8 Suicide as a Way of Belonging: Causes and Consequences of Cluster Suicides in Aboriginal Communities

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Whatever insight I might have into Aboriginal suicide I acquired unintentionally during two years that I lived as an ethnographic researcher in Cross Lake, Manitoba, a northern Aboriginal reserve community. I had initially intended to do a long-term study of the community's campaign, then in its early stages, to redress grievances following from the construction of a large-scale hydroelectric project in the early 1970s and from the failure of a compensation treaty, the Northern Flood Agreement, signed in 1977. The strategy of implementing the Northern Flood Agreement, mainly through petty claims of compensation for broken boat propellers caused by floating debris or snowmobiles lost or damaged in weakened ice conditions, was clearly not meeting anyone's aspirations for the treaty's promises of employment and community development. A commitment to public transparency in a new political process was the principal reason for the community's review of my curriculum vitae in a public meeting and their subsequent request that my family and I live with them for two years to witness and report on the conditions of their lives and on their campaign to change these conditions through defining new relationships with the federal and provincial governments and with the Crown corporation Manitoba Hydro. It was in this context that I began my work as an ethnographic researcher, concentrating most of my attention on the complex, shifting political dynamics brought about by a new strategy of legal pressure and public lobbying.

But when, in 1999, three suicide-related deaths and a spate of suicide attempts occurred in close succession, my attention and involvement in events went in quite another direction. It was clear that locally staffed institutions – the Pimicikamak Cree Nation Health Services and the Awasis Child and Family Agency – were already overwhelmed by the extent of their responsibilities, having inherited a clientele that had a high frequency of addictions, mental illness, and family crises. Consequently, they were wholly unprepared for the occurrence of several suicides and numerous suicide attempts in close succession. A hastily prepared application by the Health Authority to the federal government for funding of an intervention program was categorically rejected, without any offer of assistance to clarify the application format and procedures. It took several months for the Health Authority to submit a new application, for the proposal to be negotiated with federal officials, and for an intervention program – reduced in scope to a telephone crisis line – to

be implemented. Meanwhile, the nursing station, on the front line of response to the crisis, faced even greater constraints, with staff shortages so severe that during several weeks in 1999 it became necessary to close the building and accept only emergency cases, with a hand-lettered sign on the inside window of the locked main entrance calling for patients to self-triage in accordance with very basic criteria: "Life or death situations, e.g., heart attack; uncontrolled bleeding; choking."[1] Community leaders, faced with what they regarded as an unresponsive government, were forced to accept a situation in which to garner the resources they needed they would have to reveal the extent of the crisis to a wider public in an appeal to justice, opening their situation of suffering and incapacity to distant sympathizers and, through that sympathy, exerting pressure on public officials to act responsibly. It was under these circumstances that my attention turned more urgently to Aboriginal youth suicide.[2]

I begin my effort to understand cluster suicide among Aboriginal youth with the premise that suicide can be both an individual act – perhaps the ultimate expression of individual will and struggle with conscience – and a social phenomenon, influenced by common conditions and experiences and by shared values, beliefs, symbols, and practices. The social influences on suicidal behaviour, although not as immediate as the individual act of self-destruction, are attested to by the phenomenon sometimes referred to as the *contagion effect* – evident, for example, in high rates of suicide among those who witness media reports on completed suicides. And it is especially evident in *suicide clusters*, a pattern of concentrated self-destruction that occurs in particular communities, such as campuses, barracks, and in the instances I will explore here, Aboriginal villages.

The term "suicide cluster" has much the same meaning as the popular concept of an "outbreak": a high number of self-inflicted deaths occurring in temporal *and* geographical proximity (Gould, Wallenstein, and Davidson 1989, 17) – bringing with it the discomforting idea that suicide can somehow be contracted from others through an "epidemic" in a way analogous to disease. The most obvious explanation for such intense episodes of self-destruction does in fact centre on a "contagion" effect, with one self-inflicted death appearing to be connected by emotional disturbance and imitation to other suicidal acts, apparently resulting in (and from) dramatic increases in depression and anxiety disorders among surviving community members. But it is not at all clear how suicidal acts can produce such a contagion effect. It could be that some who are shocked, disturbed, and aggrieved by the suicide or attempted suicide of a friend or family member become more distressed, but not suicidal, after the event. Others who are already depressed, anxious, hopeless, or angry may be strongly influenced by an idea or action derived from the suicidal behaviour of others, while the degree of their distress remains essentially unchanged.[3] Cluster suicides seem to involve a central paradox that follows from the fact that those who commit or attempt suicide are often driven by profound loneliness, neglect, or a sense of being unimportant and invisible, while, at the same time, this condition of loneliness becomes directly or indirectly shared with others. There appears to be a kind of perverse sociability at work in which self-destruction itself becomes a basis for linkage

between individuals, a source of group behaviour beyond more widely accepted social norms (Coleman 1987, 3).

Public knowledge of such events in some of Canada's Aboriginal communities has in recent years greatly increased at the same time that it has become contracted and oversimplified. When an unusually high number of self-inflicted deaths occur in a small reserve village in a short space of time, the media occasionally respond with coverage communicated to a wide public, breaking down the barriers of community isolation with stark images of poverty and grief, bringing immediate attention to the occurrence of the deaths and the social circumstances in which they took place. Today, virtually anyone in the world who has regularly read a daily newspaper or visited Internet news sites is in some way aware of the exceptionally high rates of suicide in some Aboriginal communities in Canada. For those who do not look beyond what is of necessity selected and superficial information, Aboriginal people come to be seen as typically impoverished, depressed, and suicidal.

But comparison of national statistics with those of Aboriginal communities in crisis dispels the idea that cluster suicides are the norm for the Aboriginal population as a whole. The generally high suicide rate for so-called status Indians nationwide – approximately 29:100,000 compared to 13:100,000 for Canada as a whole – is actually a consequence of very high frequencies in particular Aboriginal communities or regions, whereas other areas report no suicides at all. Ward and Fox (1977), for example, investigated a "chain of deaths" in which 8 suicides took place over a 12-month period from 1974 to 1975 in a large reserve community in northern Ontario, resulting in a rate of 267:100,000 for that year. Other communities in northern Ontario have more recently faced comparable crises. Preliminary data from the Sioux Lookout First Nations Health Authority, responsible for 15 reserve communities that have experienced suicide "epidemics" or "clusters" within the past 10 years, reveal the occurrence of some 270 self-inflicted deaths within a population of 15,000, comprising a suicide rate of approximately 180:100,000.[4] Very high rates of suicide, concentrated in space and time, were also reported from northern Manitoba, before the 1999 crisis in Cross Lake. Norway House, a reserve community approximately 100 kilometres by road from Cross Lake, experienced 8 youth suicides from 1981 to 1984, resulting in an overall rate of 77:100,000 (Ross and Davis 1986); and Cross Lake itself, as I discuss below, experienced a similar crisis from 1986 to 1987. A central issue raised by such suicide clusters becomes apparent only when they are viewed in the context of national statistics. Clearly, if crises of this kind were the norm for Native communities nationwide, the suicide statistic for Canada's Aboriginal population would be much higher than it is. Suicide rates are not evenly shared by all Aboriginal communities but tend to be sharply elevated in some and substantially lower than that of the general population in others.[5]

One of the potential reasons for this variability is that self-destruction can in some circumstances become central to group belonging. Suicidal behaviour occurs with greatest intensity where the idea of purposefully ending one's life has become an aspect of a

shared outlook on life, particularly within youth groups that are isolated from usual pathways to socialization with older generations. To fully understand the phenomenon of suicide clusters, we must therefore abandon the (often implicit) idea of community as necessarily associated with the values of comfort, consolation, and security. In some circumstances, particularly among some groups of young men, self-destruction can itself become a central value of social life. In the absence of life-affirming examples of security and hope, young people will occasionally construct their own forms of solidarity, premised on rejecting security, abandoning expectations of a better future, and, ultimately, negating their personal attachments to life itself.

Part of what I intend to do here is to reduce the social distance between analyst and actor in the study of collective suicide. Having lived in an Aboriginal community as a social-science researcher during a time when a suicide crisis occurred, I can now act on an opportunity to present a perspective that is informed over the long term by an understanding of the social background, events, and people in which a heavy concentration of suicide attempts and completed suicides took place. Such a crisis cannot, of course, be anticipated from the point of view of planned research, and in the thick of events it did not occur to me to apply formal methods that might reveal, with professionally recognized standards of precision, such things as the extent of depression or suicide ideation in the community. But there is still much that can be gained from a more interpretive ethnographic approach, one that begins with the accidental circumstances of being in a time and place in which a suicide cluster could be, as much as possible, witnessed and experienced. I intend to draw on this experience in an effort to better understand the occurrence – in *some* Aboriginal communities – of a socially concentrated will to die.

Cross Lake's Crises

During the two years that I lived in Cross Lake, Manitoba, from 1998 to 2000, there were altogether 9 deaths from suicide, most of them occurring in a 6-month period, this in a community of a little more than 4,500 residents.[6] The suicide crisis swept through the village with the force of a natural disaster, only without the minimal consolation of an explanation for the ruin and suffering left in its wake. There was no tornado, no earthquake, to account for loved ones lost and no recognizable possibility of rebuilding and restoration, only unanswered and unanswerable questions. Besides the strong emotions that followed from the premature end of life, the acts of suicide left friends and families with little understanding of their cause, inviting regret, guilt, and above all widespread anxiety about the apparent willingness to die among some of those in the victim's circle of friends and siblings.

Added to the emotional injury of completed suicides were the anxiety, sorrow, guilt, and impotent anger that followed from a simultaneous spate of suicide attempts and

threats of suicide. During the Cross Lake crisis, "survivals" from attempted suicide were far more common than deaths by suicide. The Royal Canadian Mounted Police reported to the press that in Cross Lake in 1999 there were 141 requests for assistance involving threatened or attempted suicide, and the local nursing station acted on many other cases of self-harm in which the police were not called in.[7] These ranged from such incidents as "calls for help" involving mild overdoses of over-the-counter medication to more serious events, such as miraculous, timely survivals from hanging. Each of these events added itself to the community's networks of news, sorrow, and anxiety.

The results of an intervention program further revealed the manner and extent to which the idea of suicide had taken hold. The Cross Lake Band Office reports on its website that a 24-hour suicide crisis line established in September 1999 logged 18,688 calls in its first three years, a rate of approximately one call every 84 minutes.[8] If the events of suicide completions and attempts were not enough to create an impression of a widespread potential for self-destruction, this remarkable figure seems retrospectively to confirm the fact of its existence.

This impression of deep-seated suicidality was further reinforced by considering the records and recollections of suicide in Cross Lake. Some 10 years earlier, in 1986 and 1987, the same thing had happened, the same pattern of deaths, attempts, rescues, and frantic efforts to intervene by volunteer counsellors who, before long, had worked themselves to the point of "burnout." In a 6-month period between 1986 and 1987, there were approximately 60 police and nursing-station interventions in suicide attempts and 7 completed suicides.[9] One of the members of this group of suicidal youth, who himself attempted suicide three times, recalled that at this time suicidal behaviour "was becoming like a norm, where you hear about it and you go 'ha!' and people would laugh and joke about it. Kind of like a normal thing" (Cross Lake, 31 March 1999).

Nevertheless, in a courageous effort to counteract the influence of this "norm" in Cross Lake, a handful of volunteer counsellors formed an impromptu Crisis Committee and worked themselves to exhaustion, with little political support and too great a burden of young clients who saw no place for themselves in the future, seemingly nurturing the will to end their lives.[10] Since most suicide attempts occurred within 3 or 4 hours after midnight (possibly because this is a time of diminished social activity), volunteers would often be up at night dealing with threats of suicide, then return home in the morning to get their children ready for school and get themselves to the jobs that they continued to hold in addition to their volunteer counselling. One of these counsellors recalled the effects of emotional pressure and overwork that went along with close involvement with a core group of suicidal youth: "It got to the point for me that every time I heard a loud noise, like a door slamming or something, I thought it was another shot gun going off" (Cross Lake, 13 November 1998).

Former counsellors from this earlier crisis were those who first recognized in 1999 that the pattern of self-destruction was repeating itself. The only essential difference was that the second crisis tended to involve people in their late twenties or early thirties,

whereas the crisis a decade earlier most commonly involved those in their late teens and early twenties. In other words, in Cross Lake a pattern is evident, with a particular group more often dangerously or lethally committing acts of self-destruction.

Once we recognize that an unusually high number of suicides have occurred within a relatively short period of time and in a clearly defined community, the task of explanation can no longer be accomplished by focusing exclusively on the "proximal" factors, the life events and circumstances of individuals. With so many threatened, attempted, and completed acts of suicide happening in such proximity, we are forced to recognize the occurrence of a crisis that goes beyond the usual manifestation of mental illness, that is larger than individual life histories, and that can be explained only by considering the social context in which suicide somehow gained wide currency.

Suicide is a notoriously difficult phenomenon to understand, above all in those cases that seem to follow from the effects of social contagion. But our knowledge can be advanced when we highlight this complexity by pointing to the difficulties and multiple possibilities, both in the realm of mental health crisis and in the realm of ideas, inherent in trying to understand cluster suicides in Canada's Aboriginal communities.

Interpreting Cluster Suicides

The wide differences in rates of suicide between Aboriginal populations as a whole and those places in which suicide clusters have occurred is one of the strongest indications we have of a social origin to suicide, encouraging an approach that is more encompassing than the focus on the suicide victim and his or her immediate family or social entourage. Where self-destruction is most concentrated, the possibility is greatest that it is being influenced by shared ideas and values.

The idea of a collective dimension to suicide among the peoples of Australia and New Zealand was considered in 1926 in a comparative study by Marcel Mauss, "Effet physique chez l'Individu de l'idée de mort suggérée par la collectivité" (The physical effect in individuals of the idea of death suggested by the collectivity). According to Mauss, suicide can sometimes result from the elaboration of collective ideas, above all moral and religious ideas, that compel individuals toward self-destruction "by suggestion." This influence on individual behaviour of shared ideas about acceptable or inevitable death resulting from spiritual forces is, he proposed, a clear indication of the influence of social life on the motives and behaviour of individuals. Group pressure and education can create a foundation of belief that, under the least provocation, can unleash "ravages or overexcitement of forces" (2004, 315). Although contemporary suicide research has largely dispensed with the colonial cultural stereotypes built into the material invoked by Mauss, his general observation of a collective dimension to self-destructive behaviour, traceable largely to the influence of shared ideas, remains a significant, yet largely overlooked, point of analytical departure.

This influence is evident from accounts of Cross Lake's suicides in 1986 and 1987. This crisis appears to have first occurred principally among members of a close-knit group of friends who had grown up in abusive homes, who were then separated when some of them were sent to distant foster homes, and who were reunited in Cross Lake in their mid- to late teens. As often occurs in such groups, security and comfort were provided by one among them – let us call him George. As one of this group of friends remembered, their parents' drinking parties were dangerous events in families with histories of violence and sexual abuse: "We'd have to sneak out the window and go sleep in the bush in the middle of the night ... come out in the morning when everyone was passed out." It was in these circumstances that George gave hope to his younger siblings. "He was telling my brothers and my sisters not to worry, that he was going to take care of them" (Cross Lake, 31 March 1999).

George, who had become the focus of a youth group's security, was the first to die by suicide in 1986, suffering a traumatic and public death in the local nursing station from a self-inflicted gunshot wound. Soon, another of the same group survived a self-inflicted gunshot wound from a 303 British rifle. The self-inflicted deaths and attempts at suicide from this point seemed to gain momentum: "After that there just seemed to be lots and lots of suicides. It wasn't too long after that [that] my ... she hung herself. [And another of our friends] shot himself a couple of months after that too. They tried to stop him. The only thing he said was, 'Hey, I'll say hi to all those guys for you,' and pulled the trigger" (Cross Lake, 31 March 1999).

One of the striking things to emerge from this narrative is the very public nature of self-inflicted death in this suicide crisis. In a remote community surrounded by wilderness, those who took their lives did not do so distantly and quietly but died in ways that were sure to be witnessed by others. Suicides that occurred in crowded reservation housing, especially in the context of house parties, gave the widest possible exposure to the fait accompli of self-destruction. The most direct way to communicate the *idea* of suicide was through one's choice in the *act* of suicide. Nor was the nursing station a setting that offered privacy during a situation of crisis; rather, it offered self-destruction to public view in crowded facilities, in which a significant number of spectators of the violent consequences of suicidal acts were almost certain to be friends or relatives of the victim.

The point seems to emerge from this case material that there can be a group dynamic involved in the development of a suicide cluster and that the idea of suicide can be directly or indirectly promoted through group dynamics. This is an aspect of the study of suicide that is not adequately understood. The social or cultural processes or "routes of exposure" by which susceptible individuals come to seriously accept the idea of suicide are tremendously significant but remain unclear (Gould, Wallenstein, and Davidson 1989). In some instances at least, there can be much more happening behind the events of cluster suicides than an unusually intense and unresolved form of collective grief or individual identification. How does the idea of suicide become so entrenched, so widely accepted as

an escape from unbearable distress, that it can be acted on by many or most members of a community? It would appear from Cross Lake's experience that the thought of suicide can in some circumstances become normalized and, I would argue, even become part of a group's self-image.

This observation takes us in a direction that has not been adequately explored in the study of suicide. Michael Kral has convincingly pointed out that a strong emphasis in suicide research has been on some notion of individual "perturbation," on the state of intolerable psychological distress in all its myriad forms that creates a motivation for suicide, but that "we know next to nothing about lethality: how the idea of suicide becomes internalized and later selected as a course of action by some people" (1998, 223). Distress, no matter how severe, is not always acted upon in lethal acts of self-destruction, so why is it that conditions of unbearable suffering will lead some to take their own lives while others do not? Kral suggests that "the only direct 'cause' of suicide is the *idea* of suicide and ways to do it, and that in order to better understand suicide we need to know more about how ideas are spread throughout society and become part of an individual's repertoire" (1994, 253). The social study of suicide, then, involves the complex task of accounting for historical and social conditions that might contribute to "perturbation" *and* the often less tangible influence of culture on the currency and form of the idea of suicide. Understanding how the idea of suicide becomes internalized is particularly relevant for suicide clusters because the very nature of the phenomenon suggests the influence of collective ideas, even the possible influence of collective self-image or identity, on the frequency of suicide.

Historical Etiology

Virtually everyone who tries to understand the social origins of suicide in indigenous communities now pays particular attention to their distinctive historical background, marked very often by the impacts of political domination, displacement, and economic marginalization, which can be seen as having widely ramifying effects on nearly every aspect of life and society. Such histories are often invoked as sources of explanation for high frequencies of mental illness, addictions, family violence, and self-destruction. But the nature of the connection between past trauma and present crisis is not well understood, and most of those who link history with self-destruction seem to simply assume an effect of collective psychological disturbance that follows naturally and predictably from a colonial legacy or from more immediate disruptions to community autonomy and viability. If, as the findings of psychology have long revealed, the events and memories that shape individual personality are ambiguous and complex, how much more equivocal and subject to variability and reinvention must be the collective interpretations of a community's history.