AN ESSAY ON SUICIDE AND DISEASE IN CANADIAN INDIAN RESERVES: BRINGING DURKHEIM BACK IN

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Abstract / Résumé

The argument presented in this paper is informed by a Durkheimian paradigm, namely, that the high incidence of suicide (and the pathological risk syndromes associated with suicidal behaviour) among Aboriginal people in Canada are manifest and latent functions of the Reserve system. The latter is a "closed" system of human interaction as it has evolved over the years and maintained by popular hegemony and state authority. Goffman's analysis of "total institutions" also helps throw light on the socio-economic "incompleteness" of Reserve life.

Mon propos s'articule autour d'un paradigme de Durkheim, à savoir, que le taux élevé du suicide (et les sydromes pathologiques hasardeux associés aux comportements suicidaires) parmi les peuples autochtones du Canada font partie intégrante et manifeste à la fois du système des réserves. Celui-ci est une structure fermée des rapports humains qui a évolué au fil des ans, maintenue par l'hégémonie populaire et l'autorité de l'état. Sur un deuxième plan l'analyse de Goffman des "institutions totalisantes" semblerait éclairer "l'inachèvement" socio-économique de la vie de réserve.

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> [S]uicide among Aboriginal people [in Canada]... [is] the symptom of deeper problems... After careful consultation and study, Commissioners have concluded that high rates of suicide and self-injury among Aboriginal people are the result of a complex mix of social, cultural, economic and psychological dislocations that flow from the past into the present. The root causes of these dislocations lie in the history of colonial relations between Aboriginal peoples and the authorities and settlers who went on to establish "Canada", and in the distortion of Aboriginal lives that resulted from that history.
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> We have also concluded that suicide is one of a group of symptoms, ranging from truancy and law breaking to alcohol and drug abuse and family violence, that are in large part *interchangeable* as the expressions of the burden of loss, grief and anger experienced by Aboriginal people in Canadian society (Canada, 1994:2).
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> Chaque société est prédisposée à fournir un contingent déterminé de morts voluntaires (Durkheim [1897], 1960:15).

Emile Durkheim (1858-1917) argued that the rate of suicide and its correlates have their origin in the impact of socio-economic and cultural phenomena, which stems from forces external to the individual. His major treatise on the subject published in 1897 continues to receive token acknowledgement in scientific papers dealing with suicide, but the implication of Durkheim's main thesis tends to be ignored or hurriedly bypassed. It is true that his insightful classification of types of suicide—*egoistic, altruistic and anomic*[1]—provides a useful typology, but little attention is paid to the implications of his central idea, that: "Each society is predisposed to contribute a definite quota of voluntary deaths."

The central argument presented in this essay is that the alarmingly high incidence of violent "pathological" behaviour—suicide, homicide, wife and child abuse, fighting and crime in general, together with heavy drinking and substance abuse—among contemporary Canadian Indians is, by and large, the outcome of continued subjection over a long period of time to life on Reserves as the latter social formations have developed over the years. The syndrome of violence noted above correlates, moreover, very closely with the poor physical health profiles found among Reserve dwellers, and, together, these trends are related to their shared socio-economic (and politico-legal) position in Canadian society. Comparable trends occur

among Reservation Indians in the United States (Reznik and Dizmang, 1971), various groups of Inuit, and among those people in other parts of the world, particularly in Australia (Hunter, 1993), who live encapsulated in similar social formations.

The grim reality of this structural arrangement is the portentous manner in which it has altered people's ways of life over the years in the creation of what might be called encapsulated, artificial and incomplete communities separate from the "real world." This disaffiliated condition of Reserve communities parallels, despite some obvious differences (both analogically and homologically), such social formations as company towns, military bases, penitentiaries, nunneries, asylums, certain kibbutzim and other "closed" communities, including urban ghettos.

The research for this paper, and the formulation of the general arguments presented in it, were formed by what I have termed a *diasynchronic* approach, that is to say, the attempt to conceptualise social relationships through time (diachronic) together with those occurring at particular periods in time (synchronic) because they are partners in the same sociological system (Carstens, 1991:xvi; see also Hunter, 1993:24). The value of this paradigm is that it facilitates free use of the comparative method.[2]

Some people, Aboriginals and others, disapprove of critical analyses of Reserves as communities in the modern world, because they fear, quite erroneously, that any controversial discussion of the system may provide a vote for the termination of Indian status. Some liberal academics deliberately gloss over the sickness and violence on Reserves because they find it "inappropriately damning" to the people who spend their lives on one of the approximately two-and-a-quarter thousand parcels of Reserve land in Canada.

Background to the Issues of Aboriginal Health

Diamond Jenness, writing in the early 1930s about the Aboriginal people of North America, with a main focus on Canada, painted a very gloomy picture of the disastrous effects the European presence had on these Native peoples. Jenness believed that whether they resisted or submitted to "the onslaught of civilisation," their collective health was soon devastated by alien diseases. It is well known, for example, that their numbers were decimated periodically by smallpox, from the early 17th until the second half of the 19th Century. The other plagues that struck from time to time included typhus, influenza and tuberculosis. Then there were the demoralising effects of alcohol, notably whiskey and brandy, dispensed by the keg at the trading posts to Native peoples "just when they needed all

their energy and courage to cope with the new conditions that suddenly came into existence around them" (Jenness [1932], 1977:254).

European presence and the fur trade also depleted much of the traditional food supply, a depletion that forced Aboriginal enmeshment in a new socio-economic system with which they were unfamiliar and, therefore, greatly disadvantaged. "One by one they ceded their territories to the invaders, and whenever European colonisation was proceeding, submitted to confinement on narrow reserves" (*Ibid.*:257). As time went on, Chiefs became Chiefs only in name, as real authority passed from their hands. Jenness concludes that: "If considerable numbers [of Indians] still cling to the Reserves that were allotted to them long ago, it is not because they are, in most cases, incapable of holding their own under modern conditions, but because as wards of the government they enjoy certain economic advantages which they would lose by accepting citizenship" (*Ibid.*:260).

In Jenness's time there were still enormous disparities between the health status of the Indians and the national populations of Canada and the United States. Those disparities come as no surprise, given the grossly inadequate "health-care" systems that had been provided for Aboriginal people by the old colonial establishments in the past, when medical services were entrusted to missionaries, the military at outpost field stations, and representatives of the fur trading companies. Moreover, health care did not even improve in Canada during the first half-century of dominion status, and it was as late as 1904 when Dr. Bryce, the first superintendent of state medical services, was appointed. But Bryce's attempt to establish a treatment programme for tuberculosis in Aboriginal communities received little support from the state and the post was soon terminated, remaining vacant for 17 years. In 1927, the new incumbent, Colonel E.L. Stone, took up the tuberculosis problem and expanded the limited health-care facilities for Native people (See Waldram *et al.*, 1995:136, 156 ff.; Young, 1994:25-6).

There was a great improvement in Indian health over the next 50 years, as borne out by a gradual *increase* in *life expectancy* and *decrease* in both the *infant mortality rate* and the incidence of tuberculosis. A similar trend also occurred among the Indian population in the United States (see, for example, Bachman, 1992; and especially Dobyns, 1983).

This does not mean that *infectious diseases* have disappeared among Aboriginal Americans, for the latter are still exposed to higher risks by comparison with national populations, especially for such diseases as meningitis, hepatitis and pneumonia, and new infectious diseases such as AIDS. Tuberculosis is on the increase as Canada enters the 21st Century. Meanwhile, there has been a precipitous increase among Native Americans in the incidence of *non-communicable diseases* (cancer, ischemic heart

disease, stroke, hypertension, dyslipidemia, obesity, diabetes, and gall bladder problems). The causes of many chronic diseases, especially diabetes, hypertension, obesity and cardiovascular disease have been attributed to rapid changes in lifestyle involving, for example, poor dietary habits and low levels of physical activity. And, as if these afflictions were not enough, Indian communities are now plagued by unparalleled accident and injury rates, high degrees of heavy drinking and substance abuse, varieties of crime, factionalism, wife and child abuse, homicide and psychiatric problems. All these social pathologies together constitute a major part of the syndrome with which suicide is associated among these Aboriginal people. The major causes of all these pathologies lie in a multifaceted socio-economic history (cf. Kirmayer, 1994:3-58), old and recent, of the Indians of North America and the Europeans who involved them in a new way of life—especially that of segregation and confinement in Reserves.

According to the 1991 census, approximately a million Canadians identified themselves as Aboriginal, that is, just under 4% of the total population of Canada given as 27,296,859. The term "Aboriginal" has many meanings in Canada, as it does in other parts of the world. Some appellations are political; others refer only to census categories, while others indicate membership, real or legendary, in ethnic groups.[3]

Suicide as Social Pathology

The extent and magnitude of the problem of suicide faced by Aboriginal people in Canada are reflected in statistics that point to an average Aboriginal suicide rate that is three times that of the total Canadian rate. Some of the regional and community variations are more alarming. Aboriginal youths living on Reserves, for example, have a suicide rate of five or six times that of their age-group peers in the general Canadian population (Kirmayer *et al.*, 1993/94a:5). And in some provinces, Indians comprise up to half of all suicides.[4] Comparable trends have been reported from the United States, where considerable attention has been given to regional, cultural, and tribal variations.[5]

Suicide rates also vary considerably according to age and gender. Thus, in the national Canadian population suicide under the age of 12 is uncommon, but the rate increases dramatically during the teenage years, reaches a peak between the ages of 23 and 25, and declines thereafter with some minor peaks. While similar trends with regard to suicide and age occur among Aboriginal people, there are marked differences in the numerical rate. Thus, "a Status [Reserve] Indian adolescent is 5-6 times more likely to die from suicide than the average Canadian adolescent" (*Ibid.*,:15). While gender differences in suicide rates among Status (Reserve) Indians are

comparable to those of the general population, they are amplified by higher rates in both males and females. Female adolescent Status Indians are 7.5 times more likely to commit suicide than female adolescents in the total population. Similarly, in the 20-29 years age range, the suicide rate for female status Indians is 3.6 times the rate for all Canadian females (*Ibid.*,:15-16).

Variations in suicide rates among Aboriginals are also reported to be statistically correlated with marital status, ethnic and regional differences. Other demographic reports include the observation that acts of suicide by Reserve dwellers occur very frequently at home (or close to home), suggesting strong centrifugal involvement with the dark side of Reserve life. Jail suicides are also common. Related to the above are "cluster suicides," that is, the grouping of suicides in both time and location, suggesting a learned pattern of self-destructive behaviour within the context of peer or family groups (Shore, 1975:86-91; Davidson *et al.*, 1989:2687-2692; Hunter, 1993:133-165; Kirmayer *et al.*, 1993/94a:19-23).

Risks Associated With Suicide

The idea that any single factor—or even a group of factors—can be said to be *the sole final cause* of a complex phenomenon such as suicide is no longer a tenable or legitimate explanatory position in the medical or social sciences. At best one can speak of statistical and logical correlations between sets of observed data. It is only very rarely that perfect and definitive correlations can be deduced from data collected during epidemiological or sociological research. In the former discipline (and in clinical medicine) the "causes" of specific diseases are now regarded as risks[6] (meaning the hazards, dangers and exposures to mischance or peril) whose prevalence have an influence on one's health. In other words, a principle of degrees of exposure to risks has been introduced as an explanatory design—to get away from misleading notions of simple causality. Thus, the major risk factors in ischemic heart disease are given as cigarette smoking, hypertension, and elevated serum cholesterol levels, while other, less acute, risk factors are listed as diabetes, physical inactivity, obesity, stress, and personality characteristics. The fact that most of these risk factors can be eliminated altogether, or significantly reduced, suggests that "ischemic heart disease is largely a preventable disease" (Young, 1994:121).

The epidemiological risks of Aboriginals committing suicide while living on a Reserve (or its equivalent) are not only more numerous and complex, but their origins go back a long way, and are closely related to wider socio-economic and political contexts of European expansion and present-

day national social formations.[7] The purpose of studying so-called risk factors is to identify variables that act singly or in interaction to increase the likelihood of suicide. Risk factors may reflect individual vulnerabilities, or they may be social factors that affect specific groups of people or whole communities (Kirmayer *et al.*, 1993/94a:24). While successful suicides are relatively rare occurrences, the idea of suicide is in fact extremely common. The enormity of the problem has been brought into prominence in epidemiological analyses where it has been pointed out that recorded suicide mortality rates represent but the tip of a statistical iceberg. For every successful suicide there are many more parasuicides, i.e. attempted suicides (Young, 1994:194), and there are many unrecorded suicides.

Research carried out over the years into the nature of suicide, and the symptoms and factors surrounding and associated with the high suicide rate among Native peoples, both in Canada and the United States, confirms the complexity of the risks and roots of suicide. There does, however, seem to be general agreement in the literature that a distinction, if not a clear one, can be made between major risk factors and a much longer inventory of general risk factors. Also listed are, what are considered to be the predisposing factors that some suicide-prone individuals seem to acquire during their lives. See Figure 1.

It requires only a cursory examination of the list to appreciate that nearly all of the items originate as forces that are external to the individual, both in time and place. Even the major risk factors have exterior origins. Heavy drinking and alcoholism have their roots in colonial days (Jenness, op. cit. 249-64; Levy and Kunitz, 1971:97-128; *Ibid.*, 1974). Solvent sniffing (Remington and Hoffman, 1984) can hardly be described as a traditional custom. Psychological problems also have their roots in social problems associated with the outside world. Predisposing factors, on the other hand, might be considered part of the genetic domain, but it is difficult to conceive of these operating in an environmental vacuum. It has, however, been argued that Indians have a genetic predisposition to alcoholism and heavy drinking. In point of fact, the data on which these studies are based seem to have been wrongly interpreted, as Young (1994:210-215) has so conclusively shown. And in some communities, both the heavy drinkers and the alcoholics seem genetically to have fewer "Aboriginal genes."

Durkheim's *faits sociaux*

Given the external nature of the above "Indian suicide risks," it is appropriate to look closely at Durkheim's complex theoretical treatise on the nature and causes of suicide published over a century ago.[8] Durkheim, as is well known, insisted that his discipline (sociology) dealt only with what

Major Risk Factors (in random order):

Heavy drinking and alcoholism;
Substance abuse (including solvent sniffing);
Mental problems associated with social problems;
The inability to perform one's social roles adequately;
Previously attempted suicide.

Other Risk Factors (in random order):

Social disorganisation;
Breakdown of communal ties;
Breakdown of traditional values;
Loss of traditional culture;
Acculturation stress;
No strength to tackle a problem, and blind to any way out;
Conflicts in social relationships;
Chronic factionalism;
Wife and child abuse;
Victim of incest and/or rape;
Quarrels with kin and close friends;
Disorganised family life/family pathology;
Daredevil and self-destructive behaviours;
Marital problems;
Poor socio-economic circumstances by which most Aboriginals live (compared with the general population);
Poverty;
Geographical isolation;
Social isolation;
Economic disadvantage;
External socio-economic factors;
Unemployment;
Political disempowerment;
Alienation and anomie;
Enforced residence on Reserves;
Enforced education in residential schools;
Loss of relatives and friends by death;
Greater number of caretakers as a child, and childhood separations;
Chronic stresses of daily life;
Living on a Reserve;
High rates of arrest, in trouble with the law (especially being confined to jail);
Being male, especially between the ages of 10 and 50 years;
Being female between ages agres 20 and 30 years.

Predisposing Factors (in random order):

Extremes of temperament (aggressivity, impulsivity and inhibition);
Hopelessness;
Cognitive rigidity;
Major depression and other psychiatric disorders.

Figure 1: Risk factors as correlates to high suicide rates among Native peoples in Canada and the United States

he called *faits sociaux*[9] (social facts), which should not be confused with biological or psychological phenomena. But as Steven Lukes (1973:216-217) points out, Durkheim's proposition did not rule out his interest in and preoccupation with three social-psychological propositions: (1) that individuals need always to be attached to a social goal; (2) that the individual must *not* be so committed to a transcendental goal as to lose all personal autonomy; and (3) that people's passions need to be regulated though not to excess:

> Durkheim's theory of suicide therefore amounts to this: that under adverse social conditions, when men's social context fails to provide them with the requisite sources of attachment and/or regulation, at the appropriate level of intensity, then their psychological or moral health is impaired, and a certain number of vulnerable, suicide-prone individuals respond by committing suicide (op. cit. p. 217).

Lukes' fresh presentation of Durkheimian theory is important because it does unshackle the extreme social determinism so often wrongly or inaccurately attributed to Durkheim. In fact, careful reconsideration of Durkheim's position on the social causes that generate suicide, as elaborated in *Le Suicide*, leads one to the conclusion that Durkheim's *causes* are, in fact, *risks*,[10] inherent in the socio-cultural world, having many parallels with those *risks* (and *risk conditions)* detailed in contemporary literature found in epidemiology and psychiatry. See Figure 2.

Durkheim's inventory was, in effect, part of the process of identifying a system of risks that can impair the mental health of the individual "by rendering social bonds inadequately or excessively effective...thereby reducing his immunity to suicide..." (Lukes, 1973:215). Durkheim, moreover, sought to demonstrate that collective tendencies are, in fact, real social forces, that act on the individual from without.[11] And, while he does not say so in so many words, it is crucial to the argument to infer that a significant number of these forces do operate at the level of unconscious collective *representations*. In similar fashion, Karl Mannheim (1936), writing many years later, used the term "collective unconscious" to refer to the reality of certain intellectual forces not yet unmasked by existing consciousness.[12]

Incomplete Communities

Goffman's Total Institutions

It was Erving Goffman (1961:3-124) who insisted that society (the socio-cultural world in general) was a composite comprising many differing

- States of the various social environments;
- What is most deeply constitutional in each national temperament;
- The nature of...civilisation,...the manner of its distribution among different countries;
- The moral state [or] temperament [or] constitution of society or groups;
- Ideas and sentiments;
- Common ideas, beliefs, customs and tendencies;
- Current opinion;
- The weakening of traditional beliefs and...the state of moral individualsim;
- The loss of cohesion in religious society;
- Excessive individuation;
- Currents of depression and disenchantment...expressing society's state of disaggregation [and] the slackening of social bonds;
- The set of states, acquired habits or natural predisposition making up the military spirit;
- Traditionalism [when] it exceeds a certain degree of intensity;
- Crises, that is, disturbance of the collective order;
- A moral constitution *sui generis*, itself resulting from a weakening of matrimonial regulation;
- Pessimistic currents;
- A state of crisis and perturbation;
- A state of disaggregation;
- The state of deep disturbance from which all civilised societies are suffering.

Figure 2: Durkheim's *social causes and currents* generating suicide (in random order).

styles and patterns of interaction (institutions and communities), each having "encompassing tendencies" that capture the time and interests of its respective members in varying degrees and by different methods. Some of these formations encompass so powerfully that their natures are delineated by barriers to social intercourse with the outside, to the extent that they are incorporated into the physical plan as locked doors, high walls, barbed wire, water, forests or moors. He called these "total institutions."

Goffman's total institutions are essentially "closed" communities created by the dominant society. They include homes established to care for the "incapable and harmless," TB sanitaria, mental hospitals, penitentiaries, P.O.W. and concentration camps, army barracks, boarding schools, work camps, colonial compounds, abbeys, monasteries, convents and other cloisters (op. cit. pp 4-5).

Goffman's interest in the internal structure of total institutions involved him in an evaluation of the effects on people's lives of the contrived practice of forcibly breaking down the boundaries separating work, play and sleep in the real world and then bringing these three basic needs together again in a "single rational plan purportedly designed [by policy makers] to fulfil the official aims of the institution." Goffman noted that successful implementation of the plan by the administration depended, to a large extent, on maintaining formal distance between a large "managed group" and a smaller supervisory staff, and keeping everyone under surveillance. *Goffman could well have added company towns and Native Reserves to his list of total institutions.*

Company towns[13] offer a very appropriate archetypical model for the study of so-called "closed communities." Company towns the world over, in addition to being spatially isolated, reflect high degrees of closedness in general. In addition to the sole ownership of the resources, all property and administration are entirely in the hands of the company. Houses, shops, schools, hospitals, libraries, recreation facilities, etc. are all subordinated entirely to the design, control and will of the owners. Companies make their own rules and regulations regarding the everyday lives of all their employees. Typically, company towns are unincorporated and are inhabited entirely by employees and their dependants. To mark and ensure that separation from the outside world, company towns are often fenced off, with checkpoints, not unlike border crossings from one state to another, the company controlling both the entrance as well as the departure of its workers and their families (and those of the occasional visitor). Residents are entirely dependent on the company for almost everything they require for their day-to-day existence.

Company towns are highly stratified formations, economically and socially, providing a complex hierarchical spectrum of occupations ranging from the elevated position of the general manager to the lowly ranks of the exploited workers at the bottom.

But while management enjoys higher wages, more authority and social prestige than others within the company "estate," real authority and power resides in the domain of commerce and trade located outside in metropolitan centres in the host country and (more frequently) abroad.[14]

Comparisons between similar types of social formations never produce perfect correlations. Thus, while Reserves can be regarded as creations of capitalist systems, they can hardly be said to generate massive capital for the state (although as low-priority recipients of social and development programmes they do save money for both the state and the private sector). Reserves differ, moreover, in population size and density, degrees of isolation and closedness, missionary influence, etc., and not all company towns are enclosed by barbed wire fences with checkpoints through which all must pass. But the presence of structural variation should not rule out comparison given the high degree of closedness which they share. Closedness, moreover, is largely a function of established systems of authority and power located beyond community bounds, and it is these corridors of power that determine the internal structure and shape of these "environmental bubbles" in which the people concerned must live (Cohen, 1977: 35, 38, 76-86). While it is tempting to describe these social units as artificial communities, a more appropriate characterisation is their cultural *incompleteness*,[15] illustrating, among other things, that members and residents have little or no effective control over their collective and individual destinies.

As incomplete communities, modern company towns share very few characteristics and qualities with contemporary urban centres. And, at best, they can be likened to factories isolated from their urban location and operated by a specially recruited workforce, housed in isolated lifeless "suburban" clones, or in single-sex bunkhouses, hostels and compounds—and cut off from the rest of the world. Indian Reserves are also weakly and incompletely linked to the spectrum of benefits offered by the larger society. Law and administration, education, welfare, medical, dental and other social services all derive from a single source, the Canadian state.

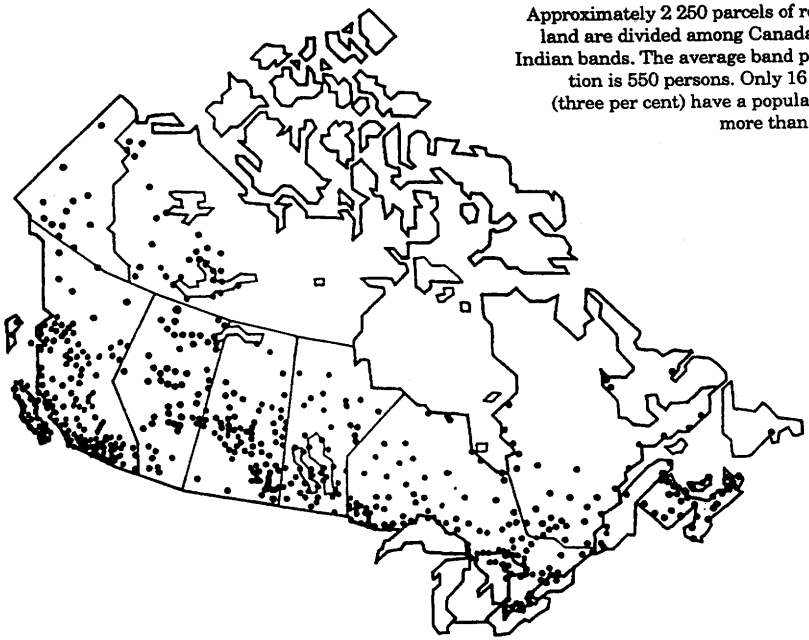
Canadian Indian Reserves[16]

The existing laws concerning the Indians of Canada were consolidated and amended to form the Indian Act of 1876. The Act stipulated who Indians were, who they were not, and how they were expected to fit into Canadian society. Indians were defined in terms of criteria forged by the state, which now regarded them as being separate from "persons," thereby dividing (and classifying) the population of Canada into two separate estates—Canadian persons and Indians. This classification had little to do with race, and the main criterion for being an Indian, as far as the state was concerned, was to be an approved resident of a Reserve to which the Crown held legal title.

Nowadays membership in each Band (Reserve community) is recorded officially in a "Band list." The list contains the following details about each

Indian Reserves in Canada 1991

Each dot represents a reserve or a cluster of reserves



Approximately 2 250 parcels of reserve land are divided among Canada's 606 Indian bands. The average band population is 550 persons. Only 16 bands (three per cent) have a population of more than 2 000.

member: full name, date of birth, marital status, religious affiliation and whether resident "on" or "off" the Reserve; and a numerical code identifies each person by prescribed individual and family numbers. The Band list is thus a very important document—important to individuals because it provides proof of membership and therefore entitlement to all the privileges (and the disadvantages) that the state provides and guarantees for Status Indians. The lists are also crucial to the state's efficient patronage of its clients and control of its wards. There are 606 Indian Bands in Canada comprising approximately 2,250 parcels of Reserve land (see Map). Most Bands are small, with an average population of 550 persons. Only 16 Bands (3 percent) have populations of more than 2,000 (Canada, 1992:8).

The Indian Act also makes provision for the election of Chiefs and councillors, but the results of all elections must be confirmed by the governor-in-council who has authority to depose Chiefs at any time. Band councils have no power and very little authority, but they are expected to frame rules acceptable to the state for the better administration of their communities, and to administer the laws laid down in the Act.

Modernising the Status Quo

The Indian Act has been constantly amended over the years to accommodate changing attitudes and circumstances on the Reserves and in the wider world. For example, the amendments to the Indian Act in 1951 made it possible for Indians to drink in beer parlours and other licensed premises after years of being deprived of that right, but it was not until the early 1960s that they were permitted by law to purchase liquor for consumption at home. Also, women Band members were given the right to vote at elections for Chiefs and councillors; Bands were given more powers (as newly defined) to exercise control over Reserve land; and Band councils were now allowed to manage their own revenue and promote local development schemes.

While there has been an indulgent liberalisation of the Act over the years, these reforms should be interpreted as part of the trend to modernise the status quo. If Indian Bands are to remain subject to the exclusive authority of the federal government, the existing legal and bureaucratic procedures must be updated from time to time to maintain their effectiveness. In other words, all amendments to the Act are, in reality, no more than steps in the process of modernising the Reserve system, and the majority of all social services continue to be provided by the state through its administrative wing, the Department of Indian and Northern Development. One of Heather Robertson's informants, Willie Denechoan, a medicine man at Hay Lake put it this way: "The Government has us in a little box, with a

lid on it. Every now and then they open the lid and do something to us and close it again" (Robertson, 1970: frontispiece).

Reserve populations, as collective socio-economic and political wards of the state, have occupied structural positions not unlike those of the inmates of Goffman's total institutions since their inception more than a century and a quarter ago. Moreover, the stage for the enforcement of the Indian Act in 1876 had already been set during the colonial period (and earlier), as Indian groups interacted with traders, settlers, the military and the missionaries. Indian Chiefs and fur trade Chief factors, for example, confronted each other on such matters as the politics of furs and rights to land. Missionaries confronted Indian shamanical priests (and vice versa) over religious ritual and belief. Settler representatives negotiated with Indian Chiefs and headmen for land, but often they simply stole the land. And, as the institutions of colonial government and administration developed and were formally routinised, Indian agents, a new breed of officials, were appointed to stage-manage agencies where they presided over the affairs of the Indians.[17]

While the course of that process is well known, the hegemonic and coercive control of Native people's lives has a long history. In the early years, both negotiation and compromise were possible, but continued interaction only strengthened the hand of the Europeans. This paved the way for a new social order of domination of the former by the latter and culminated in the encapsulation of Indians on Reserves, making it impossible for them to control their destiny. The role of missionaries in the creation and establishment of the new limited world in which the Indians now live is also well known. Not only did church teaching confront and destroy the sacred tenets of Indian religion, but, in league with the state, the churches took control of education in residential schools (Miller, 1996).

If the Indian Act (and the Reserve system created by the Act) defined the parameters of the socio-economic expression for Indian people, what was the spin-off of that structure? Two consequences stand out prominently. First, was the modification and total disruption of the mode of subsistence and the household economy. Second, was the rapid growth of insidious factionalism.

The Emergence of New Modes of Subsistence

At the time of contact most of the Aboriginal people of Canada variously hunted, fished, and gathered wild foods, and the effect of the fur trade and European settlement on the traditional economy is well known. With the establishment of Reserves, notably in the southern half of the territory, creation of new modes of subsistence became necessary for survival. In

some parts of the country, where conditions were suitable, Indians took up ranching and agriculture like their settler neighbours. But, after the turn of the century, shortage of land and population increase forced many into wage labour outside their Reserves, and some "emigrated" to join Canada as enfranchised citizens.

Thus, the Reserves were never viable economic communities, even as subsistence enclaves for impoverished people. This state of affairs is reflected in the economic returns and patterns of economic livelihood on Reserves for over a century. In 1991, the unemployment rate of the total Aboriginal population was 25 percent, as compared to 10 percent for the rest of Canadians, while the national labour force participation rates were 57 percent and 68 percent, respectively (Waldram *et al.*, 1995:20-22). The plight of Reserve dwellers is more serious, and, as Menno Boldt (1993:238) points out, "on-reserve Indian unemployment rates remain relatively static, at near 70 percent."

With regards to income, the annual income of 54 percent of the Aboriginal population was less than $10,000 per annum, as opposed to 35 percent of the total Canadian population. The percentage of Indians earning more than $40,000 was only 5 percent, as opposed to 15 percent of the total population. "On-reserve" Indians (65 percent) and Inuit (57 percent) are worse off than any other group, having annual incomes of less than $10,000. To quote one specific case, *the total household income* on the Okanagan Reserve (in 1980) was *less than* $10,000 for 45 percent of households (Carstens, 1991:185-187).

Closely linked to income is the standard of housing. Aboriginal households house more people per room than non-Aboriginal households. And 49 percent of Aboriginal houses needed repairs in 1991, as opposed to 32 percent nationally. The figure for Reserve dwellers is much higher with 68 percent needing repairs. Twenty percent of the drinking water on Reserves was considered undrinkable by national standards. Fewer Reserve dwellings had flush toilets and electricity, and 43 percent of houses on Reserves relied entirely on wood for heating purposes. The level of education achieved by Canadians of Aboriginal descent is much lower than the national average and expectation. For example, 17 percent did not complete grade nine, only half of the 15 - 49 age bracket completed high school, and only 3 percent completed a university degree in 1991 (Waldram *et al.*, 1995:20-22; Canada, 1992).

The most telling detail of all, however, regarding the level of poverty and degree of economic dependence is reflected in the high proportion of individuals and domestic families receiving social assistance from the state. For example: "In 1985, over half the total Indian reserve population received

social assistance or welfare payments as compared to nine percent of the national population. In addition, more than 70 percent of the Indians who received welfare payments were unemployable" (Frideres, 1988:199).

The Rise of Destructive Factionalism

While the Indian Act defined both the physical and political boundaries of Reserves, it also, in interaction with the new dependent domestic economic system, gave rise to destructive factionalism. Unlike cliques, which are small exclusive groups, factions (which are common in many societies) tend to be quite large aggregations whose members insist that they share certain specific ideological commitments. These ideologies are always shaped and maintained by opposition to the values of other factions or the status quo. Thus, the operation of factionalism involves selfish and mischievous ends, as well as the use of unscrupulous methods of operation. It must, however, be noted that the members of one faction see themselves, at any one time, as holding the proper and desirable ideals, against which the ideas of others stand in total opposition. Factions are always involved in ongoing conflicts of interest, competition over scarce resources, as well as in competition for power and influence (Gulliver, 1977:63-64; Hunter, 1993: 258-265).

The study of factions is important because factions constitute informal and unstructured associations for channelling conflict, reinforcing particular ideologies, and for drumming up support for action surreptitiously. Thus, as open categories, they can be infiltrated by fifth-column operations of opposing factions. But they can also close rank in order to prepare for some kind of concerted action, as in the case of a faction transforming into a political party (Carstens, 1991:158-159).

While factionalism, as I have described it, existed in some form in the past, Reserve factionalism is the manifestation of struggles over scarce resources on Reserves within the confines of the limited psycho-socio-economic system in which they are encapsulated. This explains, in part, why daily life on so many Reserves is fraught with disproportionate measures of social conflict, including malicious factionalism and interpersonal feuds, petty exchanges of insults, fisticuffs, individual backbiting, assault, wife beating, child abuse and neglect, truancy, transgression of the law, heavy drinking, homicide and, of course, suicide. Some of this centripetal behaviour might be interpreted as being part of the unconscious process of deflecting the anger and hostility people feel, away from the external institutions that control their lives, to kin and neighbours. Vandalism is another form of aggressive behaviour, but here the aggression is directed against public property as a rejection of mainstream Canadian institutions.

Foster (1960-1961) reported similar patterns of behaviour in peasant communities where interpersonal relations deteriorate when land and other commodities are in short supply.[18]

The Process of Mortification

There is, as has been indicated above, general agreement in the contemporary scientific literature by both epidemiologists and psychiatrists with regard to the factors associated with Reserve suicide. These include a pattern of multiple risks (and correlations between them) ranging from poverty and poor housing to paternalism and the legacy of colonial and pre-colonial eras. Few, if any, of these clusters of risk behaviours are connected with an Aboriginal way of life.[19]

Goffman (1961:12-48) came to the conclusion in his work on total institutions that the life and culture of people living in closed communities underwent a process of mortification over time. He called the end result of this process *disculturation* because it involved the *untraining* of people so encapsulated. Historically, Band members on Indian Reserves have undergone a very similar experience of disculturation and untraining, exacerbated and heightened by the length of time they and their forbears have been exposed to the effects of encapsulation in a Reserve. The formal establishment of Reserves not only accounted for loss of land and its resources, but for the process of stripping people of their Aboriginal rights as well as much of their cultural apparel including language and religion over the years. And the notorious Indian residential schools were established by the state to *untrain* Indian children with respect to their language and religion, and then have them *retrained* by the teachers, priests and other staff of the Roman Catholic, Anglican and United churches (Miller, 1996:3-11, 406-443 *et passim;* Johnston, 1988)

In drawing parallels between Indian Reserves and other social formations—peasant communities, company towns, "total institutions" (Goffman), military bases, expatriate communities—it is important to stress the one crucial difference: Reserves have become permanent organisational fixtures that have reproduced themselves biologically as populations, and structurally and culturally as incomplete and artificial communities for a hundred and twenty-five years.[20] In this regard, it is possible to speak of the emergence over time of what has been called "reservation culture," a culture that stands in total opposition to traditional Aboriginal worlds.[21] It is essential, therefore, to realise that Indian suicidal behaviour and its concomitant social pathologies, constitute the destructive manifestation of that culture and the social processes that sustain it. Moreover, the syndromes (clusters) of suicidal risk behaviours, many of which are themselves patho-

logical, must, therefore, be located in the total historical context of the Reserve system. Suicide is but one part of a complex syndrome that includes family violence, heavy drinking[22] and substance abuse, reckless driving, living dangerously, factionalism, truancy and criminal behaviour.[23] As Judge Murray Sinclair—himself an Aboriginal—argued in his 1992 address to a conference on suicide prevention that the sad truth of the extremes of violence (including suicide) among Aboriginal people is but a function of their history. Following Frantz Fanon (1963), he maintained that when people have long been oppressed, reactions to the restraints of colonial entrapment can quickly become violent—a violence that is often turned inwards to self, family, friends and others in the local community (Sinclair, 1998:165-178). See Figure 3.

Despite the differences between Reserves and other incomplete closed communities, a high percentage of the residents in the latter also display high rates of alcohol consumption, high levels of displaced aggression, depression, and mental illness (see for example, Bonner, 1992; Leenaars *et al.*, 1998; Lipschitz, 1995). One very comprehensive study by a physician (Michalowsky, 1987:iii–v, *et passim*) on the effects of living in small diamond-mining company towns studied in South Africa shows that 28 percent of White residents were heavy drinkers, consuming alcohol at least once a day—a figure nearly twice as high as that of the general White population; that 30 percent were depressed, which is more than double the rate of the general population; and that the average number of "clinically disturbed" White people in these company towns was almost 19 percent. The study also concluded that residents of all four company towns suffered from high rates of psychosomatic illnesses and anxiety states. Regrettably there was no discussion of suicide, death or death rate in Michalowsky's work, but an independent, non-statistical sociological study of one of the communities suggested a high suicide rate (quite separate from mine accidents) over the years (Carstens, 2001). And Lipschitz (op. cit.) makes some important observations about the high incidence of suicide in urban ghettos, colleges and prisons, on military bases and among patients in the confines of medical wards in the United States. Recent research on fraternities shows that members of these institutions have high rates of alcohol consumption, violence and suicide (*The Guardian Weekly,* 1999). These observations parallel the Canadian experience where high rates of suicide (and the clusters of syndromes associated with them) have been recorded among Aboriginal people living in urban ghettos (Young, 1994; Kirmayer, 1993/94 a,b).

Ghettos by their construction and nature exhibit high degrees of "closedness," and, as communities, they are very incomplete. In the case

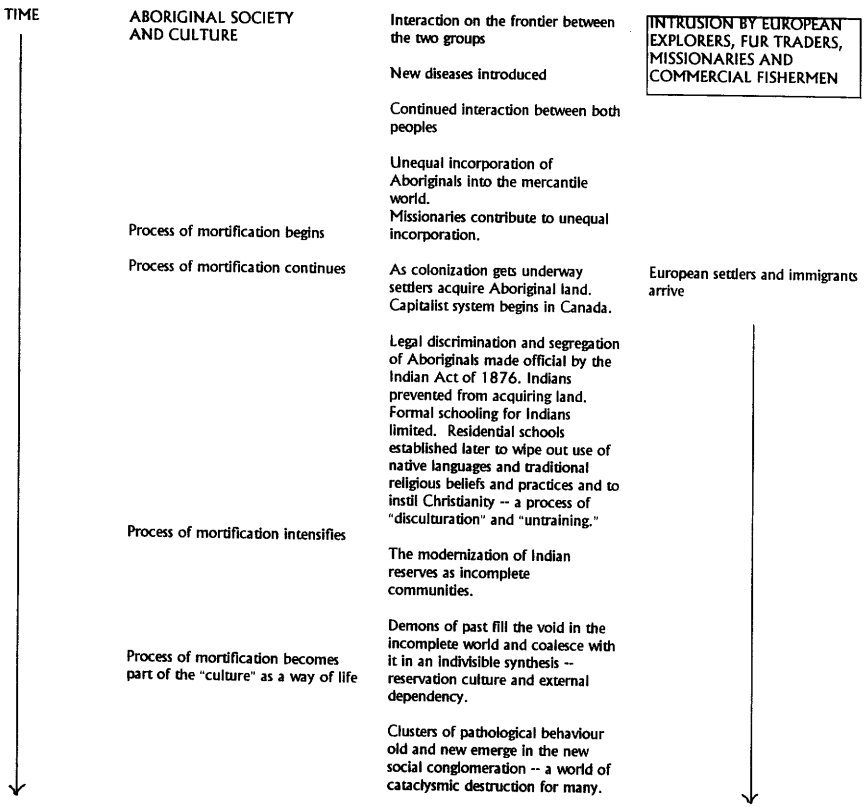


Figure 3: Mortification Process of Reserve-dwellers in Canada

of Canadian Aboriginal ghetto-dwellers, all experienced the same processes of mortification as those living more or less permanently on Reserves. In fact, the majority of urban Aboriginals still retain roots in the Reserves (see Frideres, 1988:137-229).

Socio-Economic Predisposition

When Durkheim ([1897] 1952: 51) wrote that "every Society is predisposed to contribute a definite quota of voluntary deaths", he meant that societies and communities which generate and reproduce specific high-risk patterns through time are predisposed to produce high rates of suicide, suicide being part of those socio-cultural systems (cf. Kral, 1998). Conversely, low-risk patterns are correlated with low rates of suicide. This conclusion, albeit somewhat tautological, sums up the general argument that the complex of risk factors, as highlighted by epidemiologists and psychiatrists, are linked to high rates of suicide and the clusters of social pathologies associated with them. Here the various arena in which these patterns of risk behaviour occur have been narrowed down from what Durkheim called "Society" to community—more specifically to Reserve communities located in one part of the post-colonial world. This is not to play down the relevance of interaction between communities and the wider society. On the contrary, in the case of Native Reserves in Canada, it is the wider and more powerful society that created and shaped them (conquest by socialisation), which led to a predisposition to develop related clusters of pathological risks.[24]

This is not the place to begin a discussion on the important debates on the dangers, undesirability and implications of terminating Indian status in Canada. However, when Aboriginal leaders begin their task of planning community reforms for socio-economic reconstruction and self-government, they will have to come to terms with the conclusion that "modernising" any version of the Indian Act for short term financial gains, or token functionary control over other resources will not help the struggle towards self-determination or reduce the intensity of the syndromes associated with a high rate of suicide. Chandler and Lalonde (1998) have recently reported some encouraging trends in certain British Columbia Reserve communities. They found, for example, that there had been a significant decline in youth suicide rates on those Reserves where members of the community were actively involved in land claims, education, health services, cultural facilities, police and fire services, and, especially self-government—a move towards greater community completeness.

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Notes

1. For a scholarly analysis of Native American suicide using Durkheim's typology see Davenport and Davenport (1987)
2. While the groundwork for this paper was carried out almost entirely as library research, the formulation of the theoretical ideas could never have been achieved without the sociological experience of intensive fieldwork as a social anthropologist among Salish people living on Reserves in British Columbia (Carstens, 1991), in a single-industry company town in South Africa (Carstens, 2001), and the research I did many years ago among the inhabitants of Reserve people in South Africa and Namibia (Carstens, 1966). I am reminded also that some of the ideas informing the thesis presented here were first formulated in a paper based on a series of lectures at the Summer Institute on Canadian Society in 1967 (Carstens, 1971).
3. One census usage divides the Canadian Aboriginal population in terms of their ancestry as follows: 744,845 with North American origins, 43,000 with Inuit origins, 174,710 with Métis origins, and 40,120 with multiple Aboriginal origins, giving a total of 1,002,675. It is of considerable significance to record that 38,000 Aboriginals refused to participate in the census, and these are not included in the total.
4. See Chandler and Lalonde (1998) for a short analysis of variations in suicide rates among Aboriginals in British Columbia.
5. See Bachman (1992). James Shore (1975:86-91) reported that there was a range of between 8 and 120 suicides per 10,000 among Indians living on Reservations in the American southwest and northwest, with similar variations in each geographical area.
6. The notion (and theory) of risks occupies an important place in modern social thought, in which risks are regarded as afflictions generated, as it were, by society, notably "civilized" society. See Ulrich Beck (1992).
7. See the recent report by Alberta Judge John Reilly summarised in the *Globe and Mail* September 22, 1999 ("Judge lays blame for [Stoney Reserve] Suicides.")

8. In addition to *Le Suicide,* Durkheim's general theoretical ideas are set out in his other works. See especially *De la Division du Travail [The Division of Labor in Society]* (1893) and *Les Règles de la Méthode Sociologique [Me Rules of the Sociological Method]* (1895).
9. Willer (1968:180) has very appropriately suggested that "social acts" is a more accurate translation of Durkheim's usage. See Meštrovic (1992:78-89) for an enlightened discussion of this issue.
10. Durkheim presents these in a variety of ways throughout his work; and we are all indebted to Steven Lukes (1973:214-216) for sorting this material for us.
11. See Michel Tousignant (1998:291-306) for a comparative study of suicide in so-called small-scale societies. Tousignant, a psychologist, uses an acculturation paradigm, and limits his criticism of "Durkheim's theory" to the concepts of egoism, altruism and anomie.
12. For an original and creative discussion of suicide and the internalization of culture, see Kral (1998).
13. For excellent introductions to the nature of company towns in North America see James Allen (1966) and Rex Lucas (1971). See also Porteous (1970).
14. Some other parallel social formations of this particular order include military bases (Wolf, 1969; McFeat, nd), expatriate communities (Cohen, 1977:5-129), various early utopian communities (Laidler, 1948), and kibbutzim, etc. It can, of course, be argued that membership in many of these communities is largely voluntary.
15. My use of the phrase "cultural incompleteness" must not be confused with Breton's idea of "institutional completeness." See Breton (1964:193-205).
16. There is large literature dealing, in part or in full, with Indian Reserves in Canada. Of special merit are Sinclair [1992] 1998 and Frideres (1988). The following comprise a short list of other useful works on the topic: Boldt (1993), Braroe (1975), Brody (1981), Canada (1876-present), Canada (1997), Cardinal (1969), Carstens (1991), Cumming and Mickenberg (1972), Dunning (1959), Fisher (1977), Lithman (1984), Long and Boldt (Editors) (1988), Miller (1991), Robertson (1970), Shkilnyk (1985). For two excellent books on public policy and Indian administration see Dyck (1991), and Dyck and Waldram (Editors) (1993).
17. I have avoided use of the term "acculturation" because it suggests inter alia smooth transition and change without questioning the nature of the interaction between different societies and groups of people in a colonial setting.

18. Some years later, Foster expanded his ideas to include a much wider range of behaviours which he called "The Image of Limited Good." Foster writes:

> By "Image of Limited Good" I mean that broad areas of peasant behavior are patterned in such a fashion as to suggest that peasants view their social, economic, and natural universes—their total environment—as one in which all the desired things in life such as land, wealth, health, friendship and love, manliness and honor, respect and status, power and influence, security and safety *exist in finite quantity* and *are always in short supply,* as far as the peasant is concerned. Not only do these and all other "good things" exist in finite and limited quantities, but in addition *there is no way directly within peasant power to increase the available quantities.* It is as if the obvious fact of land shortage in a densely populated area applied to all other desired things: not enough to go round. "Good," like land, is seen [by peasants] as inherent in nature, there to be divided and redivided, if necessary, but not to be augmented...
>
> [In] a special—but extremely important—way, a peasant sees his existence as determined and limited by the natural and social resources of his village and his immediate area. Consequently, there is a primary corollary to the Image of Limited Good: if "Good" exists in limited amounts which cannot be expanded, and if the system is closed, it follows that *an individual or a family can improve a position only at the expense of others.* Hence an apparent relative improvement in someone's position with respect to any "Good" is viewed as a threat to the entire community. Someone is being despoiled whether he sees it or not. And since there is uncertainty as to who is losing—obviously it might be ego—*any* significant improvement is perceived, not as a threat to an individual or a family alone, but as a threat to all individuals and families (Foster, 1965).

19. See Young (1994), Kirmayer (1994, 1993/94a and 1993/94b), Waldram *et al.* (1995), Kral (1998), Canada (1992 and 1994), Shore (1975), Dobyns (1983), Levi and Kunitz (1971), Remington and Hoffman (1984), Leenaars *et al.* (1998).

20. Despite high infant mortality rates and adult death rates, Reserve populations have increased enormously since the turn of the century, largely by natural increase, after a period of significant decline (see Frideres, 1988:138-148).

21. The idea of Reservation culture should not be regarded as a "cultural identity" in the sense that the latter notion is often presented. See for example Berry (1999).

22. Of the Inuit of Greenland, where community structures similar to those of Reserves exist, Thorslund ([1990] 1992:151) found that "almost everyone was intoxicated by alcohol when they committed suicide." He also claims that suicides in his sample were committed in a most aggressive way, close to parents, lovers and friends, thereby strongly suggesting displaced aggression. But whether or not alcohol is a causal factor or simply a contributing risk, one cannot avoid the conclusion that every act of suicide is a violent act directed against the self. See also Hunter (1993:133-199) for a psychiatrist's conclusion based on intensive fieldwork among Aborigines in Western Australia regarding alcohol abuse, suicide and other violence.

23. The intensity of these afflictions are insightfully portrayed in the literary genre of Native men and women fiction writers such as Tomson Highway, Jeannette Armstrong and Ian Ross. Tomson Highway's two plays, *The Rez Sisters* (1988) and *Dry Lips Oughta Move to Kapuskasing* (1989), and his novel *Kiss of the Fur Queen* (1998) are powerful works of literature dealing with the struggles of Aboriginals to cope with the modern world amid the crises and ambiguities of life, many of which are played out in the divisive lives on Reserves and the outside world. Themes include violence, heavy drinking, suicide, family feuds and disagreements—all of which are staged in a genre reminiscent of a Pinter play. Jeannette Armstrong's *Slash* (1985)[23] is a more political novel dealing with the trials of a young man who leaves the Reserve in an attempt to make his way in the Aboriginal political movements of the 1960s. Armstrong and Highway also portray their feelings of anger and resentment towards the colonial powers for preventing Aboriginal people from being trained as producers and consumers in the capitalist society. Ian Ross's *fareWel* (1997) is a play whose theme is spawned from the social realities of living in the Reserve system. The play centres, amongst other things, on disempowered people attempting to gain power in the restricted contexts of a "closed" world.

24. I have touched only peripherally on the Inuit of Canada in this essay, largely because they are administered separately from registered Indians, and there is no legislation comparable to the Indian Act defining them. However, with regard to the respective health (ill-health) profiles and patterns of violence among the Indian and Inuit, there is a very high correlation, due surely to their similar colonial histories (O'Neil, 1984, 1986; Kirmayer *et al.*, 1998; Katt *et al.*, 1998; Young, 1994). Very recently the *Toronto Star* (1999) quoted a British source

which claimed that the Innu of Labrador and Quebec have the highest suicide rate in the world—178 per 100,000 people.

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