THE SOCIAL DETERMINANTS OF ELEVATED RATES OF SUICIDE AMONG INUIT YOUTH

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“If the populations of ‘mainland’ Canada, Denmark and the United States had suicide rates comparable to those of their Inuit populations, national emergencies would be declared.”

Upaluk Poppel, representative of the Inuit Circumpolar Youth Council, presentation to the United Nations’ Permanent Forum on Indigenous Issues, May 18, 2005

It has not always been the case that the world’s Inuit population has suffered from the tragically high rates of death by suicide that they experience today.

The 150,000 Inuit alive today are an indigenous people inhabiting Greenland, the Arctic regions of Canada, the north and west coasts of Alaska, and the Chukotka peninsula in the Russian Far East. A maritime people, Inuit traditionally relied on fish, marine mammals and land animals for food, clothing, transport, shelter, warmth, light and tools. Until fairly recent times, there was a remarkable cultural homogeneity across their homelands, but that began to change as the four states in which Inuit now find themselves consolidated their grips over their Arctic regions.

Beginning in the 1950s, governments across the Arctic subjected Inuit to intense disruptions of the lifeways they were accustomed to. The details varied considerably across the region, but the fundamental economic, political and social processes of incorporation and sedentarization were similar. These processes of incorporation and sedentarization also took place at somewhat different times in different parts of the Arctic, and had somewhat divergent outcomes.

A transition in suicide patterns

The earliest existing data on suicide among Inuit comes from Greenland. Writing in 1935, Dr. Alfred Berthelsen calculated an annual suicide rate of just 3.0 per annum per 100,000 population for the period 1900 to 1930. (By comparison, the most recent suicide rate for Denmark is 13.6 per 100,000, 11.6 for Canada and 11.0 for the USA.) He concluded that the few suicides occurring in Greenland at that time were all the result of serious mental illnesses. As late as 1960 there was still the occasional year when there were no recorded suicides by Greenlanders.

The transition from the “historical pattern of suicide by Inuit” to the “present-day pattern of suicide by Inuit” was first documented in North Alaska by psychiatrist Robert Krauss. In a paper presented at a conference in 1971, he noted:

In the traditional pattern, middle-aged or older men were involved; motivation for suicide involved sickness, old age, or bereavement; the suicide was undertaken after sober reflection and, at times, consultation with family members who might condone or participate in the act; and suicide was positively sanctioned in the culture.

In the emergent pattern, the individuals involved are young; the motivation is obscure and often related to intense and unbearable affective states; the behaviour appears in an abrupt, fit-like, unexpected manner without much warning, often in association with alcohol intoxication; and unlike the traditional pattern, the emergent pattern is negatively sanctioned in the culture.

This suicide transition among Inuit was experienced first in North Alaska in the late 1960s, then in Greenland in the 1970s and early 1980s, and then again in Canada’s Eastern Arctic in the late 1980s and through the 1990s. Each time the transition occurred, it resulted in a higher overall rate of death by suicide.

The temporal sequence in which the “regional suicide transitions” occurred is noteworthy, as it mirrors – roughly one generation later – the processes of “active colonialism at the community level” (We need to differentiate between “active” and “passive” colonialism as some Inuit populations had been colonized for several generations – but in those cases the colonial powers had not attempted to substantially reorgan-
ize Inuit society as they depended on the persistence of the communal mode of production to ensure a supply of marine mammal products, fox pelts, etc.) One of the positive aspects of state intervention in Inuit life was the rapid decline in the incidence of tuberculosis. We can therefore use the decline in tuberculosis incidence as a historical marker of the early years of “active colonialism at the community level”. The historical sequence in which Inuit infectious disease rates fell (as a result of the introduction of Western medicine) was the same order in which Inuit rates of death by suicide later rose across the Arctic.

What the basic statistics tell us

Even though the existing data on suicide among Inuit is quite limited, the basic statistics we do have can tell us a fair amount about what has happened and what is happening.

In each jurisdiction for which data is available, suicides first increased dramatically among young men. For Greenland, Dr. Peter Bjerregaard has shown that suicide began to increase among men born after 1950 – the very year in which the Danish state initiated an intensive programme to turn Greenland into a “modern welfare society”… a process in which Greenlanders had very little say.

Today, suicide rates among Inuit are several times higher among young men than they are among women of the same age, older men and women; and many times higher than among their peers in “mainland” Denmark and “southern” Canada and the US. It is difficult to find words that adequately describe the amount of suicide-related pain and trauma that has been suffered in Inuit communities in recent years.

In each Inuit jurisdiction, there are some subregions that developed and sustained far higher rates of suicide than others. In Alaska, the Northwest Coast has by far the highest rates. In Greenland, the suicide rate among young Inuit men peaked first in Nuuk in the early 1980s, then along the rest of the west coast in the late 1980s, and finally on the east coast in the early 1990s. Suicide by young men in East Greenland reached a rate of 1,500 per annum per 100,000 population, surely one of the highest suicide rates ever recorded anywhere on earth, before finally beginning to decline. In Nunavik (the Inuit part of northern Quebec), the Hudson coast has suffered from a much higher suicide rate than the Ungava coast, while in Nunavut the Qikiqtaiani (formerly Baffin) region has a markedly higher suicide rate than the two mainland regions.
Simultaneously, there are places in the Arctic where suicide rates are decreasing — those sub-regions of the Inuit world that have experienced the most “development” in recent decades. In Greenland, suicide rates among young men in Nuuk have declined significantly over the past 25 years while they have remained stable on the rest of the west coast and risen considerably in East Greenland. A similar shift appears to be underway in Alaska, where the suicide rate among Alaska Natives residing in “urban Alaska” is now less than a third that of Alaska Natives residing in “bush Alaska”.

Exploring why

These statistics are really nothing more than “body counts” that tell us very little about why these people chose to end their lives. In order to develop more effective suicide prevention strategies, we would ideally like to know the rates and patterns of family history and early childhood experiences; mental disorders; medical history; education history; work history; relationship history; substance use/abuse; engagement with the justice system; availability of, access to and use of health care services; and other factors that may have played a role in the suicidal behaviour of these persons. We would also like to know about the presence or absence of a number of protective factors.

An important body of research exists on mental health in Greenland. In a recent article, the two leading figures in health research there in recent decades – Drs. Peter Bjerregaard and Inge Lynge – added the observation that “Suicidal thoughts occur more often in young people who grew up in homes with a poor emotional environment, alcohol problems and violence. … the socioeconomic and structural features of the home were less important than the emotional environment for the development of personality disorders. A logical sequence of transgenerational events would be that modernization leads to dysfunctional homes due to poor parental behaviour (alcohol and violence). This in turn results in suicidal thoughts, suicides and also substance
abuse among the children of those parents.” These conclusions are entirely consistent with the results of research on suicidal behaviour elsewhere in the world.11

The Ph.D. project of the Dutch researcher Markus Leineweber also contributed to our understanding of suicide in Greenland.22 Leineweber worked with death certificates and police reports for deaths occurring between 1993 and 1995 that were deemed by the authorities to have been suicides and, where possible, he obtained limited amounts of additional data on the deceased. His conclusion was that frequent conflict within the family and with friends, a recent life-threatening experience, expressing suicidal intentions and the acute abuse of alcohol could be identified as the most common characteristics among Greenlanders who ended their lives by suicide.

An equally important body of research has been accumulated in Nunavik by Dr. Laurence Kirmayer and his colleagues at McGill University.23

The impact of adverse childhood experiences

There is also a vast array of research on mental health that is of relevance to Inuit insofar as Inuit are “people” like everyone else, in addition to being members of a specific indigenous group.

Of particular relevance to the Arctic at this moment in history is the developing literature on the negative impact of what are termed “adverse childhood experiences”. In short, early childhood experiences – both positive and negative – can significantly impact on the physical, mental, behavioural and economic well-being of both the child and of the adolescent and adult (s) he grows up to be.

Researchers have documented the profound impact that adverse childhood experiences – emotional, physical and sexual abuse; neglect or otherwise problematic parenting; substance abuse within the family; violence within the family; etc. – can have on a person’s mental and emotional health as an adult. They found a “strong, graded relationship” between adverse childhood experiences and an array of negative outcomes later in life, meaning that experiencing a range of such negative experiences has a cumulative effect which makes it much more likely that a range of mental and emotional problems will arise.14 There are a number of other studies that support the hypothesis that adverse childhood experiences have a strong impact in mental health during a person’s adolescent and young adult years as well.15

The impact of positive early childhood experiences has also been demonstrated, by evaluations of a range of early childhood intervention programs. Some have been shown to provide at-risk children with both a better start in life and better mental health outcomes later in life.

Emergence of a new ‘life script’

The Australian psychiatrist Robert Goldney has suggested that all human societies are likely to suffer a “base rate” of suicide in the range of 5 to 10 per annum per 100,000 population as a result of biological and other factors that are simply a part of the human condition.16 The difference between the “base rate” and rates that are significantly higher than the “base rate” is, he believes, primarily the result of social determinants.17

The only logical explanation for the dramatic increase in suicide rates among Inuit living in different regions of the Arctic, with similar outcomes among the sexes and age groups, at different and distinct time periods, is that a similar “basket” of social determinants has impacted heavily on Inuit societies at different times across the different regions and sub-regions. The manner in which Inuit in different regions of the Arctic in recent decades experienced history several decades ago may have had significant impacts upon the mental health of their children, the next generation of young Inuit, who in some cases were the first Inuit to grow up in settled communities.

The fact that suicide rates among young Inuit men residing in the most developed areas of the Arctic (Nuuk in Greenland and the cities in Alaska) have fallen in recent decades suggests that this “basket” of social determinants is still at work, and that it continues to change over time.

It may be that young men who have grown up in these new conditions – stronger health care systems, higher rates of school success, higher employment rates, more role models, generally better living conditions – both get a better start in life and have a greater chance of becoming happy, successful adults. In effect, a new “life script” may have come into existence in urban areas across the Inuit world. In the “olden days”, boys grew up seeing the adult men around them being busy and productive, being good husbands and parents, and taking pride in their various accomplishments. The opportunity to grow up seeing – and to be parented by – adult men who are happy and successful is not uncommon in the Arctic, but socioeconomic circumstances result in the opportunity being greater in some places than in oth-
ers. The young Inuit men at greatest risk appear to be those who are situated somewhere between the historical Inuit “life script” and the emerging urban Inuit “life script”, in communities and families where unemployment and social dysfunction are more common.

We are also living in a time of increasing social differentiation among Inuit, a process that has a mental health component to it. In Nunavut, for example, some young Inuit find themselves living in a world of almost limitless opportunity while the daily reality of other young Inuit is one of historical traumas being transmitted through their family and community, overcrowded housing, a weak school system with a 75% drop-out rate, limited employment opportunities, sociocultural oppression, and drifting through their teenage years stoned on marijuana.

And while the settlement of Inuit land claims and the establishment of regional public governments that Inuit effectively control have gone a long way to redressing the power imbalance that scarred several generations of Inuit, this kind of healing does not happen overnight. “There is still a lot of bitterness toward the government here,” the Mayor of a Nunavut community was recently quoted as saying. “It’s passed down from generation to generation.”

Challenges of suicide prevention

Robert Goldney’s suggestion that any society’s suicide rate is a combination of a human “base rate” and the result of social determinants specific to that society can help us develop a clearer picture both of what is happening in Inuit society and what might be done to positively impact on it in terms of mental health outcomes.

Inuit take their lives for the same reasons that other people commit suicide – plus some other reasons specific to Inuit societies as they exist today. The challenge of suicide prevention in the Inuit regions, then, can be seen as the same challenge that all peoples on the planet have PLUS the challenges that are unique to the social determinants underlying elevated rates of suicide among Inuit youth.

If one were to pose the fundamental question, “Why are Inuit societies generating such a high proportion of suicidal young people?”, “high rates of adverse childhood experiences” would have to be among the answers. For 50 years now the Arctic has been a rough place to be a child. In the Canadian Arctic, the generation of Inuit who first began to display elevated rates of suicidal behaviour was the first generation to grow up in settled communities – at a time when the communities were raw and rough, when substance abuse was...
just beginning to ravage families, and when discrimination was an everyday fact of life. Some families had the coping skills and resiliency required to protect their children from these social forces, but others did not. Similarly, some people who suffered during those years have since healed — but many others are passing their historical trauma on to their own children.

That being said, we must keep in mind a caution expressed by Laurence Kirmayer: “The location of the origins of trauma in past events may divert attention from the realities of a constricted present and murky future; which are the oppressive realities for many aboriginal young people living in chaotic and demoralized communities.”20 Weak health and education systems, poverty, high rates of all kinds of violence, high rates of substance abuse and generally poor living conditions also help answer the question.

**Time to get serious about suicide prevention**

Quite a lot — but by no means enough — is known about the effectiveness of various types of suicide prevention strategies.21 There is a voluminous literature available for the medical/academic researcher, the government program manager and the average person who wants to help make a difference. The websites of the World Health Organization, the public health authorities in different countries, and myriad suicide prevention organizations all share hard-won insights. Examples of “good practice” abound; one of them — the community development process that has taken place in the Aboriginal Australian community of Yarrabah — is described in this magazine. We cannot hope to prevent all suicides, but there is abundant evidence that we can prevent some suicides — perhaps even many suicides.

Given the severity of the suicide crisis in Inuit communities today and the fact that it has been developing for several decades, it is both remarkable and appalling how long it has taken the public governments in the Arctic to take concerted action to prevent suicides from occurring.

Alaska took the lead, with a report issued by a Special Committee of the State Senate (chaired by Iñupiat State Senator Willie Hensley) in the late 1980s, a grants program that sought to provide communities with the resources and support required to try community-based projects they felt would make a difference, a program to train mental health para-professionals to work in their home villages, the formation of a multisectoral Statewide Suicide Prevention Council and, most recently, the development of an Alaska Suicide Prevention Plan.

Despite two decades of very high suicides rates, Greenland did not really begin to take suicide prevention seriously until 2003 — when Health Minister Asii Chemnitz Narup saw the need to move beyond scattered interventions and develop a coherent strategy along the lines recommended by the World Health Organization.

A multisectoral Isaisalimgit Inuusirmi Katujjatigiit (Embrace Life Council) based loosely on the Alaskan model was formed in Nunavut in 2004, and has received substantial financial support from the fledgling Government of Nunavut (GN). Also in 2004, the GN publicly committed itself to preparing “a suicide prevention strategy with a focus on wellness”. However, no work was done to develop such a plan until January 2007 when Nunatsiaq News — the more serious of the territory’s two weekly newspapers — began asking embarrassing questions about the GN’s failure to deliver on its promise. A bland, safe22 and utterly uninspired “strategy” was quickly whipped up, with a modest “to do” list that could have been completed already if the government had actually set out to do so back in 2004. The GN official who co-ordinated the development of the strategy said that she was not surprised by complaints about the speed and direction of the government’s efforts: “I understand that, but at the same time you have to be what I’d call the parent. Sometimes a toddler really wants something but it might not be the best thing for her at that time.”23

More — far more — can and should be done to try and prevent suicidal behaviour in Inuit communities. The quote with which I opened this article suggested that “mainland” Canada, Denmark and the United States simply would not tolerate suicide rates comparable to those of their Inuit populations — that national emergencies would be declared. Unless appropriate and concerted efforts are made, it is entirely possible that Inuit suicides will remain at or near their current rates for the foreseeable future. It is high time public health emergencies were declared in and by the Inuit regions themselves, and that all levels of governments in those jurisdictions should aspire to becoming world leaders in culturally-appropriate suicide prevention.

**Notes and references**

1. Russia in the case of the Inuit of Chukotka; the United States of America in the case of Alaskan Inuit; Canada for Inuit ranging from the Inuvialuit of the Mackenzie Delta region right across to the Inuit living on the Labrador Coast; and, Denmark in the case of Greenlanders.

No reliable data are available for the Inuit of Chukotka. The term “Eastern Arctic” here refers to Nunavik (Northern Quebec) and the Qikiqtaali (formerly Baffin) region of Nunavut. The Kivalliq (formerly Keewatin) and Kitikmeot regions of Nunavut are the “Central Arctic”, and the Inuvialuit region is the “Western Arctic”.

The term “Greenlanders” as employed in this article technically refers to “persons born in Greenland”. Most of the statistical data on rates of death by suicide among Greenlanders used in this article were developed by Dr. Peter Bjerringard of Denmark’s National Institute of Public Health, from raw data obtained from Greenland’s Embedelagesinstitutionen (Chief Medical Officer) and Statistics Greenland. The statistical data on rates of death by suicide among “Alaska Natives” were obtained from the Alaska state government’s Division of Vital Statistics. It is unfortunately not possible to “unpack” statistics aggregated for “Alaska Natives” to obtain data specific to the state’s Iñupiat and Yu’pik populations. The statistical data on rates of death by suicide among Inuit in the different regions of Arctic Canada were developed by the author, from raw data obtained from a variety of official sources.

There is no reliable data are available for the Inuit of Chukotka. Defined as Anchorage, Kenai Peninsula Borough, Mat-Su Borough, Fairbanks Borough and Juneau.


Their data comes from about as non-Inuit a source as one can imagine – a retrospective cohort study of 9,460 adult “health maintenance organization” members in a primary care clinic in San Diego, California who completed a survey addressing a variety of health-related concerns which included standardized assessments of lifetime and recent depressive disorders, childhood abuse and household dysfunction – but there is no reason to suspect that their findings do not apply to Inuit as much as they do to any other population. See: Anda, Robert F., et al., 2006: The enduring effects of abuse and related adverse experiences in childhood. In European Archives of Psychiatry and Clinical Neuroscience 256 no. 3, pp. 174-86; Chapman, Daniel P., et al., 2004: Adverse childhood experiences and the risk of depressive disorders in adulthood. In Journal of Affective Disorders 82 no.2, pp. 217-25; Dube, Shanta R., et al., 2001: Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. In Journal of the American Medical Association 286 no. 24, pp. 3089-96, and others. See also the work of Michael De Bellis on “developmental traumatology”, such as The Psychobiology of Neglect. In Child Maltreatment 10 no. 2,(2005), pp. 150-72. The public health impact of childhood adversity is evident in the very strong association between childhood adversity and depressive symptoms, antisocial behavior, and drug use during the early transition to adulthood.” Schilling, Elizabeth A., et al., 2007: Adverse childhood experiences and mental health in young adults. In BMC Public Health 7 no. 30.


9  We should, however, keep in mind that all suicides occur within both (A) a medical context (i.e. the complex biological interactions taking place within the brain of the victim); and, (B) the social context within which the victim developed, and then lived his/her life.


11  That being said, it should be noted that different people take their lives for different reasons. Just as some children who grow up in deeply dysfunctional homes survive and thrive later in life, some children who grow up in stable and happy homes and who experience few adverse childhood experiences die by suicide later in life. This is important to keep in mind when discussing suicide in a society such as that of the Inuit, who have been deeply traumatized by several decades of high suicide rates. One cannot assume that any one suicide is rooted in childhood trauma.


13  Working Papers are available at www.mcgill.ca/tcpsych/research/cmhr/working-papers/


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22  No suicide prevention strategy in Nunavut should be taken seriously if it fails to include an evaluation of the adequacy of the counseling resources available to the residents of Nunavut communities and the support provided by the territorial government to the grassroots suicide prevention committees that exist in many communities – and an evaluation of the impact of the strategy itself.


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