Chapter 8

SUICIDE IN CONTEMPORARY PAPUA NEW GUINEA: AN ATTEMPT AT AN OVERVIEW

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There is a stark quality in any assessment of death by suicide, and few of life's passages convey such immediacy and termination. One is caught within the antinomy of a panhuman, collective possibility we all share and an intensely focused, utterly personal act. This antinomy is not complete, however, for a third element provides a triad: there is also an immediate existential situation attending that act, for some set of specific circumstances conjoin to inform the decision which leads to it. One might say that suicide thus pays little respect to geography, yet I shall attempt to provide some information concerning it in the independent state of Papua New Guinea, from the perspective of a behavioral scientist and medical anthropologist with clinical experience in mental health.

Papua New Guinea, referred to for convenience as PNG, will be familiar to most readers, yet some brief comments may be useful. It occupies the eastern half of a very large island, second only to Greenland, divided into PNG to the east and the Indonesian province of Irian Jaya to the west (Pataki-Schweizer 1984; Setyonegoro, Satya and Gunadi 1978). Melanesian cultural proveniences characterize the indigenous peoples of both parts and include some seven hundred definable languages, roughly one-quarter of the world's total. PNG's population was 3,200,000 in 1983, 52% male and 48% female. Originally the northern half of PNG was a German possession, Kaiser Wilhelmsland, claimed by Bismark Germany in the 1880s. The southern half, claimed by Britain at the same time as British New Guinea, became Papua under Australian administration. Independence was achieved in 1975. A sizeable portion of the country's population, the Central Highlands, was totally unknown to the outside world until the mid-1930s, and sizeable areas remained uncontacted as recently as the 1960s. This situation still exists in isolated pockets of the country's rugged terrain. Thus traditional, transitional and more modern life-styles are simultaneously present, experiencing the acceleration and stress of rapid acculturation and social change (Pataki-Schweizer 1983a). This situation is evident in the changing health patterns of the country, as shown in Table I.

Stressors related to traditional and modern life-styles are reflected in this table, although specific mental health problems as such are not listed. Some information is available which should, however, be used with caution. The first one thousand psychiatric referrals for PNG during the period 1959-1969 were characterized by clinical schizophrenias (34.9%) and indicated a crude referral rate of 47.2/100,000 (Burton-Bradley 1969). A World Health Organization project in 1979 monitored in-patients and out-patients in the national capital, Port Moresby, and concluded from this limited protocol that "leading conditions were schizophrenia and affective psychosis" (Moi 1979; also see Murphy 1978). A more detailed study was conducted in 1983, and provided a prevalence rate of "major mental disorders" ranging from 23.8 to 56.1 per 10,000 at ages 15-plus, for several local populations. This study also provided an incidence of psychiatric hospitalization for 1980-1981 of 5.8/10,000 for ages 15-plus. This compares with Western Samoa, is somewhat lower than Kiribati, and is higher than Vanuatu over a roughly comparable timeframe (Murphy 1983; see Table 2). It is uncertain, however, if such figures provide any coherent broader picture of mental health problems in PNG (a limitation recognized in the reports), because of isolation, traditional constraints, lack of administrative contact and followup and in particular, unreported cases. This is particularly true for suicide.

Any epidemiology is characterized by, and suffers from, the problem of scale, and while we gain by structuring general rates, we lose in terms of critical local behavioral variables. The assessment of suicide in PNG poses particular difficulty because of the absence of generalized data and the difficulty of obtaining it with respect to geographical and cultural constraints. Data for PNG is sparse and highly selective, usually health facility- group- or locale-related, and still excludes sectors of the national population.

In addition to the information provided by Poole in his chapter for this volume, some evidence is available for several societies in the Highlands which provides crude suicide rates ranging from 8.5 to 17.0 per 100,000. However, the rate for one of these Highland groups, ages 15-45, is 34/100,000 for both sexes. And the rate among females in that age cohort (61/100,000) is much higher than that for males (7/100,000), making for a male/female ratio of 1:8.9. These are high figures when compared to say, Australia with 11.1/100,000 in the 1970s or certainly the very low rate of 1.8/100,000

reported for aborigines in a remote area of northern Australia. (Smith 1981, see Table 3).

An even higher figure of 72/100,000 is given for a very traditional group in the Highlands, closer to the border with Indonesia and in a different cultural provenience than those cited above. Ten ranked "causes" of suicide cases for this group are given: bereavement, no reason, witches, quarrelled, scolded, adultery, accused as witch, frustration, misfortune, and fright (Weeks 1981). It is interesting that the first three include 'no reason,' and rank essentially equally (total: 58% of the cases). These factors are also reported elsewhere in the country in association with the act of suicide. They are hardly exhaustive, however, and the matter of causality is far more complicated, as reflected for example in the triad posited earlier.

The popular assumption that traditional populations are free of mental illness has, in conjunction with the very selective nature of available data, led to conclusions that suicide is relatively rare in these societies. Yet there is evidence, such as given here, which challenges this assumption (cf. Stanhope 1967). The assertion is also made that suicide now occurs more often in urban than rural centers. There is some evidence that this is possible, but the situation is much more complicated than a simple urban/rural dichotomy would account for. The National Capital District (Port Moresby and its immediate area) indicated an "urban" rate of 10.7/100,000 for 1982, with major regional rates from 1.7 to 2.2 and an overall rate of 2.4/100,000 for the country, derived from police daily incident reports (see Table 4; Murphy 1983). However, these aggregate rates are much lower than the preceding Highland rates given, and certainly much lower than suicide rates among the rural Bimin-Kuskusmin discussed by Poole in his chapter.

Some very recent data from Port Moresby indicate a suicide rate of 5.5/100,000, derived from coroner records, with a male/female ratio of 1:1.47 and a modal cohort of females aged 15-35 (age is difficult to determine, since much of the population is nonliterate and nonnumerate and there is no national or provincial recording of births or deaths.) In this study, there were also far more attempted suicides by females (4:1), for whom the preferred method (attempted or completed) was poisoning by chloroquin, an anti-malarial drug. The second choice was hanging which was employed equally by both sexes (Bage and Faru 1984; see Tables 4 and 5).

The higher PNG rates are cohort-specific, yet available general rates

appear to be substantial. The general impression from fieldwork is that, to some degree, suicide in these societies is recognized as a way of resolving grievous personal problems. Whether it is "socially acceptable" is a more complicated matter involving deeper cultural premises and also comparative semantics. Overall, the lack of an accurate denominator population, the nonparametric nature of the data itself, and the traditional enculturation underlying the psychodynamics of most of the national population lead one to suspend judgement on inclusive rates. Furthermore, almost nothing is available on that enigmatic and related phenomenon, attempted suicide.

Yet figures, however indicative and of whatever Durkheimian elegance, remain symbols devoid of emotion, at least for considerations of suicide. Returning to the triad suggested at the beginning, if we are to understand the act of suicide, we must consider the individual and the contextual circumstances involved. While assessments still appear to fall short of any real insight, some patterns do emerge for PNG from cases studies and ethnography. Interpersonal conflict, often between spouses, appears as a major precipitant and "shame," while often present, does not appear to be the prime or dominant factor. Indeed, this point is similar to that concerning suicide in Truk, raised by Hezel (1981), who observes that shame is not singled out as their explanation for suicide. I do not know if "anger" is a perceived or attributed cause in PNG, although one does hear the observation in Tok-Pisin that em i kros long em, "he/she was angry at her/him." Rather, another possibility is that a severe and instrumental ego-dissociation is involved, which would have particular impact on adolescents and younger adults (Beckett, personal communication, 1975).

Referring to the triad again, one might add another element, that of the "observer." These are often spouses, lovers or relatives who are left to deal with the aftermath of suicide, and they are the most immediate sources of information. This addition would produce a tetrad or pyramid, a reasonable configuration for those domains in the suicide nexus. Matters are compounded greatly if there is a cross-cultural condition involved, such as the non-indigenous mental health worker dealing with an indigenous suicide. Since I believe that some degree of trans-cultural communication is possible, given the deeper function of culture with respect to human needs and the commonality of the sapient condition, one concludes that the situation is not impossible. Rather, it is very difficult and demanding, especially in light of the second

element of that tetrad, the uniquely personal internal state effecting the act of suicide. The following vignette, taken from a short story derived from the actual dual suicide of a Highland woman who drowned herself and her young son, gives a poignant example of this difficulty and the felt intensity associated with it. The speaker is an expatriate:

> I took Kelare over to the store to make a formal identification, and watched him standing over his son, and realized I had nothing to say to him, and could do nothing for him, and didn't even have the slightest idea what he was thinking, or even who he was. They were his wife and child rolled in the government's rice sacks... They had lived here a year... I saw the woman — and spoke with her — every day... She laughed a lot and loved the boy — and I have eaten kaukau with her... And then on Monday they come up and tell me she has just gone into the river. And when I ask Kelare tomorrow — I have to as coroner — I won't know whether what he is giving me is the truth... Because there are things they won't say and parts they won't let me know... But, until today, I thought it was different with Kelare... (Shearston 1979).

The above speaks to the complexity of human motivation, which reaches a zenith or nadir in the case of suicide. Fortunately there are useful methods, approaches, and concepts available for which the social and behavioral sciences are as germane as the clinical sciences. In the case of PNG, we find a basic datum of traditional cultures and their still deeply-seated values, as are assessed by Burton-Bradley (1975) in their relation to any analysis of suicide in tradition-based societies. We also find that modernization has now made major inroads to many of those self-continued cultural units, sometimes reasonably, sometimes disastrously as in the case of cargo cults, and in any case inexorably. Indeed, if the desire by humans for experience and understanding beyond the immediate constraints of daily life is any indication, the use of stimulants and substance abuse can also put one very close to prodromal states antecedent to self-extinction, as in cases of the use of ethanol, methylated spirits, methanol and, more recently cannibis in PNG (Pataki-Schweizer 1976, 1982a, 1982b). In our desire for transcendence beyond a specific state of being, we approach the edges of our psychobiology, and on occasion do not return from the quest; not for destruction, but for release.

Despite what is essentially a paucity of data, some general points can still be reasonably made concerning suicide in Papua New Guinea. First, it does occur among all ethnic groups which have been queried about it; second,

what rates are available vary greatly internally and with respect to societies elsewhere; third, suicide still occurs in essentially traditional sociocultural settings for the majority of the population; fourth, new information inputs have made strong inroads into PNG with often disproportionate acculturative effects on mental health, with possible implications for suicide (Pataki-Schweizer 1981a); fifth, urbanization is now proceeding including peri-urban and squatter settlements (Pataki-Schweizer 1981b), and appears to correlate with an increase in suicide; sixth, suicide appears to occur and have occurred more frequently among females; seventh, reporting of both suicides and attempted suicides is intermittent; eighth, methods used are similar to other Pacific cultures, including hanging as a preferred traditional method, drowning, ingesting traditional poisons, chloroquin, and more recently paraquat among younger females (Wolfahrt 1981); ninth, it appears that PNG societies condone suicide as a solution to personal problems, though whether it is socially acceptable or actually sanctioned remains uncertain; and tenth the psychodynamics motivating suicide in PNG are not readily explicated by recourse to generalizations about emotional states, e.g. shame, guilt or retaliation.

It does not do to get too mired in abstruse concepts, yet a consideration of suicide evokes questions of ontology, epistemology and metaphysical concerns. We can however focus in on these categories, since they all occur in some cultural milieu which partly provides meaning for them. Specifically, we are presuming to discuss the act of death enacted by an individual on himself. Yet that word can have different meanings both for different cultures, and for different individuals. What are the conceptual limits of "life" for an Ok Sapmin elder, compared with myself, quite apart from the technical complexities of determining clinical "death?" I do not know explicitly, but I do know that there are profound differences in the perceived, apperceived, cognized and empathized meanings between him and myself, as with any transcendental mobility across the interface of life vis-a-vis death and the reverse. Rather than giving primacy to any one discipline, this justifies the need for a variety of data about suicide, and, indeed, requires that we suspend our preferred tools of trade.

From the information available concerning suicide in Pacific societies, some commonalities appear. Broadly speaking, the behavioral patterns suggest that certain disordered relations between an individual and some other person or persons, present or absent, may lead that individual into a state in which

emotions can no longer be controlled internally and demand resolution. While cultural norms, sanctions and sensitivities may situate or exacerbate that state (such as shame), these are not the ultimate prime movers to the act of self-annihilation; rather, there results some intolerable and immediate internal nexus of emotion which exceeds the psychobiological tolerances of that individual, and the cognized act follows. We can not yet see into that immediacy, or do so only through our own filters darkly.

In conclusion, health in the broader sense includes factors which are not explicitly curative. The psychiatric epidemiology we are considering here implies what I would call a "behavioral epidemiology," inasmuch as certain non-morbid behavioral states are antecedent to and provide the context for specific subsequent morbidity or decisive acts such as suicide (Pataki-Schweizer 1983b). Transcultural comprehension of health requires sociocultural, psychosocial and psychocultural information which put major pressures on, for example, the methods of ethnography, yet activities such as medical anthropology are firmly grounded in that approach and rationale. While it is not true that we thus know more and more about less and less, any disciplinary orthodoxy (and that is what the enactment often is) coupled with wide uncertainties at present about the appropriate relation between quantitative, qualitative and scalar domains does not promote understanding. This is particularly true for contemporary health concerns. Indeed, what does result is often self-serving, restricted and reflexive, if not retrospective. Any consideration of suicide evinces how far we are from a paradigm (itself an uncertain proposition) which can yield valid information from behaviorally valid information and generate understanding, while at the same time offering a hermeneutic coherence, some praxis of usefulness. And in the case of suicide in societies where traditional factors still provide guides for living, it is no longer sufficient to simply return the next day to continue the interviews. This is in fact to endorse a reciprocally alienating format, and we all remain the poorer for it.

REFERENCES

Bage, S., and P. Faru
1984 Suicide in an Urban Population of Papua New Guinea. Port Moresby: Department of Community Medicine, University of Papua New Guinea.

Burton-Bradley, B. G.
1969 Papua and New Guinea Transcultural Psychiatry II. The First One Thousand Referrals. Australian and New Zealand Journal of Psychiatry 3:130-136.

1975 Stone Age Crisis - A Psychiatric Appraisal. Nashville: Vanderbilt University Press.

Hezel, F. X.
1981 Summary of Conclusions, Micronesian Seminar, Conference on Suicide in Truk, April 22-24. Truk: Caroline Islands, Trust Territory, Pacific.

1984 Cultural Patterns of Trukese Suicide. Ethnology 23: 193-206.

Moi, W.
1979 Report on the Census of Psychiatric Patients. W.H.O. Project on Monitoring Mental Health Needs. Papua New Guinea: Department of Health.

Murphy, H. B. M.
1978 Mental Health Trends in the Pacific Islands. Noumea: South Pacific Commission.

1983 Assignment Report : Promotion of Community Psychiatry. Manila : World Health Organization, Regional Office for the Western Pacific.

Pataki-Schweizer K. J.
1976 Meth-Drinkers and Lotus-Eaters: Some Educational Aspects of Transcultural Psychiatry in Papua New Guinea. Australia and New Zealand Journal of Psychiatry 10:129-131.

1981a Contemporary Stress Syndromes. In Historical Dictionary of Oceania. Westport: Greenwood Press, p. 275.

1981b Squatter Settlements. Ibid., p. 59.

1982a The Introduction of Alcohol among the Wonenara Anga. In Through a Glass Darkly: Beer and Modernization in Papua New Guinea, M. Marshall, ed. Boroko: Institute of Applied Social and Economic Research, Pp. 211-215.

1982b Cannibis Sativa in Papua New Guinea: Situation and Context. Paper presented at the Eighteenth Annual Symposium, Medical Society of Papua New Guinea, September 10-11.

1983a Health and Rapid Psychosocial Change in a Developing Country: Papua New Guinea in the 1980s. Report, Western Pacific Advisory Committee on Medical Research, Sub-Committee on Behavioral Science and Mental Health, First Meeting. Manila: World health Organization, Regional Office for the Western Pacific.

1983b Health and Epidemiology in Four Tropical Cultures. Symposium on Epidemiology and Health in the Tropics. International Epidemiological Association Regional Meeting, Singapore, October 3-6.

1984 Assignment Report: Sociocultural and Psychosocial Inputs to Health Programmes in Irian Jaya, Indonesia. New Delhi: World Health Organization, Regional Office for South-East Asia.

Setyonegoro, R.K., J. Satya and H. Gunadi
1978 Psychiatry in Irian Jaya. Papua New Guinea Medical Journal 21(3):248-251.

Shearston, T.
1979 Something in the Blood. St. Lucia: Brisbane University Press.

Smith, D.
1981 Suicide in a Remote Preliterate Society in the Highlands of Papua New Guinea. Papua New Guinea Medical Journal 23(4):242-246.

Stanhope, J. M.
1967 Suicide in Papua and New Guinea. Medical Journal of Australia 1:140-141.

Weeks, S. ed.
1981 Health. In Oksapmin: Development and Change. E.R.U. Occasional paper No. 7. Port Moresby: Educational Research Unit, University of Papua New Guinea, Pp. 19-29.

Wohlfahrt, D. J.
1981 Paraquat Poisoning in Papua New Guinea. Papua New Guinea Medical Journal 24(3):165-167.

Table 1

Disease Trends in Papua New Guinea
(Rank ordered, for periods from 1922 through 1980)

1922-1939	1960-1972	1978-1980	(USA 1982)
1. Pneumococcal	Gastro-enteritis	Pneumonia	Heart Disease
2. Tuberculosis	Accidents/ Violence	Malaria	Neoplasms
3. Bacillary Dysentery	Cancer	Meningitis	Cerebrovascular Diseases
4. Septic Infections	Heart Disease	Accidents/ Violence	Accidents/Suicides and Homicides
5. Tropical Ulcer and Sequellae	Perinatal	Heart Diseases	Pulmonary Diseases
6. Enteric Fever	—	S.T.D.	Pneumonia and Influenza

Source: Pataki-Schweizer 1983b

Notes

Selected Crude Rates (per 1,000) determined from PNG Dept. of Health data, 1978-1980:

CBR:	41.2	Malaria:	41.3 (positive slides/population)
CDR:	14.2	Tuberculosis:	2.7 prevalence
IM:	80.7	Leprosy:	9.1 prevalence

Table 2

Selected Psychiatric Hospitalization Rates (per 10,000) in Oceania
(Ages 15-plus)

Area	Rate	Dates
Vanuatu	3.1	1970-77
Papua New Guinea	5.8	1980-81
Western Samoa	6.2	1972-76
Kiribati	9.3	1972-77

Source: Murphy 1983

Table 3

Suicide Rates (per 100,000) for Selected Highland PNG Societies, 1970s

A.

Area	Rate
Range of Available Information	8.5-72.0
Yari Basin, Southern Highlands Province	34 Ages 14-45 61 Ages 14-45, female 7 Ages 14-45, male
Ok Sapmin Locale, West Sepik Province	72 All ages

B. Comparative Rates

Low Example: Australian Aborigines Northern Territory Situate	1.8
Medial Examples: U.K. Australia U.S.A. Truk Hungary	 8.2 11.1 12.5 32 40.3
High Example: Truk (Ages 15-25)	200

Sources: Smith 1981; Morgan 1982; Hezel 1984

Table 4

PNG Suicide Rates (per 100,000), Urban and Regional

Area		Rate
Urban (National Capital District 1982):		10.7
By Regions, 1982:	Papua	2.2
	Highlands	1.7
	North	2.1
	Islands	2.8
	Average	2.4
Urban, Port Moresby, 1974-83		5.5
Mode$_1$: Ages 20-24:		9.6
Mode$_2$: Female, 20-24:		15.8

Sources: Murphy 1983; Bage and Faru 1984; Pataki-Schweizer 1984

Table 5

Suicides Using Chloroquin, Port Moresby, 1972-1982

Category	Attempted	Completed
N	37	30
Average Age	22.0 ± 7.1	28.0 ± 11.1
M:F Ratio	1:4	1:1.6
Estimated Rate, Effected: 11.5/100,000		
Estimated Rate, Female, Completed: 16.7/100,000		

Sources: Bage and Faru 1984; Pataki-Schweizer 1984