Suicide among Aboriginals: A “Burning” Public Health Issue in Need of Solutions

Raymond Tempier, MD, MSc, FRCPC^{1,2,3}

The Canadian Journal of Psychiatry /
La Revue Canadienne de Psychiatrie
2016, Vol. 61(11) 682-683
© The Author(s) 2016
Reprints and permission:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/0706743716655787
TheCJP.ca | LaRCP.ca

There is no question that suicide among Aboriginal peoples is a big and dramatic health issue in Canada as well as in other countries. This series of 3 articles will try to shed some light on a complex and pressing public health problem that we, as health professionals, must address. The Truth and Reconciliation Commission of Canada recently released a report focusing on all aspects of the status of First Nations peoples, including health status. This report identified suicide (rates) as an indicator of the progress in closing the gap between Aboriginal and non-Aboriginal communities. Suicide rates are quite high, and it is well known that suicide rates among Aboriginal populations are at least double that found in the general population.¹ Kirmayer² noted that among Aboriginals, there is an increase in suicide rates, and this author also stressed the fact that suicides often occur in clusters, a marked distinctive characteristic of Aboriginal suicides.

Culture and language play an important but unclear role in the rise of suicide and mental health problems, in general. It seems that there is definitely a link between language, a major expression of culture, and suicide rates. For example, Chandler and Lalond³ found lower suicide rates among British Columbia Aboriginal communities where the native language was still spoken. Hallet et al.⁴ stipulated that many Aboriginal languages are in danger of disappearing and consequently contributing to the disappearance of cultural identities. These identities, which Aboriginal languages mediate, are definitely in threat. Hallet et al.⁴ added that failure to achieve any viable sense of self or cultural continuity is strongly linked with self-destructive and suicidal behaviors. Suicide is in fact the ‘coal miner’s canary’ of cultural distress, as Hallet et al.⁴ wrote. We still know very little about the intersection of culture, suicide, depression, and history, according to Waldram.⁵ One has to develop an integrated explanation of why some communities have much lower suicide rates than others and why some individuals suffer so much more distress than others. These 3 articles try to give some interpretations on a complex phenomenon such as suicide among Aboriginal people; they also propose some solutions about how to address and respond to this complex problem.

The first article addresses similarities and differences in suicide prevention between the Māori in New Zealand and indigenous peoples of Canada. Hatcher⁶ stresses the fact that the problem of indigenous suicide is linked to coping with losses secondary to colonization in both former colonies such as New Zealand and Canada. Of major importance is the assessment of the identity in all clinical encounters as a cultural evaluation should be part of a psychiatric interview with any patient, as Hatcher⁶ proposes. Both countries share an ancient colonial model where ‘thwarted belongingness’ refers to a combination of loneliness and an absence of relationships marked by reciprocal care, as Hatcher⁶ stipulates. In clinical practice, this means that, for example, clinicians who see Māori, the Aboriginal people of New Zealand, are expected to say something about themselves as part of the initial ‘ritual of encounter’—a form of a ‘cultural handshake’.⁶ This stresses a trivial means of establishing rapport with a patient, but to me, it goes further than breaking the ice and divulging our own values or culture, watching to be culturally sensitive and respectful. We know as health professionals that we might be different, but we are ready to overcome our differences.

The second article, by Kral,⁷ focuses on suicide among the Inuit or the indigenous peoples of the Arctic. There are reasons why we put the focus on the Inuit as they have the highest suicide rates in the world; between 1999 and 2003, rates averaged 135 per 100,000, more than 10 times the general Canadian population rates.⁸ Recent original research based on psychological autopsies of Inuit-completed suicides showed that risk factors are childhood abuse, family histories of depressive disorders, substance abuse, and

¹ University of Ottawa, Ottawa, Ontario

² Montfort Hospital, Ottawa, Ontario

³ Ontario Psychiatric Outreach Program, Iroquois Falls, Ontario

Corresponding Author:

Raymond Tempier, MD, MSc, FRCPC, Montfort Hospital, 713 Montreal Rd, Ottawa, ON, K1K 0T2, Canada.

Email: raymondtempier@montfort.on.ca

cluster B personality disorders.⁹ But according to Kral,⁷ there is more to it than that, as suicide risk factors are associated with colonization, dispossession, culture loss, and social disconnection. The historical traumas for the Inuit have resulted from such events as stays in residential/boarding schools and forced lifestyle change.⁷ Kral⁷ proposes different intervention and prevention strategies that appear to be working for the Inuit in Canada. Waldram⁵ shows how the effects of historical trauma discount the person and how historical trauma has become an idiom of distress for indigenous peoples that can lead to illness but also healing. When communities lack a sense of cultural continuity, the risk increases further. So, it is so important for these people to get back their traditions.

Narrative therapy of the kind described in the third article appears to be a promising way, and this help ‘clients’ build a narrative identity with more personal continuity. This type of therapy might improve the protection of the person against suicide, as Mehl-Madrona proposes.¹⁰ In the absence of strong empirical data on psychotherapy with Aboriginals to review, I asked Dr. Mehl-Madrona, as an experienced practitioner, to provide some guidance based on his expertise—justifying perhaps the best level of evidence currently available. This is a ‘clinical commentary’ based on his clinical notes done during narrative psychotherapies of suicidal Aboriginal patients. Three main themes that can be seen as risk factors for suicide were sorted out: 1) relationship breakup, 2) public humiliation, and 3) high levels of unremitting chronic life stress, including poverty and relative isolation. A review of the case notes resulted in several common reasons for a suicide attempt to occur such as 1) to “show” how badly they had been hurt, 2) to stop the pain, 3) to save face in a difficult social situation, and 4) to get revenge. According to this author, substances also were often involved in suicide attempts, such as alcohol and street drugs.

These 3 articles are quite useful in adding ideas and suggestions on how to improve better prevention and treatments. We know that there is already a national Inuit suicide prevention strategy called ‘Inuit Tapirit Kanatami’¹¹; we are looking for a national Aboriginal suicide prevention strategy in taking into account the diversity of Aboriginal people’s cultures. We hope that the Act Respecting a Federal Framework for Suicide Prevention will be translated into concrete

and applied strategies, including enhanced access to culturally sensible and culturally safe services. We need to move faster to address and bring practical solutions to tackle this major public health problem in all parts of Canada.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Safinofsky I, Webster G. The epidemiology of Suicide in Canada. In: Cairney J, Streiner D, editors. *Mental disorder in Canada: an epidemiological perspective*. Toronto: University of Toronto Press; 2010. p. 373.
2. Kirmayer L. Suicide among Canadian Aboriginal peoples. *Transcultural Psychiatr Res Rev*. 1994;31:3-58.
3. Chandler M, Lalond C. Cultural continuity as a hedge against suicide in Canada’s First Nations. *Transcultural Psychiatry*. 1998;35:191-219.
4. Hallet D, Chandler MJ, Lalonde CE. Aboriginal language knowledge and youth suicide. *Cogn Dev*. 2007;22:392-399.
5. Waldram J. *Revenge of the Windigo: the construction of the mind and mental health of North American Aboriginal peoples*. Toronto: University of Toronto Press; 2004.
6. Hatcher S. Indigenous suicide: a global perspective with a New Zealand focus. *Can J Psychiatry*. 2016;61(11):684-687.
7. Kral MJ. Suicide among Inuit in Canada. *Can J Psychiatry*. 2016;61(11):688-695.
8. Public Health Agency of Canada. *Analysis of statistics mortality data*. Ottawa: Government of Canada; 2012.
9. Chachamovich E, Kirmayer L, Haggarty J, et al. Suicide among Inuit: results from a large, epidemiologically representative follow-back study in Nunavut. *Can J Psychiatry*. 2015; 60(6):268-275.
10. Mehl-Madrona L. Indigenous knowledge approach to successful psychotherapies with Aboriginal suicide attempters. *Can J Psychiatry*. 2016;61(99):696-699.
11. Crawford A. A national suicide prevention strategy for Canadians: from research to policy and practice. *Can J Psychiatry*. 2015;60(6):239-241.