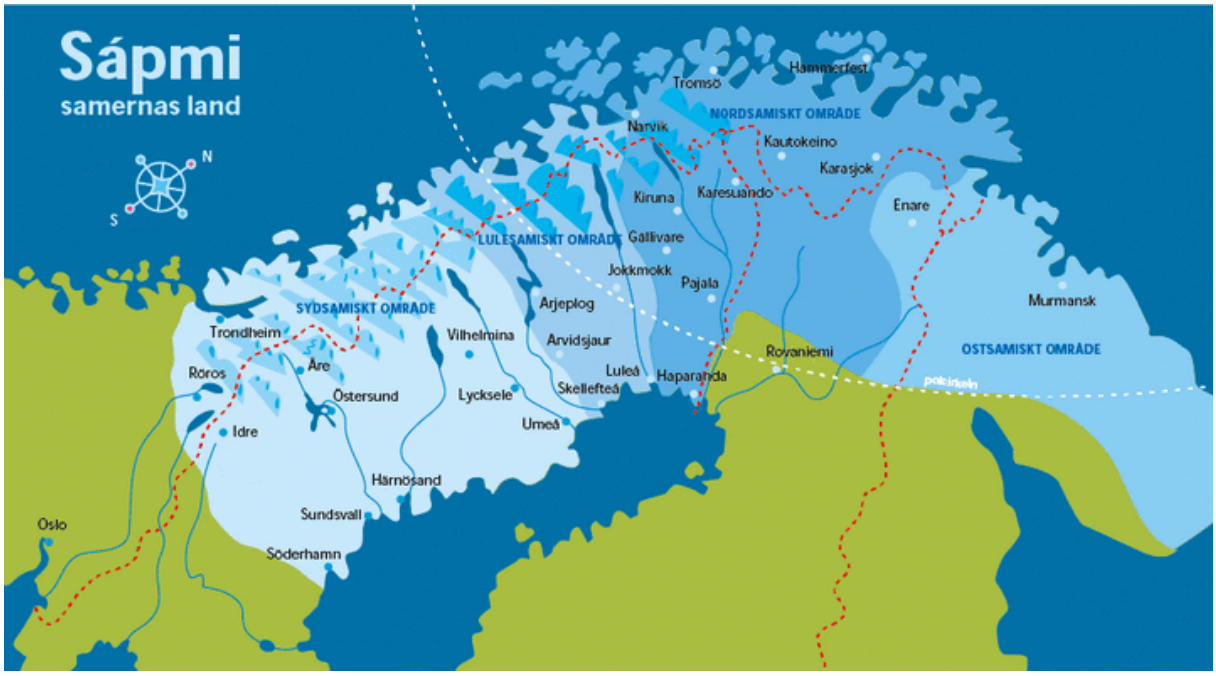
The thesis is divided into 10 chapters. Chapter 1 has introduced the theme of the thesis and provides this overview. Chapter 2 introduces the context of this research, including Sápmi, the Sámi and their rights in the health research context. Furthermore, it includes introductions to policies regarding Sámi suicide prevention and recommended approaches as described by the WHO. Chapter 3 provides an overview of previous research concerning mental health among Sámi, including subsections on suicide and suicidality, as well as mental ill-health, substance abuse, ethnic discrimination, violence and health care research. Chapter 4 specifies the aims of this thesis, as well as the specific research goals in the three studies within it. Chapter 5 concerns theoretical foundations for studying cultural aspects of suicide in general and cultural meanings of suicide in particular. Chapter 6 introduces relevant perspectives regarding research ethics in the intersections of medical science, the study of suicide and an Indigenous (Sámi) context. Chapter 7 describes the research methods used together in studies I and II and separately in study III. The findings are presented in Chapter 8. In Chapter 9, the results are discussed, including relating the findings to current research in international Indigenous suicide prevention and critical suicidology, and a proposition for improved structure and evaluation of Sámi suicide prevention is put forth. Chapter 9 ends with an in-depth discussion of some aspects of the methods used in the thesis, including an attempt to understand how ethical values laid down in a proposal for research ethics in Sámi health research came into play within this thesis. The conclusions, implications for clinical and public health practice and further research are presented in Chapter 10.

The thesis ends with a list of the works cited and the three articles (two published in peer-review journals and one in the form of a submitted manuscript) that comprise the foundation of the thesis.

# 2 Background

## 2.1 The Sámi and Sápmi

*Figure 1. Sápmi: land of the Sámi. The map shows the approximate area and division into South-, Lule-, North- and Eastern Sámi cultural areas. The map is in Swedish and from Samiskt Informationscentrum ('Sámi information centre); reproduced with permission.*




The Sámi (in northern Sámi language) are the Indigenous people in northern Scandinavia and north-western Russia, henceforth referred to as *Sápmi* (Figure 1). Sámi have no defined borders for their traditional lands, but today's depiction of Sápmi usually includes at least the land where Sámi reindeer herding—one of the traditional Sámi livelihoods—is conducted. This area stretches from Hedmark (Norway) and Dalarna (Sweden), in the southwest, to the Kola Peninsula in Russia. Sámi have traditionally lived off the land, subsisting on small-scale farming, fishing, hunting and reindeer herding. The latter activity, as a central part of Sámi culture, is protected as a Sámi livelihood in both Norway and Sweden. On the Norwegian side of Sápmi, the right to own reindeer is exclusive to the Sámi, and reindeer herding is organised in reindeer grazing districts based on traditional organisation principles. Similarly, the right to own reindeer in Sweden is exclusive to members of reindeer herding communities (RHCs), of which most are Sámi. Although some Sámi still provide for their families through reindeer herding, those families are now a minority within the Sámi community, which is characterised by its diversity and active engagement in all sectors of modern society, both within and outside of Sápmi. For example, there are large groups of Sámi in the capital cities of Oslo, Stockholm and Helsinki. Sámi language and culture are distinct in different parts of Sápmi. In Norway and Sweden, North-, Lule-, Pite-, Ume- and South Sámi languages are spoken. In Finnish parts of Sápmi, Northern-, Inari- and Skolt Sámi languages are spoken.

## 2.2 Sámi identity and ethnicity

Understandings and discourses of race, ethnicity and identity in historical and contemporary contexts inside and outside the Sámi society influence who is—and who is not—considered a Sámi (Pettersen,

2014). On the one hand, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007), signed by Norway, Sweden and Finland (but not the Russian Federation) assures the right of Indigenous peoples themselves to collectively self-declare and identify who they are in accordance with their customs and traditions. This declaration might provide the basis for a clear-cut definition. However, the self-understanding of Sámi has been continuously re-negotiated in relation to objectives that have shifted in importance over time. For example, Sámi political scientist Ragnhild Nilsson (2019) has shown how the Sámi in Sweden, under the influence of Swedish laws, gradually shifted their understanding of themselves (that is: who they are, or claim to be) during the 20th century from a relational understanding to a rights-based one. Nilsson describes this shift in relation to the gradually diminishing importance of the traditional family and value systems *maadtoe* and *laahkoe*, which emphasise the Sámi people's relationships and responsibilities between themselves and the land, and the rising need and possibility to defend Sámi rights within the Swedish national law and court systems, inspired by the international Human Rights discourse. Arguably, when such a change occurs, it also affects an individual's identity(-ies). Interestingly, Sámi ethnologist Åhrén (2008) has described how Sámi youth in Sweden navigate their Sámi identity(-ies) in relation to the understanding of ones' authentic—true—Sámi identity as being intrinsically tied to one's positionality and closeness to reindeer herding. The guiding principle is that stronger ties to reindeer herding equals a stronger—more authentic—Sámi identity. Although the Sámi have traditionally not only survived as reindeer herders, the idea that this activity has such an influence on identity makes sense from a historical-legal perspective because Swedish policies have separated Sámi based on livelihood. Somewhat simplified, reindeer herding Sámi were to be kept separate and maintain their Sámi rights, while non-reindeer herding Sámi lost their Sámi rights and were to be assimilated (Lantto, 2012). In Norway, on the other hand, the state policy was that *all* Sámi were to be 'Norwegianized' regardless of livelihood (Minde, 2003).

The historical and social understandings of race, and the temporal shifts of the social meaning of this category ('race') in Nordic societies, have also influenced the Sámi, their identity and how it has—or not—been acknowledged in demographic and health contexts. Axelsson (2010) has shown how the Swedish state tried to keep track of the Sámi from the mid-19th century up until the end of the Second World War, and how influential the Swedish Institute for racial biology was in the design of the 1930 census. However, the last time Sámi identity was counted in a Swedish census, in 1945, 'Sáminess' was constructed based on the language spoken. The subsequent decisions by the Swedish state to discontinue counting Sámi is not known to have been discussed publicly, but Pettersen's (2014) rendition of arguments cited by the Norwegian bureau of statistics (Statistisk sentralbyrå, 1956, p. 20f) for their similar abandonment of asking about race in the Norwegian censuses, might be somewhat elucidating:

> *[r]acial mixing has now proceeded so far that it will often be very difficult to determine the race to which large groups of the population belong", "[m]oreover, a large proportion of the Sámi /…/ live exactly the same lives as the population in general and have completely adapted to Norwegian culture and tradition", and "[t]he concept of "race" had also become so strongly discredited due to wartime circumstances, that it surely would give rise to indignation if such a question were to be included on the enumeration forms.*

Sámi organisations in Norway protested this change and got the Norwegian census of 1970 to include extra material in some of the parts of Nordland, Troms and Finnmark counties, with regard to questions on Sámi ethnicity. However, during the next 50 years, Sámi identity and ethnicity would not be counted.

## 2.3 Demography and rights in the health research context

The current estimates of the number of Sámi *'are typically in the order of 60 – 70 000 Sámi in total, who are typically distributed with 40 000 Sámi in Norway, 20 000 in Sweden, 7 500 in Finland and 2 000 in Russia'* (Pettersen, 2014, pp. 11–12). However, these estimates are uncertain and have been criticised. For example, the estimation of 20 000 Sámi in Sweden was a prospective estimate made on the basis of reindeer owner registries that claimed—in 1975—that there would be around 20 000 Sámi in Sweden in the year 2000 (Axelsson, 2010; Statens Offentliga Utredningar, 1975).

A present source of knowledge on Sámi numbers are the registries for the electoral rolls of the Sámi parliaments in Norway and Sweden. These registries are publicly accessible, kept by the Sámi parliaments themselves. To be registered as a Sámi voter, one must fulfil the demands of self-identification (consider oneself a Sámi). Also, the Sámi language must have been spoken in the family no less than two (in Sweden) or three (in Norway) generations back. As of 30 June 2019, 18 103 Sámi were registered as voters in Norway (Sámi parliament of Norway, 2019), and 8 766 Sámi in Sweden were eligible for voting in the 2017 Sámi parliament elections (Sámi parliament of Sweden, 2019). However, one may note that even though some Sámi obviously have chosen not to apply for the right to vote, there have been controversies and protests against the suspected inclusion of non-Sámi in the registries, both in Norway and Sweden (Poggats, 2019).

The connection between the right to be acknowledged, and counted, and the relation to Indigenous health rights have been highlighted by the United Nations Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health. In his official report of the mission to Sweden (in 2006), he concluded that the lack of possibilities to identify who is a Sámi constitutes a major obstacle in the search for new knowledge, design of intervention and, ultimately, for health itself:

> *Without data disaggregated on the grounds of race and ethnicity, how do the authorities know the scale and nature of this problem? If they do not know the scale and nature of the problem, how can they devise the most appropriate interventions? If an intervention were introduced, how would they know whether or not it was effective?* (Hunt, 2007, p. 30)

> *He regrets that he found little, if any, evidence that Sweden has translated the special status of the Sámi into meaningful, practical measures in the health context* (Hunt, 2007, p. 17)

Hence, aside from the direct consequences of difficulties in researching Sámi health, Hunt also made the argument that this is a rights issue, and Sweden has failed to translate Indigenous rights into meaningful measures in the health context. Similarly, the recently completed Proposal for Ethical Guidelines for Sámi Health Research and Research on Sámi Human Biological Material (Kvernmo et al., 2018), argued—based on Indigenous rights—that Sámi have the right to collective consent in health research, and to be acknowledged and recognised as Sámi in health registers:

> *As a people, the Sámi are entitled to learn about their own health. The registration of ethnic affiliation is a prerequisite for knowledge of ethnic groups' health situation and living conditions. Ethnic registration has previously been misused, also by researchers. Consequently, as a variable, ethnicity must be used in all contexts in a balanced and responsible manner to ensure that research contributes to knowledge and not to stigmatisation. Sámi ethnicity shall be recognised and acknowledged in a culturally safe and responsible manner that preserves Sámi values and the standards associated with Sámi affiliation.* (Kvernmo et al., 2018, p. 7)

The Sámi parliament in Norway approved the proposal and the guidelines are being implemented in Norway's system for ethical review of medical research.

## 2.4 Suicide and prevention among Indigenous peoples

Although not true for all Indigenous peoples, the available research suggests that most Indigenous peoples experience disproportionate suicide rates. Hence, being Indigenous might be considered a risk factor for suicide in most investigated contexts (Dudgeon et al., 2018; Pollock et al., 2018). This potential is also true for the Arctic region, where suicide rates among Indigenous peoples have been researched in Alaska, Canada, Greenland, the Nordic countries and parts of Russia (Young et al., 2015). To understand this issue, researchers have highlighted local and global processes, including historic and contemporary processes of colonisation, marginalisation, forced assimilation, destruction of Indigenous culture, rapid societal change and lack of societal developments. Furthermore, several the same scholars have criticised mainstream suicidology, claiming that it fails to understand dynamics that drive suicide among Indigenous peoples (Alcántara & Gone, 2007; Chandler & Proulx, 2006; Collins et al., 2019; Hallett, Chandler, & Lalonde, 2007; Kral, 2013; Tatz, 2005, 2017; Wexler, Chandler, et al., 2015; Wexler, White, & Trainor, 2015). While some of the critics argue that suicide in the indigenous context(s) is an altogether 'different' phenomenon from suicide in the mainstream western world (Tatz, 2005, 2017), others argue that the drivers of indigenous suicide are partially different. Regardless of this principal issue, the main sentiment is that one cannot detach Indigenous suicidal behaviour from the realities of historical and present-day inequalities. It is common for approaches that investigate such links to focus on factors above the individual level, namely family, community, social, cultural, contextual, political and historical factors (Arctic Council Sustainable Development Working Group, 2015, 2019; Clifford, Doran, & Tsey, 2013; Collins et al., 2019; Dudgeon & Holland, 2018; Wexler, Chandler, et al., 2015)

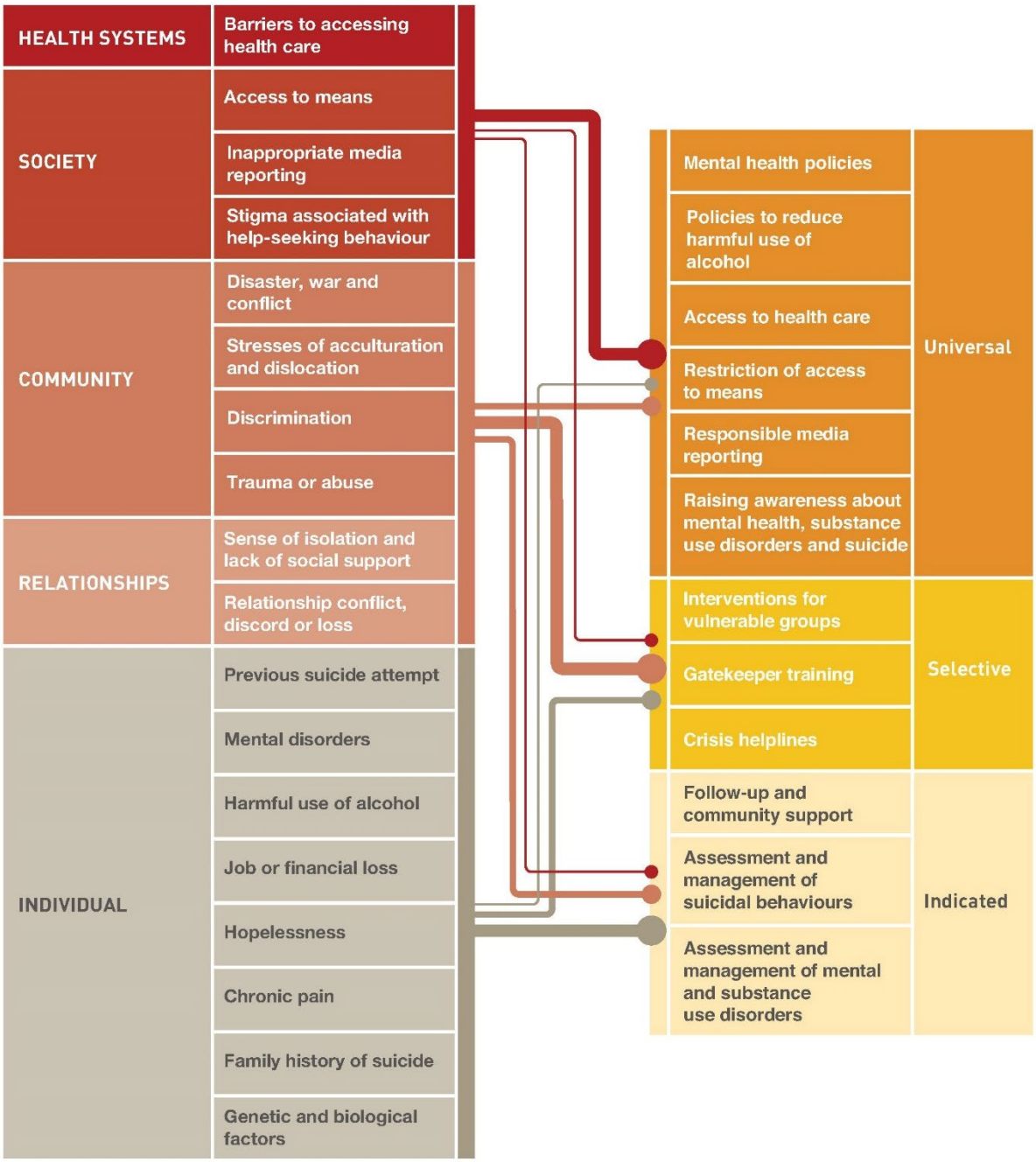
In a theoretical article, O'Keefe, Tucker, Cole, Hollingsworth, and Wingate (2018) have described and examined how general, cultural-based and Indigenous frameworks might help to understand suicide among American Indian/Alaska Native (AI/AN) peoples. According to them, general theories of suicide have seldom been tested in AI/AN contexts. While cultural models of suicide might acknowledge certain elements that are important for understanding suicide in the Indigenous contexts, including specific cultural meanings of suicide divergent from the norms of western society, they also fall short. O'Keefe and colleagues mean that the specific elements of Indigenous experiences should be included in models of suicide in order to capture the entirety of the phenomena. From this perspective, Indigenous frameworks are said to better incorporate the historical, social and cultural factors that influence health in Indigenous-specific ways. Such models are often more holistic—they do not exclude the mental from the physical—and include spiritual dimensions: *'these frameworks are guided by Indigenous epistemologies and are in line with a call for defying dominant ways of*

*thinking/systems that have oppressed AI/AN peoples, asserting sovereignty and self-determination in research and healthcare'* (O'Keefe et al., 2018, p. 791).

Regarding prevention, this line of thinking centers the importance of Indigenous identities, communities and cultures as mediating factors for mental health, resilience and suicide prevention. A particularly strong impact has come from studies showing that communities that were able to maintain strong self-determination and cultural continuity fared better (in terms of youth suicides) than those that did not (Chandler & Lalonde, 1998; Chandler & Proulx, 2006; Hallett et al., 2007). Recently developed Indigenous-specific suicide prevention plans echo that understanding and include a focus on how Indigenous self-determination and culture might strengthen communities for increased resiliency and suicide prevention (Australian Government, 2013; Inuit Tapiriit Kanatami, 2016; Sámi Norwegian National Advisory Unit on Mental Health and Substance use & Saamicouncil, 2017). Similarly, the main theme of the 2020 iteration of the 'World Indigenous Suicide Prevention conference' is 'Strength in our communities', with a focus on 'protective factors through building identity, resilience and culture' (First Nations Health and Social Secretariat of Manitoba, 2020).

With regard to suicide, the WHO (2014) recommends that countries strategize, coordinate and implement comprehensive suicide preventive plans. To this end, approximately 40 countries around the world have thus far developed national suicide prevention programs (WHO, 2018). Plans for action can be divided into different levels of intervention, from the population wide (universal), to the focus on at-risk groups (selected) and at-risk individuals (indicated). Figure 2 depicts known key risk factors for suicide and the corresponding relevant interventions, as described by the WHO (2014). The WHO suggests that Indigenous people are potentially vulnerable at-risk groups for which suggested interventions include gatekeeper training, crisis hotlines, community prevention initiatives and culturally tailored interventions. Furthermore, the WHO acknowledges that Indigenous suicidal behaviour might not be detachable from the historical and social realities of Indigenous peoples, including the experiences of being colonized, as: 'among Indigenous groups, territorial, political and economic autonomy are often infringed and native culture and language negated. These circumstances can generate feelings of depression, isolation and discrimination, accompanied by resentment and mistrust of state-affiliated social and health-care services, especially if these services are not delivered in culturally appropriate ways' (WHO, 2014, p. 52).

*Figure 2. Key risk factors for suicide aligned with relevant interventions (the lines reflect the relative importance of interventions at different levels for different areas of risk factors). This figure is taken from the World Health Organization publication 'Suicide Prevention - A Global Imperative' (2014). Reprinted with permission.*



## 2.5 Suicide prevention in Norway, Sweden and Finland from a Sámi perspective

Finland was the first country in the world to implement a national suicide preventive programme, in the late 1980s (WHO, 2018). However, neither that programme nor subsequent national plans in Nordic parts of Sápmi (Norway, Sweden and Finland) have included Sámi in meaningful ways. An example of this deficiency is the national action plan to prevent suicide and self-harm in Norway (2014–2017; Helsedirektoratet, 2014). It mentions the Sámi, but it does not articulate any aim or action to specifically target Sámi. Furthermore, the only county municipality within traditional Sámi territory in Norway to have developed a regional action plan (Nordland county) does not mention Sámi (Nordland fylkeskommune, 2014).

The Swedish national plan for suicide prevention aims to reduce suicide to zero. This goal ostensibly indicates that the plan is highly prioritised; although it fails to mention Sámi (Socialstyrelsen & Statens Folkhälsoinstitut, 2006). However, Sámi health, especially mental health and suicide, have emerged on the regional agendas of northern health care authorities in Sweden during the last few years. Sámi, as a specified group, have appeared in regional plans to improve mental health and prevent suicide in the Region Jämtland Härjedalen (Strömsunds kommun et al., 2017, 2018), and they were included in an agreement with the three northernmost regions in Sweden (Norrbottens läns landsting et al., 2015). The agreement states that suicide prevention among Sámi should be carried out as integrated targets in the regions' efforts to improve access to and the quality of clinical services for Sámi patients, through mobilising and increasing Sámi cultural and language competency among the health care providers, as well as through providing gatekeeper training for Sámi.

A scoping review on suicide prevention among Indigenous peoples in the Arctic failed to identify any studies on suicide prevention among Sámi (Redvers et al., 2015). However, a report from the Arctic Council Sustainable Development Working Group (2015) describes the 'Sámi Psychiatric Youth Team', at SANKS, as a promising practice. The report highlights that the easy access (self-referral) psychiatric service serves 80–120 young (18–30 years old) patients seeking help to deal with drug use and/or suicidality each year. Furthermore, the unit's frequent use of text messages is considered to be an innovative practice, and the service is considered to be a success given that no patients have taken their lives.

## 2.6 Plan for suicide prevention among Sámi

The 'Plan for suicide prevention among Sámi People in Norway, Sweden, and Finland' (PSPS) was developed in 2016–2017 as a joint project between SANKS and the Saami council. It aims *'to supplement the suicide prevention work already conducted in Norway, Sweden, and Finland /…/ the strategies thus point to specific challenges and needs of the Sámi people that cannot be considered covered in the countries' general suicide prevention efforts'* (Sámi Norwegian National Advisory Unit on Mental Health and Substance use & Saami Council, 2017, p. 3). The plan outlines 11 strategies and suggested measures based on available scientific evidence and consultations with Sámi grassroots engaged in suicide prevention among them (Table 1). The plan contains no evaluation piece, and no report with regard to the process or fulfilment of the strategies or aims has been published.

*Table 1. Strategies and suggested measures in the 'Plan for suicide prevention among Sámi people in Norway, Sweden and Finland' (Sámi Norwegian National Advisory Unit on Mental Health and Substance use & Saami Council, 2017).*

| Strategy | Suggested measures |
|---|---|
| Strategy 1: Focusing efforts on the Sámi men | • Place special focus on the Sámi men in suicide prevention among the Sámi people. |
| Strategy 2: Producing statistics and strengthening research on suicide among the Sámi | • Enhance the ability to produce statistics on the occurrence of suicide among the Sámi and its trend over time.<br>• Initiate new research projects that examine suicide among the Sámi people, including causes and the best ways to prevent suicide among the Sámi. |
| Strategy 3: Strengthening Sámi self-determination | • Ensure that the Sámi are given a real opportunity for self-determination by allowing them to influence decisions that have direct or indirect impacts on their ability to control their own situation. This endeavour includes all aspects of the Sámi community, such as education, culture and language, but it is particularly important to the Sámi working in traditional industries in which they must be allowed the right to influence processes that threaten to destroy the basis of their subsistence. |
| Strategy 4: Initiating efforts to recognize and deal with historical traumas | • Initiate efforts, including research, to clarify how historical and intergenerational traumas affect the health and suicidality of the Sámi people today.<br>• Initiate broad societal efforts to better deal with and process the consequences of historical traumas on the Sámi people and individuals. |
| Strategy 5: Strengthening and protecting the Sámi cultural identity | • Work actively to strengthen young Sámi people's cultural identity through language-enhancing efforts and opportunities to partake in cultural activities.<br>• Protect and develop existing Sámi cultural and linguistic environments, including the opportunity for Sámi education and training, especially in areas where the Sámi are in the minority and where existing Sámi cultural and linguistic environments are dependent on individuals or are otherwise fragile.<br>• Establish Sámi cultural and linguistic environments in areas where the Sámi people live and where there are no such environments. |
| Strategy 6: Reducing the Sámi's exposure to violence | • Strengthen Sámi organisations and institutions that work to reduce the Sámi's exposure to violence and combat bullying and ethnic discrimination.<br>• Ensure that Sámi victims of violence have access to Sámi-speaking and cultural expertise if they seek help and support to get out of relationships where they are subjected to some kind of violence. |

| | |
|---|---|
| | Today, access to this varies widely, and support systems are only found in Norway. |
| Strategy 7: Reducing the Sámi's experiences of ethnic discrimination | • Reduce ethnic discrimination against the Sámi people through general awareness-raising work in the surrounding majority populations.<br>• Strengthen Sámi organisations and institutions and ensure that they actively work to help individual Sámi deal with the negative health consequences from ethnic discrimination. This includes, among other things, taking responsibility to recognize and stand up against ethnic discrimination targeted at Sámi individuals.<br>• Strengthen the Sámi's resilience, i.e. resistance, against negative health consequences of experiencing ethnic discrimination. |
| Strategy 8: Increasing diversity and acceptance in the Sámi community | • Break the taboo, stigma and negative attitudes related to non-normative sexuality and gender identity throughout Sápmi. This action requires actively strengthening the forces and organisations working towards these goals. |
| Strategy 9: Securing the Sámi's right to equal, linguistically and culturally adapted mental health care | • Educate health care professionals in Sámi culture.<br>• Enhance access to Sámi-speaking health care professionals.<br>• Strengthen and develop existing organisations that provide linguistically and culturally adapted mental health care to the Sámi people. Competence must be available both locally where the Sámi live and in the form of more specialized health care. The SANKS model of a centrally located unit and smaller satellite offices can be extended to other countries. |
| Strategy 10: Educating and mobilizing the Sámi civil society for suicide prevention | • Communicate the importance of participation from the entire community, not just health care providers, and that all contributions can make a difference in suicide prevention.<br>• Enhance suicide prevention cooperation between different parts of the Sámi civil society, including Sámi organisations, institutions, care providers, private individuals and others.<br>• Initiate and conduct further training in suicide prevention, such as ASIST and SafeTalk, targeted at especially important professional groups and the Sámi community. |
| Strategy 11: Initiating and strengthening cross-border cooperation for suicide prevention | • Initiate cooperation between all parties, including governments, health care providers, regional and municipal organisations, Sámi organisations and others who play an important part in suicide prevention among the Sámi people.<br>• Include the Sámi perspective in countries' general suicide prevention efforts, both nationally and internationally. This endeavour entails including special focus on the specific needs of Indigenous peoples in national suicide prevention programs. |

# 3 Previous research related to Sámi mental health and its social determinants

From being almost non-existent, Sámi health research has grown during the last 20 years. Today, it encompasses both somatic and mental health issues (Kvernmo et al., 2018; Mehus & Bongo, 2012; Andersdatter Siri, 2015; Sjölander, 2011; Sjölander, Edin-Liljegren, & Daerga, 2009; Stoor, 2016). Within the somatic (Storm Mienna & Axelsson, 2019) and mental health domains (Stoor, 2016), most health-related knowledge is found for Sámi in Norway, followed by Sweden (with severe gaps), Finland with very limited knowledge and Russia, where knowledge is extremely limited (Heatta & Snellman, 1996; Poppel et al., 2015; Snellman, Hetta, & Dubovtseva, 1998). Furthermore, Sámi perspectives on health, such as traditional medicine and traditional knowledge relating to health, is likely very limited in all countries (Stoor, 2016), with exceptions regarding studies on health systems (Nymo, 2011), cultural understanding of health (Bongo, 2012; Langås-Larsen, Salamonsen, Kristoffersen, Hamran, et al., 2018; Minde & Nymo, 2016),traditional shamanistic and healing practices in the modern context (Langås-Larsen, Salamonsen, Kristoffersen, & Stub, 2018; Sexton & Buljo Stabbursvik, 2010; Sexton & Sorlie, 2008; Sexton & Sørlie, 2009), and prevalnce of use of such practices among Sámi in Norway (Kristoffersen, Stub, Melhus, & Broderstad, 2017). For the purpose of this study, the following account on previous Sámi health research will not include somatic health. Rather, it will focus on the social and mental dimensions of health to provide an in-depth account of knowledge regarding suicide among Sámi.

## 3.1 Suicide

Knowledge on suicide among Sámi is limited (and outdated) due to the lack of registered ethnicity in Nordic death registries. However, three cohort studies have investigated historical suicide rates among Sámi as compared to matched control groups of the majority population in the same areas. Data from those cohort studies, in Northern Norway (1970–1998), Northern Sweden (1961–2000) and Northern Finland (1979–2010), are presented in Table 2. Based on that data the Arctic health epidemiologist Kue Young and colleagues commented that:

> *Unlike other health indicators, where disparities between Sami and non-Sami are very small or non-existent, there is an excess of suicide among Sami. Among men, the excess ranged from only 17% higher in the Swedish cohort to as much as 2.5 times higher in the Finnish cohort during the period 1997–2005. On the other hand, there is no excess suicide risk among Sami women in any of the 3 cohorts.* (Young et al., 2015)

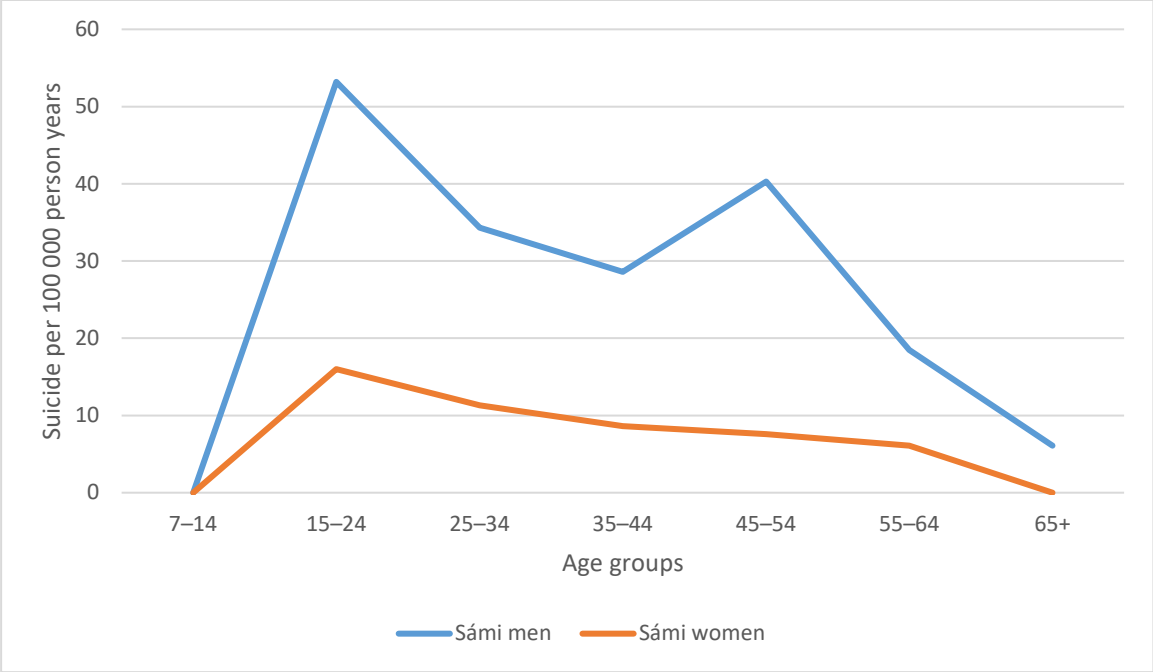
*Table 2. Standardised mortality rates (SMR) for suicide Sámi, compared to the majority populations in Northern Norway, Northern Sweden and Northern Finland. The data are from Silviken et al. (2006), Hassler et al. (2005), Soininen and Pukkola (2008) and Young et al. (2015).*

| | Cohort | Men | Women |
|---|---|---|---|
| **Norway, 1970–1998** | Entire cohort | 1.27[1,2] | |
| | Finnmark | 1.50[2] | 1.55 |
| | Troms | 0.74 | 1.00 |
| | Nordland | 0.42 | 3.17 |
| | Core areas (Inner Finnmark) | 1.54[2] | 1.31 |
| | Coast | 1.24 | 1.21 |
| | South | 0.41 | 1.51 |
| | 1970–1980 | 1.17 | 1.14 |
| | 1981–1990 | 1.36 | 1.92 |
| | 1991–1998 | 1.20 | 0.81 |
| | Non-reindeer herders | 1.30 | 1.34 |
| | Reindeer herders | 1.06 | 0.66 |
| **Sweden, 1961–2000** | Entire cohort | 1.17[2] | 0.76[2] |
| | Non-reindeer herders | 1.05 | 0.67 |
| | Reindeer herders | 1.50 | 1.12 |
| **Finland (Inari and Utsjok municipalities), 1979–2010** | Entire cohort | 1.78[2] | 1.26 |
| | 1979–1987 | 1.83 | (no case) |
| | 1988–1996 | 1.07 | 1.93 |
| | 1997–2005 | 2.55[2] | 1.2 |
| | 2006–2010 | 2.32 | 1.2 |

[1] Both men and women

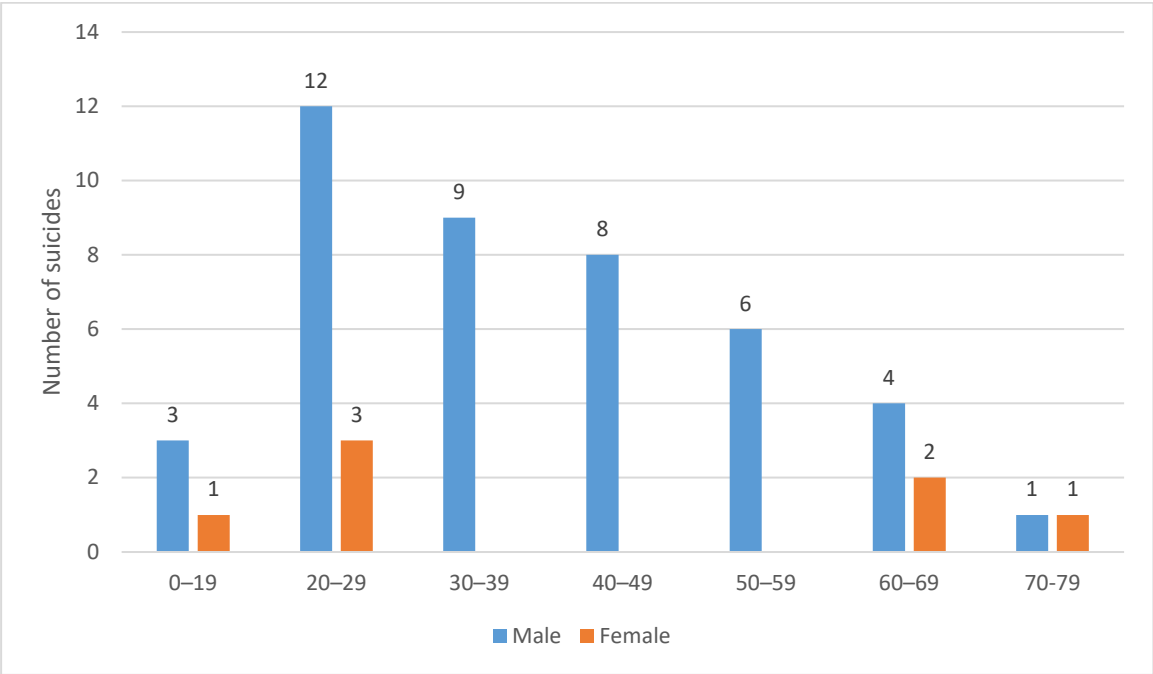
[2] Rates where the observed difference was statistically significant (95% confidence interval).

*Figure 3. Suicide per 100 000-person years among Sámi in Northern Norway, by sex and age, 1970–1998. Data are from Silviken et al. (2006).*




Data from Silviken et al. (2006), concerning Sámi in Norway, also showed that aside from Sámi having been at greater risk of dying by suicide as compared to Norwegians, the relative risk among Sámi of dying by suicide was greatest among the young men (Figure 3). No similar data, divided into age and sex, is available for the cohort studies from Sweden and Finland, but a study from Sweden on suicide among Sámi reindeer herders (1961–2017) reported that most suicides occurred among young men aged 20–29 (Jacobsson et al., 2020) (Figure 4).

*Figure 4. Suicide among reindeer herding Sámi in Sweden (1961–2017) by sex and age. Data from Jacobsson et al. (2020).*



Hassler, Sjolander, Johansson, Gronberg, and Damber (2004) and Jacobsson et al. (2020) found that the use of more violent methods (shooting and hanging) was very common among Sámi men (Table 3). When making international comparisons, the higher relative risk of suicide among younger men, and the use of more violent methods such as shooting and hanging are also characteristics of suicide among other Indigenous peoples in the Arctic (Young et al., 2015).

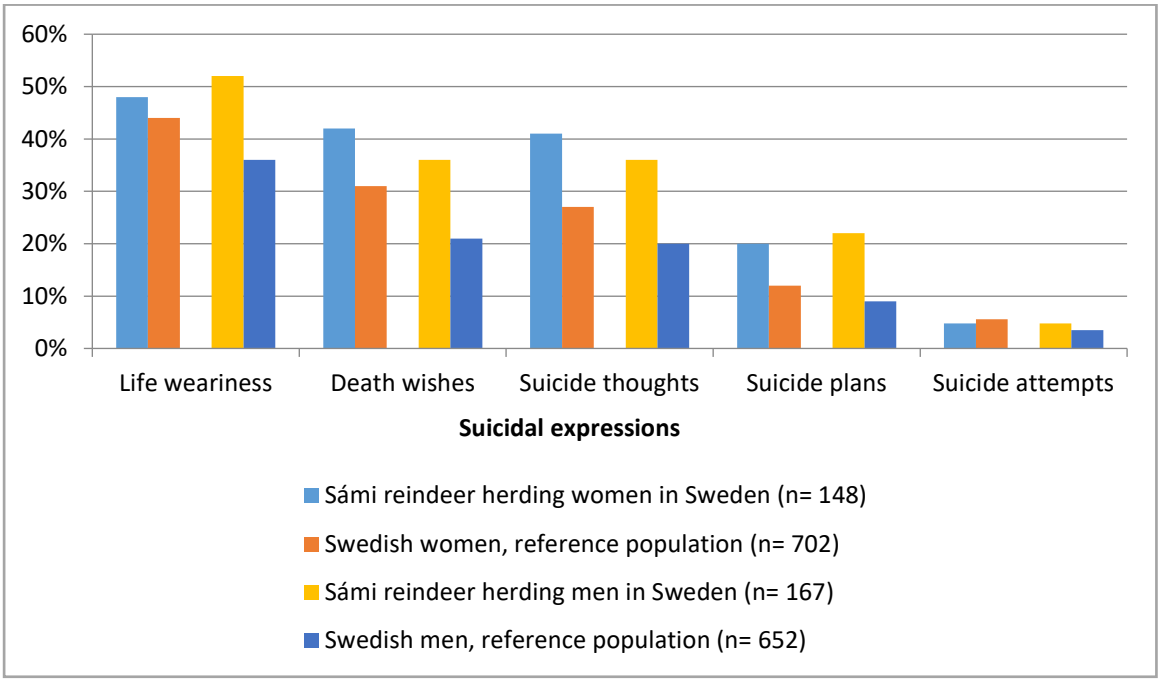
*Table 3. Suicide methods among reindeer herding Sámi in Sweden (1961–2017) and Sámi in Norway (1970–1998) by country and sex. The data are from Silviken et al. (2006) and Jacobsson et al. (2020).*

| | **Reindeer herding Sámi in Sweden, 1961–2017** | | | | **Sámi in Norway, 1970–1998** | | | |
|---|---|---|---|---|---|---|---|---|
| | **Men** | | **Women** | | **Men** | | **Women** | |
| | N | % | N | % | N | % | N | % |
| Shooting | 27 | 63 | 1 | 14 | 29 | 41 | 0 | 0 |
| Hanging | 11 | 26 | 1 | 14 | 26 | 37 | 10 | 53 |
| Intoxication | 4 | 9 | 2 | 29 | 9 | 13 | 5 | 26 |
| Drowning | 0 | 0 | 2 | 29 | 2 | 3 | 4 | 21 |
| Stabbing | 1 | 2 | 1 | 14 | 2 | 3 | 0 | 0 |
| Jumping | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| Other, not reg | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| Total | 43 | | 7 | | 70 | | 19 | |

## 3.2 Suicidality and attitudes towards suicide

Suicidality, or suicidal expressions, has been studied among Sámi in Norway and Sweden. A questionnaire study in Finnmark, the northernmost county in Norway, found no ethnic differences in suicidal expressions between Sámi and Norwegian youth (13–16 years old; Kvernmo & Rosenvinge, 2009). In the 'The North Norwegian Youth Study' (conducted in 1994–1995 and 1997–1998), 9.2% of Norwegian youth and 10.5% of Sámi youth reported suicide attempts; this difference was not statistically significant. However, specific ethnic risk factors for reporting suicide attempts were found among Sámi, including living with only one parent, increased use of alcohol and reporting having over-protective parents. These factors were hypothesised to represent non-normative situations among Sámi (Silviken, 2009; Silviken & Kvernmo, 2007).

*Figure 5. Suicidal expressions among reindeer herding Sámi in Sweden, and a Swedish reference population, by ethnicity and sex, measured with the Attitudes Towards Suicide (ATTS) scale in 2007–2008. The data are from Kaiser and Salander Renberg (2012).*




In Sweden, reindeer herding Sámi and young adult Sámi have been shown to report significantly more suicidal expressions compared to Swedish reference populations (Kaiser & Salander Renberg, 2012; Omma, Sandlund, & Jacobsson, 2013) (Figure 5). However, neither Sámi reindeer herders nor young adult Sámi reported significantly more suicide attempts (the most severe suicidal expression after suicide). However, in-group comparisons among young adult Sámi revealed significantly greater risks for suicide plans among Sámi in south Sámi areas (26%), those who also reported experiencing ethnic discrimination (25%) and among reindeer herding Sámi (31%; Omma et al., 2013).

An interview-questionnaire study on health and living conditions among Indigenous peoples in the Arctic (the SLiCA-study) found Sámi in Sweden reported statistically significant less suicidal plans (5%) than Sámi in Norway (11%) (Broderstad, Eliassen, & Melhus, 2011). However, among Sámi in Sweden, only 196 of 224 participants answered the question regarding suicidal plans, raising questions as to the reliability of the Swedish data set (Stoor, 2016).

## 3.3 Alcohol abuse

Although stereotypical images of the Sámi as heavy drinkers have been part of mainstream culture throughout Nordic parts of Sápmi, research on Sámi drinking habits has failed to confirm this supposition (Kaiser, Nordström, Jacobsson, & Salander Renberg, 2011; Omma & Sandlund, 2015; Orjasniemi, 2012; Spein, 2008; Spein, Sexton, & Kvernmo, 2007; Spein, Sexton, & Kvernmo, 2006). It seems Sámi do not generally drink more than non-Sámi peers. It has been hypothesised that the lack of ethnic differences might be related to the effects of the Laestadianist religious movement, which is strong among Sámi and preaches temperance in relation to alcohol. In a study among Sámi youth in northern Norway, this hypothesis was partially confirmed (Spein, Melhus, Kristiansen, & Kvernmo, 2011). However, in both Sweden and Finland, studies have found that male Sámi reindeer herders

constitute a risk group for dangerous drinking as compared to Swedish men and Finnish reindeer herders, respectively (Kaiser et al., 2011; Poikolainen, Näyhä, & Hassi, 1992).

## 3.4 Mental ill-health

Studies on mental health in Northern Norway have failed to show ethnic differences between Sámi youth and Norwegian peers (Bals, Turi, Skre, & Kvernmo, 2010, 2011; Bals, Turi, Vitterso, Skre, & Kvernmo, 2011; Heyerdahl, Kvernmo, & Wichstrom, 2004; Kvernmo, 2004; Kvernmo & Rosenvinge, 2009; Silviken & Kvernmo, 2007). However, among adults the situation is different, with Sámi men reporting significantly more psychological distress compared to Norwegian men in the population-based SAMINOR 1 Questionnaire study (Hansen & Sørlie, 2012). Further, in SAMINOR 2 (2011–2012) both Sámi men and women reported significantly more mental health distress compared to non-Sámi in the same areas, as measured using the Hopkins Symptoms Check List (HSCL-10; Eriksen et al., 2018). Furthermore, among Sámi in Sweden, poorer mental health has been found both among young adult Sámi (Omma, Jacobsson, & Petersen, 2012) and reindeer herding Sámi (Kaiser, Sjolander, Liljegren, Jacobsson, & Renberg, 2010) as compared to the Swedish majority populations in Sámi areas. For example, using the Hospital Anxiety and Depression Scale [HADS], 38% of male Sámi reindeer herders reported clinically relevant anxiety problems, compared to 19% of rural and 23% of urban Swedish men in Northern Sweden. (Kaiser, 2011).

## 3.5 Ethnic discrimination

Sámi in Norway reported being subjected to ethnic discrimination much more than Norwegians (4 to 10 times more common) in the SAMINOR 1 (2003–2004) population-based study, and this experience increased with stronger Sámi identity (being a Sámi speaker and having more Sámi-speaking parents and grandparents). Similar results were found in SAMINOR 2 (2011–2012), with every other Sámi with the strongest Sámi identity having experienced some form of discrimination, and 1 in 3 having experienced ethnic discrimination (Hansen, Minton, Friborg, & Sørlie, 2016). In Sweden (2007–2008), experiencing ethnic discrimination was common among Sámi youth (55%) and young adult Sámi (45%). Furthermore, among young adult Sámi, this phenomenon was more common among those who speak Sámi or are reindeer herders (70%), i.e. having a stronger Sámi identity (Omma et al., 2012; Omma & Petersen, 2015). As noted above in the section on suicidality, Omma et al. (2013) also found that reporting suicidality was significantly more common among young adult Sámi who also reported having been subjected to ethnic discrimination.

Given that ‘experience of ethnic discrimination’ was measured in the SAMINOR 1 and 2 studies, and in the study by Omma et al. (2013), one may note that ‘racism’ was not mentioned in those questionnaires. However, a previous study among Sámi in Sweden—which also used ethnic discrimination as the main concept—found that 3 out of 4 Sámi agreed with the statement that Sweden as a country was racist—at least to some degree (Lange, 2001). This finding can be interpreted to suggest that the term ‘ethnic discrimination’ might not be all-inclusive of the Sámi’s experiences of negative treatment due to them being Sámi.

## 3.6 Exposure to violence

Studies investigating exposure to violence among Sámi are rare. However, the SAMINOR 2 questionnaire study (in Norway) found that both Sámi and non-Sámi report high exposure to interpersonal violence, including emotional, physical and/or sexual violence (Eriksen, Hansen, Javo, & Schei, 2015). Sámi generally reported more exposure than non-Sámi, with Sámi women being most exposed (49%): significantly more than non-Sámi women did (35%). However, an exception from this was that there were no ethnicity-dependent differences in exposure to sexual violence among men. Independent of this, feminist scholars have pointed to both the Sámi society and Sweden not highlighting or working towards specifically decreasing violence towards Sámi women (Burman, 2017; Kuokkanen, 2015),

## 3.7 Health care research

The scarce literature regarding health care among Sámi reveals a system not responsive to their needs. Sámi speakers in Norway are more dissatisfied with primary care than non-Sámi speakers (Nystad, Melhus, & Lund, 2008), the Sámi in Finland are less satisfied with social and health care services than the majority population (Heikkilä, Laiti-Hedemäki, & Pohjola, 2013) and Sámi reindeer herders in Sweden more often lack trust in primary care and mental health services compared to Swedish controls (Daerga, Sjolander, Jacobsson, & Edin-Liljegren, 2012). Furthermore, findings among Sámi mental health patients indicate that they might benefit somewhat from ethnic matching (Sámi patient–Sámi therapist; Møllersen, Sexton, & Holte, 2009), might not agree with (Norwegian) therapists' positive evaluation of the shared therapeutic alliance (Sorlie & Nergard, 2005) and experience a lack of attention paid to their spiritual needs in mental health therapy (Sexton & Sørlie, 2009). Bongo (2012) has argued that the Sámi understanding of health—including Sámi indirect communication styles regarding health—is not acknowledged, or well understood, in the Norwegian health care system. Furthermore, other nursing scholars have highlighted the shortcomings in the Norwegian health care system, where the varied and dynamic nature of Sámi patients' needs (similar to all patients' needs)—pertaining to their culture and language—seem mostly reduced to stereotypes or are not prioritised. Consequently, there have been few or haphazard adaptations for Sámi patients in Norway (Blix & Hamran, 2017; Dagsvold, 2019; Dagsvold, Møllersen, & Stordahl, 2015, 2016). In light of this perception, it perhaps makes sense that other researchers report that Sámi patients might be attempting to adapt themselves to fit a system they perceive as built to fit the majority of the population, including trying to present themselves as 'perfect patients', with a clear set of symptoms and not requiring any 'special treatment' based on them being Sámi (Hedlund & Moe, 2000; Melbøe, 2018; Melbøe, Johnsen, Fedreheim, & Hansen, 2016; Ness, Enmarker, & Hellzèn, 2013).

# 4 Aims

The overarching aim of this thesis was to explore and elucidate how suicides are understood among Sámi and what specific actions have been taken to prevent suicide among Sámi in Nordic[3] parts of Sápmi. The specific aims were the following:

- to explore and make sense of the cultural meaning(s) of suicide among Sámi in Sweden (study I);
- to explore and describe cultural meanings of suicide among Sámi in Norway (study II);
- to identify, describe and analyse suicide prevention initiatives targeting Sámi, in Norway, Sweden and Finland during 2005-2019 (study III).

[3] The Nordic region, or 'Nordic Countries', refers to Iceland, Denmark, Norway, Sweden and Finland, including their territories (Greenland, the Faroe Islands, Åland islands and Svalbard). Hence, the Nordic parts of Sápmi refer to all parts of Sápmi except the Kola Peninsula, in northwestern Russia.

# 5 Theory: framing the cultural meanings of suicide

While one might think that defining suicide is straight forward, that is not necessarily the case, as evident in the lack of consensus on a clear definition. Perhaps testament to this outlook, recent WHO reports on suicide provide no definition of suicide (WHO, 2014, 2018, 2019a, 2019b).

In his attempt to define suicide, Edvin Schneidman (1985)—labelled as 'the father of modern suicidology' (Leenaars, 2010)—underscored that suicide is a conscious decision by an individual faced with a 'multidimensional malaise' for which the individual sees suicide as the best solution:

> *Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution.* (Schneidman, 1985, p. 203)

Schneidman emphasized that this definition was bound in time and space to the contemporary Western world, highlighting the cultural dimension of any such definition. Similarly, Boldt (1988, p.106), stressed that:

> *Suicide is a cultural artifact, and no one who commits suicide does so without reference to the prevailing normative standards and attitudes of the cultural community. Therefore, cause of suicide can be understood only with reference to the socio-cultural norms and attitudes that govern each cultural community /.../ In order to develop valid social scientific theories of cause, suicidologists must make a paradigmatic shift from the prevailing universal, invariant definition of suicide to systematic research into culture-specific meanings of suicide.*

For the particular purpose of this study, a clear and unambiguous definition of suicide is not necessary. Rather, it is important to recognize that there are differences in the way people understand suicide, even within cultures, and that part of the task of suicidologists is to highlight those understandings in order to align suicide prevention with local understandings and improve prevention. Hence, central to that task is to investigate how suicide is understood in different cultures and contexts: in other words, the cultural meaning(s) of suicide (Hjelmeland, 2010).

## 5.1 Culture in suicidology

Culture is a concept that encompass a very broad range of human activity, perhaps all human activity, and as such it is not easy to define. However, in an attempt to do so in the context of psychological research, Marsella, Dubanoski, Hamada, and Morse (2000, p. 50) proposed that culture is:

> *shared acquired patterns of behaviour and meanings that are constructed and transmitted within social-life contexts for the purposes of promoting individual and group survival, adaptation, and adjustment. These shared acquired patterns are dynamic in nature (i.e. continuously subject to change and revision) and can become dysfunctional.*

While it is likely that there is no 'perfect' or uncontested definition of culture, the particular content of the above definition makes it suitable for the purpose of this thesis. The important aspects include that culture is socially constructed, dynamic (changing) in nature and learnt (acquired), as opposed to something essential, static and given from birth. In this research, it is important to stress that culture is

not understood as something that cannot change, and the people of a specific culture (such as Sámi) are not 'destined' to elicit particular behaviours, meanings and norms of that culture. Rather, culture is always changing due to the interactions among people, their context and environment. Thus, understanding culture is akin to trying to understand a moving target. Therefore, it is important to acknowledge that what is considered culture, or aspects thereof, is always contested to some extent. However, that fact is not the same as saying that cultural phenomenon does not exist, or that using the concept of culture to understand human activities is meaningless. Rather, it means that culture is (very) complex.

Another important aspect of Marsella and colleagues' definition of culture is the understanding that these shared acquired patterns—the 'building blocks' of culture—can become dysfunctional. In other words, even though culture should be recognised as a force that strives to increase '*individual and group survival, adaptation, and adjustment*', such patterns can fail both in individuals and groups. For example, shared patterns developed in one context might not be useful in another (or if the context changes). Hence, I argue that culture—understood as tools for adaption and adjustment (shared patterns of behaviour and meaning)—should be pragmatic in nature. From this view, it is legitimate to challenge 'culture' (shared practices) if 'it' fails to provide good tools for adjustment and adaptation. Furthermore, as a Sámi researcher interested in culture in relation to suicide, I recognise that it is part of my responsibility to work on identifying whether there are dysfunctional shared patterns of importance to suicide among us—and to challenge those patterns if necessary—in order to improve suicide prevention among Sámi.

There are many ways to include 'culture' in suicidological research (Hjelmeland, 2010, 2011). For example, in suicidology, it is widely accepted that differences in suicide rates among ethnic groups, cultures and contexts reflect, or manifest, cultural differences. An example of studies that investigated the cultural aspect of suicide is the examination of differences among cultures (most often operationalised as 'countries' or 'races') in the male to female ratio of suicide deaths, and subsequently evaluating the culture as the possible driver behind the found differences. In this endeavour one perhaps hypothesises about the cultural reasons as to why this ratio seems to be generally higher among Indigenous populations than non-Indigenous populations, or in low- as compared to high-income countries. This kind of research is of course welcome and important (Colucci & Martin, 2007a, 2007b), but researchers interested in cultural aspects of suicide have argued that only investigating differences in suicide incidences, as manifestations of culture, merely scratches at the surface. To understand suicide as the multifaceted phenomenon it is, and to develop culturally relevant suicide prevention programs, investigating the cultural meanings of suicide is essential (Boldt, 1988; Colucci, 2006; Hjelmeland, 2010, 2011; Hjelmeland & Knizek, 2010; Kral, 2012; Redvers et al., 2015).

## 5.2 The cultural meanings of suicide

Given that 'suicide' and 'culture' are not clear-cut or uncontested concepts, it would be surprising if the 'cultural meanings of suicide' were. Rather, there are different perspectives of what the 'cultural meanings of suicide' are, ranging from the individual motives of persons who die by suicide in different contexts, to how those suicides are understood and in what ways such understandings are related to other facets of specific cultures. A particularly strong critique of the lack of attention to cultural aspects of suicide has come from Menno Boldt:

> *… it is clear that the individual plays a crucial role in the suicidal process, from ideation to completion, and that the individual makes the ultimate decision. Yet, no one who commits suicide does so without reference to the prevailing normative standards and attitudes of the cultural community. Every individual who commits suicide, whether on impulse or as a well-planned act, whether in response to an immediate event or as an end-product of a prolonged experience, does so with reference to internalized cultural norms and prevailing attitudes.* (Boldt, 1988, p. 97)

In his theoretical article from 1988, Boldt argues that even though suicide researchers have not been able to reach consensus on a theoretical definition of suicide, they have done so in practice, namely by agreeing that it is an individual act of 'willing and wilful self-termination'. He acknowledges the benefits of this universal definition: it enables easy comparisons of suicide rates between intra- and international contexts. Furthermore, he does not argue that this definition is untrue but rather reductionist and simplistic, causing suicide research to stagnate and struggle with improving suicide prevention strategies (this view has been more recently echoed by Hjelmeland and Knizek, 2010). While he does acknowledge that this task is not easy, and that there is a risk that reaching clarity in debating the nature of suicide is clouding this task, he stresses the importance of just getting on with the work (research):

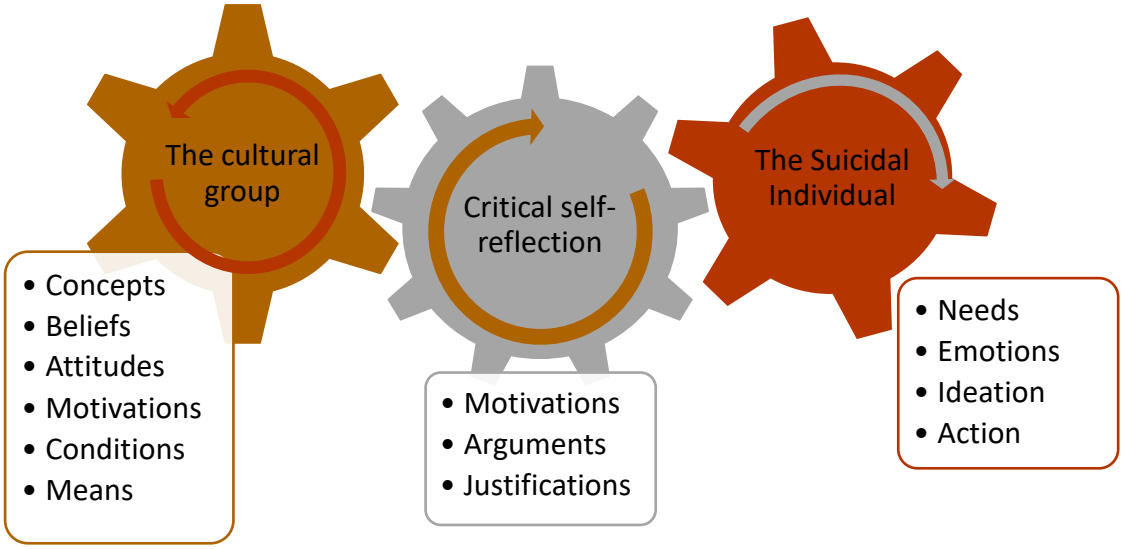
> *the recognition and study of the cultural relativity in the meaning of suicide is an urgent need in the present phase of suicide research. Only by differentiating as precisely as possible the culture-dependent meanings of suicide, and by systematically bringing these into a research paradigm, can the development of valid theories of causation, prevention, prediction, and treatment begin.* (Boldt, 1988, p. 102)

Boldt's point is that 'no man is an island', and over-emphasising the individual in suicide distorts reality because suicide is not *only* an intra-psychological process. Rather, he suggests that the sociocultural understandings of suicide in the cultural community(-ies) provides the suicidal individual with 'the concepts, beliefs, attitudes, experience, motivations and even the conditions and the means for suicide' (Boldt, 1988, p. 96). As the cultural community changes between (and indeed, within, acknowledging sub-cultures) contexts and times, so does the cultural meanings of suicide.

> *The cultural meanings are derived from cultural experience and encompasses the historical, affective qualities that the act symbolizes for a cultural group. It incorporates both sacred and secular values, but not necessarily official religious or legal doctrines if these have lost their relevance or force within a cultural community. The meaning of suicide exerts its influence when it becomes of personal importance to the person and when it has the adherence and sanction of the community.* (Boldt, 1988, p. 94)

In this sense, even the individual meanings for suicide are a product of the cultural group. However, by no means is the entering of cultural meanings into the suicidal process envisaged as a straightforward process of simply transferring the values of the cultural community to the individual. Instead, Boldt argues that this is a complex process wherein the individual engages in a form of dialogue (internal and/or external)—negotiating her suicidality in relation to the cultural meanings of suicide in her cultural community(-ies) (Figure 6).

*Figure 6. A model for the decisional process wherein cultural meanings becomes part of the individual's path to suicide. This figure is freely interpreted from Boldt (1988).*




Boldt describes this process as one where the individual actively engages in self-reflection and critical evaluation:

> *The individual, through his or her self-reflective intellect and creative imagination, is able to evaluate critically the prevailing normative values and societal expectations in regard to suicide – and can envisage alternative meanings.* (Boldt, 1988, p. 97)

Thus, even though one aspect of this dialogical process is that the individual searches for justification and acceptance for the suicidal act, Boldt acknowledges that the individual is accountable and responsible for his or her actions. However, in this search for 'arguments' to justify the suicidal act, the individual becomes inseparably entangled in the web of cultural meanings of suicide—even when the act in itself might be a protest to prevailing cultural norms—negotiating his or her suicidality and navigating his or her actions.

## 5.3 Researching cultural meanings of suicide

Researching cultural meanings of suicide may be undertaken in different ways, including both quantitative and qualitative approaches. Quantitative approaches might include questionnaire-based survey research with representative samples, examining culture-specific (or, indeed, general) aspects of attitudes towards suicide, as argued by Lester (2012, p. 91):

> *The cultural meaning of suicide can be ascertained only by interviewing a representative sample of individuals in the various cultures in order to assess their attitudes toward suicide.*

However, the approach suggested by Lester is not possible in the Sámi context because establishing a representative sample from a specified population demands the demography of that population is known. The Sámi demography is unknown because registering ethnicity is not allowed in Scandinavian countries. Beyond this factor, qualitatively oriented researchers might respond that such an approach is too instrumental and not very useful as the subject of study—the cultural meanings of suicide—are complex, multifaceted and manifold also within the same culture, far from obvious and often unconscious (Boldt, 1988; Hjelmeland & Knizek, 2010). In other words, not every individual defined as a 'bearer' of a particular culture is an equally useful informant with regard to the meanings of suicide within that culture. Again, Boldt has written about this issue, as have Colucci and Lester (2012), citing Boldt and Douglas:

> *Most participants in a culture are not aware of the philosophies underlying the meaning of suicide. They relate to the meaning of suicide reflexively rather than reflectively. They are conditioned to conform unthinkingly to society's normative standards and expectations.* (Boldt, 1988, p. 98)

> *Rather than being obvious, the meanings of suicide are very complex and obscure, not alone to the theorists, but to the social actors as well.* (Douglas, 1967, p. 158)

Furthermore, culture cannot necessarily be meaningfully separated from context, a fact that led Hjelmeland (2011) to stress that 'cultural context is crucial in suicide research and prevention'. Hjelmeland argues that while quantitative research has its place in suicidology, qualitative research must be employed to meaningfully understand the role(s) of culture and context and their interplay.

A growing body of research has investigated cultural meanings of suicide using qualitative approaches (Adinkrah, 2012; Hjelmeland, Akotia, & Knizek, 2010; Osafo, Hjelmeland, Akotia, & Knizek, 2011). Focus groups as a data collection method have been used in western youth cultures (Colucci, 2007; Roen, Scourfield, & McDermott, 2008) as well as among Indigenous peoples, both in low-income countries such as Uganda (Mugisha, Hjelmeland, Kinyanda, & Knizek, 2011), and in Arctic parts of Alaska, in the United States (Wexler, 2006, 2009). Using this method, Wexler (2006, 2009) showed how the cultural meaning of suicide among Inupiat youth were related to colonialism, as well as how those discourses of colonialism left the youth without realistic routes of action to address and change their situation, leading to lack of hope and rise of hopelessness; contributing finally to the very high suicide rates found among youth in Inupiat communities (Wexler, Silveira, & Bertone-Johnson, 2012).

# 6 Research ethics

This chapter presents some of the ethical perspectives that might be of importance for conducting border crossing (in more than one country) suicidological research among Indigenous Sámi (Figure 7).

*Figure 7. Ethical dimensions of relevance for the studies in this thesis.*


## 6.1 Medical research ethics and ethical review systems for health research in Sápmi

In the Nordic countries, medical research ethics developed from the Nüremberg trials, codified in the Declaration of Helsinki (World Medical Association, 2013), which constitutes the guideline medical researchers are to follow. The declaration includes several principles of interest for this thesis, i.e. including the individual's right to privacy and confidentiality (principle 24), to informed consent (principles 25–32) and research on vulnerable groups and individuals (principles 19–20). Furthermore, principle 23 establishes that research ethics committees shall be organised to consider, comment, provide guidance, approve and monitor medical research. This principle is realised in all the countries within Nordic parts of Sápmi.

The systems for medical research ethics in Norway, Sweden and Finland are similarly organised, with Regional medical ethical review committees located at medical universities. These committees' function as the first level, rejecting or granting approval to go ahead with research, based on their assessment of the provided research protocols. Norway, Sweden and Finland all employ a system with a central ethical review board that deals with issues such as appeals. The overall aim of the system is to fulfil the respective countries laws on medical research.

After conducting the studies within this thesis, Sweden has reorganized its review system. The regional placements of the committees were kept but their 'regionalized' responsibility was discontinued in favour of a single national pool. This change means that ethical reviews in Sweden is now carried out irrespective of which region of the country the researchers are based or the research

takes place. Hence, if the northernmost committee might have held specific competence on health research among Sámi (something they were not obliged to do), that competence is no longer systematically utilised. This is very different from the Norwegian practice, where the northernmost ethical review board reviews all Sámi health research, very recently (autumn 2020) complemented with a Sámi medical review board reviewing projects based on the ethical guidelines in Sámi health research (Kvernmo et al., 2018).

## 6.2 Suicidological research ethics

Those who are bereaved by the trauma of a suicide experience go through a complicated process when trying to make sense of their loss; they find constructive ways to interact with people around them (Shields, Kavanagh, & Russo, 2017). Due to this phenomenon, research participants who are bereft due to suicide can be considered a vulnerable group in medical suicidological research, according to principles 19–20 of the Declaration of Helsinki. Therefore, it is the responsibility of researchers to ensure that those participants' needs receive the required attention: to make sure that participants do not suffer negative consequences when participating in research. However, suicidologists have highlighted that important research might sometimes be hindered by a misguided concern for the wellbeing of participants in research on suicide (Dyregrov et al., 2011). For example, it might be important to clarify that asking about suicidality is not dangerous in itself (Hjelmeland, Dieserud, Dyregrov, & Knizek, 2010), as also pointed out by the WHO in an attempt to debunk myths on suicide (2014). Furthermore, a Norwegian interview study found that all (100%) bereaved participants reported being positive or very positive towards having participated in that study (Dyregrov, 2004). Similarly, a Swedish questionnaire-based study found that only 2 (1 bereaved and 1 matched control) out of 1 043 participants reported that they might be negatively affected in the long term by having answered the questionnaire (Omerov, Steineck, Dyregrov, Runeson, & Nyberg, 2013). However, this finding should not be taken as there being no risks associated to participating in suicidological research; rather, it is an indicator that even though such participation may be stressful and painful, it is not dangerous; it might even be experienced as positive and constructive if conducted in a respectful, safe and trauma-informed manner (Dyregrov et al., 2010; Dyregrov et al., 2011; Omerov et al., 2013). Furthermore, a qualitative study on the experiences of people who are bereft due to traumatic death (including, for example, death due to traffic accidents and suicide) in Sámi areas in Norway, conducted by a group of researchers with in-depth cultural understanding of the Sámi context, reported no specific issues concerning conducting qualitative studies with bereaved Sámi (Dyregrov, Berntsen, & Silviken, 2014; Silviken, Berntsen, & Dyregrov, 2014; Silviken, Slettli Gundersen, Berntsen, & Dyregrov, 2015).

## 6.3 Indigenous and decolonising research ethics

Maori scholar Tuhiwai Smith (2012) stated that 'research is a dirty word' in the Indigenous world(s), illustrating the negative attitudes towards western science that she means is common among Indigenous peoples. According to Tuhiwai Smith, such attitudes are grounded in Indigenous individuals' and societies' negative experiences of research. Furthermore, her view is that the 'western paradigm' of knowledge creation is entangled in the colonial practices of power and degradation of Indigenous people. From this understanding, Tuhiwai Smith argues that science and research in Indigenous contexts should take a critical stance and strive towards decolonization. For this purpose, she proposes utilizing Indigenous methodologies in research.

However, there is no consensus of what Indigenous methodologies are. Most scholars who utilise or advocate for its use might agree that it emphasises the research process itself, as well as contextualising the research and its results from an Indigenous perspective. Denzin, Lincoln, and Smith (2008) argue that even though Indigenous methodologies are influenced from a variety of different traditions within Western academia, they should be considered a distinct set of methodologies. In what ways such methodologies are different is perhaps less clear (Gone, 2018), but Denzin et al. (2008) mean that some aspects will always have to be present in Indigenous methodology, including the acknowledgement of Indigenous peoples' rights—including the right to self-determination—within the research context. In addition, given that Indigenous methodology is concerned with centering Indigenous perspectives, they acknowledge the need for regional, and indeed local, understandings of what this factor means. It is thus logical that there can be no single checklist for whether a particular researcher or research project can or should be understood as within or outside the Indigenous methodology framework. Rather, it is an issue that must be related to the context of the research.

Shawn Wilson (2001, 2008) is an Indigenous Canadian psychologist who suggests that Indigenous methodology, contrary to western knowledge production, is based on a view of knowledge as relational by nature. In other words, the common (in the Western world) understanding of knowledge as something that research and researchers *produce* is misleading. Instead, he argues that knowledge is co-created, transferred and only meaningful within a relational framework where particular understandings gain value. From this point of view, the task of the researcher is not one of 'discovering' new knowledge but rather creating a setting in which knowledge can be co-created. From this perspective, the researcher becomes more of a 'ceremony master': someone whose task it is to assist others, rather than to do and think by him- or herself. Again, the context in which knowledge occurs becomes central, and Wilson argues that for knowledge to be authentic and relevant from an Indigenous point of view such contexts must be respectful of Indigenous culture and ways of doing things (and indeed allow for ceremonies where it is appropriate). This perspective actualises the need for research protocols to be culturally safe and thus provide Indigenous participants with a safe space to take part in the knowledge activities.

## 6.4 A history of unethical research among Sámi

In Norway and Sweden, medical researchers have conducted unethical (and unscientific) studies among Sámi while attempting to scientifically prove that the Sámi were an inferior race compared to the Nordic race. For example, these studies included nude photographs and skull measurements, sometimes taken from living subjects, and sometimes from Sámi human remains. Central to this research among Sámi in Sweden was the Swedish Institute for Racial Biology (Hagerman, 2015). The Institute was inaugurated in 1922, having received the support of all political parties represented in the Swedish parliament. From an Indigenous decolonising perspective, the breadth of the societal support, paired with the aim to prove Sámi as an inferior race and the unethical methods used, makes the activities and context of the Institute a textbook example of how historical research practices were both unethical and used in the service of colonising and degrading Indigenous people. Furthermore, even though racial biology, including its research practices, has been widely discredited in contemporary academia, its effect on the relations between Sámi, researchers and the state lives on. An example of this phenomenon is that the Sámi are calling for the repatriation of Sámi human remains, with a number of repatriations having occurred since the first in Northern Norway, in 1997. The biggest repatriation of Sámi human remains (25) on the Swedish side of Sápmi took place in

Lycksele (Lïkssjuo), in August 2019. Those remains had been dug up from a Sámi burial site in central Lycksele as late as during the 1950s and kept at the Swedish History Museum in Stockholm.

## 6.5 Development of Sámi health research ethics

Indigenous-specific ethical guidelines and systems have often been put in place in Indigenous contexts in the western world, including the United States, Canada, Australia and New Zealand (Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010; Eliassen, 2016; Health Research Council of New Zealand, 2010; Hudson, Milne, Reynolds, Russell, & Smith, 2010; National Health and Medical Research Council, 2018). Although there are no Scandinavian equivalents, the research ethics committees in Norway acknowledged—to a certain extent—a 'Sámi domain' in research ethics when arranging a seminar on Sámi research and research ethics in 2002 (Nasjonale forskningsetiske komité for samfunnsvitenskap og humaniora, 2002). Following this action, the northernmost medical research ethics committee (REK-Nord, at UiT - the Arctic University of Norway) employed a Sámi consultant for expertise in matters concerning Sámi health research projects. This practice was discontinued after a few years but was not replaced by other mechanisms (Stordahl, Tørres, Møllersen, & Eira-Åhren, 2015).

More recently, researchers and Sámi themselves have voiced critique over the lack of Indigenous perspectives in research ethics in Sápmi. The Sámi parliament in Sweden noted and criticised the lack of Sámi health research guidelines, a phenomenon that creates uncertainty as to whether Sámi health research in Sweden meets international standards in this regard (Stoor, 2016). Furthermore, the Sámi parliament in Sweden has established an 'ethics council', mainly to advise on issues concerning return, storing and repatriation of Sámi human remains. Based on analysis of research proposals to a general Sámi research programme in Sweden, Drugge (2016) showed that there is much diversity in terms of, whether and how researchers regard Sámi research ethics. Some researchers addressed Sámi-context-specific needs for ethics in research, while others did not comment on that issue at all.

On the Norwegian side of Sápmi, researchers have called for the Sámi parliament in Norway to take the lead in working to establish systems that are more responsive to Sámi needs (Stordahl et al., 2015). Furthermore, the Centre for Sámi Health Research (SSHF) at UiT – the Arctic University of Norway, which had gathered Sámi biological material through the SAMINOR studies, declared they would not open up those samples for genetic research without a system in place to safeguard Sámi rights in the process. The SSHF then compiled reports on previous health research data for Sami health research in Norway during the last 30 years (Andersdatter Siri, 2015), as well as what guidelines for ethical conduct in health research were in place in other Indigenous contexts in the Western world (Eliassen, 2016). These reports then laid the foundation for the establishment of a commission, by the Sámi parliament of Norway, which proposed Ethical Guidelines for Sámi Health Research and Research on Sámi Human Biological Material (Kvernmo et al., 2018).

*Figure 8. Important values for ethical guidelines for Sámi health research and research on Sámi human biological material. This figure is adapted from 'A proposal for Ethical Guidelines for Sámi Health Research and Research on Sámi Human Biological Material' (Kvernmo et al., 2018)*


The proposal includes two main principles: 1) the right of Sámi to be acknowledged (addressing the need for registering Sámi ethnicity) and 2) the Sámi right to self-determination in health research (addressing the need for collective consent). Figure 8 depicts important values for the ethical guidelines, as described in the proposal. The proposal has been accepted and supported by the Sámi parliament in Norway, which aims to secure a new ethical review process for Sámi health research, running in parallel to (complementing but not replacing) the ordinary medical ethical review process in health research in Norway. In Sweden, there are currently no similar initiatives, but the tri-lateral 'Nordic Sámi convention', which is a proposed convention on Sámi issues that would be signed by Norway, Sweden and Finland, deals with the issue. The last iteration of the convention (not signed by the states because the Sámi parliaments in all three countries, for unrelated reasons, rejected it) does include an article 24, on research and ethics, stating that: *'... research shall be conducted in accordance with accepted research ethical rules and in accordance with the international principles adopted for research on Indigenous peoples.'* (Förhandlingsdelegationernas förslag till Nordisk Samekonvention, 2017, article 24). This particular article is uncontested, but international standards in similar countries include a considerably more structured approach then is the case in Nordic Sámi health research, and thus political initiatives would surely have to follow if the convention were to be ratified.

# 7 Methods

In this chapter, the methods and procedures for studies I, II and III are described.

All studies employed qualitative methods to answer the research questions. The methods for papers I and II were similar. In these studies, a snowball recruitment technique was utilised to create multiple focus group discussions (FGDs) on the Swedish (study I) and Norwegian (study II) sides of Sápmi. The third study, on suicide prevention initiatives among Sámi, was a mapping of such initiatives. The methods of studies I and II are described together, while the methods for study III are presented separately.

I initiated and collected the data for study I while I was a master's student at the Department of Psychology, Umeå University, in 2012, with Niclas Kaiser (second author on the article) as my supervisor. The analysis for study I was conducted during the autumn of 2014, and the article was written in early 2015, while I was working for SANKS. The data collection for study II was carried out in the spring of 2014 within a research project initiated and run by my main supervisor, Anne Silviken, and myself. The analysis and article writing took place in 2017 and 2018, after my enrolment in the PhD school at the Faculty of Health sciences, UiT. I collected the data for study III during the summer of 2019 and wrote the submitted manuscript during the following year. I was employed as a full time PhD student at SANKS, affiliated to the Centre for Sámi Health Research (SSHF), Department of Community Medicine, at UiT, from December 2016 until May 2020.

## 7.1 Methods for studying cultural meanings of suicide

### 7.1.1 Recruitment principles

The recruitment of participants for studies I and II were guided by four inclusion and exclusion principles. Firstly, it was important to recruit participants who were likely to be knowledgeable for the purpose of the study. This criterion meant recruiting people with breadth and depth of experience(s) related to how Sámi understand suicide. I strived to recruit participants with in-depth first-hand knowledge, such as bereaved individuals (who had had relations with Sámi who had taken their lives), as well as participants with other forms of experiences relevant to the study, including work experience from suicide prevention among Sámi. In study II, I also actively included informal and formal community leaders, as they would be knowledgeable about their community—also with regard to suicide among Sámi in the community and how others might understand that. Secondly, it was important to recruit participants who would form dynamic and safe focus groups where participants would likely be comfortable and willing to share and discuss their experiences of this potentially very sensitive topic. Furthermore, fostering this environment would create a rich source for data, suitable for analysis, reflective of the diversity within Sámi society. I wanted to make sure to recruit participants with diverse life experiences in general, based on characteristics such as age, sex, Sámi background(s), language competency and work experience. I also worked with strategic recruitment of people with some matching characteristics, such as living in, or being connected to, specific communities (four focus groups in study I and five focus groups in study II) or age groups (one focus group in study I, consisting only of young adults). The reasons for this effort was in part pragmatic—to include participants who could gather at a convenient location—but also in order to create groups where participants were likely to have at least some pre-existing network relations, to ultimately create a culturally safe setting for the discussion. Thirdly, it was important to recruit participants in a way

that was respectful of Sámi culture and traditions, and would result in FGDs reflective of local Indigenous understandings and operationalisations of the first two principles. This endeavour allowed other community members to suggest participants they considered as knowledgeable and suitable for participating in the FGDs, based on descriptions of the desired qualities. Fourthly, it was important to exclude participants who might be at risk of traumatisation from participating in the FGDs. Thus, participants who might be at risk of lasting negative effects from taking part in group discussions on suicide, as assessed by themselves or the researchers, or had been bereaved within a year of the FGD, were excluded. To fulfil these principles, the snowball sampling technique was employed.

### 7.1.2 Snowball recruitment strategy

The snowball technique was slightly different in studies I and II, reflective of both the breadth of my Sámi networks in Sweden and Norway, respectively, and of differences in the infrastructure of Sámi society in the two countries. In Sweden, where I have an extensive Sámi network and Sámi institutions are few and far between, I relied on my own network and contacts within Sámi organisations. Hence, key informants were identified by me, and I subsequently contacted and asked them to participate in the study as well as to name other potential participants. The method was then repeated until five or six participants had agreed to participate in each FGD. In Norway, where my personal Sámi network is more limited—but Sámi institutions are stronger and includes SANKS and the Centre for Sámi Health Research (SSHF) —I utilised my professional networks for recruitment. My colleagues at SANKS and SSHF working in, or connected to, the specific areas included in the study were asked to function as key informants for the snowball recruitment technique. Those key informants in Norway were thus not asked to participate, but only to suggest other participants.

*Table 4. Participant characteristics in studies I and II.*

| | **Study I, Sweden** | **Study II, Norway** |
|---|---|---|
| **Number of participants** | 22 | 22 |
| **Sex** | 16 women (73%), 6 men | 15 women (68%), 7 men |
| **Age (years)** | 18–63, mean 39.5 (male = 35.3, female = 41.0), median 42 | 19–74, mean 48.6 (male = 50.7, female = 47.6), median 47.5 |
| **Professions** | Health workers, artists, language workers, cultural workers, reindeer herders, craftsmen, businessmen, politicians, students and retired | Mental health workers, suicide prevention workers, artists, language workers, cultural workers, reindeer herders, fishermen, politicians, students and retired |
| **Ethnicity** | Sámi (n = 21) and non-Sámi (n = 1) | Sámi (n = 20) and non-Sámi (n = 2) |

### 7.1.3 Participants

The sample characteristics for studies I and II are presented in Table 4. Both studies included 22 participants, of whom almost all were Sámi. Although we aimed for an equal sex ratio, more women than men participated in both Sweden (~3:1 female to male ratio) and Norway (~2:1 female to male ratio). The participants in Sweden were generally 10 years younger than those in Norway (39.5 years compared to 48.6 years). However, the mean age difference was in part a result of a difference in

recruitment strategy: one of the FGDs in Sweden was solely comprised of young adults (mean age 24.75 years). While sex-age differences were small in Norway, men who participated in Sweden tended to be younger than women in the same study (male mean age = 35.3 years, female mean age = 41.0 years). The participants in both studies had diverse professional backgrounds, with health workers, artists, language workers, reindeer herders, politicians, students and retirees being represented in both studies. In Norway, the FGDs were located in small local communities only, in South-, Lule-, Marka-, North- and coastal Sámi areas. By contrast, in Sweden the FGDs were located in North-, Ume- and South Sámi communities, as well as in the Swedish capital of Stockholm and in Umeå (the latter with young adult Sámi; see Table 5).

*Table 5. Focus group discussion (FGD) characteristics in studies I and II.*

| | **Study I, Sweden** | **Study II, Norway** |
|---|---|---|
| **Data collection** | Spring 2012 | Spring 2014 |
| **FGD locations** | 5 | 5 |
| **FGD lengths** | 90–120 minutes | 105–125 minutes |
| **Transcribed data corpus** | 74 024 words | 82 969 words |
| **FGD locations/communities** | Stockholm, Östersund, Umeå (young adult Sámi), Lycksele and Kiruna | Snåsa, Drag, Skånland, Manndalen and Tana |
| **FGD co-facilitators (number of FGDs)** | Jon Petter Stoor (5), Niclas Kaiser (4) | Jon Petter Stoor (4), Anne Silviken (5) |

### 7.1.4 Procedure

All informants were contacted by phone, except for some participants in two FGDs in study I who were recruited at gatherings arranged by Sámi NGOs (Sámiid Riikasearvi and Sáminuorra). Potential informants were given verbal information about the study and offered written material. Both verbal and written information included the right to withdraw at any time without stating a reason or suffering negative consequences. The participants were offered reimbursements for the costs of travel and lost job income (only in study II) but no payment or reward for participation. Informed consent was given in writing before the FGDs. All FGDs were recorded (audio only), and I subsequently transcribed them, with exception of three FGDs in study II, which were transcribed by an external transcriber.

FGDs were arranged at different types of venues including hotels, schools and community centres. The participants were asked to assign at least three hours for their participation, as the procedure for the FGDs included a meal and a snack before and/or after the FGDs. The sharing of a meal or snack before FGDs provided an informal milieu for the facilitators and participants to get to know each other before the FGD, including sharing relational connections (as described to be part of a Sámi cultural protocol in the introduction of this thesis). The facilitators made sure to introduce themselves not only as professionals but also from the perspective of their relationship with the Sámi communities. Before the discussions, the participants were provided time to ask questions about the study. The participants were also encouraged to act and talk as they would in a normal conversation about the subject, and

enter into voluntary non-legally binding confidentiality agreements. All participants verbally declared their intents not to share specifics of what was discussed outside the group, including who participated besides themselves. All FGDs were open-ended and started off with a single prompting question: 'When talking about suicide among Sámi, what do you think is most important that we talk about?'

FGDs where led by an active and a passive facilitator, except for the last FGD in both studies where there was only one facilitator. All facilitators were trained psychologists, except for myself during the data collection of study I, as I was a graduate student in psychology at that time. The active facilitator actively participated in the discussion, with the aim to support all participants to share their views. This endeavour included being actively present and listening, providing short summaries of the themes discussed, asking for clarifications and different views and in general supporting the group to stay focused on the aim of the study ('keep the group on track'). Given the nature and context of the FGDs, it was also important that the active facilitator was observant of the participants' emotional states and tried to adapt the conversation to allow strong emotions but also assist in regulating them in a flexible way. In practice, this meant making space for feelings of sadness and joy, including participants crying and laughing. The common atmosphere during FGDs can be described as respectful turn taking rather than a discussion. Thus, direct shifts of opinions were rarely exchanged —a slower, more indirect and storytelling way of conversing was mainly preferred. The role of the passive facilitator was to take notes during the FGD and to provide a summary to the participants at the end of it. In this way, the participants were given an overview of what had been talked about, in what ways, and what could be possible interpretations. The participants were then given time to react and respond to the summary, including withdrawing, correcting and expanding on themes, as well as to introduce new themes that had not been previously discussed.

### 7.1.5 Analysis

The analysis phase began during the FGDs; the facilitators started their interpretations of each discussion. After each FGD, the facilitators had a conversation about what had transpired, what themes had been brought up, how they might connect to what participants in other FGDs had said and if there were opportunities to follow up the discussed themes in subsequent FGDs. In this way, preliminary analyses continuously shaped subsequent data collection, as is common in qualitative methodology. After transcription of the FGDs, the text-based analysis differed between studies. Study I employed qualitative content analysis, while study II utilised reflexive thematic analysis.

#### Study I: qualitative content analysis

While starting as a quantitative approach to data processing, qualitative content analysis has evolved to include interpretative dimensions beyond the manifest content, and this branch has become a common method in qualitative health sciences (Elo & Kyngäs, 2008). Although influential scholar Sandelowski has labelled the method free of 'a priori commitment to any one theoretical view of a target phenomenon' (Sandelowski, 2000, p. 337), it should not be considered a merely analytical tool that is free of theory (Graneheim, Lindgren, & Lundman, 2017; Sandelowski, 2010). Rather, it is a method that can be flexibly applied to qualitative data, both inductively and deductively (Elo et al., 2014). Furthermore, in part due to the flexibility of qualitative content analysis, achieving overall trustworthiness is reliant upon the author's ability to present the study in a way that enables readers to form a well-grounded opinion of this concept (Graneheim et al., 2017).

In this case, the aim of the analysis was to systematically and inductively analyse the transcribed FGDs to search for re-emerging patterns of meaning reflective of the meanings of suicide among the participants, and subsequently define, demarcate and describe those patterns. The analysis followed a modified version of Graneheim and Lundman's (2004) stepwise model, described in Table 6.

*Table 6. Analytical model used in study I, modified from Graneheim and Lundman (2004).*

| | **Action** |
|---|---|
| **Step 1** | The entire material was read through several times |
| **Step 2** | Units of meaning were identified and extracted into text excerpts. |
| **Step 3** | The text excerpts were condensed while trying to keep the original meaning intact. |
| **Step 4** | The excerpts were interpreted into codes and discussed with a co-author, followed by adjustments and re-coding. Some excerpts were not meaningful in relation to the aim of the study and were not further analysed. |
| **Step 5** | The codes were categorized and abstracted into themes and discussed with a co-author. The process included several re-categorisations (moving back and forth between codes and themes) and re-reading of the original transcripts to ensure that themes were reflective of the content as a whole. |
| **Step 6** | All authors (of article I) read the material and the analysis. Through critical discussion, we decided to exclude some themes relating to the experience of participating in the FGDs (considered outside the scope of the article) and redefining other themes (refining and demarcating borders and relations between them). |
| **Step 7** | The findings were presented numerous times in Sámi contexts, resulting in feedback and in-depth discussions with a wide range of Sámi. This undertaking served to refine the understanding of the findings. |

### Study II: reflexive thematic analysis

Thematic analysis (TA) shares history with content analysis, and some scholars even claim to use 'thematic content analysis' (Braun, Clarke, Hayfield, & Terry, 2019). However, leading scholars within the field have called for increased methodological clarity and an increased focus on correct classification of the employed methods. To that end, the TA version used in study II, described by Braun and Clarke (2006), was later re-labelled by the same researchers to avoid confusion with other forms of TA. Hence, the method described here (below) is referred to as 'reflexive thematic analysis' (reflexive TA), although it was called 'thematic analysis' in article II. In an attempt to specify in which ways this method differs from the qualitative content analysis that was previously employed, it can be said that even though qualitative content analysis also recognizes the subjective nature of knowledge (Graneheim et al., 2017), reflexive TA can perhaps be labelled as 'more subjective', i.e. rejecting positivist epistemology completely (Braun et al., 2019). Thus, reflexive TA rejects the notion of value-free and objective knowledge and emphasizes the importance of researchers making conscious choices about how to approach the specific research process, and data, and being transparent about those choices.

In study II, the epistemological base can be described as social constructivist: inferred from the use of a social constructivist definition of culture, as well as descriptions of values that 'tri[ed] to ensure participants were in control of the creation of their own narratives'. Further, this study is inductively oriented; in other words, the findings emerged through a bottom-up, data-driven approach. Then, reflexive TA was used to systematically explore the data in search of re-emerging patterns that reflected cultural meanings of suicide and subsequently define, demarcate and describe those patterns.

*Table 7. Comparison between phases of reflexive thematic analysis and corresponding analytical steps in study II.*

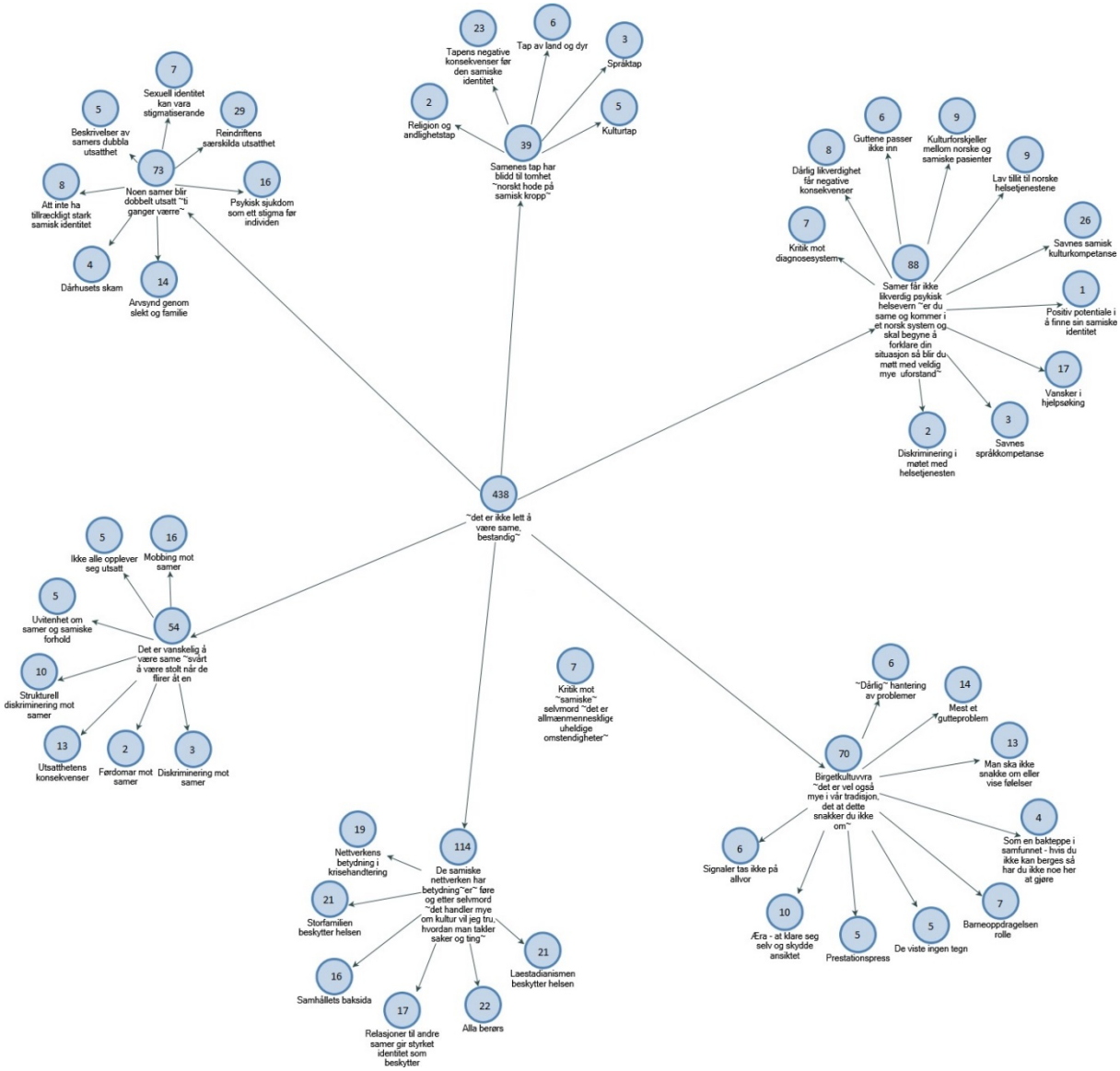
| Phases of reflexive TA (Braun et al., 2019) | **Actions taken during analytical process of study II** |
|---|---|
| **Familiarization** | All authors read through the transcripts while noting interesting excerpts |
| **Coding** | I generated preliminary codes inductively and used these to construct mind maps (one per FGD), which depicted a structure of preliminary sub- and main categories.<br>All authors discussed the notes of interesting excerpts, codes and structure of mind maps. |
| **Generating initial themes** | Based on the discussion among all authors, a preliminary thematic structure across the entire data corpus was agreed upon. I revisited the codes and re-categorized them in a deductive trial and error process based on the thematic structure agreed upon by all authors. This endeavour resulted in new mind maps (one per theme). |
| **Reviewing themes** | I 'tested' the thematic structure through writing narrative descriptions of each category and theme (narrating how the categories belonged together thematically). The thematic maps together with the narratives connected to categories and themes were read and discussed by all authors. |
| **Defining and naming themes** | I named all themes, and all authors again discussed the thematic structure (this action resulted in removing a main theme that was considered too abstract). |
| **Producing the report** | I wrote an article draft, which all authors commented upon several times before submission, followed by two revisions based on reviewers' comments. Late-stage changes included clarification of the narrated passages in the 'findings' sections of the article (Stoor, Berntsen, Hjelmeland, & Silviken, 2019). |

Table 7 provides a comparison of the phases described by Braun and Clarke as central to the analytical method in reflexive TA and how those steps were performed in study II. One may note that this categorization includes an element of 'forcing' what was actually done into a framework that might appear to be linear. However, I experienced this process as not entirely linear. Indeed, at times it was rather 'blurry', which is the way it usually is, according to Braun et al. (2019). An example of this lack of linearity and blurring of phases is the construction of mind maps for each FGD, which I have placed

as corresponding to the phase of ‘coding’, in Table 7. In reality, this endeavour marks the start of the ‘generating initial themes’ phase.

Throughout the analytical process, NVIVO software was used in order to manage coding and categorisation of the data corpus. The software was also used to create mind maps for the structural and thematic overview, with continuous re-working during the analytical process. An example of such a map is presented in Figure 9. This particular map was used late in the analytical process of study II, and changes introduced after its creation included the removal of a main overarching theme (the point in the middle).

*Figure 9. A work-in-progress mind map for thematic overview during the analytical process of study II. The numbers represent the number of excerpts in each category and theme. This map was created with NVIVO software and is presented in Norwegian-Swedish.*



## 7.2 Method for mapping suicide prevention initiatives

Study III aimed to identify, describe and analyse suicide prevention initiatives targeting Sámi, in Norway, Sweden and Finland during 2005–2019. This 'mapping' of initiatives was pragmatic in nature, as opposed to systematic, due to us (the authors of the submitted manuscript) not being able to identify other ways of scoping for initiatives specifically targeting Sámi. Instead, the method was based on the particular strength of our research group; our experience of working in the field. Thus, the first and second step (identifying and describing) meant utilising our knowledge and experience of having participated in a number of suicide prevention initiatives among Sámi. The third step, analysing the initiatives, were an interpretative step, based on the 'what is the problem represented to be?'-approach (WPR) (Bacchi, 2016). Bacchi's WPR-approach was developed as a policy analysis tool within political science, as a way of critically analysing how different policies might problematize the issue they are meant to address. As suggested by the name, and described by Bacchi, the method presupposes that *'what we propose to do about something indicates what we think needs to change and hence what we think the 'problem' is'* (Bacchi, 2016, p. 16). Hence, the point of the analysis is to uncover 'problematizations', including where policies 'place' a problem. For example, Bacchi has used her tool to critically examine the embedded problematizations of 'the alcohol problem', as formulated through international WHO policies on alcohol use and restriction. Among other findings, perhaps even more complex, the article 'shows how proposals to reduce availability of alcohol tend to produce absenteeism as the responsibility of unreliable workers'. In its original version, WPR includes 6 questions to be posed to the specific policy under study, uncovering different layers of analysis, including backtracking the origins of specific problematizations. For the purposes of this study, we choose to mainly utilise the first step of the approach. This step Bacchi has described as a 'clarification exercise' (Bacchi, 2015, p. 132), which is also how it is used in study III. There, the purpose was clarifying how suicide prevention among Sámi was meant to function, as seen from the perspectives embedded within the identified prevention initiatives. This, in turn, was important because a) suicide is a complex issue, and consequently there are many potential ways to seek its prevention, and b) these potential ways had not previously been explored in the context of suicide prevention initiatives targeting Sámi, and c) during the course of the mapping, it became evident that many initiatives lacked an explicit rationale for suicide prevention, making clarifying those rationales important. The three steps carried out in mapping prevention initiatives are described in the following.

### 7.2.1 Identifying initiatives

Initiatives were identified and compiled into a list based on pre-existing knowledge of initiatives having taken place, as well as the research group contacting colleagues in the field and asking for other relevant initiatives. The inclusion criteria were that the prevention initiatives should have taken place during 2005–2019, in Norway, Sweden and/or Finland, and were specifically targeting Sámi, as shown by the initiative making some kind of adjustment to fit the Sámi. Organisers and funders of the identified prevention initiatives were asked to share documentation concerning the initiative. Initiatives were included even though they did not explicitly state a suicide prevention aim in written documentation of the initiative, if such an aim had indeed been known among organisers and participants. However, initiatives that had been identified were excluded if we could not also identify either written documentation or had first-hand experience of having taken part in the initiative. One initiative was excluded because of this.

### 7.2.2 Describing initiatives

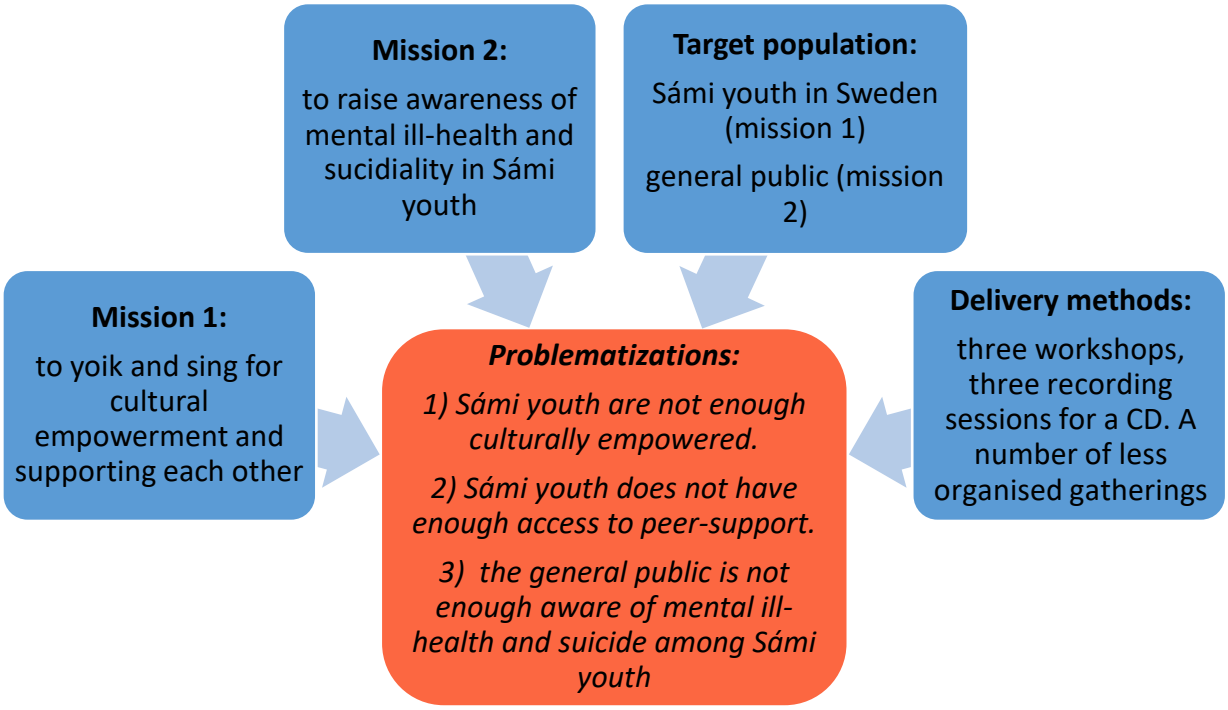
Inspired by Ridani et al (2015), a template for input of relevant information concerning the initiative was created. Descriptive data concerning each identified initiative was thus compiled regarding name, year(s) of operation, region(s) or country(-ies) of operation, delivery method(s), participant information, administering organisation, funding source, evaluation included, as well as what sources had been used to compile the information.

### 7.2.3 Analysing initiatives

In the analysis phase, the information compiled for each initiative was treated as the dataset upon which an interpretative analysis was performed, aiming to clarify the specific problematizations of suicide among Sámi embedded in suicide prevention initiatives among Sámi. As described, this meant posing the 'what is the problem represented to be?'-question to the information regarding each narrative. Thus, the analysis was based on information regarding stated aims and missions of initiatives, delivery methods, what population was targeted as well as the other known characteristics of initiatives. The number of problematizations for each initiative could differ between initiatives, reflecting the diversity and amount of activities within each initiative. An example of this process is found in Figure 10, where the analysis of the project 'Vaajmoe' is used as an example, yielding three problematizations. Identified problematizations were categorised into groups based on where they placed the problem to be addressed, drawing from the WHO framework of risk and protective factors. The categorisations thus included different levels suggested for effective suicide prevention, including individual, relational, community/culture, social and health systems levels. This last step of the analysis was a deductive process, whereas the earlier steps of the analysis (as well as identifying and describing initiatives) were inductive.

The practical process of analysing initiatives started with me reading through the material concerning each initiative and making a preliminary suggestion as how to answer the 'what is the problem represented to be?'-question. My suggestions were then sent to the co-authors who commented and made suggestions for changes. This dialogue took place over email and online-meetings, with no physical meetings because of long distances and travel regulations. When consensus was reached in terms of content of problematizations, I suggested a preliminary categorisation informed by WHO's suggested levels for suicide interventions. The co-authors supported this categorisation.

*Figure 10. What is the problem represented to be? An example of the analytical process of uncovering problematizations regarding suicide among Sámi, found within suicide prevention initiatives. Example concerning the project 'Vaajmoe', run by the Sáminuorra youth organisation during 2010-2015.*




## 7.3 Ethical considerations

The focus group studies followed the ethical principles of privacy and confidentiality to the fullest extent possible (World Medical Association, 2013). However, all the participants in a given focus group were aware of the identities of the other participants in the same group. Nevertheless, privacy and confidentiality was ensured, for example, with anonymisation of the participants' identities in the published articles. Furthermore, all the participants were encouraged to enter into (voluntary, non-binding) confidentiality agreements with regard to the identities of the other participants and material shared during the FGDs. All individuals chose to do so.

The participants were offered information about the study at several points during recruitment. Information about the study was given verbally at first contact with potential participants, and written information was emailed or mailed, according to the participants preferences (note that some participants in study I participated immediately after being recruited, and thus it was not possible to send them additional information). This material included information on the participant's right to withdraw from the study at any given point in time, without stating any reason. All participants were given time to ask questions about the study, and all provided written informed consent before participating. No participants have thereafter retracted their consent.

In addition to the considerations mentioned above, we took care to ensure that the research process would live up to standards from a Sámi ethical perspective. However, this endeavour was not done from the point of understanding the Sámi as a vulnerable group, as suggested in the Helsinki declaration. Rather, it was a consequence of acknowledging the negative impacts of earlier research

practices among Sámi and the need to rebuild (earn) trust for researchers working among Sámi, as well as an acknowledgment of the risk of participants not being able to feel secure and, in a position, to freely share their experiences and thoughts.

### 7.3.1 Ethical approvals

Study I was granted ethical approval by the northern regional ethical committee in Umeå, northern Sweden (Norra etikprövningsnämnden). Study II was considered by the Regional committee for medical and health research ethics – north (Regional etisk kommitte – Nord), at UiT – the Arctic University of Norway, Northern Norway. However, they assessed that it was not considered medical research, and therefore was not in need of medical ethics approval. The Norwegian Centre for Research Data approved the management of sensitive personal information in the study. Study III does not concern human subjects, nor does it use personal data, and does therefore not require medical ethics approval.

## 7.4 Funding

This research was supported by several grants. The main funding was granted by the Northern Norway Regional Health Authority (Helse Nord RHF), as seed money (three months' salary in 2014), and as a 3-year PhD-student grant (2016–2020). SANKS provided funding through grant 05/2014. Furthermore, a personal Fulbright Arctic Initiative grant (2018–2019) from the Fulbright foundation in Sweden allowed me to serve as a visiting research scholar during spring 2019 at Stacy Rasmus' research group, Center for Alaska Native Health Research (CANHR) at the University of Alaska, Fairbanks, US. In the interest of transparency, it should also be noted that other research and project grants, institutional employments and appointments have indirectly made this dissertation possible. These sources include employment at SANKS and the Sámi Parliament in Sweden. Likewise, it was supported by a project grant for developing a Plan for Suicide Prevention Among Sámi in Norway Sweden and Finland (2017), on behalf of SANKS and the Saami Council, granted by NordRegio (Nordic Council of Ministers) and the Sámi Parliament in Norway. Appointments as Norwegian representative to the Arctic Council Sustainable Development Working Groups projects on suicide prevention among Indigenous peoples in the Arctic (during Canadian and American Chairmanships, 2013–2015 and 2015–2017, respectively), and serving as a member, appointed by the Sámi Parliament in Norway, on the committee to develop Ethical guidelines for Sámi health research and research on Sámi human biological material, have also been very helpful. During my time as a PhD student, I have had my offices at Várdduo - Centre for Sámi Research, UmU (December 2016 – April 2019) and the Department of Epidemiology and Global Health, UmU (from May 2019), while all the time being affiliated with the Centre for Sámi Health Research at UiT (from December 2016).

# 8 Findings

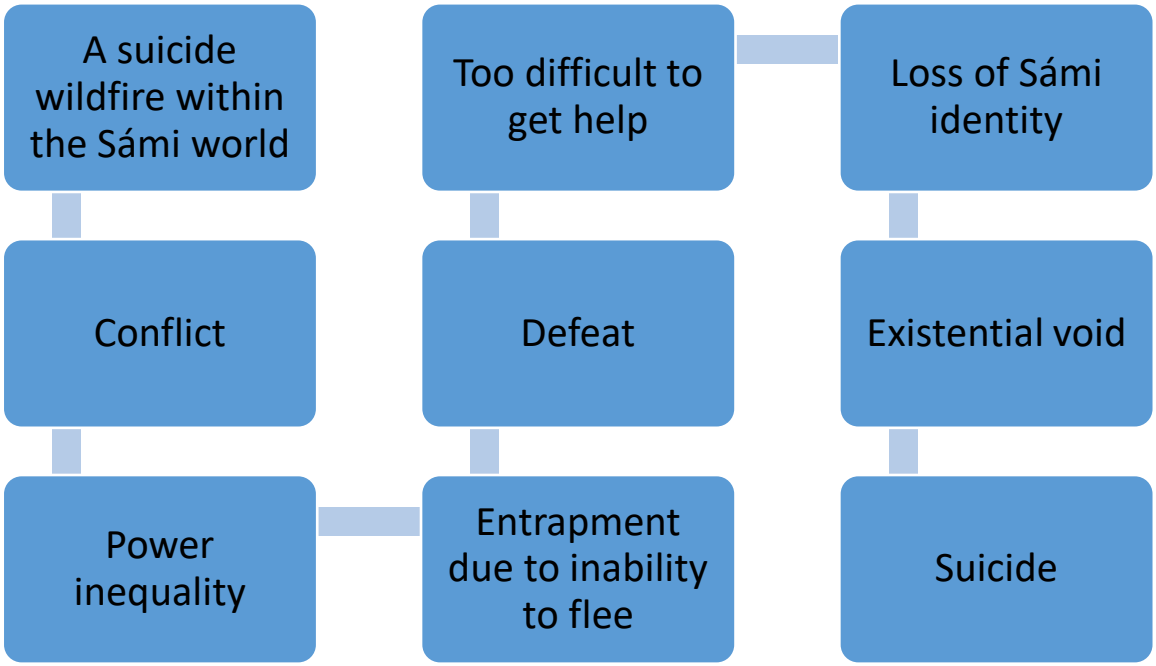
## 8.1 The cultural meanings of suicide among Sámi in Sweden

The findings in paper I concern the cultural meanings of suicide among Sámi in Sweden. They are the results of a qualitative content analysis performed on transcriptions from five focus group discussions (FGDs) held with Sámi (21) and non-Sámi (1) individuals in Sweden, in 2012.

From the analysis, four themes emerged to construct an overarching narrative of 'Sámi as lemmings. The narrative analogy of 'Sámi as lemmings' was based on some of the abilities of the *Lemmus lemmus*.[4] Those abilities include the tendency of lemmings not to flee, even when faced by a much stronger opponent, resulting in many dead lemmings when, for example, they are run over by reindeer herders on motorcycles, all-terrain vehicles or snow mobiles. According to the narrative presented in study I, Sámi are like lemmings in the sense that Sámi are engaged in a fight for their culture against a much stronger opponent and—just like the lemming—Sámi are unable to flee because they will not give up their identity. In this way, Sámi who die by suicide are understood as Sámi who have been placed in an existential void due to the attacks on their identity and who could not go on living in that situation.

The narrative, depicted in Figure 11, comprises the themes 'A wildfire in the Sámi world', 'The Sámi are fighting for their culture and the herders are in the middle of the fight', 'Difficult to get help as a Sámi' and 'Suicide as a consequence of Sámi losing (or having lost) their identity'.

*Figure 11. The overarching narrative of 'Sámi as lemmings'; reprinted from Stoor, Kaiser, Jacobsson, Salander-Renberg, and Silviken (2015).*




The theme 'A wildfire in the Sámi world' consisted of shared experiences regarding the structure of the 'Sámi world' as highly interconnected, in the sense that as a Sámi, one is tightly connected to

[4] English: 'Norwegian lemming'

many other Sámi in a network structure of relations. Those relations are multiplex, meaning that one can have many simultaneous relations to one person (relatives, friends, colleagues, etc.). Furthermore, participants described how that close-knit network could become the communication apparatus people used when someone had taken his or her life, to the point where participants could describe the fear and anxiety in picking up the phone if a more distant relative would call—given that it could be another message that someone had taken his or her life. In this way, the strong and positive network could turn into a 'suicide wildfire', which was sometimes described as contagious.

The theme 'The Sámi are fighting for their culture and the herders are in the middle of the fight' consisted of an understanding shared in the FGDs of how Sámi and Sámi culture was experienced as being under immense pressure from the majority culture in a way that forces people who want to remain Sámi to be engaged in a fight for their culture. The processes understood to be threatening Sámi culture, and reindeer herding in particular, included conflicting land use (water and wind power plants, infrastructure such as roads and railroads, extractive industries including mining and forestry and tourism), too many predators (protected by the Swedish state) living off the reindeer and increasingly problematic climate. It also included threats from within, such as conflicts regarding whose Sámi identity was considered authentic and whose was not, as well as conflicts among reindeer herders due to reindeer herding being a zero-sum game, as governed by Swedish legislation. Furthermore, as reindeer herding was considered central to Sámi culture and way of life, being a reindeer herder was experienced as the best way of maintaining a Sámi identity. Somewhat paradoxically, as reindeer herders were central to Sámi culture and that culture is put under pressure, being a reindeer herder also meant being very much involved in this fight for culture. This situation was described as something of a trap, where those with a strong Sámi identity who wanted to maintain it would be stuck in this conflict.

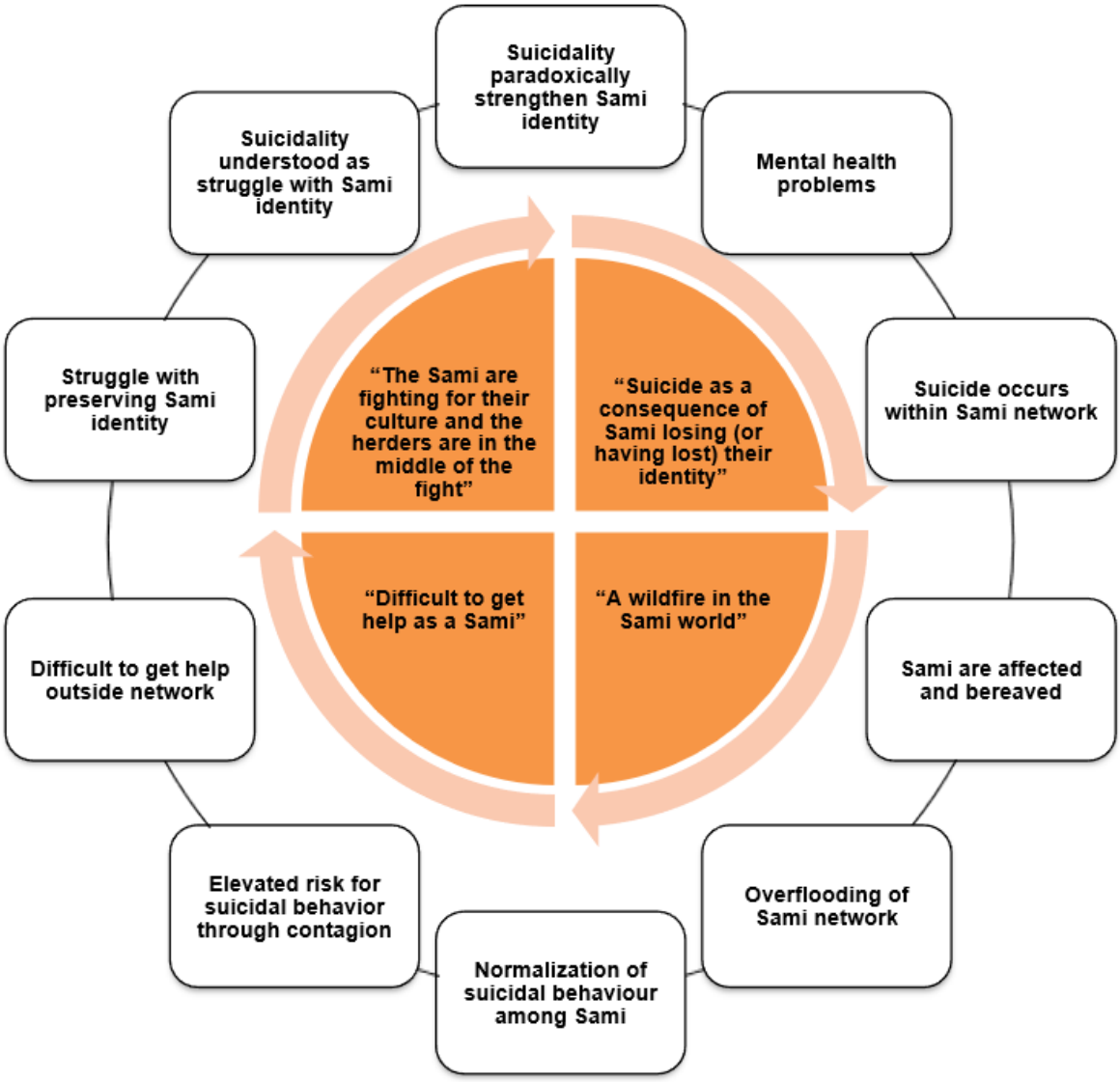
The theme 'Difficult to get help as a Sámi' consisted of different experiences related to the difficulties of seeking and accepting help in times of mental hardships. These difficulties included that there could be norms among Sámi that one should not talk about mental hardships, and that the (Swedish) health care system was not prepared to help struggling Sámi because health care personnel were not familiar with Sámi culture and did not speak Sámi. There were fears that Sámi in need of help would either refrain from doing so or had to explain and defend Sámi culture—as was the experience that Sámi had in other social arenas.

Finally, the theme 'Suicide as a consequence of Sámi losing (or having lost) their identity' was derived from an understanding of those who had died in suicide being predominantly young reindeer herding men. These individuals were understood as no longer capable of enduring the difficulties of living in the conflict (described above; 'The Sámi are fighting for their culture and the herders are in the middle of the fight') and would rather die than leave their Sámi identity. Characteristic of this theme was also the empathy and understanding expressed towards those who had taken their lives, and the understanding that those who had taken their lives had not been regarded as depressed but rather the opposite, as joyful persons far removed from the risk of dying by suicide. These experiences framed the persons taking their lives within normality—as opposed to being regarded as 'crazy' or 'mentally ill'.

In the article (Stoor, Kaiser, Jacobsson, Salander-Renberg, and Silviken, 2015) we suggested that the themes could be understood in relation to some underlying socio-cultural processes, which were visualized in a model (Figure 12). The model might be helpful in understanding the socio-cultural

processes through which suicidality might become associated with being Sámi. This, in turn, is troublesome, as it would mean that engaging in suicidal behaviour could paradoxically be interpreted as an expression of Sámi identity.

*Figure 12. Theoretical model of meanings (inside the circle) relating to suicide among Sami in Sweden, and socio-cultural processes (outside) possibly underlying those meanings.*




## 8.2 The cultural meanings of suicide among Sámi in Norway

The findings in paper II are the results of the reflexive TA of five FGDs with 22 Sámi (20) and non-Sámi (2) individuals in Norway in 2014, with a focus on the cultural meanings of suicide among Sámi in Norway.

The reflexive TA produced six themes relating to the aim of the study, including 'Sámi are treated negatively by the majority society', 'Some Sámi face negative treatment from other Sámi', 'The historic losses of the Sámi have turned into a void', 'Sámi are not provided with equal mental health care', 'The strong Sámi networks have both positive and negative impacts' and ''Birgetkultuvvra' might be a problem'.

The theme ‘The strong Sámi networks have both positive and negative impacts’ concerns how the participants shared understandings of the strong multiplex Sámi network and the impacts that being part of that network could have before and after suicides. Positive aspects included that the network was supportive—strengthening the resilience of its members—and would become ‘activated’ after suicides, to tend to the bereaved. On the other hand, negative aspects included that the individuals would not apply for help outside of the network out of fear of becoming stigmatised. The strength of the network also meant that the social impact of a suicide was ‘reinforced’ through the network, even when one did not have direct network connections with the person taking his or her life.

The theme ‘Sámi are treated negatively by the majority society’ involved an understanding of Sámi as being subjects to negative treatment (racism, discrimination, bullying and lack of understanding) from the majority society to such an extent that this vitriol resulted in systemic emotional violence towards Sámi. This negative treatment might be more intense towards those understood as having a more ‘authentic’ Sámi identity, such as reindeer herders. Nevertheless, the resulting increased emotional burden, or stress, was regarded as connected to suicide among Sámi.

The contents of the theme ‘Some Sámi face negative treatment from other Sámi’ related the issue of negative treatment towards other Sámi from Sámi (‘in-group’, or ‘lateral’, violence). Examples of Sámi who might be subjected to that treatment included those who broke norms of heterosexuality, lacked an ‘authentic enough’ Sámi identity or were stigmatised for their family relations or mental health issues. The participants highlighted that these processes would cause increased stress among those subjected to negative treatment from other Sámi and might also deny them of social support otherwise found in Sámi society.

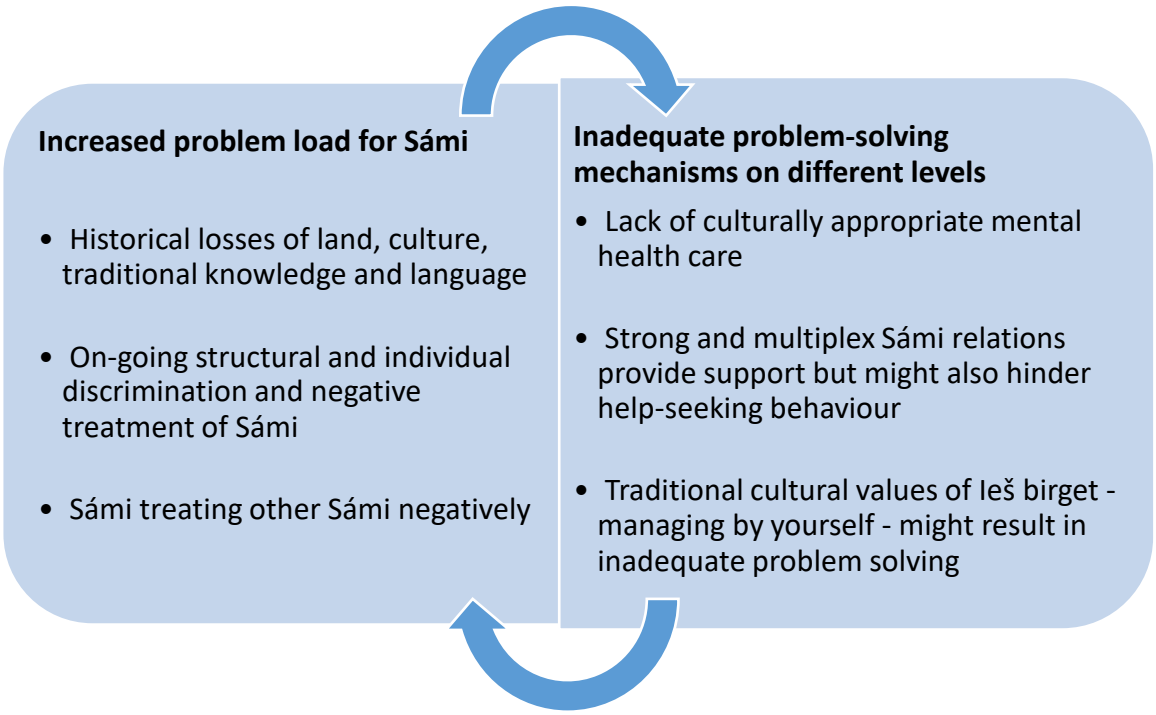
The theme ‘The historic losses of the Sámi have turned into a void’ concerned the historical processes that have led to Sámi losing much of their culture (language, connection to older generations, ancestors, land, animals and religion) and how modern Sámi consequently might struggle with their identity—or have it replaced by a void—and thus experience feelings of anger, despair and shame. This loss of identity and place in Sámi culture was understood as related to suicides among Sámi.

Within the theme ‘Sámi are not provided with equal mental health care’, the participants related negative experiences of—and attitudes towards—(Norwegian) mental health care services, as well as structural issues concerning the organisation of such services (lack of responsiveness to Sámi-specific needs), which were understood to negatively impact Sámi. The participants shared their fears that this deficiency could possibly lead to Sámi not applying for help when struggling with suicidality, or receiving less than optimal care when they do.

The theme ‘‘Birgetkultuvvra’ might be a problem’ concerned two somewhat paradoxical understandings. Firstly, that traditional upbringing techniques might be vanishing, leaving Sámi children and youth growing up ‘too weak’ to deal with the hardships of life. Secondly, that traditional norms and values passed to youth (supposedly, through upbringing) had resulted in Sámi who are ‘too hardened’, lacking social problem-solving skills (i.e. asking for help when struggling) due to fear of losing face if speaking openly about their negative feelings or asking for help with suicidality.

The findings in study II were visualised within two frames of understanding: that Sámi face increased problem load (not encountered by non-Sámi) and that Sámi might have inadequate problem-solving mechanisms. Both of these facets might increase the risk of suicide among Sámi (Figure 13).

*Figure 13. A visual model of the results in study II; reprinted from Stoor et al. (2019).*




## 8.3 Suicide prevention initiatives among the Sámi in Norway, Sweden and Finland

### 8.3.1 Characteristics of prevention initiatives

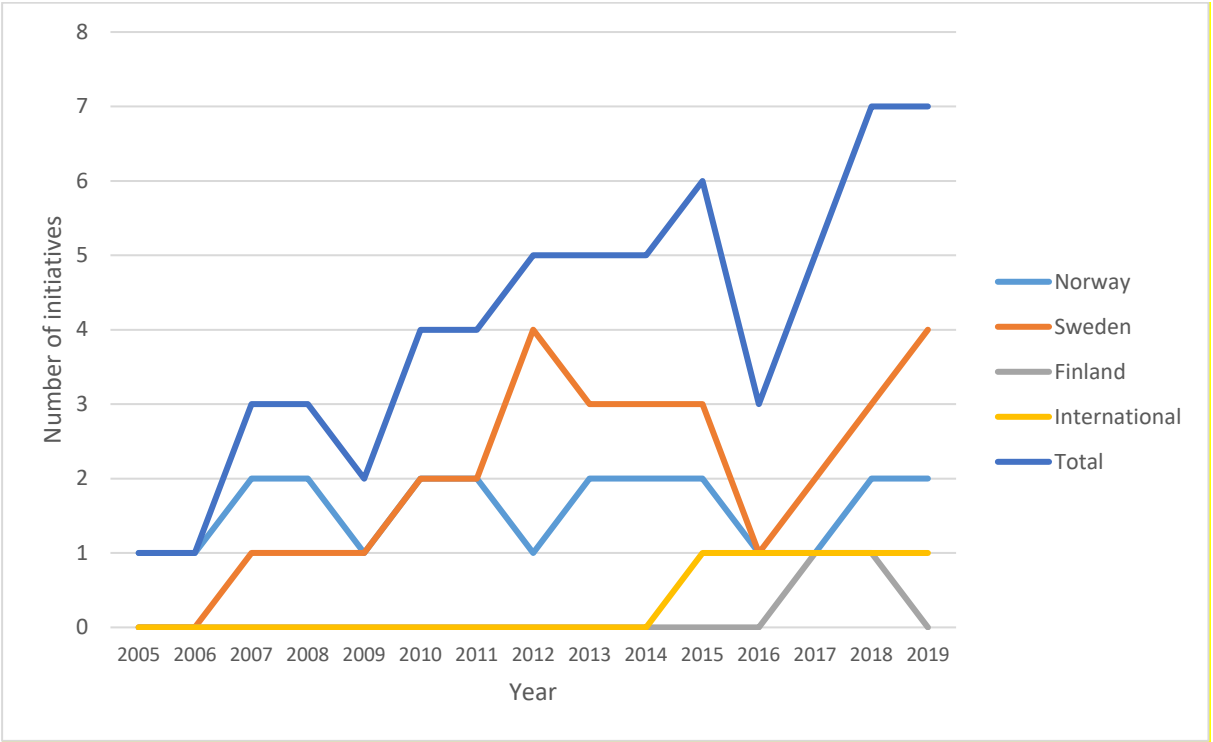
Paper III identified 17 suicide prevention initiatives targeting Sámi in Nordic countries between 2005 and 2019. The initiatives were unevenly distributed between countries, with nine in Sweden, five in Norway, one in Finland and two border-crossing initiatives. Only one initiative was identified for the first year, but the number of initiatives rose thereafter (Figure 14). Four initiatives were still on-going at the end of 2019, and planned to continue during 2020.

The identified initiatives were mostly run by health care organisations and non-governmental organisations (including one religious' organisation), but also included a local consortium and an international Arctic project run through the Arctic Council's Sustainable Development Working Group (SDWG). While most projects run by health care organisations were funded by those organisations themselves, most other initiatives were funded through publicly available project grants. In some cases, these grants were directed specifically to suicide prevention initiatives, but that was not always the case. For four projects run by Sámi and Swedish NGO´s, the funding mechanism seemed to affect the way the initiative was constructed. In those projects, suicide prevention was not an explicit goal in written documentation, although it was known as a goal by organisers and participants. Similarly, some projects referred to national prevention policies and strategies in motivating their particular approaches, while some did not. Again, there was a difference between projects run by health care organisations, and other projects. Projects run by health care organisations were implicitly aligned with national prevention policies, whereas other projects either did not mention any alignment with existing policies, or sought to broaden those – as was the case with an initiative that created a Sámi-specific suicide prevention plan.

The initiatives used different delivery methods and targeted different groups. Targeted groups varied from the general public (both Sámi and non-Sámi) and whole communities, to more specific groups such as service providers, Sámi youth, reindeer herding Sámi or identified at-risk individuals (self-identified or identified by professionals in school context). The most common delivery methods were public meetings and workshops. Among the workshop-based initiatives, most were focused on implementing international suicide prevention training programs in the Sámi context. These included the 2-day programs Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (MHFA) and the half-day course SafeTALK. ASIST was utilized in Norwegian and Finnish parts of Sápmi, whereas MHFA was used in Sweden. The MHFA, ASIST and SafeTalk courses were adapted to the Sámi context through being delivered by Sámi health care personnel or non-Sámi health care professionals with Sámi cultural competence. Other initiatives were adapted in other ways, including tailor-made prevention workshops grounded in the Sámi cultural practice of yoiking (a Sámi form of 'singing'). One initiative also sought to develop a Sámi-specific version of the Canadian SafeTALK prevention program, adapted to (northern) Sámi language and culture.

Few initiatives included thorough evaluation. Those who did included either brief statements by project organisers regarding the participants' experiences, or more lengthy process evaluations. Process evaluations included a stated need to ground projects locally, paying attention to issues of culture and context, to make sure initiatives were relevant for target groups. One initiative attempted a more thorough quantitative data collection, but the outcomes of the questionnaire were not reported due to low response rate.

*Figure 14. Number of suicide prevention initiatives targeting Sámi in Norway, Sweden, Finland and internationally, per year (2005–2019).*

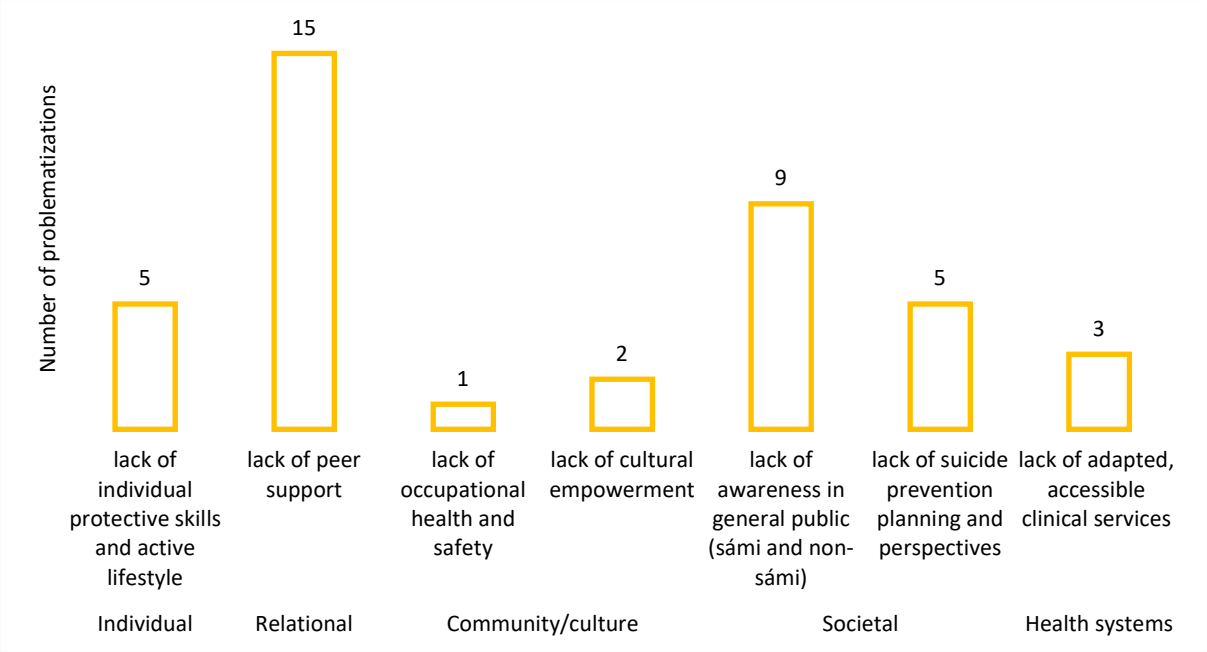


### 8.3.2 Problematizations of suicide embedded in suicide prevention initiatives

An analysis utilizing the WPR approach generated 40 problematizations of suicide among Sámi in the studied suicide prevention initiatives. These problematizations were clustered into seven thematic categories. Figure 15 presents the thematic categories in relation to where the problematizations 'place' the problem in relation to suggested levels of suicide prevention (see Figure 2). Five problematizations were related to 'lack of individual protective skills and active lifestyle', fifteen to 'lack of peer support', one to 'lack of occupational health and safety, two to 'lack of cultural empowerment', nine to 'lack of awareness in general public (Sámi and non-Sámi)', five to 'lack of suicide prevention planning and perspectives' and three to 'lack of adapted, accessible clinical services'. For a full list of the problematizations, see Appendix 3.

The five problematizations categorised as related to individual shortcomings were lack of active lifestyle, lack of coping skills, lack of conflict management skills, lack of tools for emotion regulation and lack of self-care skills. The activities seeking to address those issues mainly included workshops, but also a school-based self-care program for young kids ('Zippy's friends'), and a program to increase physical activities among at-risk youth. The other programs were not based on pre-defined curriculums but specifically targeted young men, young male reindeer herders, and young reindeer herders (irrespective of sex), and focused on improving the participants general self-care skills, conflict management skills and regulation of emotion (through using traditional yoiking techniques).

*Figure 15. What are the problems represented to be in Sámi suicide prevention initiatives? Number of problematizations in thematic categories, and suggested corresponding levels of intervention.*




The problematizations categorised as related to lack of peer support could generally be divided into two groups. The first group of problematizations were found in initiatives seeking to implement international suicide prevention programs including the ASIST and MHFA programs, which were directed towards the general public, specific 'gate-keeper' professionals (working in schools, health care systems) or reindeer herders. Problematizations relating to these programs focused on specific aspects of peers' support, such as shortcomings in identifying, engaging and referring (if necessary)

potential suicidal persons to professional help. The other group of problematizations related to lack of peer support in a less specific way, but did explicitly target risk groups for suicidality, such as young Sámi or reindeer herding Sámi. Contrary to the first group, the activities adhering to this group of problematizations built mostly on participants co-creating the contents through sharing and discussing topics of their own concern, sometimes facilitated by an older peer sharing his or her story of overcoming suicidality. A problematization and related activity that stood out as different from the other, and borders at being a health system initiative, was the Sámi telephone crisis hotline initiative, manned by Sámi non-professional volunteers.

The problematizations relating to the community and cultural level were concerned with the lack of occupational health and safety in Sámi reindeer herding communities, as well as lack of cultural empowerment among young Sámi. An initiative related to reindeer herding industry sought to increase the industry's work with occupational health and safety, whereas initiatives connected to a perceived need for cultural empowerment focused on promoting yoiking as a way of culturally empowering young Sámi workshop participants.

Problematizations pointing to societal level problems as important to address for suicide prevention among Sámi included two types. One focused on shortcomings in suicide prevention planning and perspectives, whereas the other focused on lack of awareness in the general public, both Sámi and non-Sámi. Awareness-raising activities included public meetings to discuss suicide, as well as compiling a report and a leaflet containing informational regarding suicide and suicide prevention among Sámi. Lacks in suicide prevention and planning was addressed through creating a local community prevention plan, a Sámi-specific prevention plan, a plan for occupational health and safety within a reindeer herding community, as well as arranging a digital storytelling workshop for Indigenous youth as a way of strengthening their perspective in the discourse on suicide prevention in the Arctic.

The problematizations of suicide among Sámi connected to health systems pointed to those systems not being sufficiently adapted and accessible to meet Sámi needs. The activities seeking to address them focused on improving identification and referral of at-risk individuals from school-based health care to other levels, improving the general knowledge on Sámi health issues within the universal health care system in northern Sweden, and running a psychiatric service specifically adapted to and targeting young Sámi (aged 15-30) with drug use and/or suicidal behaviour, using a low-threshold approach (easy access; accepting self-referral and utilising digital tools such as online consultations).

# 9 Discussion

## 9.1 Triangulating findings between studies

The findings from the focus group studies on cultural meanings of suicide in Sweden (study I) and Norway (study II) showed considerable overlap, but also some notable differences, in terms of content. Furthermore, the results of study III – particularly the specific problematizations of suicide and the categorisations of these – at least to some extent related to the findings of study I and II, elucidating similar themes as potential drivers of suicidal behaviour among Sámi. I will start this discussion chapter by focusing on what I perceive to be the main commonalities and differences between the results of the individual studies, and what the implications of these might be for improved suicide prevention among Sámi. Thereafter, I discuss the findings in light of Indigenous and critical perspectives within suicidology and in relation to other findings concerning Sámi identity and health. I end this chapter by discussing the methods used in this thesis.

*Figure 16. A schematic model of how findings (themes) in studies I and II might be understood as related to each other. Themes from study I to the left in blue, from study II to the right in green and common themes in the middle, in orange.*

### The strong Sámi networks increase the impacts of suicide

In both study I and study II, participants highlighted that although being part of the Sámi network was normally a positive and resilience-strengthening experience (not least after the occurrence of a suicide). However, being part of that network also meant that they were heavily affected by suicides among Sámi, even when not near geographically or in terms of direct family relations. According to the participants, this was a result of the multiplexity of the Sámi network, where relations are strong and overlapping between different social domains (family, work, friendship etc.). In other words, the findings suggest that the strength of the cultural fabric – the relations between people – increases the impact of each suicide. To the extent that the re-occurrence of this theme reflects actual differences between Sámi networks and non-Sámi networks, this means that the network of traumatized individuals after a suicide might be wider (also in terms of geographic reach) among Sámi than in majority populations. This, in turn, means that attempts to prevent increased suicide risk due to contagion effects after a Sámi takes his or her life might be more complex than in non-Sámi settings. It also calls for intervening professionals to be aware of these cultural differences. This interpretation is further supported by previous research regarding experiences of being bereaved among Sámi reindeer herders in Sweden as compared to non-Sámi 'northerner' Swedes. For example, although reindeer herding Sámi did not report being more affected by suicides among significant others within one's own family, they did report being more affected by suicide among significant others *outside* one's own family, to an extent that reflected a significant difference between them and their Swedish counterparts (Kaiser and Salander Renberg, 2012).

In terms of practical proposals for better suicide prevention among Sámi, the risk that such network effects leave many bereaved is a good argument to make sure bereaved Sámi have access to postvention services. This was addressed in the aim of one particular activity identified in study III, which set up a local branch of a national (Norwegian) association for the bereaved by suicide, which purpose we interpreted to be to improve peer support for the bereaved. Furthermore, Silviken et al (2015) have pointed to culture-specific grieving processes being common among bereaved Sámi, suggesting a need to make sure that health systems are culturally adapted. However, in this context it should also be noted that the Sámi-specific suicide prevention plan, PSPS, did not include any strategies specifically addressing postvention (see Table 1). Given that this was a central theme in both study I and study II, and also found in study III, I argue that this reflects a shortcoming of the PSPS, rather than an issue of less importance for Sámi. Furthermore, as Sámi ethnicity is not registered in death certificates and registries in Nordic countries, maintaining informal relations with the Sámi networks actually represents the only way of monitoring suicide mortality among Sámi in real-time, which in turn might be important in order to prevent suicide clusters. For these reasons, I suggest that future iterations of the PSPS should include strategies aimed both at utilising informal Sámi networks as information sources, but also strengthen support for Sámi bereaved.

### Lack of mental health services adapted to the needs of Sámi

Shortcomings of health systems as regards their capacity to deliver accessible and adapted mental health services for Sámi patients were thematised both in study I and study II, as well as highlighted by problematizations and prevention activities in study III. In these studies, the 'health systems'-theme was mostly related to on a general level rather than a specific, although the participants experiences shared in the FGDs, and the types of interventions found in study III, might provide some more specificity as to what might not be working for Sámi. For example, participants in the FGDs related lack of cultural understanding on behalf of health care personnel as an obstacle to help-seeking – and

one that they associate with suicide among Sámi. Similarly, a strategy of the PSPS also recommends 'Securing the Sámi's right to equal, linguistically and culturally adapted mental health care'. This focus is further supported by findings concerning Sámi's experiences of health systems in Norway and Sweden, which does not seem to meet Sámi's needs (see 3.7 Health care research for a summary of that research) – as well as the general note by WHO (2014, p. 52), as regards the need to ensure that as a measure for suicide prevention, Indigenous people have access to proper mental health care systems that are adapted to their needs.

A few of the prevention initiatives found in study III might both serve to corroborate the need for improvement of mental health systems as part of suicide prevention among Sámi, and represent attempts at doing so in practice. For example, the easy-access 'Sámi Psychiatric Youth team' in northern Norway, attempts at making psychiatric treatment as easy to access among young Sámi as among non-Sámi peers. Similarly, although not as direct, one of the main aims of the 'Knowledge network for Sámi health' was to improve the general level of knowledge on Sámi health among health care practitioners within the northern Swedish health care authorities. However, one might note that although Sámi have access to universal health care systems in Norway, Sweden and Finland, these systems have different approaches in terms of adapting services to fit the cultural and language needs of Sámi service users (Lavoie et al, Forthcoming). In Norway, culturally and linguistically (primarily North Sámi) adapted services have been available at SANKS in Karasjok since at least 2001. Sámi in proximity of SANKS´ satellite offices (located in Drag, Snåsa, Røros and Oslo) have access to adapted services, but might have to travel to Karasjok for specialized Sámi-centric psychiatric services. Sámi in other parts of Norway, as well as in Region Jämtland Härjedalen (in Sweden) and the Lapland Hospital District (in Finland) also have some access to SANKS services (through self-referral in Norway, with referral from local health services in Sweden and Finland), but will either have to travel or use distance bridging technology to access services (Lapin sairaanhoitopiirin, & Helse Finnmark HF, 2007; Region Jämtland Härjedalen & Finnmarkssykehuset HF, 2015; Stoor, 2015). Although not regarded as a suicide prevention initiative (and therefore not included in study III), another output of the Swedish 'Knowledge network for Sámi health' is actually its efforts to develop similar patient transfer agreements between SANKS and other northern Swedish health care authorities, improving Swedish Sámi's access to SANKS services (Norrbottens läns landsting, Region Jämtland Härjedalen, & Västerbottens läns landsting, 2015).

Based on these results, I argue that it is clear that improvement of health systems performance in terms of accessibility and adaptability to Sámi people's needs should be a concern for future suicide prevention among Sámi, as study III has already shown is currently the case. Furthermore, it is clear that access and adaptations vary to a great extent. In study III, we argue that it is worrying that improvement of health care systems is not found to be a more common and central activity for suicide prevention among Sámi. It is beyond the scope of this dissertation to point out the specific needs, but future research on mental health systems serving Sámi should seek to adopt a pan-Sámi perspective, in order to be able to make comparisons of what services are available in what contexts, to highlight what and where needs are greatest, and to discuss what services might have the biggest positive impact for struggling Sámi.

### Internal and external threats lead Sámi to struggle

The participants in both study I and study II described their well-being as threatened by the majority society, as well as internal conflicts, and connected this experience with suicide among Sámi,

suggesting they were underlying risk factors for suicide among Sámi. These threats included interpersonal behaviours such as bullying, lack of understanding and actions motivated by racism towards Sámi. However, participants also pointed to more systemic issues, such as Sámi struggling to maintain control and access to traditional lands due to extractive industries, water and wind power plants, societal infrastructure (including roads and railroads) and tourism. In addition, findings suggested that excessive levels of predators feeding on reindeer have caused the traditional reindeer husbandry to be less profitable and more stressful, and the legislation of traditional livelihoods has not been adapted to Sámi ways of doing. Furthermore, participants in both studies highlighted that there might be internal hierarchies among Sámi that direct negative treatment towards individuals who may be viewed as carrying stigma of belonging to certain families, struggling with mental health issues or not conforming to gender norms or norms of heterosexuality. There was also an understanding that Sámi who are seen as less 'authentic', for example, due to their livelihood not being traditional or lacking Sámi language competency, might be experiencing negative consequences such as exclusion. Study III did not succeed in identifying prevention initiatives that sought to address these issues. We argued instead that several of these issues might not be addressed in suicide prevention targeting Sámi because they are seen as too contentious, threatening status quo within both majority society and Sámi society. However, some of the problematizations regarding the lack of peer support among specific Sámi groups might be related to this. For example, it could be argued that increased peer support among young Sámi reindeer herders, or young Sámi, is meant to counterbalance oppression of young Sámi. It might also be argued that the focuses on increasing awareness and mental health literacy are meant to address a need to decrease stigma of mental health issues among Sámi. However, if this was the intention of such initiatives, it was not very clearly stated in project reports.

Whereas interpersonal discrimination of Sámi has been researched among Sámi in Norway (Hansen, 2015) and young Sámi in Sweden (Omma, Jacobsson, & Petersen, 2012) – and found to be both common and to affect health negatively – in-group ('lateral') violence has not been documented in research. In this regard, especially study II in this thesis breaks new ground, as it highlights not only how individuals and systems associated with majority society might affect Sámi negatively, but also how internal power relations, attitudes and behaviours, including violence, might be harmful for Sámi to an extent FGD participants suggested as related to suicide among Sámi.

The PSPS does indeed address a few the specific issues mentioned above. Its strategies include 'Strengthening Sámi self-determination' (especially as it pertains to Sámi individuals' right to maintain traditional livelihoods) and 'Increasing diversity and acceptance in the Sámi community', specifically 'break[ing] the taboo, stigma and negative attitudes related to non-normative sexuality and gender identity throughout Sápmi'. Indeed, these strategies might be seen as political and challenging to both majority and Sámi societies. However, as noted in the discussion of study III, the fact that no activities were identified targeting such issues (as suicide prevention) does not necessarily mean that such actions are not undertaken at all. Rather, it might mean that not all actions that are potentially preventing suicide are regarded as such, as was exemplified with the Sámi youth project 'Queering Sápmi' which aimed to support and normalise non-conforming gender and sexuality identities among Sámi, and a multi-level project to address sexual violence in a specified Sámi community. From a suicide prevention perspective, it might be important to note that Sámi non-governmental organisations seem to have been more likely than other organisations to initiate and administer initiatives that might be considered too challenging or critical. This highlights the importance of

continuing to engage Sámi civil society in suicide prevention efforts, which is also one of the specific strategies of the PSPS.

### Suicide as a consequence of Sámi struggling to maintain their identity

Findings from both study I and study II highlighted how participants felt that Sámi identity was threatened, and how suicide among Sámi was understood to be related to loss of Sámi identity, whether due to historical losses of culture, language, or to present day conflicts regarding land and water; pressuring Sámi to abandon traditional livelihoods. Loss of Sámi identity was described as leading to disconnection from people, culture and context, which was associated with feelings of hopelessness, despair, 'being lost', or being in an existential void. Suicide was framed as a 'solution' to such a situation, and participants shared their understanding, even sympathy, for suicide in that situation. Some participants also shared that they might, or would, consider suicide as a legitimate option if faced with losing their Sámi identity. No other theme or issue discussed during the FGDs was talked about in this way.

There were similar elements connected to 'managing by oneself, or dying by suicide' described in both study I and II. For example, in study I it was embedded within the metaphor of Sámi as lemmings: 'being Sámi means to fight for Sámi identity'. According to this narrative, one cannot back down from 'fighting for Sámi identity' and still maintain a Sámi identity. A parallel may be the sentiment from study II of 'if you do not birget [manage], then you don't belong here'. While this view might be interpreted as fatalistic, I argue that another way of formulating the same sentiment would be 'without Sámi identity life has no meaning, and one cannot live without meaning'. The important thing to understand then is that, from this perspective, suicide becomes a meaningful act when the meaning of life was threatened or lost.

As I interpret it, the two problematizations categorised as 'lack of cultural empowerment' found in study III, and their associated prevention activities, sought to address this issue. In both cases, the activities sought to imbue young Sámi participants with a sense cultural empowerment through engaging them in collective yoiking as a way of strengthening their resiliency against suicidality and suicide. However, given that the issues of threatened identity as related to suicide among Sámi came out clear from both study I and study II, and also is found as a strategy in the PSPS, it was surprising that study III found only 2 of 40 problematizations embedded within existing suicide prevention initiatives utilising this rationale. In the discussion of study III, we hypothesised that this might be due to understanding and addressing suicide among Sámi in such a way comes across as too challenging, or critical, of majority society – and perhaps also highlights conflicts within Sámi society. For example, focusing on on-going and historical issues connected to processes of assimilation might be understood as re-engaging in conflicts best laid to rest, between different groups of Sámi who managed – or did not – to pass on Sámi language, culture and identity to the next generation, while living in a system that might have varied from not supporting Sámi identity to actively oppressing it. This is indeed an infected topic that might easily turn into a 'blame game' unless handled with care. However, in terms of suicide prevention, I think it is clear that a prevention rationale centered on promoting and strengthening Sámi culture and identities should be a core aspect of tailor-made prevention initiatives targeting Sámi. There is also considerable room for improvement in utilising this rationale more often in future prevention planning.

## 9.2 Different findings in different contexts?

In terms of differences between study I and II, it is noteworthy that the centres of gravity differed somewhat, between the findings in study I and II as well as in terms of what prevention initiatives were found in different countries in study III. The FGDs in Sweden focused more on the present than the past, and mostly highlighted the negative impact of factors external to Sámi society. The FGDs in Norway were slightly more focused on within-group issues, and highlighted history as well as the present. Furthermore, the make-up of prevention initiatives was different in Sweden and Norway. Initiatives in Norway were mostly run by health care organisations and other public (community-level) organisations, whereas in Sweden, non-governmental organisations were the more likely organisers and initiatives focused more on tailor-made approaches, targeting specific Sámi risk groups and utilising culture as a prevention mechanism.

There are a number of different factors that could have contributed to these differences, including differences in study designs, but also that such differences reflect 'real' diversities in cultural meanings of suicide and rationales for suicide prevention, depending on Sámi contexts. My best attempt at explaining these differences include a little bit of both. Firstly, there are more and stronger Sámi institutions in Norway than I Sweden, also considering the differences in population sizes. As this was a factor in the recruitment process (which utilised professional Sámi networks in mental health care and health research in Norway), it is possible that the make-up of participants differed in systematic ways (this risk is further discussed in the section 'Methodological discussion', below). However, it is also possible that the Norwegian and Swedish Sámi contexts differ to such an extent that cultural meanings of suicide differ accordingly, and that this is what was reflected through the slightly different results. Differences in strength and commonality of Sámi institutions might thus reflect differences between contexts that are more substantial. If so, the findings would suggest that what it means to be Sámi differs between Norway and Sweden, and a reasonable interpretation would be that Sámi identities are currently more threatened by majority society in Sweden then in Norway, in general. However, another possible reason for the slightly different findings between Norway and Sweden might be the composition of research groups, which also differed (this risk is also further discussed in the section 'Methodological discussion', below). It cannot be ruled out that the make-up of researchers made certain understandings possible, and others less so, which could be what is reflected in differing results. My own interpretation is that it is likely a mix of all above-mentioned factors. However, the differences should not be overstated. I maintain that the similarities outweigh the differences, especially between study I and II.

## 9.3 What works in suicide prevention among Sámi?

Of the 17 initiatives identified in study III, several included practically oriented process evaluations based on the guidelines provided by the funders for reporting about the outcomes. Some of the issues highlighted in such reports concerned both the successfulness of, and the difficulties in, building upon local capacity and cooperation. For example, while the evaluation of the Sámi crisis telephone line reported that the connections with, and engagement from, local Sámi communities were imperative for running the service, it was the lack of professional experience—including a complete lack of resources for professional support—that finally resulted in the project's shut down. Thus, process evaluations contained some useful information for future prevention projects. However, only two projects (both led by experienced suicide researchers) conducted systemized evaluations on whether and how the activity fulfilled its aim. The only project to measure outcomes using a quantitative approach let the

participants of its 13 ASIST workshops complete a survey with regard to their experiences and learning outcomes. However, due to low participation rates, the project was not able to publish any of the findings. In the end, the initiatives analysed in study III provided few lessons in terms of strengthening the knowledge regarding what works in suicide prevention among Sámi.

This shortcoming is perhaps illustrative of the situation regarding the evaluation of suicide prevention among Sámi, as well as the broader Arctic Indigenous context. For example, the international consortium of researchers involved in the Arctic Council's initiative 'Reducing the Incidence of Suicides in Indigenous Groups—Strengths Through Networks' (RISING SUN) commented that '…the challenges of conducting rigorous research and evaluation in the Arctic hinder the development and implementation of best practices. Suicide prevention research in these locations is constrained by geography, lack of culturally relevant measures with thorough psychometric testing, small populations and research strategies that prioritize local control and cultural relevance over generalizability and rigor-enhancing scientific conventions' (Collins et al., 2019, p. 152).

### Diversity or haphazardness?

The overview of types of activities conducted in Sámi suicide prevention (study III) shows a considerable diversity in actions, in terms of their numbers in different countries, focus and aim, as well as the organisations involved. However, with the exception of within-country coordination of mental health literacy/gatekeeper training in Sweden (which is an on-going effort), there was little evidence of coordination among activities or planning beyond the specific initiative. Rather, it seems that the activities were conducted 'haphazardly', with no specific activity following logically from the last. While such a situation does not necessarily mean that the activities themselves were not useful, it is likely that it impairs learning between activities, and it risks hampering prioritisation of aims above the specific level of activity. This phenomenon is perhaps less problematic for the identified mental health literacy/gatekeeper training programs, as they are supported by governmental health authorities and based on priorities for suicide prevention in the general population (and delivery of the same programmes to Sámi based on arguments of equality in services). However, for small-scale bottom-up projects run by or in cooperation with Sámi NGOs, this lack of coordination is a real cause for concern because it means that such projects are initiated without the guidance and support necessary to demonstrate effectiveness and achieve sustainability. Projects that might be experienced as successful, including being well adapted to Sámi cultural and linguistic prevention needs, risk being discontinued or heavily reliant on external funding mechanisms, of which the organisers have little control. Again, an example might be the Sámi crisis telephone line, which was reported to fail mainly due to the lack of professional support and supervision, or the Sámi youth choir, which was kept going against the odds for years through volunteers and shifting funding mechanisms, including private donations.

It is difficult to speculate as to the reasons for the current situation, but the fact that national policies on suicide prevention do not include meaningful focus on suicide prevention among Sámi is likely to play a part (Helsedirektoratet, 2014; Socialstyrelsen, & Statens Folkhälsoinstitut, 2006). Hence, a reasonable way of looking at this issue is to state there has been no coordinated suicide prevention efforts among Sámi because there has been no political will to make that happen, at least not at the national levels. However, increased engagement by Norway, Sweden and Finland on suicide prevention projects for Indigenous people in the Arctic within the Arctic Councils Sustainable Development Working Group (Arctic Council Sustainable Development Working Group, 2015, 2019; Collins et al., 2019; Crawford, 2019; Larsen et al., 2010) might signal a change of direction, where

suicide among Sámi increasingly becomes an issue of importance on the national political agenda. The fact that the Swedish government has recently tasked the Sámi parliament in Sweden to participate in developing the new Swedish strategy for mental health and suicide prevention is also in line with this.

### A suggestion for improvement in suicide prevention among Sámi

To better capitalise on the engagement in suicide prevention among Sámi, to increase learning from activities and ensure that suicide prevention workers are supported in their work (whether paid or un-paid), I propose the need for strengthening the initiation, organisation and evaluation of suicide prevention activities among Sámi. Furthermore, because the Sámi are an Indigenous people and as such are entitled to participate in developing their own health priorities (United Nations Declaration on the Rights of Indigenous Peoples, 2007), I suggest that such an effort also calls for the creation of an institution with a mandate and resources to act on behalf of the Sámi people. While this endeavour might be considered naïve and politically radical in the Sámi/Nordic context, such centers have been realised in other parts of the Western world, including New Zealand (Te Au - National Māori Suicide Prevention Centre of Aotearoa) and Australia (Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention - CBPATSISP). I argue that these institutions' work to promote suicide prevention in Indigenous peoples might provide guidance as to how suicide prevention could be strengthened among Sámi, which would be a prerequisite for learning about what works in Sápmi.

### An example from Australia

The CBPATSISP is a government-supported university-based centre in Australia that started its activities by conducting a comprehensive review of the evidence for suicide prevention among Indigenous Australians. It learned from evidence in other populations and conducted a number of roundtable discussions with both Indigenous communities and other stakeholders in Indigenous suicide prevention. This undertaking resulted in the report 'Solutions that work: What the evidence and our people tell us' (Dudgeon et al., 2016), which includes a set of tools for improved suicide prevention among Indigenous Australians, aligned with their National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Australian Government, 2013). The set includes tools for the assessment of Indigenous suicide prevention activities (a guide for the primary health authorities, as well as state- and territory-level stakeholders seeking to initialize and design Indigenous prevention programs) and a 'community tool' to empower the Indigenous community to develop and implement a community suicide prevention plan. Furthermore, the set includes an 'Evaluation Framework' tool designed to evaluate suicide prevention activities that are already underway and to provide guidance around evaluation while in the planning stages. The hopes with these documents are—as they would be if also realized in the Sámi context—that increased guidance and support will lead to more suicide prevention projects undertaken in the Indigenous context, based on genuine and respectful collaboration with Indigenous stakeholders. Ultimately, this endeavour should result in culturally appropriate and effective prevention activities that are systematically evaluated and continuously improved.

## 9.4 Indigenous and critical suicidological perspectives

This thesis presents a Sámi perspective on suicide, centering on sociocultural dynamics related to suicide among Sámi and on how an individual's suicide is an act that makes sense to other Sámi when they place it within the context of struggles of maintaining a Sámi identity. This perspective is congruent with at least two contemporary trends within suicidology: the 'Indigenous perspective' and

the 'critical perspective', which sometimes merge. The Indigenous perspective highlights how suicide (among Indigenous peoples in western countries) cannot be sufficiently understood without being placed within the context of historic and present-day inequities, including different forms of oppression of Indigenous individuals and societies. The critical perspective attempts to deconstruct what is perceived to be a tendency of mainstream suicidology to pathologise suicide while disregarding that many individuals who take their lives cannot (and/or should not) be categorized as mentally ill.

A task force on suicide prevention among American Indian and Alaskan Natives (Wexler, Chandler, et al., 2015) presented their recommendations for improvements in suicide prevention research as 'simple dichotomies in an effort to highlight alternative perspectives that suggest future directions for Indigenous suicide prevention research' (Table 8). Wexler, Chandler et al. (2015, p. 895) highlight how they perceive mainstream suicidology to fall short in terms of elucidating the relationship between the Indigenous individual taking his or her life and his or her connection to the larger (Indigenous) sociocultural context, which is often fraught by socioeconomic disadvantage, historical oppression and culture destruction:

> *Puzzling through the complex connections between individual and community health shapes many of the most promising contributions to the Indigenous suicide research agenda (as seen, e.g., in the importance of culture as prevention), yet relatively little attention has been given to this aspect of the problem in mainstream research /…/ The health disparities made evident by cross-cultural variations in suicide rates may be better understood as the culmination of cultural wounds inflicted on whole communities and whole ways of life or as a consequence of structural violence, in which processes of disadvantage, marginalization, and exclusion are woven into institutions and social practices.*

*Table 8. Recommendations for improvements in suicide prevention research, laid down by the task force on suicide prevention among American Indian and Alaskan Natives in Wexler, Chandler, et al. (2015).*

| Challenges | Future Directions |
|---|---|
| • Constraining assumptions of Western approaches to inquiry<br>- Reductionist perspectives<br>- Focus on the present and future | • Expansive commitments of Indigenous approaches to inquiry<br>- Holistic perspectives<br>- Focus on the past as well as the present and future |
| • Individual-level factors<br>- Conceptualizing suicide as a psychological problem<br>- Aggregating Indigenous suicide rates across time and place<br>- Development of expert-driven, valuable intervention formats<br>- Emphasis on risk and vulnerability | • Community-level factors<br>- Conceptualizing suicide as a social problem<br>- Localizing Indigenous suicide rates in specific community contexts<br>- Development of community capacity and collaboration on design of local programs<br>- Emphasis on protective factors, resilience, and well-being |

There are striking resemblances between the recommendations for future directions by the American task force and the findings of studies I and II regarding how suicide is understood among Sámi, including the importance of cognizing suicide in light of historical processes and holistic perspectives. Furthermore, studying the 'cultural meaning' perspective on Indigenous suicide, as done in this thesis, offers a way of understanding the link between the 'cultural wounds' (so labelled by the American task force on suicide prevention, cited above) and the individuals' suicidal behaviours. This endeavour provides a piece in the puzzle between individual and community health or, in this case, ill-health. To the extent that the American recommendations might hold value in the Sámi context, the community-level factors highlighted as related to suicide among Sámi might potentially hold keys to improved suicide prevention among Sámi. For example, there might be some substance in linking the continuously shrinking reindeer herding grazing lands (a community-level factor) to suicide among Sámi, and especially in the reindeer herding community, as suggested by the participants in these studies of cultural meaning of suicide.

Furthermore, the way that suicide is understood as related to loss of Sámi (Indigenous) identity will likely resonate with findings in other contexts where scholars have indicated that suicide is entangled in both social inequity and the loss of traditional culture (Chandler & Proulx, 2006; Chandler & Lalonde, 1998; Hallett et al., 2007; Kral, 2012, 2013; Tatz, 2005, 2017; Wexler, Chandler, et al., 2015)., This finding might thus provide further evidence that suicide prevention in 'Indigenous country' should include efforts to utilise and empower Indigenous identity(-ies) as a mediating factor for the decrease of suicidality. Furthermore, it also points to the need for suicide prevention programs to be anchored in contextualised knowledge on suicide, if they seek to deliver tailor-made suicide prevention that is adapted to the specific needs of Indigenous peoples.

Beyond this approach, critical suicide researchers will remind us that cultural meanings of suicide are not something exclusive to Indigenous communities (Hjelmeland, 2010, 2011). For example, Roen et al. (2008) investigated how suicide is socially constructed among the youth in Wales and England. They found what could be perceived as cultural meanings connected to their particular youth culture. As theorized by Boldt (1988), how the individual understands the potential meaning of engaging in suicidal behaviour should logically influence the decision to take his or her life. Opening up this discussion on the causality of suicide is relevant as mainstream suicidology has been criticised for accepting the so-called truth that 'suicide is caused by mental illness', without critically scrutinizing it. Indeed, much of the evidence for the implied causality of mental health problems and suicide comes out of psychological autopsy studies, where psychiatric diagnoses are arrived at post-suicide, based on interviews with next-of-kin (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012).

A particular response to the perceived flaws of contemporary suicide research has been the development of 'qualitative psychological autopsy' (QPA) studies, where fewer suicide cases are included than in usual psychological autopsy studies, but more informants within each case are asked, using open-ended methods, to share their understanding of why the deceased took his or her life. For example, this method has highlighted the particular (cultural) meanings of suicide among women and men in northern Uganda (Kizza, Knizek, Kinyanda, & Hjelmeland, 2012a, 2012b), as well as Norwegian elderly (Kjølseth, Ekeberg, & Steihaug, 2009, 2010) and young men without prior contact with the health care system in Norway (Rasmussen, Haavind, & Dieserud, 2017). The studies of

cultural meanings of suicide in this thesis also suggest that similar qualitative psychological autopsy studies are warranted among Sámi.[5]

In my view, the findings in the present studies support the legitimacy of the general critique of mainstream suicidology that comes from critical scholars, and scholars working in Indigenous contexts. Furthermore, even though I agree that the perspective of suicidality as related to mental health issues is useful, I also acknowledge that such a perspective is too exclusively focused on individual factors, a view that possibly contributes to obscure the role of above-individual-factors in suicide. For example, only using individual level explanations to understand the sometimes-epidemic suicide rates in Indigenous communities fails to meaningfully capture the issue(s). Mental health problems do not occur in social vacuums; in reality, they are affected by historical and social processes.

## 9.5 The role of Sámi identity in relation to health

Understanding how Sámi identity and culture might become meaningful in relation to suicide and suicide prevention is important as it might further the aim of reducing suicide. However, public debate has showed that suicide among Sámi might easily be misconstrued as the outcome of Sámi parents pressuring their kids to 'be Sámi' (Larsen, 2010). As findings in this study might be interpreted in this way if taken out of context, it is important to place the findings regarding Sámi identity and suicide in perspective.

Many of the issues in studies I and II have been highlighted in previous Sámi health research. For example, studies from the Swedish side of Sápmi have shown more psychosocial stress and increased suicidality among Sámi youth compared to their non-Sámi counterparts (Omma et al., 2012; Omma & Petersen, 2015; Omma et al., 2013) and more symptoms of depression and anxiety (Kaiser et al., 2010) as well as suicidality (Kaiser & Salander Renberg, 2012) among reindeer herding Sámi compared to non-Sámi. While studies from Norway on general Sámi populations (youth and adults) have not found significant inequities concerning mental health and non-lethal suicidal behaviour—except for Sámi men and psychological distress (Hansen & Sørlie, 2012)—compared to non-Sámi, Kvernmo (2004) maintained that Sámi youth, particularly boys, living outside the Sámi core areas have more mental health issues than Sámi growing up as the majority. All Swedish Sámi are in this minority position. Omma et al. (2013) also showed that within Swedish Sápmi, there was a gradient related to the population density of Sámi, with more suicidal behaviour among young Sámi in southern Sámi areas, where there are fewer Sámi. It might thus be a fair assumption that Sámi struggle more when their minority position is more salient. However, due to their lifestyle and strong cultural identity, reindeer herders are perhaps the most visible category of Sámi, and while research from Sweden found this group of Sámi more impacted by suicides than non-reindeer herding Sámi (Hassler et al., 2005), this outcome was not the case in a Norwegian study. That study found that although there was significant inequity in terms of completed suicide for the general Sámi population, this inequity was greatest among Sámi in Sámi core areas, and non-existent among reindeer herding Sámi (Silviken et al., 2006). Another interesting finding has been that while ethnic discrimination is associated with psychological distress (Hansen & Sørlie, 2012) and many other health domains among Sámi (Hansen,

[5] The first QPA-study among Sámi, focusing specifically on suicide among young Sámi men, is ongoing. This thesis was originally meant to include data from that study, but due to setbacks in recruitment of cases it is not yet ready for reporting.

2015), Sámi women with strong Sámi identity living in Sámi core areas are actually resilient to such impacts. The picture regarding the risk and protective factors for suicide, as well as the relationships between mental health, suicidal behaviour and suicide, is thus complex among Sámi—as it is in general (Hjelmeland et al., 2012; Hjelmeland & Knizek, 2017; Turecki & Brent, 2016).

I interpret the findings in this study as largely supporting the previous data. This includes the conclusion that Sámi identity might become a relative burden when the individual is living in a non-Sámi context, and especially to the extent that having a strong Sámi identity might mean being subjected to more negative impacts because of this sociocultural position. This view does not mean, nor should it be interpreted to mean, that *being Sámi* in itself is harmful. Rather, the findings suggest that reducing harms against Sámi, and empowering Indigenous identity(ies) and culture are potentially suicide preventive actions, among Sámi as among other Indigenous peoples (McCormick, 2000; Wexler, Chandler, et al., 2015).

## 9.6 Methodological discussion

### Are the findings trustworthy?

The goal of qualitative research is not to generalize findings in the classical quantitative meaning of the word (from sample to population), and qualitative scholars refrain from arguing that their work is 'generalizable' (Polit & Beck, 2010). However, this perspective concerns more than the issue of generalizability; it includes the supposed objectiveness of quantitative—and indeed all—research. Although there is much internal debate regarding how qualitative research should be conducted and presented, most qualitative researchers concur that no research effort is truly 'objective'. Consequently, researchers who want to achieve trustworthiness should be conscious about the nature of research as inherently subjective, and should present all relevant information regarding how the research was conducted. This transparency will allow the reader to assess the trustworthiness of the presented research. There are several suggestions as to how to do so, including several checklists (Anderson, 2010; Tong, Sainsbury, & Craig, 2007), as well as theoretical concepts and terminology. For example, Elo et al. (2014) listed 'credibility, dependability, conformability, transferability and authenticity' as commonly used terms used to describe trustworthiness in qualitative health research. Graneheim and Lundman (2004, p. 110), quoting Lincoln and Guba (1985, p. 299), and Polit and Beck (2004, p. 717) focus on credibility, dependability and transferability as aspects of trustworthiness in qualitative health research:

> */…credibility deals with the focus of the research and refers to confidence in how well data and processes of analysis address the intended focus /…/ dependability "seeks means for taking into account both factors of instability and factors of phenomenal or design induced changes", that is, the degree to which data change over time and alterations made in the researcher's decisions during the analysis process /…/ transferability, refers to "the extent to which the findings can be transferred to other settings or groups"*

These concepts could be said to correspond loosely to concepts used in quantitative research, including at least partially overlapping meanings between credibility and validity, dependability and reliability, and transferability and generalizability. Due to this overlap, some qualitative researchers argue that it is better to use the already established quantitative, positivist concepts, while others

maintain that the meanings of the concepts differ, and that using specific qualitative terms therefore makes more sense (Graneheim & Lundman, 2004).

My own perspective on these issues is in line with a social constructivist view. I acknowledge that my co-researchers and I have influenced the research processes and results in ways that we have been both able and unable to perceive. While this means that I support the view of research as inherently subjective, I maintain that such a stance does not negate the importance of striving towards objectivity. I support a view of the trustworthy researcher as someone whose task it is to be as conscious as possible about his or her decisions during the research process, to apply his or her critical and reflexive thinking upon that process, and to be transparent about choices. The trustworthiness of this thesis should thus be assessed by the reader and judged by how well I have managed to explain and justify the methods and procedures used for arriving at my findings, as well as the transparency in which that was done. This methodological discussion will therefore focus on some of the ways I have negotiated my role as a researcher, what I perceive as strengths and limitations of the utilized methods and how I view the issue of the transferability of my findings. I end this discussion by explaining how my methods might be understood from the perspective of important ethical values laid down within the proposal for Sámi health research ethics (Kvernmo et al., 2018), furthering that discourse and providing examples for future researchers.

### Negotiating the role as researcher and the dynamics of power in the research context

Attempting to provide the participants in studies I and II with a 'culturally safe' context for participating in the FGDs meant having to actively pursue that context. For example, I tried to engage with participants not only as 'a scientist', but also as a fellow Sámi. This choice was based on the understanding that no human interaction is free of power projection and that—at least in the context of actively gathering participants for a study and interacting with them—the researcher holds some formal and informal power. The formal power is related to the authoritative role of the researcher, for example, being the one who decides when, how and where the participants should gather and what they should talk about when gathering. However, the researcher might also project power in more informal and subtle ways, and these projections might be accepted by participants because of their ideas and perceptions about what research (and the role of the researcher) is. Given that such ideas and perceptions are affected by previous experiences, including norms and ways of doing research in previous times, it is fair to presume that previous interactions between researchers and Sámi individuals and communities might also become relevant in the present. It is well-known that earlier interactions between medical researchers and Sámi have been greatly influenced by ideologies such as racial biology. Therefore, it is crucial that contemporary medical research with Sámi participants is experienced as respectful and that mistakes of the past are not repeated.

### Credibility: strengths and limitations in an open-ended FGD design

The open-ended structure of the FGDs represented an attempt to transfer influence to the participants at the expense of the researchers and to allow the participants to create their individual and collective narratives in accordance with their own priorities. The potential benefits of this design were that the results might be strengthened from the perspective of authenticity, as the influence of the researchers was minimized. An adverse effect of this design might have been that the lack of directive questions (such as 'What do you think is the reason Sámi die by suicide?') means that the data set largely lacks clear and unambiguous statements (along the lines of 'I believe suicide among Sámi is caused by X'). Furthermore, the lack of a clearly defined topic made it harder to determine whether the participants

stayed on topic. On the other hand, the main task of the active facilitator was to keep the participants 'on track' and seek ways of supporting them to verbalize and share their meanings as they saw fit. Another perspective on this issue is that the participants, when given the power to choose, collectively opted for a turn-taking, non-confrontational, narrative-based dialogue rather than a 'discussion' where people exchange opinions on a clearly defined subject. While this design means that the FGDs in this thesis could not be regarded as typical FGDs, which are less open-ended, this turn-taking, non-confrontational form of dialogue can be considered a Sámi form of dialogue. This view does not mean that such communication patterns are exclusive to Sámi, but it suggests that it might be representative of Sámi communication styles, which have been described as non-confrontational (Boine, 2007) and based on storytelling, where the meaning of the story is embedded within the story told, rather than expressed in opinions (Bongo, 2012). Furthermore, when researching something as elusive as 'culture', the most clear-cut questions do not necessarily result in the most important findings. For example, qualitative researcher Dagsvold (2019) reflected on how using more open ended and less directive questions opened up the talks to include aspects she otherwise could not have foreseen, and thus improved the quality of her results.

A related, but slightly different, critique could be that there was no way of knowing if the participants were talking about the most important aspects regarding their understanding of suicide among Sámi. For example, it is possible that the participants systematically refrained from relating ideas about reasons for suicide among Sámi that they considered taboo or anticipated would be unacceptable—or even opposed—by the researchers or other participants. I regard this line of critique as legitimate, and I acknowledge such a risk. However, even though there is no way of knowing whether some topics were systematically excluded in the conversations, I argue that the fact that 'sensitive topics' such as sexual violence and non-normative sexual orientation were discussed is a testament to the open-minded atmosphere in the FGDs. Furthermore, the extent to which participants might have opted to discuss issues they considered 'safe', in the sense that those issues represented what they considered to be common and/or non-contested opinions, is not necessarily an argument against the credibility of the FGD-based studies. While 'normative' or 'mainstream' perspectives might not include all that is important concerning how Sámi understand suicide, such normative perspectives are still important aspects. In this context, it is also important to note that this thesis makes no claim of having uncovered *all* cultural meanings of suicide among Sámi, or even all aspects of the cultural meaning of suicide that emanated from the analysis of the data sets. However, I do make the claim that the findings from study I and II represent central and important perspectives of how suicide is understood in the Sámi context in contemporary Norway and Sweden.

Pertaining to the discussion above, it might be relevant to note that while conducting the 10 FGDs, the active and passive facilitator of each FGD did conduct de-briefing conversations after the FGDs. Judging by the content of those conversations, the issue we considered most problematic was not ourselves directing the participants in unfair and biased ways. Rather, one of the issues that stood out during those conversations was that the make-up of one particular FGD seemed to create a less than optimal dynamic among the participants in that FGD. In that instance, it was our understanding that a sole male participant had been sharing his views at some expense of the three women who also participated. This gender- and perhaps age-related power dynamic was unfortunate and did indeed eschew the conversation during that particular FGD. The active facilitator during that FGD could perhaps have emphasized more strongly that each participant was entitled to equal time and space during the conversation. However, for good and bad, the choice was made not to enforce that, as the

understanding of the situation was that such a decision would have been too intrusive and directive, in turn risking negatively affecting the conversation dynamic further. We considered this event a reminder that a slightly larger group (five participants) was preferable to a smaller (four participants) as it created more space for diversity and dynamic, that we could have done a better job at recruiting a more diverse group of participants (in particular, we wanted more than one male participant) and that particular personal characteristics were important to consider during recruitment. However, if the incident spurred any changes in our behaviour as facilitators or recruiters, it would have had limited impact as only one FGD remained after that. We had no other indication that a male perspective was dominating the FGDs in general, and we did not conduct any further analysis to investigate it.

### Dependability

Theoretically, overlapping of themes between studies investigating similar topics strengthen the results as regards their dependability (Graneheim and Lundman, 2004), as it suggests that the findings are more stable. In this thesis, there were considerable overlap in themes both between study I and study II, and between the themes found in the FGD studies and the approaches found in the study on suicide prevention initiatives. This re-appearance strengthens the dependability of those findings. However, as noted in the section 'Different findings in different contexts?', there were also some differences, which could be due to differences in study methodologies. For example, although there were many similarities in design between study I and II, they were not identical. They differed in terms of recruitment and methods for analysis (qualitative content analysis and thematic analysis, respectively), which might have affected what issues where highlighted in the findings. Another factor potentially affecting the findings were the composition of research groups, which differed between studies, with only Anne Silviken and myself being part of all studies.

The research design represents a risk, as personal bias might have affected the dependability of findings. For example, although the pragmatic approach to mapping prevention initiatives in study III was justifiable (because there is no feasible way to systematically and exhaustively investigate this issue), the lack of a systematic approach might have resulted in some prevention activities not being accounted for. It is possible that initiatives suitable for inclusion were not identified due to inability of the co-author from that country to identify all relevant initiatives because of shortcomings in his or her professional networks. In one case, a prevention initiative was excluded due to lack of written documentation and lack of first-hand experience by the researchers, whereas five initiatives where included because of first-hand experience on behalf of the researchers. The mapping of prevention activities should therefore not be regarded as exhaustive. Thus, future studies might change our perception of what activities have been undertaken, if they discover activities not identified in study III.

Furthermore, both study I and study II relied on recruitment methods utilizing personal networks (study I) or a combination of personal and professional networks (study II) as part of the snow-ball recruitment strategy. This issue might be more serious for study I, where my personal contacts were the point of departure for recruiting participants in each focus group (that is, I chose the individuals to contact first for each FGD). In Norway, colleagues working at either SANKS or SSHF, with in-depth knowledge and connection with local Sámi networks, suggested a number of individuals suitable for the purpose of the study who I then contacted to resume the snow-ball recruitment method. This means that the Norwegian study ran less risk of personal recruitment bias, on my part, influencing who the potential participants might be. The differences in findings between study I and II might

partly have to do with these differences in recruitment methods. If so, it could be argued that the make-up of participants in Sweden was likely more 'radical' than in Norway and that is what was reflected in the different findings. However, the contemporary Sámi context largely lacks official and public structures dealing with suicide and suicide prevention among Sámi and lacks even the most basic demographic statistics. It therefore makes sense to utilize professional networks of relevance to the research question when these exist (in Norway), and compliment those with personal networks when they do not (in Sweden and Finland). The issue could just as well be turned on its head, and one could ask if recruiting Sámi participants based on professional networks founded in institutions owned and administered by the Norwegian state does not imply that recruitment was systematically eschewed in study II, favouring the perspective of the Norwegian state. Although neither depending on personal nor professional networks might be ideal to increase dependability of findings, there might be no ideal solutions to this issue.

Contrary to Lester (2012), who argued that the cultural meanings of suicide within a specific culture and context could only be discovered by interviewing a representative sample of individuals from that culture and context, Boldt (1988) held that knowledge regarding cultural meanings of suicide was not evenly distributed in a population, or easily available as a resource for researchers to tap into. Rather, he suggested that different individuals from the same culture and context will have different levels of awareness, willingness and attitudes to talk about such matters, and will have made different interpretations of the specific meaning of suicide within their cultural context. I agree with Boldt on this issue. Researching cultural meanings of suicide is complex and there can be no guarantees that the data collection is not biased, only awareness of the risk and an aim at preventing it as best possible.

Another issue of importance pertaining to the dependability of the findings is that although attempts were made to level out power differences between researchers and participants during the FGDs, this does not mean that the researchers had no influence over how the dialogues and discussions turned out. For example, although the task of the active FGD facilitator (most often myself) was not to direct but to facilitate the conversations, he or she also became a natural point of reference for the participants throughout the conversations. This was unavoidable. If this had not been the case, the active facilitator could not reasonably seek to ensure that the group stayed on track, especially when conversing about a taboo topic that stirs up strong emotions. However, this also means that although the active facilitator sought to avoid infusing his or her own understanding of suicide among Sámi into the conversations, it might have entered the conversations through the 'kitchen door', in the form of subtle nuances found in the way the conversation was facilitated. The active facilitators might have slightly favoured certain perspectives above others, based on alignment with his or her personal understandings of the issue. As the facilitators partly changed between study I and II, this could represent an underlying factor in understanding why there were some differences in findings between those studies. My own perspective on this is in line with my social constructivist view on research, which entails that all research efforts are subjective in nature. Although we tried to minimize the impact, I acknowledge that the facilitators influenced and shaped the conversations in ways they could not foresee. A consequence of this argument is that if other facilitators (than us) had conducted the FGDs, they would have ended up with at least slightly different data for analysis. However, although it remains unknown to us what where the consequences of our specific make-up of facilitators and researchers might be, I think it is unlikely that the research group composition would be the main factor resulting in differences between studies. Rather, it is possible that our specific background, experiences and assets as researchers in this context were essential in making these studies possible.

Perhaps then, the important question might not be if other researchers had arrived at different findings, but if other researchers would, or could, have conducted similar studies?I consider the potential impact of the lack of male participants in study I and II the biggest unknown factor threatening the dependability of the thesis, as it could very well be argued that those studies were biased in favour of female perspectives (31 of 44 participants were female). As suicide is more common among Sámi men than among Sámi women, and this difference in male-to-female ratio is likely larger than in majority populations (Young et al, 2015), particular male meanings of suicide might be very important to uncover. However, it is reasonable to assume that the findings do represent issues of importance for how suicide is currently understood within contemporary Sámi culture in Sweden and Norway - but cultural meanings are not static, and it is thus likely that these meanings will change, just as Sámi culture and context changes.

### Are the results transferrable?

Qualitative scholars maintain that qualitative research methods might produce findings that are transferable in a case-by-case manner (Graneheim & Lundman, 2004) and to other contexts in abstracted form (Brinkmann & Kvale, 2015). While transfer of results in a case-by-case manner is straightforward and perhaps self-explanatory, the argument by Brinkmann and Kvale for 'analytical generalization' is that theoretical abstractions derived from studies in a particular context might also be meaningful in other contexts, depending on the relative proximity between contexts in terms of time, place, people and other factors. Using this logic, the findings from this culture and context might have transferable value to other contexts with similar features, in theoretical form.

With regard to the process of determining whether and what value context-specific research has in other contexts, qualitative researchers argue that the transferrable value is dependent upon being validated by people with in-depth knowledge on the context and circumstances 'on the receiving end' (i.e. in the context to which knowledge is transferred). It is the role of the knowledge producing researcher to suggest contexts in which this research might hold transferrable value (Graneheim et al., 2017; Graneheim & Lundman, 2004). I argue that it is most likely that similar sociocultural dynamics and understandings regarding suicide will be present in other contexts where Indigenous culture continues to exist in parallel to a dominant, majority, western culture. Aside from the Sámi context in Finland (covered in study III but not I or II), such contexts could be among Inuit, Me-tis, First nations, and Native Alaskan peoples in Denmark (Greenland), Canada and Alaska, as well as Native American peoples in United States and Aboriginal, Torres Strait Islander and Maori peoples in Australia and New Zealand. However, there are many differences between present day Sápmi and these other places. The main differences are that Sámi—with few exceptions—are a minority throughout their homelands and that the Sámi (are assumed to) enjoy similar socioeconomic standards as the majority population. This status is different from, for example, the northern Canadian territory of Nunavut, where the majority is Inuit, but ethnicity-based socioeconomical inequalities that disfavour the Inuit persist to a great extent (Inuit Tapiriit Kanatami, 2016). Other possible contexts for transfer would be non-Indigenous groups who are experiencing discrimination from the majority society—including groups categorized due to sexuality, ethnicity and race—as well as minority Indigenous peoples in non-western societies, such as the Ainu people in Japan (Lester, 2013; Lester, Saito, & Park, 2011; Sámi Norwegian National Advisory Unit on Mental Health and Substance use & Saami Council, 2017).

### Translating ethical values from theory to practice

The discussion regarding, and development of, ethical guidelines in Sámi health research has been ongoing during this thesis work (Drugge, 2016; Jacobsson, 2016; Juutilainen, 2017; Rink, Johnson, Rautio, & Eriksen, 2017; Stordahl et al., 2015). I have been part of a commission that developed a proposal for such ethical guidelines in the Sámi-Norwegian context (Kvernmo et al., 2018). When the Sámediggi in Norway accepted that proposal, it emerged as the first Sámi developed and approved research ethics framework.

The guidelines include a set of important values for research on Sámi health, including responsibility, reciprocity, cultural safety, self-determination, equal status and respect (Figure 8). However, it could be argued that a drawback with the current iteration of the proposal is flawed in that it lacks descriptions and guidance for how these values should be interpreted and enacted in research. Although the research conducted for this thesis was carried out before the establishment of the ethical guidelines, care was taken to ensure cultural safety was built-in to the design and procedure of the studies (particularly studies I and II). In Table 9, I have attempted to further scrutinize what actions might be considered to serve the interest of producing ethical research from a Sámi perspective, based on the listed values in the proposal for ethical guidelines. This endeavour provides a more nuanced and in-depth description of the ways in which this research might be considered ethical and offers examples on how the values established in the proposed ethical guidelines might be interpreted and put into action within a research project.

*Table 9. Comparison of ethical values and corresponding actions taken in studies I and II.*

| Important values for Sámi health research | **Corresponding Actions taken in studies I and II** |
|---|---|
| **Cultural safety** | I created a research process, including focus group discussions (FGDs), where Sámi's knowledge(s) is (are) valued, and Sámi ways of doing are respected and privileged. This undertaking included following 'Sámi protocols', such as allowing time and space for thorough introductions and sharing a meal before the FGD. It also meant creating a sharing space in the FGDs where indirect communication styles, such as storytelling, were accepted and valued. |
| **Self-determination** | I ensured that the participants themselves, individually and as a group, were in control of their narrative(s) during the FGDs. An example of this action is the posing of a single open-ended question that did not direct the narrative in any particular direction during the FGD. |
| **Equal status** | I tried to reduce the inherent power differences between researchers and participants through acting and sharing information transparently. Further, I attempted to construct the research process as a 'normal conversation' rather than something more distinctly 'controlled by the researchers' to reduce some of the power derived from the formal roles of the researchers during FGDs. |
| **Respect** | I acted in a respectful and honest way towards the participants and tried to ensure respectful interaction among the participants, for example, through encouraging voluntary confidentiality agreements. Another way of respecting the |

| | |
|---|---|
| | broader Sámi society was to recruit participants within the Sámi relational networks. |
| **Responsibility** | Inherent in the 'Sámi relationality' is the understanding of parties connected through relations as mutually responsible for each other. In this context, I consider myself responsible as a researcher as well as a person to represent what the participants shared in a fair and correct way. For me, that task also means acknowledging that the participants put much trust in me when sharing their thoughts and experiences on this potentially sensitive topic. For example, I understood that the participants choose to take part despite the risk when giving information to someone that might produce misrepresentations about Sámi understandings of this topic—or Sámi culture and issues in general. Therefore, the responsibility to provide a fair and correct representation of the results included to do this while keeping in mind how that representation might be (mis-)interpreted. |
| **Reciprocity** | The research was carried out as part of reciprocal relationships between the researchers and the Sámi communities. The results have been reported back ('given back') to the extent possible to the Sámi communities (mainly study I). Furthermore, giving back does not necessarily only concern the results of studies, and starting from the data collection of study I (in 2012), I have been continuously engaged in activities aimed at preventing suicide among Sámi. |
| **Integrity and recognition** | In these studies, I did not assume that ethnic Sámi, exclusively, could be carriers of relevant knowledge regarding the understandings of suicide among Sámi. Thus, I included at least three persons who did not self-identify as Sámi. In this way, I argue that these studies centered on 'Sámi knowledge' rather than 'Sámi's knowledge'; this way recognizes the inherent value and integrity of the Sámi people. |

It should be noted that the establishment of a system for ethical review of Sámi health research, with the purpose of ensuring that projects carried out have the collective support of Sámi in Norway, has been realised during the last phases of writing this dissertation. The newly founded ethical review board for Sámi health research in Norway met for the first time in august 2020.

# 10 Conclusions

To understand suicide from a cultural perspective, one should dig deeper than investigating differing suicide rates in contexts and cultures (Boldt, 1988; Colucci, 2006; Colucci & Lester, 2012; Hjelmeland, 2010, 2011; Hjelmeland & Knizek, 2010; Wexler, Chandler, et al., 2015). This thesis shows that by pursuing in-depth knowledge on how suicide is understood within a culture, one can uncover culture-specific meanings of suicide.

Among Sámi in contemporary Norway and Sweden, a culture-specific meaning of suicide is that this act is understood to occur when a Sámi loses his or her (Sámi) identity and becomes trapped in an existential void where suicide presents as a 'solution'. Furthermore, this is understood to take place in a context where Sámi well-being is threatened by oppression from majority society as well as conflict and lateral violence among Sámi, where Sámi lack access to mental health services adapted to their needs, and where impacts of suicides might paradoxically be increased through the strong Sámi networks. When suicide is understood in this way, it might become framed within normality, as a natural consequence of a 'crazy' context rather than as a 'crazy' act. One worrisome aspect of this is that enacting suicidality then might become understood as related to having a Sámi identity, and thus, suicidal behaviour might paradoxically strengthen Sámi identity, potentially increasing the risk of suicide among Sámi further.

This thesis also provides an overview of suicide preventive initiatives targeting Sámi in Nordic countries during 2005–2019, including nine in Sweden, five in Norway, one in Finland and two transnational initiatives. This confirms that considerable efforts have been invested into suicide prevention among Sámi during the last 15 years. Analysis of initiatives showed that prevention rationales pertained to shortcomings on individual, relational, community/cultural, societal and health systems levels. All initiatives were adapted to the Sámi context, varying from tailor-made, culture-specific approaches to targeting Sámi with otherwise universal approaches. However, prevention activities among Sámi were less than optimally organised (rather 'haphazardly' conducted) and the initiatives generally lacked thorough evaluation components. Furthermore, in discussing the specific make-up of initiatives, it is suggested that some prevention rationales found in the 'Plan for suicide prevention among the Sámi people in Norway, Sweden and Finland' might not be represented in suicide prevention targeting Sámi because they are seen as too challenging or critical towards majority and/or Sámi society. This includes politically charged issues such as strengthening Sámi self-determination and reducing ethnic discrimination and violence towards Sámi, as well as breaking taboos or stigmas of living with non-conforming gender or sexual identities in the Sámi society. Furthermore, we argue for the importance of not letting dominant rationales for suicide prevention (addressing shortcomings on individual and relational levels and raising awareness in the general public) obscure other, critical, approaches such as broadening perspectives in prevention planning, improving health systems for Sámi and promoting cultural empowerment among Sámi.

## 10.1 Implications for public health policy and action

The United Nations Declaration on the Rights of Indigenous Peoples states that 'Indigenous peoples have the right to be actively involved in developing and determining [their] health' (UNDRIP, article 23), that 'Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health' and that '[s]tates shall take the necessary steps with a view to achieving progressively the full realization of this right' (UNDRIP, article 24). Because Norway,

Sweden and Finland have signed the UNDRIP, it is the responsibility of those states to meaningfully include Sámi in public health policies affecting Sámi.

This thesis suggests that culture- and context-specific suicide prevention is warranted among Sámi. Specifically, based on the findings in this thesis, I suggest that such prevention measures should include prevention rationales seeking to:

- improve mental health systems for Sámi (including postvention of Sámi bereaved by suicide),
- reduce out- as well as in-group violence and oppression of Sámi (on both interpersonal and systemic levels), and
- empower Sámi culturally.

Furthermore, in the continued absence of systems to track and analyse health outcomes among Sámi in Nordic countries, contacts within the Sámi networks and communities remain the only way to monitor suicide and suicidal behaviour among Sámi in real-time.

In order to improve evaluation of suicide prevention initiatives and identify most promising practices in the Sámi context, I argue that prevention initiative organisers are in need of increased support regarding development of plans and implementation of evaluation components. Given that Sámi as an Indigenous people have the right to influence their own health systems, that Sámi contexts call for Sámi-specific prevention actions (including adapting to Sámi language and culture, and monitoring suicide through informal networks) and that prevention resources are limited, I propose the establishment of a border crossing institution with the mandate and resources to actively support and guide suicide prevention among Sámi. Inspiration for such an institution can be found in other Indigenous contexts in the Western world, such as in Australia and New Zealand/Aotearoa.

## 10.2 Implications for clinical practice

This thesis suggests that the loss of Sámi identity might increase the risk of suicide, as Sámi understand their ethnic identity as central to meaning in life. It furthermore proposes that perceptions of shortcomings in mental health services for Sámi might be a contributing factor to Sámi understanding suicide in this way, as Sámi fear they will not have access to services adapted to their cultural, contextual and language needs. To avoid fulfilling such fears, it is important that Sámi be offered services based on those needs. Therefore, mindful mental health clinicians potentially working with Sámi who are struggling with suicidality should strive towards increasing their knowledge on Sámi culture, context and language to avoid negatively affecting the access to adapted mental health services for Sámi. This implication pertains to all health care personnel within Sápmi, but especially to those in primary and psychiatric health care settings.

## 10.3 Future research

Research on suicide among Sámi is still very marginal. Suicide rates in the general Sámi population are unknown in Norway after 1998, in Sweden after 2000, in Finland after 2010 and in Russia altogether. If the current situation regarding ethnic registration in the Nordic countries does not change, new knowledge on suicide can only be obtained through research projects. This makes epidemiological research on suicide rates among Sámi very welcome. Not least, more in-depth studies on actual suicide cases among Sámi are warranted. However, there are other areas in need of research efforts as well.

My main suggestion for new research relates to suicide prevention among Sámi. For example, a research project that elucidated the issue of 'what works' in suicide prevention among Sámi would be most welcome. Such a research effort should particularly consider that there is currently lacking evidence for effective suicide prevention in the Sámi context, that Sámi suicide prevention resources are slim, that it is difficult to demonstrate that suicide prevention efforts works in this context because of suicide being a rare event in general (even more so in a small and spread out minority) and that it is likely that cultural and contextual adaptations may be of importance.

Based on the above, I suggest a participatory research design informed by work in similar contexts and available evidence in this context (e.g. Australian Government, 2013; Collins et al., 2019; Inuit Tapiriit Kanatami, 2016; Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse & Saami Council, 2017). While participatory research designs are still uncommon in Sámi health research, with a few notable exceptions (i. e. Møllersen, 2018), this method is common in health research in other Indigenous contexts, and is a recommended approach for living up to ethical demands (Kvernmo et al., 2018). Two main advantages of such a design would be that the project itself could substantially increase the scarce resources regarding suicide prevention among Sámi, and that partner organisations might provide help in dealing with anticipated needs for cultural and contextual adaptations. Potential partner organisations include Sámi NGOs that have previously been involved in suicide prevention efforts or have experience engaging in participatory research, such as Sáminuorra, Sámiid Riikasearvi, Norgga Boazosápmelaccaid Riikkasearvi and Sámiráđđi (the Saami council). Issues that could be pursued within such a research project include: What are the most effective ways of addressing community and relational factors for suicide prevention among Sámi? In what ways can the Sámi civic society be activated and empowered to improve suicide prevention among Sámi? Is there a potential for improved suicide prevention among Sámi through utilising Sámi traditional knowledge for mental health? How can a border-crossing suicide prevention network in Sápmi be established and utilised to increase the planning and systematisation of suicide prevention among Sámi? In what ways might existing suicide prevention efforts in the Nordic countries be adapted to better fit the needs of Sámi?

## 10.4 Final remarks

I end this thesis by paraphrasing Roen et al. (2008), who poignantly described the complex yet simple connection between the cultural context and the suicidal individual consciously choosing death over life. Like Roen et al, I believe that understanding the ways in which suicide can make sense offers the best ways of identifying 'points of resistance' and thus allowing the implementation of interventions to prevent suicides in the future.

> *Suicide only becomes possible insofar as it is imaginable, insofar as it is meaningful, insofar as one can make sense of it, whether as a decision, as a last resort, or as a statement of desperation. Through tracing the sense-making processes that people negotiate, there is the opportunity to identify points of resistance—instances where suicide ceases to make sense – and it is these points of resistance that provide opportunities for suicide prevention.*

# 11 Works cited


Adinkrah, M. (2012). Better dead than dishonored: Masculinity and male suicidal behavior in contemporary Ghana. *Social Science and Medicine, 74*(4), 474–481. doi:10.1016/j.socscimed.2010.10.011

Åhrén, C. (2008). *Är jag en riktig same?: en etnologisk studie av unga samers identitetsarbete* [Am I a genuine Sami? An ethnological study of identitywork among young sami]. Doctoral dissertation. Umeå, Sweden: Umeå University.

Alcántara, C., & Gone, J. P. (2007). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional–ecological framework. *Death Studies, 31*(5), 457-477. doi:10.1080/07481180701244587

Andersdatter Siri, S. R. (2015). *Bruk av samisk etnisitet i forskningsdatabaser og helseregistre* [Use of Sami ethnicity in health research and registries]. Tromsø, Norway: Senter for samisk helseforskning (SSHF), UiT Norges arktiske universitet

Anderson, C. (2010). Presenting and evaluating qualitative research. *American Journal of Pharmaceutical Education, 74*(8), 141. doi:10.5688/aj7408141

Arctic Council Sustainable Development Working Group. (2015). *Sharing hope. Circumpolar Perspectives on Promising Practices for Promoting Mental Wellness and Resilience.*

Arctic Council Sustainable Development Working Group. (2019). *Local 2 Global: Circumpolar collaboration for suicide prevention and mental wellness*.

Australian Government. (2013). *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. Canberra, Australia: Department of Health and Aging

Axelsson, P. (2010). Abandoning "the Other": Statistical enumeration of Swedish Sami, 1700 to 1945 and Beyond. *Berichte zur Wissenschaftsgeschichte, 33*(3), 263–279. doi:10.1002/bewi.201001469

Bacchi, C. (2015). Problematizations in Alcohol Policy:WHO's "Alcohol Problems". *Contemporary Drug Problems, 42*(2), 130-147. doi:10.1177/0091450915576116

Bacchi, C. (2016). Poststructural Policy Analysis : A Guide to Practice. New York, United States, Palgrave Macmillan US.

Bals, M., Turi, A. L., Skre, I., & Kvernmo, S. (2010). Internalization symptoms, perceived discrimination, and ethnic identity in indigenous Sami and non-Sami youth in Arctic Norway. *Ethnicity and Health, 15*(2), 165–179. doi:10.1080/13557851003615545

Bals, M., Turi, A. L., Skre, I., & Kvernmo, S. (2011). The relationship between internalizing and externalizing symptoms and cultural resilience factors in Indigenous Sami youth from Arctic Norway. *International Journal of Circumpolar Health, 70*(1), 37–45. doi:10.3402/ijch.v70i1.17790

Bals, M., Turi, A. L., Vitterso, J., Skre, I., & Kvernmo, S. (2011). Self-reported internalization symptoms and family factors in indigenous Sami and non-Sami adolescents in North Norway. *Journal of Adolescence, 34*(4), 759–766. doi:10.1016/j.adolescence.2010.08.005

Blix, B. H., & Hamran, T. (2017). "They take care of their own": healthcare professionals' constructions of Sami persons with dementia and their families' reluctance to seek and accept help through attributions to multiple contexts. *International Journal of Circumpolar Health, 76*(1), 1328962. doi:10.1080/22423982.2017.1328962

Boine, E. M. (2007). Ii gii ge ollesolmmoš ge liiko jus gii nu livče nu čuru das birra jorramin - Selv ingen voksne hadde likt at noen surret rundt der som en flue. Verdioverføring fra far til sønn - i en samisk kontekst. In M. A. Hauan (Ed.), *Maskuliniteter i Nord* (pp. 127–141). Tromsø, Norway: Universitetet i Tromsø.

Boldt, M. (1988). The meaning of suicide: Implications for research. *Crisis, 9*(2), 93–108.

Bongo, B. A. (2012). *"Samer snakker ikke om helse og sykdom" – Samisk forståelseshorisont og kommunikasjon om helse og sykdom. En kvalitativ undersøkelse i samisk kultur.* Doctoral dissertation. Tromsø, Norway: Universitetet i Tromsø.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. doi:10.1191/1478088706qp063oa

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic Analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 843–860). Singapore: Springer Singapore.

Brinkmann, S., & Kvale, S. (2015). *Interviews: Learning the craft of qualitative research interviewing* (Vol. 3). Thousand Oaks, CA: Sage.

Broderstad, A. R., Eliassen, B. M., & Melhus, M. (2011). Prevalence of self-reported suicidal thoughts in SLiCA. The Survey of Living Condition in the Arctic (SLiCA). *Global Health Action, 4*. doi:10.3402/gha.v4i0.10226

Burman, M. (2017). Men's intimate partner violence against Sami women : a Swedish blind spot. *Nordic Journal on Law and Society, 1*(1-2), 194-215. doi:10.36368/njolas.v1i01-02.18

Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2010). Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans (2nd ed.). Ottawa, Canada: Secretariat on Responsible conduct of Research

Chandler, M., & Proulx, T. (2006). Changing selves in changing worlds: youth suicide on the fault-lines of colliding cultures. *Archives of Suicide Research, 10*(2), 125–140. doi:10.1080/13811110600556707

Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*(2), 191–219.

Clifford, A. C., Doran, C. M., & Tsey, K. (2013). A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand. *BMC Public Health, 13*, 463. doi:10.1186/1471-2458-13-463

Collins, P. Y., Delgado, R. A., Jr., Apok, C., Baez, L., Bjerregaard, P., Chatwood, S., . . . Wexler, L. (2019). RISING SUN: Prioritized outcomes for suicide prevention in the Arctic. *Psychiatric Services, 70*(2), 152–155. doi:10.1176/appi.ps.201700505

Colucci, E. (2006). The cultural facet of suicidal behaviour: Its importance and neglect. *Australian e-Journal for the Advancement of Mental health, 5*(3), 234–246. doi:10.5172/jamh.5.3.234

Colucci, E. (2007). "Focus groups can be fun": the use of activity-oriented questions in focus group discussions. *Qualitative Health Research, 17*(10), 1422–1433. doi:10.1177/1049732307308129

Colucci, E., & Lester, D. (2012). *Suicide and culture: Understanding the context*: Cambridge, MA: Hogrefe Publishing.

Colucci, E., & Martin, G. (2007a). Ethnocultural aspects of suicide in young people: A systematic literature review part 1: Rates and methods of youth suicide. *Suicide and Life-Threatening Behavior, 37*(2), 197–221. doi: 10.1521/suli.2007.37.2.197

Colucci, E., & Martin, G. (2007b). Ethnocultural aspects of suicide in young people: a systematic literature review part 2: Risk factors, precipitating agents, and attitudes toward suicide. *Suicide and Life-Threatening Behavior, 37*(2), 222–237. doi: 10.1521/suli.2007.37.2.222

Crawford, A. (2019). *PROJECT CREATES. Circumpolar Resilience, Engagement, and Action Through Story. Report submitted to the Sustainable Development Working Group, Arctic Council, February 14, 2019.*

Daerga, L., Sjolander, P., Jacobsson, L., & Edin-Liljegren, A. (2012). The confidence in health care and social services in northern Sweden--a comparison between reindeer-herding Sami and the non-Sami majority population. *Scandinavian Journal of Public Health, 40*(6), 516–522. doi:10.1177/1403494812453971

Dagsvold, I. (2019). *Cultural adaption of mental health services to the Sami. A qualitative study on the incorporation of Sami language and culture into mental health services.* Doctorial dissertation. Tromsø, Norway: UiT - the Arctic University of Norway.

Dagsvold, I., Møllersen, S., & Stordahl, V. (2015). What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment. *International Journal of Circumpolar Health, 74*, 26952. doi:10.3402/ijch.v74.26952

Dagsvold, I., Møllersen, S., & Stordahl, V. (2016). "You never know who are Sami or speak Sami" Clinicians' experiences with language-appropriate care to Sami-speaking patients in outpatient

mental health clinics in Northern Norway. *International Journal of Circumpolar Health, 75*, 32588. doi:10.3402/ijch.v75.32588
Denzin, N. K., Lincoln, Y. S., & Smith, L. T. (2008). Handbook of critical and indigenous methodologies. Thousand Oaks, CA: Sage.
Duoglas, J. (1967). The social meaning of suicide. Princetin, NJ: Princeton University Press.
Drugge, A.-L. (2016). How can we do it right? Ethical uncertainty in Swedish Sami research. *Journal of Academic Ethics*, 1–17. doi:10.1007/s10805-016-9265-7
Dudgeon, P., & Holland, C. (2018). Recent developments in suicide prevention among the Indigenous peoples of Australia. *Australasian Psychiatry, 26*(2), 166–169. doi:10.1177/1039856218757637
Dudgeon, P., Milroy, J. A., Calma, T. A., Luxford, Y., Ring, I., Walker, R., . . . Holland, C. (2016). *Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. Crawley, Australia: University of Western Australia.
Dudgeon, P., Ring, I., Leyendekkers, G., McClintock, K., Lawson-Te Aho, K., King, M., . . . Stoor, J. P. A. (2018). *Global Overview: Indigenous Suicide Rates*. Perth, Australia: University of Western Australia.
Dyregrov, K. (2004). Bereaved parents' experience of research participation. *Social Science and Medicine, 58*(2), 391–400. doi:10.1016/s0277-9536(03)00205-3
Dyregrov, K., Berntsen, G., & Silviken, A. (2014). The need for and barriers to professional help-a qualitative study of the bereaved in Sámi areas. *Suicidology Online*, (5), s. 47-58.
Dyregrov, K., Dieserud, G., Straiton, M., Rasmussen, M. L., Hjelmeland, H., Knizek, B. L., & Leenaars, A. A. (2010). Motivation for research participation among people bereaved by suicide. *OMEGA-Journal of Death and Dying, 62*(2), 149–168. doi:10.2190/OM.62.2.d
Dyregrov, K. M., Dieserud, G., Hjelmeland, H. M., Straiton, M., Rasmussen, M. L., Knizek, B. L., & Leenaars, A. A. (2011). Meaning-making through psychological autopsy interviews: The value of participating in qualitative research for those bereaved by suicide. *Death Studies, 35*(8), 685–710. doi: 10.1080/07481187.2011.553310
Eliassen, B. M. (2016). *Etiske retningslinjer for helseforskning på urfolk* [Ethical guidelines for Indigenous health research]. Trondheim, Norway: Senter for samisk helseforskning, UiT – Norges arktiske universitet
Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115. doi:10.1111/j.1365-2648.2007.04569.x
Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open, 4*(1), 2158244014522633. doi:10.1177/2158244014522633
Eriksen, A. M., Hansen, K. L., Javo, C., & Schei, B. (2015). Emotional, physical and sexual violence among Sami and non-Sami populations in Norway: The SAMINOR 2 questionnaire study. *Scandinavian Journal of Public Health, 43*(6), 588–596. doi:10.1177/1403494815585936
Eriksen, A. M. A., Hansen, K. L., Schei, B., Sørlie, T., Stigum, H., Bjertness, E., & Javo, C. (2018). Childhood violence and mental health among indigenous Sami and non-Sami populations in Norway: a SAMINOR 2 questionnaire study. *International Journal of Circumpolar Health, 77*(1), 1508320. doi:10.1080/22423982.2018.1508320
First Nations Health and Social Secretariat of Manitoba. (2020). World Indigenous Suicide Prevention Conference. Retrieved from https://wispc2020.ca/
*Förhandlingsdelegationernas förslag till Nordisk Samekonvention* (2017). Retrieved from https://www.sametinget.se/111445
Gone, J. P. (2018). Considering Indigenous research methodologies: Critical reflections by an Indigenous knower. *Qualitative Inquiry, 25*(1), 45–56. doi:10.1177/1077800418787545
Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today, 56*, 29–34. doi:10.1016/j.nedt.2017.06.002
Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105–112. doi:10.1016/j.nedt.2003.10.001

Hagerman, M. (2015). *Käraste Herman: Rasbiologen Herman Lundborgs gåta*. Stockholm, Sweden: Norstedts.
Hallett, D., Chandler, M. J., & Lalonde, C. E. (2007). Aboriginal language knowledge and youth suicide. *Cognitive Development, 22*(3), 392–399. doi: 10.1016/j.cogdev.2007.02.001
Hansen, K. L. (2015). Ethnic discrimination and health: The relationship between experienced ethnic discrimination and multiple health domains in Norway's rural Sami population. *International Journal of Circumpolar Health, 74*, 25125. doi:10.3402/ijch.v74.25125
Hansen, K. L., Minton, S. J., Friborg, O., & Sørlie, T. (2016). Discrimination amongst Arctic Indigenous Sami and Non-Sami Populations in Norway-the SAMINOR 2 questionnaire study. *Journal of Northern Studies. 10*(2):45-84.
Hansen, K. L., & Sørlie, T. (2012). Ethnic discrimination and psychological distress: a study of Sami and non-Sami populations in Norway. *Transcult Psychiatry, 49*(1), 26–50. doi:10.1177/1363461511433944
Hassler, S., Johansson, R., Sjolander, P., Gronberg, H., & Damber, L. (2005). Causes of death in the Sami population of Sweden, 1961-2000. *International Journal of Epidemiology, 34*(3), 623–629. doi:10.1093/ije/dyi027
Hassler, S., Sjolander, P., Johansson, R., Gronberg, H., & Damber, L. (2004). Fatal accidents and suicide among reindeer-herding Sami in Sweden. *International Journal of Circumpolar Health, 63*(Suppl 2), 384–388. Doi: 10.3402/ijch.v63i0.17941
Health Research Council of New Zealand. (2010). *Guidelines for Researchers on Health Research Involving Māori*. Auckland, New Zealand: Health Research Council of New Zealand.
Heatta, O. M., & Snellman, A. (1996). *Behovsanalyse vedrörande helsetjenester til urbefolkningen i Nord-Russland*.
Hedlund, M., & Moe, A. (2000). *"De forstår ikke hva som er viktig for oss": helsetjenester og sørsamer*. Steinkjer, Norway: Nord-Trøndelagsforskning.
Heikkilä, L., Laiti-Hedemäki, E., & Pohjola, A. (2013). *Saamelaisten hyvä elämä ja hyvinvointipalvelut*. Rovaniemi, Finland: Lapland University Press.
Helsedirektoratet. (2014). *Handlingsplan for forebygging av selvmord og selvskading 2014–2017*. Oslo, Norway: Helsedirektoratet.
Heyerdahl, S., Kvernmo, S., & Wichstrom, L. (2004). Self-reported behavioural/emotional problems in Norwegian adolescents from multiethnic areas. *European Child and Adolescent Psychiatry, 13*(2), 64–72. doi:10.1007/s00787-004-0359-1
Hjelmeland, H. (2010). Cultural research in suicidology: Challenges and opportunities. *Suicidology Online, 1*(1), 34–52.
Hjelmeland, H. (2011). Cultural context is crucial in suicide research and prevention. *Crisis, 32*(2), 61–64. doi:10.1027/0227-5910/a000097
Hjelmeland, H., Akotia, C. S., & Knizek, B. L. (2010). A qualitative study of attitudes toward suicide and suicide prevention among psychology students in Ghana. *OMEGA--Journal of Death and Dying, 62*(2), 169–186. doi:10.2190/OM.62.2.e
Hjelmeland, H., Dieserud, G., Dyregrov, K., & Knizek, B. L. (2010). Er det farlig å snakke med folk om selvmord? [Is it dangerous to talk with people about suicide?]. *Tidsskrift for den Norske Laegeforening, 130*(10), 1018–1019. doi:10.4045/tidsskr.10.0218
Hjelmeland, H., Dieserud, G., Dyregrov, K., Knizek, B. L., & Leenaars, A. A. (2012). Psychological autopsy studies as diagnostic tools: are they methodologically flawed? *Death Studies, 36*(7), 605–626. doi:10.1080/07481187.2011.584015
Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior, 40*(1), 74–80. doi:10.1521/suli.2010.40.1.74
Hjelmeland, H., & Knizek, B. L. (2017). Suicide and mental disorders: A discourse of politics, power, and vested interests. *Death Studies, 41*(8), 481–492. doi:10.1080/07481187.2017.1332905
Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika guidelines for Māori research ethics: a framework for researchers and ethics committee members.* Wellington, New Zealand: Health Research Council of New Zealand.
Hunt, P. (2007). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt - MISSION TO SWEDEN*.

Inuit Tapiriit Kanatami. (2016). *National Inuit Suicide Prevention Strategy*.
Jacobsson, L. (2016). Is there a special ethics for Indigenous research? In A.-L. Drugge (Ed.), *Ethics in Indigenous Research, Past Experiences - Future Challenges* (7 ed., pp. 45–56). Umeå, Sweden: Vaartoe – Centre for Sami Research, Umeå University.
Jacobsson, L., Stoor, J. P. A., & Eriksson, A. (2020). Suicide among reindeer herding Sámi in Sweden, 1961–2017. *International Journal of Circumpolar Health, 79*(1), 1754085. doi:10.1080/22423982.2020.1754085
Juutilainen, S. A. (2017). *Structural racism and indigenous health. A critical reflection of Canada and Finland.* Doctoral dissertation. Oulu, Finland: Oulu University.
Kaiser, N. (2011). *Mental health problems among the Swedish reindeer-herding Sami population: in perspective of intersectionality, organisational culture and acculturation.* Doctoral dissertation. Umeå, Sweden: Umeå University.
Kaiser, N., Nordström, A., Jacobsson, L., & Salander Renberg, E. (2011). Hazardous drinking and drinking patterns among the reindeer-herding Sami population in Sweden. *Substance Use and Misuse, 46*(10), 1318–1327. doi:10.3109/10826084.2011.577884
Kaiser, N., & Salander Renberg, E. (2012). Suicidal expressions among the Swedish reindeer-herding Sami population. *Suicidology Online, 3*, 114–123. doi:10.3402/ijch.v72i0.19862
Kaiser, N., Sjolander, P., Liljegren, A. E., Jacobsson, L., & Renberg, E. S. (2010). Depression and anxiety in the reindeer-herding Sami population of Sweden. *International Journal of Circumpolar Health, 69*(4), 383–393. doi:10.3402/ijch.v69i4.17674
Kizza, D., Knizek, B. L., Kinyanda, E., & Hjelmeland, H. (2012a). An escape from agony: A qualitative psychological autopsy study of women's suicide in a post-conflict Northern Uganda. *International Journal of Qualitative Studies on Health and Well-being, 7*, 1–13. doi:10.3402/qhw.v7i0.18463
Kizza, D., Knizek, B. L., Kinyanda, E., & Hjelmeland, H. (2012b). Men in despair: A qualitative psychological autopsy study of suicide in Northern Uganda. *Transcultural Psychiatry, 49*(5), 696–717. doi:10.1177/1363461512459490
Kjølseth, I., Ekeberg, Ø., & Steihaug, S. (2009). “Why do they become vulnerable when faced with the challenges of old age?” Elderly people who committed suicide, described by those who knew them. *International Psychogeriatrics, 21*(5), 903–912. doi:10.1017/S1041610209990342
Kjølseth, I., Ekeberg, Ø., & Steihaug, S. (2010). Why suicide? Elderly people who committed suicide and their experience of life in the period before their death. *International Psychogeriatrics, 22*(2), 209–218. doi:10.1017/S1041610209990949
Kral, M. J. (2012). Postcolonial Suicide Among Inuit in Arctic Canada. *Culture, Medicine and Psychiatry, 36*(2), 306–325. doi:10.1007/s11013-012-9253-3
Kral, M. J. (2013). "The weight on our shoulders is too much, and we are falling": Suicide among Inuit male youth in Nunavut, Canada. *Medical Anthropology Quarterly, 27*(1), 63–83. doi:10.1111/maq.12016
Kral, M. J., Wiebe, P. K., Nisbet, K., Dallas, C., Okalik, L., Enuaraq, N., & Cinotta, J. (2009). Canadian Inuit Community engagemant in suicide prevention. *International Journal of Circumpolar Health, 68*(3), 292–308. doi:10.3402/ijch.v68i3.18330
Kristoffersen, A. E., Stub, T., Melhus, M., & Broderstad, A. R. (2017). Prevalence and associations for use of a traditional medicine provider in the SAMINOR 1 Survey: a population-based study on Health and Living Conditions in Regions with Sami and Norwegian Populations. *BMC Complementary and Alternative Medicine, 17*(1), 530. doi:10.1186/s12906-017-2037-0
Kuokkanen, R. (2015). Gendered violence and politics in Indigenous communities. The cases of aboriginal people in Canada and the Sami in Scandinavia. *International Feminist Journal of Politics, 17*(2). doi:10.1080/14616742.2014.901816
Kvernmo, S. (2004). Mental health of Sami youth. *International Journal of Circumpolar Health, 63*(3), 221-234. doi:10.3402/ijch.v63i3.17716
Kvernmo, S., & Rosenvinge, J. H. (2009). Self-mutilation and suicidal behaviour in Sami and Norwegian adolescents: prevalence and correlates. *International Journal of Circumpolar Health, 68*(3), 235–248. doi:10.3402/ijch.v68i3.18331

Kvernmo, S., Strøm Bull, K., Broderstad, A., Rossvoll, M., Eliassen, B.-M., & Stoor, J.P.A (2018). *Proposal for Ethical Guidelines for Sámi Health Research and Research on Sámi Human Biological Material*. Karasjok, Norway: Sámidiggi.

Lange, A. (2001). *SAMI ON DISCRIMINATION A questionnaire and interview study of ethnic discrimination commissioned by the Discrimination Ombudsman (DO)*. Stockholm, Sweden: Centrum för invandringsforskning (CEIFO).

Langås-Larsen, A., Salamonsen, A., Kristoffersen, A. E., Hamran, T., Evjen, B., & Stub, T. (2018). ”We own the illness”: a qualitative study of networks in two communities with mixed ethnicity in Northern Norway. *International Journal of Circumpolar Health, 77*(1), 1438572. doi:10.1080/22423982.2018.1438572

Langås-Larsen, A., Salamonsen, A., Kristoffersen, A. E., & Stub, T. (2018). “The prayer circles in the air”: a qualitative study about traditional healer profiles and practice in Northern Norway. *International Journal of Circumpolar Health, 77*(1), 1476638. doi:10.1080/22423982.2018.1476638

Lantto, P. (2012). *Lappväsendet: Tillämpningen av svensk samepolitik 1885-1971* (Vol. 14). Umeå, Sweden: Centrum för Samisk forskning, Umeå universitet.

Lapin sairaanhoitopiirin, & Helse Finnmark HF. (2007). Yhteistyosopimus erikoissairaanhoidosta Lapin sairaanhoitopiirin (LSHP) ja Helse Finnmark HF:n välillä - Samarbeidsavtale om spesialisthelsetjenester mellom Lapin sairaanhoitopiiri (LSHP) og Helse Finnmark HF [Agreement of cooperation on specialized health services between Lapin sairaanhoitopiiri (LSHP) and Helse Finnmark HF].

Larsen, C., Pedersen, C., Berthelsen, S., & Chew, C. (2010). *Hope and resilience: suicide prevention in the Arctic, November 7–8 2009 Conference Report*.

Larsen, D. R. (2010, Nov 29). Frp: Barn presses til å være samer. *NRK Sápmi*. Retrieved from http://www.nrk.no/kanal/nrk_sapmi/1.7399407

Lavoie, J. G., Stoor, J. P. A., Rink, E., Cueva, K., Gladun, E., Viskum Lytken Larsen, C., Healey Akearok, G., & Kanayurak, N. (Forthcoming). Cultural competence and safety in Circumpolar countries: an analysis of discourses in healthcare.

Leenaars, A. A. (2010). Edwin S. Shneidman on suicide. *Suicidology Online, 1*(1), 5–18.

Lester, D. (2012). The Cultural Meaning of Suicide: What Does That Mean? *Omega - Journal of Death and Dying, 64*(1), 83-94. doi:10.2190/OM.64.1.f

Lester, D. (2013). Suicide and culture. In D. Lester & J. R. Rogers (Eds.), *Understanding suicide: A global issue* (pp. 209-232): ABC-CLIO, Santa Barbara, CA

Lester, D., Saito, Y., & Park, B. C. B. (2011). Suicide among Foreign Residents of Japan. *Psychological Reports, 108*(1), 139–140. doi:10.2466/12.PR0.108.1.139-140

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage.

Marsella, A. J., Dubanoski, J., Hamada, W. C., & Morse, H. (2000). The measurement of personality across cultures: Historical, conceptual, and methodological issues and considerations. *American Behavioral Scientist, 44*(1), 41–62. doi:10.1177/00027640021956080

McCormick, R. M. (2000). Aboriginal traditions in the treatment of substance abuse. *Canadian Journal of Counselling and Psychotherapy, 34*(1), 25–32.

Mehus, G., & Bongo, B. A. (2012). *Kunnskapsoppsummering og litteraturgjennomgang av samiske helse- og omsorgstjenster – med særlig vekt på demens, terminalomsorg og kulturens betydning i pleie- og omsorgsutøvelsen*. Alta, Norway: Høgskolen I Finnmark.

Melbøe, L. (2018). Cultural sensitivity and barriers: Sami people with disabilities facing the welfare system. *Community Development Journal, 53*(3), 537–555. doi:10.1093/cdj/bsy025

Melbøe, L., Johnsen, B.-E., Fedreheim, G. E., & Hansen, K. L. (2016). *Situasjonen til samer med funksjonsnedsettelse(r)*. Stockholm, Sweden: Nordens Välfärdscenter.

Minde, G., & Nymo, R. (2016). Open the medical room: how indigenous patients’ cultural knowledge appears in the meetings with the health care providers during the rehabilitation process. In M.A.Hart, A. Dawne Burton, K. Hart, G. Rowe, D. Halonen and Y. Pompana (Eds.), *International Indigenous Voices in Social Work (pp. 83-100).* Cambridge, UK: Cambridge Scholars Publishing,

Minde, H. (2003). Assimilation of the Sami - Implementation and consequences. *Acta Borealia, 20*(2), 121–146. doi:10.1080/08003830310002877

Møllersen, S. (2018). Physical strain, external demands, and work pleasure in a mobile pastoral population of the Arctic. *Medical Research Archives, 6*(3). doi:10.18103/mra.v6i3.1708
Møllersen, S., Sexton, H. C., & Holte, A. (2009). Effects of client and therapist ethnicity and ethnic matching: A prospective naturalistic study of outpatient mental health treatment in Northern Norway. *Nordic Journal of Psychiatry, 63*(3), 246–255. doi:10.1080/08039480802576043
Mugisha, J., Hjelmeland, H., Kinyanda, E., & Knizek, B. L. (2011). Distancing: A traditional mechanism of dealing with suicide among the Baganda, Uganda. *Transcultural Psychiatry, 48*(5), 624–642. doi:10.1177/1363461511419273
Nasjonale forskningsetiske komité for samfunnsvitenskap og humaniora (NESH). (2002). *Samisk forskning og forskningsetikk* (Vol. 2). Oslo, Norway: De nasjonale forskningsetiske komiteer.
National Health and Medical Research Council. (2018). *Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders*. Canberra, Australia: National Health and Medical Research Council.
Ness, T. M., Enmarker, I., & Hellzèn, O. (2013). Experiences of being old and receiving home nursing care. Older South Sami narrations of their experiences—An interview study. *Open Journal of Nursing, 3*(1), 1–7. doi:10.4236/ojn.2013.31001
Nilsson, R. (2019). The consequences of Swedish National Law on Sámi self-constitution—The shift from a relational understanding of who is Sámi toward a rights-based understanding. *Ethnopolitics*, 1–19. doi:10.1080/17449057.2019.1644779
Nordland fylkeskommune. (2014). *NULLVISJON SELVMORD. Handlingsplan 2015 - 2020* [Vision Zero Suicide. Actionplan 2015-2020].
Norrbottens läns landsting, Region Jämtland Härjedalen, & Västerbottens läns landsting. (2015). *Att samverka och handla. Överenskommelse för psykisk hälsa i Sápmi* [To cooperate and take action. Agreement for mental health in Sápmi].
Nymo, R. (2011). *Helseomsorgssystemer i samiske markebygder i Nordre Nordland og Sør-Troms. Praksiser i hverdagslivet." En ska ikkje gje sæ over og en ska ta tida til hjelp".* Doctoral dissertation. Tromsø, Norway: Universitetet i Tromsø.
Nystad, T., Melhus, M., & Lund, E. (2008). Sami speakers are less satisfied with general practitioners' services. *International Journal of Circumpolar Health, 67*(1), 114–121. doi:10.3402/ijch.v67i1.18246
O'Keefe, V. M., Tucker, R. P., Cole, A. B., Hollingsworth, D. W., & Wingate, L. R. (2018). Understanding Indigenous suicide through a theoretical lens: A review of general, culturally-based, and Indigenous frameworks. *Transcultural Psychiatry, 55*(6), 775–799. doi:10.1177/1363461518778937
Omerov, P., Steineck, G., Dyregrov, K., Runeson, B., & Nyberg, U. (2013). The ethics of doing nothing. Suicide-bereavement and research: ethical and methodological considerations. *Psychological Medicine*, 1–12. doi:10.1017/s0033291713001670
Omma, L., Jacobsson, L. H., & Petersen, S. (2012). The health of young Swedish Sami with special reference to mental health. *International Journal of Circumpolar Health, 71*, 18381. doi:10.3402/ijch.v71i0.18381
Omma, L., & Petersen, S. (2015). Health-related quality of life in indigenous Sami schoolchildren in Sweden. *Acta Paediatrica, 104*(1), 75–83. doi:10.1111/apa.12786
Omma, L., & Sandlund, M. (2015). Alcohol use in young indigenous Sami in Sweden. *Nordic Journal of Psychiatry, 69*(8), 621–628. doi:10.3109/08039488.2015.1028437
Omma, L., Sandlund, M., & Jacobsson, L. (2013). Suicidal expressions in young Swedish Sami, a cross-sectional study. *International Journal of Circumpolar Health, 72*, 19862. doi:10.3402/ijch.v72i0.19862
Orjasniemi, T. (2012). The wet province – Drinking in Lapland. *Drugs: Education, Prevention and Policy, 19*(1), 32–39. doi:10.3109/09687637.2011.565824
Osafo, J., Hjelmeland, H., Akotia, C. S., & Knizek, B. L. (2011). The meanings of suicidal behaviour to psychology students in Ghana: A qualitative approach. *Transcultural Psychiatry, 48*(5), 643–659. doi:10.1177/1363461511417319
Pettersen, T. (2014). *Sámi ethnicity as a variable: Premises and implications for population-based studies on health and living conditions in Norway.* Doctoral dissertation Tromsø, Norway: UiT - The Arctic University of Norway

Poggats, T. (2019). Het debatt om Sametingets röstlängd [Hot debate on electoral roll of the Sámi parliament]. Retrieved from https://sverigesradio.se/artikel/6622237
Poikolainen, K., Näyhä, S., & Hassi, J. (1992). Alcohol consumption among male reindeer herders of Lappish and Finnish origin. *Social Science and Medicine, 35*(5), 735–738. doi:10.1016/0277-9536(92)90011-e
Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods*: Philadelphia, PA: Lippincott Williams & Wilkins.
Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: myths and strategies. *International Journal of Nursing Studies, 47*(11), 1451–1458. doi:10.1016/j.ijnurstu.2010.06.004
Pollock, N. J., Naicker, K., Loro, A., Mulay, S., & Colman, I. (2018). Global incidence of suicide among Indigenous peoples: a systematic review. *BMC Medicine, 16*(1), 145. doi:10.1186/s12916-018-1115-6
Poppel, B., Andersen, T., Beach, H., Bernard, N., Broderstad, A. R., Duhaime, G., . . . Turcotte, C. (2015). *SLiCA: Arctic living conditions: Living conditions and quality of life among Inuit, Saami and indigenous peoples of Chukotka and the Kola Peninsula*. Copenhagen, Denmark: Nordic Council of Ministers.
Rasmussen, M. L., Haavind, H., & Dieserud, G. (2017). Young men, masculinities, and suicide. *Archives of Suicide Research*, 1–17. doi:10.1080/13811118.2017.1340855
Redvers, J., Bjerregaard, P., Eriksen, H., Fanian, S., Healey, G., Hiratsuka, V., . . . Chatwood, S. (2015). A scoping review of Indigenous suicide prevention in circumpolar regions. *International Journal of Circumpolar Health, 74*, 27509. doi:10.3402/ijch.v74.27509
Region Jämtland Härjedalen, & Finnmarkssykehuset HF. (2015). *Överenskommelse om sjukvård och samarbete mellan Region Jämtland Härjedalen och Finnmarkssykehuset HF (FIN) - Avtale om helsehjelp og samarbeid mellom Region Jämtland Härjedalen og Finnmarkssykehuset HF (FIN)* [Agreement on health care and cooperation between Region Jämtland Härjedalen and Finnmarkssykehuset HF (FIN)].
Ridani, R., Shand, F. L., Christensen, H., McKay, K., Tighe, J., Burns, J., & Hunter, E. (2015). Suicide prevention in Australian Aboriginal communities: a review of past and present programs. *Suicide and Life-Threatening Behavior, 45*(1), 111-140.
Rink, E., Johnson, R. M., Rautio, A., & Eriksen, H. A. (2017). *The ethics of community based participatory research with Sami communities in Northern Finland: An exploratory study*. Paper presented at the The Ninth International Congress of Arctic Social Sciences (ICASS IX), Umeå University.
Roen, K., Scourfield, J., & McDermott, E. (2008). Making sense of suicide: a discourse analysis of young people's talk about suicidal subjecthood. *Social Science and Medicine, 67*(12), 2089–2097. doi:10.1016/j.socscimed.2008.09.019
Sámi Norwegian National Advisory Unit on mental Health and Substance use, & Saami Council. (2017). *Plan for Suicide Prevention among the Sámi People in Norway, Sweden, and Finland*. Karasjok, Norway: Sámi Norwegian National Advisory Unit on Mental Health and Substance Use & Saami Council
Sámi parliament of Sweden. (2019). Statistik från sameröstlängden [Statistics from the electoral roll to the Sámi parliament]. Retrieved from https://www.sametinget.se/6434
Sámi parliament of Norway. (2019). Sametingets valgmanntall 2019 [The electoral roll to the Sámi parliament 2019]. Retrieved from https://sametinget.no/Valg/Valgmanntall/Sametingets-valgmanntall-2019
*Sámiid kulturpolitiikalaš prográm'ma: dåk'kehuvvun Davviriikaid VII sábmelaš-konferænsas Váččiris 11-14.8.1971 = Samernas kulturpolitiska program = Saamelaisten kulttuuripoliittinen ohjelma*. (1974). Helset [Helsinki], Finland: Davviriikaid sámiradđi.
Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*(4), 334–340. doi:10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G
Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health, 33*(1), 77–84. doi:10.1002/nur.20362
Schneidman, E. (1985). *Definition of Suicide*. New York, NY: Wiley.

Sexton, R., & Buljo Stabbursvik, E. A. (2010). Healing in the Sami North. *Culture, Medicine and Psychiatry, 34*(4), 571–589. doi:10.1007/s11013-010-9191-x
Sexton, R., & Sorlie, T. (2008). Use of traditional healing among Sami psychiatric patients in the north of Norway. *International Journal of Circumpolar Health, 67*(1), 135–146. doi:10.3402/ijch.v67i1.18250
Sexton, R., & Sørlie, T. (2009). Should traditional healing be integrated within the mental health services in Sámi areas of northern Norway? Patient views and related factors. *International Journal of Circumpolar Health, 68*(5). doi:10.3402/ijch.v68i5.17384
Shields, C., Kavanagh, M., & Russo, K. (2017). A qualitative systematic review of the bereavement process following suicide. *Omega (Westport), 74*(4), 426–454. doi:10.1177/0030222815612281
Silviken, A. (2009). Prevalence of suicidal behaviour among indigenous sami in northern norway. *International Journal of Circumpolar Health, 68*(3), 204–211. doi:10.3402/ijch.v68i3.18336
Silviken, A., Berntsen, G., & Dyregrov, K. (2014). Etterlattes erfaringer med lokalt hjelpeapparat i samiske områder i Nord-Norge [Bereaveds' experiences with local support system in Sami areas in northern Norway]. *Sykepleien Forskning, 1*, 37–41.
Silviken, A., Haldorsen, T., & Kvernmo, S. (2006). Suicide among indigenous Sami in Arctic Norway, 1970-1998. *European Journal of Epidemiology, 21*(9), 707–713. doi:10.1007/s10654-006-9052-7|10.1007/s10654-006-9052-7
Silviken, A., & Kvernmo, S. (2007). Suicide attempts among indigenous Sami adolescents and majority peers in Arctic Norway: prevalence and associated risk factors. *Journal of Adolescence, 30*(4), 613–626. doi:10.1016/j.adolescence.2006.06.004
Silviken, A., Slettli Gundersen, L., Berntsen, G., & Dyregrov, K. (2015). Sudden and unexpected death in Sámi areas in Norway - A qualitative study the significance of religiosity in the bereavement process. *Suicidology Online, 6*, 53–63.
Sjölander, P. (2011). What is known about the health and living conditions of the indigenous people of northern Scandinavia, the Sami? *Global Health Action, 4*(1). doi:10.3402/gha.v4i0.8457
Sjölander, P., Edin-Liljegren, A., & Daerga, L. (2009). *Samernas hälsosituation i Sverige: en kunskapsöversikt* [The health situation of the Sámi in Sweden: a compilation of knowledge]. Kiruna, Sweden: Södra Lapplands forskningsenhet, på uppdrag av Sametinget.
Snellman, A., Hetta, O. M., & Dubovtseva, M. (1998). Post-Soviet Russian indigenous health: The Sami people of the Kola Peninsula. *International Journal of Circumpolar Health, 57*(Suppl 1), 636–638.
Socialstyrelsen, & Statens Folkhälsoinstitut. (2006). *Förslag till nationellt program för suicidprevention – befolkningsinriktade och individinriktade strategier och åtgärdsförslag* [Proposal for national programme for suicide prevention – public and individual strategies and proposals for action].
Soininen, L., & Pukkola, E. (2008). Mortality of the Sami in northern Finland 1979-2005. *International Journal of Circumpolar Health, 67*(1), 43–55. doi:10.3402/ijch.v67i1.18227
Sorlie, T., & Nergard, J. I. (2005). Treatment satisfaction and recovery in Saami and Norwegian patients following psychiatric hospital treatment: a comparative study. *Transcultural Psychiatry, 42*(2), 295–316. doi:10.1177/1363461505052669
Statens Offentliga Utredningar (1975). *SOU 1975:100. Sameutredningen. Samerna i Sverige: stöd åt språk och kultur: betänkande*. Stockholm, Sweden: Liber/Allmänna förlaget
Spein, A. R. (2008). Substance use among young indigenous Sami--a summary of findings from the North Norwegian Youth Study. *International Journal of Circumpolar Health, 67*(1), 122–134. doi: 10.3402/ijch.v67i1.18248
Spein, A. R., Melhus, M., Kristiansen, R. E., & Kvernmo, S. E. (2011). The influence of religious factors on drinking behavior among young indigenous Sami and non-Sami peers in northern Norway. *Journal of Religion and Health, 50*(4), 1024–1039. doi:10.1007/s10943-010-9335-x
Spein, A. R., Sexton, H., & Kvernmo, S. (2007). Substance use in young indigenous Sami: an ethnocultural and longitudinal perspective. *Substance Use and Misuse, 42*(9), 1379–1400. doi:10.1080/10826080701211693

Spein, A. R., Sexton, H., & Kvernmo, S. E. (2006). Longitudinal drinking patterns in indigenous Sami and non-indigenous youth in northern Norway. *Journal of Ethnicity in Substance Abuse, 5*(3), 103–117. doi:10.1300/J233v05n03_06

Statistisk sentralbyrå. (1956). *Folketellingen 1. desember 1950. Åttende hefte. Personer født i utlandet - fremmede statsborgere - bruken av samisk og kvensk.* Oslo, Norway: Statistisk sentralbyrå.

Stoor, J. P. A. (2015). Varför söker svenska samer vård i Norge? - om kultur och kontext i samisk psykiatri [Why do Swedish Sámi seek care in Norway? - on culture and context in Sámi Psychiatry]. *Socialmedicinsk tidskrift, 92*(1), 1565861.

Stoor, J. P. A. (2016). *Kunskapssammanställning om psykosocial ohälsa bland samer* [Compilation of knowledge on psychosocial health among Sami]. Kiruna, Sweden: Sametinget.

Stoor, J. P. A., Kaiser, N., Jacobsson, L., Salander-Renberg, E., & Silviken, A. (2015). "We are like lemmings": making sense of the cultural meaning(s) of suicide among the indigenous Sami in Sweden. *International Journal of Circumpolar Health, 74*, 27669. doi:10.3402/ijch.v74.27669

Stoor, J. P. A., Berntsen, G., Hjelmeland, H., & Silviken, A. (2019). "If you do not birget [manage] then you don't belong here": a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway. *International Journal of Circumpolar Health, 78*(1), 1565861. doi:10.1080/22423982.2019.1565861

Stordahl, V., Tørres, G., Møllersen, S., & Eira-Åhren, I.-M. (2015). Ethical guidelines for Sami research: the issue that disappeared from the Norwegian Sami Parliament's agenda? *International Journal of Circumpolar Health, 74*(1). doi:10.3402/ijch.v74.27024

Storm Mienna, C., & Axelsson, P. (2019). Somatic health in the Indigenous Sami population-a systematic review. *International Journal of Circumpolar Health, 78*(1), 1638195. doi:10.1080/22423982.2019.1638195

Strömsunds kommun, Östersunds kommun, Krokoms kommun, Bergs kommun, Bräcke kommun, Ragunda kommun, . . . Region Jämtland Härjedalen. (2017). *Handlingsplan för kommunerna i Jämtlands län och Region Jämtland Härjedalen. Område psykisk hälsa 2016 – 2020.* [Actionplan for municipalities in Jämtland county and Region Jämtland Härjedalen. Mental health sector 2016-2020].

Strömsunds kommun, Östersunds kommun, Krokoms kommun, Bergs kommun, Bräcke kommun, Ragunda kommun, . . . Region Jämtland Härjedalen. (2018*). Suicidpreventiv handlingsplan för kommunerna i Jämtlands län och Region Jämtland Härjedalen. Område psykisk hälsa, År 2019-2030.* [Suicidpreventive actionplan fo the municipalities in Jämtland county and Region Jämtland Härjedalen. Mental health sector, years 2019-2030]

Tatz, C. (2005). *Aboriginal Suicide is Different: a portrait of life and self-destruction*. Canberra, Australia: Aboriginal Studies Press.

Tatz, C. (2017). Suicide and sensibility. *Death Studies, 41*(8), 542–550. doi:10.1080/07481187.2017.1333358

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. doi:10.1093/intqhc/mzm042

Tuhiwai Smith, L. (2012). *Decolonizing methodologies: Research and indigenous peoples* (2nd ed.): London, UK: Zed books.

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet, 387*(10024), 1227–1239. doi:10.1016/S0140-6736(15)00234-2

*United Nations Declaration on the Rights of Indigenous Peoples*. (2007).

Wexler, L. (2006). Inupiat youth suicide and culture loss: Changing community conversations for prevention. *Social Science and Medicine, 63*(11), 2938–2948. doi:10.1016/j.socscimed.2006.07.022

Wexler, L. (2009). Identifying colonial discourses in Inupiat young people's narratives as a way to understand the no future of Inupiat youth suicide. *American Indian and Alaska Native Mental Health Research, 16*(1), 1–24. doi:10.5820/aian.1601.2009.1

Wexler, L., Chandler, M., Gone, J. P., Cwik, M., Kirmayer, L. J., LaFromboise, T., . . . Allen, J. (2015). Advancing suicide prevention research with rural American Indian and Alaska Native populations. *American Journal of Public Health, 105*(5), 891–899. doi:10.2105/AJPH.2014.302517

Wexler, L., Silveira, M. L., & Bertone-Johnson, E. (2012). Factors associated with Alaska Native fatal and nonfatal suicidal behaviors 2001-2009: Trends and implications for prevention. *Archives of Suicide Research, 16*, 273-286. doi:10.1080/13811118.2013.722051

Wexler, L., White, J., & Trainor, B. (2015). Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach. *Critical Public Health, 25*(2), 205–217. doi:10.1080/09581596.2014.904039

Wilson, S. (2001). What is an Indigenous research methodology? *Canadian Journal of Native Education, 25*(2), 175-179.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods.* Winnipeg/Halifax, Canada: Fernwood Publishing.

World Health Organization. (2014). *Preventing suicide: A global imperative*. Geneva, Switzerland: World Health Organization

World Health Organization. (2018). *National suicide prevention strategies: Progress, examples and indicators*. Geneva, Switzerland: World Health Organization

World Health Organization. (2019a). *Preventing suicide: A community engagement toolkit*. Geneva, Switzerland: World Health Organization

World Health Organization. (2019b). *Suicide in the world: Global Health Estimates*. Geneva, Switzerland: World Health Organization

World Medical Association. (2013). World medical association declaration of helsinki: Ethical principles for medical research involving human subjects. *JAMA, 310*(20), 2191–2194. doi:10.1001/jama.2013.281053

Young, T. K., Revich, B., & Soininen, L. (2015). Suicide in circumpolar regions: an introduction and overview. *International Journal of Circumpolar Health, 74*, 27349. doi:10.3402/ijch.v74.27349

# Papers and Appendices

**Paper I**

Stoor, J. P. A., Kaiser, N., Jacobsson, L., Salander Renberg, E., & Silviken, A. (2015). 'We are like lemmings': making sense of the cultural meaning(s) of suicide among the Indigenous Sami in Sweden. *International Journal of Circumpolar Health*, 74. doi:10.3402/ijch.v74.27669

**Paper II**

Stoor, J. P.A., Berntsen, G., Hjelmeland, H., & Silviken, A. (2019). 'If you do not birget [manage] then you don't belong here': a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway. *International Journal of Circumpolar Health*, 78(1). doi:10.1080/22423982.2019.1565861

**Paper III**

Stoor, J. P. A., Eriksen, H., & Silviken, A.
'Mapping of suicide prevention initiatives among Sámi in Norway, Sweden and Finland'
Submitted manuscript

**Appendix 1**

Supplementary Material to Paper III: Table 1. Descriptive characteristics of Suicide Prevention Initiatives targeting Sámi in Sweden.

**Appendix 2**

Supplementary Material to Paper III: Table 2. Descriptive characteristics of Suicide Prevention Initiatives targeting Sámi in Norway, Finland and Internationally.

**Appendix 3**

Supplementary Material to Paper III: Table 3. Problematizations, category and level of intervention suggested, yielded through applying the 'what is the problem represented to be?'-method on suicide prevention initiatives targeting Sámi in Norway, Sweden and Finland.

# Paper I

INTERNATIONAL JOURNAL OF CIRCUMPOLAR HEALTH

co-action PUBLISHING

ORIGINAL RESEARCH ARTICLE

# ''We are like lemmings'': making sense of the cultural meaning(s) of suicide among the indigenous Sami in Sweden

**Jon Petter A Stoor[1]*, Niclas Kaiser[2], Lars Jacobsson[3], Ellinor Salander Renberg[3] and Anne Silviken[1,4]**

[1]Sami Norwegian National Advisory Board on Mental Health and Substance Abuse (SANKS), Finnmark Hospital Trust, Karasjok, Norway; [2]Department of Psychology, Umeå University, Umeå, Sweden; [3]Division of Psychiatry, Department of Clinical Sciences, Umeå University, Umeå, Sweden; [4]Centre for Sami Health Research, Department of Community Medicine, UiT – The Arctic University of Norway, Tromsø, Norway

***Background***. Suicide is a widespread problem among indigenous people residing in the circumpolar Arctic. Though the situation among the indigenous Sami in northern Scandinavia is better than among some other indigenous people, suicide is still regarded as a major public health issue. To adapt prevention strategies that are culturally attuned one must understand how suicide is understood within context. That is, the cultural meaning(s) of suicide.

***Objective***. To explore and make sense of the cultural meaning(s) of suicide among Sami in Sweden.

***Design***. Open-ended focus group discussions (FGDs) on the topic ''suicide among Sami'' were carried out in 5 Sami communities in Sweden, with in total 22 strategically selected Sami participants. FGDs were recorded, transcribed verbatim and analyzed through employing content analysis.

***Results***. From the FGDs 4 themes emerged including ''The Sami are fighting for their culture and the herders are in the middle of the fight,'' ''Suicide as a consequence of Sami losing (or having lost) their identity,'' ''A wildfire in the Sami world'' and ''Difficult to get help as a Sami.''

***Conclusions***. Findings indicate that Sami in Sweden make sense of suicide in relation to power and identity within a threatened Sami cultural context. Suicide is then understood as an act that takes place and makes sense to others when a Sami no longer has the power to maintain a Sami identity, resulting in being disconnected from the Sami world and placed in an existential void where suicide is a solution. The findings are useful in development of culturally attuned suicide prevention among Sami in Sweden.

Keywords: *Sami*; *suicide*; *indigenous*; *identity*; *Sweden*; *qualitative study*

Responsible Editor: Kue Young, University of Alberta, Canada.

*Correspondence to: Jon Petter A Stoor, Sami Norwegian National Advisory Board of Mental Health and Substance Abuse (SANKS), Finnmark Hospital Trust, Stuorraluohkka, Post box 4, NO-9735 Karasjok, Norway, Email: jon.petter.anders.stoor@finnmarkssykehuset.no

Received: 19 February 2015; Revised: 4 August 2015; Accepted: 7 August 2015; Published: 1 September 2015

Indigenous people residing in the circumpolar Arctic have been found to account for some of the highest suicide rates worldwide. However, within the Arctic region there is great variance both within and across indigenous populations in different territories and contexts. Very high suicide rates have been reported from indigenous peoples in Russia (1), Alaska (2), Canada (3) and Greenland (4) while suicide rates among the indigenous Sami in Scandinavia are moderate (5). However, there are some striking commonalities with the situation in other parts of the Arctic, including elevated rates in comparison with majority populations (in the Sami case in comparison with Norwegians, Swedes and Finns), high suicide rates among young men, suicide clusters and use of highly lethal methods such as firearms and hanging (5,6). Also, the negative impacts of suicide seem to be higher in Sami communities than majority society (as compared to rural and urban populations in Sweden), with higher prevalence's of exposure to suicidal expressions among Sami youth (7) and reindeer herding Sami (8).

Suicide is strongly related to mental health disorders, but researchers are also stressing the importance of understanding suicide among indigenous people in the Arctic in the context of long-lasting (9) and on-going (10)





Citation: Int J Circumpolar Health 2015, **74**: 27669 - http://dx.doi.org/10.3402/ijch.v74.27669

colonialization processes, including rapid social changes resulting in the breaking of traditional indigenous structures and insufficient social development. Indeed, some researchers partly reject the western psychiatric perspective and claim that "aboriginal suicide is different" (11), and that a different framework therefore has to be used to make sense of the phenomenon. In *Sápmi* (land of the Sami), Kaiser (12), Omma (13) and Silviken (14) have all argued that cultural context in general, and the difficulties of maintaining traditional livelihoods such as reindeer herding in particular, is crucial to understanding suicidal behaviour among Sami.

Hjelmeland and Knizek (15) have argued that qualitative methodology must be employed to understand cultural meaning(s) of suicide in particular contexts, and focus group discussions (FGDs) have been used as a culturally attuned way of investigating this (16,17), also among indigenous people in the Arctic (10). Acknowledging the need for better understanding of indigenous ways of making sense of suicide to make prevention culturally attuned and relevant to the indigenous community (18), the present study aims to explore and make sense of the cultural meaning(s) of suicide among Sami in Sweden.

## Method

The researchers were aware, from personal experience, that suicide among Sami was frequently talked about in different Sami contexts in Sweden, and wanted to explore such talk in search for the cultural meaning(s) of suicide among Sami. To do so, the study employed open-ended FGDs (without interview guide and no topics introduced by the researchers) in which the participants (PTs) could set their own agenda, self-regulate and be in control of the narrative they individually and as a group created – eschewing and highlighting aspects of their choice. This approach assumedly made sure that topics covered in the FGDs were reflective of normative narratives regarding suicide among Sami in Sweden. The collected material was then explored in search of patterns of meaning (19), employing content analysis (20). The study followed the principles of the Helsinki declaration and was approved by the regional ethical committee at Umeå University, Sweden. In addition, although there are no specific ethical guidelines in Sweden for Sami research, the study paid attention to ensure a culturally safe process overall.

### *Sample*

Altogether 22 Sami PTs were recruited by the first author using a snow-ball method. They were strategically chosen based on recommendations and dialogue with Sami organizations and utilization of the private network of the first author, himself a Sami. To ensure dynamic FGDs and a rich dataset, care was taken to recruit PTs that were diverse in terms of: Sami identity (North-, Lule-, Ume- and Southsami), Sami language competency, work experience (traditional livelihoods, health care professionals, culture workers and academics among others), sex (which proved difficult, ending up with 6 male and 16 female PTs), age (ranging from 18 to 63 years of age) and experience(s) of suicide among Sami.

### *Procedure*

Five FGDs, varying in length between 1.5 and 2 hours, were held during spring 2012 on different locations in Swedish *Sápmi*. PTs were informed of aims and intentions of the study, including that participation might trigger strong emotions and that the researchers (of whom the second author was an experienced clinical psychologist) were prepared to deal with this. Informed consent was given prior to FGD. PTs were not financially compensated, except for travel expenses and a meal before or after (then combined with snacks before) the FGD. Encouraged by the researchers, all groups opted to engage in voluntary confidentiality agreements in regard to each other's narratives. The PTs were also encouraged to talk freely, as they would have in a "normal" group conversation, before initiating the discussions with the phrase "When talking about suicide among Sami, what you think is most important that we talk about?" The FGDs were led by either the first or second author (with the other taking notes and presenting a summary for the group to comment upon before ending) whose main priority was to support the participants voices through clarifying answers, asking for other opinions and making sure that all PTs were heard. The FGDs were audio taped and transcribed verbatim by the first author as soon as possible after the FGDs (within days, prior to the next FGD). The transcripts (de-identified to ensure the anonymity of the PTs) resulted in a data corpus of 122 pages (12 point, single-spaced).

### *Analysis*

The analysis phase overlapped data collection, with the researchers reflecting on their experiences directly after each FGD and the first author taking notes during transcription (in-between FGDs). Those notes were used to create a preliminary understanding of topics that seemed important, which allowed the researchers to better navigate the next FGD; aiming at gaining a more full understanding of topics already talked about (in previous FGDs) as well as looking out for new perspectives and/or topics. When all material was transcribed the first and second author conducted a content analysis guided by Graneheim and Lundman's (20) stepwise model, with the whole data corpus (from all FGDs) being collapsed into a single dataset. The purpose of the analysis was to inductively and systematically explore the material in search of re-emerging patterns of meaning that could be said to reflect meanings of suicide among the PTs, and then define, demarcate and describe those patterns.



Citation: Int J Circumpolar Health 2015, **74**: 27669 - http://dx.doi.org/10.3402/ijch.v74.27669

1) To get an overview, the whole material was read through several times by the first and second author.
2) Units of meaning were identified and extracted into excerpts by the first author.
3) The excerpts were shortened (“condensed”) by the first author, while trying to keep the original meaning intact. The second author independently did the same thing with a smaller portion of the excerpts and then compared those with the first author’s, to ensure consistency.
4) The shortened excerpts were turned into codes, based on interpretations of the latent content. The coding was carried out by the first author who repeatedly discussed interpretations with the second author (who read the material), followed by adjustments and re-coding (hence trying to ensure plausibility in interpretations). A portion of the excerpts was labelled “miscellaneous” because of the researchers’ inability to meaningfully interpret those excerpts in relation to the aims of the study.
5) The codes were abstracted and categorized into themes by the first author, then discussed between the first and second author. This was a process that included several re-categorizations (moving back and forth between codes and themes), as well as reading of the original transcripts to ensure that the themes were reflective of the content as a whole.
6) The other authors read the material and provided a critical discussion of it, resulting in excluding some themes relating to the PTs experiences of participating in the FGDs (deemed to be outside the scope of the article) and redefining (refining and demarcating borders and relations between) other themes.
7) The findings have been presented (by the first author) on numerous occasions (at least 10 times with Sami audiences) since 2012, resulting in a great deal of feedback and in-depth discussion with a wide range of Sami people (audiences including, for example, Sami mental health care personnel and groups of young male and female herders attending suicide prevention initiatives). Even though not part of the original methodology, these interactions have created a cumulative process of continuously re-viewing the findings in light of these experiences, resulting in a more refined understanding of the results at hand.

## Results

From the analysis emerged 4 themes including “The Sami are fighting for their culture and the herders are in the middle of the fight,” “Suicide as a consequence of Sami losing (or having lost) their identity,” “A wildfire in the Sami world” and “Difficult to get help as a Sami.” The themes are presented (below), with quotes from FGDs (using codes to identify individual PTs; the first letter indicating focus groups from A to E), to illustrate certain aspects.

### *The Sami are fighting for their culture and the herders are in the middle of the fight*

A central topic in the FGDs was that Sami are engaged in a fight to maintain Sami identity and culture, which was described as threatened by the surrounding society, and sometimes also from within. The outside threats included exploitation of Sami lands (by forestry, tourism, mining activities, wind- and hydro power plants and societal infrastructure), conflicts with authorities and local communities that often involved what was perceived as discrimination, including derogatory speech and/or actions. Also, specific threats to reindeer herding were described, such as weather conditions (including global warming and negative effects on grazing lands), amounts of predators on the land and legislation that makes it very hard to start as a new herder or come back again if you, or your father, have left. Inside threats included Sami not respecting each other’s identity as authentic (e.g. due to lack of language competency and/or association to traditional livelihoods) and conflicts among herders due to herding being a zero-sum game (if one herder increases his herd, the others must reduce). Even though some PTs pointed out that being part of these conflicts were not always healthy, it was described that being Sami was to continue fighting for Sami identity despite the hardships, as illustrated by this change of opinions between 2 PTs:

> B3: I think that the Sami; that we are a very resilient people. That is, we’re used to many hardships and we don’t give up easily.
> B5: are we resilient or are we foolhardy? [Laughter].

In this context of conflict, reindeer herding was described as something of a stronghold for Sami culture. To live as a herder was understood as the best way to preserve Sami identity and be able to pass the legacy on to new generations but, perhaps paradoxically, also to be standing in the middle of the Sami fight, sometimes even being trapped within it:

> B4: The reindeer herders are trapped in a cultural prison. (. . .) They are entrapped in their culture.
> B2: I don’t know if I agree with you. A prison, in my opinion, is a place I can’t escape from. And I live in my culture, and I do not want to leave – so therefore it is not a prison.

This particular discussion (above) went on to conclude that Sami are like lemmings, meaning that they will continue to fight for their identity, regardless of their chances.[1]

[1]The lemming, found in mountain and tundra areas throughout Sápmi, is known among Sami for its fiery behaviour, never fleeing when threatened, often placing them in harm’s way.

### *Suicide as a consequence of Sami losing (or having lost) their identity*

The PTs associated the topic "suicide among Sami" to actual suicide cases among young Sami men who were living within, or associated with, reindeer herding. It was also said that those who had died in suicide were often regarded as joyful persons, that others didn't think had had suicidal wishes or plans. To this a bereaved friend said:

> D2: He was absolutely not a person you saw as depressed or anything (. . .) it didn't show! Suddenly one day he was just gone.

Empathy was expressed in regard to those who had died, and the act of suicide was described as understandable in light of the existential predicament of a herder who was in danger of losing, or had lost, the means or power to continue life as a Sami. As another herder put it:

> E4: I can somehow understand it – the reasoning [behind it] (. . .) what is the alternative here in life? (. . .) if it was my life and I did not have it [the herding] anymore – why shouldn't I cross over?

Suicide was thus framed within normality in this cultural context, as a way to avoid the existential void that would have been the (perceived) consequence of life without reindeer herding. A young man said it like this:

> E1: [the suicides] are strongly associated with reindeer-herding (. . .) and with identity, also. (. . .) if you are faced with a choice between to abandon your own identity – that is your life really – to do something else, maybe there won't be much left of yourself?

### *A wildfire in the Sami world*

The PTs referred to a positive experience of belonging to a small, close knit Sami community, even when the "community" spanned over great geographical distances where Sami sometimes lived far apart from each other. The Sami network was described as "multiplex," with each person having several different connections to the same other person (through family relations, work colleagues, friendship and membership in the same community), with a great many (Sami) connections in total. It was described that when a suicide occurs within the network, it becomes activated and over-flooded with communication about the suicide. A participant described it like this:

> B2: You live in this network; you talk to these people (. . .) when something happens in a Sami community, it's like wildfire between the communities about what has happened.

To be part of the network at such times was described as overwhelming and very emotional, including feelings of surprise, anger, fear and being without control. Another PT, a father, expressed his worry about it like this:

> C4: It almost became a mass-hysteria among young Sami (. . .) on Facebook it took enormous proportions. (. . .) It was like a grassfire that only spread (. . .) and many became extremely affected by that.

The implicit fear that suicide would spread through contagion within the network was also explicitly expressed by others:

> A4: It is almost as if it was contagious!

### *Difficult to get help as a Sami*

In the FGDs, it was said that the Swedish health care system was not fit to help struggling Sami. PTs had heard of Sami who had sought out mental health care, but then experienced their Sami identity as an obstacle both related to cultural values among Sami (possibly meaning that Sami should not talk about mental health problems), and the lack of Sami cultural knowledge among health care personnel. Worry was expressed that Sami will not seek help when they need it, or that they will have to explain and defend their culture and lifestyle before they can get help. Sami were described to be used to that kind of explaining and defending, though not in the help-seeking context but from conflicts with authorities and non-Sami locals, and it was described as something difficult and challenging. A PT said:

> A5: [you're] afraid that you won't be understood in the Swedish care system. It is hard to talk about reindeer herding or the Sami culture.

## Discussion

The aim of this article is to explore and make sense of the cultural meaning(s) of suicide among Sami in Sweden. First, we note that there is relatively little contradiction within the results. While this could be due to several reasons, including a selection bias or relative unanimity among the Sami in regard to this issue, we believe the most conceivable explanation is the presence of a single prevailing narrative, so strong that it overshadows other narratives. We suggest that the symbolic image imbedded in "We're like lemmings" might be regarded as a central part of that narrative, including that Sami, just like lemmings, are perceived to be fighting for survival but often face defeat due to power inequality.

In Fig. 1, we give an illustration of how this narrative might provide an understanding of suicide, as an act that takes place and makes sense to others when a Sami become entrapped in (due to being unable to back down from) a conflict, but no longer has the power to maintain a Sami identity, resulting in being disconnected (from the Sami world) and placed in an existential void where suicide is a solution. This highlights that suicide is framed by the Sami participants as acts within the socio-cultural normality (thus excluding suicide as acts of "crazy" people), affecting individuals engaged in a fight for their Sami identity. A key feature of the lemmings' analogy is that lemmings



Citation: Int J Circumpolar Health 2015, **74**: 27669 - http://dx.doi.org/10.3402/ijch.v74.27669

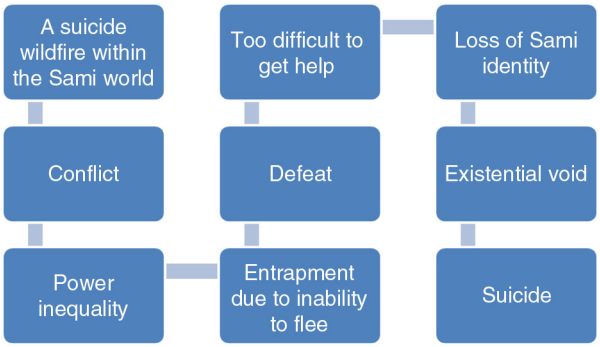



*Fig. 1.* Illustration of a prevailing narrative on suicide among Sami, as interpreted by the authors in relation to the results.

do not die by their own hand but from their inability to flee in face of death. That is, in this perspective, suicide is a consequence of the threats from majority society against the Sami culture. We argue that these converging meanings of identity and power in relation to suicide (as acts in a political context, yet within normality) make up a very problematic socio-cultural dynamic wherein engaging in suicidal behaviour, or even dying by suicide, can paradoxically *strengthen* Sami identity. To the extent that this narrative is part of the socio-cultural context in which struggling Sami individuals navigate their actions, those individuals might chose to engage in suicidal behaviour to be part of the social narrative placing them inside the Sami world rather than, for example, talk openly about their *individual* mental health issues (and risking experiencing oneself as disconnected from the Sami world due to breaking a cultural taboo). In Fig. 2, we seek to theoretically illustrate what socio-cultural processes (the outer circle) we believe might be underlying the themes that emerged in this study.

While the problems formulated within the themes could be regarded as shared experiences to a degree where they become socially accepted as normative, they are not necessarily "true" in the objective sense, but rather perceived to be. However, many of the issues raised also make sense in light of previous research. For example, there is little doubt that reindeer herding is very central to Sami identity (21,22), that this life is seriously threatened and that this combination causes mental health problems and contributes to suicidality among reindeer herders (8,12,13,22). Also, the close-knit Sami world has been previously proposed as a possible factor behind suicide clusters and contagion effects among Sami (6–8). Furthermore, low confidence in (Swedish) health care among Sami reindeer herders is documented and has been interpreted as a hindrance for full enjoyment of such services (23). Also, at least some of the elements in the "We're like lemmings" narrative can fit rather well within mainstream models of suicidality, as can be illustrated through examining the narrative in light of the "Interpersonal–Psychological Theory of Attempted and Completed Suicide" (IPT-ACS) and it's key features; *thwarted belongingness*, *perceived burdensomeness* and *acquired capability*, as proposed by Joiner (24). The *perceived burdensomeness* (perceiving yourself as a burden to others or the society) described in the IPT-ACS can be related to the Lemmings-narrative as an internalized perception deriving from the Swedish mainstream society disregarding Sami value, for example expressed through exploitations of Sami land without consent, and failure to address Sami needs for culturally attuned health care – areas where Sweden have received international critique from United Nations officials (25). The *thwarted belongingness* (perceiving yourself as having lost prior established meaningful relationships) can be interpreted in conjunction to the existential void (loss of Sami identity and connectedness to the Sami world) perceived to be the result of individual defeat due to lack of power to continue the fight for Sami identity. Furthermore, the prerequisite of an *acquired capability* to enact lethal self-injury is very present in the image of Sami as lemmings, maybe it is even the key feature of it, since lemmings are known for their capability to be fearless in face of death. This also makes sense in light of traditional Sami upbringing values aiming at youngsters becoming autonomous, self-determined and hardened (26), which paired with the reindeer herders extensive experience of killing reindeers (traditionally done with a precisely aimed knife stick) and other animals (with rifle) might have habituated them to not fearing death or bodily harm – and hence acquire the capability to inflict lethal self-injury.

### Limitations

First, it is important to note that this is a qualitative study that explores the cultural meaning(s) of suicide, not the suicides *per se*. Furthermore, there are some other serious limitations to this study, including the small number of participants (ruling out generalizing findings, even among Sami in Sweden), the high risk for selection bias (in spite of actions taken to recruit PTs that were diverse) due to the snow-ball recruitment method, based in part on utilization of the private network of the first author, as well as the very high likelihood that PTs eschewed topics during data collection. Another limitation is that all FGDs were held in Swedish, likely resulting in difficulties for PTs with other mother tongue (Sami) and discussions not being able to fully tap into cultural understandings which might be imbedded within, and not translatable from, Sami language. In fact, it is likely that another study design, with other PTs and researchers, would have ended up with different results, or at least made other interpretations of similar results.

However, the limitations were hard to avoid and should be considered in relation to the study's aim, including investigating a potentially sensitive (for some, certainly taboo) subject within an indigenous group with

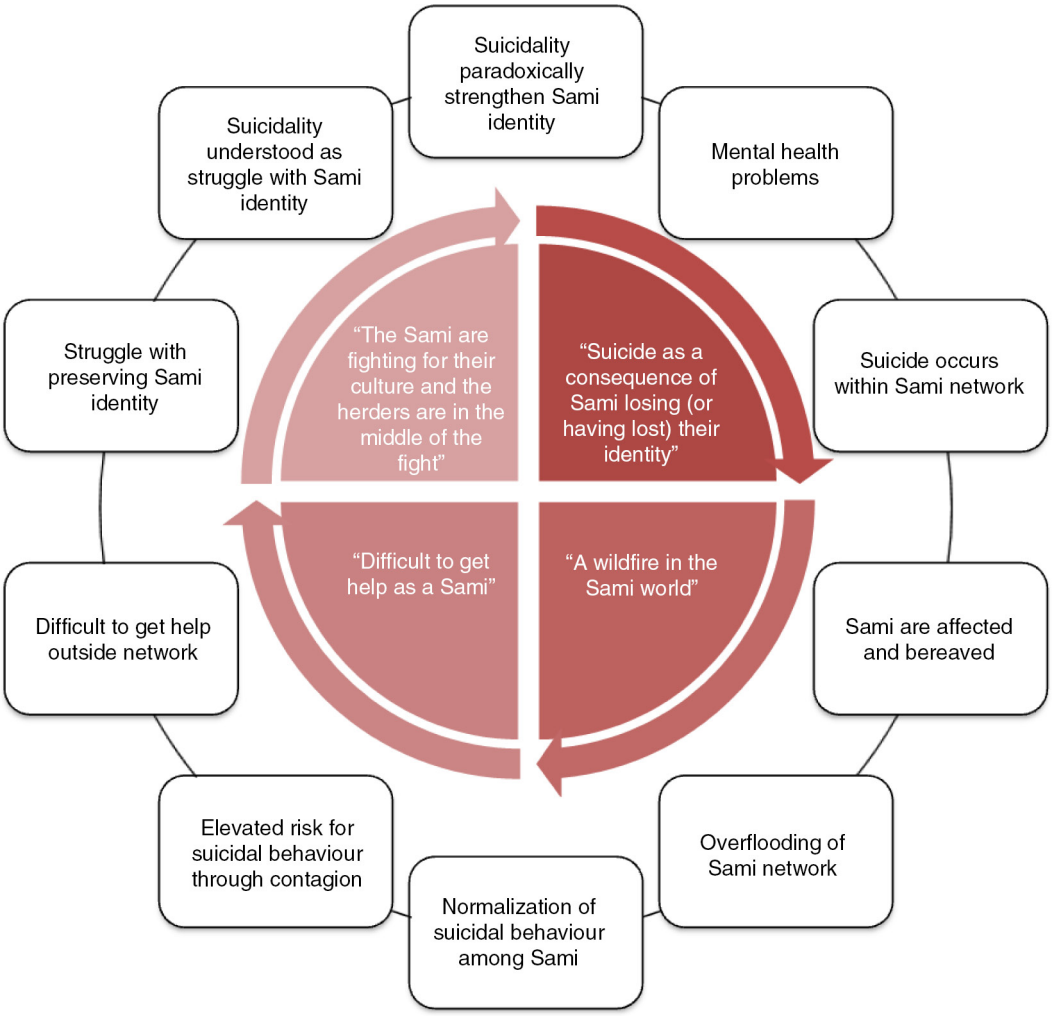



*Fig. 2.* Theoretical model of meanings (inside the circle) relating to suicide among Sami in Sweden, and socio-cultural processes (outside) possibly underlying those meanings.

well-grounded historical reasons to mistrust the academic society in general and health researchers in particular (for example, due to "scientists" taking skull measurements to prove Sami racial inferiority during the first half of the 20th century) (27). Furthermore, researchers have described how Sami often face numerous obstacles when talking about health problems with (non-Sami) professional personnel, including having to overcome Sami cultural norms of (not) talking about such problems (28) and navigating a complex trans-cultural arena when doing so (29). In light of this, the first author being an *insider* was something of a prerequisite for ensuring a culturally safe research process, including reducing potential power inequalities between academic researchers and indigenous participants as well as striking a line between respecting Sami traditions and scientific demand (for example, done through taking time to get to know each other, including sharing a meal and revealing kinships, before continuing to the FGDs). Furthermore, the very intention of choosing open-ended FGDs was to provide PTs with a possibility to assume agency (thereby reducing the influence of the researchers and the risk of contaminating data), and thus be able to highlight and eschew the discussions as they saw fit; freely creating a narrative reflective of their cultural meanings of suicide. From our perspective, the strive for trustworthiness and ethically sound decision-making converged in this study, and all things considered we propose that the results are indeed reflective of some – *though not necessarily all* – key features of the cultural meanings of suicide among Sami in Sweden. The extent to which these results might be transferable is a question for the reader to answer, but it is advised that any attempt to transfer and interpret these results in other contexts should be done jointly, and cautiously, between indigenous knowledge holders and academic scholars.

## Future research

In general, perhaps with the exception of suicide rates (5,6), we still have limited scientific knowledge regarding



Citation: Int J Circumpolar Health 2015, **74**: 27669 - http://dx.doi.org/10.3402/ijch.v74.27669

suicide among Sami. At this point we propose that further research be conducted in 2 specific directions. First, in-depth investigation of actual suicide cases could help shed light on the suicidal processes leading up to suicide among Sami, for example whether this process includes specific cultural and/or contextual features of importance (which this study implies that it does). Second, exploring and/or developing culturally attuned suicide prevention initiatives carry a potential to reduce suicide rates among Sami. In regard to the latter, we would support strengthening "pan-Sami" border crossing collaborations on suicide prevention and establishing closer links between researchers, Sami communities (especially youth organizations) and governmental institutions responsible for decision making and delivering of health care services in *Sápmi*.

## Conclusions

This study adds to, and complements, previous research on suicide among Sami through providing in-depth exploration of the cultural meanings of suicide among Sami in Sweden (as understood and talked about by Sami). The resulting narrative of "Sami as lemmings" highlights issues of power inequality and identity struggle in relation to suicide. In the discussion, we show that while these understandings also makes sense in light of previous research and a mainstream model of suicidality, they can possibly increase suicidality among Sami as struggling individuals might strengthen their (threatened) identity through enacting (Sami) suicidality. We propose that suicide prevention among Sami should take this into account to make best use of the preventive potential. After all, "suicide only becomes possible insofar as it is imaginable, insofar as it is meaningful, insofar as one can make sense of it, whether as a decision, as a last resort, or as a statement of desperation" (16, p. 2089).

## Acknowledgements

The authors thank the Sami participants for their courage and generosity when sharing often deeply private thoughts and painful experiences with us and the other participants. *Ollu giitu!*

## Conflict of interest and funding

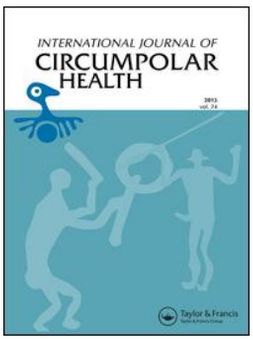
The authors have no potential conflict of interest.

## References

1. Sumarokov YA, Brenn T, Kudryavtsev AV, Nilssen O. Suicides in the indigenous and non-indigenous populations in the Nenets Autonomous Okrug, Northwestern Russia, and associated socio-demographic characteristics. Int J Circumpolar Health. 2014;73:24308, doi: http://dx.doi.org/10.3402/ijch.v73.24308
2. Wexler L, Silveira ML, Bertone-Johnson E. Factors associated with Alaska Native fatal and nonfatal suicidal behaviors 2001–2009: trends and implications for prevention. Arch Suicide Res. 2012;16:273–86.
3. Kirmayer L, Brass G, Holton T, Paul K, Simpson C, Tait C. Suicide among Aboriginal people in Canada. Ottawa: Aboriginal Healing Foundation; 2007.
4. Bjerregaard P, Larsen CVL. Time trend by region of suicides and suicidal thoughts among Greenland Inuit. Int J Circumpolar Health. 2015;74:26053, doi: http://dx.doi.org/10.3402/ijch.v74.26053
5. Young TK, Revich B, Soininen L. Suicide in circumpolar regions: an introduction and overview. Int J Circumpolar Health. 2015;74:27349, doi: http://dx.doi.org/10.3402/ijch.v74.27349
6. Silviken A, Haldorsen T, Kvernmo S. Suicide among indigenous Sami in Arctic Norway, 1970–1998. Eur J Epidemiol. 2006;21:707–13.
7. Omma L, Sandlund M, Jacobsson L. Suicidal expressions in young Swedish Sami, a cross-sectional study. Int J Circumpolar Health. 2013;72:19862, doi: http://dx.doi.org/10.3402/ijch.v72i0.19862
8. Kaiser N, Salander Renberg E. Suicidal expressions among the Swedish reindeer-herding Sami population. Suicidol Online. 2012;3:114–23.
9. Kral MJ. Postcolonial suicide among Inuit in Arctic Canada. Cult Med Psychiatry. 2012;36:306–25.
10. Wexler L. Identifying colonial discourses in Inupiat young people's narratives as a way to understand the no future of Inupiat youth suicide. Am Indian Alsk Native Ment Health Res. 2009;16:1–24.
11. Tatz C. Aboriginal suicide is different: a portrait of life and self-destruction. Canberra: Aboriginal Studies Press; 2005.
12. Kaiser N. Mental health problems among the Swedish reindeer-herding Sami population: in perspective of intersectionality, organisational culture and acculturation. [PhD dissertation]. Umeå (Sweden): Umeå University; 2011.
13. Omma L. Ung same i Sverige: livsvillkor, självvärdering och hälsa [Young Sami in Sweden: life circumstances, self-evaluation and health]. [PhD dissertation]. Umeå (Sweden): Umeå University; 2013.
14. Silviken A. Reindrift på helsa løs. Arbeidsrelatert stress i reindriftsnäringen i lys av Mark Williams modell "Cry of Pain" [Reindeer herding affecting health negatively. Work-related stress within reindeer herding industry in light of Mark William's model "Cry of Pain"]. Suicidologi. 2011;16:10–4.
15. Hjelmeland H, Knizek BL. Why we need qualitative research in suicidology. Suicide Life Threat Behav. 2010;40:74–80.
16. Roen K, Scourfield J, McDermott E. Making sense of suicide: a discourse analysis of young people's talk about suicidal subjecthood. Soc Sci Med. 2008;67:2089–97.
17. Mugisha J, Hjelmeland H, Kinyanda E, Knizek BL. Distancing: a traditional mechanism of dealing with suicide among the Baganda, Uganda. Transcult Psychiatry. 2011;48:624–42.
18. Redvers J, Bjerregaard P, Eriksen H, Fanian S, Healey G, Hiratsuka V, et al. A scoping review of Indigenous suicide prevention in circumpolar regions. Int J Circumpolar Health. 2015;74:27509, doi: http://dx.doi.org/10.3402/ijch.v74.27509
19. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3:77–101.
20. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24:105–12.
21. Åhrén C. Är jag en riktig same?: en etnologisk studie av unga samers identitetsarbete [Am I a genuine Sami? An ethnological study of identity work among young Sami]. [PhD dissertation]. Umeå, Sweden: Umeå University; 2008.
22. Kaiser N, Ruong T, Renberg ES. Experiences of being a young male Sami reindeer herder: a qualitative study in perspective of mental health. Int J Circumpolar Health. 2013;72:20926, doi: http://dx.doi.org/10.3402/ijch.v72i0.20926

23. Daerga L, Sjolander P, Jacobsson L, Edin-Liljegren A. The confidence in health care and social services in northern Sweden – a comparison between reindeer-herding Sami and the non-Sami majority population. Scand J Public Health. 2012;40:516–22.
24. Joiner TE. Why people die by suicide. Cambridge, MA: Harvard University Press; 2005.
25. Hunt P. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt – MISSION TO SWEDEN; 2007. p. 17. [cited 2015 Augest 22]. Available from: http://daccess-ods.un.org/TMP/8284759.52148438.html
26. Javo C, Alapack R, Heyerdahl S, Ronning JA. Parental values and ethnic identity in indigenous Sami families: a qualitative study. Fam Process. 2003;42:151–64.
27. Ledman AL, editor. Ethics in indigenous research – past experiences, future challenges. Umeå, Sweden: Centre for Sami Research (CeSam) – Vaartoe, Umeå University; in press.
28. Bongo BA. "Samer snakker ikke om helse og sykdom": samisk forståelseshorisont og kommunikasjon om helse og sykdom: en kvalitativ undersøkelse i samisk kultur ["Sami don't talk about health and illness": Sami horizon of understanding and communication about health and illness. A qualitative study in Sami culture]. [PhD dissertation]. Tromsø, Norway: University of Tromsø; 2012.
29. Dagsvold I, Møllersen S, Stordahl V. What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment. Int J Circumpolar Health. 2015;74:26952, doi: http://dx.doi.org/10.3402/ijch.v74.26952

# Paper II



International Journal of Circumpolar Health

ISSN: (Print) 2242-3982 (Online) Journal homepage: https://www.tandfonline.com/loi/zich20

# "If you do not *birget* [manage] then you don't belong here": a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway

Jon Petter Anders Stoor, Gro Berntsen, Heidi Hjelmeland & Anne Silviken

**To cite this article:** Jon Petter Anders Stoor, Gro Berntsen, Heidi Hjelmeland & Anne Silviken (2019) "If you do not *birget* [manage] then you don't belong here": a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway, International Journal of Circumpolar Health, 78:1, 1565861, DOI: 10.1080/22423982.2019.1565861

**To link to this article:** https://doi.org/10.1080/22423982.2019.1565861

INTERNATIONAL JOURNAL OF CIRCUMPOLAR HEALTH
2019, VOL. 78, 1565861
https://doi.org/10.1080/22423982.2019.1565861

Taylor & Francis
Taylor & Francis Group



# "If you do not *birget* [manage] then you don't belong here": a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway

Jon Petter Anders Stoor [a], Gro Berntsen[b], Heidi Hjelmeland[c] and Anne Silviken[a,d]

[a]Sámi Norwegian National Advisory Unit on Mental Health and Substance Use, Finnmark Hospital Trust, Karasjok, Norway; [b]Northern Norway Violence, Traumatic Stress and Suicide Prevention Resource Centre, University Hospital of North Norway, Tromsø, Norway; [c]Department of Mental Health, Norwegian University of Science and Technology, Trondheim, Norway; [d]Centre for Sámi Health Research, Department of Community Medicine, UiT – the Arctic University of Norway, Tromsø, Norway

**ABSTRACT**

Suicide is a major public health issue across the Arctic, especially among Indigenous Peoples. The aim of this study was to explore and describe cultural meanings of suicide among Sámi in Norway. Five open-ended focus group discussions (FGDs) were conducted with 22 Sámi (20) and non-Sámi (2) participants in South, Lule, Marka, coastal and North Sámi communities in Norway. FGDs were recorded, transcribed verbatim and analysed employing thematic analysis. Six themes were developed from the analysis: *"Sámi are treated negatively by the majority society"*, *"Some Sámi face negative treatment from other Sámi"*, *"The historic losses of the Sámi have turned into a void"*, *"Sámi are not provided with equal mental health care"*, *"The strong Sámi networks have both positive and negative impacts"* and *"'Birgetkultuvvra' might be a problem"*. The findings indicate that the participants understand suicide among Sámi in relation to increased problem load for Sámi (difficulties in life not encountered by non-Sámi) and inadequate problem-solving mechanisms on different levels, including lack of equal mental health care for Sámi and cultural values of managing by oneself (*"ieš birget"*). The findings are important when designing suicide prevention initiatives specifically targeting Sámi.

**ARTICLE HISTORY**
Received 12 June 2018
Revised 27 November 2018
Accepted 4 January 2019

**KEYWORDS**
Sami; Saami; focus group discussions; mental health; Sápmi; Sapmi

## Introduction and background

### *Suicide among Indigenous peoples in the Arctic and Sápmi*

Suicide is a major public health issue across the Arctic [1], and statistics from Alaska, the United States [2], Nunavut, Canada [3], Greenland [4] and northern Russia [1,5] show alarming suicide rates, especially among the Indigenous peoples of the north. Suicide rates are moderate in arctic Norway and Sweden, but Sámi have died more often from suicide than majority populations [1,6–8]. As is the case among many other Indigenous people in the Arctic; "harder" methods (including weapons and hanging), suicide clusters, and elevated suicide rates for young men are found more commonly among Sámi than in majority populations [1]. Studies from Sweden have also indicated that each suicide among Sámi might have broader social impacts, leaving more people bereaved, possibly due to the extended family networks among the Sámi [9,10].

### *The Sámi context*

Sámi have lived in Sápmi (the Sámi homelands; in Arctic and sub-arctic parts of Scandinavia and the Kola peninsula in Russia) since time immemorial. Sámi have their own languages and cultures, traditionally based on subsistence such as hunting, fishing, herding reindeer and small-scale farming. However, the Sámi societies of today are characterised by a broad and diversified spectrum of traditional and modern/western values and livelihoods.

As many other Indigenous peoples, the Sámi have also been colonised. In Norway, the Norwegianization period started in the 19th century, a governmental policy aiming at assimilating the Sámi people into the majority population. This policy was enforced, for example, through placing Sámi children in boarding schools where their languages were prohibited, and not allowing individuals without Norwegian names and language skills to buy land [11]. As a result of the Norwegianization and the lack of ethnic registries it is unknown how many Sámi there are today. However, Sámi have organised themselves in resistance,

**CONTACT** Jon Petter Anders Stoor jon.petter.anders.stoor@finnmarkssykehuset.no Sámi Norwegian National Advisory Unit on Mental Health and Substance Use, Finnmark Hospital Trust, Stuorraluohkka, Post box 4, Karasjok NO-9735, Norway

which during the last 50 years has gained political momentum resulting in official recognition of Sámi as an Indigenous people, establishment of Sámi parliaments in Norway, Sweden and Finland, as well as revitalisation of Sámi languages and cultures. Furthermore, the Norwegian government has made an agreement with the Sámi Parliament in Norway to consult with the Sámi on matters affecting them, as well as to organise a truth commission to investigate the Norwegianisation policy and other injustices against the Sámi people [12].

### Culture and context in suicide

Mainstream suicidology has for a long time focused on uncovering risk factors for suicide and suicidal behaviour; such as mental health problems, including alcohol and drug abuse. Critics argue that that line of research has reached a dead end in terms of coming up with better methods for suicide prevention, and instead emphasise that qualitative research into cultural and contextual aspects of suicide could be a way forward [13–15]. That corresponds well with the dominant discourse within Indigenous suicidology, which points out that one must look at the historical and social underpinnings to understand the contemporary suicide and mental health crisis among Indigenous persons [16,17]. Those underpinnings include the historical and on-going colonisation and general modernisation processes which have brought societal turmoil through rapid and fundamental changes as well as weakening of traditional societal structures, languages and cultures.

What "culture" is is debated, but the following definition has been proposed by Marsella et al. [18]. "shared acquired patterns of behavior and meanings that are constructed and transmitted within social-life contexts for the purposes of promoting individual and group survival, adaptation, and adjustment. These shared acquired patterns are dynamic in nature (i.e. continuously subject to change and revision) and can become dysfunctional."

Qualitative methodology is well suited to consider cultural and contextual issues in relation to suicide [14,15,19]. Focus group discussions (FGDs) have previously been used to investigate cultural understandings of suicide in specific populations [20,21], also among Indigenous peoples in the Arctic [22–24]. The study by Stoor et al [24] explored the cultural meanings of suicide among Sámi in Sweden and found that it was understood to be connected to difficulties of maintaining Sámi identity, i.e. to maintain the traditional reindeer herding culture in face of difficulties posed by modern society and lack of (Sámi) political power. Such inside perspectives complement the discourse on suicide prevention to include sociocultural and contextual aspects, which is considered crucial if one wants to reduce suicide among Indigenous peoples in the north [25–28].

The aim of this study is to explore and describe cultural meanings of suicide among Sámi in Norway.

## Method

### Positioning

The research group consisted of two Sámi (first and second author) and two people from the majority population in Norway (third and last author). The last author has long-standing work relations with Sámi communities. We acknowledge that our subject positions have impacts on our research, including how participants regard and interact with us; in turn affecting how and what data can be gathered, as well as our scope and competencies in interpreting and analysing the findings. We acknowledge that the interdependent nature of relationships within the Sámi world is key to getting the trust necessary from participants. This means that we could not have carried out this study without some of us being "insiders", that is, Sámi.

### Sample

Twenty-two participants were recruited through snowball sampling technique, based on the personal and professional networks of the first and last author, as well as colleagues at the Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse (Finnmark hospital trust) and Centre for Sámi Health Research (UiT – the Arctic University of Norway). Participants were chosen based on their knowledge and experience with suicide among Sámi (including being bereaved, but not within the last year), their professional work in mental health and/or suicide prevention and their formal and informal roles as community leaders. Furthermore, recruitment aimed at including participants with diverse personal backgrounds in terms of ethnic background, work experience, sex, age and experience(s) of suicide among Sámi (Table 1).

### Procedure

Five focus group discussions (FGDs), varying in length between 105 and 125 min, were held during spring 2014 in South, Lule, Marka, coastal and North Sámi areas on the Norwegian side of Sápmi. Participants were contacted, informed, and invited to participate by phone. Those interested received the same information by email (or regular mail, if preferred) and again at the

scene of the FGD, where they also gave their written informed consent. The procedure included resources, time and space for culturally appropriate activities such as revealing kinships (and other important relationships) as well as sharing a meal before the FGD. Participants were also reimbursed for travel expenses and lost job income. To ensure authentic and rich discussions, the participants were encouraged to agree on voluntary confidentiality and to speak their mind as they would have done "in an ordinary conversation on the topic". Furthermore, care was taken to allow participants to be in control of the narrative they created, on their own and as a focus group. Thus, the FGD was open ended and the only predetermined prompting question was; "When talking about suicide among Sámi, what do you think is most important that we talk about?"

FGDs were facilitated by the first and last author, who took turns being active and passive. The active facilitator supported the participants as they shared their views, asked for more opinions, made sure that everyone was heard and respected and in general helped to keep the group on track (posed follow-up questions, clarified meanings etc.). The passive facilitator took notes and presented those before the ending of the FGDs, which gave the participants a chance to withdraw statements, clarify what they meant and/or add more topics, should they want to. The facilitators discussed the notes after each FGD in order to be able to identify and follow up interesting topics during the subsequent FGDs. The discussions were recorded and transcribed verbatim. The total data corpus (all transcripts) includes 82,969 words.

### Ethics

The study adhered to the Helsinki declaration [29], that is by allowing all participants informed consent and the right to withdraw from the study without stating any reason or suffering other negative consequences. Furthermore, in line with a proposal for ethical guidelines in Sámi medical research [30], we sought to create a culturally safe context for all participants, in this instance for example through sharing food and revealing kinships before the FGD. The Norwegian Centre for Research Data approved the study.

**Table 1.** Sample characteristics.

| Category | Description |
|---|---|
| No. of participants | 22 |
| Sex | 15 women, 7 men |
| Age | 19–74 years, mean 48,6 y (male = 50,7 y, female = 47,6 y), median 47,5 y |
| Profession | Mental health workers, suicide prevention workers, cultural workers (artists, language workers, personnel in cultural centres), reindeer herders, fishermen, politicians, students and retired. |
| Ethnic background | Sámi (n = 20) and non-Sámi (n = 2). |

### Analysis

The analysis was inductive and guided by thematic analysis as formulated by Braun and Clarke [31], with the aim to systematically explore the data in search of re-emerging patterns reflecting cultural meanings of suicide, and then define, demarcate and describe those patterns.

All authors read all the transcripts and took notes, highlighting interesting excerpts. The first author constructed mind maps (one per FGD) with excerpts sorted in preliminary sub- and main categories. The authors then compared notes, discussed the mind maps and agreed on what the re-emerging patterns of meaning were, creating a preliminary thematic structure. The first author then engaged in a trial and error process, moving around excerpts and categories, ending in the construction of new mind maps based on the agreed upon themes (one per theme). As the latent content of a few excerpts and categories was possible to interpret in different ways, they were allowed to belong to more than one theme. The first author described and named each category and theme and all authors discussed those and checked that interpretations were reasonable.

## Findings

The analysis resulted in 44 categories belonging to 6 themes (see Table 2) and 1 single category not belonging to any theme. The single category was made up of seven excerpts interpreted as direct or indirect critique of understanding suicide among Sámi as "Sámi suicides", possibly meaning that some participants were not familiar with such a narrative or that they meant it was not appropriate to talk about it in that way. The category is mentioned here in the interest of transparency but is not discussed in the following.

Findings are presented thematically and illustrated with quotes, using a code of letters and numbers to specify individual participants (letters A–E referring to which FGD the specified participant belonged to).

### Sámi are treated negatively by the majority society

Participants connected suicide among Sámi to Sámi experiencing negative treatment, ethnic discrimination and racism, including; prejudices and bullying against Sámi, and structural discrimination. Examples of negative treatment included (intentional) use of derogatory

terms such as "damn Sámigirl", but also non-intentional effects of non-Sámi making jokes about their Sámi peers lacking stereotypical attributes of "Sáminess". This was described by one participant reflecting on how a seemingly friendly joke could be perceived as emotional violence:

> *C1: 'Where are your komager [traditional pointy shoes]?' – of course it was a joke and not seriously meant all the time, but when we hear it a hundred times, a thousand times, it becomes more than a joke*

Even though it was also stressed that not all Sámi necessarily experience such negative events, those who did expressed frustration and felt it drained their energy and coping abilities. An example of this was a participant struggling with taking pride in her Sámi identity due to both non-intentional, but harmful, lack of knowledge, and bullying of her as a Sámi:

> *D4: You give up!/…/They wonder if I live in a lávvu [traditional Sámi tent for nomadic lifestyle] and whether we have chiefs/…/It's difficult being proud when they laugh at you*

The negative treatment was understood as creating a context wherein Sámi face systemic emotional violence, especially when officials (including health care personnel) treated Sámi like that. This was especially highlighted in relation to reindeer herding Sámi and their families, who are often regarded as "more authentic" carriers of traditional Sámi culture were described as suffering from more negative treatment than other Sámi.

Experiencing this kind of negative treatment, and the resulting feelings of shame and anger, was described as a life burden connected to suicide among Sámi.

### *Some Sámi face negative treatment from other Sámi*

Another theme in the discussions was an understanding that some Sámi face both negative treatment from the majority society as well as being socially excluded, or not fully accepted, within the Sámi society. For example, this included Sámi without "strong enough" Sámi identity, being part of a family with a bad reputation (family stigma), being regarded as a person who was mentally ill or had "been to the madhouse" (psychiatric facilities), or not conforming to the norm of heterosexuality. Even though being subjected to more negative treatment than other Sámi (because of a double stigma) was regarded as bad indeed, being denied a rightful place within the Sámi society was said to be even worse. In this way, the negative treatment of Sámi from other Sámi was not only understood as related to suicide through increasing "the burden of being a Sámi", but also through denial of access to a place of safety and shelter from negative treatment.

> *A2: We all know [about] feelings of being different within Norwegian society. But I thought about if you´re different in one way or another within the Sámi society, it must be ten times harder, that is – if you feel different there*

### *The historic losses of the Sámi have turned into a void*

The discussions highlighted how Sámi identity and health was experienced as negatively affected by historical processes where Sámi have suffered losses of culture (such as traditional knowledge, religion, language and relationship with nature and animals).

> *C1: The [Sámi] society has had a long, long period of oppression, of course it weighs in, it makes the burden heavier, I think*

Stories shared included being scolded in school for speaking Sámi, not learning traditional knowledge because it was replaced by other curricula in school, and how modern lifestyles and exploitations of land and water had led to Sámi experiencing weakened bonds with nature, animals, older generations and ancestors. These losses were related to feelings of worthlessness, homelessness, being ashamed, wanting to give up and feeling empty; "like within a void". A group discussed what emptiness meant in this case:

> *E1: You feel kind of worthless, small in this world. Because there´s no belonging no matter where you turn. Not looking back in time, nor ahead.*
>
> *E4: Yes, it is really that sense of belonging.*
>
> E1: I mean you become worthless, plain and simple.
> Interviewer: Who do you become then?
>
> *E1: Yes, who do you become then? Then you are not so careful anymore.*
>
> *E2: You become kind of homeless.*
>
> *E1: Homeless, yes, helpless.*

In this way they described how Sámi had lost meaningful sociocultural belongings and connections, and how the appurtenant experiences of existential homelessness, psychological worthlessness, and helplessness may contribute to suicide.

### *Sámi are not provided with equal mental health care*

The discussions emphasised lack of equal mental health care for Sámi, and how this can contribute to suicide. It was said that Sámi often have less trust in the (Norwegian)

**Table 2.** Results including number of excerpts, categories and themes.

| Number of excerpts | Category | Theme |
|---|---|---|
| 3 | Discrimination against Sámi | **Sámi are treated negatively by the majority society** |
| 2 | Prejudices against Sámi | |
| 5 | Not everyone experience negative treatment | |
| 16 | Bullying against Sámi | |
| 10 | Structural discrimination against Sámi | |
| 13 | Consequences of negative treatment | |
| 5 | Lack of knowledge about Sámi and Sámi contexts | |
| 29 | Reindeer herders face much negative treatment | |
| 14 | Inherited family stigma | **Some Sámi face negative treatment from other Sámi** |
| 8 | To not have strong enough Sámi identity is a problem | |
| 5 | Individuals facing more negative treatment struggle | |
| 4 | Having visited psychiatric hospital stigmatises | |
| 16 | Mental illness as a stigma for the individual | |
| 7 | Deviant sexuality might lead to social exclusion | |
| 5 | Loss of culture | **The historic losses of the Sámi has turned into a void** |
| 2 | Loss of religion and spirituality | |
| 3 | Loss of language | |
| 6 | Loss of land and animals | |
| 23 | The negative consequences of the losses of Sámi identity | |
| 2 | Discrimination from the healthcare system | **Sámi are not provided with equal mental health care** |
| 8 | Less than perfect equality results in negative consequences | |
| 6 | The boys do not fit into the care system | |
| 7 | Critique against the diagnostic system | |
| 9 | Differences of culture between Norwegian and Sámi patients | |
| 9 | Less trust in Norwegian health care systems | |
| 1 | Health potential in discovering your Sámi identity | |
| 26 | Sámi cultural competence is lacking | |
| 3 | Language competency is lacking | |
| 17 | Problems when asking for help | |
| 22 | Everyone helps out after a suicide | **The Sámi networks have significance** |
| 21 | The Laestadianism movement protects health | |
| 19 | The social networks supports in times of crisis | |
| 17 | Relationships with other Sámi protects identity, which protects health | |
| 16 | The disadvantages of keeping together as Sámi | |
| 21 | Extended family protects health | |
| 6 | Failed individual problem solution | **Birgetkultuvvra might be a problem** |
| 7 | Impacts of traditional and non-traditional childrearing | |
| 5 | They showed no signs of suicidality | |
| 13 | One should not talk about or show (negative) feelings | |
| 14 | It is mostly a boys' problem | |
| 5 | Pressure to perform perfect | |
| 6 | Signs were not taken seriously | |
| 4 | There is no room for being a failure | |
| 10 | Honour means to manage yourself and not lose face | |
| 7 | Critiquing Sámi suicides | |

health care system because of perceived shortcomings of the system. The main reasons stated for this was lack of culture and language competencies among health care professionals, resulting in bad or postponed treatment due to the clinician having to learn so much about Sámi cultures and context – often from the Sámi patient – before being able to proceed to treatment:

> *D3: If you are Sámi and you enter a Norwegian health care system and have to explain your situation, then you're faced with so much folly*

However, some participants also shared stories of being directly, sometimes intentionally, badly treated or discriminated against by health care personnel, because of their Sámi identity. Furthermore, the very organisation of services was said to be more negative for Sámi patients than others due to Sámi cultures and norms not being reflected in service delivery. These negative experiences of, and attitudes towards, mental health care was said to prevent Sámi people from seeking help for their suicidality, thereby implying the lack of equal mental health care as an issue related to suicide among Sámi.

> *D4: I do not want to seek help/…/I think that If I should have sought out help/…/what will I encounter, like? Because I can't stand it, that becomes more of a struggle for me then to just keep on carrying the load by myself.*

### *The strong Sámi networks have both positive and negative impacts*

The significance of family and other interpersonal relationships within the Sámi community was expressed continuously during the discussions, especially in relation to strengthening of health, resilience and recovery in face of

suicide. The bonds within the Sámi society were described as a positive, strong and intrinsic network of relationships. The extended Sámi family was described as very important in terms of upbringing and socialisation to norms. However, the strong relationships within the network caused profound impacts when someone died of suicide:

> *A5: You identify at once/…/you almost know the family to some, you always know someone who knows [them], that's how it is*

Much like with family, in communities where the laestadianism movement [a pietistic movement within the protestant churches in northern Scandinavia] is strong the participants also mentioned the congregation as an important source of resilience. All these networks were described as functioning like helpers after suicide, managing the crisis for those most bereaved; helping with everything from money, cleaning and all sorts of practical things, and also someone to talk to and just keep you company. This was described as the Sámi way, or "how we do it":

> *A2: You visit these houses, you are there with them, you go straight into that nuclear family and you talk to people. And you stay there, make coffee, and in a way, you just "spin around" there to a great extent*

It was also said that the strong sense of family and community could have negative side effects; that it could lead to families not wanting to seek help from outsiders (i.e. mental health services) to deal with suicidality due to the risk of the whole family being labelled – stigmatised – with a bad reputation.

### *"Birgetkultuvvra" might be a problem*

Birgetkultuvvra; the "hardening" and ideal of "ieš birget" [to manage by yourself] in the Sámi way of bringing up children was problematised. Some meant that decline of traditional upbringing styles might lead to parents not preparing their children enough for the harsh reality that awaits them as adults. However, others related such upbringing styles to prevailing ideals (especially among boys) of not showing weakness, talking about negative feelings or asking for help. Furthermore, such ideals were connected to people who had killed themselves through those individuals often being described as persons who did not communicate their distress, or ask for help:

> *E1: I have thought about shame and guilt and I have thought that those things are hard to talk about, it is something that we hide away within ourselves. It is kind of like this: you are not strong if you talk about suicide, you are not strong then, in a sense, you are weak then.*

It seemed that this issue came down to the importance of not losing face, that you should be regarded as a perfect person without mental problems, who belonged in the Sámi world and had (his) honour intact. Some participants also pointed to a possibility that such meanings could be so embedded in culture that they were almost rendered "invisible", but could be stated like this:

> *E3: If you do not birget [manage] then you don't belong here/…/if you're good for nothing you might as well die*

## Discussion

The aim of this study was to utilise FGDs to explore and understand cultural meanings of suicide among Sámi in Norway. In the following, the findings are contextualised and discussed in relation to previous research and the present Sámi context. In the discussion, the six themes are organised in two broad frames of understanding; increased problem load for Sámi and inadequate problem-solving mechanisms on different levels (Figure 1).

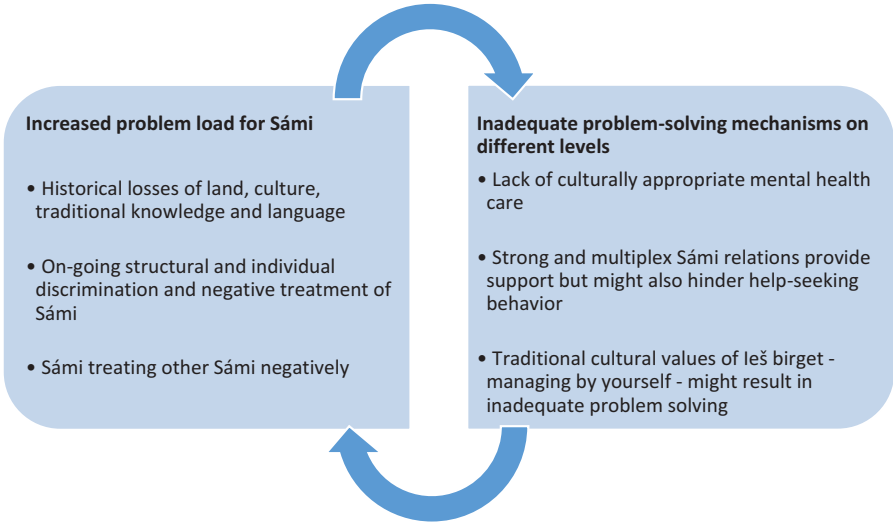



**Figure 1.** Visual model of results.

### Increased problem load for Sámi

The participants highlighted ways in which life might be more difficult for Sámi than the majority population, implying that increased problem load is related to suicide among Sámi. Issues discussed included discrimination against Sámi, and Sámi treating other Sámi negatively, but also how Sámi's historical losses of land, culture, traditional knowledge and language(s), might lead to Sámi struggling with their identity (as Sámi); becoming "empty" or "homeless". Some of these issues, especially discrimination, have been well documented in research. Experiencing oneself as discriminated is ten times more common among Sámi than (majority) Norwegians [32], and those who report this are more likely to also report worse health [33,34]. Furthermore, Omma et al. [10] found that young adult Sámi on the Swedish side of Sápmi experiencing themselves as discriminated against, also reported significantly more suicidality [10]. In addition, Eriksen et al. [35] found that Sámi in Norway reported being subjected to more emotional, physical and sexual violence than majority Norwegians, both growing up and as adults. However, it is unknown if, and to what extent, these issues are attributed to negative treatment and violence from other Sámi. Actually, both historical losses (in relation to health) and Sámi treating other Sámi negatively are understudied in Sápmi [36]. One may also note that concepts such as lateral violence (which in this case would refer to violence between Sámi), historical trauma and racism seldom have been used to shed light on these issues in the Sámi context [36].

### Inadequate problem-solving mechanisms on different levels

The findings highlighted several themes that could be said to address the issue of inadequate problem solving for suicidal persons as central to suicide among Sámi. For example, Sámi in Norway are entitled to equal mental health care services, but participants maintained that shortcomings in the health system were structural and included lack of language competency, lack of culturally adapted services and prejudiced health care personnel. This is well known, and research has confirmed that Sámi patients are more dissatisfied than the majority population with primary health care [37], that use of Sámi language in the Norwegian health system is complicated (even when language competency is available) [38,39] and that ethnic matching in client – therapist relations (Sámi-Sámi, Norwegian-Norwegian) might have positive treatment effects in psychiatry [40], implying that cultural competence is beneficial.

The impacts of the strong and multiplex network relations within the Sámi world was discussed in the FGDs, as it was among Sámi in Sweden, too [24]. Similar to the Swedish study, our findings included both positive and negative aspects, including how the networks are activated after a suicide, with people coming together and supporting the bereaved. Other researchers have also noted the importance extended family networks has in caring for the sick or vulnerable among Sámi [41]. However, some participants in this study shared their fear of an opposite effect, namely that suicidal individuals would not want to seek help because of fear that it would lead to social exclusion of themselves, or their families, if others knew about their distress.

Boine [42] and Javo et al. [43] have shown that Sámi parents emphasise that their children, especially their boys, learn to be autonomous and self-reliant. Participants in this study discussed and criticised such traditional values of "ieš birget" – in northern Sámi meaning: "to manage by yourself" – which they meant could contribute to suicide among Sámi. One participant connected this to a sort of fatalistic "undercurrent" in society, a norm perhaps, which could be verbalised: "if you can't *birget* [manage], then you don't belong here" or "if you are good for nothing you might as well die." As culture should serve as a vehicle to pass on adaptation capabilities, this can perhaps indicate that the traditional value of "ieš birget" might have become dysfunctional in the modern day context. In other words: values like "ieš birget" may be beneficial in many ways, certainly in traditional societies with harsh climate and few resources, but concern was shared that being too self-reliant and independent might be a trap in the modern world, where a more relational problem-solving strategy, such as asking other's for help, would be more adaptive. Findings like these are not unique, as researchers focusing on the role of masculinity in suicide have argued that similar values underpinned suicidal actions in other contexts, for example among young men in Norway [44] and men in Australia [45].

### New frameworks for understanding health and suicide in the Sámi context

Clark et al. [46] have described how the use and understanding of the term "lateral violence" among aboriginal Australians in the Melbourne area might lead to social change, proposing that changing the way we understand health phenomenon holds the power to reframe it in a way that makes it possible to take action. Similarly, disparities in health that otherwise might be

considered a stigma for Sámi might be easier to talk about and study if the framework for addressing those disparities is changed. For example, in a 2015 debate following the publication of a series of newspaper articles on sexual abuse in a small Lule Sámi community [47], Kalstad Mikkelsen [48] framed the sexual violence in her home community in terms of "lateral violence". She maintains that the historical, and on-going oppression and discrimination of Sámi has led to them feeling ashamed, and that it is this shame that might result in sexualised violence against other Sámi. Furthermore, she argues that understanding these links is key to successfully addressing the issue inside the community itself. Similarities between Kalstad Mikkelsen and findings in this study are apparent, as when participants referred to historical and on-going discrimination and oppression of Sámi resulting in Sámi feeling empty, homeless, "like within a void"; in the end describing it as a factor in suicide among Sámi.

It is important to relate to these frameworks of understanding, for example lateral violence and historical trauma influencing suicidality among Sámi, when designing health interventions in the Sámi context. For example, if empowering Sámi identities is considered key among Sámi themselves both in suicide prevention and addressing sexual violence among Sámi, an intervention that fails to acknowledge this might be seen as stigmatising Sámi further; hence increasing the likelihood that the intervention will have small, or opposite, effects.

### *Strengths and limitations*

This study is based on data from focus group discussions with 20 Sámi, and 2 non-Sámi participants, and we cannot know to what extent the participants' understanding of suicide among Sámi are representative for all Sámi in Norway. However, in qualitative research it is not the intention to generalise findings to the whole population, but rather to gain deeper insight into the phenomenon of study. We argue that the open-ended dialogues and the cultural safety provided through the procedure and context of FGDs fostered honest and reflective conversations that support the credibility and overall trustworthiness of the study [49]. Utilising the snow-ball method strengthened the credibility since we were able to include members of the Sámi communities that other members held in high esteem and saw as knowledgeable for the purpose of the study. In addition, we put together focus groups that were diverse in terms of backgrounds, in order to bring many perspectives into the discussions and create FGDs where participants felt safe enough to speak openly about this highly sensitive topic (including voicing critique, which some did). The credibility of the study was also strengthened by continuous discussion of findings between researchers with different personal and academic backgrounds, ensuring that interpretations were reasonable.

The dependability and transferability of the study is hard to assess since socio-cultural meanings shift naturally over time and contexts. The open-ended design also limits dependability in itself. However, the similarity and overlap in themes between this study and the previous one, among Sámi in Sweden [24], is an argument for at least some dependability and transferability of findings. Transferability beyond this, such as to other Sámi and Indigenous contexts in the western world, should be done cautiously and not without profound insight into the relevant context.

## Conclusions

The findings indicate that the participants understand suicide among Sámi as connected to historical, contextual and cultural issues including historical and on-going oppression of Sámi, negative treatment of Sámi by other Sámi, a lack of problem solving mechanisms on different levels including; shortage of relevant and culturally safe mental health care, issues connected to the complexity and strength of Sámi networks, as well as traditional cultural values supporting "managing by yourself" rather than employing relational problem solving strategies. The findings are relevant for development of suicide prevention strategies in the Sámi context in Norway.

## Acknowledgements

We give thanks to the participants of this study, who generously shared their thoughts with us.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Funding

This work was supported by the Sámi Norwegian National Advisory Unit on Mental Health and Substance Use; under Grant 05/2014; and Helse Nord RHF under Grant PFP1297-16.

## ORCID

Jon Petter Anders Stoor http://orcid.org/0000-0002-1580-8307

## References


[1] Young TK, Revich B, Soininen L. Suicide in circumpolar regions: an introduction and overview. Int J Circumpolar Health. 2015;74:27349.

[2] Herne MA, Bartholomew ML, Weahkee RL. Suicide mortality among American Indians and Alaska Natives, 1999–2009. Am J Public Health. 2014;104(Suppl 3):336–342.

[3] Chachamovich E, Kirmayer LJ, Haggarty JM, et al. Suicide among inuit: results from a large, epidemiologically representative follow-back study in Nunavut. Can J Psychiatry. 2015;60(6):268–275.

[4] Bjerregaard P, Viskum Lytken LC. Time trend by region of suicides and suicidal thoughts among Greenland inuit. Int J Circumpolar Health. 2015;74:26053.

[5] Sumarokov YA, Brenn T, Kudryavtsev AV, et al. Suicides in the indigenous and non-indigenous populations in the Nenets Autonomous Okrug, Northwestern Russia, and associated socio-demographic characteristics. Int J Circumpolar Health. 2014;73:24308.

[6] Silviken A, Haldorsen T, Kvernmo S. Suicide among indigenous Sami in arctic Norway, 1970–1998. Eur J Epidemiol. 2006;21(9):707–713.

[7] Hassler S, Johansson R, Sjolander P, et al. Causes of death in the Sami population of Sweden, 1961–2000. Int J Epidemiol. 2005;34(3):623–629.

[8] Soininen L, Pukkola E. Mortality of the Sami in northern Finland 1979–2005. Int J Circumpolar Health. 2008;67(1):43–55.

[9] Kaiser N, Salander Renberg E. Suicidal expressions among the Swedish reindeer-herding Sami population. Suicidol Online. 2012;3:114–123.

[10] Omma L, Sandlund M, Jacobsson L. Suicidal expressions in young Swedish Sami, a cross-sectional study. Int J Circumpolar Health. 2013;72:19862.

[11] Minde H. Assimilation of the Sami-implementation and consequences. J Indigenous Peoples Rights. 2005;3.

[12] The government of Norway. The Sami people. 2018 cited 2018 Sep 17. Available from: https://www.regjeringen.no/en/topics/indigenous-peoples-and-minorities/Sami-people/id1403/

[13] Hjelmeland H, Knizek BL. Suicide and mental disorders: a discourse of politics, power, and vested interests. Death Stud. 2017;41(8):481–492.

[14] Hjelmeland H. Cultural context is crucial in suicide research and prevention. J Crisis Intervention Suicide Prev. 2011;32(2):61–64.

[15] Hjelmeland H, Knizek BL. Why we need qualitative research in suicidology. Suicide Life Threat Behav. 2010;40(1):74–80.

[16] Katz LY, Elias B, O'Neil J, et al. Aboriginal suicidal behaviour research: from risk factors to culturally-sensitive interventions. J Can Acad Child Adolesc Psychiatry. 2006;15(4):159–167.

[17] Kirmayer L, Brass G, Holton T, et al. Suicide among aboriginal people in Canada. Ottawa, ON: Aboriginal Healing Foundation; 2007.

[18] Marsella AJ, Dubanoski J, Hamada WC, et al. The measurement of personality across cultures: historical, conceptual, and methodological issues and considerations. Am Behav Sci. 2000;44(1):41–62.

[19] Andoh-Arthur J, Knizek BL, Osafo J, et al. Suicide among men in Ghana: the burden of masculinity. Death Stud. 2018;42(10):658–666.

[20] Colucci E. "Focus groups can be fun": the use of activity-oriented questions in focus group discussions. Qual Health Res. 2007;17(10):1422–1433.

[21] Roen K, Scourfield J, McDermott E. Making sense of suicide: a discourse analysis of young people's talk about suicidal subjecthood. Soc Sci Med. 2008;67(12):2089–2097.

[22] Wexler L. Identifying colonial discourses in Inupiat young people's narratives as a way to understand the no future of Inupiat youth suicide. Am Indian Alsk Native Ment Health Res. 2009;16(1):1–24.

[23] Wexler L. Inupiat youth suicide and culture loss: changing community conversations for prevention. Soc Sci Med. 2006;63(11):2938–2948.

[24] Stoor JPA, Kaiser N, Jacobsson L, et al. "We are like lemmings": making sense of the cultural meaning(s) of suicide among the indigenous Sami in Sweden. Int J Circumpolar Health. 2015;74:27669.

[25] Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse, Saami Council. Plan for suicide prevention among the Sámi people on Norway, Sweden, and Finland. Karasjok, Norway; Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse; 2017.

[26] Redvers J, Bjerregaard P, Eriksen H, et al. A scoping review of Indigenous suicide prevention in circumpolar regions. Int J Circumpolar Health. 2015;74:27509.

[27] Inuit Tapiriit Kanatami. National Inuit Suicide Prevention Strategy. Ottawa, Canada: Inuit Tapiriit Kanatami; 2016.

[28] Hansen AM, Virginia RA, Tepecik Dis A, et al. Community Wellbeing and Infrastructure in the Arctic. Aalborg University; 2016.

[29] World Medical Association. World medical association declaration of helsinki: ethical principles for medical research involving human subjects. JAMA. 2013;310(20):2191–2194.

[30] Strøm KS, Bull K, Broderstad AR, et al. Proposal for ethical guidelines for Sámi health research and research on Sámi human biological material. Karasjok, Norway: Sámediggi/Sámi Parliament of Norway; 2018.

[31] Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.

[32] Hansen KL, Melhus M, Høgmo A, et al. Ethnic discrimination and bullying in the Sami and non-sami populations in Norway: the SAMINOR study. Int J Circumpolar Health. 2008;67(1):97–113.

[33] Hansen KL. Ethnic discrimination and health: the relationship between experienced ethnic discrimination and multiple health domains in Norway's rural Sami population. Int J Circumpolar Health. 2015;74:25125.

[34] Hansen KL, Sørlie T. Ethnic discrimination and psychological distress: a study of Sami and non-Sami populations in Norway. Transcult Psychiatry. 2012;49(1):26–50.

[35] Eriksen AM, Hansen KL, Javo C, et al. Emotional, physical and sexual violence among Sami and non-Sami populations in Norway: the SAMINOR 2 questionnaire study. Scand J Public Health. 2015;43(6):588–596.

[36] Stoor JPA. Kunskapssammanställning om psykosocial ohälsa bland samer [Compilation of knowledge on

psychosocial health among Sámi]. Kiruna, Sweden: Sametinget/Sámi Parliament of Sweden; 2016.

[37] Nystad T, Melhus M, Lund E. Sami speakers are less satisfied with general practitioners' services. Int J Circumpolar Health. 2008;67(1):114–121.

[38] Dagsvold I, Møllersen S, Stordahl V. What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment. Int J Circumpolar Health. 2015;74(1):26952.

[39] Dagsvold I, Møllersen S, Stordahl V. "You never know who are Sami or speak Sami" Clinicians' experiences with language-appropriate care to Sami-speaking patients in outpatient mental health clinics in Northern Norway. Int J Circumpolar Health. 2016;75:32588.

[40] Møllersen S, Sexton HC, Holte A. Effects of client and therapist ethnicity and ethnic matching: a prospective naturalistic study of outpatient mental health treatment in Northern Norway. Nord J Psychiatry. 2009;63(3):246–255.

[41] Langås-Larsen A, Salamonsen A, Kristoffersen AE, et al. "We own the illness": a qualitative study of networks in two communities with mixed ethnicity in Northern Norway. Int J Circumpolar Health. 2018;77(1):1438572.

[42] Boine EM. Ii gii ge ollesolmmoš ge liiko jus gii nu livče nu čuru das birra jorramin - Selv ingen voksne hadde likt at noen surret rundt der som en flue. Verdioverføring fra far til sønn - i en samisk kontekst [No grown-up would have liked if someone buzzed around them like a fly. Transferring values from father to son – in a Sámi context]. In: Hauan MA, editor. Maskuliniteter i Nord. KVINNFORSKs skriftserie Senter for kvinne- og kjønnsforskning. Tromsø: Universitetet i Tromsø, Norwegian; 2007. p. 127–141.

[43] Javo C, Alapack R, Heyerdahl S, et al. Parental values and ethnic identity in indigenous Sami families: a qualitative study. Fam Process. 2003;42(1):151–164.

[44] Rasmussen ML, Haavind H, Dieserud G. Young men, masculinities, and suicide. Arch Suicide Res. 2018;22 (2):327–343.

[45] River J. Suicide and hegemonic masculinity in Australian men. Illions (IL): Charles C. Thomas Springfield; 2014.

[46] Clark Y, Augoustinos M, Malin M. Lateral violence within the aboriginal community in Adelaide: "it affects our identity and wellbeing". J Indig Wellbeing. 2016;1 (1):43–52.

[47] Berglund EL, Henrikssen TH, Amdal H, et al. Den mørke hemmeligheten [The Dark Secret]. VG. 2016 cited 2018 Mar 19. Available from: https://www.vg.no/nyheter/innenriks/tysfjord-saken/den-moerke-hemmeligheten/a/23706284/Norwegian

[48] Kalstad Mikkelsen A. Taushet, tabuer og tapte ansikter - angår det oss? [Silence, taboos and people loosing face - does it concern us?]. Bårjås. 2016;(1):46–58. Norwegian.

[49] Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24 (2):105–112.

# Paper III

**Title**: “Mapping suicide prevention initiatives targeting Indigenous Sámi in Nordic countries”


## Authors*:*

*Jon Petter A. Stoor[1,2], Certified psychologist, MSc*

*Heidi A. Eriksen[3], MD, PhD*

*Anne C. Silviken[2,4], Certified psychologist, PhD*

## Affiliations:

[1] Department of Epidemiology and Global Health, Umeå University, Umeå, Sweden

[2] Centre for Sámi Health Research, Department of Community Medicine, UiT – the Arctic University of Norway, Tromsø, Norway

[3] Utsjok Primary Health Care Centre, Utsjok, Finland

[4] Sámi Norwegian National Advisory Unit for Mental Health and Substance Use, Finnmark Hospital Trust, Karasjok, Norway

## Corresponding author:

Jon Petter A. Stoor

Department of Epidemiology and Global Health, Umeå University, SE-901 87, Umeå, Sweden

Email: petter.stoor@umu.se

# Abstract

**Background:** Suicide is a major public health issue among Indigenous Sámi in Nordic countries, and efforts to prevent suicide in the Sámi context are increasing. However, there is no literature on suicide prevention initiatives among Sámi.

**Objective**: To map suicide prevention initiatives targeting Sámi in Norway, Sweden, and Finland during 2005-2019.

**Method**: Initiatives were identified and described through utilizing networks among stakeholders in the field of suicide prevention among Sámi, acquiring documentation of initiatives and utilizing the authors first-hand experiences. The described initiatives were analyzed inspired by the "What is the problem represented to be?" (WPR)-approach.

**Results**: Seventeen initiatives targeting Sámi were identified during 2005-2019, including nine in Sweden, five in Norway, one in Finland and two international initiatives. Analysis with the WPR-approach yielded 40 problematizations regarding how to prevent suicide among Sámi, pertaining to shortcomings on individual (5), relational (15), community/cultural (3), societal (14) and health systems levels (3). All initiatives were adapted to the Sámi context, varying from tailor-made, culture-specific approaches to targeting Sámi with universal approaches. The most common approaches were the gatekeeper and mental health literacy training programs. The initiatives generally lacked thorough evaluation components.

**Conclusion**: We argue that the dominant rationales for suicide prevention were addressing shortcomings on individual and relational levels, and raising awareness in the general public. This threatens obscuring other, critical, approaches, such as broadening perspectives in prevention planning, improving health systems for Sámi, and promoting cultural empowerment among Sámi. Nevertheless, the study confirms considerable efforts have been invested into suicide prevention among Sámi during the last 15 years, and future initiatives might include a broader set of prevention rationales. To improve evaluation and identify the most promising practices, increased support regarding development of plans and implementation of evaluation components is needed.



**Key words:** Sami, Saami, Indigenous, arctic, suicide prevention, mental health, WPR-approach

# Background

Suicide is a public health issue of much concern in the Arctic, especially among the Indigenous peoples due to their higher suicide mortality compared to the non-Indigenous peoples (1). Among Sámi, the Indigenous people of northern Norway, Sweden, Finland, as well as the Kola Peninsula in Russia, the situation has been better than the Indigenous peoples elsewhere in the region. However, cohort studies highlighting suicide rates for Sámi in northern Norway (1970-1998), Sweden (1961-2000) and Finland (1979-2010) (1-4) show that suicide rates have been consistently elevated among Sámi men compared to non-Sámi men. Although the suicide rates among Sámi in Nordic countries (not including Sámi in northwestern Russia, for whom no data is available) are lower, suicide among Sámi in Norway and among reindeer herding Sámi in Sweden still share some characteristics with suicide in other Indigenous Arctic groups, including the commonality of violent methods and that young men are most vulnerable (1, 3, 5).

The World Health Organization (WHO) maintains that suicide is a multifaceted public health problem that calls for countries to strategize, coordinate and implement complex and comprehensive prevention plans. Preventive actions can be universal (target the whole population); focus on at-risk groups, such as minority groups with elevated rates of suicide (potentially including Indigenous people); or at-risk individuals, such as people exhibiting suicidal behavior (6). The WHO highlights that Indigenous peoples often qualify as an at-risk group, and suicide in those contexts should be understood in relation to community and group factors related to the colonization of Indigenous territories: “among Indigenous groups, territorial, political and economic autonomy are often infringed and native culture and language negated. These circumstances can generate feelings of depression, isolation and discrimination, accompanied by resentment and mistrust of state-affiliated social and health-care services, especially if these services are not delivered in culturally appropriate ways” (7). This understanding of sociopolitical issues (e.g., family, community, social, cultural, contextual, political and historical factors) permeating suicidal behavior among Indigenous peoples is also evident in the academic literature (8-12). Among Sámi, qualitative studies on cultural meanings of suicide in Norway and Sweden point in a similar direction, for example, highlighting suicide among Sámi as related to a loss of Indigenous identity, language, culture and land rights (13, 14). Because of Indigenous peoples right to self-determination in relation to how best to address their health issues and because of evidence pointing to suicide in Indigenous contexts as permeated by context-specific factors, Indigenous peoples are developing their own suicide prevention policies, for example, in Australia and northern Canada (15, 16).

Finland was the first country in the world to start a national suicide prevention program in the late 1980s (6). However, neither that program nor subsequent national plans in Nordic parts of Sápmi

(Norway, Sweden and Finland) have included Sámi in meaningful ways. For example, even though the latest national action plan to prevent suicide and self-harm in Norway (2014-2017) (17) mentions Sámi, it fails to articulate any aim or action targeting them. In Sweden, the current national prevention strategy does not mention Sámi at all, although it aims at reducing suicide to zero, supposedly indicating its high political priority (18). The lack of inclusion of Sámi in the national prevention policies was the background for the development of a specific plan for suicide prevention among Sámi, through a joint effort between a regional branch of the Norwegian health system (tasked with ensuring equity in mental health outcomes for Sámi in Norway) and the Saami Council, a pan-Sámi non-governmental organization (NGO) (19). However, lack of scientific evidence was a challenge in developing the Sámi suicide prevention plan, as neither a scoping review on peer-reviewed English language articles on suicide prevention programs among Arctic Indigenous peoples nor a report including Scandinavian language grey literature on psychosocial health issues among Sámi in Sweden, succeeded in identifying studies or reports on suicide prevention initiatives in the Sámi context (20, 21). Therefore the aim of this study was to identify, describe and analyze suicide prevention initiatives targeting Sámi in Norway, Sweden and Finland during 2005-2019.

# Method

We (the authors) were not aware of any systematic replicable method for scoping the diverse sources that could potentially contain information regarding suicide prevention initiatives among Sámi in the Nordic countries. Because of this, we chose a pragmatic approach building on the particular strengths of our research group: our experiences from working in the field of suicide prevention among Sámi in Norway, Sweden and Finland, respectively. The mapping of initiatives was conducted in three steps: identifying, describing and analyzing. The purpose of the interpretative analysis was to clarify how suicide prevention among Sámi was meant to function, as seen from the perspectives embedded within the identified prevention initiatives. This is important as suicide is a phenomenon characterized by its complexity; hence, there are many potential ways to seeks its prevention. Since those ways among Sámi have not been previously investigated in the academic context, it makes sense to provide a roadmap that both describes what has been done before and with what intentions. An adaptation of the "What is the problem represented to be?" (WPR)-approach was selected as the analytical tool. The WPR-approach is a policy analysis tool developed by Carol Bacchi, which presupposes that *"what we propose to do about something indicates what we think needs to change and hence what we think the 'problem' is"* (22). It is a flexible method that can be employed in different ways (including parts of, or the whole original method), utilizing different data (written, verbal or non-verbal, including symbolic "languages") for different purposes. Bacchi exemplified how the WPR-approach might work with an analysis of a policy regarding violence

towards women, where the policy suggests that women should be given access to self-help courses. A WPR analysis of such a policy would then highlight how the policy "places" the problem of violence towards women (and the responsibility to fix it) among the women themselves, as opposed to elsewhere (among the perpetrators of violence, for example).

## Identifying

Potential initiatives that had taken place in the period 2005-2019 were identified through inquiring professionals, researchers, organizations and other stakeholders engaged in the field of suicide prevention among Sámi in Norway, Sweden and Finland. As there is no coordination or system available for tracking suicide prevention initiatives in this context, the author's extensive networks within respective countries was helpful in this process, which was carried out by phone and email. A list of initiatives was compiled, and organizations/institutions responsible for administering and/or funding initiatives were requested to provide project reports and other documentation regarding those initiatives. The list included initiatives explicitly aimed at preventing suicide among Sámi, as well as some initiatives without this being explicit. The latter were included if other available information suggested that the initiative was relevant, although not explicitly framed as suicide prevention because of a need to conform to funding mechanisms primarily meant to support other goals. Furthermore, universal suicide prevention initiatives in Sámi areas (i.e., not focusing explicitly on Sámi) were included if these included adaptations to fit Sámi needs, such as employing Sámi personnel for better reach among the Sámi population. Initiatives for which we failed at acquiring written material were excluded if we also lacked first-hand experiences. One initiative was excluded because of this.

## Describing

A template, inspired by the review on suicide prevention projects in Aboriginal Australia by Ridani, Shand (23), was created and available information regarding the initiatives was inserted. Thus, the following descriptive data was included: name and year; aim or mission; target population and geographic reach (region, country); delivery method(s), including participant information (if available); administering organizations; funding institutions; and what evaluation data was reported. Information on what source(s) was used for compiling the descriptive data was also included.

## Analyzing

The compiled data was read through for the purpose of employing an interpretative analysis inspired by the WPR-approach and combined with a thematical categorization of the problematizations found. In this case, the question "What is the problem(s) represented to be?" was posed to the descriptive data compiled in the template. The interpretation of how each initiative problematized suicide was thus based on the aims, delivery methods (activities carried out), target population, and

other characteristics of the identified initiatives. In practice, this process was conducted through the first author making a preliminary suggestion as how to answer the question for each initiative, and the other authors checking, suggesting changes and/or confirming that those interpretations were reasonable, in a back and forth process (through emails and online meetings, due to physical distances). Several problematizations for each initiative were allowed, especially for initiatives with multiple prevention actions undertaken. The problematizations were then thematically categorized based on the content of the problematizations (where they *placed* the problem), informed by the WHO's framework of suicide risk and protective factors as related to individual, relational, community/culture, social or health systems levels (6, 7, 24).

### Ethical considerations

Medical research ethics in Norway, Sweden and Finland do not extend beyond studies involving individuals or biomedical material. However, discussions on how to better safeguard the collective rights and needs of Sámi in research have caught traction in recent years (25-29), especially in health research in Norway, where a system of Sámi-specific ethical guidelines and review is being implemented in 2020 (30). Issues of potential concern regarding this study, from a Sámi collective perspective, is the risk of researching suicide prevention in the Sámi context contributing to an increase in social stigma for Sámi (through Sámi identity being connected to suicidality). However, we believe potential benefits outweigh the risks, as Sámi organizations have made clear that research relating to suicide and suicide prevention in the Sámi context is of importance for being able to improve suicide prevention among Sámi.

## Results

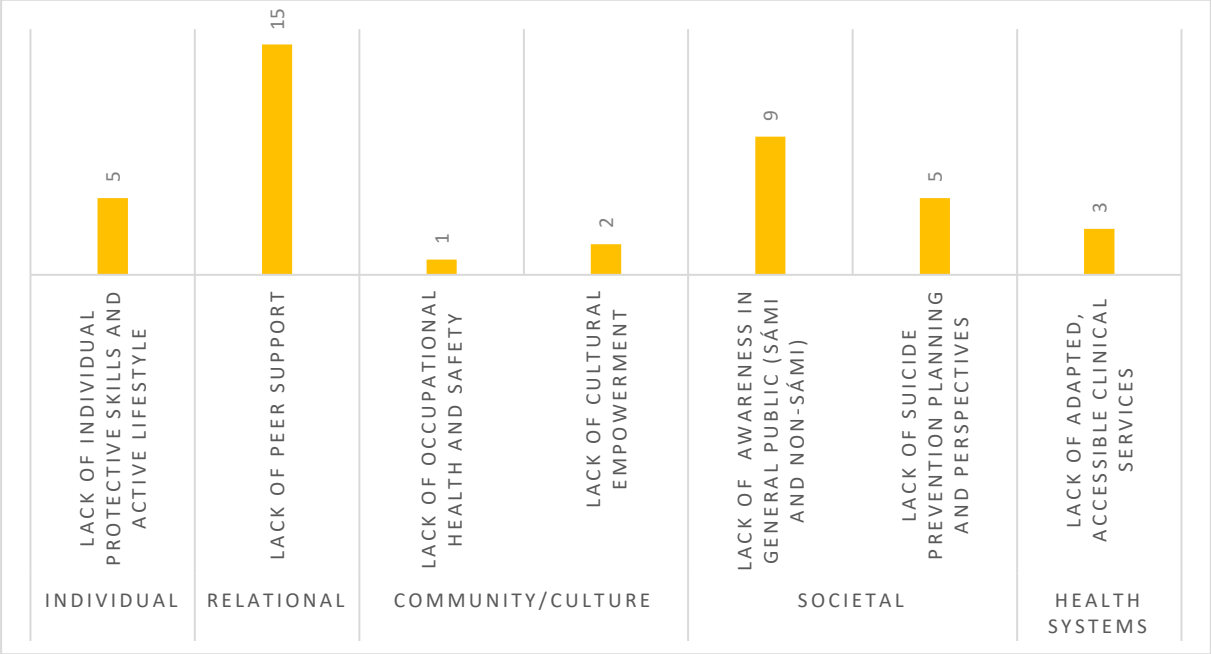
The sources used for compiling and describing the initiatives included 12 project reports concerning 11 initiatives, as well as first-hand accounts for 12 initiatives. The results are presented in the form of a summary of what problematizations of suicide were found to be embedded within the initiatives and what actions were carried out to address those problems. Also, a narrated overview of other characteristics of the identified initiatives was included. Detailed tables of identified initiatives and problematizations of suicide are provided as supplementary material.

### Problematizations of suicide and actions to address those problems

A total of 17 suicide prevention initiatives were identified to have targeted Sámi in Norway (5), Sweden (9), and Finland (1) specifically, as well as in all those countries internationally (2). Analysis of the identified initiatives utilizing the "What is the problem represented to be?"-question yielded 40 problematizations regarding how to prevent suicide among Sámi (Figure 1). The problematizations were compared and thematically categorized depending on interpretation of where they "placed"

the problem (i.e., what problems they aimed at fixing, as a way of preventing suicide) (Figure 2). The thematic categories included “lack of individual protective skills and active lifestyle” (5 problematizations), “lack of peer support” (15), “lack of occupational health and safety” (1), “lack of cultural empowerment” (2), “lack of suicide prevention planning and perspectives” (5), “lack of awareness in general public (Sámi and non-Sámi)” (9) and “lack of adapted, accessible clinical services” (3).

*Figure 1. What are the problems represented to be in suicide prevention initiatives targeting Sámi? Number of problematizations in thematic categories and suggested corresponding levels of intervention.*




Problematizations related to individual shortcomings included lack of active lifestyle, lack of coping skills, lack of conflict management skills, lack of tools for emotion regulation and lack of self-care skills among Sámi kids, youth and young adults. Activities to address these shortcomings included a local project providing a program for encouraging outdoors activities for at-risk youth. Furthermore, other projects arranged workshops focused on 1) exploring the use of yoiking as a tool for improved emotional regulation among young Sámi men, 2) teaching conflict management tools and 3) promoting self-care skills for young male reindeer herders, and young reindeer herders (irrespective of sex), respectively. These workshops were based on in-group dialog rather than predefined curriculum.

The most common type of problematization (15 out of 40 problematizations) related suicide among Sámi to the relational level, specifically, “lack of peer support.” Activities meant to address this issue were aimed both at strengthening the general social support within specific groups of Sámi (such as youth and young adults, among men and/or within reindeer husbandry) and trying to achieve specific changes in the general Sámi population through implementation of mental health literacy and gate-

keeper training programs. Almost all the activities aimed at addressing the relational level shortcomings were workshop-based (delivered in workshop formats), either with predefined curriculum from internationally used prevention programs, such as Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (MHFA), or using workshops to strengthen bonds and within-group support through talking about shared challenges. For the latter type of workshops, a common method was gathering youth/young adult Sámi and letting them listen to a slightly older peer, who functioned as a role model and shared his/her story of dealing with and overcoming suicidality, and then having the group talk and discuss the content recognized within that story. Another approach to increasing peer support was starting a telephone-based crisis hotline run by Sámi laypersons.

Problematizations of suicide related to the community and culture levels of intervention included both "lack of occupational health and safety" within reindeer herding and "lack of cultural empowerment" among Sámi youth and young Sámi men. Activities to address these problems included a project aimed at increasing and systematizing efforts to strengthen the occupational health and safety work within the reindeer herding industry and two workshop-based projects utilizing yoiking (a Sámi form of cultural expression, similar to singing) as tool for cultural empowerment among young Sámi.

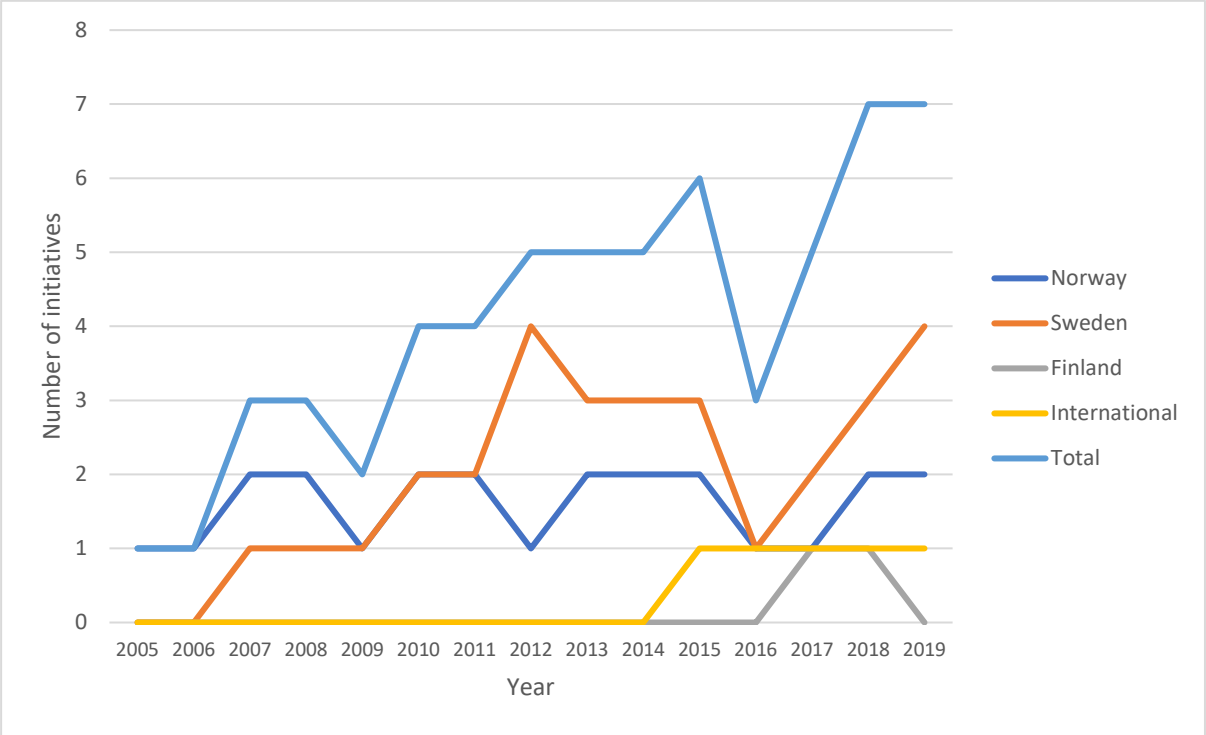
Problematizations identified as related to the societal level of intervention included "lack of suicide awareness in both the Sámi and non-Sámi general populations" and "lack of suicide prevention planning and perspectives." Activities aimed at increasing awareness of suicide included arranging open meetings to discuss suicide in the Sámi context, as well as producing information leaflets and reports containing information regarding the issue. Activities aimed at strengthening prevention planning and inclusion of relevant perspectives included, for example, creating prevention plans on a local community level and on a general Sámi level, as well as a project teaching Indigenous youth methods for digital storytelling in an effort to support their perspectives to be heard.

Lastly, problematizations related to health systems included "lack of adapted, accessible clinical services." Activities aimed at addressing this included running a low-threshold psychiatric service focusing on suicidality and drug use among Sámi youth and young adults, trying to improve the general level of knowledge relating to Sámi health within the universal health care systems in northern Sweden (focusing on personnel in psychiatry and primary health care), as well as improving recognition and referral of at-risk youth from school-based nurses to other parts of the health system in a local community context.

## Characteristics of the identified initiatives

Only one initiative was identified for 2005-2006, but the number of initiatives rose thereafter (Figure 2). From 2010 and onwards, about five initiatives have been simultaneously on-going. Four initiatives were still on-going and planned to continue during 2020, including three in Sweden and one in Norway.

*Figure 2. Number of suicide prevention initiatives targeting Sámi in Norway, Sweden, Finland and internationally, per year (2005-2019).*




Few initiatives connected their specific activities to overarching priorities of suicide prevention strategies. However, projects run by health care organizations were implicitly connected to national suicide prevention strategies, as their mission was to deliver prevention training workshops to Sámi, which were chosen for implementation on a national (universal) level. Also, one initiative referred to national prevention strategies, as it sought to create a Sámi-specific prevention plan meant to complement already existing universal plans. The initiatives targeted different groups, including the Sámi (and non-Sámi) general public, whole communities, youth, reindeer herders, young male reindeer herders, at-risk individuals (self-identified or identified by school personnel), and service providers.

In terms of delivery methods, 12 initiatives, at least to some degree, employed workshops and/or public meetings as delivery methods; eight of these included specific suicide prevention training workshops for improved mental health literacy and so called gate-keeper training. These included two initiatives providing the 2-day Australian MHFA course among Sámi in Sweden, three initiatives

providing the 2-day Canadian ASIST course among Sámi in Norway and one initiative providing it among Sámi in Finland. Furthermore, the half-day Canadian SafeTALK course was provided one time by one initiative in Sweden.

All initiatives were somewhat adapted to the Sámi context, although the width of adaptations was wide, ranging from the only adaptation being to recruit Sámi participants for an otherwise not adapted prevention activity to creating tailor-made approaches for specific Sámi groups, utilizing Sámi cultural activities as part of the initiative. The initiatives implementing ASIST and MHFA programs in the Sámi contexts showed few signs of Sámi-specific adaptations beyond being delivered by Sámi health care personnel or culturally competent non-Sámi personnel. However, one initiative in Norway aimed at producing a northern Sámi version of the SafeTALK intervention, which will be adapted in terms of culture and language.

The identified initiatives were administered by organizations alone, in cooperation or in consortiums. Five initiatives were administered by Sámi and Swedish NGOs, together or alone, and one by a religious organization. Seven initiative were administered by public health care organizations, and the rest by different organizations working together or entering into consortiums. Most initiatives administered by health care organizations were funded by themselves, whereas most other initiatives were funded by a range of publicly available project grants.

While most initiatives lacked thorough evaluation, some process-oriented evaluations in project reports pointed to the importance of anchoring projects locally or being community driven, as well as paying attention to issues of culture and context to make sure projects were appealing and relevant to target populations. One initiative attempted to conduct a questionnaire-based evaluation of the outcomes of providing gatekeeper training workshops, but it was reported that meaningful statistical processing was not possible due to the low response rate.

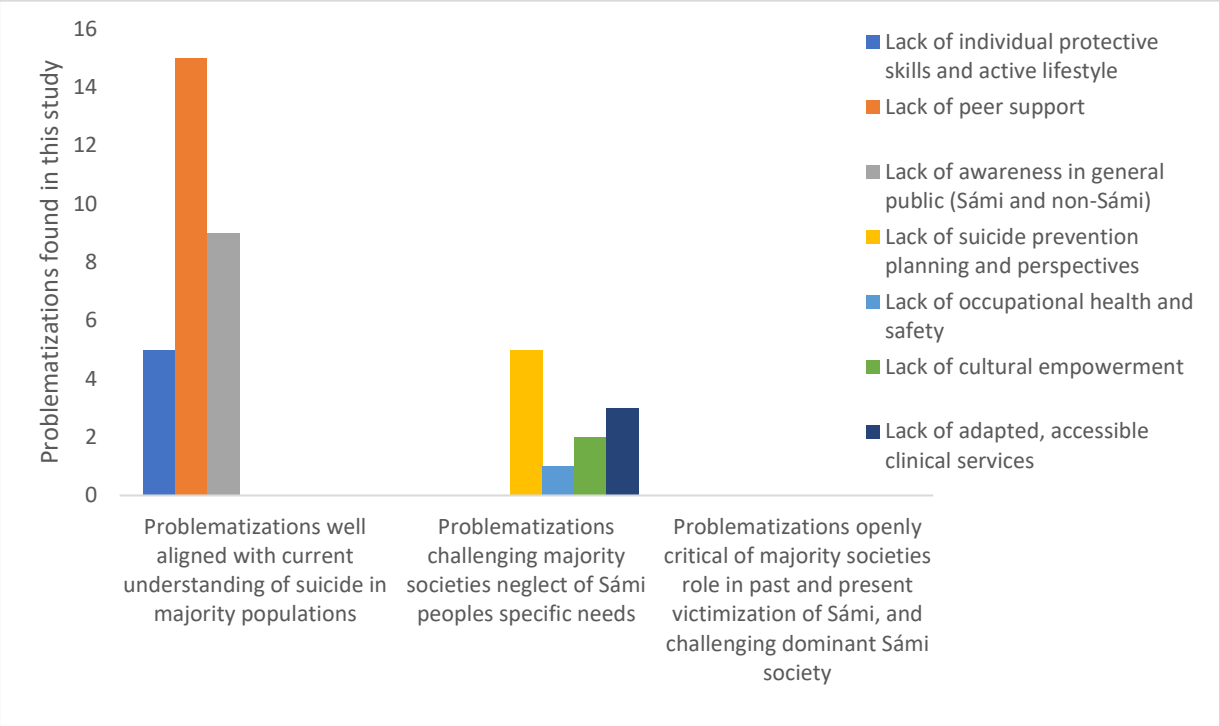
# Discussion

This study has mapped suicide prevention initiatives targeting Sámi in Norway, Sweden and Finland. The following discussion focuses on some of the characteristics of these initiatives, and our interpretations of what these tell us about how society represents the problem of suicide among Sámi. Also, inspired by the WPR-approach, we asked what problematizations of suicide were not visible in the present study and some implications thereof.

Firstly, it should be noted that there was considerable diversity in terms of prevention approaches, as the problematizations and adhering activities sought to understand and address issues on all levels suggested for suicide prevention by the WHO (individual, relational, community/cultural, societal and

health systems levels). However, most of the problematizations (three out of four) found in this study placed the problem on individual-relational levels (individual shortcomings or lack of peer support between individuals) or lack of suicide awareness in the general public. Although we regard these focuses and the activities accompanying them as well aligned with national (non-Sámi) prevention policies (17, 18), which are both useful and welcome initiatives in the Sámi context, their dominant position might be problematic for a number of reasons. Firstly, this focus mainly places the problem (and therefore the responsibility to fix it) among struggling Sámi, their peers and the rather unspecific category of "the general public." This is only partly supported by available evidence. For example, attitudes towards suicide in Sámi risk groups for suicidality was, if anything, less problematic than among non-Sámi peers, reindeer herding Sámi had no different attitudes to suicide as compared to the majority of Swedes (31) and young adult Sámi were actually less prone to think that talking about suicide increases the risk, less likely to think that one could not stop an individual whose mind was made up, and more aware of suicide in general when compared to Swedish peers (32). Arguably, this points to lack of suicide awareness and peer support not being what's driving suicidality within Sámi risk-groups for suicidality (31, 32). Secondly, placing the focus on these particular issues might obscure other important problematizations found in this study, such as the lack of prevention planning and perspectives, shortcomings in health systems, lack of occupational health and safety in reindeer herding and lack of cultural empowerment among Sámi youth. Also, those issues are more aligned with Sámi-specific priorities found in the Sámi suicide prevention plan, which stresses the need to also understand and address suicide through up-stream intermediary factors, including the historical and sociocultural contexts (19). Actually, when comparing the strategies in the Sámi-specific prevention plan with the problematizations found in this study, we noted that some strategies were not covered at all by the identified initiatives, perhaps because they could be considered critical or challenging towards Sámi or the majority society. What we are suggesting then, is that whether and to what extent problematizations and prevention activities might potentially be challenging the status quo in society, it could be an underlying factor if such activities were initiated in the first place and subsequently registered in this study (Figure 3). For example, the most common problematizations might be the most frequent because they are well aligned with the normative understanding of how to address suicide in the majority (non-Sámi) populations of Nordic countries. On the other side of the spectrum, prevention rationales that we did not identify included those that might be considered challenging or critical to Sámi and/or the majority society, including tension-full issues such as strengthening of Sámi self-determination, efforts to recognize and deal with historical traumas among Sámi, reducing Sámi exposure to violence (including sexual violence) and ethnic discrimination, and breaking taboo, stigma and negative attitudes related to non-normative sexuality and gender identity among Sámi.

*Figure 3. Number of problematizations found in this study, depending on categorization of whether and how such problematizations challenges majority and Sámi societies.*




The potential consequences of this make-up of problematizations and activities might be that suicide among Sámi, as seen from recent prevention initiatives, is predominantly construed as a problem residing at the individual and relational levels, which also possibly could be solved by raising awareness in the general public. In our view, such an understanding of suicide among Sámi would negate the complexity of the problem and obscure not only the role of factors such as "infringement of native culture and language, lack of territorial, political and economic autonomy, the need for culturally appropriate health systems" (6) but also the need to critically challenge norms within Sámi society that might be contributing to suicide, for example, those associated with masculinity and within-group ("lateral") violence. However, it should also be noted that activities, such as the truth and reconciliation commission in Norway, the "Queering Sápmi" project in Sweden (33), and the multilevel efforts to address sexual violence in the community of Tysfjord, seem well aligned with strategies in the Sámi prevention plan, although not framed as suicide prevention. This, in turn, raises the critical question if suicide prevention activities really offer the best suicide prevention in this context. Regardless, it seems the development of the Sámi-specific prevention plan in 2017 offers future initiatives a path to aligning their priorities with the rationales found in the prevention plan, thus covering a fuller spectrum of activities needed for improved prevention among Sámi.

The most common form of problematization of suicide in this study (lack of peer support) was mainly connected to two different types of initiatives. On the one hand, health care authorities

implemented international suicide prevention training programs targeting gate-keepers, the general public or reindeer herding Sámi ASIST in Norwegian and Finnish parts of Sápmi, and MHFA in Swedish parts of Sápmi). On the other hand, there were a smaller group of initiatives targeting Sámi at-risk groups (more specifically (young men, young reindeer herders, and young reindeer herding men) run by Sámi NGOs. Comparing them is interesting because critical suicide researchers have argued that the first type of program is problematic in Indigenous settings, as they build on assumptions of universality in suicide, suicidal behavior, pedagogic style and conceptualization of distress, which might fail to address the realities of Indigenous participants (34). Instead Wexler, White (35) propose that suicide prevention in such settings should be built on community-based context-specific approaches, allowing for a better match with Indigenous people's needs. Actually, the programs run by Sámi NGOs fit that description rather well, as the main content of these initiatives was co-created by the participants themselves, in the form of sharing and discussing suicide from the participants perspectives, and sometimes using Sámi cultural practices (yoiking) as a tool for cultural empowerment. Again, this is well in line with Redvers, Bjerregaard (20), whom after scoping for Indigenous suicide prevention initiatives in the Arctic circumpolar regions from 2004 to 2014, suggested that "there is resounding agreement [among researchers] that culturally-grounded solutions and community-based programs are keys to understanding and approaching suicide prevention." Building on this, we argue that a discussion on what should be future priorities for Sámi suicide prevention is warranted, not in the least because the initiatives that might be labeled "bottom-up approaches, grounded in community priorities" (the initiatives run by Sámi NGOs) relied on funding from external grants, which was the reason they did not publicly present as suicide prevention activities. However, without proper evaluations, it is difficult to support arguments on whether suicide prevention in Sámi contexts is more appropriate and/or effective using adaptations of universal programs or tailor-made community-based programs.

Concerning the evaluation of initiatives, the main finding was that there were a lack of them. For example, it would have been desirable that initiatives presented clear rationales of how the activities within them were meant to reduce suicide, they identified key factors for achieving this, and included predefined measures of success, including outcome measures. The fact that only one initiative tried to measure outcomes using quantitative data suggest that implementers did not try very hard, that they lacked capacity, and/or that the task was too complex. Regardless of the reason, this problem is not unique to this context. Authors of a systematic review of suicide prevention interventions targeting Indigenous peoples in Australia, the United States, Canada and New Zealand succeeded in identifying only nine evaluated Indigenous suicide prevention programs during 1980-2012 (10). This led them to suggest that evaluation resources and know-how might be unavailable or

stretched too thin due to other priorities taking precedence (for both Indigenous communities and research groups), and running scientifically rigorous evaluation programs that are respectful, adapted to cultural and contextual needs, involve Indigenous communities as equal partners and build Indigenous research capacity might simply be to resource demanding. However, Clifford, Doran (10) also highlight that stronger bonds between researchers and communities might lead to less expensive processes. One pragmatic way of addressing this has been developed in Australia, a context with similar characteristics and challenges as Sápmi. There, the "Indigenous Suicide Prevention Activity Evaluation Framework" is an easy-to-use tool being promoted for use by prevention initiative organizers, hopefully resulting in initiatives including evaluation components already at planning stages (36). From our perspective, and the need to improve the evaluation of suicide prevention initiatives among Sámi, adopting this Australian approach seems both reasonable and feasible.

## Methodological discussion

Although the pragmatic approach chosen to map prevention initiatives was an integral part in making this study possible, the lack of a systematic approach meant taking the risk of knowledge gaps and personal bias influencing the inclusion of initiatives. For example, it is reasonable to assume that personal bias made us more likely to succeed in identifying initiatives we were somehow involved in. Furthermore, excluding identified initiatives when lacking written documentation only if we ourselves had not been involved in them resulted in excluding one initiative, thus confirming that personal bias affected the inclusion/exclusion of initiatives. As a fact, this means that the overview of prevention initiatives targeting Sámi created in this study is not exhaustive.

As is the case in all qualitative research, the specific competencies and experiences of those performing the analysis is reflected through its results. Although we do represent a diverse group of researchers, it is likely that other researchers would have interpreted the same data in at least slightly different ways. However, we sought to increase transparency in describing how analysis was carried out and including supplements with substantial amounts of data regarding each initiative. This makes it possible for the reader to evaluate how reasonable our interpretations were through identifying other potential ways to analyze the same material. In accordance with other qualitative scholars, we argue that this strengthens the overall trustworthiness of the study (37, 38).

# Conclusions

This study identified 17 diverse initiatives specifically targeting Sámi for suicide prevention in Norway (5 initiatives), Sweden (9) and Finland (1), as well as internationally (border-crossing) (2), during 2005-2019. Utilizing the WPR-approach, the analysis of strategies embedded within those initiatives

showed that suicide among Sámi was understood to take place because of a perceived lack on multiple levels, all suggested for suicide prevention by the WHO (individual, relational, community/cultural, societal and health systems levels). However, we argue that the dominant perspectives were individual-relational, as well as focusing on informing the general public, which might misplace the problem of suicide among Sámi in the sense that it simplifies the issue and risks obscuring critical approaches, such as including local, Sámi and Indigenous youth perspectives in prevention planning, improving health systems for Sámi, and seeking to promote cultural empowerment among Sámi. Furthermore, the lack of prevention rationales addressing certain issues included in the Sámi-specific prevention plan (lateral violence among Sámi, ethnic discrimination of Sámi, historical trauma inflicted due to colonial practices and exclusion of Sámi with non-conforming sexual or gender identities) led us to question if those have been considered too critical or challenging towards Sámi or majority societies, preventing initiatives from addressing them. However, we acknowledge that the identified findings confirm that there has been considerable effort invested in preventing suicide among Sámi during the last 15 years, and with the development of the Sámi-specific prevention plan (released 2017), future initiatives might potentially align their priorities with its full spectrum of strategies. Also, if the evidence base for suicide prevention among Sámi is to be strengthened and promising practices identified, it is important to improve the evaluation of prevention activities. For this to happen, we suggest that initiative administrators need structural support as regards developing evaluation plans and implementing them.

# List of Abbreviations

ASIST Applied Suicide Interventions Skills Training

MHFA Mental Health First Aid

NGO Non-governmental organization

WHO World Health Organization

WPR "What is the problem represented to be?"

# Declarations

## Ethics approval and consent to participate

Not applicable. For discussion of ethical aspects pertaining to Sámi collective rights and needs, see the Methods section.

## Consent for publication

Not applicable

## Availability of data and materials
Project reports (in Scandinavian and/or English languages) used during the current study are available from the corresponding author on reasonable request.

## Competing interests
The authors declare that they have no competing interests.

## Funding
This work was supported by Northern Norway Regional Health Authority under Grant PFP1297-16.

## Authors' contributions
JPAS led conception, design and analysis of data; gathered data in Sweden; and drafted and revised the manuscript. HAE gathered data in Finland and revised the manuscript. ACS gathered data in Norway and revised the manuscript. All authors read and approved the final manuscript.

## Acknowledgement
The authors would like to thank Professor Lars Jacobsson at the Division of Psychiatry, Department of Clinical Science; Professor Miguel San Sebastián at the Department of Epidemiology and Global Health and Várdduo – Centre for Sámi Research; Professor Isabel Goicolea and Ida Linander, also at the Department of Epidemiology and Global Health, all at Umeå University, for reading and commenting on earlier drafts of this manuscript.

## Authors' information
While currently affiliated with the Department of Epidemiology and Global Health at Umeå University and the Centre for Sámi Health, Department of Community Medicine at UiT – the Arctic University of Norway, during most of the time for writing this article, JPAS was an employee of Sámi Norwegian National Advisory Unit for Mental Health and Substance Use (SANKS), Finnmark Hospital Trust, Karasjok, Norway.

1. Young TK, Revich B, Soininen L. Suicide in circumpolar regions: an introduction and overview. Int J Circumpolar Health. 2015;74:27349.
2. Hassler S, Johansson R, Sjolander P, Gronberg H, Damber L. Causes of death in the Sami population of Sweden, 1961-2000. Int J Epidemiol. 2005;34(3):623-9.
3. Silviken A, Haldorsen T, Kvernmo S. Suicide among indigenous Sami in Arctic Norway, 1970-1998. Eur J Epidemiol. 2006;21(9):707-13.
4. Soininen L, Pukkola E. Mortality of the Sami in northern Finland 1979-2005. Int J Circumpolar Health. 2008;67(1):43-55.
5. Jacobsson L, Stoor JPA, Eriksson A. Suicide among reindeer herding Sámi in Sweden, 1961–2017. Int J Circumpolar Health. 2020;79(1):1754085.
6. World Health Organization. National suicide prevention strategies: progress, examples and indicators. Geneva, Switzerland; 2018.
7. World Health Organization. Preventing suicide: a global imperative. Geneva, Switzerland; 2014.
8. Collins PY, Delgado RA, Jr., Apok C, Baez L, Bjerregaard P, Chatwood S, et al. RISING SUN: Prioritized Outcomes for Suicide Prevention in the Arctic. Psychiatr Serv. 2019;70(2):152-5.
9. Arctic Council Sustainable Development Working Group. Sharing hope. Circumpolar Perspectives on Promising Practices for Promoting Mental Wellness and Resilience.; 2015.
10. Clifford AC, Doran CM, Tsey K. A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand. BMC Public Health. 2013;13:463.
11. Dudgeon P, Milroy JA, Calma TA, Luxford Y, Ring I, Walker R, et al. Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. Crawley, Australia: School of Indigenous Studies, University of Western Australia; 2016.

12. Wexler L, Chandler M, Gone JP, Cwik M, Kirmayer LJ, LaFromboise T, et al. Advancing suicide prevention research with rural American Indian and Alaska Native populations. Am J Public Health. 2015;105(5):891-9.
13. Stoor JPA, Berntsen G, Hjelmeland H, Silviken A. “If you do not birget [manage] then you don’t belong here”: a qualitative focus group study on the cultural meanings of suicide among Indigenous Sámi in arctic Norway. Int J Circumpolar Health. 2019;78(1):1565861.
14. Stoor J, Kaiser N, Jacobsson L, Salander-Renberg E, Silviken A. "We are like lemmings": making sense of the cultural meaning(s) of suicide among the indigenous Sami in Sweden. Int J Circumpolar Health. 2015;74:27669.
15. Inuit Tapiriit Kanatami. National Inuit Suicide Prevention Strategy. 2016.
16. Australian Government. National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Canberra, Australia: Department of Health and Aging; 2013.
17. Helsedirektoratet. Handlingsplan for forebygging av selvmord og selvskading 2014–2017. Oslo, Norway: Helsedirektoratet; 2014.
18. Socialstyrelsen, Statens Folkhälsoinstitut. Förslag till nationellt program för suicidprevention – befolkningsinriktade och individinriktade strategier och åtgärdsförslag. Stockholm, Sweden; 2006.
19. Sámi Norwegian National Advisory Unit on mental Health and Substance use, Saami Council. Plan for Suicide Prevention among the Sámi People in Norway, Sweden, and Finland. Karasjok, Norway: Sámi Norwegian National Advisory Unit on mental Health and Substance use; 2017.
20. Redvers J, Bjerregaard P, Eriksen H, Fanian S, Healey G, Hiratsuka V, et al. A scoping review of Indigenous suicide prevention in circumpolar regions. Int J Circumpolar Health. 2015;74:27509.
21. Stoor J. Kunskapssammanställning om psykosocial ohälsa bland samer [Compilation of knowledge on psychosocial health among Sami]. Kiruna, Sweden: Sametinget; 2016.
22. Bacchi C. Poststructural Policy Analysis : A Guide to Practice. 1st ed. 2016. ed. Goodwin S, editor. New York: Palgrave Macmillan US; 2016.

23. Ridani R, Shand FL, Christensen H, McKay K, Tighe J, Burns J, et al. Suicide prevention in Australian Aboriginal communities: a review of past and present programs. Suicide and Life-Threatening Behavior. 2015;45(1):111-40.
24. World Health Organization. Public Health Action for the Prevention of Suicide: a Framework. Geneva, Switzerland: WHO Document Production Services; 2012.
25. Stordahl V, Tørres G, Møllersen S, Eira-Åhren I-M. Ethical guidelines for Sami research: the issue that disappeared from the Norwegian Sami Parliament's agenda? 74. 2015.
26. Drugge A-L. How Can We Do it Right? Ethical Uncertainty in Swedish Sami Research. Journal of Academic Ethics. 2016:1-17.
27. Jacobsson L. Is there a special ethics for Indigenous research? In: Drugge A-L, editor. Ethics in Indigenous Research, Past Experiences - Future Challenges. Sámi Dutkan. 7 ed. Umeå, Sweden: Vaartoe - Centre for Sami Research; 2016. p. 45-56.
28. University of the Arctic. Report: Workshop on developing guidelines for Arctic research ethics 2018 [June 17 2019]. Available from: https://www.uarctic.org/news/2018/2/report-workshop-on-developing-guidelines-for-arctic-research-ethics/.
29. Juutilainen SA. Structural racism and indigenous health. A critical reflection of Canada and Finland. Oulu, Finland: Oulu University; 2017.
30. Kvernmo S, Strøm Bull K, Broderstad A, Rossvoll M, Eliassen B-M, Stoor J. Proposal for Ethical Guidelines for Sámi Health Research and Research on Sámi Human Biological Material. Karasjok, Norway: Sámediggi/Sámi Parliament of Norway; 2017.
31. Kaiser N, Salander Renberg E. Suicidal expressions among the Swedish reindeer-herding Sami population. Suicidology online. 2012;3:114-23.
32. Omma L, Sandlund M, Jacobsson L. Suicidal expressions in young Swedish Sami, a cross-sectional study. Int J Circumpolar Health. 2013;72:19862.
33. Bergman E, Lindquist S. Queering Sápmi. Samiska berättelser bortanför normen. Umeå, Sweden: Qub förlag; 2013.
34. Wexler LM, Gone JP. Culturally responsive suicide prevention in indigenous communities: unexamined assumptions and new possibilities. Am J Public Health. 2012;102(5):800-6.
35. Wexler L, White J, Trainor B. Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach. Critical Public Health. 2015;25(2):205-17.
36. The Aboriginal and Torres Strait Islander Suicide Prevention Project. Indigenous Suicide Prevention Activity Evaluation Framework. ;2016
37. Graneheim UH, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: A discussion paper. Nurse Educ Today. 2017;56:29-34.
38. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105-12.

# Appendix 1

*Supplementary Table 1. Descriptive characteristics of suicide prevention initiatives targeting Sámi in Sweden.*

| **Initiative** | **Samiskt krisnätverk [Swedish: Sámi crisis network]** | **Vaajmoe [south Sámi: heart]** | **Piloting Mental Health First Aid in Västerbotten, Sweden** | **Biegganjunni [north Sámi: whirlwind]** | **Aktavuohta [Lule Sámi: to be in contact with someone]** | **Kunskapsnätverk för samisk hälsa [Swedish: Knowledge network for Sámi health]** | **Mannen myten och Sáminuorra [Swedish: The man the myth and Sáminuorra]** | **Occupational health and safety plans in reindeer herding communities in Sweden** | **Folkmöte om suicidproblematik [Swedish: Public meeting on suicidality]** |
|---|---|---|---|---|---|---|---|---|---|
| **Program administrator** | Swedish church | Sáminuorra (Sámi youth association in Sweden) | Socialpsykiatrisk centrum, Region Västerbotten | Sámiid Riikasearvi (The National Association for Sámi in Sweden) | Sámiid Riikasearvi (The National Association for Sámi in Sweden) | Region Norrbotten, Region Västerbotten, Region Jämtland och Härjedalen, Region Dalarna in collaboration with Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS), the Sámi parliament in Sweden and Sámi NGOs in Sweden. | MÄN (a Swedish NGO for men to act against men's violence towards women) in collaboration with Sáminuorra (Sámi youth association in Sweden) | Sámiid Riikasearvi (The National Association for Sámi in Sweden) | SANKS, Norrskenet primary health care centre, Swedish church (Vittangi congregation), Knowledge network for Sámi health, and Sohppar Sámisearvi (Association for Sámi in Soppero) |
| **Source of information** | Project reports (2) | Project report, first-hand account. | Project report, emails with organizers. | Project report, first-hand account. | Project report, first-hand account. | Project report, phone calls and emails with organizers. | First-hand account | Project report. | First-hand account |
| **Year(s)** | 2007-2017 | 2010-2015 | 2012 | 2012-2013 | 2014-2015 | 2017- | 2018- | 2018- | 2019 |
| **Country** | Sweden | Sweden | Sweden | Sweden | Sweden | Sweden | Sweden | Sweden | Sweden |
| **Target group for suicide prevention** | At-risk Sámi in Sweden | Sámi youth in Sweden | Sámi reindeer herding community members in Västerbotten county, Sweden. | Young Sámi reindeer herding men in Sweden (17-35 years of age) | Young Sámi reindeer herders in Sweden (18-25 years of age) | Sámi health care personnel and providers in Swedish Sápmi. Sámi in Norrbotten, Västerbotten, Jämtland and Härhedalen, and Dalarna counties. | Young Sámi men in Sweden (16-30 years of age) | Members of Sámi reindeer herding community of Raedtevaerie, Sámi in Sweden (leaflet) | The Sámi population of upper Torne river valley, in Sweden |

| Initiative | Samiskt krisnätverk [Swedish: Sámi crisis network] | Vaajmoe [south Sámi: heart] | Piloting Mental Health First Aid in Västerbotten, Sweden | Biegganjunni [north Sámi: whirlwind] | Aktavuohta [Lule Sámi: to be in contact with someone] | Kunskapsnätverk för samisk hälsa [Swedish: Knowledge network for Sámi health] | Mannen myten och Sáminuorra [Swedish: The man the myth and Sáminuorra] | Occupational health and safety plans in reindeer herding communities in Sweden | Folkmöte om suicidproblematik [Swedish: Public meeting on suicidality] |
|---|---|---|---|---|---|---|---|---|---|
| **Project aim/ mission** | Deliver easy access to crisis support by Sámi volunteers. | Yoik and sing for cultural empowerment and supporting each other, as well as to raise awareness of mental health and suicidality among Sámi youth | Pilot the Mental Health First Aid (MHFA) course in Sweden, train 2000 individuals and evaluate the program. Within this program, to train Sámi gate keepers in the Mental Health First Aid program. | Arrange inspirational workshops for young reindeer herding men, promoting gender equality. Strengthen peer support through sharing and talking about life experiences. Strengthen mental well-being through teaching conflict management skills. | Spread information about life as a young reindeer herder. Create a network for young Sámi reindeer herders, arrange educational workshops for them, including to share survivors' stories, educate in conflict negotiation techniques and mental health promotion. | Strengthening health care practitioner's knowledge in Sámi health to improve quality and access for Sámi patients. To train Sámi health personnel to be MHFA instructors and train Sámi in the program. | Challenge destructive masculinity in a Sámi context, including to strengthen social support between young men, culturally empower them through arranging a yoik workshop and train them to use yoik as a tool for emotional regulation. | Supporting a Sámi reindeer herding community (RHC) to create and implement an occupational health and safety plan as a pilot. Using the experience of the pilot to support other RHCs to do the same. Producing a leaflet on suicide prevention among Sámi to be distributed to Sámi in Sweden. | Raise awareness about suicide and train the public in the SafeTALK program |
| **Delivery methods including participants, if available** | Telephone service manned by Sámi volunteers on Friday and Sunday nights | Three workshops, three recording sessions for a CD recording. An unknown number of less organized gatherings | One two-day MHFA course was carried out with participants from one Sámi reindeer herding community. | Three two-day workshops focused on strengthening peer support and conflict management | Nine women and 11 men participated in six two-day workshops (of which one primarily focused on promoting psychosocial well-being), a Facebook group for in-group communication, and an Instagram account for spread of information to the general public. | Creating a network for knowledge transfer among health care practitioners in the regional health care authorities in Sápmi (on the Swedish side). Developing a digital Internet-based tool for providing cultural training for health care personnel in Sámi areas. Seven Sámi health workers were | About 10 men participated in one yoik workshop focused on exploring yoik (traditional singing) as a tool for emotional regulation. | A consultant conducted interviews and group consultations used for creating an occupational health and safety plan. A leaflet with articles on suicide awareness was distributed along with monthly | A public meeting on suicidality and a half-day SafeTALK workshop in Övre Soppero, Norrbotten county (40 persons). |

| Initiative | Samiskt krisnätverk [Swedish: Sámi crisis network] | Vaajmoe [south Sámi: heart] | Piloting Mental Health First Aid in Västerbotten, Sweden | Biegganjunni [north Sámi: whirlwind] | Aktavuohta [Lule Sámi: to be in contact with someone] | Kunskapsnätverk för samisk hälsa [Swedish: Knowledge network for Sámi health] | Mannen myten och Sáminuorra [Swedish: The man the myth and Sáminuorra] | Occupational health and safety plans in reindeer herding communities in Sweden | Folkmöte om suicidproblematik [Swedish: Public meeting on suicidality] |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | trained to be MHFA instructors. Three two-day MHFA courses were carried out. | | Sámi media "Samefolket". | |
| **Evaluation (main content)** | The hotline was used 52 times during 2007 to 2010 and one time between 2015 and mid-2016. No measures in between. Low usage rate was attributed to low professionalism in service deliverance (no supervision for volunteers). The service was shut-down due to low usage of service | Project report includes some process evaluation, in which project coordinators report participants growing personally and as a group. It is also mentioned that the project generated media attention, thus contributing to raising awareness | The national project included a randomized controlled trial and a focus group study, but no analysis was conducted on delivering MHFA to Sámi specifically. However, one planned MHFA course with members from different reindeer herding communities was canceled due to low turnout of participants. | Project report includes some process evaluation, stating that activities were carried out as planned and a majority of participants reporting having enjoyed taking part in the project | Project report includes process evaluation, which included reports of participants being very positive to having taken part in the project, some describing it as "life changing." Generally, the project was carried out according to plan, with exception of one workshop (out of six) where several facilitators fell ill at the same time | Process evaluation suggests difficulties in recruiting participants for MHFA courses. In improving this Region Jämtland Härjedalen will be developing a new program based on mental health literacy training combined with traditional Sámi handicraft (Vætnoe) | On-going project. The planned workshop was postponed due to too few planning to attend. Higher turnout (about 10 participants) was achieved after partnering with a Sámi education institute | No evaluation was performed, but fewer activities than planned were carried out due to long start-up, which was related to a great need to inform the consultant of the Sámi reindeer herding culture and context | Not available |

# Appendix 2

*Supplementary Table 2. Descriptive characteristics of suicide prevention initiatives targeting Sámi in Norway, Finland and internationally.*

| **Initiative** | **Samisk psykiatrisk ungdomsteam (PUT) [Norwegian: Sámi Psychiatric Youth team]** | **Åpenhet og nærhet,(Norwegian: Openness and Intimacy)** | **Public meetings and ASIST in South Sámi areas** | **Finnmark – et selvmordstryggere samfunn [Norwegian: Finnmark – a suicide safe society]** | **Adaptation of SafeTALK to Northern Sámi** | **EALLIN [North Sámi: Life]** | **Selvmordsforebygging i Sápmi / Preventing suicide in Sápmi** | **Circumpolar Resilience, Engagement and Action Through Story (CREATeS)** |
|---|---|---|---|---|---|---|---|---|
| **Initiative administrator** | Sami Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS), Finnmark hospital trust, Norway. | A local consortium led by the municipality (health and social services and the school), including local associations, Leve Finnmark and Mental Helse, and Sami Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS). | Sami Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS) | County governor of Finnmark, Northern Norway Violence, Traumatic Stress and Suicide Prevention Resource Centre (RVTS Nord), Sami Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS) | VIVAT Selvmordsforebygging in cooperation with the Regional resource centres for Violence, Traumatic Stress and Suicide Prevention in Northern and Mid Norway (RVTS Nord and RVTS Midt) and SANKS | Utsjok primary Health care centre | Sami Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS) and Saami Council | Inuit Circumpolar Council (ICC), Finland and Canada, under the Arctic Council Sustainable Development Working Group (SDWG). |
| **Source of information** | Service description in other report. First-hand account. | Project report. First-hand account. | First-hand account. | Project report, first-hand account. | First-hand account. | First-hand account. | Project report (prevention plan). First-hand account. | Project report |
| **Year** | 1990-2020 | 2007-2008 | 2010 - 2011 | 2013-2015 | 2018 - | 2017-2018 | 2015-2017 | 2018-2019 |
| **Country** | Norway | Norway | Norway | Norway | Norway | Finland | International | International |
| **Project aim/ mission** | Deliver easy access psychiatric treatment of suicidality and drug use, which meets the needs of culturally and language | Implementation of a multilevel approach to suicide prevention among youth and adults in Tana municipality, including training gate keepers in the Applied Suicide Intervention Skills Training (ASIST) program, reduce vulnerability to suicide and strengthen resilience in youth by | Raise awareness about suicide and train gate keepers in the Applied Suicide Intervention Skills Training (ASIST) program | Raise awareness about suicide and train gate keepers in the Applied Suicide Intervention Skills Training (ASIST) program | Develop a northern Sámi adaptation of the SafeTALK program, adapted to Sámi culture and available in Northern Sámi language. | Train gatekeepers in the Applied Suicide Intervention Skills Training (ASIST) program | Create a plan for suicide prevention among Sámi in Norway, Sweden and Finland. | To create stories for youth engagement and knowledge translation to support the suicide prevention and mental wellness efforts of the Arctic States. Create and share digital stories related to suicide from |

| Initiative | Samisk psykiatrisk ungdomsteam (PUT) [Norwegian: Sámi Psychiatric Youth team] | Åpenhet og nærhet,(Norwegian: Openness and Intimacy) | Public meetings and ASIST in South Sámi areas | Finnmark – et selvmordstryggere samfunn [Norwegian: Finnmark – a suicide safe society] | Adaptation of SafeTALK to Northern Sámi | EALLIN [North Sámi: Life] | Selvmordsforebygging i Sápmi / Preventing suicide in Sápmi | Circumpolar Resilience, Engagement and Action Through Story (CREATeS) |
|---|---|---|---|---|---|---|---|---|
| | competent care for young Sámi | early recognition and referral for mental health issues, supporting an active lifestyle for identified at-risk youth, mental health literacy training in school, strengthen peer support through creating meeting places for well-being. | | | | | | the perspective of Arctic Indigenous youth |
| **Target group for suicide prevention** | At-risk young population (15-30 years of age) in Sámi core areas in Northern Norway, and Sámi throughout Norway (some service delivery in Sweden via distance bridging technology). | The general and at-risk youth and adult population of Tana municipality (Sámi and non-Sámi), Norway. | The Sámi population in south Sámi areas in Norway. | The general population of Finnmark county, including the population of Sámi core areas in Norway. | Sámi in Norway. | Sámi in Finland. | Sámi in Norway, Sweden and Finland | Arctic Indigenous youth. Sámi youth from Norway, Sweden and Finland (18-25 years of age). |
| **Delivery methods including participants, if available** | Psychiatric outpatient services in person and/or with distance bridging technology. | Five ASIST courses, with 85 participants (20% men). Mental health literacy training in school for older kids, "Zippy's friends" curriculum for young kids (focusing on developing coping skills), and information meetings at the youth club. Screening of mental health in 9th grade and follow-up talks with school nurse for referral. Outdoor fun physical activities (canoeing, dog-sledding, snow-boarding, kiting, rock climbing, etc.) for specifically targeted youth (13-25 years of | An unknown number of public meetings on suicide prevention, combined with an unknown number of ASIST courses. | Ten public meetings on suicide prevention, combined with 13 ASIST courses, in nine of the municipalities in Finnmark, including in Sámi core areas (Kautokeino, | Development of Northern Sámi adapted SafeTALK program. | Six ASIST courses delivered in northern Finland. | Reviewing literature on suicide and suicidality among Sámi in Norway, Sweden and Finland. Conducting consultations with Sámi grassroots involved in suicide prevention and developing a plan for suicide prevention based on available literature and | Six Sámi participated in two digital storytelling workshops (one in Finland) and one knowledge translation workshop. |

| Initiative | Samisk psykiatrisk ungdomsteam (PUT) [Norwegian: Sámi Psychiatric Youth team] | Åpenhet og nærhet,(Norwegian: Openness and Intimacy) | Public meetings and ASIST in South Sámi areas | Finnmark – et selvmordstryggere samfunn [Norwegian: Finnmark – a suicide safe society] | Adaptation of SafeTALK to Northern Sámi | EALLIN [North Sámi: Life] | Selvmordsforebygging i Sápmi / Preventing suicide in Sápmi | Circumpolar Resilience, Engagement and Action Through Story (CREATeS) |
|---|---|---|---|---|---|---|---|---|
| | | age). Information meetings regarding suicide and mental health with local village associations. Set up of local association for bereaved. Local events on international suicide prevention days. Creation of Tana municipality plan for suicide prevention (including most activities listed above). | | Karasjok, and Tana/Nesseby). | | | consultations. Plan released March 2017. | |
| **Evaluation (main content)** | According to a report from 2015 (not updated), the service serves 80-120 patients per year, and no patients have died by suicide while being a patient (no follow-up). Service discontinued in 2020. | Project report includes process evaluation, which showed most planned activities were carried out according to plan, while recruiting men to ASIST courses was difficult, even with approx. 80 specifically selected men being invited. Success factors are reported to have been: local leadership, high sense of urgency and commitment from municipality and local organizations, and support from outside professionals (SANKS and RVTS-Nord). | Not available | Evaluation showed that 298 persons (unknown ethnicity) took the ASIST courses, and t the project appeared in 17 media pieces, of which six where in Sámi media. A questionnaire given to participants got too few responses for meaningful statistical evaluation and was hence not reported. | Not available (on-going project) | Not available | Not available | Project report includes process evaluation, which showed activities had been carried out according to plan, and participating youth reporting finding it challenging, meaningful, positive and enjoyable to take part in the project. |

# Appendix 3

*Supplementary Table 3. Problematizations, category and level of intervention suggested, yielded through applying the "What is the problem represented to be?"-approach on suicide prevention initiatives targeting Sámi in Norway, Sweden and Finland.*

| Problematizations | Category | Level |
|---|---|---|
| Young Sámi men do not have enough tools for emotional regulation | Lack of individual protective skills and active lifestyle | **Individual** |
| Sámi (and non-Sámi) youth at risk of suicidality do not have an active enough lifestyle | | |
| Sámi (and non-Sámi) young kids do not have enough coping skills to deal with life's challenges, conflicts and mental health issues | | |
| Young reindeer herders do not have good enough skills to take care of themselves/increase mental well-being | | |
| Young male reindeer herders do not have good enough conflict management skills | | |
| Sámi youth do not have enough access to peer-support | Lack of peer support | **Relational** |
| Young male reindeer herders do not have enough access to peer support | | |
| Young reindeer herders do not have enough access to peer support | | |
| Young Sámi men do not have enough access to peer support | | |
| At-risk Sámi do not have enough access to adapted crisis support (telephone helpline run by Sámi volunteers) | | |
| Reindeer herding Sámi do not have enough knowledge to recognize individuals with a mental health and substance use-related crisis and to intervene, including referring to professionals | | |
| Sámi do not have enough knowledge to recognize individuals with a mental health and substance use-related crisis and to intervene, including referring to professionals | | |
| Sámi do not have enough knowledge to recognize when someone is thinking about suicide and connect them to an intervention provider | | |
| Sámi and non-Sámi do not have enough knowledge and skills to recognize persons at-risk of suicide and to intervene, including referring to professionals | | |
| Sámi do not have enough knowledge and skills to recognize persons at-risk of suicide and to intervene, including referring to professionals | | |
| Sámi do not have enough knowledge and skills to recognize persons at-risk of suicide and to intervene, including referring to professionals | | |
| Sámi needs culturally and language-wise adapted course curriculum to recognize signs of suicidality, engaging individuals in talking about it, and connecting them to an intervention resource | | |
| Sámi (and non-Sámi) do not have enough knowledge and skills to recognize persons at-risk of suicide and to intervene, including referring to professionals | | |
| Sámi (and non-Sámi) school kids do not have enough knowledge regarding how to support each other for improved mental health | | |
| Sámi (and non-Sámi) bereaved by suicide do not have enough peer support | | |
| Sámi reindeer herding communities do not work enough on occupational health and safety | Lack of occupational health and safety | **Community/Culture** |
| Sámi youth are not culturally empowered enough | Lack of cultural empowerment | |
| Young Sámi men are not culturally empowered enough | | |
| Indigenous youth are not enough included in knowledge translation regarding suicide prevention in the Arctic | Lack of suicide prevention planning and perspectives | **Societal** |
| Sámi reindeer herding communities are not structured enough in their occupational health and safety efforts | | |
| Suicide prevention for Sámi (and non-Sámi) is not enough strategized on the local level | | |
| Sámi-specific suicide prevention needs are not addressed by existing general (universal) suicide prevention work | | |
| Suicide prevention among Sámi is not strategized enough for effective prevention | | |

| Problematizations | Category | Level |
|---|---|---|
| The general public is not enough aware enough of mental health and suicide among Sámi youth | Lack of awareness in general public (Sámi and non-Sámi) | **Societal** |
| The general public is not aware enough of the lives of young reindeer herders | | |
| The general public is not aware enough of how Indigenous youth understand suicide in the Arctic | | |
| Sámi are not aware enough of the issue of suicide among them | | |
| Sámi and non-Sámi are not aware enough of the issue of suicide among them | | |
| Sámi are not aware enough of the issue of suicide among them | | |
| Sámi public are not aware enough of suicide among them | | |
| Sámi (and non-Sámi) are not aware enough of suicide among them | | |
| The general public is not aware enough of the issue of suicide among Sámi | | |
| Young Sámi at-risk population do not have enough access to Sámi-specific (culturally and language adapted) psychiatric treatment of suicidality and drug abuse | Lack of adapted, accessible clinical services | **Health systems** |
| Health care personnel are not knowledgeable enough in regards to Sámi health, to be able to deliver good enough quality and access to care to Sámi patients | | |
| Sámi (and non-Sámi) youth at-risk of mental health issues are not recognized and referred to psychiatric services to a large enough extent by school health services | | |

# Errata

In Paper I, it is erroneously claimed that all the participants in the study were Sámi; in the abstract (‘22 strategically selected Sami participants’) and under the heading ‘Sample’ (‘Altogether 22 Sami PTs were recruited’). This was not the case, and ‘Sámi participants/PTs’ should be changed to ‘Sámi (21) and non-Sámi participants (1)’.

In Paper II, under the heading ‘Suicide among Indigenous peoples in the Arctic and Sápmi’, the sentence ‘As is the case among many other Indigenous people in the Arctic; ‘harder’ methods (including weapons and hanging), suicide clusters, and elevated suicide rates for young men are found more commonly among Sámi than in majority populations’ should not include the words ‘suicide clusters’. It should also specify to which Sámi populations we referred, changing the last part of the sentence to read ‘among Sámi in Norway, and reindeer herding Sámi in Sweden, than in majority populations. References should also include Silviken et al. (2006) and Jacobsson et al. (2020).