

### 3. An Anthropology of Suicide

Thus even the author of the entry on suicide in the *Encyclopaedia of Religion and Ethics* writes, with unconcealed relief: 'Perhaps the greatest contribution of modern times to the rational treatment of the matter is the consideration ... that many suicides are non-moral and entirely the affair of the specialist in mental diseases.' The implication is clear: modern suicide has been removed from the vulnerable, volatile world of human beings and hidden safely away in the isolation wards of science.

—A. Alvarez<sup>1</sup>

#### 1. Science and suicide

Methodology has always been a problem for the humanities and social sciences, which feel that they miss out or are inadequate in the face of the 'scientific method' of the natural and biological disciplines. While not perceiving their work as illegitimate or invalid, they wish it were more amenable to demonstrable proof. If they could quantify, preferably mathematically and statistically, they seem to say—they would have validity, and thence legitimacy, the essential quality of physics, chemistry, geology and some branches of medicine. Even that doyen of American political science, Harold Lasswell, tried to reduce the study of politics to a 'science' of 'decision-making', believing that if each decision could somehow be reduced to an atomistic, measurable reality, then, with appropriate tags, we could watch the process of a decision—its formulation, adoption, implementation and consequences. He forgot that many decisions are not decisions and do not lend themselves to such analysis since they remain withdrawn, abandoned, hidden or unreported. For example, my decision on what material to omit from this report is known only to me, and therefore cannot be 'tagged'.

Most suicide studies are preoccupied with numbers—in percentages or as rates. Some go to the lengths of being 'double blind', or at least, controlled studies. Several Aboriginal projects have been rejected by grant-giving bodies because the applicants were not able to design a study using a non-Aboriginal control group. *There are simply no other groups whose backgrounds and circumstances so match the Aboriginal experience that the effects of any causative factor can be studied.* Aboriginal birth, life and death differ so much in quality from the non-Aboriginal that attempts at explanation through quantification are futile. So, too, is Aboriginal suicide.

#### 2. Suicide and the Royal Commission

Suicide is often the province of statisticians. In Australia, it has also largely remained in what Alvarez calls 'isolation wards'. The RCIADIC was the first major exercise to begin to identify Aboriginal suicide in a context beyond confinement. Of the Report's 2,277 pages, 569 traverse 'the underlying issues which explain the

disproportionate number of Aboriginal people in custody'. The Commission summarises, in one excellent volume, all there is to be said about Aboriginal incarceration, but says very little indeed about suicide outside of custody. It examines:

- 'the legacy of history';
- aspects of contemporary Aboriginal life, including the status of Aborigines;
- demographic and social indicators of health, income, housing;
- indigenous mechanisms of social control;
- Aboriginal identity;
- relations with the non-Aboriginal community;
- Aborigines in the criminal justice system and relations with the police;
- young Aboriginal people in the criminal justice system;
- the harmful use of drugs and alcohol;
- schooling;
- employment and poverty;
- land needs; and
- the issue of self-determination.

Only thirteen pages are devoted to 'Pretended Suicide' (a term I find unacceptable), 'Reasons for Suicide' and 'Epidemic and Multiple Self-Inflicted Deaths'.<sup>2</sup> Even so, much of the material—admittedly summarised from lengthy submissions—deals with factors relevant to the individual deceased who came within the terms of reference. There is little discussion of youth suicide outside of custody, or about its possible causation. While the Commission was, admittedly, confined to suicide in custody, its discussion of suicide outside of custody is peripheral and almost irrelevant.

The section begins with what can be called the classic 'silly buggers' explanation. The 1987 *Report on Yarrabah Suicides* by A. F. Wattridge, a public servant, was a Commission exhibit. In part, Wattridge wrote:

the usual purpose of the suicide attempt is to seek and/or regain the attention and affection of a boyfriend or girlfriend after a quarrel ... It is fairly common on communities for men to shoot themselves through the fleshy part of the upper arm with a .22 rifle. This action gains maximum sympathy from girlfriends ... Stabbing or slashing of the arm, leg or chest are common methods of 'attempting suicide'. Again there is usually no major damage unless an artery is accidentally severed.<sup>3</sup>

For not entirely clear reasons, the Commission called this form of ambivalent suicide, 'pretended suicide'—that is, there was 'no intention of killing oneself and ... it occurs under an impulse of strong emotion, such as helplessness or desperation'. The word 'pretend' is hardly consonant with so strong an emotion as 'desperation'.

The Commission then moves from ‘pretended’ suicide to the reasons for successful suicide. Admitting that psychiatric and psychological evidence given encompassed a ‘range of causal factors, underlying issues, and contextual phenomena’, there was clearly an acceptance that suicide relates to ‘multiple psychological stresses’, ‘long term stresses’ and ‘short term stresses’. Heavy drinking syndromes, ‘lack of self-esteem’, ‘the sense of failing oneself, one’s family or one’s community’ were suggested. Dr Joseph Reser’s theory of ‘reactance’ was posited: ‘the human tendency to attempt to restore freedom of action when it is taken away’. Later I will elaborate on this reason: ‘to imitate the style of suicide of one’s kin, friends or Aboriginal compatriots in other communities as a type of mass protest in opposition against the forces of authority and institutionalism.’ The Commission paid attention to the factors suggested in the Adelaide *Taking Control* study, particularly instability in parenting, unemployment and welfare dependence, ill-health and drug abuse, police involvement, physical and/or sexual abuse, anger, self-perception and their adverse perception by non-Aboriginal society.<sup>4</sup>

By comparison, the Maori prison inmate study examined such risk factors as psychological/psychiatric disorders, family, attempted suicide, possible biochemical and genetic factors, exposure to suicidal behaviour, stressful life events and triggers such as depression or shame. There is an interesting tension in New Zealand suicide research: on one hand, a strong drive to encapsulate all suicide as a form of mental disorder, or to give precedence to the psychiatric above the politico-social aspects; on the other, an insistence that cultural factors are the key. Thus, of importance is the suicide’s relationship to his *whanau* (extended family), his *wairua* (spirituality), his sense of *whakama* (shame), his *whakamomori* (state of mind that can result in suicide), his *iwi* (tribe) and his *hapu* (sub-tribe).

It is self-evident to say that suicide research is quintessentially guesswork. The dead can’t explain. Even when they do leave notes—and I have now read too many in coroners’ files—there is little in the way of communicating what really warranted the act. The behaviour exemplified by the 75-year-old man who carefully puts his affairs, his house and even the garbage in order, leaves a precise note as to why he now, with terminal cancer, cannot live without his recently deceased wife, is rare in any society. Aboriginal suicides rarely leave notes. In New South Wales, perhaps unlike the RCIADIC case studies, there is much less in the way of evident ‘pretended’ shooting in the fleshy arms. Nor is there any *systematic* study in New South Wales and the Capital Territory, as there has been in New Zealand, of parasuicides on their admission to or discharge from hospital casualty departments. Even if there were such ‘interviews’, it is doubtful whether a nurse, hospital orderly or even a trained health professional could elicit anything much better than the ‘I-feel-guilty-I’ll-confess-to-any-motivation-you-might-suggest-to-me’ response.

The Commission, like so many other studies, tended to confuse underlying factors, or personal or familial factors involved in a particular suicide, as reasons, explanations or motives for the action. There are many people whose lives are beset by these, or even more stressful factors, who do not commit or attempt suicide; conversely, many of those who appear to have endured none of these factors or stressors, do so.

### 3. The need for a broader focus

I am trained in several disciplines, but not psychology. Doubtless, individuals in trouble need personal help from people trained in psychiatry, psychology, social work and their related disciplines. But the patient-therapist relationship is, of necessity, confined to just that. It can't venture much beyond the individual and the immediate family. To understand why dozens of youth in a particular social or racial grouping take their own lives, and then to suggest ways of mitigating that behaviour, seems a reasonably sensible task: yet this 'group' task can only be approached by a discipline or disciplines that embrace something wider than the individual. This does not mean simply modifying the individual approach to make it suitable for group use. It means using whatever lenses are available to examine this behaviour in particular societal contexts, including the social, sporting, historic, geographic and political. Since a good deal of Aboriginal suicide occurs in clusters, we must examine the social context of the cluster and not merely that of the individual. Yet that pluralising of suicide promotes a class or group behaviour and detracts from the individual at risk.

Who or what comprises a cluster? Since the suicides do not occur in typical Durkheimian social isolation, or always in states of classical anomie or fatalism, we need to focus on the sort of society in which the suicides originate. Henry Morselli, Durkheim's predecessor, explained as long ago as 1879 that suicide was no longer 'the expression of individual and independent faculties, but certainly [is] a social phenomenon'.<sup>5</sup> Whatever amelioration psychiatric treatment might have wrought, it has not been able to stem the rapid rise in Aboriginal suicide rates.

### 4. Suicide in history

In 1621, Richard Burton's treatise on *The Anatomy of Melancholy* described suicide as tragic but nonetheless a fatal end common to those who suffered from melancholia. This medical model, or vision, was ignored. By the 1600s, suicide was one of the lowest possible criminal acts in Britain: the suicide 'is drawn by a horse to the place of the punishment and shame, where he is hanged on a gibbet, and none may take the body down but by the authority of the magistrate'.<sup>6</sup> Burial was usually at the crossroads so that carriages would trample the dead, by now seen as a vampire; and if that were not enough, a stake was driven through the heart and a stone placed over the deceased's face—to prevent any rising. A suicide was declared a *felon de se*, and his properties forfeited to the Crown rather than passing to his inheritors. This practice was abolished as late as 1882. Only in 1870 was the law about inheritance and property changed: lawyers invented, in effect, a protection against a silly law which not only deprived a suicide of the right to bequeath but also denied him a religious burial. The lawyers, not the doctors, devised the notion, and the fiction, that suicide occurred because 'the balance of his mind was disturbed'. Alvarez reminds us of Professor C. E. M. Joad's pertinent aphorism, relevant to so many countries until the middle of the twentieth century, 'that in England you must not commit suicide, on pain of being regarded as a criminal if you fail and a lunatic if you succeed.'

What was once a mortal sin and a criminal offence is now a private vice, something shameful, kept in the closet, something not mentioned if at all possible; as Alvarez puts it, ‘less self-slaughter than self-abuse’. Suicide ceased being criminal in Britain in 1961 and in Australian states essentially between five and twenty years ago.<sup>7</sup> Suicide, as disturbed balance of the mind, was to become, and remain, the domain of the psychiatrists, the clinical psychologists, a few sociologists and social workers, and a great many statisticians. With ‘depression’ and ‘stress’ now bywords in our Western society, suicide is seen as the extreme of both, and hence even more the domain of those who deal in these matters and who are in a position to prescribe antidepressants. There is a logical slippage in these perspectives of psychiatric and pharmaceutical treatment of ‘depression’: medication may relieve depression, but this does not mean that ‘depression’ is the cause of the suicidal impulse. There remains, however, a strong lay perception that the right pill will solve the problem.

The nineteenth century label of ‘unsound mind’ left the burden of suicide, in all its manifestations and consequences, with the medical professions. No one else wanted it and, surprisingly, the church was relieved to be absolved of an insoluble ‘moral’ and ‘mortal’ problem. Apart from the usual shibboleths about ‘misfits’, ‘wasted lives’, ‘tragedy’, or even ‘cost to the state’, one outstanding feature of young suicide is that it utterly rejects all of us—everything we can offer by way of love, family, a sense of belonging or of identity, learning, progress, creativity, leisure, pleasure, societal feelings, civility and civilisation and, not least, a belief in a future. The psychoanalyst James Hillman suggests that ‘suicide is the paradigm of [their] independence from everyone else’<sup>8</sup>. This is unacceptable to society at large and manifests as a counter rejection, on our part, of ‘them’.

## 5. Towards an anthropological approach

From the inception of my study, a number of researchers and policy-makers have expressed interest in how I gathered my data. Trained in political science, public administration and the law, I have also ‘practised’ as a sociologist. However, for this exercise, I found it necessary to move towards an anthropological approach: intensive fieldwork, heavy reliance on informants, visits to locales (double-checking with documents where possible), a degree of participant observation and, importantly, the use of what is called in German, *Verstehen*, one’s intuitive understanding of situations, especially when one has long experience. To use the old ‘onion’ metaphor, one must always be aware of what is clearly the outer layer of ‘truth’, of what comprises the second, third, fourth layers, and finally, an intuition when one is getting reasonably close to the centre. The finality of self-inflicted death blocks all knowledge of the individual’s deeper intentions and there is, therefore, no ultimate ‘truth’ to be found.

To all this must be added that, in matters of such personal intensity and sensitivity, trust is the key to people talking to the researcher. Police were wholly co-operative because they are either concerned about youth behaviour in general, or a little fearful lest this was another ‘custody’ probe, or relieved of insecurity by virtue of strong

letters of commendation about me from their senior Commissioners. Coroners were anxious to contribute, again out of concern at the escalating youth suicides, and in response to a letter from the Office of the State Coroner approving the research project. Doctors, nurses, mental health workers and juvenile justice staff were willing to discuss anything, with anyone, in the face of the problems confronting them. The Royal Commission has left a psychological scar on people. There was general relief when it was confirmed that we were examining suicide *outside of custody*.

Aboriginal trust is another matter. My wife Sandra and I were not threatening: presented as middle-aged grandparents, with some 36 years of working in Aboriginal societies. (Single people, especially younger men, can be seen as a threat.) We had no clipboards or tape recorders, and no vehicles with 'government' decals. My books on Aborigines in sport were reasonably well known, especially the picture book, *Black Diamonds*. Where communities had not seen the book, I gave them copies for their school or community hall, as something in return for what I was to ask for and take away. We would phone and/or fax ahead to a land council or medical service, inform an administrator that we wanted to talk about the problem of 'too many young people taking or trying to take their lives', and obtain permission to visit. Almost without exception, responses were eager, asking, in return, whether we would agree to a meeting, meaning a group session. These became more common: gatherings of anything from three to twenty people, where solidarity gave people the confidence to talk about their own children or relatives and, somewhat surprisingly, to volunteer their own experiences of mutilation and failed attempts at suicide. These meetings could last for two to three hours. I always explained that this research task was a 'mission impossible', but gave my assurance that I would do what I could, without being able to deliver any magical elixir. Everyone was enormously generous with information, their feelings, and the names of people we should contact. Sandra always asked if there was any objection to her taking notes. On the two occasions when there were objections, the notebooks were put away.

We were given abundant witness reports of suicidal behaviour, and first-person descriptions of attempted suicide. We did not ask those who had attempted suicide why they had acted as they did. People discussed family circumstances, their frustration, alienation, anger, and sometimes hatred; they talked openly about the hitherto unmentionable topics of drug abuse, child abuse, child molestation, incest, and the 'abdication' of parenting. They always talked of the need for local people to be trained in appropriate counselling.

[The research project was approved by Macquarie University's Ethics Committee. However, the ethical protocols do not allow, in advance, for such spontaneous meetings, for unexpected networking and unforeseeable expressions about suicide attempts. Nor, I would add, should they try to cover every contingency.]

The 'isolation wards of science' usually require that all information be reduced to numbers—otherwise the method is regarded as merely 'anecdotal'. That word no longer means a narrative of or about an event, but rather a story, or a 'story', bordering

on hearsay, clearly unreliable because it is ‘unverifiable’. Rather than put as much objective distance between myself and the subject matter, I always choose to make the relationship as close and subjective as possible. Trust produces more layers of truth than any other methodology, and in this most intimate of studies, it is the most important relationship.

Trust is also a matter of patience. In this field of work, one has to stay around a while, be seen in cafes and supermarkets, in pubs, poolrooms, craft and cultural centres, at football practice or at the matches, in hospitals, talking to people, getting the feel of a town and its tensions, however superficially. Where are you from? and what are your connections? are Aboriginal questions as pertinent to me as to any newly-arrived Aborigine.

Our fieldwork notes were typed and edited. I intend placing copies, under restricted conditions of access, in the library of the Australian Institute for Aboriginal and Torres Strait Islander Studies in Canberra. While suicide files in coroners’ courts are matters of public record, the notes contain names which are not for public knowledge. I have chosen not to reveal any names. No one insisted on this confidentiality: the insistence is mine. In this report, I have, where necessary, used invented initials to disguise identity. I have also avoided, except where the term is used in documents, *indigenous* or *Indigenous* suicide, for the reasons given earlier.

## **6. The sample in this study**

Appendixes I and II list the communities visited and the people interviewed in depth. Between July 1997 and October 1998, 55 communities were visited in New South Wales and the Australian Capital Territory (Walgett and Forbes had one suicide each, and those cases are included in Table II below). Two locations, Wollongong and Newcastle, were ‘visited’ only in the sense of examining deaths in the files of the Office of the State Coroner in Glebe. The two cities are too large, and the Aboriginal populations too scattered, to obtain the same kind of results as in rural and remote centres. The centres visited were carefully selected on the basis that there were reliable census figures for the Aboriginal and non-Aboriginal populations; that we knew something of the histories of these communities and something of their repute as ‘good’ towns or ‘bad’ towns (that is, good for Aborigines or places of tension and overt discrimination); and that some were on the coast, some inland, some in the central west and some in the far west. In retrospect, there were a few weaknesses in the selection: the choice of Dungog, believed to have a small Aboriginal population but which, in effect, has none; the omission of the cluster of towns in southern central New South Wales, namely, Griffith, Leeton, Narrandera, Wagga and Junee; and the omission of visits to Blacktown, Bankstown, Redfern, Parramatta and Penrith. Again, the kind of fieldwork possible in small country towns simply does not work as readily in large urban centres—unless there is a discrete area of community living and infrastructure, as in La Perouse in central Sydney.

We spent five weeks in New Zealand, not to replicate the Australian study but to gather information from local researchers about suicide research among Maori and Pacific Islanders. In Dunedin, Christchurch, Wellington, Carterton, Auckland, Manakau and Hamilton, we met academic researchers, suicide prevention personnel, police, coroners, Maori psychiatrists and *iwi* counsellors, and Maori residents who had lost children. We learned much from a country which now ‘boasts’ the second highest male and female youth suicide rates in the world. The comparative and learning-from-another-experience approach offers a sense of perspective (rather than ‘solution’ or ‘explanation’), something easily lost in studies such as this. While in South Africa in 1997, contact was made with perhaps the leading researcher working on African suicide, hitherto not a problem of any dimension. References to Alan Flisher’s work appear in chapter 9.

We interviewed, in depth, 388 people:

- 208 Aborigines, most of whom were working in Aboriginal agencies;
- 12 Maori in agencies;
- 41 non-Aboriginal people working with or for Aboriginal organisations in New South Wales, the ACT and Queensland;
- 10 New Zealand agency personnel;
- 7 psychiatrists in New South Wales, 4 in New Zealand and 2 in South Africa;
- 5 Australian Federal Police and 5 New Zealand Police;
- 31 New South Wales and ACT coroners, 4 in New Zealand and 1 in the United States; and
- 66 NSW Police personnel.

Eight people listed in Appendix II appear in two capacities, hence 388 and not 396, the total of the above list. Although this is a massive sample, the cost of some \$40,000 over close on three years (excluding my university salary), was not expensive, but it was certainly time-consuming, difficult, and physically and emotionally draining, requiring fairly regular debriefing and counselling for the two researchers.

This study is not simply about Aboriginal youth suicide, about the high rate of Aboriginal self-destruction. Rather, it takes Aboriginal youth suicide as the starting point for a contextual analysis and critique of contemporary Aboriginal and non-Aboriginal life in rural towns and urban centres. Youth suicide—whether Aboriginal, Maori, Pacific Islander, black African in South Africa—cannot be comprehended, let alone alleviated, by the statistics of suicidology. It is imperative that all scholars and agency personnel understand and appreciate the social and political context of this violent behaviour. Until the contexts within which these suicides occur are appreciated and absorbed into intervention strategies, the present medical and ‘mental health’ approach, which so often seeks to ‘pathologise’ Aboriginal youth suicide, will not succeed—beyond, perhaps, alleviating the pain of a few individuals with suicidal intent.

**Endnotes 3. An Anthropology of suicide**

1. Alvarez, 92–3.
2. RCIADIC, vol. 2, 117–30.
3. Ibid., 117.
4. Ibid., 127–29.
5. Alvarez, 92.
6. Ibid., 64.
7. Victoria in 1967, Western Australia in 1972, Queensland in 1979, South Australia in 1983, Australian Capital Territory in 1990, New South Wales in 1993, and Northern Territory in 1996.
- 8 Hillman, 91.