Suicide among New Zealand Maori: is history repeating itself?


Suicide rates for New Zealanders identified as Maori were analysed for the period 1957-91 and compared with those for non-Maori people. Overall, Maori men had about half the risk of suicide of non-Maori men, and Maori women one-third the risk of non-Maori women. Nevertheless, there was a sharp increase in suicide rates for Maori aged 15-24 years during the period studied, with rates for the 1987-91 time period of 35.2/100,000 for men and 6.0/100,000 for women. These were similar to the high suicide rates of young non-Maori New Zealanders. Suicide among Maori in pre-European times appears to have been embedded in traditional culture and may have occurred particularly among bereaved women; today the pattern is one of high rates in young men who are likely to have been alienated from their culture.

A common stereotype of the suicide patterns of colonised indigenous peoples is of low suicide rates before colonisation, followed by very high contemporary rates resulting from the impact of colonisation on the traditional way of life. For the Maori people of New Zealand there were no written records before the arrival of the first Europeans, but the documented evidence on Maori suicide by early European writers suggests that, far from being rare, suicide was very much part of traditional Maori society.

Marsden (1), referred in a journal written in 1819 to suicide as occurring commonly among Maori people. Maning (2), writing under the nom-de-plume "a Pakeha Maori" to denote simultaneously his close association with the Nga Puhi people and his European (pakeha) origin, claimed that "In the first years of my residence in the country (suicide) was of almost daily occurrence". Dieffenbach (3) and others described the ritual suicide of widows on bereavement, often by hanging, and suicide because of shame or disgrace. White (4) and Gudgeon (5) gave details of cases in which death was seen as preferable to life without honour. According to Johnstone (6), another motive for suicide was frustrated love.

Clearly the comments of early European writers are a very limited basis on which to build a picture of suicide in pre-European Maori society, and it is possible that some writers could have highlighted aspects of Maori life that they regarded as sensational. Another source of information is Maori oral tradition. The existence of stories about suicides coming from a variety of iwi (tribes) supports the impression of the early settlers that suicide (whakamomori) was an accepted feature of Maori society. All the motives described above are echoed in the traditional stories of Puhi-Huia, a grieving widow, Pare, who was frustrated in love (7), Te Aohuruhuru, who was shamed publicly (8) and Tikawe, whose husband forsook her for another (9). It is noteworthy that all of the above were women. The story of Tikawe includes mention of Motutawa, a "famous suicide cliff", and Oppenheim (10) tells of how Whangaroa harbour is said to have taken its name (Whakamomori) from a suicide. Maning (2) believed that suicide was declining rapidly during his time in New Zealand. "I do not believe that one case of suicide occurs now for twenty when I first came into the country". According to Polack (11) the custom of suicide following bereavement was becoming less common during the late 1830s.

It is impossible to know the actual suicide rates that lay behind these historical accounts. Suicide among Maori people today, however, is more susceptible to objective analysis. Has the stereotype of suicide in colonised indigenous people any more validity for New Zealand today than in the past? To identify recent patterns of suicide among Maori
people, we analysed suicide rates for people identified as Maori in New Zealand for the last 35 years and compared them with rates for non-Maori people.

Material and methods

The numbers of deaths from suicide (International Classification of Diseases, Ninth Revision [ICD 9], rubrics E 950–959) in people identified as Maori and non-Maori for the period 1957–91 were obtained from the annual publications of the National Health Statistics Centre. Age-specific suicide rates for the two ethnic groups were derived for men and women separately for successive decades and the most recent five-year period.

Cumulative suicide rates for ages 0–74 years were calculated for each quinquennium for Maori and non-Maori men and women. The cumulative suicide rate provides an estimate of the risk an individual would have of committing suicide before 75 years of age if no other causes of death were in operation. A cumulative rate is an age-standardised rate, enabling direct comparisons between different populations.

Methods used by Maori people for committing suicide were examined for the two sexes separately, for successive decades and the most recent five-year period. For each period, cumulative rates (0–74 years) were calculated for the two sexes for poisoning with solid or liquid substances (ICD 9 rubric E 950), hanging, strangulation and suffocation (E 953), firearms and explosives (E 955) and for all other methods combined.

Results

The numbers and rates of Maori male and female suicides from 1957 to 1991 are shown in Table 1. For Maori men and women aged 15–34 years, suicide rates increased significantly over the 35 years. While for Maori women in this age group the risk of suicide has almost doubled, it has increased three-fold among Maori men. The most dramatic increase among Maori men aged 15–34 years has occurred since 1986, whereas among Maori women aged 15–34 years suicide rates increased most in the 1977–86 time period.

Overall, Maori men have half the risk of suicide of non-Maori men and Maori women have about one-third the risk of non-Maori women (Fig. 1). The cumulative suicide rate (0–74 years of age) has increased significantly over the 35-year period for Maori men but not for Maori women. These overall trends are similar to those among non-Maori men and women.

The age-specific suicide rates for Maori and non-Maori men and women for the decade 1982 to 1991

<table>
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<th>Time period</th>
<th>0–14</th>
<th>15–24</th>
<th>25–34</th>
<th>35–44</th>
<th>45–54</th>
<th>55–64</th>
<th>65–74</th>
<th>75–84</th>
<th>85+</th>
<th>CSR (%)</th>
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<td>14</td>
<td>11</td>
<td>8</td>
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<td>17</td>
<td>13</td>
<td>13</td>
<td>4</td>
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<td>19.4</td>
<td>21.0</td>
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1 Cumulative suicide rate.
Suicide among New Zealand Maori

Fig. 1. Trends in Maori and non-Maori male and female cumulative suicide rates (0–74 years of age) for five-year time periods from 1957 to 1991.

Fig. 2. Maori and non-Maori male and female age-specific suicide rates for the 1982–91 time period.

Fig. 3. Trends in Maori male cumulative suicide rates (0–74 years of age) according to method.
Discussion

The pattern of Maori suicide has changed greatly in New Zealand since the 1950s. The extent of this is not immediately evident, because changes in cumulative suicide rates for Maori men and women were modest, and rates remained substantially lower than for non-Maori, particularly among women. Age-specific rates, however, showed a different picture. Suicide rates for Maori youth increased sharply so that by 1987-91 they were little different from those of their non-Maori counterparts, thus sharing in national youth suicide rates among the highest in the developed world (12).

Maori rates are believed to be underestimated in mortality statistics because of the methods of ascertainment of ethnicity used for death registrations and for censuses. Some Maori deaths are classified as non-Maori by default, because the recording of Maori ethnicity on a death certificate depends on the undertaker ascertaining that the person had 50% or more of Maori biological origin. Brown (13) estimated the underestimating of Maori deaths to be of the order of 28%. In an Auckland study of coronary heart disease mortality (14), Maori mortality was
found to have been understated by 82% when national death registrations were compared with a register that used a close relative’s assessment of the cultural affiliation of the deceased to determine ethnicity. Understatement on death certificates is unlikely to have been as pronounced for suicide as for coronary heart disease, because the distressing circumstances would probably have resulted in fuller information emerging about the victim, but understatement could still have been substantial. Another issue concerns the denominators used in calculating mortality rates. Whereas death certificates have always used a biological definition of ethnicity, the quinquennial census shifted from a biological definition to self-identification of ethnicity in 1986. Brown (13) had estimated that the use of a cultural affiliation question instead of a biological question in the census would result in an increase of the Maori population of only about 3%. This was because many Maori census respondents had probably already been answering the ethnic question on the basis of self-identification rather than biological origin. The denominators used for calculating Maori suicide rates were thus based on a broader definition of Maori ethnicity (particularly from 1986 onwards) than the numerators. This is likely to have added to the underestimation of Maori suicide rates resulting from misclassification on death certificates.

The true Maori cumulative suicide rates could therefore have been as high as those of non-Maori for men, although they would have still been lower for women. The Maori youth suicide rates, already a cause for concern, might in reality have been even higher than those of non-Maori young people.

The Maori and non-Maori cumulative suicide rates shown in Fig. 1 were not adjusted for social class. Smith and Pearce (15), in a study of determinants of Maori mortality, calculated the relative risk for suicide in Maori men aged 15-64 years of age (compared with non-Maori men). Their adjustment for social class had the effect of slightly increasing the difference between Maori and non-Maori risks of suicide. In the present study, adjustment for social class would also be expected to widen somewhat the difference between Maori and non-Maori.

Methods used by Maori people for committing suicide changed over the 35 years studied. Hanging became the main method of suicide for men. Many of these hangings would have occurred in custody: 71% of suicides by hanging in Maori men aged 15-49 years in New Zealand in the years 1980-88 occurred in custody (16). For Maori women, poisoning (which did not even feature as a method of suicide in 1957-66) became the commonest method, tending to replace methods other than hanging or firearms.

These patterns of suicide differed somewhat from those of the total New Zealand population. Among the total New Zealand male population, hanging was increasingly used as a method of suicide over the same period, but did not have the same dominance as a method because firearms and carbon monoxide were also used increasingly for suicide (17). The adoption of poisoning as a method of suicide by Maori women echoed on a smaller scale the increase in total female suicide by poisoning in New Zealand in the 1960s. For the total female population, however, this increase was followed by a marked decline which coincided with reducing the prescription of barbiturates (17), whereas for Maori women the frequency of suicide by poisoning declined only slightly.

For both sexes the current Maori pattern of declining suicide rates with increasing age bears little resemblance to the non-Maori patterns, which were characterised by an increase after 55 years of age in men and a steady increase until about the age of retirement in women. At present it is only possible to speculate on the reasons for this. In Maori society, older people are held in great esteem and carry much tribal responsibility. The valued roles available to them as they mature, and their greater involvement in Maori cultural life compared with young people (18) may enhance their sense of security and wellbeing, and this may partly explain the persistently low rates at older ages for Maori people. The birth-cohort analysis showed that the risk of suicide for Maori born since about 1966 was about the same as for non-Maori whereas it used to be lower. It cannot yet be discerned whether the recent generation of young Maori will carry risks of suicide similar to those of non-Maori throughout life or whether their risks will be lower in later life. If a secure Maori cultural identity is a protective factor for Maori old people, then future suicide rates in present generations of young Maori may depend partly on the extent to which they embrace this identity.

The steep rise in Maori youth suicide paralleled the rise in suicide for all young New Zealanders. Like Australia (and to a lesser extent Canada and the USA), New Zealand has witnessed the worrying development of youth suicide rates that are unusually high in relation to total suicide rates, compared with most Western countries (19). The disproportion of youth suicide compared with total suicide rate is much more striking within the Maori population, as can be seen in Fig. 2. This type of pattern has been observed in a number of indigenous peoples, for example, among certain native North American tribes (20, 21), in Micronesia (22), among Aboriginal people in Australia (23), and in Western Samoa (24). The youth suicide rates in some of these communities were much higher than those of Maori young people — for example, Rubinstein (22) found young male suicide rates of well over 150/100,000 in some
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Micronesian islands in 1975–79, and in 1986 the suicide rate for native Canadian men aged 15-29 years was over 100/100,000. (25) Disintegration of the traditional way of life, particularly family life, substance abuse, and a feeling of being stranded between two cultures are factors thought to underlie high youth suicide rates among some indigenous peoples (20–22, 26).

It will be important to ascertain to what extent suicide among Maori youth has increased because of factors related to their ethnic background, and to what extent the rise in suicide is because Maori youth increasingly resemble non-Maori youth in their behaviour, including suicidal behaviour. Although the similarity in rates between young Maori and non-Maori New Zealanders might lead one to imagine that similarities in problems and behaviour underlie these results, it is notable that non-fatal suicidal behaviour has been very different in the two ethnic groups. In 1976–85, young Maori men and women had much higher rates of hospital admission for non-fatal self-inflicted injury than young non-Maori people (27).

Maori youth have experienced much more adverse social conditions than those of non-Maori youth. They have been educationally disadvantaged, with 37% of Maori school leavers in 1991 leaving without a qualification compared with 16% of all school leavers (28). Their unemployment rates have also been much higher – in 1991, Maori men and women aged 20–24 years were twice as likely as non-Maori to be unemployed (29). In 1991, first admission rates for alcohol and drug dependence for Maori men and women aged 15–24 years were considerably higher than for non-Maori men and women (30). Some problems of young non-Maori people are thus being experienced in greater severity by young Maori people. An important point of difference is the proportion of suicides that occurred in custody. In 1980–88, 23% of all suicides among Maori men aged 15–24 years occurred in prison or police custody, compared with only 2.2% among non-Maori men (16). Although the suicide rates of Maori and non-Maori youth are similar, it cannot be assumed that reasons behind the rates are similar. Cultural factors cannot be ignored.

Belonging to the group is very important for Maori. Durie (31) observed that traditionally Maori did not seek to own or possess anything, but to belong. One belonged to a family that belonged to a hapu that belonged to an iwi. For young Maori today the sense of belonging to their social group remains a key element of their personal identity. Therefore to be ostracised from the group or to participate in risk-taking behaviour in order to maintain their status within the group may lead the individual to become vulnerable to suicide. Conversely, the security afforded by acceptance within a group may protect the young Maori from suicide when everything seems against them. The unity within the group may provide a feeling of wellbeing and mutual support that mitigates against suicide.

The cultural alienation of many Maori young people must be taken seriously as a possible factor underlying Maori youth suicide. Eckersley (32) has stressed the importance of culture with its "ability to provide a sense of belonging and purpose, and so a sense of meaning and self-worth, and a moral framework to guide our conduct". He suggested that just as the consequences for indigenous people are seen when their culture is undermined, so countries like Australia and New Zealand may be seeing the consequences of the failure of modern Western culture to meet such fundamental human requirements. Young Maori and non-Maori New Zealanders may therefore each be experiencing cultural deprivations of different kinds, which contributes to their high rates of suicide.

Whereas many traditional societies are believed to have had low suicide rates, it appears that suicide was not uncommon among the Maori people in pre-European times, for example when honour was lost or a wife was bereaved. For Maori people in recent decades, suicide has been less common than for non-Maori people, especially at older ages. The recent increase in suicide among young Maori men and women to very high levels gives concern that history might be about to repeat itself, particularly if these high rates carry through to older ages. Nevertheless, the emerging pattern is very different. Whereas in the past, the act of suicide was embedded in traditional culture and may have occurred particularly among bereaved women, today it occurs mainly among young men who are likely to have been alienated from their culture.

References

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