International Journal of Conflict and Violence

urn:nbn:de:0070-ijcv-20101108
IJCV: Vol. 4 (1) 2010, pp. 124 – 133

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Vol. 4 (1) 2010

ISSN: 1864-1385

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Contemporary indigenous first nations psychologists have developed an alternative frame for viewing suicide that not only shifts the focus from individual-level to group-level explanations, but challenges discourses that position group-level influences as "risk factors" that can be easily subsumed within standard repertoires for suicide prevention. First nations psychologists show the violent legacy of colonization has left a dark shadow on the contemporary lives of young people, so that around the world, suicide rates for indigenous peoples are much higher than for non-indigenous peoples in the same country. These arguments, which rely on historical accounts, cannot be neatly demonstrated using empirical data, but form an important part of a self-determination movement among indigenous peoples, directly challenging unequal power relations in society as a means to seek redress for particular issues of inequity like rates of youth suicide. We present a theoretical case study and analysis of contemporary suicide among Maori youth in New Zealand. In a traditional Maori conceptualization, individual well-being is sourced and tied to the well-being of the collective cultural identity. Therefore, individual pain is inseparable from collective pain and the role of the collective becomes that of carrying individuals who are suffering. The state of *kahupo* or spiritual blindness (Kruger, Pitman, et al. 2004) is characterized by a loss of hope, meaning, and purpose and an enduring sense of despair. It bears the symptoms of chronic dissociation or separation of the physical from the spiritual and vice versa. We describe community empowerment practices and social policy environments that offer pathways forward from colonization towards *tino rangatiratanga*, or indigenous self-determination, noting significant obstacles along the way.

Around the world, suicide rates for first nations (indigenous/aboriginal) peoples that have been colonized and positioned as a minority in their homeland are more than double that for other groups in the same country. Mainstream researchers have framed the issue in terms of discrete risk factors, such as unstable family situation or drug use, but have also included loss of culture and acculturative stress among the instrumental factors driving indigenous suicide (Collings and Beautrais 2002). Indigenous researchers have advocated a more holistic approach where the "primary intervention" to reduce indigenous suicide is not to target individual-level risk factors, but the restoration of culture at the group level. This approach is grounded in political awareness, expressed by Lorde as: *"the master's tools will never dismantle the master's house"* (1979). An individual-level epidemiological approach addresses the symptoms of colonization, but does not address the root cause of the high rate of indigenous suicide, which according to indigenous researchers is the traumatic loss of culture over generations.

1. Indigenous Suicide Rates and Mainstream Interventions

Suicide completion rates for indigenous populations are 1.5 to 4 times higher than those of other ethnic groups in the United States, Canada, Australia, and New Zealand based on epidemiological data. Coupe's literature review (2005) found increased suicide rates among first nations compared to other ethnic groups in the same country: 1.7 times higher for American Indians and Native Alaskans, triple for Canadian Inuit and Metis in age-specific comparisons and double in gender-specific comparisons, three to four times higher for Australian Aborigines, and 1.5 times higher for New Zealand Maori. Beautrais and Fergusson (2006) comment on the problem of reliably identifying ethnic identity

to produce accurate epidemiological studies of suicide rates, which is likely to result in *under-reporting* of indigenous suicide rates (i.e., many suicides are not ethnically identified but might be of an indigenous person).

Evidence of effective interventions for suicide prevention with indigenous populations are numerically rare and limited in scope (Cutcliffe 2005; Proctor 2005). Most interventions target specific discrete indigenous populations at the tribal level (May, Serna, Hurt, and DeBruyn 2005; EcoHawk 2006), and so are difficult to generalize. Some interventions have been found wanting, as they have been designed for non-indigenous populations, are acultural, disregard historical trends, and treat suicide as individualized psychopathology (Lalonde 2000, cited in Cutcliffe 2005). Although there is value in certain other orthodox psychological treatments for known risk factors for suicide amongst indigenous populations such as drug and alcohol abuse (Echohawk 2006; Perez 2006), such treatments fail to reach sufficiently large numbers of indigenous youth. The risk factors approach where certain indicators trigger intervention may be inadequate for indigenous populations, where the consistent evidence of high rates of risk across cultures suggests a root cause that cannot be addressed using individual-level interventions. This has led to research supporting a collective response to suicide prevention that links reductions in suicide rates in discrete indigenous populations with progress towards self determination and self governance (Chandler and Lalonde 2000).

2. The Legacy of Colonization

Colonization, like race and ethnic identity, is taken for granted by those in privileged positions, and tends not to be seen as having explanatory power that accounts for suicidal behavior in colonized populations. There is an emerging acceptance of the role of acculturative stress and colonization by non-indigenous suicide researchers (Collings and Beautrais 2002). However, the epidemiological approach they adopt is limited by the fact that the impacts of colonization cannot easily be measured at the individual level. Hence, in mainstream research, obvious and immediate risk factors like mental illness, depressed mood, and drug and alcohol abuse offer proximal and scientifically observable proof that the "mad, sad or bad" status of the colonized indigenous person is instrumental in their suicidal tendencies (Collings and Beautrais 2002). Following these lines, Coupe's doctoral dissertation on Maori youth suicide prevention (2005) identified a correlation between Maori suicide and loss of cultural identity, but her study of three samples of outpatients attending New Zealand hospitals found that the pre-eminent risk factors for medically significant suicide attempts were health-related. At the individual level, these results might be replicated among other indigenous populations, but they neither tell the whole story nor show how a path forward might be constructed.

Indigenous and non-indigenous peoples can journey along a pathway towards a common goal of equality, liberation, and justice. However, according to Lorde's thesis (1979), which is supported by other indigenous scholars like Churchill (1996) and Ramsden (2000), at other points unequal power relations drive a wedge through this relationship. The dominant power holders tend to forget the part that their culture played in the oppression of the indigenous other throughout history. Indigenous people, on the other hand, seek justice and restoration of power and authority to exercise control over their fate and become acutely aware of their lack of power to do so. A violent colonial past leaves a legacy in the cultural lives of the people that were once targets of this violence, even as a process of denial lives on in the cultural life of the dominant group (Sibley, Liu, Duckitt, and Khan 2008). This paper articulates a logic of intervention in indigenous suicide prevention that relies on the restoration of culture at the group level as a response to the situation of Maori, the first peoples of New Zealand.

3. Cultural Identity as a Collective Resource in Suicide Prevention

The foundation of this logic is *whakapapa*, or knowledge and practice of kinship relationships. *Whakapapa* is the beating heart of Maori identity; it is what makes Maori unique (Kruger et al. 2004; Te Rito 2007). *Whakapapa* is the knowledge and practice of kin relationships that creates core features of the traditional social organization of Maori culture: *whanau* (family), *hapu* (sub-tribe), and *iwi* (tribe). A person is not treated as an individual in Maori culture, but as part of a web of social relationships involving a mutuality of responsibilities to the collective and connections to one another that transcend time and space. *Whakapapa*

(kinship) is a strength and deterrent to mental illness because it renders individual pain a collective concern rather than treating it as a personal issue as typical in psychology (Duran and Duran 1995). *Whakapapa* is considered to be the pre-eminent and culturally prescribed form of Maori identity.

Hence, cultural identity as expressed through such concepts as *whakapapa* may be instrumental in the promotion of good mental health and positive psychological outcomes for Maori (Durie 2001; Durie, Fitzgerald, Kingi, McKinley, and Stevenson 2002). Conversely, any act that removes or tampers with intact cultural identities may be considered to be detrimental. The potential for cultural development to mediate suicide risk and the role of cultural identity as a protective factor has been theorized by Lawson-Te Aho (1997) and Durie (2001). It is also an active area of current research. Coupe (2005), for instance, has explored correlations between loss of culture and depression and their implications for suicide attempts amongst Maori. The implication for Maori youth suicide prevention is that the *hapu* and *iwi* (sub-tribe and tribe) have a culturally enshrined obligation to act in situations of suicide risk.[1]

Moreover, the survival and healing of the tribal or sub-tribal kin group is contingent upon the survival and healing of each individual connected by blood (acknowledged through *whakapapa*) to the collective identity of the tribe or sub-tribe. This is the culturally appropriate way of framing suicide prevention for Maori. Individual and collective well-being are interconnected as part of one process (Kruger et al. 2004). Kruger et al. (2004) illustrate this point in the conceptualization of *whanau* (family) violence prevention: "Whanau (family) is about birthright. There are rights and responsibilities and obligations that come with whanau (family). If someone committed a misdemeanor you might go to the next member of the whanau (family) and then that person gets hoha (angry) with the person who committed the misdemeanor. This is the manifestation of social responsibility. Geography means nothing. Whakapapa (kinship) makes you responsible. When there is violence in the whanau (family), the whanau (family) is involved in spite of what has been said about the violence and in spite of whether they talk about it or not" (2004, 9).

4. A Maori Development Agenda

A movement for indigenous control and authority over all aspects of indigenous life has characterized the indigenous political agenda and established the case for claims about indigenous rights. In their contribution to Allwood and Berry's overview of indigenous psychology (2006), for example, Nikora, Levy, Masters, and Waitoki state that "Indigenous psychology in A[otearoa]/NZ has always been a part of how Maori approach wellness, health, and being, stemming from a world-view that values balance, continuity, unity, and purpose", and conclude that "For psychology, the Maori development agenda is to create psychologies to meet the needs of Maori people in a way that maintains a unique cultural heritage, and makes for a better collective Maori future. It is a journey towards Maori self-determination."

The clear evidence of the traumatizing impacts of colonization in the claims before the Waitangi Tribunal (investigating breaches of the law during the colonial process) sets an agenda for change that is driven by both reactive and pro-active imperatives. Reactive in the sense that suicide is seen as a by-product of a colonizing and oppressive set of experiences that needs to be countered. Pro-active in the sense that development with Maori at the helm of a culture-appropriate process may actually negate the need for suicide prevention. The thesis is that when Maori youth are engaged in their own development and reclaiming their own cultural identity, it gives them purpose, meaning, and thereby a will to live.

For Maori, development is based on the revitalization of kinship traditions and the distinctive strengths and resiliencies that flow from a strong working knowledge of one's tribal identity (Kahu and Wakefield 2008). Durie as-

1 Among most traditional Maori groupings, the sub-tribe or *hapu*, consisting of several families organized together in a village structure, was probably the more influential organizational structure. The tribe, however, is the only Maori collective grouping that is recognized by the state.

serts that the bases of Maori development are identity and relationship (2001). Therefore, we hypothesize that when kinship-based cultural identity is intact and relationships are positive and functional, suicide can be prevented. Individual trauma becomes a shared burden and the collective carries the load of the burdened ones, supporting, encouraging, and embracing them in the collective relationship that is bounded by kinship. Empirical evidence for this as yet is lacking, and, moreover, is difficult to obtain given the lack of boundaries between today's tribal groupings and mainstream society. There is probably no single tribal group in New Zealand where a majority of its members by lineage could be found to still reside in lands that traditionally belonged to the tribe (and are now generally in non-Maori hands). The process of colonization was thorough.

5. Challenges Facing the Development Agenda at the Group and Individual Levels

The restoration of indigenous people's rights is understood as an issue of the colonizing power relinquishing control over resources, language, and the cultural development of indigenous peoples. However, there are many complexities that confound the basic power relations underpinning colonization.

Fanon (1952) and Memmi (1991) examine the role of the colonized as oppressor. Internal group struggles within some Maori tribes for power and control over decision-making and resource allocation (particularly over assets that have been returned to tribal authorities as a part of the settlement of colonial-era grievances) could be construed as an indigenous population taking on the oppressive stance of the colonizer. Practices that place stringent criteria around membership of the tribal collective deny a number of indigenous people a place as part of that tribal collective. The ability to be heard as a Maori woman inside a male-dominated tribal authority structure may also be hard to attain, creating a situation of double oppression for Maori women.

Similarly, when members of an indigenous group allow the struggle for control and money within their collective to take precedence over kinship-based relationships, then kinship is compromised and reciprocal obligations abandoned. The heartbeat of Maori identity is kinship relations, so a challenge to kin-based belongingness can lead to a real sense of abandonment. The loss of knowledge of identity as Maori, or challenges to a person's right of belonging does not mean that the fact of kinship can be extinguished. The fact of kinship remains as a spiritual reality, continuous and permanent. However the lived expression of it changes, sometimes in a very negative direction. In Maori terms, suicide is associated with a state of mind characterized as *kahupo* (Kruger et al. 2004), meaning loss of hope, meaning, and purpose, and an enduring sense of despair. It bears the symptoms of chronic dissociation or separation of the physical from the spiritual and vice-versa—the psychological separation of the individual from the collective.

Equivalent states of spiritual pain and suffering exist in other indigenous cultures that have been colonized. The spirit is the core of indigenous well-being. Indigenous cultures all have a word for the spirit, indicating that it is a central and critical construct in indigenous well-being. Spiritual pain and suffering is considered to be linked to the existence of mental illness. The wounded spirit carries various orthodox psychological interpretations such as sub-clinical depression, post-traumatic stress and post-colonial stress (Duran and Duran 1995; Lawson-Te Aho 1997). The psychological process that best describes the impacts of colonization and historical trauma is cumulative psychic wounding (Duran and Duran 1995; Edwards 2002). This recognizes that historical trauma is multigenerational (Cashin 2001). Braveheart describes collective complex trauma as historical trauma inflicted over time on a group of people who share a specific ethnic, national, or religious group identity or affiliation (1999). It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to those events. Empirical research with non-indigenous populations has also demonstrated that the shadow of the past can live on in the present, through collective memories (Pennebaker, Paez, and Rimé 1997) or social representations of history (Liu and Hilton 2005) that condition individual psychological processes.

Soul wounding is a term developed by indigenous researchers to acknowledge that the effects of colonization are understood primarily as spiritual injury (Clearing-Sky

2007). Soul wounding has been described as an outcome of the ongoing trauma of colonization (Braveheart 2003). It is characterized by a loss of hope and leads to depression (Byers 2006), post-traumatic stress or a specific type of multigenerational trauma (Cashin 2001), and suicide (Lawson-Te Aho 1997), among other outcomes. These are all indications of a people in profound pain. Suicide amongst Maori indicates a wounding of the spirit. A strong and intact set of cultural identities based on time-honored cultural practices with intact kinship serves to insulate and protect Maori youth from the legacy of colonization and historical trauma. However, it does not fully erase the historical trauma birthed in colonization. Similarly, other self-destructive behaviors can be linked to the wounded indigenous spirit, like self-mutilation or excessive drug use (Napolean 1995). Conversely, a healthy spirit for Maori includes an identity that is linked to the collective identity of Maori.

The rebuilding of collective traditional cultural structures includes a transfer of resources (from the government) and the return of decision-making authority and power to the hands of tribes. This is a process known as *tino rangatiratanga* or tribal sovereignty (tribal self determination). Tribal sovereignty creates the conditions needed for the collective to care for the welfare and well-being of the Maori individual based on kinship obligations. Regaining tino rangatiratanga is integral to the healing of the wounded indigenous spirit, as is the understanding that this requires a full release from the oppressive state of being in bondage to others who seek to harm and whose actions have created harm. Whether the state of bondage is outwardly or inwardly driven, tino rangatiratanga demands nothing less than authority and power being given back to, or taken back by, indigenous peoples. Ironically, suicide is often misconstrued as the ultimate act of self-determination rather than the ultimate act of oppression and victimhood forged within a deeply wounded spirit. It seems that once the spirit is deeply and profoundly wounded and thereby rendered vulnerable to death, suicide becomes a possible way in which the wounded spirit can be translated out of a place of misery and despair into a place of escape from the conditions which bind it. EchoHawk proposes that this process occurs for Native American youth (1991).

It is impossible to turn back the pages of time to recreate a pure, uncontaminated set of pre-colonial kinship-based traditions and social structures. However, unless Maori are able to exercise control over the design of interventions for suicide prevention, the solution will continue to be improperly framed in Western psychological traditions as an individualized, deficit-focused problem inside the individual. This renders the continuity of the trauma of colonization invisible, except in the form of statistics showing massively higher rates of indigenous suicide. Maori cannot look to Western psychological traditions (a colonizing/assimilationist tradition) for this kind of healing. Instead, a reclamation of the authority and resources to develop culture appropriate responses to suicide is needed. This means the reinstatement of *tino rangatiratanga* (tribal sovereignty) based on *whakapapa* (kinship) relations and functioning inside the framework of best cultural practices (Kruger et al. 2004). This is particularly important given that the colonizers' tools cannot be expected to dismantle the colonizers' house (Lorde 1979).

6. Kia Piki Te Ora O Te Taitamariki: The Maori Youth Suicide Prevention Strategy

Kia Piki Te Ora o Te Taitamariki, the Maori component of the New Zealand youth suicide prevention strategy, was drafted in 1997 following extensive research with key leaders in Maori development and research on indigenous suicide prevention in a global perspective (Lawson-Te Aho 1997). The positioning of suicide prevention as an issue of development rather than the limited clinical treatment of pathology marked a radical departure from the way suicide amongst Maori youth had previously been understood and treated. Policymakers treated suicide as a universal youth phenomenon with universal risk factors, and although it was acknowledged that the "problem" may be more significant for Maori, there was no concept of soul wounding and intergenerational trauma stemming from colonization. It was claimed that there was insufficient evidence to verify the links to colonization and it therefore lacked explanatory power (Lawson-Te Aho 2009). The fact that Maori suicide was subsumed into the broader picture of New Zealand suicide prevention confirmed that government policymakers and suicide prevention researchers did not view Maori suicide as separate or different from suicide in the general population.

In the policy arena, culture was largely invisible in terms of offering explanations for apparent differences in the onset, causation, maintenance, and therefore prevention of mental illness, including suicide. The early work of Durie (1977) and Tipene-Leach (1984) promoted the idea that cultural differences were clearly evident in the therapeutic process and that to ignore these differences was potentially dangerous for the Maori patient. Furthermore, Durie proposed that Maori needed to be understood and counseled differently based on culturally determined communication styles and cultural meanings that drove different health behaviors (1987). Therefore, the early advocacy of a separate strategy for Maori youth suicide prevention was based on the creation of a policy argument that actively recognized cultural differences in psychology.

Creating space inside orthodox policy processes was very challenging when these failed to see Maori as different in any way. Universality and "one size fits all" were the order of the day. Cultural specificity was gaining popularity in public health programming yet no one had made the conceptual leap to the development of public policy based on the need for a different and specialized cultural treatment of Maori mental health issues.

For proponents of parallel development, the concomitant development of Maori political action provided additional impetus for the development of a specialized Maori suicide prevention strategy using the argument that the best intervention was one that was driven *by Maori for Maori* and that took into account the pressing desire of *iwi* (tribes) and Maori communities to lead their own development (Lawson-Te Aho 1997). The common concern driving the development of specialized Maori initiatives including suicide prevention was that no one understood the psychology of Maori better than Maori and that the tribes had a key role to play. The tribes held the political authority to press for tribal development to enable them to meet their cultural obligations to their members.

Some of the tribes understood that if Maori were killing themselves in increasing numbers, they had to act because the survival of individuals was pivotal to the survival of the collective. However, these tribes were also battle-weary, consumed by the long struggle for redress for loss of land and for political and cultural autonomy, and by the devastating outcomes of oppression including premature loss of life and multi- and inter-generational suffering (Wakefield and Kahu 2008).

A further development of the late 1980s (when the rationale for having a separate Maori youth suicide prevention strategy was being crafted), and in the lead-up to the 150th anniversary of the signing of the Treaty of Waitangi (the basis for New Zealand nationhood under British sovereignty), was the issue of Maori rights to self-determination. This shaped the arguments for a separate Maori suicide prevention strategy as an issue of rights rather than needs. The debate about rights versus needs opened a serious challenge to the government and policy-makers of the time because it meant that the failure of the government to provide for the health needs of Maori was potentially a breach of treaty rights and the government could perhaps be held accountable in an international court for human rights breaches.

In 1999, Kia Piki Te Ora o Te Taitamariki was implemented as a regional coordination service led by Maori for Maori. Led by Maori suicide prevention coordinators and positioned in *iwi* (tribal) health and social services and Maori development organizations around New Zealand, the program began. There were six Kia Piki pilot sites. The roles of the Kia Piki coordinators were to coordinate the responses to Maori youth who were seen as being "at risk" in each community by working with government-funded services to ensure that they knew about the program and the prioritization of Maori youth suicide prevention in the local community. However, when set in the context of an already underfunded social services sector, building relationships across the sector and amongst health and social providers proved to be a daunting challenge.

A robust Kia Piki model was developed. As a strategy it included emphases on *whanau* (family), *hapu*, and *iwi* development, positioning Maori youth in the context of those larger cultural structures. It also emphasized Maori youth being instrumental in *whanau*, *hapu*, *iwi*, and Maori youth development as an exercise in tino rangatiratanga/

self-determination. There was also an emphasis on the development of general population or "mainstream" service responses to Maori youth so that rather than being sites of secondary victimization processes, Maori youth were able to access the support and help that they needed in a culturally responsive way. Part of the strategy involved a process described as decolonization training, in which Maori youth were to be taught about the real impacts of colonization and the seeds of enlightenment needed to advance an agenda of self-determination would be sown. The early emphasis on decolonization training was not declared but it was assumed that it would arise out of the focus on Maori youth development and the reclamation of *tino rangatiratanga*. Underpinning the strategy was the building of a knowledge base around suicide prevention efforts that recognized the role of a strong cultural identity as pivotal to suicide prevention amongst Maori youth.

7. Kia Piki Te Ora o Te Taitamariki: The Maori Component of the New Zealand Youth Suicide Prevention Strategy Eleven Years On

Kia Piki was based on recognition of the vital need for Maori to control their own responses to suicide amongst Maori youth through the vehicles of *iwi*, *hapu*, and Maori community development. Moreover, this was not seen as a response to a mental health need that the government and other external stakeholders would benevolently respond to but a right that Maori youth were fully entitled to as part of *whanau*, *hapu*, and *iwi*.

Suicide prevention amongst Maori youth was understood primarily as a process of rebuilding, reclaiming, healing, and restoring the collective of *whanau*, *hapu*, and *iwi* and involving indigenous youth in their own development as means of reversing the impacts of the soul wounding that took place during colonization with resounding impacts through generations.

But Kia Piki did not live up to its promise as a model. A lack of funding starved the program of the ability to initiate substantial innovations on its own, and coordinators were unable to mobilize established government service providers to depart from their routines and consider how they could assist *iwi*, *hapu*, and *whanau* development as a strategy for suicide prevention. *Iwi* also suffered from an overload of demands for their limited resources and were unable to meet the challenges on their own.

In the end, the strategy failed to be anything more than a Maori-led coordination service in terms of its immediate impacts on the prevention of Maori youth suicide. However, it did change the youth suicide prevention discourse from one in which Maori were like any other youth to one that validated the explanatory power of colonization, the strengths and resiliencies associated with a strong cultural identity, and the imperative that suicide among Maori youth be considered as an issue of counter-development and of individual and collective authority and self determination. It also created the rationale for Maori youth suicide to be understood in context of the global struggle of indigenous peoples for more than survival, the struggle for healing, justice, and restoration on all levels.

8. Where To From Here?

According to the latest statistics, Maori youth are still committing suicide 1.9 times more often than their non-indigenous counterparts. However, Maori are firmly resolved to heal and restore themselves without waiting for the government to save them. One strand of response is the development of theories of urban development, and the resituating of Maori identities in contemporary urban settings (Borrell 2005). This includes acknowledging that many Maori today are irretrievably non-traditional in their lifestyles and their social connectedness, and that this should not be treated as a deficit in and of itself (McIntosh 2005). Where the central issue is the tailoring of services rather than the cultural constitution of the services themselves, the effective delivery, outreach, and application of mainstream suicide prevention interventions to particular Maori environments remains an important consideration.

However, the larger strands emanate from positive tribal development initiatives that are restoring, healing, and building vision and hope for Maori individuals in the context of these traditional cultural networks and structures. From the authors' perspective, the answer to Maori youth suicide is somehow linked to the positive forward movement of the collective, and its interactions with service providers embedded in the national mainstream. Tribes

are beginning to wield more political and economic power, driven by the engine of treaty settlements returning assets and funds expropriated during the colonial era. The Maori Party has emerged as an autonomous political vehicle for wielding Maori political influence in parliament. These factors are changing the political landscape in New Zealand, making indigenous visions like that expressed in Kia Piki more realizable, and less likely to be swallowed up by standard bureaucratic processes. They allow breathing room for a social constructionist approach to research methodologies and epistemologies (see Denzin and Lincoln 2004).

A new generation of researchers and policy-makers will have to face issues summarized by Allwood and Berry's review of indigenous psychologies around the world, since: "The local culture is unanimously identified as both a source of inspiration for developing an IP [indigenous psychology], and as a concrete goal in achieving an IP" (2006, 254), making indigenous suicide prevention efforts simultaneously descriptive *and* prescriptive. Indigenous psychologists in New Zealand (like indigenous psychologists in other parts of the world, see Bhawuk 2008) do not view the drive towards cultural restoration as something that can or should be verified by empirical means—it is rather a cultural imperative from which empirical benefits are likely to be derived. It will be a challenge for indigenous psychologists to simultaneously push forward their vision of cultural restoration *and* be open to empirical influences providing advice and feedback as to when and where to focus their efforts.

To indigenous psychologists, the agenda for tribal development was set in history. The imperative that tribes must struggle to work for the well-being of families and individuals is sourced in the enduring legacy of colonization. However, it is also more positively sourced in kinship, in the obligations stemming from kinship and history. Those in tribal leadership must be accountable for the roles that they are entrusted with, to work for the betterment of their people. Maori are moving forward in positive development mode. Like all good things this will take time but it will be worth waiting for in the end.

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