

## 6. The Nature of Aboriginal Suicide

Suicide is only a medico-legal term and a mode of death. Self-destruction is a more comprehensive term for investigation. But the term suicide is too deeply entrenched. It also has a mystique and fascination in its sibilants. Suicide is ... 'the human act of self-inflicted, self-intentioned cessation'.

—Louis Wekstein<sup>1</sup>

... a serious suicide is an act of choice, the terms of which are entirely of this world; a man dies by his own hand because he thinks the life he has [is] not worth living.

—A. Alvarez<sup>2</sup>

Suicide is the end result of a process, not the process itself. In most behaviour disorders we have at least part of the process at hand for examination. In suicide all we usually have is the end result, arrived at by a variety of paths. Unravelling the causes after the fact is well nigh impossible.

—Joseph Zubin<sup>3</sup>

### 1. Suicide theories

Emile Durkheim's *Le Suicide*, perhaps the most seminal work in the field, took a long time to be translated into English.<sup>4</sup> Research has moved on since he formulated the categories of *egoistic*, *altruistic* and *anomic* suicide. Egoistic suicide is due to slight or poor social integration into family, religious or state life. Importantly in the context of this study, Durkheim contended that suicide rates fall during great crises because the society is more strongly integrated, with the individual participating more actively in social life. The rarer *altruistic* suicide results from excessive identification and integration. The individual makes himself subservient to higher commandments of a religious or political kind. *Anomic* suicide follows trauma, catastrophe, or a loss, with resultant alienation, social isolation and loneliness.

The only Durkheimian category of any use in this study is anomic suicide. Even then it does not suit. Despite Aboriginal society's being in crisis, and, following Durkheim's theory, being more integrated, suicide is increasing rather than decreasing. This is occurring in parallel with Aboriginal society's *disintegration* (as discussed in chapter 2) rather than integration, in response to crisis. Much of suicidology is about 'classifications', revealing a fascination with taxonomies. Hillman disparages this, arguing that 'for all their research, their clues to suicide from case studies and diagnostic classifications yield trivia'.<sup>5</sup> Amid a plethora of classifications since Durkheim, I have found Louis Wekstein's taxonomy to be the most useful, even though he also deprecates most attempts at definition, including his own, as 'leaving much to be desired'. His descriptions are convenient categorisations rather than attempts at definition, motivation or explanation. They also widen the traditionally narrow 'mental-ill health' approach.

1. *Chronic suicide*: the masking of an orientation towards death by excessive use of alcohol and/or drugs. This overlaps with several other categories. Serious research is required into whether Aboriginal substance use and misuse has some positive attributes, as Hunter contends,<sup>6</sup> or whether such chronic abuse is nothing more nor less than large numbers of people masking an intended cessation of self. Is chronic suicide perhaps the most lingering form of suicide? More frightening, in many ways, is the question of whether this is a form of mass suicide?

2. *Neglect suicide*: where the victim ignores reality factors, for example, the diabetic who indulges in dietary indiscretions and then ‘forgets’ to take his or her medication. There is also another dimension of neglect by Aboriginal youth: the neglect of risks and of danger. This is discussed below.

3. *Sub-intentional suicide*, allied to neglect: where, for example, the person drives through red lights, simultaneously denying the intent while, in fact, promoting self-destruction.

4. *Surcease suicide*: this is what Wekstein calls ‘rational suicide’, an auto-euthanasia, where the person’s plight is, in fact, irremediable, hence an intellectual decision to self-destruct. I discuss below another form of ‘rational’, or even ‘political’, suicide.

5. *Psychotic suicide*: here the victim doesn’t intend dying, but attempts to excise, extirpate, in effect, to exorcise his psychological inadequacy.

6. *Focal suicide*: which is the idea of partial death, where a limited part of the body is killed. Self-mutilation, maiming, contrived accidents and some types of sexual impairment, such as deliberate genital damage, fall into this category. This may overlap with the previous category.

7. *Automatisation suicide*: the attempt to relieve pain by drugs, and when no result is achieved, to continue taking painkillers, robotically, until death ensues.

8. *Accidental suicide*: the result of misinformation, or poor timing—a miscalculation or a blunder.

9. *Suicide by murder*: that is, attacking a person of superior strength or weaponry in order to promote or effect one’s own death.

10. *Existential suicide*: the notion of Albert Camus, the (French) winner of the Nobel Literature prize in 1957. He posited the idea of suicide as ending the burden of hypocrisy, the meaninglessness of life, the *ennui* and lack of motivation to continue to exist. This category has the most interest for me and for this study. In similar vein, Viktor Frankl’s philosophy and therapy, originating in a Nazi concentration camp, was that only those with *purpose in life* survive (such conditions). I believe that much of Aboriginal suicide is, broadly speaking, a Camus-type ending of the meaninglessness,

or a Frankl-type lack of purposefulness, which has nothing to do with mental illness.

Suicidology is much concerned about attempted suicide and ‘suicide ideation’. Several experts argue for a more concerted approach to *intent*, that is, examining intent as between (a) the suicide gesture; (b) the ambivalent suicide attempt; (c) the serious suicide attempt; and (d) the completed suicide. Clearly there are gradations between thinking about suicide and suicidal gestures. But the line between ambivalent act and serious attempt is difficult to draw, and even harder where someone is interrupted in the attempt, as has happened in a great many Aboriginal youth cases. Wekstein refers to American conferences which defined attempted suicide as any act which appears to have a life-threatening potential or carries such a potential and intent, but which does not result in death. Regrettably, this must include gestures and ambivalences, in short, everything short of actual suicide. An examination of the methods of attempted suicide may help to differentiate the gesture and the ambivalent gesture from the serious act. Certain methods are almost inevitably lethal, as in jumping, gun or weed-killer usage.

In the previous chapter, mention was made of Stengel’s views on attempted suicide: that attempts are about six to eight times as prevalent as completed suicides, that conscious self-destructive acts, ‘however vague and ambiguous’, are serious, and require special study.<sup>7</sup> (Many reports, especially from Alaska, suggest not six to eight but between 50 and 300 times as prevalent.) Two of Stengel’s concepts are worth examining: first, his somewhat strange notion that ‘self-destructive behaviour not associated with the idea of death is not suicide’. There may be some similarity between this and Wekstein’s category of accidental, or even focal suicide. His second idea needs careful reflection: that the suicide, ‘while it seems to aim solely at destroying the self, [it] is also an act of aggression against others’. This approximates Joseph Reser’s ‘reactance’ theory—suicide as a form of protest against the forces of authority and institutionalism. Some of what I have to say below falls into this category.

## 2. The classic profile of youth suicides

The traditional or classic youth suicide profile is characterised by, *inter alia*, severe depression, feelings of hopelessness, social isolation, anger, impulsiveness, poor or disturbed interpersonal relationships, unemployment, dramatic changes in the nature of family life, and a disjunction between ‘theoretical freedom’ (to be independent, free of constraints) and experiential autonomy.<sup>8</sup> Seligman would add learned helplessness and pessimism as key factors.<sup>9</sup> Some of these factors and values are relevant in all cultures, but many relate only to modern Western, ‘Anglo’ and middle-class lifestyles.

Barry Maley’s 1994 study showed a statistical correlation between male suicide and unemployment. The 20 to 24-year-old group, with a longer period of unemployment, was more at risk: they had no prospect of making a living, no prospects of enduring relations with women and no social status. Isolation, especially in rural areas, was both physical and social. The lack of social and interpersonal relations appeared to be the most significant risk factor, followed by unemployment and its meaning for self-esteem,

followed then by family circumstances.

Aboriginal youth suicides do not fit the conventional profiles. Thus,

- There is little evidence of clinical depression in the accepted sense.
- There appears to be little or no correlation between suicide and diagnosable mental illness.
- There has been little change in Aboriginal family life in the past 30 or 40 years. The formalities of Christian marriage and the sociology of the Western nuclear family are not part of the subculture. Most Aboriginal communities today are matriarchal, held together by the women. There has been no sudden change due to the rise of feminism, the liberation and changing roles of women, or the reversion to single-parenthood now more common in non-Aboriginal family life.
- Aboriginal youth have never had the ‘theoretical freedom’ which Hassan presents as a norm: they have, on the contrary, an early, practical autonomy, that is quite singular, one castigated by white society as lax, lacking in care or supervision. While some Aboriginal suicides appear to centre on broken love relationships, the majority do not. Most Aboriginal youth have an altogether different perspective on sexual and love relationships, which are not dependent on suitors having social status or the solidity of a ‘good living’. With a few exceptions, the ‘classical’ notion of suicide appears irrelevant to an understanding, let alone the alleviation, of Aboriginal suicide.
- While there is certainly alienation from white society, there is no internal social isolation in the sense that Durkheim understood or intended the term. There is much Aboriginal ‘togetherness’, especially among youth. In the chapter following, I discuss the Aboriginal propensity to commit minor offences in order to be sent to Minda, a juvenile facility, and [then] to re-offend immediately on release in order to return to that facility. There is togetherness and a strong sense of integration—in Minda even—away from family.

We are left with anger, hopelessness, lack of purpose, *ennui*, and pessimism. Norman Farberow, the American scholar, is the only researcher I have read who inverts the usual order of risk factors and suggested causes of suicide.<sup>10</sup> The great majority begin with ‘current conditions’, such as abusive and suicidal parents, broken homes, excessive mobility and transiency. From these, they move to ‘causal constructs’, such as delinquency, substance abuse, antisocial behaviour, school failure, and negative personal relationships. Then follow ‘precipitating factors’, such as poor school performance, joblessness, loss or threatened loss by divorce or rejection by lover, and rejection by ‘a significant other’. These, in turn, lead to the ‘reactive states’ of depression, anxiety, guilt, shame, inadequacy, confusion, and ambivalence. What follows are ‘dependent constructs’—feelings of worthlessness, helplessness and hopelessness. Farberow argues, as I do, that *we need to start, not end, with these dependent constructs*.

These ‘constructs’ do not necessarily explain the propensity for self-cessation of life, but they go a great deal further towards understanding of the suicides. There is a

need to look further, and to this end we need to examine some facets of suicide-threatening and parasuicidal behaviour before arriving at the portrait of the Aboriginal suicide proper.

### 3. The movement towards suicide

‘The incompletes are bad and scary, the kids who are not trying to live’. That remarkable analysis is from an Aboriginal worker in the Homeless Youth Unit in Taree. She is talking about boys who threaten suicide every time they are taken to cells, and girls who ‘slash up’. Importantly, she is not talking about a few individuals, but about a plurality, a collective and group phenomenon. The significance of this must be stressed: *the suicidal behaviours in these communities have become patterned, ritualised and even institutionalised*. David Lester, among many other suicide researchers, has come to recognise that attempted suicide and completed suicide fall ‘on a continuum of varying suicidal intent’ and are not separate, less serious actions.<sup>11</sup> The threat, and the actuality, of self-harm in the cells is universal, and serious. ‘I’ll neck myself’, or ‘I’ll neck myself and you’ll be in trouble’ is common across the State. There is an urgent need to examine the female propensity for ‘slashing up’ when in custody or in police trouble. Throughout this study, youth was conveyed as being male, with very much secondary attention to, or concern about, girls.

Female suicide is somewhat neglected. The numbers and the rates are much lower, but there is evidence that attempted suicide is much more frequent in females than males among Aborigines, Maori and most North American Indian groups. The difference is probably due to method of choice rather than difference in intent. Aboriginal men use rope, cord or gunshot, and inevitably succeed. Women, and girls in particular, swallow whatever tablets are to hand. Often—and here illiteracy may be some kind of mixed blessing—they cannot read the labels on their mothers’ medication packages, and so take non-fatal substances such as vitamin tablets or hormone prescriptions. Paracetamol in sufficient quantities does kill, but in many instances these parasuicides are treated in casualty units.

‘Slashing up’ is common. Several informants contended that it is most common amongst those who have been sexually abused, and that the slashing begins at an early age. A suggestion worth serious consideration is that slashing and other similar forms of mutilation are not suicide attempts, but rather the reverse: a letting of blood in order to feel the warmth and the vitality of life, an *affirmation* that one is alive.

The responses to attempted suicide differ widely. Some police view it as a ‘neo-suicidal’ action based on despair and hopelessness. Others see it, not as an egotistical cry *for attention* but, if they were to use Mark Williams’ words, as ‘a cry *of pain* first, and only then a cry for help’.<sup>12</sup> Some police describe, in their own words, what Shneidman calls a certain kind of psychological pain, or *psychache*.<sup>13</sup> Some police insist that it is a threat that only occurs under drug or alcohol influence and is either bluff or bravado or both. One ACLO contends that the threat is a macho thing, producing

hero-worship for he who dares. An experienced ACLO from Queanbeyan tells me that ‘young people of today have got no fear of dying. That’s the least of their worries; rather it’s a fear of living’. Another ACLO says its a matter of ‘talking silly’. Others again see the threats as a political statement, a weapon, an evoking of the simplest reprisal weapon available to ‘disempowered’ people, namely, an action which could lead to Royal Commission-type investigations. Another Aboriginal perspective is that it takes alcohol to disinhibit the normally present but suppressed and masked suicidal feelings.

There is an abundance of suicidal behaviour in communities, yet most service personnel and almost all Aboriginal family members insist that there are no warnings, no signs, and few actions which warrant serious attention. The Aboriginal health education officer in Narooma insists, ‘when young people threaten, they try it’. He also describes what he calls ‘indirect suicide’, people living on the edge, who engage police in car chases, drink and then climb cliffs, the ‘kids who have no care about tomorrow’. Many others have endorsed this perception of ‘*kids who don’t necessarily want to be dead but don’t want to be in life either*’. In both Kempsey and Taree, there is evidence of young people, especially girls, running in front of trucks at night. One can speculate that knife-edge and dangerous behaviour is born out of a realisation that life is short indeed, especially for males. These youngsters do not read articles about their poor life expectation, but they do attend, from a very early age, an astonishing number of funerals of young relatives. In most towns in this study, one funeral a week would be normal, the deceased often a young victim of disease, accident or violence.

A few cases will illustrate my contention about the movement towards suicide.

- A police officer in Narooma related the following story about a 13-year-old girl ‘who is out to self-destruct’. She had not only been sniffing petrol, but drinking it. Her father reported her to the police as a runaway. The police officer found her, but couldn’t find anyone to consult professionally in Narooma. The stepmother took her back home but found her too aggressive, and so she was taken to Sydney. Two days before this interview [with me], the girl jumped from the third floor of her Sydney accommodation and broke both legs. The officer believes she has even injected herself with petrol.
- At Taree, many young people are seen as ‘risk-runners’ and one case of ‘sub-intentional’ suicide is worth reporting as a speculation. A man of 24 was in hospital for chronic golden staphylococcus infection, which was being treated with antibiotics, intravenously administered. Warned repeatedly to complete the treatment, one Saturday he discharged himself from hospital to play competition football. He died on the field.
- A professionally qualified Aboriginal mental health worker told me the story of a 25-year-old male, a chronic alcoholic, who left school early and spent his whole life in town Z. He has low literacy skills. He threatens that he will get a gun, shoot all the nurses and then hang himself. He tells police he will shoot them all and hang himself. My informant is convinced he will do all or some of the above.

He publicly displays his intentions by, for example, walking down the main street of Z with a coil of rope around his neck. He has attempted suicide in the cells and been cut down. He provokes police. When he gets no response, he beats up on women. My informant says there is no help for this young man in Z.

- An Aboriginal health education officer in Nowra relates the life of a woman, removed from her parents at age 2. She told my informant that, at the age of 25, she wanted to die because she was ‘old’. She was first raped when she was seven months pregnant with her first child. When the child was little, she was raped again. She has three children, all in care. She began painting as personal therapy, catharsis and self-salvation.
- The Aboriginal mental health counsellor at Nowra is treating a man of 50, a stolen child from aged 2, placed in Bomaderry until the age of 7. At Mt Penang juvenile institution, from the age of 7 to 18, he was repeatedly raped. Hired out to do farm work, he was repeatedly raped. Two years out of institutional life, he found his natural father, who raped him while drunk. He has attempted every conceivable form of mutilation and damage to himself.
- At Menindee in the far West, an 18-year-old hanged himself in the local park. He had mugged a kindly old lady and believed she had died. She had not. Since his death, three Aboriginal men—one aged 15, who has attempted suicide, one aged 25, heavily sedated on Prozac and other anti-depressants (who persistently burns himself with cigarettes), and a 28-year-old who has tried hanging six times—meet at the cemetery to visit the grave. With a carton of beer, they commune with their dead friend: each drinks one beer, and they pour one into the grave mound for the deceased, until a sense of communion is achieved. I talked individually and at length with each man, and believe, as do their parents, that they will probably suicide before long.
- At Wilcannia in 1998, a girl of 8 placed a rope around her neck and tried to jump from a branch. Her 12-year-old female companion rescued her. The latter was interviewed by a female ACLO, a respected town elder, who asked her whether the 8-year-old was involved in an accident or a ‘game gone wrong’. The answer was ‘no’, that this was a serious attempt. The girl is small and immature for her age. She is related to a 12-year-old who hanged himself in the town. In New South Wales in 1999, the senior children’s magistrate ruled that a (non-Aboriginal) 10-year-old boy, who deliberately pushed a 6-year-old into a dam, could not be tried for manslaughter because he was *doli incapax*, that is, because he was between 10 and 14, he lacked the mental capacity to commit a crime. This case raises the question of how an 8-year-old can, and does, form the intention to take her own life. My conclusion is that death is more readily familiar to Aboriginal children in their socialisation processes than it is to non-Aboriginal children. But I am not certain of the answer to a question about their knowledge of *self*-death?

Documenting and quantifying the attempted suicides is an impossible task. An important New Zealand study interviewed 129 attempted suicides in ‘semi-structured interviews ... to retrospectively construct a life history’.<sup>14</sup> Interviews used a variety of

standard psychological tests, including: the Parental Bonding Instrument, a 25–item questionnaire containing a 12–item subscale; and the Structured Clinical Interview for *DSM-III-R* to diagnose selected mental disorders. The study found that 90.1 per cent of those who made a serious attempt had a mental disorder. In Lismore, a public health nurse at the Public Health Unit has produced a protocol for use by admitting doctors or nurses at the local hospital.<sup>15</sup> Each protocol questionnaire has multiple choice questions under the headings: Thoughts, Plans, Psychiatric Disorder, Mood, Means, Medical Problem, Suicidal History, and Support. Apart from the inappropriate language, and the inappropriateness of the actual questions for Aborigines, the realities are: first, that Aboriginal parasuicides tend to hide, treat themselves, or seek out ambulance officers for non-hospital attention; second, they are most unlikely to respond to the phrasings of these protocol questionnaires; third, it is doubtful whether anything like 90 per cent (as in New Zealand), or even 50 per cent, were suffering from a mental disorder.

Many Aborigines have a strong antipathy to hospitals. They see Health, Mental Health, the hospital, and related agencies as the equivalent of ‘the welfare’, and it was ‘the welfare’ who used to dislocate families and remove children.

Professor Mason Durie, a Maori psychiatrist and educator, has given us an explanation that may well capture the attitude of Aboriginal youth to hospitals, ‘welfare’ agencies and questions about attempted suicide. He says the reason behind Maori objection to Pakeha intervention is that ‘it’s not just the whiteness, it’s the style’. ‘How do you feel?’, he argues, is a classic, white middle-class question. For ‘kids on the edge’, he says, ‘this question drives them either to explosion or no answer.’ However, I suspect that in the Aboriginal case, whiteness is as strong an emotion as style. Noteworthy is Durie’s conviction that ‘mental ill-health is not the biggest cause of suicide; that the mental health strategies are too narrow and that mental health services for Maori are often hopeless’.

Two Aboriginal health workers in Coffs Harbour talk of suicide by negation of help, that is, people rejecting what the hospital has to offer for reasons of distrust mentioned above, or for spiritual reasons. The grandfather of one of these informants was the last tribal man to be fully initiated in the Coffs Harbour area. He developed gangrene in one foot. He refused to go to hospital, stating that amputation would destroy his spiritual wholeness. He died, untreated. Finally, there was hardly an interview conducted in which the Aboriginal interviewee did not mention either a personal attempt or attempts by one or more immediate family members. They consider themselves, in their words, ‘survivors’.

The extent of the idea of suicide among Aborigines is best demonstrated by the responses in a large number of in-depth interviews conducted by the professional staff at Bennelong’s Haven—site of the original Kinchela Boys Home—a major drug and alcohol rehabilitation unit. Interviews with 129 women residents from 1 July 1992 to 15 July 1997 revealed that 53, or 41 per cent, had attempted suicide. Of 435 males interviewed between those dates, 223, or 51 per cent, had attempted suicide, making a total of 276 parasuicides in a sample of 564, that is, 49 per cent of the residents in the

program. It would be unwise to relegate or diminish this finding on the ground that it was confined to addicts in one program. There are, literally, legions of people in this State who offer the same information about their experiences with attempted suicide.

The Ministry of Maori Development gave us some preliminary, and unpublished, figures for attempted suicides.<sup>16</sup> Two advisers on Maori policy talked at length about under-reporting of Maori suicide and of attempted suicide. In the latter category, and based solely on hospital sources, the Maori female numbers were exactly five times the Pakeha figures, and the Maori male numbers three times the non-Maori. This is consistent with the findings of the Maori Suicide Review Group, which recorded that in 1992, Maori had the highest hospitalisation rates for self-injury at 85.7 per 100,000 persons, followed by a Pakeha rate of 78.<sup>17</sup>

#### 4. Aspects and categories of Aboriginal suicide

The novelist and suicide, Cesare Pavese, once said that ‘no one ever lacks a good reason for suicide’.<sup>18</sup> While there are factors, or ‘reasons’, in Aboriginal suicide which are seemingly universal, there are important aspects which make it different. These differences need to be stressed, recognised, absorbed, appreciated and acted upon if any prevention or alleviation strategies are to be attempted. There are also regional differences—not only between states and territories, but within states—requiring specific attention. Continuing a philosophy and policy of locating Aboriginal suicide in ‘mainstream’ suicide, or of footnoting or sidelining ‘indigenous origin’ suicide as an interesting but marginally different genre, is unacceptable and unproductive.

*There is a separate Aboriginal suicidology—perhaps even separate Aboriginal suicidologies.*

##### (a) ‘Yaandi’

There is much evidence from witnesses that youth suicide is commonly associated with cannabis, or *yaandi*, an Aboriginal term for the substance. The association can be categorised not so much as an *addiction* but as an *obsession* with the substance. In at least six instances in our study, young men, between 16 and 20, insisted on being physically near a constant supply. A few left solid family circles to live out bush, where they could be close to their own small cultivation. Several were found hanged at those sites. Many autopsy reports reveal the presence of cannabis.

Police across the State were adamant that the worst case scenarios for them are dealing with youth in pubs at closing time, where the drinkers are also cannabis users. They rate, in degrees of difficulty, a plain drinker as a 3 out of 10 problem, a cannabis user as a 6, and a mix of the two as an 8 or 9. They assert that there is an apparent calm and laid-back quality to the marijuana men, but that they are prone to unexpected outbursts of violence. There can be no doubt that, in the past twenty years, Aboriginal youth has taken strongly to this substance: it is omnipresent, is used regularly, and is

cultivated and sold in several communities. There is circumstantial evidence that hydroponically grown cannabis magnifies behavioural change. It is also said to be more addictive. It is chemically more potent, and produces more explosive behaviour in situations of violence, arrest, and detention in cells. It is also probable that a form of psychosis results from cannabis obsession and overuse.

*(b) Suicide Notes*

Notes are extremely rare in Aboriginal suicide. We have seen evidence of notes in possibly no more than four or five cases for the periods 1995 to 1998. Coroners vary in their estimates of note-leaving in non-Aboriginal suicide, but commonly suggest 50 per cent. (The inquests officer in Dunedin informed us that possibly 60 per cent of Maori youth suicides in the South Island leave notes.) The context here is confirmed suicide verdicts, not those who overdose deliberately, or crash into the only tree on either side of the road.

There are many evidentiary signs of suicide apart from the note. I believe the note is an exaggerated facet of suicide deriving from nineteenth century fiction and twentieth century films. At best, it is indicative of literacy skills, which few young Aborigines have, and of a premeditative, reflective and contemplative disposition or action (as shown in the not uncommon case of German Jews, discussed below).

*(c) Illiteracy as a contributing factor*

Illiteracy is a key to much of this. The majority of Aboriginal youth showing suicidal behaviour cannot read or write, or cannot read sufficiently well to absorb other than the most elementary popular materials, like picture magazines. In a group, the one or two who can read cover for the others, as interpreter or spokesperson. Disguise of illiteracy is commonplace. The illiterate can become surprisingly well-informed through omnipresent television and radio, even without tuning into the 'serious' wavelengths of electronic communications.

Illiteracy creates its own frustrations and anger. Incomprehension alienates, as does being inarticulate. Violence is often the only means of expressing feelings: physicality, of whatever kind, is a substitute for a lack of verbal skills. Most Aborigines speak Aboriginal English. It is a *lingua franca*, perhaps a language of its own, with a different grammar, syntax, vocabulary, terminology, idiom, sign language and body language. This should not come as a startling discovery: several educators and linguists have for long advocated Aboriginal English as a medium of school instruction. Those providing services ought to be informed of, and educated about, this language. Resorting to pidgin and child-talk is not appropriate. In short, there is no intellectual intercourse between youth and the people they deal with in their external lives. The ensuing frustration is relevant to the violence, slashing up, self-mutilation, and self-destruction.

There may even be an important correlation between illiteracy and deafness. The Maori Health Research Unit at the Dunedin medical school funds a program to instal

grommets in children's ears to help with chronic 'glue ear' infection, a common cause of deafness. At least 20 per cent of Maori prison inmates who are considered to be at risk for suicide are seriously deaf.<sup>19</sup> We know that there is widespread hearing deficiency in Aboriginal youth, and the relationship between 'glue ear', illiteracy and suicidal behaviour may be worth pursuing.

*(d) A different typology of suicide*

It may be possible to construct a profile or paradigm of Aboriginal suicide, partly from existing theories, classifications and categories, and partly from some innovative classification arising from this study. The following might prove worthy of consideration, as a way towards achieving an understanding of that which Hillman calls the 'soul' of the suicide.

(i) The 'political' suicides

'Political' may seem a bizarre word to use in this context. It is also difficult to define when used in the phrase 'making a political statement'. Konrad Kwiet has given us insight into 'political' suicides by German Jews as early as 1933. In a farewell letter, Fritz Rosenfelder said he was 'unable to go on living with the knowledge that the movement to which national Germany is looking for salvation considers him a traitor to the fatherland ... I leave without hate or anger ... and so I have chosen a voluntary death in order to shock my Christian friends into awareness.'<sup>20</sup> At best, this type of suicide is a public declaration of anger or grievance designed to gain a hearing, possibly even a response. It is an attempt at power, in Robert Dahl's classic sense that power is involved where A has power over B to the extent that he can get B to do something that B would not otherwise do. In my context, it is an effort to move someone, or something, to a response. Some of Aboriginal suicide is of this kind: an 'I'll show you', 'I'll get even with you', a 'you'll be sorry', 'you'll lose your job', 'you'll pay for this ...' statement. A 14-year-old in central New South Wales shot himself in front of his assembled family in 1997. There had been a row about his staying out late at night, and then brandishing (what turned out to be) an unusable rifle, which was taken from him. He found another, usable weapon and announced his 'equation': his life in exchange for their loss and sorrow. Several weeks earlier, his 18-year-old cousin, at another central NSW town, shot himself in front of the family, again after a row about his late night hours. These cases appear to be the beginning of a new pattern, namely, shooting in front of an audience, with assertions, or 'political statements', about independence, status, or lack of care.

(ii) The 'respect' suicides

An even more disturbing variant is the demand for a respect which was *seen* not be accorded, or was *not* accorded, in life. Interviews with immediate relatives have confirmed that X or Y, from aged 12 upward, had been 'nobodies', seemingly unwanted, often neglected (even though not socially or physically isolated), disrespected or 'dissed'. That black American expression has not yet reached our shores, but the idea

has. These young men are often 'disempowered' by the stronger wills or personalities of younger siblings and see themselves as displaced family members. They will take on their older siblings or older boys in general although they are trounced in basketball games, lose the fist fights, the snooker or pool games, the video games. They are given no respect by anyone. Their response has been articulated and overheard in more than a handful of cases: 'you'll all have to come to my funeral'. And, of course, everybody does.

The 14-year-old mentioned above was a 'nobody' all his life. Constantly moved by his young mother between and within states, he lived with a succession of his mother's *de facto* partners. His funeral was something to behold. Four hundred people, including two busloads of Aboriginal prisoners from Broken Hill and another cohort of prisoners from Long Bay in Sydney, came to a town of a thousand residents. (The RCIADIC recommended that funds be available for prisoners to attend funerals of kith and kin.) At least 30 additional police came to the town to supervise the well-attended wake. The church was overflowing. The lad had his 'respect'.

Although his case was more 'political' in my sense, it illustrates a dictum posited by Sigmund Freud: that 'our unconscious does not believe in its own death; it behaves as if it were immortal'. Alvarez comments: 'thus suicide enhances a personality which magically survives'. In other words, young suicide is an act of physical destruction, but the psyche, or soul, or the unconscious, is conceived as continuing to live. Listening to many of the threats, it appears to me that many of these young people believe that they will be there to witness the sorrow, regret, remorse, revenge or respect that their acts will, or did, create. It is suggested in the verb: 'I'll *see* you in trouble'. The Christchurch suicide researcher, Annette Beautrais, tells me that suicide notes from 14 to 18-year-old New Zealanders contain messages to the effect that 'we we will be around watching out for you as we know what you're doing'.

There is no doubt that much of this kind of suicide occurs in clusters, in families, or in small communities. Five in one Nowra family is an extreme case, perhaps, but the two gunshot suicides discussed above occurred in reasonably proximate towns by boys who were first cousins. This form of 'respect' will, I believe, increase and so will the clusters. The universally used term by informants throughout this study is that youth lack 'self-esteem'. It is a mantra that hopes and seeks to explain and to solve: self-esteem, once achieved, will bring an end to assaults, drug and alcohol-taking, even suicide. However, what constitutes self-esteem is the gamut of factors and forces described thus far in this report. In the final chapter, I describe one or two potentially positive programs which may help illiterate, angry, frustrated, helpless youth to articulate their goals and the obstacles which have to be overcome to achieve them.

### (iii) The grieving suicides

Much of Aboriginal life in New South Wales, as elsewhere, is consumed by grieving for relatives who die in infancy, or die young, or from disease, accidents or various kinds of violence. 'Old' death, as in a granny or aunty of 80, is less common.

Much time is spent at funerals and mourning rituals of a more Western kind. The wakes that follow cost large amounts of money, especially for quantities of alcohol and food (that the children look forward to consuming). There is almost none of the expiation, purgation and catharsis which stem from the organised ritual mourning ceremonies still practised in Aboriginal northern Australia. One North American study, discussed in chapter 9, mentions ‘prolonged unresolved grief’ among Indian youth suicides.

There is, then, a perpetual cycle of grief. The suicide of a popular 33- year-old sportsman in Coffs Harbour, a role model for all, resulted in grief all the way from Sydney to Tweed Heads, and then west, lasting almost a year and a half. He was mourned even by those who were not blood kin. A commonly used term in the suicide literature is ‘copy-cat’. It has a pejorative ring. But what it is, when seen in context, is communing, emulating, joining and not merely imitation. The Menindee grievers are the starkest example we encountered, but there is much evidence from relatives of young male suicides that their lives centred on grief of this kind. There are no mechanisms in place, certainly no appropriate mechanisms or avenues, in any of the communities we visited, for grief counselling.

(iv) The ‘ambivalently rational’ suicides

My sense of ‘rational’ is quite different from Wekstein’s notion of the irremediably ill person who plans an auto-euthanasia. A psychiatrist colleague, Michael Diamond, suggests to me that there is sometimes an ambivalent suicide, in the following sense. A youth feels socially integrated, alive, comradely in his gang or group membership. He feels a ‘high’ in a venture, such as a break-and-enter, especially if there is no detection. He may still feel on a ‘high’ when the group faces arrest, then remand, then court with lawyers representing him. He may retain that ‘high’ when placed in custody. However, when, for example, he falls foul of a warder and is placed on various penalties, or in isolation, he suddenly runs into a brick wall: there is no *camaraderie* available, no social integration to assist him. He sees, in a rational moment, an answer to his seemingly insoluble dilemma: suicide.

(v) The ‘appealing’ suicides

Emanuel Marx’s study of the social context of violent behaviour (in Israel) contends that appealing violence occurs when a person ‘has reached the end of his tether, and feels unable to achieve a social aim unaided by others. It is a “cry for help”’.<sup>21</sup> It is partly a cry addressed to a public, ‘and partly an attempt to shift some of their obligations towards their dependents onto others’. The person who cannot make that public appeal for help, nor persuade his family to share his (personal and social) responsibilities, engages in violence towards others and finally towards self, as a desperate means to regain the support of his family or kin. An Aboriginal elder and leader in Fingal, South Tweed Heads, believes that suicides occur ‘because life at home is too awful! There are very few normal family relationships.’ In an earlier fieldwork study, I reported the case at Raukkun in South Australia, where an Aboriginal

man attacked his brother with an axe early in 1989. Admonished later by the local policeman's wife, he replied: 'Sorry, I'll never do that again: I'll only hurt myself'.<sup>22</sup> The Director of Booroongen Djugun, near Kempsey, tells me that 'sometimes kids hang themselves, and in the process you can see that they're not sure, you can see it on their dead faces.' He is not the only informant to talk of finding youngsters hanging, but with fingers desperately trying to reverse or stop the process.

(vi) 'Empowerment' suicides

Aboriginal youth rarely experience autonomy, self-fulfilment, or personal sovereignty over their physical, material or internal lives. The vague modern term, 'disempowerment', does, however, convey this condition. There is an overlap between this phenomenon and the lack of respect discussed above.

Elsewhere I have discussed the motives of a number of Aboriginal sportsmen and women: they see sport as the only arena in which, even without education, income and opportunity, they can compete on equal terms. It is their only chance to pit their bodies, minds, energies and skills against an opposition.<sup>23</sup> Henry Collins's view of boxing expressed this outlook: 'I felt good when I knocked white blokes out. I knew I was boss in the boxing ring. I showed my superiority ... they showed it outside.' This embodies what the German sociologist Max Weber meant by power: 'the chance of a man or of a number of men to realise their own will in a communal action even against the resistance of others who are participating in the action'.<sup>24</sup>

Several parasuicides have indicated that they perceive suicide as their only avenue to 'realise their own will'. It is their moment of autonomy and empowerment, suggesting that the only 'thing' they own is their physical life. For once, fleetingly, they can manage it, dispose of it, even against the opposition of those close to them, or those they see as antagonistic. Hillman has a poignant phrase for this: that within this 'negative selfishness', there is '*a small seed of selfhood*'—the suicide's 'ultimate empowerment'.<sup>25</sup>

(vii) The 'lost' suicides

Many Aboriginal youth feel the direct effects of racism and alienation. Some articulate a sense of emptiness, a loss of culture, especially ritual and spirituality. Others know there is a 'hole' in their lives, but don't know what it is. They suffer the label 'Aborigine', yet cannot comprehend what it is in 'Aborigine' that causes such antagonism or contempt.

Dr Erahana Ryan, New Zealand's only female Maori psychiatrist, talks of Maori youth who suffer 'stress of loss of who they are'.<sup>26</sup> She talks about 'the emptiness of blighted, warped, eviscerated urban Maori life'. There is a likely parallel in contemporary Aboriginal life.

(e) *Who to turn to?*

Hopelessness is a universal among youth in such contexts. Phrases like ‘no light at the end of the tunnel’, ‘hopelessness’, ‘no horizons’, ‘no skills’, come off most people’s lips. An important difference, or variation, in the Aboriginal world, is that there is no one in their universe to act as guide, mentor, signposter in a transition to betterment. They really do have to make decisions unaided. The home is filled with family in like circumstances. There is no classical ministering priest. The school counsellor, even if seen as a guide, is overworked. The usual welfare agencies, even if considered, are there only by appointment, usually on their own premises, nine to five on weekdays. The only constantly available resources are police officers and ACLOs. The police are neither trained for this, nor, clearly, trusted by youth. The ACLOs do yeoman service, but their overload is staggering.

As discussed earlier, there are no ‘guru’ figures, respect figures, trust figures in their young lives. More importantly, they do not have an ‘enlightened witness’ in their lives, the kind of person who psychoanalyst Alice Miller says are not cruel to them and who enable them to become aware of the cruelty done to them by parents or family members. Miller sees the role of a witness as ‘supporting’ and ‘corrective’.<sup>27</sup> Such witnesses have knowledge of the truth of what is being done to the young person, thus allowing them to believe in something while retaining a sense of belonging to humanity. Once they lose that thread of connection to parent, immediate family, or enlightened witness, all is lost.

Asked what they’d like to do in life, several Aboriginal youngsters have told me that they would like to change their present circumstances. But none has any comprehension of how to commence the move from point A to point B. A great many cannot even read about techniques to alter their situation. By contrast, in much of middle-class Australia there is a plethora of help: from teachers, counsellors, careers advisers, tutors, ambitious parents, computer programs, website information, good doctor-patient relationships, access to all manner of advice bureaux: places of help to which they can be directed.

## 5. Conclusion

There is much written, and generally believed, about suicide being a ‘mental health’ problem. Peter Neame, for example, quotes from the *Guidelines on the Management of Suicidal Patients* prepared by the New Zealand Ministry of Health in 1993: ‘Although the causes of suicide are complex and a number of factors may combine to lead any individual to take their own life, it is generally accepted that at least 94% of people who die by suicide were suffering from a mental illness at the time of their death.’<sup>28</sup>

I do not accept that generalisation. Without a detailed profile by competent assessors, it is impossible to assert ‘mental illness’ as the key causation in Aboriginal suicide. On the contrary, my information—derived from interview with kin, and with those who provided services to the deceased and to the parasuicides in this study—is that mental illness, in the strict pathological sense, was rarely a factor. To be perturbed, disturbed, stressed, uneasy, *dis*-eased, anxious, confused, aggressive, delinquent, obnoxious, aggressive, is to be normal. There is a common mischief abroad that only good or appealing feelings and behaviours are normal and that objectionable ones are abnormal, and, therefore, indicate illness. Put another way, compliant behaviours are deemed normal, and all other behaviours are ‘pathologised’.

One of the 43 in this study drowned himself on the eve of serious charges of child molestation and sexual abuse. The evidence we have points to ‘rational’ suicide as a way out of a bleak future. From our reading of the files, and from interviews concerning about half of the 43 suicides, it would appear that only two of the suicides were being attended to, and treated for, a ‘mental illness’, such as severe clinical depression, bipolar disorder, and the like.

An attempted broad, albeit speculative, model of Aboriginal suicide could be expressed as:

- a broad-based community norm of Wekstein’s chronic suicide, that is, a use of alcohol, or drugs, or both, to mask an orientation which suggests ‘a preference for obliteration rather than life’; in conjunction with
- a general lack of purpose in life, a hopelessness about the present and future, an *ennui* that is all-pervasive, that manifests as existential suicide, whether in symbolic form or as actual self-destruction.

Within that broad compass, there appear to be clear, or seemingly clear, cases of:

- accidental or indirect suicide or sub-intentional suicide, that is, the risk-runners, those who dice with danger;
- focal suicide, the slashers, the self-mutilators, those who ‘kill’ an offending part of the body;
- political suicide, that is, those making an overt statement about their lack of care, or about their desire for revenge or retaliation;
- respect suicide, those who perceive themselves so utterly forlorn and forsaken that suicide is the only way to command a focus on self;
- grieving suicide, the surcease (in Wekstein’s terms) not of irremediable illness, but of irremediable grief;
- rational suicide, those who find an inspirational answer to that which appears unanswerable;
- appealing suicide, violence to others and then to self, as an appeal for support and assistance;

- empowerment suicide, much akin to respect, where the person feels so unempowered or disempowered that suicide is the only way to exercise autonomy or personal sovereignty, to exert his or her will in a successful action; and, possibly,
- ‘stress of loss’ suicide, where no meaning is to be found in an Aboriginality which is meant to produce an inner sense of belonging from within, and which is the basis of so much antagonism from without.

The chairman of the Fingal Bay council has a much more succinct perspective on young Aboriginal suicide:

- ‘they are tired, worn out, worn down, even the young ones’;
- ‘they have no physical or mental stamina left’;
- ‘they are tired of the same depressed lifestyle’;
- ‘it is a quick way out of dilemmas.’

There is much talk in suicidology about the proximal and the distal causes of suicide. The medical-psychiatric approach is to examine proximal risk factors, those considered close to the point of origin of the problem: depression, a family history of suicide, past attempts at suicide, substance abuse and personal conduct problems. Certainly this is one way to obtain clinical data about those who seek treatment, or are sent for treatment, for any of the above reasons. The health professionals tend to see the distal or socio-environmental approaches, those more distant from the essence of the problem, as important, but of little use in clinical practice.

My conclusion is the antithesis, namely, that unless health care practitioners—psychiatrists, psychologists, general practitioners, nurses, social workers, mental health workers, health educators—become holistically knowledgeable about the wide variety of Aboriginal societies who encompass 106,000, or possibly 150,000 people in New South Wales, their clinical, proximal approach will touch but a few of the many who are involved in suicide behaviour. They need to comprehend more than a history of oppression and the legacies of colonialism. What is occurring is a new violence, of which suicide is but one facet. And within that facet, there are behaviours motivated or occasioned by *many* things other than the personal family histories of suicide, aggressive behaviour, substance abuse, ‘depression’ and other mental illness.

**Endnotes 6. The Nature of Aboriginal Suicide**

1. Wekstein, 25–35.
2. Alvarez.
3. *Ibid.*, 74.
4. Durkeim, 1968 ed.
5. Hillman, 42.
6. Hunter, chapter 5, 90-132.
7. Stengel.
8. Hassan, 1995, 53–61.
9. Seligman, chapters 1, 2 and 3.
10. Peck, Farberow and Litman, 196
11. Lester, 1989, 109–10.
12. Williams, xiii.
13. Shneidman, 4.
14. Beautrais *et al.*, 1996, 1009–14.
15. Dietrich and Kempton, 87–93.
16. Tane Cassidy and Helen Leaky, Wellington.
17. Maori Suicide Review Group, 25.
18. Alvarez, 99.
19. Dr John Broughton, personal communication.
20. Kwiet, 147.
21. Marx, 2–3.
22. Tatz 1995, 320–22.
23. *Ibid.*, 111.
24. Weber, 180.
25. Hillman, 92, 196–7.
26. Personal communication.
27. Miller, 167–75.
28. Neame, 9.