

# **SUICIDE AMONG INDIGENOUS PEOPLES: WHAT DOES THE INTERNATIONAL KNOWLEDGE TELL US?**

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## **Abstract / Résumé**

Indigenous people around the world have the highest suicide risk of any identifiable culture (or ethnic group). It is a youth epidemic. The World Health Organization (WHO) had called for action. The research by scholars, Indigenous and non-Indigenous, from the Arctic, Canada, Australia, Greenland, United States of America (USA), New Zealand, Brazil and Siberia, is presented. These international studies show that suicide is multi-determined in Indigenous people; simple answers (or their solutions) are fabrications. Colonialism and the difficulties faced ever since are cited as a common factor worldwide. It is concluded that much greater cooperative international efforts are needed to not only understand, but also to predict and control the epidemic.

Partout dans le monde, les populations autochtones affichent le risque de suicide le plus élevé parmi toutes les cultures ou tous les groupes ethniques reconnus. Il s'agit d'une épidémie chez les jeunes. L'Organisation mondiale de la Santé (OMS) a lancé un appel à l'action. L'auteur présente les recherches menées par des universitaires autochtones et non autochtones dans l'Arctique canadien, en Australie, au Groenland, aux États-Unis d'Amérique, en Nouvelle-Zélande, au Brésil et en Sibérie. Les études internationales indiquent que le suicide est déterminé par de multiples facteurs chez les peuples autochtones. Les réponses ou les solutions simples sont des fabulations. Partout dans le monde, on mentionne comme facteurs communs le colonialisme et les difficultés qui en ont découlé. En conclusion, l'auteur met de l'avant la nécessité d'accroître les efforts internationaux de collaboration pour non seulement comprendre, mais aussi prédire l'épidémie et lutter contre elle.

Almost a million people die by suicide each year (World Health Organization, WHO, estimate). This is staggering; indeed, a report of WHO (2002), *World Report on Violence and Health*, found that more people die by self-directed violence than terrorism, wars and homicides combined. Even more alarming, the report noted the existence of high-risk groups. Indigenous people are one, if not the highest risk group identified. (Of course, there are Indigenous groups with very low rates. See Table 1, Tribal suicide rates in America.) WHO reported that, "suicide rates have increased strikingly among Indigenous peoples." Young men are especially at risk. There are multiple reasons, but WHO reported:

Various explanations have been put forward for the high rates of suicide and suicidal behaviour among Indigenous peoples. Among the proposed underlying causes are the enormous social and cultural turmoil created by the policies of colonialism and the difficulties faced ever since by Indigenous peoples in adjusting and integrating into the modern-day societies. (p.190)

Research, however, is lacking. There have been few efforts to bring together our understanding of suicide among Indigenous peoples around the world. WHO called for more study and encouraged cooperative efforts. WHO suggested that we need to know what the international knowledge tells us. A special issue of *Archives of Suicide Research* (ASR) heeded this call; the volume was published in ASR, 2006, Vol. 10 – 101-224. My co-editors were Marlene EchoHawk, David Lester, Lindsey Leenaars, and Elisabeth Haramic. This presentation presents a summary of the findings of the report, *Suicide among Indigenous Peoples: The Research*, the first international volume of its kind. This report heeded a call for cooperative efforts by WHO. It begins to answer the question: What does the international knowledge or research tell us about suicide among Indigenous peoples?

### **Indigenous Peoples and Suicide**

Allow me to begin with some quotes from Jon Perez's Foreword to the report, entitled, *Suicide among Indigenous People: Foreword*. Jon Perez is Director, Division of Behavioral Health, Indian Health Services, the United States of America. Dr. Perez stated:

In my own experience, clinical intervention for suicide in Indian Country operated well ahead of the literature. It was a lonely, uncertain place and, at least in my personal practice, it ran counter to much of what the available literature indicated. If that wasn't bad enough, what the literature said worked in one culture did not necessarily translate well in

**Table 1**  
**Tribal Suicide Rates in America**  
**(from Lester, 2006. Used with permission)**

<b>Tribes</b>	<b>1910's</b>	<b>1920's</b>	<b>1930's</b>	<b>1940's</b>	<b>1950's</b>	<b>1960's</b>	<b>1970's</b>	<b>1980's</b>
Aleut							16	
Apache					26	18	40	
Blackfoot						125		
Cherokee							23	
Cheyenne	22	21	13	6	40	48		
Eskimo							42	
Kwakiutl						40	149	
Lumbee							9	
Navajo					8	13		
Ojibway					6		56	
Papago						100		
Pima						40	7	
Pueblo					10	55		
Pueblo (Hopi)					8	13	30	17
Shoshoni							38	
Shoshoni-Bannock						98		
Shoshoni-Paiute					113			
Sioux							73	31
Tlingit							30	
Yaqui								
<hr/>								
Rates per 100,000								

another, and therein is a story I think illuminates many of the problems faced by those who work in this field among so many diverse people around the world....

I am writing a foreword for a volume that tells me we don't have to guess so much any more. It also tells me the knowledge base continues to expand, and that we are now sharing among a growing international team of researchers, clinicians, community leaders, and wisdomkeepers who are engaged in important, substantive work to save lives. It is also work that, in its sharing, lessens the isolation and gives hope: that most precious of commodities in this ongoing struggle for life and health. (Perez, 2006, 101-102)

Suicide, as noted, is a common problem among Indigenous people across the world (WHO, 2002). Historically it was, however, much less common. This is true in the Arctic. Lucien Taparti (1998), an Elder in the

Arctic, has stated:

In the past we hardly used to hear of suicides in our communities and would hear of them every so often only... Only once in a blue moon you'd hear of suicides in one of the communities. But nowadays, in one year there would be quite a few suicides. (p. xi)

The same is true around the world. Suicide was, in fact, rarely known in traditional Aboriginal society, but suicide and suicidal behaviours are now, for example, at epidemic levels in the Arctic. Epidemiology is the study of the incidence, distribution and determinants of a disease or an event, such as suicide (see Durkheim, 1897; Satcher, 1998). There are few early epidemiological observations about suicide in the Canadian North. Early records on suicide suggest epidemic levels in the Arctic (Weyer, 1932/1962; Boas, 1964). Weyer and Boas, however, exaggerated their reports, loosely collecting data from diverse events, not only self-inflicted death (Kirmayer, Fletcher & Boothroyd, 1998). Even more so, youth suicide was very scarce in the old days, but not so today (Leenaars, Wenckstern, Sakinofsky, Dyck, Kral & Bland, 1998).

Today, the rates are quite different than in the past. Suicide rates in the Arctic have strikingly increased in the last 40 years as among many Indigenous people (WHO, 2002). Canada's North has high rates of suicide, in fact, in many communities. Abbey, Hood, Young and Malcolmson (1993) have, for example, reported rates of 59.5 to 74.3 per 100,000 in some communities in the Arctic, compared to around 13.5 per 100,000 in the general Canadian population. The highest risk group is the young males (15-24); Wotton (1985), for example, reported a rate as high as 295 per 100,000. Regrettably, there is evidence that the rates of suicide are increasing in Indigenous people, notably the young, in the Arctic like elsewhere around the globe (WHO, 2002). Yet, it is not uniform; suicide rates vary dramatically in the Arctic. Some communities, in fact, have very low rates, by any international comparison (Leenaars, 1995). Not only is this *fact* true in other "peoples," but also this has been known since the very first epidemiological studies on suicide among Indigenous groups (May & Dizmang, 1974). This, thus, raises a basic question in public health, beginning with John Snow, the Father of Public Health<sup>1</sup>: What accounts for the differences? Why high rates? Why low rates? What accounts for an epidemic, whether cholera or suicide? Why do some people, to use Taparti's words (1998), "work hard" to persevere? What does the research tell us? Taparti says, "Our ancestors went through hardships, and everyday too they had work to do – everyday, whether it was summer, fall, winter, or spring."

## **Understanding Suicide Among Indigenous Peoples**

Understanding suicide is complex, more complex than—to continue with my Arctic example—the early commentators in the Arctic like Weyer suggested (Leenaars, 2006). Suicide has increasingly been understood as a multidimensional event (Leenaars, 1996; Shneidman, 1985; WHO, 2002). There are no simple answers to our question. As in all suicides, there are biological roots and psychological factors such as pain, mental constriction, frustration of needs, and so on. Suicide is, however, not simply a biological and/or psychological event. Suicide is equally an event with socio-cultural factors (Hunter, 1991a & b; Leenaars, 1995, 2006). As is well known, the Indigenous people have experienced profound cultural change in their lives and this rapid change has had a major impact on the Inuit and Aboriginal people everywhere (Royal Commission on Aboriginal People, 1995; Read, undated; WHO, 2002). Thus, it is easy to conclude that a socio-historical account, the context is crucial for understanding contemporary suicide in Indigenous people, and thus, for answering our questions (Hunter, 1991b; Leenaars, 1995; Leenaars, Anawak & Taparti, 1998).

Let me turn to the recent insights of WHO (2002) on the known facts about suicide among Indigenous people in the Arctic and Australia:

In Australia, Aboriginal groups were the object of stringent racial laws and discrimination as late as the 1960s. When these laws, including the restrictions on alcohol sales, were lifted within a short period in the 1970s, the rapid social changes in the previously oppressed Indigenous peoples gave rise to instability in community and family life. This instability has continued ever since, with high rates of crime, delinquency and imprisonment, violence and accidents, alcohol dependence and substance abuse, and a homicide rate that is tenfold that among the general population.

In the Canadian Arctic in the early 19<sup>th</sup> century, epidemics swept the region as the first outsiders—whalers and fur traders—arrived, taking tens of thousands of lives and leaving the population reduced in size by two-thirds by 1900. By the 1930s the fur trade had collapsed, and Canada introduced a welfare state in the Arctic. In the 1940s and 1950s missionaries came to the Arctic and there was an attempt to assimilate the Inuit. Feverish exploration for oil, starting in 1959, further added to the social disintegration.

Research on suicide among the Canadian Inuit has identified several factors as likely indirect causes of suicide, including:

- Poverty;
- childhood separation and loss;
- accessibility to firearms;
- alcohol abuse and dependence;
- a history of personal or familial health problems;
- past sexual or physical abuse (p. 190)

To understand the suicides, however, we have to go beyond the general, epidemiological findings and give voice to the people. Narrative accounts have, in fact, a long history in people's past (Hunter, 1991a; Leenaars, 1995, 2006). In the Arctic, it is called "Unikkaartuit."

Lucien Taparti has stated:

Many of us have experienced losing someone. That's why I really want to talk about it. If I were silent, I know it wouldn't be of help. We have to be visible and if we are visible then that's how the problem will become visible.

Researchers have reflected on this pain from around the world—from Brazil to Canada to Greenland to Australia to Siberia—all corners of the world.

## **Culture**

The PAIN of the people is "deep in the psyche." Traditional ways among the people had been forgotten. Acculturation was the norm. People don't know who they are, where they came from, and where they are going. How the people think, how they talk...has been affected deep in their psyche. The Indigenous people had not only their lives, but also their culture stolen. Culture is the collective meaning and value of a people. The Royal Commission on Aboriginal Peoples (1995) in Canada wrote:

Culture is the whole complex of relationships, knowledge, languages, social institutions, beliefs, values and ethical rules that bind a people together and give a collective and its individual members a sense of who they are and where they belong. (p. 25)

Culture is rooted in one's land. It is a vast heritage. It is a worldview. The colonialists initiated actions to destroy that meaning and this deeply affected the mind and spirit of the people. The best analogy that I can offer from the North is the iceberg. In the Arctic, icebergs are large and what people are beginning to struggle with in the North is likely the tip of the iceberg. The knowledge in the special 2006 issue of ASR presents some of the first cooperative efforts to print the research, a response to WHO's call to action.

Understanding is the best way to prediction and control (Leenaars, 2005). Healing is possible; the authors in the issue here and there of-

ferred some sign posts for prevention. There are possible protective factors. Many Indigenous people in the Arctic and around the world believe healing is, in fact, now occurring.

Lucien Taparti stated, “people have been crying inside for a long time.” Yet, he sees hope in culture. Lucien Taparti stated:

We all have different lives, different cultures, and we can't say that the qablunaat have a strong culture. All of us came from our ancestors and if we could grasp that back then there were less suicides, perhaps we could start utilizing our culture for prevention. We'll have to know more about the cultures of our ancestors, and try to follow them and try to help each other more. We can use many peoples' cultures, whether they may be the qablunaats', the Dene's, or even the Inuit's culture. If we can be more aware of people's cultures, I'm sure we would be able to come up with something that would be of benefit.

Lucien Taparti gives snow as a metaphor to the solution in the North and, I believe, the globe. He stated:

We really have to start thinking of ways to rectify things. I'm sure this can be achieved somehow, but I don't know the answer to it. If solutions came from a larger community it could be a starting point, and even if they think they couldn't come up with solutions, they would be able to do so. Just as long as they have appropriate laws (rules) that they'd use. As long as the rules are capable of being followed. I'll use snow as an example: it is worked on by different people – some are very good with snow and some are able to work with it but not as well. That's why we use different types of snow to work with. Snow was our means of survival, even when we were young and even when we became adults. I wasn't worried at all, knowing that we'll get an iglu, even when there was going to be a blizzard. That was one of the laws and I followed it; so that was our life and the iglus were where our lives were. That's how we used to live in the winter time.

“Long times,” as Indigenous people would say, are needed for healing. In the report, we learn some of what we know about the ‘iceberg.’

Lucien Taparti has made the following observation in the North:

If we started tackling different things that we were capable of doing on our own, we couldn't really think of other things to get into. Soon as we were capable to do things that we had to follow, we didn't have much to be concerned with,

not like our young people I see today. That's how it is with our culture from the harsh region; our cultures are all different and we need to keep our culture visible. If we ignore the issue, it is obvious that it won't get rectified.

The solution, according to Lucien Taparti, is "to teach our young people of their own culture, whether it be Inuit culture, qablunaat's culture...."

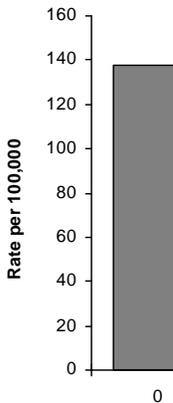
### The Studies

We will next briefly introduce the contributions in the Report (Leenaars, EchoHawk, Lester, et al., 2006), from Indigenous and non-Indigenous people alike, from around the world. These authors are some of the scholars in the field; their stories/studies allow us to understand suicide in Indigenous people better.

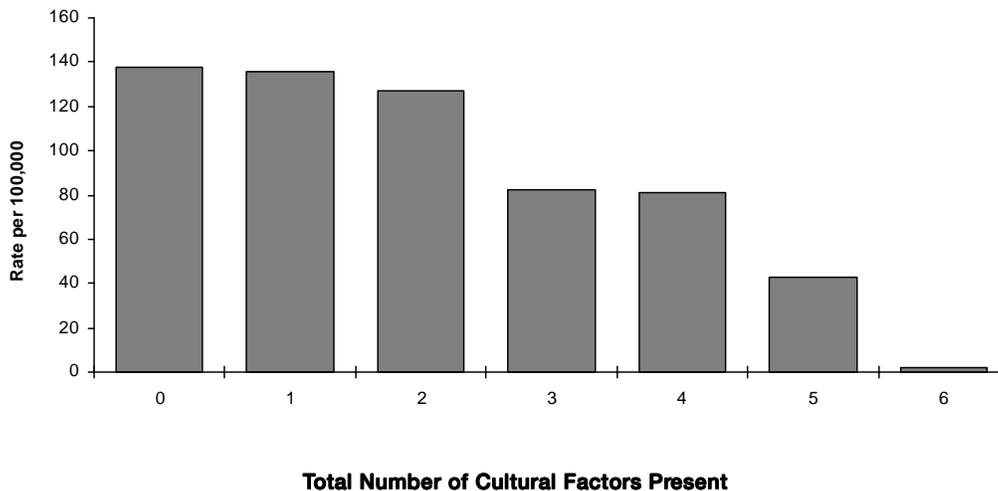
David Lester (2006), Center for the Study of Suicide, Blackwood, NJ, USA, in "Suicide among Indigenous Peoples: a cross-cultural perspective" begins a section on studies with the question: who is 'it' that we are studying? Who are we referring to with the cultural (or ethnic) group, Indigenous peoples? This is the very first step in public health and mental health, what are we studying. Lester's list may be questionable by some; he includes, for example, Indigenous groups in Africa. There are the traditionally included groups in the Americas (Turtle Island), the Arctic, Australia and New Zealand, but then Lester adds peoples not often associated with the grouping. Yet, he makes the obvious point, a first step, who are the Indigenous people?

Michael Chandler and Travis Proulx (2006), both from the University of British Columbia, Canada in the paper, "Changing selves in changing worlds: Youth suicide on the fault-lines of colliding cultures," continue the questioning; they ask, 'how and why it came to pass that some young Indigenous people, such as Canada's young First Nations, take their lives?' They point out that the epidemic is a youth epidemic. The young suicides among Indigenous people are the highest of any identifiable cultural group worldwide. There are other questions, why someone would choose to die by suicide and why it occurs disproportionately in some groups, such as the young, in almost all identifiable Indigenous people. Figure 1 presents suicide rates by number of cultural factors present in the community (see Figure 1). It shows that the more cultural factors (such as some measure of self government; some control over the delivery of health, education, and cultural resources; some ownership of their land) in a community, the lower the suicide rate. This is true in the Arctic, America, Australia, and so on.

Ernest Hunter, Regional Psychiatrist, Queensland Health and Uni-



**Figure 1**  
**Suicide Rates by Number of Cultural Factors Present in the**  
**Community 1987-1992. (From Chandler et al., 2006.**  
**Used with permission.)**

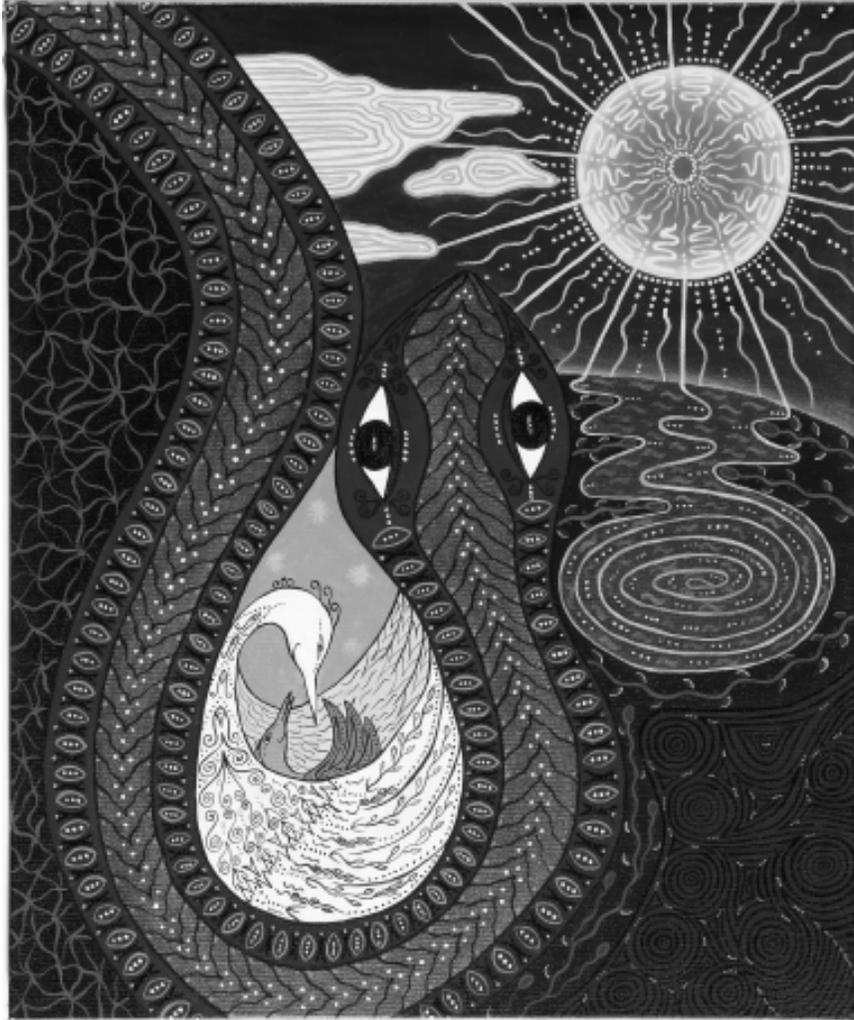


versity of Queensland, Australia and Helen Milroy (2006), Consultant Psychiatrist, Health Dept. of Western Australia, in “Aboriginal and Torres Strait Islander suicide in context,” begin to provide some answers, the context of Aboriginal and Torres Strait Islander suicide. They show the same risk patterns, as noted by the other scholars, and add the finding that the same groups are at risk for other violence: other destruction, abusiveness and alcohol/drug abuse. Many young people are survivors of violence and the cycle of violence continues. The socio-historical factors are, however, complex; no single factor can explain the phenomena, and a new possible dire question arises: What will be the future consequences? How will all these suicides and violence impact on the next generation, some so young? Hunter and Milroy conclude that we need a deeper understanding, something that all authors state.

A deeper understanding is through personal and collective knowledge. We need to give voice to the people (Picture 1). This is Helen Milroy’s (an author and Aboriginal child psychiatrist) story. The (somewhat abridged) narrative is as follows:

We are part of the dreaming. We have been in the dreaming for a long time...

Our country and people have suffered many traumas



since colonization, the magnitude of which is beyond words. Looking through trauma is like being trapped in the back of a mirror, there is no reflection of self. It is like being trapped in darkness, unable to see where to go or what is there, surrounded by 'not knowing,' paralysed by fear.

When we are wounded, our story is disrupted and life becomes fragmented. We may not be able to find our way forward....

Part of the problem in healing is being able to put all the parts together again as there are still too many of us missing. To survive as peoples distinct in culture, we have to re-

store the collective. The individual may not be able to carry the survival of the culture into eternity but the collective can.

We can return to the dreaming to heal, to rest for a while and have our spirit restored, to find our place on the serpent and recover our purpose in this life....

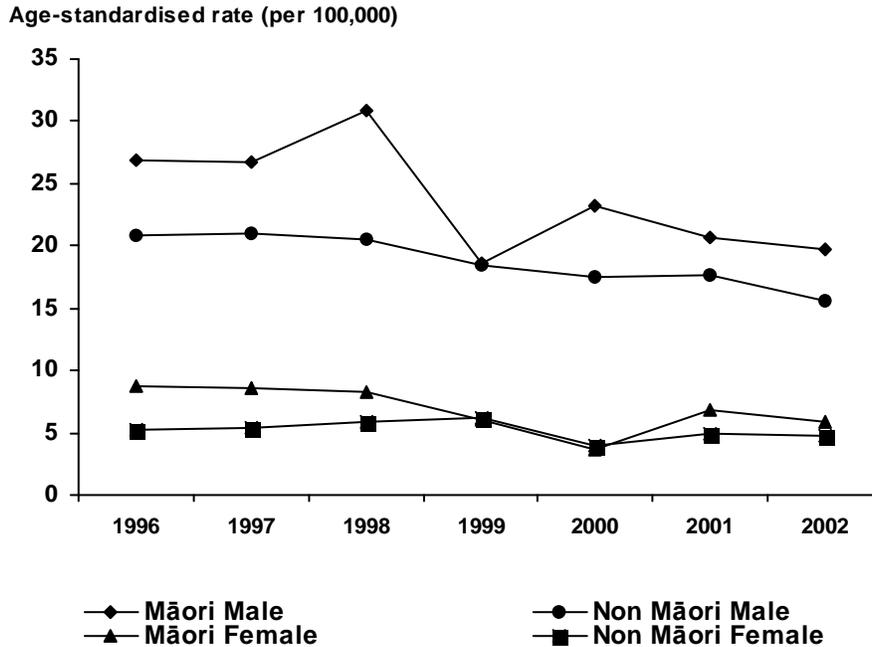
Then a new day will dawn and our ancestral guides will once again set us on our journey through life. To recover, we have to allow the sun to shed light and warmth on dark places and assist our wounds to heal. We have to shatter these warped mirrors and find our true reflection of self, spirit and country. We have to stand together, united and proud. We may not always have control over what happens to us in life, but we do have control over truth. The ultimate control we have is the coherence and continuity of our own story.

To live without spirit is to sleep without dreams and wake to oblivion.

Annette Beautrais and David Fergusson (2006), Canterbury Suicide Project, Christchurch School of Medicine, New Zealand, now predictably, in the paper, "Indigenous suicide in New Zealand," show the same epidemic in New Zealand (see Figure 2. Male/Female difference. Maori/non-Maori). The Maori men are at highest risk. Seventy-five percent of Maori suicides occur in the young! (see Figures 3 & 4. Age differences for Males and Females respectively. Maori/non-Maori) Tragically, the incidence for youth below 15 is also very high; this is true worldwide. In contrast, it is virtually non-existent in the elderly (a pattern that is opposite of non-Indigenous groups). Is this an expression of colonization? Explanation is lacking; yet, new questions arise; what are the protective factors in the elderly? Does this include culture? Can these factors, if identified, help to prevent suicide in the young? Will these protective factors help in the healing? After all, to intervene, you need to not only know what you are treating, but also how to treat it effectively.

Marlene EchoHawk (2006), Indian Health Services, USA in her report, "Suicide efforts in one region of Indian Health Services, USA" presents the current epidemiological data of suicide in the USA Indian people. It provides the much needed detail of the general: who, where, and changes. The facts are the same as elsewhere. Yet, EchoHawk does more; she presents the individual, E.S., through the method of the psychological autopsy. The richness of the unique person brings a spotlight on *pain*, parental dysfunction, sexual abuse, violence, psychopathology/imbalance, alcohol/drug abuse, incarceration, and a host of other suicidogenic realities. Only the unique can allow us to really understand the enduring scourge, both the general people and that person. We

**Figure 2**  
**Maori and non-Maori Suicide Rates Total Population by Gender**  
**1996-2002. (From Beautrais et al., 2006. Used with permission.)**



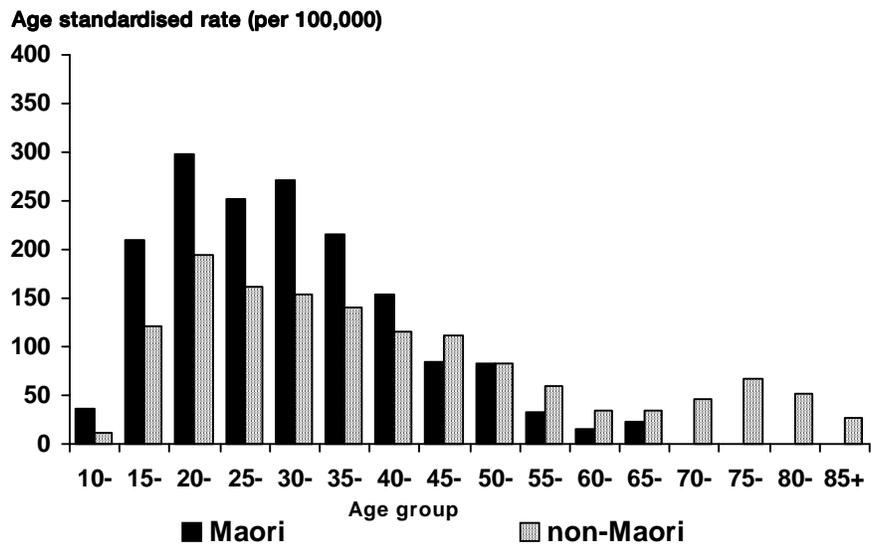
hereby report the story of one unique Indian youth that died by suicide:

Marlene EchoHawk (2006) presents a case review and psychological autopsy of E.S., Nebraska, D.O.B. -/-/76. Died by suicide -/-/92:

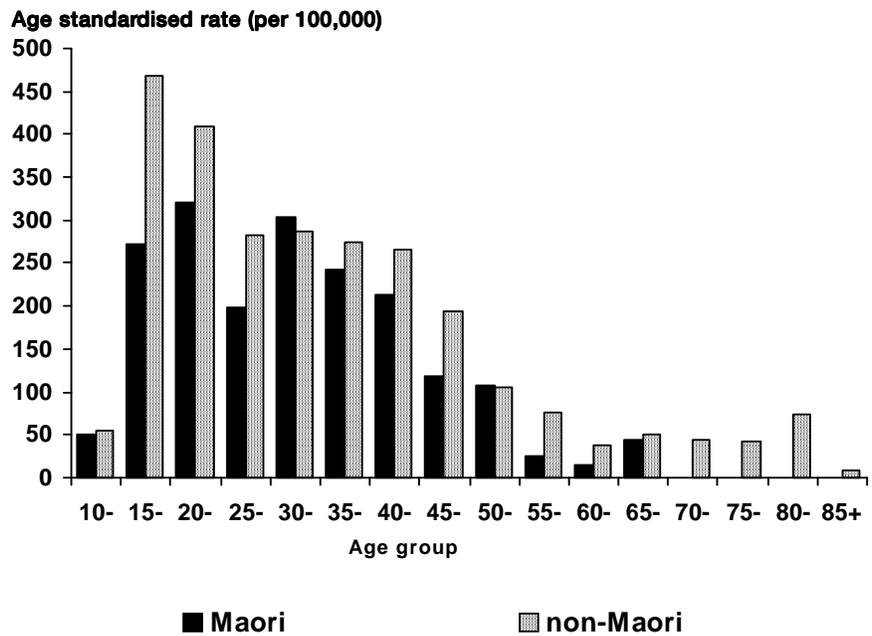
E.S. was a 16-year-old old male from Nebraska found dead by hanging in his home. His mother and oldest siblings were jailed, charged with public intoxication at the presumed time of E.S.'s death. Additionally, at the presumed time, there was reported to have been a party involving drug use (at least alcohol and cocaine) at the home, with both the adults and minors present intoxicated. E.S.'s death was determined to be suicide by the legal authorities. There was evidence he had used alcohol and cocaine.

E.S. did not have a documented history of medical or psychiatric problems. Family history indicated that he was the youngest sibling of the family, in a single parent household. It was reported that he had little paternal contact. His mother was employed. The mother and oldest half-siblings

**Figure 3**  
**Suicide and Self-inflicted Injury Hospitalization Rate, for Maori and non-Maori Males, 2001/2002. (From Beautrais et al., 2006. Used with permission.)**



**Figure 4**  
**Suicide and Self-inflicted Injury Hospitalization Rate, for Maori and non-Maori Females, 2001/2002. (From Beautrais et al., 2006. Used with permission.)**



had evidence of serious addiction problems, which was supported by their incarceration at the time of E.S.'s death. There was a major maternal history of addiction and suicidal behavior, including completed suicide by a maternal uncle when E.S. was about 10 or 11 years old. E.S. had an older full brother who had a history of counseling for anxiety about one and a half years before E.S.'s death. Reportedly he revealed a history of serious conflict between the younger and older pairs of half siblings. The conflict was thought by local professionals to have included physical and/or sexual abuse of the younger brothers by the older half-brothers. E.S. was the abused.

Based on available evidence, a set of tentative diagnoses was constructed for E.S.

Presumptive diagnoses:

Axis I: Alcohol Abuse

Alcohol Intoxication

Cocaine Intoxication

Organic Mood Disorder

Axis II: No known diagnoses

Axis III: No known diagnoses except drug intoxication

Axis IV: Stressors: 4 to 5. Severe, enduring circumstances of parental neglect, addiction, and suicidality; with probable child abuse by siblings.

Axis V: Functioning: No documented problems in data available.

The psychological autopsy process, even with the unavoidable limits on data, was valuable. E.S. was revealed in retrospect to have been an individual at risk. His case revealed much rich clinical data. Alcohol treatment, mental health treatment, and social service intervention all would have likely been indicated had he received attention before his death. There are opportunities for our care systems to improve in their responses to such risky situations.

Kevin Yoder, University of North Texas, USA; Les Whitback and Dan Hoyt, University of Nebraska-Lincoln; and Teresa LaFromboise (2006), Stanford University in the paper, "Suicide Ideation Among American Indian Youths," present an in-depth study of the diverse and often buried pain of one young Indigenous group, American Indian youth in the upper Midwest United States. They show again a high incidence of not only suicide but also suicidal behavior, such as suicidal ideation, even in the very young. It is of import to note that females were over 2 times

more likely than males to think about suicide. Maybe different people, such as male and female, express their suffering differently, but have pain nonetheless. Suicide alone does not reveal the tragedy. Yoder and his group, in fact, do the marvellous thing of empirically showing the complexity of suicide, by using sophisticated multivariate statistics (see Table 2. Logical Regression Results). They conclude, that the lack of culture, created by the policies of colonialism, even today, was “ the second strongest predictor variable (after drug use) in the multivariate model”. Hopefully, gone are not only the days of simple explanations, but also reductionistic methods with Occam’s razor on the people. It will not answer our questions.

Carlos Coloma (2006), Ministry of Health, Brazil; Joan Hoffman and Alexander Crosby, USA Center for Disease Control and Prevention, in the paper, “Suicide among the Guarni Kaiowá and Nandeva in Mato Grosso do Sul, Brazil,” once more present the same epidemiological facts in a different context, the country of Brazil. Why, despite such great geographic distances, does the pattern repeat? And, why is this pattern so different from other people? Coloma and his colleagues present some very unique work with Brazil’s Guarani people in Mato Grassso do Sul. The findings, however, are the same: there are high rates of suicide; it is an epidemic of the young (see Figure 5. Suicide rates by age group. Brazil); males are especially vulnerable; rates for children are high; other violence is high; lethal methods, such as hanging, are preferred. The pathognomonic markers are common. Yet, exploration is needed; they write, “greater social and cultural knowledge of each ethnic group” is necessary. Why do, for example, the Guarani people have higher rates than other Indigenous groups in the region? This too is sameness. The researchers conclude that suicide in the people is “an indication of life context marked by social and cultural conflicts.” The people ask, why is the world so “sick”?

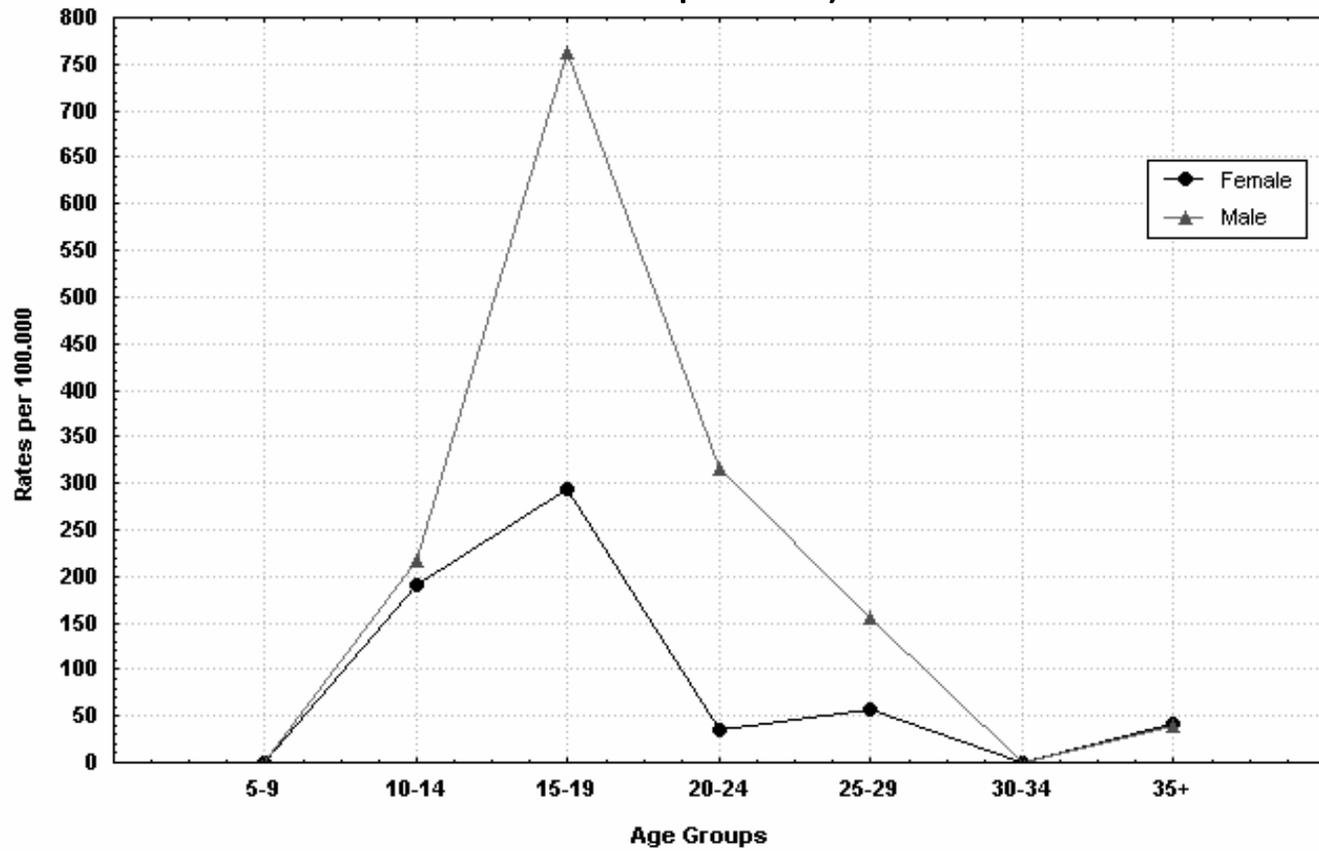
Peter Bjerregaard and Inge Lynge (2006), both at the National Institute of Public Health, Denmark, in “Suicide – a challenge in modern Greenland,” take us to the other hemisphere, the Arctic and we find the same events. The incidence of suicide in the Inuit in Greenland is high, especially the young (see Figure 6. Suicide in youth epidemic. Greenland). Indeed, rates of 500 per 100,000 have been reported and the trends show increasing rates. They explore various possibilities. They ask, do violent methods account for the phenomenon? Again, people in Greenland use hanging and shooting. Yet, single factors do not adequately explain. Violence is increasing too; suicide is, of course, an expression of violence (WHO, 2002). Colonization, rapid change, modernization and so on, are common factors, but they do not completely account for the

**Table 2**  
**Logistic Regression Results (N = 201) ( from Yoder et al, 2006.Used with permission)**

	Bivariate Models		Step 1		Multivariate Models				Step 4	
	B	$\beta$	B	$\beta$	B	$\beta$	B	$\beta$	B	$\beta$
<b>Control Variables</b>										
Reservation	-0.03	-0.00	-0.06	-0.01	0.86+	0.12	0.67	0.10	0.76	0.11
Socioeconomic Status	0.65	0.06	0.84	0.07	1.30	0.10	1.08	0.09	0.71	0.06
Gender	0.97*	0.14	0.97*	0.15	0.99*	0.14	0.92+	0.14	1.16*	0.18
Age	-0.15	-0.06	-0.17	-0.07	-0.23	-0.09	-0.28	-0.13	-0.42*	-0.19
<b>Stress and Protective Variables</b>										
Enculturation	0.03	0.01			-0.50+	-0.12	-0.59+	-0.15	-0.83*	-0.20
Negative Life Events	0.44**	0.23			0.36*	0.18	0.29+	0.16	0.32+	0.17
Perceived Discrimination	3.07**	0.20			3.47**	0.29	2.67*	0.25	2.08+	0.1
<b>Psychological Variables</b>										
Self-Esteem	-1.56*	-0.13					-1.54+	-0.14	-1.73+	-0.15
Depressive Symptoms	3.91***	0.29					1.77	0.13	1.91	0.14
Hopelessness	1.55+	0.10					-1.08	-0.07	-1.07	-0.07
Anger	1.87***	0.26					0.98	0.13	0.84	0.11
<b>Substance Use Variables</b>										
Alcohol Use	0.38**	0.16							-0.34	-0.14
Drug Use	1.13***	0.30							1.60**	0.31
Model $\chi^2$			5.32		24.35		33.57		41.93	
Degrees of Freedom			4		7		11		13	
P-Value			0.26		0.00		0.00		+0.00	

**Note:** B = unstandardized logistic regression coefficient and  $\beta$  = standardized logistic regression coefficient (calculated using the methods outlined in Menard, 1995). +p < 0.10. \*p < 0.05. \*\*p < 0.01. \*\*\*p < 0.001 (One-Tailed Tests).

**Figure 5**  
**Suicide Rates by Age Groups in 2003, Among the Guaraní Kaiowá and Nandeva. (From Coloma et al., 2006. Used with permission.)**



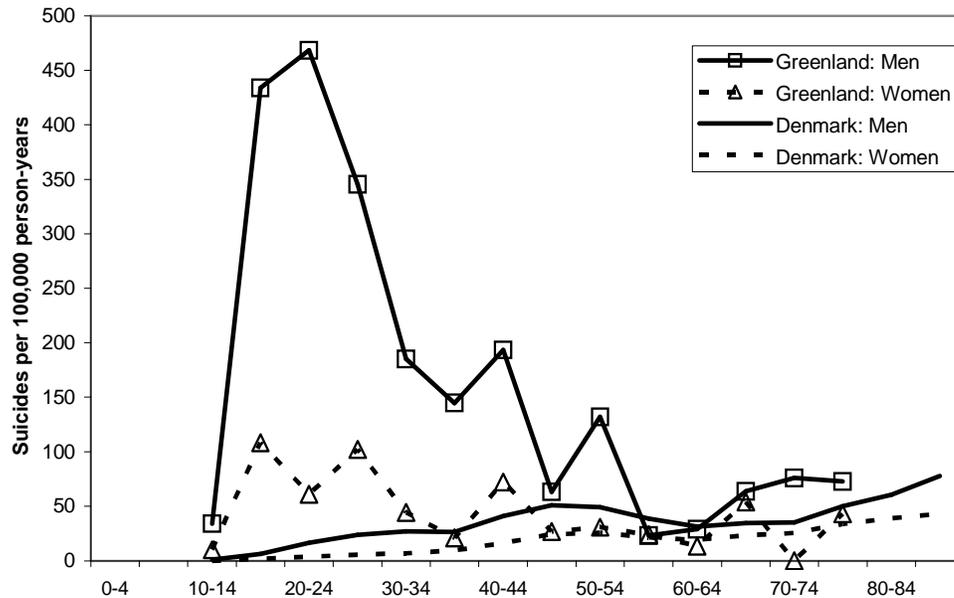
epidemic. We are left with the question: Why is there such a tragedy? What we do know: It is multi determined.

Siberia is no different. Lester (2006) in the paper, "Suicide in Siberian Aboriginal groups," reviews the available literature. A search for recent data on suicide in Indigenous people in Russia found no reference (A. Lopatin, Kemerovo State Medical Academy, Russia, Personal Communication, January 26, 2004). The people of Siberia are a forgotten people. (This is not rare, of course.) The historical records from around the 1900's suggest epidemic levels. There are, however, no current data; thus, questions remain. The people, in fact, ceased to exist during the Soviet years. Not only God or Progress, but also Lenin has been used to justify the acts committed to destroy the people. Yet, the colonialists failed. The Sámi people, for example, in Russia (and Sweden and Norway), despite the efforts of the colonialists "are alive" (Kuoljok & Utsi, 1993). On a methodological note, there are questions about the accuracy of the historical data in Siberia; reports may have been intentionally misleading. What data was recorded? These are the same questions in the Canadian Arctic and elsewhere (Kirmayer, Fletcher & Boothroyd, 1998). Today, data are needed, but likely never forthcoming from many areas of Siberia. We do, however, know that for many generations, the epidemic has existed here and there in Indigenous people around the world. Will it ever cease?

The studies, thus, show that WHO's observation that Indigenous people have the highest risk for suicide of any identifiable cultural (or ethnic) group is true around the world. Yet, explanation is lacking; we do not have an adequate answer to our question; what does the research tell us? However, having said that, we do have a good idea how it got to be this way. The same knowledge is found around the world (is this merely synchronistic?); I am struck by the similarities in not only the facts, but also the explanations. Of course, there are differences; yet, by the very fact of being Indigenous people in our world, there are even greater similarities (sameness). There are commonalities.

There are many similar and few different patterns. This tells us something. The youthful pattern of suicide in Indigenous people, for example, is the same around the world, but it is also significantly different from the rest of the developed world. This calls for not only different study, but also understanding. The projection of Western theory, such as suicide is solely due to psychiatric disorders, needs to be accommodated. Assimilation was not historically and is not now the answer. Simple explanations will not suffice; they will not answer our questions. We cannot simply force the data into our frames, medical or otherwise, although there are many who do so. That would be mental constriction, akin to

**Figure 6**  
**Age-specific Suicide Rates Among Inuit in Greenland and the**  
**General Oopulation in Denmark, 1990-1999 (From Bjerregaard et al,**  
**2006. Used with permission.)**



the suicidal mind (or colonial mind). Knowledge around the world needs to be developed. We need to understand this unique but common epidemic better.

What is it that we are observing? What have we learned? We need to understand suicide among Indigenous people better. Once we understand 'it' better, we will be able to better predict and control. Understanding, prediction and control, after all, are the very aims of all science. Yet, will the study occur? International efforts are needed to intervene, I believe, not solely single studies in one region (see as an international attempt to do so, Leenaars, Anawak, Brown, Hill-Keddie, & Taparti, 1999). Global action is called for. If there were a global epidemic of malaria or tobacco related disease, would we not call for cooperative effort? Have such international efforts not been most fruitful?

### Concluding Remarks

I am struck by the similarities of studies from around the world. There are commonalities; regrettably, the research tells us at least two: despite a worldwide epidemic, we do not know enough (despite great

knowledge among some Indigenous peoples) and the world is doing little to prevent the epidemic. Would they do nothing if it were cholera? Would they do nothing if it were SARS? When will all people own the problem and do something? WHO (2002) and the 2006 report (Leenaars, EchoHawk, Lester, et al., 2006) called for action. Suicide can be understood, predicted and controlled, among all peoples. It is not inevitable; the epidemic can be stopped. We can do much to prevent it, but what we also learned from the wisdomkeepers around the world is that prevention is not the exclusive responsibility of Indigenous people or researchers or health providers or survivors. It is everyone's business. We need to work together around the world; this too was called for by the report, *Suicide among Indigenous Peoples: The Research*.

Finally, the international research tells us more. I share a favourite story from the Arctic: In Pangnirtung, a majestic community in a deep fiord on the north east of Baffin Island at the Arctic Circle, I had heard an Elder speak. She told about the old ways, and then the whalers came. People hunted. People cleaned the whale... "and then the White man would take the catch, leaving only blubber for us." "In our way," she said, "we share the labour and the catch."

### Notes

1. In 1854, a major cholera outbreak occurred in England. Many people were dying; thousands were hospitalized throughout England. Physicians and other health workers responded with health care, but one doctor, Dr. John Snow, started to investigate the epidemic. He asked questions of patients – he asked where they had been, what they ate, what they drank, and so on. After sampling hundreds of patients, he found a common link: they all drank water from the Broad Street pump. He then did something quite unusual—and to the upset of many—he went out into the field. He went to the Broad Street pump. He studied the pump; he studied the water, etc. Dr. Snow concluded that the water was contaminated. He discovered that a sewage line was contaminating the water, in fact. This was public health research at not only its first, but its best. But Dr. Snow did more; he intervened: he removed the pump handle from the pump. Soon after that, the cholera epidemic ended. Dr. Snow is a father of public health; his work is a classic in our field.

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