Australian Aboriginal suicide: The need for an Aboriginal suicidology?

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Abstract

This article examines suicide among Australian Aboriginal peoples, and reviews current directions in suicide prevention. A particular focus is on the apparent differences discovered by other researchers in suicidal behaviour, risk factors, response to prevention programs, as well as cultures, customs and beliefs between the Aboriginal and non-Aboriginal population, and between different Aboriginal communities and groups. Despite evidence of such differences, Aboriginal suicide continues to be addressed under the same framework as the general population by national suicide prevention strategies. Also, many Aboriginal suicide prevention initiatives continue to be adapted from existing non-Aboriginal models, which are based on non-Aboriginal understandings of suicide, health and healthcare. The evidence is reviewed in the context of the argument for an Aboriginal suicidology that is separate to the current mainstream suicidology, which could have the potential to better inform the development and future direction of more effective and appropriate Australian Aboriginal suicide prevention initiatives.

Keywords
Suicide, Aboriginal people, self-harm, social and emotional wellbeing, mental health, suicide prevention

Introduction

Incomprehensive mortality and morbidity data both nationwide and within individual states and regions makes it impossible to gain a clear picture of the occurrence of suicidal behaviour in the Aboriginal population. Aboriginal suicide is currently addressed under the same framework as the general population by national suicide prevention strategies. Prevention approaches in the majority tend to be adapted from existing non-Aboriginal models, which are based on non-Aboriginal understandings of suicide, health and healthcare, as detailed in this article. However, recent research that has been conducted by Tatz (1999) and Hunter, Reser, Baird & Reser (2001) has indicated important differences in suicidal behaviour epidemiology and aetiology, not only between the Aboriginal and non-Aboriginal populations, but between different Aboriginal communities and groups.

Suicide epidemiology

Data and definitions

It is believed that the actual Aboriginal rate of suicide may be as much as two to three times higher than figures indicate. This may be due to the under-reporting of suicide as cause of death (Harrison, Miller, Weeramanthri et al., 2001;

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Tatz, 1999), the general lack of data on suicide attempts and self-harming behaviour (Centre for Mental Health, 2000), and the misclassification of indigenous status on death certificates and other data systems (Australian Bureau of Statistics: ABS & Australian Institute of Health & Welfare: AIHW, 1999).

There has been little research conducted into Aboriginal understandings and definitions of suicide and self-harm behaviour. The definition of suicide for the general population continues to be debated, the crux of the argument being the element of intent (Allen, 2000). Some perspectives see reckless behaviour and conditions such as anorexia nervosa as 'related phenomena' (Harrison et al., 2001). As Tatz (1999) states, intent is not always obvious. The other contentious issue is intentional self-harm, which may not always occur with the intent to end life. In an Aboriginal context, such behaviour has been described as occurring with an intent to provide a 'release' – '…after their wrists are cut, they often feel calm and at peace for awhile' (Cawte, 1988, cited in Reser, 1991:276). Tatz (1999:69) describes self-harm as often the reverse of a suicide attempt, in that it is '…a letting of blood in order to feel the warmth and the vitality of life, an affirmation that one is alive'.

Suicide deaths

Suicide was not known in traditional Aboriginal society (Sumner-Dodd, 1997, cited in Leenaars, Brown, Taparti et al., 1999). Even up until the 1960s, suicide was a rarity (Cawte, 1964, cited in Leenaars et al., 1999). However, the 1970s saw the incidence rates of suicide and suicidal behaviour begin to increase. By the 1980s, the situation became endemic in some Aboriginal communities (Reser, unpub., cited in Thomson, 1991). The past decade has seen suicide become a significant contributor to premature Aboriginal mortality (Hunter et al., 2001).

It is estimated that suicide rates among Indigenous peoples are at least 40% higher than the national average (National Advisory Council for Youth Suicide Prevention: NACYSP, 1998). In the general population, the suicide rate has remained relatively constant over the last century, at 21 and 5.5 per 100,000 respectively for males and females in 1995 (Hunter & Harvey, 2002). Until the 1960s, suicide was primarily a problem among the older age groups. However, by 1990, the younger age group of 15-29 years and the elderly of 75 years and over became the high-risk age cohorts (Hassan, 1996). The rate for young males has climbed dramatically. In 1998, the rate per 100,000 was 17.2 for males aged 15-19 and 35.9 for males aged 20-24. For females aged 15-19 the rate was 5.5 per 100,000, and for those aged 20-24 it was 7.1 (ABS, 2000, cited in Mitchell, 2000b). The ABS & AIHW (2001, cited in Brideson & King, 2002) reported that in 1997-99, age-specific suicide rates for Indigenous males and females were highest in the 15-24 year age group at 108 and 18 per 100,000 respectively. The rate of suicide is generally increasing in Aboriginal communities; however, this increase is distributed unevenly across both time and place (Hunter et al., 2001).

Indigenous suicide appears to occur in clusters at certain points in time in particular communities, more frequently than in the general population (Hunter & Harvey, 2002). Hunter et al., (2001) particularly note this in their analysis of suicides in the Aboriginal community of Yarrabah, in North Queensland. Tatz (1999) reports five suicides occurring within one Aboriginal family in the space of two years.

Suicide attempts

While males exhibit higher rates of suicide deaths, females exhibit higher rates of suicide attempts. Such differences have been attributed by Hassan and Tan (1989, cited in Mitchell, 2000b) to the preference males appear to exhibit for more violent methods with higher levels of lethality. In the general population it is estimated that for each completed suicide there may be up to 50 male and 300 female attempted suicides (Cantor et al., 1998, cited in Mitchell, 2000b). It is also believed that at least 60% of suicide attempts never come to medical attention (Martin, Clarke & Pearce, 1993, cited in Young People at Risk: Research & Evaluation Team, YPR:RET, 1996). Reser (1991) reports that in a research investigation of self-injury and suicide in Queensland Aboriginal communities between 1980 and 1988, 14.5% of Aboriginal respondents reported having attempted suicide, compared with 5.3% of non-Aboriginal respondents. Seventy-one percent of the attempts occurred

when the individuals were aged between 15 and 25. The pattern of higher male suicide deaths and higher female suicide attempts evident in the general population was found to be similarly evident in the Aboriginal population in the Shoalhaven region of NSW (Ranasinghe & Westley-Wise, 1999). There, the crude average annual hospitalisation rates for attempted suicide among Aboriginal people (502 per 100,000) were found to be much higher than that of the non-Aboriginal population (199 per 100,000).

Risk factors

Many of the mainstream social risk factors for suicide do not apply to Aboriginal people and their communities in the same way, if at all (Tatz 1999). Hunter and Harvey (2002) propose that risk may be better understood in terms of lifestyle rather than vulnerability to suicide as such. Risk should be considered at the community rather than individual level, and in terms of risk of harm in general, rather than suicide specifically.

Aetiology

There are important aspects that make Aboriginal suicide different. These differences vary between regions and communities. As Tatz (1999:73) states, '…there is a separate Aboriginal suicidology – perhaps even separate Aboriginal suicidologies'.

There have been few systematic research studies into the causation of Aboriginal suicide. Tatz (1999) and Hunter et al. (2001) provide the most recent comprehensive investigative reports into suicide in Aboriginal communities in NSW and North Queensland. Tatz (1999) believes that past studies, including the Royal Commission into Aboriginal Deaths in Custody, which focused mostly on suicides in custody, have tended to confuse underlying factors relevant to personal or family-related issues involved in particular cases as the reasons for the suicides, an approach which fails to explain why other individuals affected by similar issues do not take the same action.

There is a general consensus that Aboriginal suicide is the '…product of a complex set of individual, situational and sociocultural factors' (Hunter et al., 2001:8). Tatz (1999), for example, proposes eight factors in the causation of Aboriginal suicide, notably: a lack of a sense of purpose in life; a lack of publicly recognised role models and mentors outside of the sporting realm; the disintegration of the family and lack of meaningful support networks within the community; sexual assault; drug and alcohol misuse; animosity and jealousy evident in factionalism; the persistent cycle of grief due to the high number of deaths within many communities; and illiteracy, which results in exclusion and alienation.

Psychiatric illness

It has long been held that psychiatric illness is most frequently present in cases of attempted and completed suicide. Depression is frequently cited as the precipitating cause of Aboriginal suicidality; however, there has been little reference to the cultural context and meanings of depression-like behaviour (Reser, 1991). Thomson (1991:68) states, 'It is also probable that the completed suicides are just the tip of a large iceberg of increasing mental distress and disorders experienced by many Aborigines'.

Tatz (1999) proposes that Aboriginal suicidality is not always the domain of mental health. He reports little evidence of clinical depression in the Aboriginal suicide cases he investigated, and little or no correlation between Aboriginal suicide and diagnosable mental illness. Reser (1991) also argues that mental illness cannot be considered a causative factor in many of the Aboriginal suicides in custody. It should be noted that Tatz (1999) conducted this research retrospectively, relying on available records and personal accounts from family members and friends of the deceased. Further longitudinal research would provide more conclusive results. It is also interesting to note that Tatz (1999) does not appear to view the substance-related disorders related to drug and alcohol misuse as mental illnesses, despite these being included in the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition* (American Psychiatric Association, 2000).

Impulsivity, intoxication and symbolism

Aboriginal suicide is often impulsive and frequently occurs in the context or aftermath of intoxication (Hunter et al., 2001; Tatz, 1999). Numerous Aboriginal family members reported to Tatz (1999) that there were no warning signs

to alert them of the impending suicidal behaviour. Notes are extremely rare in Aboriginal suicide cases, which Tatz (1999) believes is indicative of the level of illiteracy within Aboriginal communities, and a lack of premeditation and planning. Reser (1991:274) notes that Aboriginal suicides '…constitute more of a reactive emotional response to a particular situation or set of events'. This impulsivity is clearly associated with alcohol use (Hunter & Harvey, 2002).

MacAndrew and Edgerton (1969, cited in Hunter et al., 2001:75) conceived the theory of 'drunken comportment', whereby over the course of socialisation people learn what their society knows about drunkenness, and then accept and act on this knowledge. In some Aboriginal communities this can be seen in the pattern of binge drinking followed by violence and self-destructive behaviour. Hunter et al. (2001:75) deduce that alcohol '…appears to be a necessary but not sufficient precondition, its impact mediated by the associated lifestyle of risk but demanding certain other contextual factors for this to express as self-harm'. Thus, Hunter et al. (2001) see alcohol as playing more of an enabling rather than causative role in suicide, acting as a precipitant which helps tip the balance against the real cause – the 'lifestyle of risk'. Tatz (1999) theorises that alcohol use often constitutes a coping mechanism; it creates the impression of social interaction, often facilitating extremes of emotion, and provides a temporary escape from alienation, anxiety and vulnerability. The end result of such dependence is the failure to develop more adaptive, long-term coping and problem-solving skills. In this context, in situations of alcohol-induced emotional extremes, perhaps the impulsivity of Aboriginal suicide can be better understood: suicidal, self-harm and other seemingly reckless and destructive behaviours may be an individual's most ready resource.

The predominance of hanging as a method has been studied by Hunter et al., (2001), who describe it as both a political and poignant symbolic statement. Aboriginal suicide deaths in custody have been seen to be '…a powerful symbolic statement of oppression and injustice' (Reser, 1991:268). Hanging itself has been a stark symbol of Aboriginal punishment from colonial days, through to the Royal Commission into Aboriginal Deaths in Custody, with connotations of injustice, murder, defiance and martyrdom (Hunter et al., 2001). The cultural meaning of hanging in Aboriginal societies is believed to entail connotations of capital punishment, the legal system, and genocide; it has been featured in many recent films, song lyrics, plays, posters and the media in general; it is an easy yet effective means which requires minimal readily available equipment; it has a suggestive and invitational quality as many others have died the same way; it has connotations of magic and sorcery; and there is a sense of camaraderie and solidarity in copying the means of suicide used by a relative or friend (Hunter et al., 2001).

Hunter et al. (2001) cite accounts from Aboriginal people describing their encounters with malevolent spirits and spirits of deceased relatives and friends. These spirits commonly entice the individual to suicide. Combined with drug and particularly alcohol use, a sense of compulsion and lack of control pervades.

Places where people have died by suicide take on local meanings and associations within a community (Hunter et al., 2001). Such places are known to have a suggestive and invitational character, and often these areas are physically modified as much as possible to help minimise further suicide activity. Death is more readily familiar to Aboriginal children (Tatz, 1999). Grieving is common and constant; there is no opportunity to deal with the grief that follows one death before another occurs, and access to any form of grief counselling is minimal. Suicide deaths, particularly by hanging, are frequently witnessed by many members of the community, who experience first hand the impact such deaths have on the community (Hunter et al., 2001). Such deaths often spark a cluster of suicides in Aboriginal communities, of similar methods, gender and age groups, suggesting an observational learning, modelling, imitative, catalytic role.

Racism and discrimination

Aboriginal youth are being assimilated into the western culture, but only to the lowest class of lifestyle. Tatz (1999) found that many youth expressed a sense of emptiness and a general

loss of culture, particularly ritual and spirituality. Aboriginal youth are commonly caught between two cultures (Donaghy, 1997). Daily life may require moving between both Aboriginal and non-Aboriginal cultures, both of which can hold conflicting expectations, roles and responsibilities. At times, acceptance in each may be conditional and restricted. Hunter and Harvey (2002) propose that Aboriginal youth are experiencing an increased awareness of the difference between their own socioeconomic circumstances compared with those of non-Aboriginals around them.

Scientific and institutional racism inherent in past and present policies affecting Aboriginal people have ensured their dependence on the State (Eckermann, Dowd, Martin et al., 1992). Aboriginal people are frequently confronted with a 'negative looking-glass' from non-Aboriginal society, resulting in considerable insecurity about self and culture (Cooley, 1956, cited in Eckermann et al., 1992). Many Aboriginal people experience racism during school, when seeking employment or housing, in their contact with police or other public officials, and in their daily contact with other members of the Australian non-Aboriginal population (Gray, Trompf & Houston, 1991). The media commonly over-sensationalise Aboriginal issues, focusing on negative aspects, and frequently assuming an anti-Aboriginal position.

Suicide prevention

Aboriginal suicide prevention and the National Strategy

Generally there is a lack of documented suicide prevention interventions targeting Aboriginal people (Harrison et al., 2001). The NACYSP (1998) has trialled a range of Aboriginal suicide prevention approaches, including community development and education programs; activity programs; and the provision of small grants for life promoting activities. Aboriginal suicide prevention objectives are generally based on the two strategies of inclusion in the implementation of mainstream suicide prevention programs and the development of Aboriginal-specific approaches.

The National Youth Suicide Prevention Strategy ran from 1995 to 1999 (Tatz, 1999). Aboriginal people were a 'target group' for the Strategy. However, Mitchell (2000b) noted achievements for this group were somewhat limited, with early intervention projects not adequately exploring issues of Aboriginal access and engagement; and a deficiency in 'postvention'(after a suicide death has occurred) projects, assessment of accessibility of programs and the use of existing collaboration mechanisms. Postvention has been identified as being of high priority for Aboriginal communities because of the frequency of death and lack of grief support available in these communities (Mitchell, 2000b; Tatz, 1999).

The National Suicide Prevention Strategy, funded in the 1999-2000 Federal Budget, runs for four years (Tatz, 1999). Aboriginal people are included in its framework, however, Tatz (1999) states there needs to be a separate Aboriginal Strategy, with its own framework, addressing region-specific and appropriate strategies.

Aboriginal suicide prevention interventions

Aboriginal suicide prevention interventions generally fall into the following categories provided by the NACYSP (1998): development of personal skills; creation of supportive environments; strengthening communities; re-orienting health systems; and building better public policy. Programs are frequently adapted from mainstream predecessors (see Brideson & King, 2002; Capp, Deane & Lambert, 2001; Clarke, Harnett & Shochet, 1998; Tatz, 1999), and while many report positive feedback from participants, difficulties continue to exist in ensuring the program reaches those most in need in the community.

Programs that have been developed and implemented specifically by and for the communities they are intended for, and that foster empowerment appear to have more long-term success. The involvement of Aboriginal communities in the programming and delivery of services has been shown to bring about a heightening of personal and community awareness (Eckermann et al., 1992), and increased self-respect and dignity (Choo, 1990). Aboriginal involvement, consultation and control also results in a higher level of commitment to achieving desired outcomes, decreases the likelihood of dependency, and

fosters empowerment (Thompson, 1996). Levels of community ownership or commitment have been shown to relate to the extent to which suicide is identified as a priority issue by the community concerned (Hunter et al., 2001; Mitchell, 2000a).

Programs that connect young Indigenous people with their traditional culture and spirituality have been highlighted as important in suicide prevention (NACYSP, 1998). Leenaars et al., (1999) stress that this does not mean going back to the old ways, but rather that healing will come through the re-learning of the traditional ways and meanings by using the new ways.

In the area of mental health, narrative therapy has been successfully adapted to the needs of Aboriginal people in counselling and therapeutic contexts, and Aboriginal-specific therapies are being developed (Commonwealth Department of Health and Aged Care, 2000; Hunter et al., 2001).

The need for evaluation

Brady (1995, cited in Allen, 2000) notes that the result of the lack of documented evidence of the performance of Aboriginal suicide prevention initiatives is that activities are being implemented with no way of justifying the time, energy and funds, and no guarantee that they are not in fact doing harm. Evaluations that do exist are mostly based on specific target groups, for example students in high schools (Clarke, Harnett & Shochet, 1998) or select communities, for example the Shoalhaven Aboriginal Gatekeeper Training Program (Capp, Deane & Lambert, 2001). This means that evaluation findings cannot be presumed to be applicable to Aboriginal communities elsewhere (Hunter et al., 2001), because of the heterogeneous nature of Aboriginal groups (as in tribes), as well as of Aboriginal communities (which can be made up of Aboriginal people from numerous 'groups').

It is not easy to demonstrate a program's impact on actual suicide rates for several reasons. The low incidence of suicide, even in groups at high risk, complicates a formal evaluation of suicide prevention activities (Harrison et al., 2001). Many programs could take years to translate into such outcomes. The poor quality of suicide data is another factor. Also, the causes of suicide are often complex, relating to many factors, which makes it difficult to attribute changes in incidence over time to a single intervention, or element of an intervention. Because interventions are likely to be offered in communities with high suicide rates, the interventions are a result of the suicide rate, rather than the suicide rate reflecting a lack of effectiveness of the intervention (Mason, 1991). Another difficulty is the lack of access to suicide data experienced by Aboriginal communities themselves (Hunter et al., 2001). Rates of attempted suicide are also problematic as outcome measures, due to the differences already discussed between suicide and self-harm, and because not all suicide attempts present to a health service, which means that no information is collected on them.

Such difficulties have led to a focus on impact measures rather than outcome measures alone, which concern evaluating how program components meet objectives (Hawe et al., 1990, cited in YPR:RET, 1996). Process evaluation measures are also important because they help to ensure that interventions are not actually causing harm (Mrazek & Haggerty, 1994, cited in YPR:RET, 1996).

A feature of many studies has been the use of culturally unsuitable methodology, contradictory claims and poor reporting (Swan & Raphael, 1995). The majority of suicide studies have been preoccupied with the scientific method – numbers, percentages and rates (Tatz, 1999). Many have been controlled studies, some even going to the extent of being'double-blind'. The difficulty in achieving this in studies of Aboriginal suicide is the unavailability of a control group. Allport (1942, cited in Leenaars et al., 1999) has stated that the scientific approach has its place in understanding Indigenous suicide, yet so too does the idiographic, narrative, qualitative approach. The narrative approach can be appropriate in evaluating Aboriginal suicide prevention interventions because it has been '…the way to knowledge among Indigenous people since the world began' (Leenaars et al., 1999:342).

The need for an Aboriginal suicidology?

Aboriginal suicide death and attempt rates differ notably between the Aboriginal and non-Aboriginal population. Characteristics of

suicidal and self-harm behaviour appear to differ as well, such as the occurrence of suicide clusters in Aboriginal communities. Aboriginal suicide risk factors have been recently shown to differ to those noted in the general population, in particular the cycle of grief and loss in Aboriginal people that commonly receives little resolve. Of critical importance is the indication of differences in suicide aetiology, in particular the reported rarity of mental illness in Aboriginal suicide cases, and the strong link with alcohol and other drug use.

It can be argued that the existence of such important differences clearly indicates the need for such behaviour to be addressed under a separate framework from that targeting the general population. The basis of this framework needs to be an Aboriginal suicidology which is separate to the current mainstream suicidology. Some would argue that this is a step back to the segregationist policies of the past. It could also be argued that this would provide little incentive for mainstream services to ensure their service is as culturally sensitive and appropriate as possible for Aboriginal people, as well as give services a reason to 'palm-off' Aboriginal clients elsewhere. However, it can also be argued that an Aboriginal suicidology would be in line with the policy of Aboriginal self-determination, a popular catch-phrase in politics which is defined by the Aboriginal and Torres Strait Islander Commission (1998:11) as 'Aboriginal communities deciding the pace and nature of future development as significant components within a diverse Australia'.

An Aboriginal suicidology could also have the potential to better inform suicide research, and the development and future direction of Aboriginal-specific suicide prevention initiatives that are 'Aboriginal-specific' not because they have been adapted from non-Aboriginal models, but because they have been based on Aboriginal understandings of suicide and self-harm behaviour. Such research and development must respect and accommodate the unique nature of different Aboriginal groups and communities, and the need for suicide prevention initiatives to be designed to specifically suit individual communities.

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