

## 9. Lessons from Abroad

Understanding is never a collective phenomenon. It is based on sympathy, on intimate knowledge, on participation. It depends upon a communication of souls and is appropriate to the human encounter, whereas explanation belongs to the viewpoint of the natural sciences. Understanding attempts to stay with the moment as it is, while explanation leads away from the present, backwards into a chain of causality, or sideways into comparisons.

—James Hillman<sup>1</sup>

### 1. Comparative suicide studies

Much of my professional life has been devoted to comparative studies: in race politics and, later, in genocide studies. Comparison may not bring understanding, but an examination of similarities and differences can help us to learn and to distil, always with the aim of improving or, idealistically, ameliorating or preventing racist and genocidal behaviour.

I am less certain about the value of comparison in suicidology. As Hillman contends, to compare is to move sideways: it deflects from the path towards understanding, and it decorates rather than illuminates the heart of the matter.

First published in 1965, the second edition (1997) of Hillman's *Suicide and the Soul* has a 'Postscript of Afterthoughts'.<sup>2</sup> Discussing who owns the soul, he says he tires of the individual *versus* collective argument:

We need a wider context that embraces both. So, this Postscript proposes the *anima mundi* [literally, the soul of the world] as that context, and a definition of self as the interiorization of community. Suicide, literally 'self-killing', now would mean both a killing of community and involvement of community in the killing.

Just as Dr Kevorkian's assisted suicide campaign in the United States has very publicly opened the issue, so Hillman pleads that suicide should be judged 'by some community court', comprising legal, medical, aesthetic, religious, and philosophical interests, as well as by family and friends. In this way, self-death can 'come out of the closet'. The act of suicide will still remain individualistic, but judgement of the suicide as part of, or interior to, a community may help to liberate Western civilisation's 'persecutory panic' when suicide, or the threat of suicide, arises. We must, he concludes, get away from 'police action, lockups, criminalization of helpers, dosages to dumbness'.

In this context, it is worth seeking some lessons from abroad—from communities which may approximate, but which can never be parallel, let alone be identical to, diverse Aboriginal communities.

## 2. South Africa

South African literature provides little insight into Aboriginal suicide. The demography and the politics—and even the nature of the racial discrimination and oppression—are so different that comparison is not appropriate. However, some pointers can be obtained from South African research.

Alan Flisher *et al* report what is possibly the world's highest rate of adolescent mortality from external causes: 56.8 per cent of 16,348 deaths between the years 1984 and 1986.<sup>3</sup> The researchers point to the 'far-reaching social and political changes that are taking place in South Africa, resulting in instability and, hence, health-damaging behaviour (such as substance abuse and interpersonal violence)'. A high urbanisation rate exposes teenagers to road accidents, the commonest form of death among the adolescents. 'Risk-taking behaviour may contribute to these deaths.'

Flisher and his colleagues then studied risk-taking behaviour in a sample of 7,340 Cape Peninsula high-school students.<sup>4</sup> They combine an interesting, if not curious, set of risk-taking behaviours: suicide, cigarette-smoking, alcohol use, drug use, road behaviour and sexual behaviour. A comprehensive theoretical framework, incorporating the psychological, social and environmental dimensions of adolescent health behaviour, was used. In search of a syndrome of risk behaviour, they sought instances of attempted suicide within 12 months of the administration of the research instrument. Of the 7,430 students,

- 19 per cent had 'seriously thought about harming themselves in a way that might result in their death';
- 12.4 per cent had told someone that they intended to end their lives;
- 7.8 per cent had actually attempted suicide.<sup>5</sup>

In the period 1984 to 1986, the suicide rate for youth aged 15 to 24 was 25.75 per 100,000 for white males and 9.5 for white females. For black Africans, it was a low 2.3 and 1.1 respectively.<sup>6</sup>

The lowest incidence of suicidal feeling in the high-school study was among the Xhosa-speaking youth. The researchers attribute this 'to the adverse social circumstances of these students'. They quote Lester as arguing that suicide is less likely where people have an outside source to blame for their misery. Other factors might be cultural taboos, the prevalence of relatively close family ties, and 'a propensity for expressing emotions in somatic [physical or bodily] terms'.

Mayekiso, at the University of Transkei, reports on the paucity of research among black youth. In a study of 80 adolescents, aged 15 to 19, at the Ngangelizwe High School at Umtata, he found 'perceived causes of adolescent suicide'.<sup>7</sup> The results are fascinating:

- 100 per cent did not approve of suicide in principle;

- 64 per cent did not consider suicide an option;
- 36 per cent said suicide was an acceptable option in certain circumstances.

Students were asked what they perceived to be the causes of suicide:

<b>Causes</b>	<b>Per cent</b>
Impulse	8
Teenage pregnancy	22
Loss of loved one	6
Conflict with parents	38
Peer group conflict	1
School problems	1
Love relationship problems	8
Financial problems	11
Substance abuse	5

More interesting were the reasons advanced which deterred individuals from self-destroying:

<b>Answers</b>	<b>Per cent</b>
Concern about their parents	26
Fear of God's punishment	25
Concern about other family members	13
Fear of death	7
Hope for a solution	14
Social support	5

His conclusion is '*that suicide is generally unacceptable to Blacks.*'

The South African material is refreshing in that it seeks an understanding of suicide from within the living adolescent cohort. However, several aspects of this research are, regrettably, simply not possible in Australia. First, there is a Christian aspect to black African lives which is uncommon among Aborigines. The virtues of virginity until Christian marriage, the sanctity of indissoluble marriage and the fear of God's punishment are not part of Aboriginal mores. Second, the Flisher and Mayekiso studies are based on questionnaires, self-administered by youth, in their mother-tongues. Africans prize education. In the pre- and post-*apartheid* eras, learning is revered, and is seen as *the* avenue to social mobility and betterment. It is highly unlikely that Aboriginal teenagers would respond to such questionnaires, administered in high schools which most perceive as being 'alien'—places in which most would rather not be.

Finally, Flisher tells me that black suicide may well increase with the advent of black majority rule. The centuries-long 'struggle'—an over-arching and overwhelming force in African life—is, in theory, at an end. Misery as struggle against an all-too-visible and powerful enemy is one thing: plain misery is another. If Flisher, Lester and I are correct, then inculcation of 'the system' means extending blame for one's pain

onto others, thus providing an explanation for one's misery. It seems contradictory, then, that Aborigines, who almost universally locate blame on factors outside of themselves, commit suicide in such numbers. Although I have always argued that alienation is a spur to achievement, or at least to survival, Aboriginal suicide occurs in a world which is replete with alienation of every kind.

### 3. Canada and the United States

The literature on suicide among Native American and Canadian Indian, Alaskan Native and Canadian Inuit has grown remarkably in the past decade. In 1989, for example, David Lester's *Suicide from a Sociological Perspective* covered New Mexico Indian suicides in three pages; in 1997, he was moved to publish a full-length book on *Suicide in American Indians*. Indian suicide is increasing each year.

In 1994, the American and Alaska Mental Health Research Center published the proceedings of a major conference. *Calling from the Rim* may well be the most important and coherent account of youth suicide amongst indigenous peoples. Dozens of medical and psychiatric journal papers cite quite diverse rates of Indian suicide within tribal groups, while others point to sharp differences in prevalence between tribes.

As discriminating as these studies appear to be, there remains the problem of the all-embracing title of 'tribe'. *Custer Died for your Sins* by Vine Deloria Jr, a well-known Indian rights advocate and a former Executive Director of the National Congress of American Indians, remains the most searing, and un rebutted, indictment of American Indian policy, and of white academic attitudes, especially those of anthropologists. He deplores the Little Big Horn and wigwam stereotyping of his people, and I suspect that, while he has not written specifically about suicide, his admonitions of anthropology would apply as strongly to suicidology. In essence, he condemns academe for creating 'unreal' Indians in their attempts to establish 'real' Indians. Thus, the 'bicultural people', the 'folk people', the 'drink-too-much people', the 'warriors without weapons people', the 'between-two-worlds people' are academic constructs imposed on a people who then came to believe, and live out, these external perceptions. Deloria reminds us that when academics talk of the Chippewas or the Sioux, they appear not to recognise that 'there are nineteen different Chippewa tribes, fifteen Sioux tribes, four Potawatomi tribes', and so on.<sup>8</sup>

Anthropology may well have committed many 'sins' against Indian peoples. But the anthropological approach at least attempted to get to know 'their' people and 'their' tribes. Other social science and medical disciplines have adopted a distant, statistical approach, even where there are attempts at differentiation between reservation and non-reservation residents, as in a Manitoba study.<sup>9</sup> There is no detail of lifestyle difference, only difference in geographic domain. In short, there is no context—social, historical, political—provided in these studies, apart from stating the inevitably obvious that these communities are impoverished, with high rates of unemployment, and so on.

Every study is concerned about under-reporting and about inadequate protocols for identification. The 'Manitoba aboriginal' paper states 'suicide among aboriginal people cannot be studied through the use of such traditional data sources as vital statistics records, since ethnic background is not recorded on the death certificates in any jurisdiction'.

Every study reports more attempts by females, but makes an important point that clustering is commoner among females and that more females succeed in their purpose when among the cluster. Without being explicit, there is a strong message that female youth attempted suicide is in need of serious attention.

The following summary gives us an overall picture of rates of youth suicide per 100,000 of a population generally, or for particular periods:

- The rate per 100,000 for Shoshone and Bannocks in Idaho is now 98, but it was as high as 173 in the period 1972 to 1978.<sup>10</sup>
- The Shoshone rate for the United States is 100.<sup>11</sup>
- The rates vary enormously: from 4 for the Lumbee in North Carolina to as high as 230 for Shoshone-Arapaho.<sup>12</sup>
- The rates in New Mexico range from 175.19 for the Apache, to 45.68 for the Navajo and 79.06 for the Pueblo.<sup>13</sup>
- The Indian rates for Yukon, Alberta and Saskatchewan are 61.9, 52 and 35.1 respectively.
- The Manitoba rate is 31.8. but there are interesting differences between those living on the reserve, 83.9, and those off the reserve, 59.5. Noteworthy is that the rate in the 10 to 14 cohort is 5.25, 21.7 in the 15 to 19 group, and 55.7 in the 20 to 24 year group.<sup>14</sup>
- Canada, as a whole, has an Indian suicide rate of 38.4 as opposed to the national rate of 14.1.
- In the Alaskan town of Alakanuk, in a population of 550, there were 8 suicides in a 16-month period, a figure which would equate to a rate some 20 to 24 times the national figure.<sup>15</sup>
- The Alaskan attempted suicide rates are alarming: in 1971 to 1977, between 205 and 302 per 100,000. Between 100 and 251 youth had to be hospitalised. The Indian male rate of attempted suicide is 2.7 times the national figure; the female rate is 7.5 times the national rate.<sup>16</sup>

Lester provides the best statistical summary of youth suicide, albeit with data at least a decade old. Despite regional differences, there is a sameness about many of the figures and ostensible causes. The 'indigenous' rates are at least *ten times higher* than the national rates. The attempted suicides are vastly more prevalent.

Lester admits the unreliability of standard psychology tests when used with

Indians. His checklist of the ‘standard’ underlying factors is similar to the one in common use in Australia and New Zealand: depression, hopelessness, immaturity, aggressiveness, a history of suicidal behaviour, psychiatric problems, substance abuse, parent and family conflict, lack of family support, physical and sexual abuse, and recent stress. He lists the sociological factors as social disintegration, cultural conflict, and family breakdown. However, he adds, ‘rarely is cultural conflict listed among the precipitating causes’. It is not clear whether he is being critical of that omission or whether he, himself, believes it not to be significant.

David Bechtold is one of the few researchers who talks about ‘culturally sensitive risk factors’ for males aged 12-plus:

- physical and intellectual developmental precocity (12–14);
- conceptual maturity regarding death;
- conceptual familiarity with suicide through family or peer group or media exposure;
- substance abuse, depression, antisocial behaviour;
- previous suicide gestures and attempts;
- cultural mismatch between the youth and the environment;
- suicidogenic messages from family, especially parents;
- family disruption and dysfunction;
- availability of lethal means.

Bechtold is the only author I have read who may have read Deloria. He is concerned about the negative impact of suicide publicity and asks how one establishes unequivocal moral proscriptions against suicide without calling undue attention to suicide. He also asks whether we can delineate a generalisable, culturally relevant set of risk factors for Indian people. ‘Or do we have to do it by tribe or clan? Is tribal-specific research methodologically possible?’<sup>17</sup> Deloria’s plea is for ‘a leave-us-alone-law’; ‘what we need is a cultural leave-us-alone agreement, in spirit and in fact’.<sup>18</sup>

What we can learn from this brief excursion into North America is that there may well be room for a philosophy which is neither proactive nor intrusive, one which waits patiently until one is asked to intervene, explain, or better still, to understand. Of all human behaviours, suicide may just possibly be the one that *always* needs attention, that cannot be left alone, but which needs an attention of a very different kind from the present strategies.

#### **4. The Pacific Islands**

Geoffrey White has a valuable metaphor in relation to suicide studies: ‘The international literature is full of studies which have compared suicide rates of different nations or social groups, as if this was a more or less straightforward way of taking a

society's pulse.'<sup>19</sup> In many ways, the 1984 conference on suicide in the Pacific, held at the East-West Center in Honolulu, provided a salutary lesson about the reasons why we should broaden suicide studies by subjecting them to analysis by academics from different disciplines, with different approaches.

This is not the place to summarise all the commentaries and reports on Pacific suicide. I touch only on those aspects which could be useful in Australia and New Zealand.

The 'Pacific' in this set of studies includes the Northern Mariana Islands, the Marshalls, the Federated States of Micronesia, Nauru, Kiribati, Western and American Samoa, Fiji, Tonga, Vanuatu, the Solomons, New Caledonia, Tuvalu, Tokelau, and Papua New Guinea. While there are significant variations in suicide causes and methods, it is clear that many Pacific suicides have little to do with the 'pulse' of Western, industrialised societies. For example, among the Truk and the Samoans, young male suicide is closely associated with parent-child relationships and specific cultural routines for communicating about conflict. In other words, 'suicide is a social action which usually involves not just a single individual, but an entire family or community'. (This is what Hillman says is true of all suicide, but something which most of us, in the West, refuse to acknowledge.)

In each of the Pacific regions, there are 'reasonably coherent explanations' of suicide based in traditional patterns of culture. People understand the manner of dealing with emotion, conflict and its resolution. 'Cultural concepts shape suicide as a meaningful social action.' White concludes his overview with the strong assertion 'that a concern with cultural meaning is not separate from medical or public health concerns with suicide prevention.' No one who is ignorant of cultural interpretations of suicide can deal effectively with the 'complexities of either suicide counselling or prevention'.

Western Samoa is of particular interest because many have migrated to New Zealand, where suicide of a similar kind to that of the homeland is evident. This takes the form of young males and females swallowing 'paraquat', a weed-killer which causes a painful, lingering, untreatable death. In the 1980s, the Western Samoan male rate for the 25 to 34 group reached 167 per 100,000, and for 20 to 24-year-olds it was 75.7.<sup>20</sup> There has been a dramatically increasing use of paraquat (which was introduced into the region only in 1972). The research shows a marked increase in parasuicide, 'more often female than male', amongst those who have 'no history of mental illness'. The author, Bowles, describes these parasuicides as occasioned by flight from 'an intense and intolerable situation, with death not always the well-formulated goal'. 'There is an element of ambivalence, risk-taking, a surrender to fatalism and chance in many cases'. They involve a communication directed at significant others, 'with an operant quality which puts pressure on this complementary person to respond in some way'. This, I believe, is an adequate description of what is occurring among young Aboriginal females. It is also a description which doesn't require medical diagnosis or prescription. However, Western Samoans, like so many Pacific people, and unlike Aboriginal people, have a long cultural tradition of suicide. Words for the act were first recorded in the

1860s. Hezel notes ‘suicide, embedded as it is in Trukese culture, will no doubt remain as endemic to Truk as cholera’.<sup>21</sup>

A ‘national awareness campaign’—‘to reduce the incidence of suicide in Samoa’—began in the 1980s. The program had significant philosophical premises and goals, which I discuss at some length in chapter 10.

Micronesia has had an ‘epidemic’ of youth suicide since 1960. The rate was 8 per 100,000 in 1960–63, increasing to 48 in 1980–83, and 110.6 by 1987 for the 20 to 24-year-old cohort.<sup>22</sup> The suicides are ‘patterned culturally, in terms of the characteristics of the actors, the method, and the situations’. The predominant relationship involved in suicide is one of tension between adolescent and parent. It is the youth’s conflict about parental authority, support and recognition, that leads to self-harm. The method most commonly used is hanging, in some 85 per cent of cases.

The suicide rates vary in Papua New Guinea’s Highlands—from 34 to 72 per 100,000 for both sexes. Pataki-Schweitzer has given ten ‘ranked’ causes for this latter group: ‘bereavement, no reason, witches, quarrelled, scolded, adultery, accused as witch, frustration, misfortune, and fright’. He believes the causality is much more complex than the list suggests. Of note is the consistency of scolding, as in a parent admonishing a child, as a major factor in many Pacific suicides.

The research consensus is that ‘suicide is deeply embedded in the unique cultural context of the local situation, and that suicide is often attributed with more than a single meaning within a locality’.<sup>23</sup> Suicide should not be studied apart from the cultural context which provides its patterns and meanings in each of these societies. Hezel suggests three divisions of ‘labour’: attempting to elicit the cultural patterning of suicide; inquiring into psycho-social aspects of suicide; and suicide prevention. Under cultural patterning, he suggests four questions:

1. Historical—What is the historical, ethno-historical or mythological occurrence of suicide in the culture? Is there a lexical term for suicide? What were the typical methods and traditional interpretations of suicide?
2. Contemporary—Is there a cultural script for suicide today? What are the commonly recognized situations, methods, actors, emotions, and messages communicated by the suicides in a culture?
3. Cultural evaluation—Do members of the society evaluate suicide positively or negatively? Do people make attributions or accusations of responsibility or blame for other people’s suicide?

Several of these questions have validity in my Aboriginal context. Hitherto I have criticised the monocultural ‘mental health’ approach and suggested the co-relevance of historical, political and social factors. On reflection, some of these cultural evaluations must be included, even in groups which appear to have none of the strong traditional relationships which sustain Truk or Palau or Samoan societies.

Hezel's psycho-social questions are also pertinent:

1. Social cohesiveness—Do villages or areas of high suicide rates show evidence of a lack or a disruption of cohesiveness, due to cultural change, political fragmentation or conflict, etc?
2. Social bonds—What is the strength of affiliation between victims and their family, kin group or society? Are victims generally marginal individuals?
3. Psychological profile—What is the psychological profile of the victim? Is there any mental abnormality? Can certain high-risk personality types be identified? Are suicide victims typically described, in local cultural terms, as being 'strong' or 'weak', etc?
4. Impulsivity—To what extent is the suicide an impulsive act? Does spatial or temporal clustering, or other signals, also suggest a high degree of impulsivity in the suicide acts?
5. Emotions—What are the emotions generally associated with suicide? Especially, what is the nature of 'anger' and 'shame' and how do these two emotions interplay in cultural interpretations of suicide?

These questions form a useful agenda for those seeking prevention strategies outside those which I later describe as the 'conventional' mould. Several key 'political' questions need to be added, such as the role and effect of racism, and the exclusion of native peoples from many values, systems, rights, benefits, goods and services available to a mainstream societies.

## 5. New Zealand

My professorial inaugural lecture at the University of New England in 1972 addressed comparative race politics in Australia, Canada, New Zealand and South Africa.<sup>24</sup> While disputing the commonly expressed Pakeha (European) view that 'New Zealand has the best race relations in the world', I found much that appeared positive, at least compared to Australia, in a period of radical social and political change. Re-reading the lecture, I note that I presented separatism in a positive light, not as *apartheid* but as a way of both reviving and maintaining cultural, social and political values while still participating in mainstream societal institutions. I talked of the need for 'accommodation', a notion totally antithetical to assimilation, one in which administrators and decision-makers modify their strategies in view of 'indigenous realities'. Accommodation requires a radical change of mind and thought, including the abandonment of 'them' and 'us' as superior and inferior; it requires a mindset willing to view diverse peoples as having equivalent cultural sophistication, with each achieving, in its own way, for its own time and place. While it is clear that these cultures are not the same, invidious comparisons and distinctions block the path to accommodation, to achieving what Richard Thompson calls the necessary 'community of communities' in New Zealand.<sup>25</sup> Writing in 1998, Thompson argues that the Maori

role is not simply ‘separatist’: ‘it is not a threat’. ‘It serves a necessary and positive function in a shared society; it anchors identity and is a source of confidence and self-esteem’.

Thompson’s new discussion document, *The Challenge of Racism*, provides an excellent summary of all that has changed, or not changed, since my 1960s research in New Zealand. There is no need to traverse his discussion points, except to say that Maori suicide, like Aboriginal suicide, must be seen in the cultural, social and political contexts of the nation. Maori suicide is not simply an incidental subset of New Zealand suicide.

The 1996 census lists 2,879,085 people of Pakeha descent, (72.5 per cent of the population); 523,374 of Maori descent (13.2 per cent); 202,233 of Pacific Island descent (5.1 per cent); and 173,505 of Asian descent (4.4 per cent). Maori have tired of the array of definitions of them. They claim that self-identification is the only acceptable approach: ‘Being Maori is a state of mind.’ Of interest is that the introduction to the census states: ‘People have Maori ancestry if they consider they have Maori ancestors, no matter how distant’.<sup>26</sup>

As an irregular visitor over a period of 30 years, and bearing in mind my Aboriginal-oriented lenses, there is much that is positive in and about Maori life. I do not forget Moana Jackson’s admonition that New Zealand is ‘the land of myths, lies and deceit, where things are never what they appear to be’. Whatever the truth *within*, Maori strength appears impressive from *without*: regular inclusion of Maori as stakeholders in public and social policy formulation; virtual bilingualism, at least in government language, in official documents and on public occasions; increasing use of Maori words and concepts as part of the national culture; a powerful Maori presence in national politics; an extraordinary presence, and applause, on sporting fields and in the artistic world; Maori perspectives as part of the national media, no longer relegated to quaint documentaries; Maori Studies as part of university curriculums; the new ‘ball game’ as a result of the Waitangi Tribunal and the resultant reparation, as well as restoring ownership and management of dispossessed lands. I have one especially important yardstick: that the Medical School at the University of Otago has introduced Maori material into *every* sub-discipline, and the material is examinable. For me, that is both ‘separatism’ and accommodation at its best.

New Zealanders dispute whether *Maoritanga*—Maori being, love of Maori-ness—is the exclusive property of Maori or should be available for all to share. ‘Our culture is our business’ is fairly common. At times, this assertion of sovereignty, exclusivity or even militancy spills over into matters like suicide. At the start of our research, we were ‘warned’ by a number of people that Maori are seeking to exclude non-Maori from this domain. Not so. Maori researchers, officials and parents of deceased youth were not only polite but sharing.

*(i) Maori suicide*

The Skegg, Cox and Broughton study examined Maori suicide from 1957 to 1991.<sup>27</sup> The Maori male rate was one half, and the female rate one third, of the non-Maori. For the 15 to 24-year-old cohort, the male rate was 35.2 per 100,000, and the female, 6 per 100,000. What the researchers found disturbing was the doubling of the Maori female rate, and a trebling of the male rate, over the 35-year period.

The 1987 to 1991 figures show an 'equality' of Maori and Pakeha youth suicide. Equally disquieting, according to John Broughton, is that youth steeped in *Maoritanga* are suiciding, whereas several opinions are that it is only, or mostly, the alienated-from-culture youth who take their lives. Poison is the chosen female method, hanging the male. In the 15 to 49 age group, 71 per cent of Maori suicides in the period 1980 to 1988 were by hanging while in custody.

The study concludes that the under-reporting of Maori suicide is as high as 28 per cent. This is because 'the recording of Maori ethnicity on a death certificate depends on the undertaker ascertaining that the person had 50% or more of Maori biological origin'. Death certificates use biological definition, whereas self-identification has been the census protocol since 1986. The researchers believe that Maori suicide rates, 'already a cause for concern', might now be even higher than non-Maori.

There is very little suicide beyond the age of 55. The researchers posit that elders have a greater involvement in cultural life, and that it is the culturally-deprived or alienated youth who suicide. They see culture as 'providing a sense of belonging and purpose, and so a sense of meaning and self-worth, and a moral framework to guide [our] conduct'. Despite reports of culturally 'orthodox' youth committing suicide, there is clearly a much greater sense of security for Maori youth in family, in a *hapu* or *iwi*, than in their Aboriginal counterparts in New South Wales rural areas.

The Maori Suicide Review Group was established because of alarm that, between 1971 and 1995, 47 incarcerated Maori committed suicide.<sup>28</sup> Nowhere near the 'awesome' apparatus and agenda of the Royal Commission in Australia, it nevertheless covered some common ground, especially on 'inmate management'. The 17-page account of 'Suicide by Maori' is comprehensive.

As can be expected, the Group examined risk factors in the 'literature review': psychological/psychiatric disorders, social and cultural factors, family factors, behavioural risk factors, biochemical and genetic factors (which I discuss in chapter 10), exposure to suicidal behaviour, stressful life events, and triggers. The custody suicides were believed to involve high levels of substance abuse and 'psychiatric disorder', poor 'coping skills' and social disadvantage. There is a significant difference between the Aboriginal and Maori experience of imprisonment: Maori experience 'strong feelings of shame', whereas Aborigines appear to experience anger and a sense of retaliation, rather than shame. The Group also found that Maori inmate suicides were more likely to be those serving longer sentences for violent offences. By contrast,

much of Aboriginal suicide in custody occurs within the first 24 hours, a period of high risk. Compared with the New Zealand finding on long-serving suicides, the Royal Commission found that many Aboriginal custody suicides were, and are, by people jailed for minor infractions or alcohol-related misbehaviour.

The Group examined ‘factors specific to Maori’. Maori, who comprise 13 per cent of the population, formed 47 per cent of the prison population, as at the 1993 prison census! By comparison, Aborigines, some 2 per cent of the New South Wales population, are now 14 per cent of the prison population. Of the Maori inmates, 43 per cent were under 25. Most were unskilled, unemployed, and one in four was ‘more likely to be affiliated to a gang’. Most were in jail for aggravated robbery. All Maori had longer criminal histories. In short, ‘it appears that Maori inmates are a higher risk group before they arrive in prison’. This is consonant with my view, expressed in chapter 2, that suicide in custody has less to do with custody than with the factors which are conducive to suicide *before* custody.

The Group posits that there is ‘increasing mental illness among Maori’. They are unsure whether this is something new, or something that has been evolving. The Group considered ‘economic and social disadvantage’, quoting Mason Drurie as defining this group [of inmates] as ‘caught between two cultures, isolated from both Maori and general society’. Two submissions to the Group are noteworthy:

- (a) You could almost write the lives of each of these people. They grew up in sheer hell and hell is all they have lived all their lives and the only escape for them is death.
- (b) The fact that they are in prison is not the cause. It is an avenue which allowed them to do what they intended to do; spiritually have done months before that. The rope was just ending the physical of an already spiritual death.

The Group analyses, at some length, the cultural factors, especially the ingredients which make for a healthy person. In Australia, we have no such equivalent analyses; nor can we say, with any certainty, that there are no Aboriginal, or vestigial Aboriginal equivalents. *Te taha wairua*, the spiritual quality (or Hillman’s ‘soul’), is the most basic and essential requirement for health. *Te taha wairua* also accounts for something very important in Maori life, *mana*, or status.

Then follows a detailed exposition of *whakama*, where a person perceives he has less *mana* than particular others, or has lost *mana* because of his, or someone else’s actions. This is seen as an ‘illness with a spiritual dimension, an unease which affects the whole person, body, mind and spirit’. When *whakama* goes untreated, it can lead to breakdown. Doctors diagnose it as ‘psychiatric disorder’; Maori call it *mate Maori*, Maori sickness. There may, possibly, be some cultural equivalent in Aboriginal ‘jealousing’, discussed earlier.

*(ii) Non-Maori suicide*

Suicide studies in New Zealand are, if one may so describe them, efficient, professional, compact and strongly directed towards the medical/psychiatric model. Coggan and Norton, who have done important work on youth suicide in Auckland, have also published strategy papers for reducing ‘self-directed harm’.<sup>29</sup> Their work illustrates two themes I raised earlier: first, self-harm, of the suicide variety, ‘has significant individual and societal costs, compared with other health problems’; second, a strategy is needed ‘to improve the identification, referral and treatment of persons at high risk of suicide by various caretakers and “gatekeepers” in the community’. (Gatekeepers, in this context, no doubt means medical personnel.) This work is reasonably typical of non-Maori suicide research: it is steeped in the medicalised public health model, with an occasional reference to cultural factors, or socio-economic disadvantage. Rarely is there mention of the historical and political dimensions. New Zealand research generally posits the unlikely, namely, that there is more death, and more cost to the nation, in suicide than in road accidents, in alcohol consumption and drug abuse, and in criminal behaviour. It posits what Szasz and Hillman, among others, have shown to be quite unrewarding in terms of the prevention and handling of suicide—‘treatment’ by ‘caretakers’ and ‘gatekeepers’.

The Canterbury Suicide Project, and especially the work of Annette Beautrais, is renowned. The researchers have examined many facets of suicide: from risk factors among the 13 to 24-year-olds, to the prevalence and co-morbidity disorders among the parasuicides, to childhood circumstances and adolescent adjustment among parasuicides, to access to firearms and the risk of suicide. The paradigm in most of this material is that there is probably dysfunctional or disadvantaged family circumstance to begin with. This leads to increased vulnerability to psychiatric disorder and problems of personal adjustment, both increasing the likelihood of suicide.<sup>30</sup> Further, the ‘odds of serious suicide attempt are related systematically to the extent of exposure to disadvantageous childhood experiences and family circumstances, adverse sociodemographic factors, and an individual’s current psychiatric morbidity.’<sup>31</sup>

None of the New Zealand researchers indicate whether their samples include Maori, or if they do, whether there is anything Maori-specific about causality, suicidal behaviour and responses to psychological or psychiatric tests of various kinds. To read the Maori Suicide Review Group and the work of the ‘non-Maori’ researchers is to read about two different worlds, with only an occasional ‘cross-over’ about ‘psychiatric disorder’ which may be painful and *diseaseful* for Maori, but which hardly requires the conventional ‘gatekeepers’.

Dr David Fergusson contends that although suicide is fascinating for the media, it is not the most serious issue: rather, it is symptomatic of the conditions which give rise to it. He believes in the value of ‘early start programs’, the sending out of workers into the community to try to change community ways. ‘Good’ families can become the models for others to emulate. Suicide, he argues, will end when communities achieve a degree of social health, a view one could disagree with. It is, in essence, what Hillman

calls the ‘interiorisation’ of the suicide within the community. However, in Aboriginal societies in New South Wales (and elsewhere), distance, geography, isolation within their domains, and the absence of role models, make movement towards ‘the middle class’ and its (supposed) values not only difficult but somewhat impossible.

*(iii) Some lessons*

Much can be gained from studying New Zealand practice, and many of the positive aspects have been referred to, or alluded to, in earlier chapters. In summary, the following should be noted:

(a) Suicide research

There are, in effect, two streams of youth suicide research: one looks through universal (or Western) lenses, the other embraces a Maori perspective. The former is a distinctly medical/psychological model, the latter, a cultural/spiritual one. Neither appears to incorporate earlier or contemporary history, politics, or the consequences of racism (other than to talk about ‘social disadvantage’). The Maori perspective seeks liberation from conventional suicidology, and that, I believe, is positive. However, a joining of forces seems the obvious path to follow. Although Aborigines have yet to insist on a ‘separate’ perspective, such a differentiation between Aboriginal and non-Aboriginal suicide is crucial.

Cultural ‘orthodoxy’ and a steeping of youth in *Maoritanga* appears not to be prophylaxis enough. Acculturation, re-acculturation, or what Deloria calls revivalism, has many positive consequences, and it may well lower the level of suicidal behaviour. The Yarrabah Museum (near Cairns) certainly appears to have attracted the interest of youth. *Winanga Li*, the first volume in the series ‘The Moree Mob’ is an attempt to provide genealogies and photographs of the areas known formerly as ‘Top Camp’, ‘Middle Camp’ and ‘Bottom Camp’ when Aborigines were moved from Terry Hie Hie to Moree in the early 1920s. Aborigines in that region have only just begun to find themselves, geographically for a start.

(b) Illiteracy, deafness, grief and cannabis

More Maori suicides leave notes than do Aborigines. At a guess, the general level of Maori literacy is somewhat higher. No one has yet suggested illiteracy as a relevant factor for suicide, but there is at least a high order proposition that illiteracy, and illiteracy plus deafness, is a key factor in youth disadvantage. In 1988, the Mason inquiry into maximum security and suicide found that 80 per cent of Maori in prison had a hearing problem, and that 20 per cent had a severe hearing problem. Chronic otitis media, ‘glue ear’, burst eardrums and consequent deafness have been well documented across Aboriginal Australia. These social/physical factors have as much validity as the vaguely phrased (mental) ‘stress’ factors in both countries.

‘Five generations of grieving’ is the judgement of Dr Erahana Ryan. She believes

the youth absorb feelings of racial alienation, emptiness, loss of culture, loss of self and the loss of esteem. 'Stress of loss of who they are' is the key to her therapeutic approach. To this end, she trains Maori health workers, preferably older women who have been 'through the mill'. In the Aboriginal context, there are such Aboriginal women, and several are doing similar work. What they don't have is the benefit of training and supervision, of being mentored, by someone like Dr Ryan.

There is strong anecdotal evidence that many Maori youth suicides have had a cannabis 'problem'. A Maori couple, who lost their son to suicide and who now counsel bereaved families, told me that they know of several youth suicides who were heavily 'into' cannabis: 'they can't afford the hard stuff'. They observe that 'it affects their emotions and they don't hear. They agree with all you say but show no emotional reactions.' This couple suggests a model for Australia: a counselling service by Aborigines for Aborigines.

Mate Frankovich, New Zealand's senior full-time coroner, does not dispute any of the discourse about Maori suicide, but he does point to cases which appear to have nothing to do with the factors discussed thus far, and which appear quite banal. One Maori youth, who used carbon monoxide, left a long note: his message was to the effect, 'to hell with life, if I can't have pot and I can't find a place to skateboard, I may as well die'. Another 16-year-old male, whose girlfriend looked after his 2-month-old baby, wanted sex; she said no, and he hanged himself. These may well have been the real reasons for the suicides; they may also have been the ostensible ones. We must beware the desire, or the need, to attribute deeper meanings to all youth suicides.

(c) 'Secondary victimisation'

Keri Lawson Te Aho, a consultant psychologist, talks about the legacies of racism and alienation, adding that there is 'a secondary victimisation of Maori youth' in institutions, especially in the mental health system. This is consistent with the views of the Maori Suicide Review Group, who infer that Maori prison inmates are in a 'special' category in the eyes of corrective service personnel, long-term, violent, prone to suicide, and so on. Professor Mason Durie considers that the 'mental health services for Maoris are hopeless'.

There is no need to argue the obvious case about such secondary victimisation of Aborigines in Australian institutions. It begins in schools, continues through hospitals, endures in prisons, and sometimes extends even to cemeteries. We need to ask why so few Aboriginal inmates in NSW prisons progress to the last two stages of minimum security classification.

(d) Purpose in life

We do not have statistics for Maori suicide in Hamilton, but there is a strong suggestion that the King/Queen Movement community there has a greater sense of cohesion and purpose, and a lower rate of violent behaviour. However, the Maori parents

mentioned above, lost their son when he was boarding at a Hamilton school. They say that there were at least four suicides amongst that same school cohort.

Gordon Matenga, New Zealand's only Maori coroner, is a Mormon. He is certain that the extensive participation of Maori in the Queen Movement and the adherence of so many to the Mormon Church account for the low rates of suicide. In Mormonism, the sanctity of human life is paramount. Many New Zealanders from Western Samoa, the Cook Islands and Tokelau are staunch adherents of the Catholic, Methodist and Pacific Island churches. Nevertheless, Samoans have a high rate of suicide: 'it is part of their history', says the Pacific Island co-ordinator of the New Zealand Research Council. She says 'there is contempt for people who suicide, and they are buried upside down'; 'It is worse to lose your face than lose your life'.

By contrast, Dr Rees Tapsell, a Maori psychiatrist, believes that 'a large number of Maori do not have a social glue' which would provide purpose or cohesion. 'They live on the myth of alienation': by which he means that mere membership of a group on the basis of a common feeling, or reality, of racial alienation is insufficient as a life-sustaining force in the way that nationalism, Mormonism, or Black Islam can be a 'glue'.

Sport, as in Australia, is considered by all we interviewed as 'one high spot'. In 1997, the Aranui Sports Academy was established as a way of stopping the drift of Maori and Polynesian boys out of school.<sup>32</sup> Aranui High School switched from rugby league, at which they were champions, to rugby union in order to accommodate these young men. In 1997, they beat St Bedes College in the final, to win the schoolboys' championship, As the *North and South* magazine commented, such a predominantly Maori and Polynesian team victory would hardly arouse attention, but this was 'Christchurch, the most WASPish of all New Zealand cities and until this season, the final bastion of pre-Polynesian rugby'.

The organisers realised 'that one positive thing in many of these young people's lives was sport'. All 33 members of the Academy were properly enrolled in the school. The Academy's 'take (purpose) is about changing the kids' attitudes in order to make them more employable, *not* about winning on the sports field'. Students had to complete four years of senior schooling or have been away from school for a year. In addition to sports activities, classroom work is compulsory. The boys set the agenda, 'no one else'. Needless to say, there was a howl of protest in Christchurch at the Academy's victory, with allegations of Aranui's bringing in professional rugby league adults to demolish amateur children in union. The Aranui project could be emulated in any number of New South Wales towns, where the residential divide between East side and West side (as in Christchurch) is as great.

#### (e) Coroners

Of the 74 coroners in New Zealand, only three are not qualified in law. The independence of coroners from the police is important. Under-reporting of suicide and

identification of the deceased as Maori are still serious problems, but much less so, in my view, than in Australia. The police form, 'P47 Report for Coroner', makes provision for 'Race', but this does not resolve the biological *versus* self-identification conundrum. The officer does not always 'get it right' and the coroner is not obliged to distinguish who is or is not Maori. Coronial practice benefits enormously from virtually every larger police station's having an officer designated as inquests officer. Most learn on the job. As few appear to reach the rank of sergeant, there is certainly room, in New Zealand, as in Australia, for a professional, career promotion category of inquests officer, or, as in Dallas, a death investigator, in New Zealand and Australia. Their approach and dedication are impressive, as are their symbiotic relationship with their coroners and their formal 'distance' from other police.

(f) Prevention strategies

In Chapter 10, I discuss a variety of prevention strategies in use in the Western world. In addition, there are two projects in New Zealand which were not devised for suicide but which hold promise as effective counters to a preference for death rather than life. 'Going-for-Goal: a Sport-Based Life Skills Program for Adolescents' uses a sporting metaphor to elicit young people's frustrated goals and to assist them to overcome the obstacles to their attainment. Based on an American program, essentially for Afro-American youngsters, it has been trialled by the University of Otago in Dunedin. The other is the 'Smokefree' project run by the Health Sponsorship Council in Wellington. This is very much a peer group pressure exercise in breaking the smoking habit among teenagers. Its methodology could as readily be tried as a way of bringing youth to the point where it is 'cool' to stay alive! It has the singular merit of being run for Maori youth, by Maori youth, who have 'been there'.

**Endnotes 9. Lessons from Abroad**

1. Hillman, 49 (my italics).
2. Ibid., 198–200.
3. Flisher *et al*, 1992, 77–80.
4. Flisher, Ziervogel *et al*, 1993, 469–73.
5. Flisher, Ziervogel *et al*, 1993 Part II, 474–6.
6. Flisher, Parry *et al*, 1994, 348–52.
7. Mayekiso, 40–5.
8. Deloria, 17.
9. Malchy.
10. May, 8.
11. Lester, 1997, 14.
12. Lester, 1997, 131.
13. *Calling from the Rim*, 7.
14. Malchy, 1135.
15. *Newsweek*, 15 February 1988.
16. Lester, 1997, 23–26.
17. *Calling from the Rim*, 75 ff.
18. Deloria, 27.
19. Hezel *et al*, 2–12.
20. Ibid., 15–20.
21. Ibid., 123.
22. Ibid., Rubenstein, 89–93; Chen, 60.
23. Ibid., 210–16.
24. Tatz, 1972.
25. Thompson, 103–12.
26. Ibid., 13–15.
27. Skegg, Cox and Broughton, 453–58.
28. Maori Suicide Review Group, especially 19–35.
29. Coggan and Norton, 1994, 26–31.
30. Fergusson and Lynskey, 613.
31. Beautrais, Joyce and Mulder, 1996, 1179.
32. ‘East Side Story’, *North and South*, October 1997, 74–80.