The 'Easy Street' Myth: Self harm among Aboriginal and non-Aboriginal female sole parents in urban state housing

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Abstract

Objective: To test the hypothesis that, controlling for socio-demographic factors, destructive behaviour among Aboriginal and non-Aboriginal female sole parents will not be significantly different.
Method: This study took place among an urban population of sole parents in Adelaide, South Australia, living in government housing. Two sample subsets were made up of 52 Aboriginal and 45 non-Aboriginal mothers from similar postcodes. Trained interviewers administered a questionnaire which, in addition to basic demographic data, elicited information concerning finance, housing, upbringing, experience of abuse and police interaction. The major issue of concern in the study was suicide attempt.
Results: 1-in-3 of the whole sample, 2-in-5 of the non-Aboriginal and 1-in-4 of the Aboriginal subset had attempted suicide at least once and half more than once. Statistical differences among 'attempters' vs. 'non-attempters', irrespective of ethnicity, included increased familial alcohol abuse, physical and sexual abuse, economic difficulty, poor self esteem and perceived discriminatory treatment by welfare agencies and, in the case of Aboriginals, by police.
Conclusion: The social environment is critical to understanding destructive behaviour, including self-harm, regardless of culture or ethnicity. The data show that suicide attempts among female sole parents in State-housing is one of the few health indices for which Aboriginal statistics are less than for non-Aboriginals.
Implications: It is evident that class, rather than ethnicity, better explains self-harm in this urban population. It is suggested that reluctance to access services, especially in times of crisis, relates in part to perceptions of care services and that, for Aboriginals, the value of culturally appropriate community-run services have specific public health and policy implications.

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Within the vast literature on suicide and parasuicide increasingly known as deliberate self harm or self harm,[1] there is a paucity of prevalence or population-based studies. There are few cross-cultural studies, and none that we could find centring on sole parents and self harm, despite many that indicate much is common to sole parents and suicide attempters.[2,3] Such common factors may confound any real differences between those exhibiting self harm and those who do not.[4] This in-depth, exploratory study did not permit complex causal modelling as the number of questions posed was large while the sample size was small. Rather, it suggests trends and associations the authors believe are not likely to be due to chance, and are worthy of further research, and closer policy attention and social support.

In the 1991 Census, there were 552,336 sole parent families in Australia. By 1996, this had risen to 672,868, which represented 35.6% of all families with dependent children – by far the fastest growing family type in Australia.[72] On average, 463 sole parent households were created each week between these Censuses, and the increase since 1986 has been remarkable.[5]

Aboriginal people make up about 1.5% of the Australian population. The 1986 Census showed that Adelaide, South Australia's capital with more than one million people, had the largest concentration of Aboriginal people in that State (5,696 or 40% of the SA Aboriginal population). By the 1996 Census, this number had risen sharply to 9,387 representing closer to one half (46%).

In 1986, Hugo reported that 'of all Aboriginal families in SA, more than 1-in-4 is a single parent family, compared with less than 1-in-13 of all families',[6] while in Adelaide

that rose to 31%. However, 1996 Census data shows the proportion of sole parent families to have grown to more than 1-in-3 (34.5% or 814 of 2,359 families) compared with 15% of non-Aboriginal families (or less than 1-in-7).

Three-stage study design

The Aboriginal Education Foundation (AEF) invited the Department of Primary Health Care of the Flinders University of South Australia to research issues of self harm and stress in the Aboriginal community. A three-stage study of Aboriginal social health was designed collaboratively and the Discipline of Sociology joined the cross-cultural research team. This paper reports on the major findings from Stage 3. Stage 1 consisted of designing research tools, attempting to secure funds for 'community' rather than custodial or medical research (which proved difficult), and piloting the research protocol with 11 Aboriginal families.[7] The study was launched just before the Royal Commission into Aboriginal Deaths in Custody.[8]

The 'community-based, community-paced' approach of Stage 1 proved vital to community acceptance and interest. The project was approved by the Aboriginal Health Research Ethics Committee of South Australia as well as by Flinders University. The AEF management committee, with approximately equal numbers of Aboriginal and non-Aboriginal members, created a milieu within which a positive attitude and long-term thinking were brought to bear upon an issue of considerable grief and pain within the Aboriginal community of Adelaide.[7]

Stage 2 was conducted among a random sample of 88 Aboriginal 'heads of households' derived from lists of government or Aboriginal-managed rental accommodation in which it was believed about one-third of all Aboriginal people in Adelaide were accommodated. A major finding was that a 'large minority (17%) – as a result of past traumas together with the level of stress induced by present economic, medical and other social conditions – have at least once (and often more frequently) attempted suicide' and 31% had at least given it serious thought.[9] The study identified a number of associations with self harm that were unlikely to have occurred by chance.

Methodology and sampling

One-third (30 or 32.4%) of the randomly selected Aboriginal 'heads of household' for Stage 2 were female sole parents. For Stage 3, an additional 22 were located: either nominated by AEF staff using Stage 2 housing lists to guarantee a geographical spread or by Stage 2 participants. This provided a subset of 52 female Aboriginal sole parents who, while detracting from the randomness of the sample, could be surmised to have derived from the same social environment. Too few male Aboriginal sole parents could be located to enable gender to be considered in Stage 3.

Matching a sample of non-Aboriginal female sole parents with the Aboriginal subset proved difficult because we wanted a population (rather than agency) based sample matched to postcodes of the Aboriginal sample, and budget realities precluded a major door-knock. For confidentiality reasons, access was not granted to known sole parents through government lists but the State housing agency sent 350 letters on its letterhead encouraging participation to those in our chosen postcode areas. The letter stated only that the study concerned the health of sole parents. This mail-out resulted in just a 9% response rate (n=32). To increase the size of this subset, a door-knock was carried out in a suburb where Census data indicated a concentration of sole parents. All non-Aboriginal, female, sole parents who responded to the door-step invitation or notes left at their houses yielded a further 13 – and two refusals. The final non-Aboriginal sample was therefore 45.

A level of opportunism in this sampling approach must be acknowledged; however, this was felt to be the only realistic option for the reasons described. A total study sample of 97 was therefore derived for Stage 3.

Interviews and community orientation

In an attempt to wrest social research of minorities from typically neo-colonial dynamics, the research approach and instruments developed in the Aboriginal context were then applied also in the non-Aboriginal, rather than the reverse. Further, the research centred on women's experiences.

The semi-structured schedule concerned a wide range of social and psychogenic matters of life circumstance such as perceptions of stress, educational and employment background, past experience of abuse (towards self and from others), experience of policing, parenting patterns especially the loss of family through State-sanctioned violence (before it became known as the 'stolen generation' and achieved national publicity), housing conditions, present health and health care patterns, and general outlook on life including pride in one's achievements. Only one standard research tool was used – a psychological test for anxiety used prior to each interview, partly to test its usefulness in cross-cultural situations.[8,9] In addition, a card-sort, life-event-ranking exercise devised for this project (based on a standard, stress-assessment tool) enabled participants to place a range of factors in piles of High, Medium and Low Stress (not reported in this paper).

Due to the extreme sensitivity of some of the issues discussed, it was felt inappropriate to conduct the usual test-retest reliability checks. We believe the project's validity was enhanced by the collaborative development of the principal research instrument and the significant modification of another. Both Aboriginal and non-Aboriginal interviews were carried out exclusively by trained female interviewers. Those who interviewed Aboriginal participants were either Aboriginal themselves or non-Aboriginals with many years of work experience with, and acceptance by, Aboriginal people. Confidentiality was assured, and participants were linked into social support/counselling services if the need arose.

Self harm

Self harm was first raised in interviews through a *general* question about harm to self, after a wide range of matters had been canvassed including parenting, education and employment. A later section was devoted to self harm. Questions avoided the word 'suicide' which Aboriginal team members felt was emotive. Rather,

they were asked, "Have you ever tried to take your own life?"

Results to the earlier question, "have you ever hurt yourself?", require explanation. Not all 'Attempters' replied 'yes' to this question, indicating the likelihood that it was not until later in the interview that participants felt they could disclose a former suicide attempt. This heightens the importance of trust and rapport between interviewer and interviewee, and also of Stage 1 in which instruments were jointly constructed with community input and profound distrust of standardised 'mental health' instruments was declared. Nine of the 19 non-Aboriginal Attempters did not admit to hurting themselves earlier in the interview. This compared with just two of the 13 Aboriginal Attempters, which suggests that rapport was established earlier in the latter interviews, as the interviewer was either Aboriginal or an AEF staff member with extensive experience in their community.

Further questions probed suicidal thinking, circumstances surrounding attempts, method used and help sought in relation to each episode. Such detail is not reported here and was not analysed using SPSS-X which was limited to the study's major categories and questions. For these, we accepted a <0.05 level of significance as indicating important differences between groups. Due to the large number of variables and relatively small sample, the Chi-square with Continuity Correction or the Fisher's Exact Test results are quoted within a descriptive rather than a causal framework.

Results

Similar demographic profiles (Table 1) were evident for the two groups based on indices characterised by age (median age 33 years, not shown), income levels, low educational attainment, former alcohol or drug problem (and that of former partner), drug use by relatives and relatively high 'ever-jailed' profiles.

There were some statistically significant differences. Among the Aboriginal women, there was a significantly larger family and household size, and allegations of police harassment of their households were 10 times more likely (40% vs. 4%) which was statistically significant. Among the non-Aboriginal women there was greater housing instability, with all subjects 'formerly married', and much more likely to have a telephone or to be in receipt of a Sole Parents Benefit or equivalent. A greater number reported former violence against themselves, however, both groups reported very high levels of assault. Perceptions of poor treatment by helping agencies were common to both groups.

Additional major characteristics of Aboriginal (A) compared with non-Aboriginal (NA) sole parents included:

a) perceived poor treatment as a child by care-givers (91%A: 21%NA);
b) allegations of physical abuse by police of someone in the household (27%A: 11%NA);
c) bashing of at least one of their children at some time (18%A: 20% NA); by persons known to them (90%A:75% NA);
d) multiple repeated personal bashings over an extended period (53%A:65% NA);
e) known sexual abuse of at least one of their children (6%A:20% NA);
f) sexual abuse of self (27%A: 42% NA); and

Table 1: Characteristics of Aboriginal and non-Aboriginal sole parents.

	Ab'l n=52 %	Non-Ab'l n=45 %	χ^2 or F	p
Socio-demographic				
Knew both parents	73	86	1.95	0.162
Left school earlier than wanted to	50	59	0.79	0.373
Duration of city living ≥10 years	92	95	0.06	0.811
5+ children born to self	20	0	F[d]	0.001[b]
6+ residents in house	17	0	F	0.003[b]
4+ children in care	23	0	11.85	0.0005[b]
Moved house 3+ times in last 5 years	17	58	17.13	0.0000[c]
Visitors stay over for extended periods	31	13	4.182	0.041[a]
No working vehicle available	63	42	4.375	0.03[a]
No telephone in household	52	13	16.00	0.0000[c]
Relational status (separated/ divorced or single always/widowed)	77	100	9.82	0.002[b]
On any pension or benefit	88	93	F	0.202
Currently on sole parent benefit	65	89	7.29	0.007[b]
Ever tried to gain employment	90	98	1.17	0.278
Income after tax and rent <$225/week	77	77	1.80	0.77
Recent use of emergency financial services	46	38	0.64	0.425
Ever gaoled	19	11	0.67	0.411
Psycho-social				
Ever bashed or assaulted	52	75	5.772	0.016[a]
Allegations of police harassment	40	4	14.89	0.0001[c]
Perception of poor treatment by Dept Social Security	42	42	0.00	0.965
Dissatisfied with maintenance of house	46	44	0.12	0.729
Alcohol problem – now or in past (self)	15	13	0.082	0.774
Other drug problem (self)	10	11	0.058	0.809
Ex-partner had drug problem	19	11	0.0105	0.918
Angry daily or weekly	32	73	15.953	0.0000[c]

Notes:
(a) p<0.05
(b) p<0.01
(c) p<0.001
(d) F=Fisher's Exact Test

g) major health problem at the time of interview (52%A: 40%NA).

Personal abuse (determined as such by each participant) was often from pre-school or primary school age, and often extended over several months, if not years. The perpetrator was in most cases (85%) known to them, and in half of them was a relative. There was almost total concordance regarding sexual abuse between Aboriginal and non-Aboriginal sole parents, apart from the higher frequency evident in the non-Aboriginal sample.

The findings were further analysed in two ways: suicide Attempters vs. non-Attempters in both sample sub-sets, and as a whole (Tables 2, 3 and 4).

A quarter of Aboriginal sole parents (25%) in State housing, and an even greater proportion of the non-Aboriginal equivalents (42%), reported at least one previous attempt to take their own lives (Table 3): a difference which just failed to achieve statistical significance despite its obvious disturbing social significance. Almost exactly half of both groups who reported this claimed they had attempted more than once. The same pattern was evi-

dent but with statistical significance (p=0.009) with regard to suicidal ideation. That is, a greater proportion (62%) of the non-Aboriginal sample reported thinking about killing themselves at some stage compared with 38% of Aboriginal participants. A further sombre outcome was that eight of the 19 non-Aboriginal Attempters, and four of the 13 Aboriginal Attempters, had also thought about suicide within the 'past year'. The Aboriginal suicide attempt figure was greater than that reported in Stage 1 (17%).[9]

Upbringing and current child care burden (Table 2): It was statistically more likely for Aboriginal Attempters to live in larger households with more children in their care, together with a history of having 'missed an absent care-giver' when young. They had also had less stable employment.

Substance use, sense of 'control', physical and sexual abuse (Table 2): The non-Aboriginal Attempters were significantly more likely to have had parents with alcohol problems and to report a sense of 'lack of control' over their lives. The experience of abuse (sexual and other) was seemingly so common in this group that it could not achieve statistical significance despite an extraordinary 89% of Attempters having been bashed or assaulted. However, it was statistically much more likely for the Aboriginal Attempters to report sexual abuse, a trend also evident in the non-Aboriginal Attempters but not to the same extent. Unspecified abuse in the non-Aboriginal group may have had its roots in household dysfunction related to parental and/or former partner's alcohol problems rather than to loss or absence of parents and multiple surrounding alcohol problems, as in the Aboriginal sample.

A tragic picture of alcohol abuse (defined by participants) emerged from all Aboriginal sole parents, but statistically significantly more abuse 'in at least one sibling' was reported by virtually all Attempters. This pattern also existed among non-Aboriginal Attempters in relation to parents. In addition, Aboriginal Attempters were significantly more likely to have a 'drug problem' of another, unspecified kind.

Table 3: Study sample and proportion of suicide Attempters: Aboriginal (Ab'l) and non-Aboriginal (Non-Ab'l).

Ab'l (n=52)		Non-Ab'l (n=45)	
Attempter	Non-attempter	Attempter	Non-attempter
13	39	19	26
(25%)		(42.2%)	

Table 2. Associations between Attempters (Att) and non-Attempters (Non-Att) within each cultural group.

	Aboriginal (n=52)				Non-Aboriginal (n=45)			
	Att n=13 %	Non-Att n=39 %	χ^2or F[a]	p	Att n=19 %	Non-Att n=26 %	χ^2or F	p
Socio-demographic								
Fostered in early life	46	20	F	0.07	10	8	F	0.56
Absence of available caregiver a problem in early life	27	3	F	0.035[b]	36	36	0.00	1.0
Four+ children in care	53	0	F	0.005[c]	nil cases	nil cases		
Household size 6+	38	10	F	0.03[b]	nil cases	nil cases		
No working vehicle in household	69	61	F	0.440	58	31	2.29	0.13
Stable employment history: self	54	88	F	0.03[b]	76	96	F	0.07
Stable employment former partner	45	76	F	0.07	61	73	0.258	0.61
Psycho-social								
Very dissatisfied with housing	46	18	F	0.05[b]	32	50	0.865	0.35
Perception of treatment by Dept. Social Security as unhelpful or abusive	69	33	3.78	0.051	47	38	0.058	0.80
Ever sexually abused	69	13	F	0.0002[c]	58	31	2.29	0.13
Ever bashed or assaulted	77	44	3.10	0.077	89	65	F	0.06
Alcohol problem (self)	38	8	F	0.017[b]	16	11	F	0.5
Alcohol problem (parent)	54	17	F	0.016[b]	53	19	4.11	0.042[b]
Alcohol problem (sibling)	92	51	F	0.012[b]	16	35	1.14	0.284
Alcohol problem (former partner)	83	40	5.15	0.023[b]	63	69	0.011	0.91
Other drug problem (self)	38	0	F	0.0005[c]	16	8	F	0.34
Some pride in achievement	46	50	F	0.51	100	81	F	0.054
Sense of lack of control	31	8	F	0.056	37	8	F	0.02[b]
Anxiety (Trait) Test (High Score/High Anxiety)	100	37	F	0.022[b]	73	67	F	0.55
Previous self harm (not necessarily 'life-threatening')[d]	84	13	F	0.0000[c]	53	11	7.13	0.007[c]

Notes:
(a) F=Fisher's Exact Test.
(b) p=<0.05
(c) p=<0.01 P values are quoted for Chi Square with Continuity Correction using SPSS-X.
(d) The question 'have you ever hurt yourself?' was asked long before 'suicide attempts', were probed. See text for discussion.
df = 1

'Helping' Agencies (Table 2): Aboriginal Attempters were more likely to perceive main government welfare/helping agencies as being 'abusive' as well as unhelpful, than were non-Attempters but there was little difference evident between the two non-Aboriginal subsets on this.

Psychological features (Table 2): Aboriginal Attempters yielded significantly higher 'anxiety' scores (from Stait-Trait Anxiety tests conducted prior to interviews[10]) – a trend echoed among non-Aboriginal Attempters but not to the same extent. They were statistically more likely to report self-assessed feelings of a sense of lack of 'control of one's life'. The topic of stress and anxiety requires much further research. Further reports on our data are beyond the scope of this paper.

Differences between Aboriginal and non-Aboriginal Attempters (Table 4)

A number of differences reached significance among Attempters. Many Aboriginal Attempters had been fostered as children (possibly reflecting the legacy of the 'stolen generation');[11] they had a greater number of children in their care and significantly larger overall household sizes. They more frequently identified alcohol as a problem among their siblings and were much less likely to have a telephone or a working vehicle. In addition, two-thirds reported high levels of police/household interaction, with allegations of 'harassment' from police being statistically significant. No non-Aboriginal Attempters reported this.

Non-Aboriginal Attempters were significantly less likely to have completed some form of post-school education (TAFE, etc) than the Aboriginal Attempters. They also reported less housing stability, although this was not statistically significant.

Approximately two-thirds of both groups reported feeling poorly accepted by wider society suggesting stigmatisation of sole parenthood regardless of cultural background. This proportion also lacked a working vehicle.

Abuse (Tables 1 and 2): Reported previous sexual abuse (as defined by participants) had occurred approximately five times more frequently in Aboriginal Attempters compared with non-Attempters, while for non-Aboriginals, the frequency was higher in Attempters, but not markedly so.

Previous other physical abuse (violent assault or bashing) was so common to both groups that it was unlikely to achieve significance between them with nearly two-thirds (63%) of all sole parents having experienced it (52% of Aboriginals and 75% of non-Aboriginals)(Table 1). Not surprisingly, there was a trend to such abuse being more frequent among both groups of Attempters when compared with non-Attempters. Although this did not reach significance in statistical terms (Table 2), we believe this was another particularly disturbing result.

Differences between Aboriginal and non-Aboriginal non-Attempters (Table 4)

Among non-Attempters, Aboriginal sole parents were much more likely to have four or more children in their care, less likely to have a telephone or a working vehicle in the household, and they reported significantly greater police interaction and allegations of harassment than the non-Aboriginal group. Conversely,

Table 4: Associations of Aboriginal and non-Aboriginal Attempters, and Aboriginal and non-Aboriginal non-Attempters.

	Attempters				Non-Attempters			
	Ab'l n=13 %	Non-Ab'l n=19 %	χ^2or F[a]	*p*	Ab'l n=39 %	Non-Ab'l n=26 %	χ^2or F	*p*
Socio-demographic								
Fostered in early life	46	10	F	0.031[b]	20	8	F	0.146
Education (lower less years)	46	90	F	0.011[b]	28	92	25.79	0.0000[c]
Current household structure (multi-family or temporary residents)	46	10	F	0.031[b]	34	11	2.91	0.088
Four+ children in care	46	10	F	0.031[b]	13	0	F	0.069
Total persons in household 6+	38	0	F	0.006[c]	10	0	F	0.121
No telephone in household	62	16	F	0.010[b]	48	12	8.04	0.004[c]
No working vehicle in household	69	58	F	0.392	62	31	5.90	0.015[b]
Moved house 3+ in last 5 years	23	52	F	0.191	15	61	12.85	0.0003[c]
On Supporting Parents Benefit	75	84	F	0.426	61	92	7.27	0.006[c]
Psycho-social								
Very dissatisfied with housing	46	32	F	0.319	18	50	7.52	0.006[c]
Alcohol problem in siblings	91	16	14.17	0.0001[c]	51	35	1.732	0.188
Alcohol problem in former partner	83	63	F	0.214	39	69	5.19	0.022[b]
Sense of lack of control	31	37	F	0.51	8	8	0	1.0
Police harassment	38	0	F	0.006[c]	41	8	8.21	0.009[c]
Perceived poor acceptance by wider society	69	74	F	0.54	46	58	0.830	0.361

Notes:
(a) F=Fisher's Exact Test
(b) p<0.05
(c) p<0.01 Continuity Correction applied when appropriate.
df = 1

the non-Aboriginal non-Attempters were more likely to be receiving a Supporting Parents Benefit, and less likely to have completed any further education, and more likely to have had greater household instability. Both of the latter were held in common across the non-Aboriginal sample. They were also almost twice as likely to have had a former partner with an alcohol problem.

Discussion and implications

The theoretical landscape from which to consider parenthood and sole parenthood leaves much to be desired, with much research methodologically flawed, for example, by constructing a homogeneous entity without serious consideration of culture, ethnicity or gender. Reports too often construct sole-headed households merely 'as abnormal or deviant to the nuclear family'.[5] Even less likely, but true for suicide literature in general, is an adequate consideration of the socio-economic attributes of parents.[72]

The literature reveals few clear trends with regard to ethnicity/culture, parenthood and self-harm, and the lack of studies of sole parenthood in this context is striking. Even within the suicide literature, no consistent predictors of suicide attempt were evident. Monk referred to the rarity of "well designed studies of suicide that examine psychiatric and social factors simultaneously".[33] Few cultural or class-sensitive inquiries of direct relevance to this study were found. One notable exception was Lindblad-Goldberg et al.[12] whose study of stress in black, low income, sole parent families concluded that "chronic life conditions may have a more negative effect on mental health and well-being than do discrete life events". They asserted that merely "being poor, black, female, and a single parent together form . . . a chronic source of stress". However, as 'blackness' was not compared with 'non-blackness', their analysis was limited to this 'triple or quadruple jeopardy' model which tends to compound stereotypical views.

Female sole parents reflect high rates of many psychological conditions and relational factors identified as being more frequent among suicide attempters in the general suicide literature, such as isolation and feelings of uselessness in society.[2,23,52,53] However, such indicators are usually inadequately grounded in their social contexts, particularly with regard to economic questions such as employment and unemployment.[6,22,24,53-54] Suicide attempt is more common in widowed, divorced or separated women,[15] among the socially and economically disadvantaged,[16] and possibly the unemployed.[19-22] In our study, the few descriptors which differentiated Aboriginal from non-Aboriginal female sole parents lend support to suicide attempts reflecting features of a disadvantaged class as reflected in other studies.[16,44,45]

The question of the causal association between mental illness and suicide remains problematic as proposed by Emile Durkheim over a century ago.[25] Nevertheless, commentators continue reporting this and there is growing recognition of the link between depression in the young especially, increasing suicide rates in that age group, and corresponding very low rates of utilisation of psychiatric services.[26-33,72] Without convincing supporting evidence, Black[1] asserts that deliberate self harm is almost always in the context of an [unspecified] diagnosable mental disorder. Such a level of association seems unlikely in our sample, unless more than two out of every five female sole parents in state housing can be reliably diagnosed as having such a disorder at any one time. Our study suggests such an association remains only one of many that could be made if we were to place this critical public health issue in a more meaningful cultural and social context. An implication of Black's view is that a 'mental health' intervention is called for among sole parents in state housing. Were resources to be mobilised for this, our study suggests the difficulty in reaching such a vulnerable sub-population with the required intensive support. Indeed, some Attempters told interviewers they 'trusted no-one'. Our study suggests the dimensions of this social phenomenon would seem to be considerably more complex than such literature, particularly the medical literature, infers. This has implications for 'healthy public policy' as well as for clinicians, including general practitioners.[68]

Another noteworthy theme in the literature on self-harm and women's health highlights its relation to past sexual and physical abuse.[34-39] With exceptionally high levels (two in every three participants (65%) in our study reported previous sexual or physical abuse), we suggest this is an important association. Carmen et al. cite several studies which "provide evidence of profoundly self-destructive behaviours that emerge after victimization".[39]

The role of alcohol in relation to suicide is variously reported. While Goldney[15] found no association, most researchers have found one. In our study, both alcohol and other drug abuse were commonly identified as issues in both self and families of female sole parents generally, but among Aboriginal suicide Attempters much greater correlations with personal and immediate and extended family alcohol abuse were found.[40-43]

In a ground-breaking Commonwealth Report in 1995,[73] Swan and Raphael referred to Aboriginal self harm and mental health, and stated that for data to be useful, it must be "informed by the social, cultural, physical and psychological contexts in which Aboriginal people exist".

Brice reviewed 30 years of constructions of Aboriginal 'mental health' and suicide in the literature[8,51] from a sociological perspective, concluding that the true incidence of such phenomenon in pre-Contact societies will remain impossible to determine. There is no general precedent for widespread suicide in traditional Aboriginal cultures as there apparently were in others. On the basis of the evidence available, it appears highly probable that the occasional instances of suicide were not only rare, but accompanied by appalling social conditions, a low level of psychiatric illness or fear associated with sorcery. Further, this rarity seems to have lasted well into the 1960s. The quality of research reports reviewed for this study has remained poor despite their increase through the 1970s and into the1990s.[46-51,73] Nevertheless, the profile of self harm in Aboriginal communities has been raised, and thinking and action has moved beyond custodial contexts. With 'emotional and social well-being' (the Aboriginal construction of 'mental health' from a social health perspective) becoming a major focus across Australia, especially at Commonwealth level, suicide prevention programs are becoming more widespread. Aboriginal health workers are being assisted to better understand some

clinical perspectives concerning self harm and clinicians are being encouraged to learn from Aboriginal experience.

Self harm has been explored in urban and some remote communities but it could well be another hidden problem in small country towns, with official data remaining deficient on many levels. Further, as 'injuries' per se are a major health problem in the Aboriginal context, it is noteworthy that Tatz, Hunter and Brice have all stressed the need to consider self-harm within a broader context of personalised violence against a backdrop of massive social change (including very high unemployment) which has particularly undermined male Aboriginal institutions and roles rendering many men powerless in a dominant culture that ostensibly promises much.[8,49-51] However, with youth suicide now possibly a national catastrophe[72] alongside extraordinary rates of youth unemployment (in SA over 30% for some time), such powerlessness is not confined to Aboriginal people – thus again illustrating how important is cross-cultural research.

Suicide *attempt* studies concerning culture/ethnicity are particularly rare, regardless of considerations of parenthood. Interestingly, Paykel in the US reports lower rates of suicide attempts among 'blacks' (African Americans mostly), and especially among black women[16] – a trend reflected in our study. Hassan[9] reviewed reports concerning American Indians that claimed a direct link between self-harm and colonialism which had brought about a total devaluation of cultural institutions of regulation and meaning, ultimately leading to over-representation in custodial institutions and differential treatment by police – another trend upheld in our study.[71] This link between police treatment and attitudes and Aboriginal self harm was also found in a 'mental health' study of urban Aboriginal people[47] despite a culturally unsuitable methodology (batteries of standard tests), contradictory claims, and poor reporting – a feature of a great number of epidemiological studies.[73]

In general, as Swan and Raphael noted in 1995, useful information remains scarce: "There is very clearly a need for systematic data on the extent and nature of mental health problems ... in Aboriginal people. ... Research and evaluation are essential."[73]

As hypothesised, our exploratory, in-depth study approach yielded no evidence that self-harm is more frequent among female Aboriginal sole parents than non-Aboriginal equivalents in similar social environments. Rather, it suggests quite the reverse may be the case. The following social indicators rather than *cultural* or *ethnic* (or 'mental health' considerations) per se emerged as critical for the understanding of self-harm: severely constricted life chances characterised in part by a lack of amenities for urban communication and interaction (vehicles or telephones), poor housing, financial difficulty, family composition and history, poor quality of former relationships leading to lack of trust and 'no close friend', and Lindblad et al.'s notion of 'chronic life conditions' and 'chronic source[s] of stress' which was no doubt compounded by the failure of helping agencies, and perceived oppression from police in the case of the Aboriginal sample.

It would seem that self harm is more pervasive than the 'visible' element that stimulated this research would suggest. Further, if culture or ethnicity fails to explain self harm in either Aboriginal or non-Aboriginal contexts, perhaps there is a deeper, larger and more harsh story in our urban/suburban landscape than we would prefer to contemplate. With an estimated current incidence of attempted suicide in Australia at 250 per 100,000 per year for women and 180 per 100,000 for men[69] the issue is undoubtedly a 'major public health problem that results in countless hospitalisations and physician visits, and causes substantial emotional distress and physical morbidity' and 'many who deliberately harm themselves repeat their behaviours'.[1] With many participants reporting they 'had no close friend' and 'trusted no-one' (even in streets where a sole parent was found in every third or fourth household), in addition to the range of other aspects of economic and social disadvantage canvassed in this study, loneliness and social dislocation must be a major factor in this *anomic* urban scenario.

Speculating upon the reason(s) for the apparent trend toward greater risk of suicide among non-Aboriginal female sole parents in our study is difficult and in any case should be done with caution given our sample sizes. There may be a greater resilience among Aboriginal sole parents due to a stronger sense of resistance to, and acquired toleration of, long-term, inter-generational oppression of various kinds: a 'thicker skin' due to the solidarity of 'the Aboriginal struggle' to some extent, perhaps. Their greater household size, greater likelihood of family support and greater frequency of stay-over visitors, as well as the greater number of children around them may encourage Aboriginal women to put off destructive behaviours and 'talk out' deep-seated angst. It is also possible that they, like others[44,45] do not necessarily see such behaviours as likely to result in conflict resolution. Despite the tragic cost for many, some Aboriginal people may find not only escape, but greater communal resolve, or cohesion[55] in alcohol or other drugs compared with non-Aboriginal people. Further, while substance use may be associated with greater 'outward' violence, possibly having a cathartic effect, the recently introduced provision of certain Aboriginal-run services such as health and housing may have helped to buffer some of the effects of poverty and poor health, as was suggested earlier.

Alternatively, the 'difference' in apparent levels of suicidal behaviour by culture/ethnicity, could perhaps be attributed to reporting trends regarding different views of what constituted life-threatening action.

Our study was exploratory and, while it is believed that the findings are likely to be in the direction of the sub-populations from which they were drawn, we too, "do not know whether our findings are high, low, or represent true prevalence".[14] Nevertheless, it shatters the myth that sole parents living in government rented accommodation are on 'easy street' as some commentators maintain. Further, it should be noted that a sample such as ours, by virtue of the householder's readiness to set aside a few hours to work through a complex and emotionally demanding interview schedule, was likely to have been biased toward those of relatively stable abode, even though our project was much less circumscribed than most former studies.[13] This suggests that if the more vulnerable and less stable were questioned, the results

may have been more disturbing even than those reported.

In Stage 1 we found that although most of the Aboriginal 'heads-of-households' sample had used a general practitioner in conjunction with other services, few did so in crises.[9] This non-use of many mainstream services either exclusively or on a continuing basis is well established in the literature.[55,56,70] Indeed, the Aboriginal members of the research team agreed that "Many . . . must tolerate the critical attitudes of some helping agencies who apply middle class (or other) values and mythical explanations to their lifestyles and values".[2]

It also seems that Aboriginal sole parents were more likely to perceive they endure a significant and peculiar burden or 'special treatment' through police harassment than seems to occur in the non-Aboriginal sole parent neighbourhoods (Table 4). A perception often shared by Aboriginal people was that 'surveillance' was perceived as an on-going feature of colonial domination, that police give them a 'hard time'. In the terms of the literature, this interaction with police can be considered an 'on-going strain which must be endured [almost] daily'.[9,71] Lindblad-Goldberg et al. is one of very few studies to have considered this seriously with their construction of a 'vulnerability profile' for minority groups.[12]

However, regardless of cultural background, in our study it would seem that 'helping' agencies were frequently unhelpful at critical moments of vulnerability. Furthermore, 'help' particularly from national welfare staff, was perceived by a large proportion of sole parents as not only unhelpful but 'rude and abusive', thus compounding poor self-esteem and the stigmatisation of sole parenthood. This may have made help-seeking less likely through other agencies such as counselling, respite and child care.[61-69] Literature on such issues abounds yet links have rarely been drawn between that concerning potentially life-threatening social circumstances, and public policy on sole parenthood. Our results did not hinge on (possibly distant) past episodes of self harm; rather, an on-going tendency of 'suicidal thinking' was evident. In saying this, we would not want to contribute to stigmatisation of sole parenthood as much qualitative data in our study challenged a stereotypical view of them as the 'victimised and defeated'. Despite trauma, both self-inflicted and inflicted by others, some have gained dignity and taken greater control of their lives. Indeed, more than half of both cultural groups of Attempters could identify some positive aspects arising from their self-harm experiences.

Relationship difficulties were often perceived by women in this study to be causal in terms of self-harm episodes. 'Domestic violence' was mostly male initiated, and its association with suicide attempt was statistically significant. The extraordinary level of violent trauma experienced by these sole parents (which was reportedly higher amongst non-Aboriginals), highlights the importance of services to counter male violence as well as for helping agencies to deal more sensitively with vulnerable clients. Community health workers and in particular general practitioners, may need to pay particular attention to sole parents while being sensitive to their diverse cultural backgrounds and histories.[68]

This and other studies suggest a national public health policy for sole parents requires consideration. They are a large and rapidly growing, even if diverse and at times transient, portion of the National social fabric. At the clinical level, a model for prediction of 'at risk' sole parents remains problematic but we would suggest it be developed and tested in at least Aboriginal and non-Aboriginal contexts, which would require different approaches. In either case, a systematic prospective follow-up of those deemed to be at high risk would need to accompany such a process. For the Aboriginal context, both would require close cooperation and partnership with key Aboriginal organisations,[70] several of which are beginning to develop strategies to counter self-harm.

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