



A post-Jungian perspective on 55 Indigenous suicides in Central Australia; deadly cycles of diminished resilience, impaired nurturance, compromised interiority; and possibilities for repair

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Abstract

On a 15 month Consultant Psychiatric placement in Central Australia the senior author learned that Indigenous suicide rates in this region over 2001 to 2006 were almost ten times as high as European ones. What accounts for this, and what can be done to reduce it? Within the limits imposed by organisational and service delivery priorities, the authors conducted an opportunistic qualitative study, investigating hospital records, opinions of colleagues, interviews with survivors, and Coroners' and Psychiatric reports, in an attempt to address these questions. Basic data patterns were similar to those in other Indigenous suicide studies; reflecting dire overall levels of chronic stress, and indicating an undermining of resilience. Canvassed opinions of medical colleagues, informed by contemporary epigenetic perspectives, developed this hypothesis further. Chronic deprivation and stress may have resulted in a transgenerational cascade of epigenetically impaired resilience to stress, mediated by the impact of stressed infant nurturing, resulting in Hypophyseal Pituitary Adrenal (HPA) Axis dysfunction and its behavioural sequelae (depression, anxiety, substance abuse, violence, suicide; but also impaired capacities for nurturance). The authors wondered about the impact of this on the development of that prefrontally-mediated interiority (capacity for reflective inner life) that authors like Fonagy (2004) associate with the ability to deal with extreme emotional states. Survivor vignettes reflected something of the interior process of suicidees. The suicide gestures could be read as expressions of social powerlessness and implicit pleas for the kind of nurturance that might facilitate development of a capacity for reflectiveness that might lessen impulsive emotional acting out. The developing individual's impaired capacity for an inner life may be repaired to some extent, in psychotherapy, by the application of an empathic reflective nurturance (Fonagy, 2004; Meares, 2000). What is required in a social tragedy of this magnitude goes way beyond the psychotherapist's rooms. Informed by a post-Jungian sensibility, the authors extend this model of therapeutic nurturance, as heuristic metaphor, to the notion of the larger Euro-Australian milieu as failed nurturer, with a particular focus on psychiatric and forensic services. In an attempt to see how organisations might become more effective nurturers, we used a Leximancer 'concept analysis' of Coroners' Reports to explore organisational 'collective countertransference'. The Leximancer data suggested slippage between collective intentions and outcomes, prompting a discussion of ways of enhancing the nurturing capacities in organisations/services (in this case, Psychiatry and the Law). A 'Kanyini/nurturance' project of repair is outlined.

Keywords

Central Australia, collective countertransference, epigenetic, Indigenous suicide, Jung, Leximancer, interiority, reflectiveness, resilience, nurturance

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Prologue

In 2006, the senior author, after a 10 year absence from Central Australia, accepted a 15 month placement with the Central Australian Mental Health Services; an opportunity to renew his links with Indigenous friends, mentors and patients. He noticed Indigenous suicide rates were much higher than 10 years earlier. Our paper focuses on this suicide epidemic. It is not a piece of methodologically rigorous social sciences research. The reported pieces of qualitative research are fragmentary and suggestive - prompts for more thorough research. However, in the face of an escalating tragedy of these proportions, and the psychiatric failure that it implies, a start needs to be made, an engagement. This describes such an attempt.

I. A contextualising overview

In Australia, rising national suicide rates of the 1990s appeared to plateau around 2002 (Australian Bureau of Statistics, 2003) in parallel with First World trends. Yet in the Northern Territory, where suicide rates had already been higher than the national rate since 1996, they have continued to rise, especially within Indigenous groups. Measey and colleagues (2006) report these worrying trends in the suicide demographics of the 'Top End', the more heavily populated northern region of the Northern Territory (75% of total Northern Territory population). Central Australian suicide statistics are similar.

Why is this so? Ethnopsychiatrist Colin Tatz (cited in Hoogland & Piertse, 2000, p.8) reminds us

... suicide was an alien concept in Aboriginal life... It was never mentioned by Aboriginals, anthropologists, linguists, government officials, missionaries, magistrates, pastoralists or police. In 1968, Kidson and Jones found an absence of 'classical neuroses, psychosomatic illness and suicide' among Western Desert people. John Cawte's (1974) medico-sociological expedition to Arnhem Land in 1968 found 'nothing alarming' about Aboriginal suicide rates... Hunter et al. (2001) state that 'some three decades ago the suicide of an Indigenous Australian was a rare occurrence'.

What has happened over this period? Rising suicide rates across the world and Australia cannot by themselves account for Indigenous rates rising from almost zero to gross excess;

prompting writers like Elliott-Farrelly (2004) to propose an 'Aboriginal suicidology'.

Elliott-Farely (2004), Colin Tatz (2001), Hoogland and Piertse (2000) and other writers have described a range of psychiatric psychosocial and cultural factors implicated in rising rates. The Hoogland and Piertse LifeForce Suicide Prevention Report is especially recommended for its comprehensiveness. Within it are ideas of particular interest to the qualitative investigator. One of them is Schneidman's concept of 'psychache' (Hoogland & Piertse, 2000, p.5), suggesting individuals have different *thresholds* for enduring psychological pain, beyond which suicide can be the outcome. What factors set this 'suicide threshold'? How has individual *resilience* become so disastrously eroded?

Suicide prevention initiatives in Indigenous communities

There is a large secondary and tertiary suicide prevention literature to which a range of authors like Hunter, Reser, Baird and Reser (2001), Elliott-Farrelly (2004) and Tatz (2001) have contributed. But the emic and the Indigenous perspectives are still not as salient as they could be. Indigenous psychologists and social therapists like Tracy Westerman (2004) and Judy Atkinson (2002), who have engaged powerfully for years with Indigenous people at risk, seem to be overlooked in the suicide prevention literature. One might suppose that is because they have not written articles exclusively focused on suicide, though other Indigenous authors (Absolon & Willett, 2004) have wondered about factors of cultural partiality. We need to listen carefully to Indigenous accounts, and our co-author Laurentia Grant described, at the Cairns RANZCP Conference 2006, some current Indigenous initiatives in suicide prevention in Central Australia (Petchkovsky, Cord-Udy, Lindner et al., 2006).

The suicide statistics in Central Australia 2001-2006

The boundaries of the Central Australian region are not neatly definable. Within the Northern Territory itself, the border between the 'Top End' and the 'Centre' can be elastic, depending on a range of organisational claims. At the State boundaries between South Australia, Western

Australia and Queensland, there is overlap of services, partly in recognition that ‘traditional dweller’ Indigenous people in remote communities have kinship and cultural links which are not organised along State boundaries. Nevertheless, a notion of Central Australia as comprising the urban environment of Alice Springs, the various remote areas, mining and pastoralist groups, tourist facilities and their floating populations, and the many remote Indigenous communities, has some functional merit. The outreach of the Central Australian Mental Health Services reflects this, as does that of regional Police Services.

Demographics were collected by the Life Promotion Program of the Mental Health Association of Central Australia in an arrangement with Northern Territory Police. Over the period 2001-2006 there were 74 suicides in Central Australia (see Figure 1). Of these, 55 (>70%) were of Indigenous people; 48 of them males (87%), and mainly young (87% aged under 30 years). The population of Central Australia is around 50,000; roughly 30% or 15,000 being Indigenous. Thus Indigenous suicide rates over this span were around 0.37%, versus 0.0514% - over-represented by almost one order of magnitude.

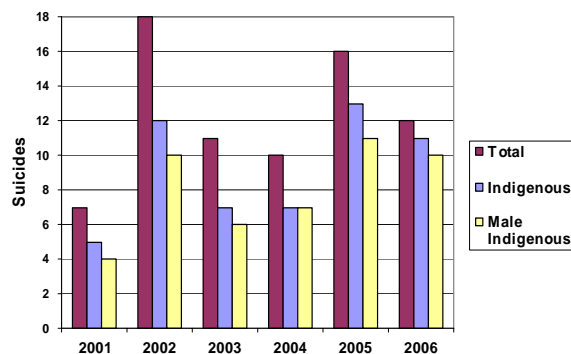


Figure 1. Suicide statistics in Central Australia 2001-2006

II. Bringing a qualitative analytic perspective to Central Australian suicidology

The subjects of a suicide study are, by definition, not available for interviews. And yet subjectivity, the experiential field that informs that final act, lies outside the scope of demographic studies. At core, we want to know

something of the subjective nature of the ‘suicide threshold’. Here, a qualitative approach could be of some use.

Even in quantitative work, the ‘neutral observer’ role is an idealised one; hence investigators’ ‘declarations of interest’ in pharmaceutical trials. In qualitative studies, the ‘bias’ of the so-called ‘observer stance’ is both assumed, articulated, and (more or less adequately) engaged; ‘declarations of interest’ are an intrinsic part of methodology. The reader should therefore be aware that the senior author trained as a Jungian analyst. This background informs the paper’s interest in the subjective field, and models of nurturance and therapy and their extension to organisations (‘collective countertransference’), as well as an appreciation of mythic and symbolic factors in Indigenous life.

In the absence of opportunities to engage with the victims of suicide, comprehensive Psychological Post-Mortems (Kelly & Mann, 1996) may have served as ideal foundational data sets for a qualitative study. However, the work commitments of an over-stretched service precluded the energy intensive requirements of the Psychological Post-Mortem process. Our opportunistic strategy, of utilising whatever came to hand in the course of our clinical, Consultant Liaison, and teaching duties covered four areas, with running notes entered into a data journal and thematic analyses performed by the senior author:

- Accessing *written case files* as were available for inspection following requests to the Alice Springs Hospital Medical Records Department and Central Australian Mental Health Services. Only nine of these could be retrieved. These were either Mental Health or Consultant Liaison notes.
- Canvassing *opinions of local medical practitioners* (including two staff physicians, three paediatricians, two senior Emergency Department personnel, and three psychiatrists) at Hospital Grand Rounds presentations by the Psychiatry Department (4 over 12 months), senior medical staff meetings (12 over 12 months), and informal opportunities to question our non-psychiatrist colleagues as part of our Consultant Liaison process.

- Conducting *interviews with suicide survivors* and their carers presenting to the Mental Health Service as routine Consultant Liaison requests (three vignettes, composed from 14 referrals to our Team over 12 months).
- Finally, there was a limited body of text available in digital format, hence suitable for *textual analysis*.

1. Written health records

A perusal of the nine written records and case entries showed a spread of themes:

- the preponderance of young males (7 males, 2 females);
- alcohol and drug abuse (all);
- hanging as a preferred method (8);
- evidence of pre-existing psychological distress (but the sample, being Mental Health Records, was biased);
- object loss in its various forms (directly recorded 6, inferred 3); and
- a range of psychosocial and cultural stressors; poverty, unemployment, deculturation.

Similar themes and patterns had been noted by various authors. Parker and Ben-Tovim's (2002) audit of Northern Territory Coroners' Reports (1991-1998) found an increase of hangings after the national fire-arm 'buy back' legislation following the Port Arthur massacre of 1996. They also referred to potentially identifiable but untreated psychiatric illness and substance abuse, and regional/cultural group differences. Hunter et al. (2001), Hoogland and Pieterse (2000) and Measey et al. (2006) all point to similar patterns.

That only such a small proportion of the documentation on the indexed 55 suicides could be retrieved gives pause for thought. Some of this slippage could be attributed to barriers to accessing case notes from the South Australian Mental Health Services. Some of it was probably internal, poor administrative linkages between Mental Health and General Medical Services. Some of it probably reflected failures of case identification and suicide risk assessment.

Such entries as were available were scattered, sparse, incomplete, often superficial, and mostly in the form of hand-written health records (Hospital and Outpatients). Cultural and linguistic factors also contributed to the paucity

and shallowness of data. The themes we identified were basic. The very scrappiness and shallowness of these documents, and the organisational barriers to accessing material, could be read as 'collective countertransference', about which later.

2. The canvassed opinions of local medical practitioners

Over the 12 months, unstructured discussions with colleagues at the Alice Springs Hospital and Central Australian Health Services at various venues and functions returned to the following propositions (which were entered in our cumulative log book).

Collective clinical opinion was that many Indigenous communities laboured under a range of gross stressors: deculturation, poverty, unemployment, educational breakdowns, economic and socio-political disempowerment patterns, both resulting in, and contributed to by, severe chronic ill health. This included hypertension, obesity, diabetes, and cerebral cardiac and renal manifestations of generalised vascular disease.

But a new epigenetic discourse was now beginning to inform medical understanding. Goldberg and Goodyer (2005) have proposed that anxiety and depression may be best understood as different aspects of a more central syndrome, an epigenetic failure of expression of resilience genes (as opposed to the 'genetically determined illness model' of depression). Environmental factors, principally failures of early nurturance and attachment (stressed mothers will produce stressed babies) will determine life-long patterns of vulnerability to anxiety and depression.

There are some partly gender-mediated modes of expression of the above (some genomic, some cultural). As Goldberg and Goodyer (2005) describe it, males tend to externalise, females to internalise. This may account for the female excess of internalising disorders (higher incidence of anxiety and depression syndromes) and the male excess of violence, including that directed towards the self, suicide.

Fish, Shahrokh, Bagot et al. (2004), describe in detail the epigenetic and neuroendocrine pathways whereby high maternal stress impairs nurturance behaviour, resulting in an epigenetic

cascade which resets the developing Hypophyseal Pituitary Adrenal (HPA) Axis and cerebral glucocorticoid receptors to a state of chronic high arousal; a 'developmentally-mediated vulnerability to stress' syndrome, and its attendant behavioural and metabolic consequences.

The work of Caspi, McClay, Moffitt et al. (2002) and their Dunedin cohort of 1,000 adolescents born between 1972 and 1973, on the interaction between MAOA, 5HTT, and COMT genes, environmental influences, and the development of violent behaviours, depression, and psychosis, strongly supports this formulation of epigenetic impact on behaviour.

Our colleagues were proposing that one major difference between Indigenous and non-Indigenous communities is that the collective neglect and marginalisation that many had suffered over generations when coupled with a weakening of sustaining connections with a traditional culture that gave worth and meaning to existence, results in a kind of transgenerational multiplier effect, leading to ever increasing levels of what Schneidman calls 'psychache' (Hoogland & Piertse, 2000, p.5), or inversely, a lowered level of resilience, and its increased levels of suicidality.

Early factors impacting negatively on developing individuals included the following (by no means comprehensive) list:

- foetal alcohol syndrome;
- pre-natal hypoproteinemia and its renal developmental consequences for the foetus;
- high levels of pre-, peri- and post-natal maternal stress, arising from high levels of ambient violence, drug and alcohol abuse, sub-standard living conditions, cultural deracination, and ethnic stigma.

This led in turn to adults who lived in chronic dysthymia, predisposed to

- excessive arousal/anxiety, depression, irritability and violence,
- substance abuse (alcohol, petrol, cannabis) to ease the pain,
- heightened sensitivity to object loss.

The nosologies of DSM-IV (dysphoria, dysthymia and depression) are insufficiently descriptive for such presentations. Such terms as the 'complex developmental PTSD' of Julia

Herman (Herman, 1992) are not universally recognised, and the Axis II Borderline taxonomy is by now so pejorative in common clinical parlance that to apply it to the Indigenous situation would be to add insult to injury. Equally of concern must be the validity of transcultural applications of Western personality taxonomies.

In summation, the above reflections had developed our exploration of resilience to include the importance of nurturance processes (inter-individual and collective) and their transgenerational aspects.

3. Interviews with survivors

Fourteen interviews, eight of them with survivors of suicide, four of them with relatives or associated health professionals, were recorded and analysed. The senior author offers three typical, illustrative vignettes. Details have been altered to preserve confidentiality. All vignettes are composites of clinical interviews.

Ronnie's perilous gestures

An 18 year old boy in a bush community wants \$25 for a Martial Arts DVD. His carer grandmother refuses the money. The boy runs to a nearby paddock, ties an old plastic hose around his neck, tethers it to a fence and drops to his knees to tighten the noose. This is the eighth time he has done it this year. Previous gestures were made in response to reprimands (a grandfather scolding him for teasing younger boys). Relatives rush to him, find him unconscious, and revive him in time. Once rescued, the boy settles, and sleeps it off in the family camp. The Health Worker tells me many people behave like that. The Drug and Alcohol Workers have come to call such episodes 'behaviourals', to distinguish from the suicidal attempts of psychotic or severely depressed people. However, last year the boy's older cousin successfully killed himself, under similar circumstances, using this same method.

David gets love again

David, a 30 year old married man, lives 500km from town and works in the cattle industry. He shoots himself in the heart, is evacuated by air, requires emergency surgery, and survives, miraculously. After four days in Intensive Care, he is off the respirator. I'm asked to see him a week afterwards.

He is more articulate and literate than many of his peers. We note scars on his forearms and chest, from previous gestures. He tells me he has three children, and a school teacher wife, and that he loves them very much. His early life was good; his parents were kind and caring, although his father had occasional drinking binges. As a youth, he also remembers an excellent European mentor, 'That old man treated me like a son, and taught me how to look after all kinds of machinery.' David has enough reflective capacity to engage easily in the thought experiment of 'you know those time machines in science fiction movies? Suppose we get into one, and go back to the minute before you shot yourself. Tell me what's happening?' David recounts,

It was the grog. We were in the kitchen. She was going on at me like she does so often. In the past, I'd yell at her and cut my arms [shows me multiple forearm scars] and say, "see how much you hurt me, how much I love you?"... but this time, I had a bit more drink on board, and I felt quiet; real strange; I'd usually have something to say, but this time, just got the gun, pressed it to my heart so she could see, and pulled the trigger.

David has none of the hallmarks of biological depression. His affect is warm and reactive, there are no neurovegetative signs or symptoms, and he tells me with a broad grin, 'I feel happy now. She's been ringing me every day, telling me how much she's sorry, how much she loves and misses me, and she's coming tomorrow... I'll never do that again.' ('We wish', the interviewer sighs to himself.)

Damien gets a moment of insight

Eighteen year old Damien attempts to hang himself with a rubber hose at home in a remote community, following an argument with his wife, who has a pattern of abusing him verbally and gesturally, and generally being over-bearing and over-controlling. He is judged sufficiently settled to not warrant air evacuation. He is seen at a remote clinic by the visiting Psychiatrist. Damien is settled; no tearfulness, nor further suicidal ideation, no residual anger; but he does complain of ongoing 'worries' about how he will get on with his wife and her family. This is his second suicide attempt in 4 months, and since the first one, the Psychiatrist has seen him on monthly community visits, struggling to establish a working relationship. During this

interview, as with the previous ones, the Psychiatrist takes care to use reflective listening modes, and speaks with him in (bad) Loritja.

There are no features to warrant a diagnosis of Major Depressive Disorder. Damien does not abuse alcohol or cannabis. The Psychiatrist experiences Damien as a very ethical young man, who has internalised injunctions about *not* lashing out at his wife when she provokes him. Damien is committed to not acting out with domestic violence. However, this self-control comes at a cost; the retroversion of anger towards himself and his hanging attempt might be understood as a catastrophic/all or nothing response to distress, when retributive anger was not an acceptable outlet.

On this basis, the Psychiatrist now ventures a more psychodynamic reflective statement about Damien's internal process, and states the essence of the above to him in (even worse) Loritja. Damien responds with an 'ah ha!' moment of insight, as he realises that his angry energies have indeed turned towards himself when they cannot find any other outlet. Pleasure and satisfaction are evident in his face. Things seemed to make sense at last. The Psychiatrist seizes the moment to discuss 'incremental' stratagems, as ways of giving optional outlets for Damien's hurt and angry feelings:

1. If she abuses him, he is to say, 'I'm walking out for 30 minutes; I'll come back then and see how you are.'
2. If she is still abusive, he is to walk out for another 30 minutes.
3. If she is still abusive, he is to stay overnight with friends or family.
4. If she still cannot take some responsibility for her provocation, he is to stay away for a week ... and so on.

The following month, Damien is pleased to see the Psychiatrist. He has retained his understanding of the previous month. He now had more internal options about what to do with his angry feelings. This had allowed him to implement a personally modified form of the behavioural response schedule, by saying to his wife, 'OK, I'll go and play cards with friends until you've settled down.' This preliminary quantum of empowerment had made domestic life more manageable. He is also getting more satisfaction from his job with Community Council. He informs his Psychiatrist that 'you

are my uncle (*kamuru*) who looks after me (*ngayunya kanyini*).' This developing positive transference in turn places the Psychiatrist under cultural obligations to bring a suitable expression of avuncular nurturance for the following visit; a shirt perhaps, or a pair of trainers.

Discussion of the interviews

A Westerner presenting with scarred forearms as a response to emotional rejection might automatically receive an Axis II Borderline diagnosis in most Anglophone clinics these days. But David has a stable long term relationship and a steady employment history in a very disadvantaged work environment. He also comes from a culture in which 'sorry cuts' are used to signify grief.

But a broader, more 'Jungian' perspective, might argue that people from his culture of origin locate (or located) their sense of being within a living connection with the Dreaming, the *Tjukurpa* (mythopoeic imagination as lived experience, if one likes); what Jungian analyst Giegerich calls the 'metaphysical In-ness' of Indigenous life, that is explicitly articulated in geographic myths and cosmologies as a 'content of conscious awareness' (Giegerich, 2004, pp. 4, 6); or as Jung puts it, Indigenous life was 'lived in a period and in a milieu in which man was still linked by myth with the world of the ancestors, and thus with nature truly experienced and not merely seen from the outside' (Jung, 1983, p.144). To use a Self Psychology/Object Relationship frame, we might say the traditional Indigenous 'self object' was a distributed one, rather than the narrower Western 'self object'.

But David is in intercultural transition. He moves in a Western culture that constructs a different kind of 'self'. He is exposed to Western Legal proscriptions against physical violence which are very different to the Indigenous ones. He now lives embedded in a nuclear family life style, as opposed to a traditional extended kinship network one. He is eager to avoid domestic violence, and turns angry impulses against himself. These actions are similar to the ritually prescribed 'sorry cuts', but now occur in a different context (the nuclear family), and for a different purpose (leverage in interpersonal relationships, rather than appeasement of the spirit of the departed). Can psychoanalytic or biogenetic structuralist models of development

help us understand the impact of such transitions on the 'inner life'? Is his 'gesture' a partial transition from the enacted emotion discerned in Homeric epics (Jaynes, 1976) and biogenetic structuralist ethnographies (Foster & Brandes, 1982), to the internally represented thinking and affect that enables the reflective interiority of some Western modes of experience?

As for the Axis I domain, it is clear we are not dealing with a classical depressive syndrome here. David's history and presentation are more indicative of the chronic low grade dysthymia and heightened impulsivity of epigenetic HPA compromise.

Damien's story supports the notion that a useful interiority, developed within a modified psychotherapeutic frame, can reduce suicide risk in an adolescent male. Ronnie, on the other hand, is also an adolescent in the throes of individuation, but without benefit of psychotherapeutic support. His formative experiences may well have been more damaging than David's or Damien's, and his social networks less adequate. But his suicidal behaviours have a similar gestural/manipulative thrust. And they too reveal some capacity for a 'theory of mind' that appreciates (and exploits) guilt and shame (and good will, that close relative of nurturance) in the other. Such gestures are not so far removed from the suicide threats that Westerners have learned to make to leverage admission to scarce public sector psychiatric beds. These gestures have a pragmatic value (gaining the benefits of hospital admission, or a Martial Arts DVD, or whatever) which rests on a reading (albeit a very restricted one) of their emotional impact within the 'Other'. But in their very extremity, they are also the acts of the radically socially disempowered.

The reader will have noted that the Mental Health Worker's countertransference ranges from distancing intellectualised defence in Ronnie's case (The Drug and Alcohol Workers have come to call such episodes 'behaviourals'), to world-weariness in David's ('We wish', the interviewer sighs to himself), to some satisfaction coupled with fears of manipulation by Damien (cultural obligations to bring... for the following visit... a shirt perhaps, or a pair of trainers). All this points to a sense of powerlessness.

4. Textual analysis

Towards an analysis of collective countertransference

Good therapists take notice of their countertransference. This can give valuable information about the patient's inchoate internal states, the therapeutic dyad's function (and dysfunction), and the therapist's own aptness or ineptness. The concept can be extended to group life. The Australian Jungian analyst Craig San Roque (2001) writes of the countertransference pain of Westerners working in Indigenous Australian settings. San Roque extends this exploration to the organisational level, developing the notion of the collective countertransference of Health Services in his essays on work with Indigenous communities in Central Australia (San Roque, 2005, 2006).

What then might be the collective countertransferences of Psychiatry and the Law, the two main organisations that engage with suicide in this region? A good place to start might be with their official reports, in this case, the Psychiatric and Coronial reports. These are in digital form, and hence open to computerised textual analysis.

For the purposes of this paper, we look at three psychiatric reports (one by N C-D, two by LP) and a large detailed Coroners' reports on three indigenous suicides in a remote community. The digital data sample is small, and must be emblematic rather than definitive.

A note on Leximancer

Leximancer (www.leximancer.com) is an innovative textual analysis program, developed by Dr Andrew Smith and colleagues at the Psychology Department at the University of Queensland (Smith, 2006). Unlike conventional text analysers, it targets intra-textual 'interactivity'. This introduces hermeneutic possibilities unavailable in other text analysis programs. Results can be presented as a list of interactive terms in ranked order, or a display of pattern of terms and their linkages in a Cartesian multidimensional space (a 'concept map'). Thus, in a Leximancer analysis of Shakespeare's 'Romeo and Juliet', the most 'interactive' term is 'Romeo', followed by 'Juliet', then 'love', then 'death'. The very banality of this example points to the power of the Leximancer analysis in identifying core informing factors and concepts.

Leximancer may thus be a useful tool to bring an alternative perspective to the thematic and conceptual sortings of investigators (the problematic 'observer stance' of qualitative methodology), but also a hermeneutic thrust, the making of unexpected meaningful connections.

Ranked Leximancer concepts

A Leximancer analysis of the Psychiatric Reports alone highlighted the salience of object loss, 'threats' in general, hanging as method of choice, and the use of alcohol and drugs (including petrol). Thus far, no great surprise. But the Leximancer ranked concepts of the Psychiatric and Coronial Reports together reveal something unexpected. Figure 2 shows the first 10 most powerfully interactive concepts.

Ranked Concept List	Absolute Count	Relative Count	
<u>Anangu Pitjantjatjara Lands</u>	362	100%	
<u>death</u>	168	46.4%	
<u>service</u>	153	42.2%	
<u>petrol</u>	131	36.1%	
<u>community</u>	119	32.8%	
<u>people</u>	101	27.9%	
<u>should</u>	83	22.9%	
<u>time</u>	77	21.2%	
<u>evidence</u>	71	19.6%	
<u>police</u>	63	17.4%	

Figure 2. Leximancer ranked concepts of the Psychiatric and Coronial Reports together

For Indigenous Australian people, land (*Ngura*) is an internal object. So we are not surprised that the leading ‘concept’ is ‘Anangu Pitjantjatjara Lands’. The centrality of ‘death’, ‘community’, and ‘petrol’ sniffing in this domain is also obvious enough. But what to make of the salience of the terms ‘service’ and ‘should’? We note that the term ‘service’ and the term ‘should’ rank high and occur frequently in the text. On the Leximancer ‘concept map’ shown in Figure 3, they interact strongly with all the other terms, and map onto the same terms. But they interact relatively weakly with each other. What is going on here?

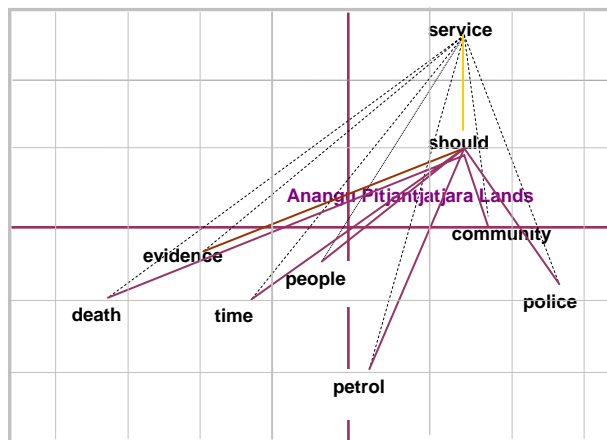


Figure 3. Leximancer concept map

The decoupling of ‘should’ and ‘services’: a piece of cultural countertransference?

When we look at the occurrence of the term ‘service’ in the text, it becomes clear that it refers to a range of Government agencies and NGOs like the Corrective Services, and various Indigenous and State Health Services. But it also refers to occasions of service, and attempts to provide services. But what about ‘should’? Why such salience? Textual examples include:

Para 35. ‘Further testing **should** be carried out so that all people with suspected brain damage can be identified and appropriate programs can be devised for them.’ <‘should’ as injunction>

Para 37. ‘It would seem that the role of the CYFS (Child Youth and Family Services) in child protection on the Anangu Pitjantjatjara Lands is being carefully monitored, and **should** be greatly enhanced by the appointment of the Coordinator of Government Services.’ <‘should’ as hope or wish>

Para 44. ‘These actions **should** go a long way towards providing Anangu with the degree of safety and protection to which they are entitled as citizens of Australia.’ <‘should’ as expectation>

‘Should’ is usually a term of moral exhortation. In this text it seems to refer to recommendations, but also to wishes and expectations. Evidently solutions will come through the moral and legal thrust that informs the legal and operational/psychiatric discourses. That the connection between ‘should’ and ‘service’ is weak suggests slippage between intention and its application, a gap between wish and action, perhaps a failure of organisational nurturing?

This organisational countertransference, a state of wishful helplessness (the powerlessness of the Law and the various ‘Services’), may also be, in its ‘projective identification’ aspect, a reflection of the powerlessness of afflicted communities, the families within them, and ultimately of the suicides struggling with their impulses - self-harming behaviours which say, ‘look at me; this is the only power I have to engage you.’

We can now recall our earlier observations about the case notes gathering process and the very scrappiness and shallowness of these documents, and the organisational barriers to accessing material. It seems that even at the level of recording and extracting notes, the ‘Services’ that ‘should’ deliver struggle to do so; evoking now familiar themes of powerlessness and breakdown of engagement. The powerlessness evident in the case notes also comes to mind.

However, a psychoanalytic sensibility would suggest that a ‘breakdown of the nurturance process’ is involved, at least at the level of inaccurate appreciation of the inner state of the other by the service provider or legislator. Non-Indigenous participants could well start by reflecting on their own states of mind in relation to the objects of intervention, their countertransferences if you like. This might provide a steadier base for a ‘collective empathy’, a more expansive intersubjective reflectivity, an attitude of nurturance whose efficacy rests on supportive evocation rather than a prescriptive agenda; where the adolescent Ronnie’s behaviour might change as a by-product of greater reflective capacity both on his part and ours, his supporters?

III. A reparative proposal: what ‘should’ be done, and ‘how’?

A Kanyini Project: Nurturing the nurturers

At the core of nurturance is a capacity to enter the other’s world at least to some extent, pain and all (countertransference awareness if you like). Nurturance breakdowns drive the psychological sequelae of epigenetic HPA Axis impairment. Empathy/‘theory of mind’ develops out of good early nurturing experiences as Rutter, Kreppner and O’Connor (2001), Fonagy (2004) and DiPietro (2000) remind us. Empathy in turn informs the quality of nurturance. The slippage between intention and action is a basic human predicament. At the organisational level, it points to a second level of failure of nurturance.

The Western Deserts dialect word for nurturing is *kanyini/kanyinyntja* (‘to hold or nurture’/‘holding or nurturing’). Nurturance, an intersubjective engagement with the object on (at least some of) its own terms, is a process which can reflexively reinforce itself, and may bridge the gap between ‘should’ and ‘services’, intention and social action. One of the ‘nurturers’ is of course the various ‘Services’. These include mainstream public sector psychiatry, whose collective countertransference vis à vis this suicide disaster is problematic. As psychoanalytic ethnographer Renata Eisenbruch puts it, ‘Chemotherapeutic discoveries have made an undeniable contribution to mental health... Psychiatrists however, conventionally treat manifest clinical conditions as if there were no need to burrow into the psychic meaning’ (Eisenbruch, 2006, p.174). Focused on biological and procedural ‘fixes’, disdaining reflectiveness and the (inter)subjective, bereft of mythopoeic imagination, we must really lift our game, develop our capacity as a profession to provide a Kohutian empathy both at the individual and the intercultural level. This is not an impossible task. But it is difficult. Medical anthropologist colleague and Flinders University PhD candidate, Juanita Sherwood (2006, personal communication), puts it thus:

What we really want is for you [Euro-Australians] to actually try to put yourselves in our shoes for a while. If you do it properly, it will be profoundly uncomfortable for you. But unless you’re prepared to do that, you won’t learn anything worthwhile about us.

What follows is a schematic and tentative set of ‘nurturance’ recommendations. This is very much a work in progress. It is underpinned locally by an ongoing exploratory consultative and negotiative process with members of some of the Indigenous communities visited by the Remote Mental Health Services. These considerations support a project of nurturance, of transgenerational repair and renewal, with a principal focus on fundamental primary prevention measures:

1. Supporting infant nurturing in the pre-, peri- and post-natal period;
2. Extending our ability as Mental Health Workers to develop a capacity for reflective empathy and hence effective nurturing;
3. Developing the capacity of organisations to be more effective nurturers.

1. Supporting infant nurturing

The point of greatest vulnerability, but also of greatest potential positive impact, is the pre-, peri-, and post-natal period. But this is an exquisitely sensitive domain. Potentially, there is nothing that a young mother finds more demoralising than commentary that can be read as critical of her efforts; nothing that a society finds more offensive than to have its nurturance patterns held up to inspection. When this is combined with construals based (inevitably) on gender dynamics (‘what would *men* know?’), cultural slippage (‘what would *they* possibly know about *our* practices?’), and the politics of representation (‘what right have *they* to speak for *us*?’), we have a minefield.

Let us acknowledge the enormous reservoirs of love, resourcefulness and courage that our various Indigenous peoples have displayed. Let us state clearly that the recommendations that follow are for our *non-Indigenous* Mental Health Workers; in whatever fields. How can we ourselves develop a better capacity for nurturing?

- Doing whatever we can to protect and support nurturance in the pre-, peri- and post-natal periods of both young mothers and infants.
- Nurturing the nurturing process itself. This might include such measures as giving Indigenous women volunteers in various communities access to distance learning nurturance programs like Campbell Paul’s

Infant and Parent Mental Health program at Melbourne University (Paul, 2006).

- Supporting *culturally appropriate preschools*. Infants exposed to optimal early life experiences can then more readily take advantage of early educational opportunities. The kinds of novel socio-culturally integrative pre-schooling programs to build competencies described by Fasoli and Moss (2005) at the 2005 Charles Darwin University Symposium 'Imagining Childhood - Children, Culture and Community' would seem very promising. Once curiosity and the capacity to interact with the Internet are enabled, the whole world is accessible.
- Engaging men in the nurturance process. This includes supporting *men* as caretakers in *Tjukurpa*-linked ways (*wati kanyilpai*). Non-Indigenous Mental Health Workers like Brian McCoy (2006) are doing valuable pioneering work with men's groups in Indigenous communities. Men are both high risk and part of the solution.

2. *Supporting the non-Indigenous worker's capacity for nurturance*

We would recommend developing, and/or supporting, as required:

- an emic, or immersed position;
- the acquisitions of Indigenous language skills;
- developing one's empathic reflectiveness (one could do worse than recommend some exposure to psychoanalytically informed personal and supervision experiences, and to meditation practices of the 'mindfulness' varieties);
- the use of psychoanalytic ethnographic approaches to facilitate intercultural engagement. The anthropologist Jadran Mimica's (2006) recent collection of papers on this subject contains some powerful essays, with graphic descriptions of how such approaches can facilitate intercultural empathy. I particularly recommend Weiss and Stanek's (2006) account of deepening interactions in the field, between themselves and a Papuan Iatmul woman, greatly assisted by the 'psychoanalytic supervisory' advice of their senior colleague, anthropologist and psychoanalyst the late Professor Morgenthaler.

At the very least, the above should make it less likely that we non-Indigenous Mental Health Workers misconstrue, or inadvertently disempower, the very people we are trying to support.

3. *Supporting nurturance at the collective/organisational level*

This is not to dismiss the value of socio-political and organisational interventions in Indigenous life. We know that this nexus of social engineering and its unpredictable consequences is the subject of an intense debate, which Hunter (2006) reviews. In a thoughtfully nuanced discussion, he summarises the emerging viewpoint of Indigenous spokespersons like Pat Dodson and Noel Pearson (2004) that the good intentions behind Social Welfare policies are 'compounding dependency and compromising Indigenous agency'. This 'intervention paradox' admits of no easy solutions. We might remember however, that in Canadian Indigenous communities, youth suicide rates vary inversely with indices of local community empowerment (ownership of land and the educational, police, and health services) (Chandler, Lalonde, Sokol & Hallett, 2003; Hunter, 2006, p.30). The following items might be supported in organisational planning and policy:

- Institutional support for the empowerment of Indigenous communities would seem to be of value, if the Canadian experience is anything to go by.
- Identifying the strengths and success stories in Indigenous nurturance projects and utilising them as models in policy development.
- Focusing on the specific natures of individual communities, rather than operating out of generic prescriptions.
- Attention to mytho-cultural (*Tjukurpa*) linkage (myth as social charter). This is delicate and difficult, but potentially powerfully healing. In Indigenous cultures, myth had an important role as social charter. In the past, *Tjukurpa*, the Dreaming, prescribed and reinforced actions. Part of the Indigenous drinking problem, as articulated by our Indigenous mentors, is that 'there is no *Tjukurpa* for grog' (Petchkovsky, San Roque & Beskow, 2003). There are examples of

reparative projects that use a mythopoeic approach; like Judith Atkinson's (2002) 'Dadirri groups' and San Roque's (1996) 'Sugar Man project' (a mythologically informed approach to alcohol management for Indigenous Australians). The evolution of *Tjukurpa*-sanctioned adaptive strategies for coping with 'wrong-skin' unions would be another example. But part of the Indigenous suicide problem is that there is no *Tjukurpa* for suicide, let alone suicide management. The Euro-Australian organisational culture is a long way from recognising, let alone practically engaging in, the mythopoeic domain.

Conclusion

For all its problems, the psychoanalytic discourse has left us with at least two transformative propositions; the pre-Kohutian notion of the *unconscious*, and the post-Kohutian praxis of *empathy*, that engaged form of appreciative listening which facilitates not only the development of interiority, the inner life, but also the development of engagement in relationship. Our paper uses the term 'nurturance' to capture the broadest sense of this Kohutian empathy, applying it to all those interactive listening processes; between mother and infant, in the therapeutic process, in and between organisations.

This *can* be extended to the intercultural engagement. Even *with* listening, however sincere for both parties, there is no guarantee even the speaker, let alone the listener, knows what's really going on. We are *all* unconscious in various ways. It takes a special kind of listening, one informed by nurturance, to facilitate the tango of creative mutuality, but once this is under way, much becomes possible, perhaps even the reduction of suicides.

But for psychiatry as a profession, this means a revaluing of the subjective and the phatic. Mainstream psychiatry's preoccupation with organisational prescriptiveness (pharmacological interventions, 'shoulds' and 'services') comes at a cost. This essay suggests some ways we might begin to develop a capacity for nurturance that projects of reparation require in the Indigenous domain.

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