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Dancing with death: the grey area between suicide related behavior, indifference and risk behaviors of heroin users

BY PETER G. MILLER, PH.D.

Suicide-related behavior (SRB) among heroin users is a complex and multifaceted continuum, including such fringe areas as indifference and "risky" behavior. The article investigates the nuances and intersections of SRB, using qualitative semi-structured interviews with 60 regular heroin users recruited primarily from syringe programs in Geelong, Australia. Twenty-eight percent of interviewees reported a previous suicide attempt and 45% reported serious consideration of it. Types of SRB reported included: Suicide attempts, instrumental suicide-related behaviors, suicidal ideation, indifference and risk-taking thoughts and behaviors. Heroin users engage in much behavior which inhabits a grey area of SRB. The use of a nomenclature which addresses the elements of lethality and intent improves the ability of research to properly define and categorize SRB in drug-using populations. But the categories should not be overinclusive; indifferent attitudes towards death and risk-taking behaviors can sometimes be a functional response to the risk environment of heroin users.

KEY WORDS: *Suicide, suicide-related behavior, indifference, ambivalence, nomenclature, heroin, injecting drug use, qualitative, intentional overdose.*

Suicide and suicide-related behavior (SRB) is a complex and multifaceted behavior. There are a range of behaviors and attitudes which fall under the banner of SRB, not all of which necessarily involve an immediate, explicit intent to kill oneself. Still many more can be seen to inhabit the grey areas between risky behavior and indifference. This article proposes that many studies of SRB fail to adequately describe the full extent and nature of the problem. This is particularly the case in problematic heroin users, many of whom regularly engage in behavior which can be interpreted as suicidal according to some definitions. The article employs qualitative data to provide concrete examples of some of the different types of SRB observed in a group of heroin users and argues for a stronger, more comprehensive nomenclature (a set of commonly understood, logically defined terms) of suicide.

Suicide-related behavior

Suicide is consistently reported to be one of the four major causes of death among heroin users, with heroin-related overdose being the most common (Davoli et al., 1993). Death due to suicide among heroin users occurs at 14 times the rate of matched peers (Harris & Barraclough, 1997) and rates of suicide in injecting drug user (IDU) populations have been reported between 1% (Darke et al., 1996) and 49% (Neale, 2000). While there are most likely many reasons for different reported suicide rates, research methodology can play a substantial role (Heale et al., 2003) and qualitative investigations of the issue generally report higher rates than quantitative methods (see Neale, 2000). Differences in reported suicide rates between countries have not been systematically reported and meaningful comparisons remain difficult because of different study methodologies and samples, representing an issue which requires further investigation. However, there are other factors which influence SRB in heroin using populations. For instance, substantial gender differences have been observed in attempted and completed suicide, with females three times more likely to attempt suicide, and males three times more likely to complete (Darke et al., 2005). Previous research in Australia has also found that during 12 months of treatment

there was no significant reduction in attempted suicide among males, but that females reported a significant decline in suicide attempts from 19.7 to 9.8% (Darke et al., 2005). The same study also reported major reductions in suicidal ideation and depressive symptoms due to treatment for both genders.

In the context of this article, it is important to begin with some definitions surrounding SRB which are drawn from O'Carroll et al. (1996):

Suicide Death from injury, poisoning, or suffocation where there is evidence (*either explicit or implicit*) that the injury was self-inflicted and that the decedent *intended* to kill himself/herself (Operational Criteria for the Determination of Suicide (OCDS) definition).

Suicide attempt A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence (*either explicit or implicit*) that the person *intended at some (nonzero) level* to kill himself/herself. A suicide attempt may or may not result in injuries.

Instrumental suicide-related behavior Potentially self-injurious behavior for which there is evidence (*either implicit or explicit*) that (a) the person did not intend to kill himself/herself (i.e., had zero intent to die), *and* (b) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end (e.g., to seek help, to punish others, to receive attention).

Suicide-related behavior Potentially self injurious behavior for which there is *explicit or implicit evidence* either that (a) the person intended at some (nonzero) level to kill himself/herself or (b) the person wished to use the *appearance* of intending to kill himself/herself in order to attain some other end. Suicide-related behavior comprises suicidal acts and instrumental suicide-related behavior.

Suicidal ideation Any self-reported thoughts of engaging in suicide-related behavior.

FIGURE 1 | **An outline indicating superset/subset relationships of the proposed nomenclature for suicide and self-injurious thoughts and behaviors**

- 1) Risk-taking thoughts and behaviors
 - A) With immediate risk (e.g., motocross, skydiving)
 - B) With remote risk (e.g., smoking, sexual promiscuity)
- 2) Suicide-related thoughts and behaviors
 - A) Suicidal ideation
 - i) Casual ideation
 - ii) Serious ideation
 - (1) Persistent
 - (2) Transient
 - B) Suicide-related behaviors
 - i) Instrumental suicide-related behaviors (ISRB)
 - (1) Suicide threat
 - (a) Passive (e.g., ledge sitting)
 - (b) Active (e.g., verbal threat, note writing)
 - (2) Other ISRB
 - (3) Accidental death associated with ISRB
 - ii) Suicidal acts
 - (1) Suicide attempt
 - (a) With no injuries (eg., gun fired, missed)
 - (b) With injuries
 - (2) Suicide (completed suicide)

SOURCE: O'Carroll et al. (1996), p. 247

Figure 1 provides an example of O'Carroll et al.'s (1996) nomenclature. Key elements of this nomenclature are: The level of injuries sustained (no injury, nonfatal injury, or death which reflects lethality); intent to die from suicide; and instrumentality (whether or not the person wished to use the appearance of a suicidal act for some other end). Each operational category is defined by its own particular combination of the above three elements (Kidd, 2003; O'Carroll et al., 1996). This article focuses on the elements of these definitions which leave a wide margin for interpretation. Namely; that behavior is self-inflicted, that there is intent "at some level" and that evidence is either explicit or implicit. Clearly,

interpretations such as “at some level” and “explicit or implicit” evidence require exploration and justification. For example, although long-term risky heroin use can be placed within the category of “Risk taking thoughts and behaviors” according to the definitions provided by O’Carroll et al., it remains to be seen whether it should inhabit a position along the continuum of SRB.

Differences in essential elements of the suicidal act, such as the level of intent and people’s desired outcome, can result in very different perceptions and interpretations of suicide (Douglas, 1967). An important area where this occurs is intentional overdose in populations of IDUs and the level of ambiguity or indifference which they exhibit towards death (Heale et al., 2003).

Another confounding element is the complex problem of the validity of self-report. Respondents report some behaviors as being suicidal in nature, but when questioned, may answer in a negative fashion because they either do not fit within their perceived notions of suicide or they do not wish to be labelled according to the construct of “suicidal” (Kidd, 2003). This would be particularly problematic if they were only to be asked a single yes or no question (have you ever attempted to commit suicide?). Terms such as “intentional” and “deliberate” can be misinterpreted and it has been found that some people who deny “intending” to overdose were experiencing strong suicidal feelings at the time (Heale et al., 2003). Alternatively, participants may acknowledge the deliberateness of the event while having a relatively low intent to actually die (Heale et al., 2003). Certainly, in many cases, the person expresses ambiguity about his/her intent to die (Neale, 2000).

Indifference Another complex phenomenon surrounding SRB in heroin users is the influence of indifference, or fatalism (whereby an individual engages in activities which are harmful to themselves over a long period but do not fit within the acute model commonly constructed as “suicide”) and where this fits

within models of SRB. From Durkheim's original research into suicide (1952/1897), indifference and attitudes towards life and death, have been found to play an important role in suicidal behavior (Cohen, 2000). It has been demonstrated that suicidal adolescents fear death to a lesser degree than nonsuicidal people (Orbach, 1988). Orbach & Glaubman (1979) suggest that "distorted and idiosyncratic" perceptions of death serve as a defense mechanism against the fear of death that arises in the face of suicidal urges which may facilitate the suicidal act itself Orbach (1988).

Kidd (2003) found that 20% of his street youth sample described the process of "giving up" and succumbing to greater and greater levels of drug "addiction," declines in health, and frequent overdoses as a way of slowly killing themselves. Such behavior may fall within the criteria for a suicidal act because the individual is engaging in a self-injurious behavior with some (nonzero) intent to die (O'Carroll et al., 1996), yet such individuals might rightfully deny having made "a suicide attempt". A study investigating adolescents' attitudes about death in relation to suicidality found that greater suicidal ideation correlated with weaker attraction to life, stronger attraction to death, and a stronger repulsion by life (Gutierrez et al., 1996). Certainly, some authors have posited that self-destructive behavior can be included under the general umbrella of suicidality, although there may be no explicit intention to hurt one's self (Maris et al., 2000).

Indifference has been documented in a number of previous studies of heroin users (e.g. Neale, 2000; Plumridge & Chetwynd, 1999). They have shown that respondents demonstrated indifferent attitudes towards their death for reasons including: No hope for the future (Rossow & Lauritzen, 1999); a desire to achieve relief from pain; to escape an unbearable situation; to show desperation; to seek help; and to punish, frighten or influence others (Neale, 2000). Plumridge & Chetwynd found that, for some of their sample, "the search for pleasure was the only motivating force in the talk of these

young men and prime among these pleasures had been the use of drugs" (1999:333). Much of this indifference might be categorized as forms of "chronic suicide" (Menninger, 1938) or "indirect suicide" (Shneidman, 1996). However, for some, this indifference can alternately be viewed as being a reaction to the risk environment which IDUs inhabit (Moore, 2004).

Risky behavior In O'Carroll et al. (1996) nomenclature of suicide, they problematize risky behavior as being part of the continuum of SRB. Smoking, alcohol use, risky sports, hazardous occupations, medical noncompliance, and other activities (including risky heroin use) may be regarded as potentially self-destructive (Shneidman, 1996), it is argued that any behavior which voluntarily places one's life at risk must logically belong within the spectrum of SRB, particularly where motives for the behavior are not clearly nonsuicidal.

However, such behaviors may not necessarily be related to suicide at all (Maris et al., 2000). Prior studies have shown that engaging in high risk behaviors does not necessarily mean that someone has a reduced fear of death or is engaging in SRB (Alexander & Lester, 1972). For example, in his investigation of risk and injury in serious recreational cyclists, a pursuit that involves regular brushes with death, Albert (1999) discusses the way that crashes and death are viewed as inevitable or unavoidable and are seen as "occupational hazards." Albert points out that although the high level of danger is constant, cyclists are not actually "death cheaters," rather "due to the unavoidably risk-laden nature of the activity, the subculture of cycling has incorporated the dangers of riding in ways that inextricably linked them to the very enactment of that life, the bike life" (1999:169). He also observed that many cyclists often carefully try to reduce the risk as far as possible, but that their environment means that the hazards they are exposed to are substantially increased. In these cases, attributions of suicidality can "pathologize" behavior that may otherwise be regarded as "normal" (Bellaby & Lawrenson, 2001).

Methods

Sixty heroin users were interviewed over a six week period in April/May 2000 at two needle and syringe program (NSP) sites in Geelong, Australia, a large regional city (pop. 200,000) 65 kms from the state capital city, Melbourne. Interview subjects were recruited using contact cards handed out by outreach workers, NSP workers and ambulance paramedics attending overdose events. To be eligible for the study, subjects had to have used heroin in the previous month.

Qualitative, semi-structured interviews were used and interviewees were encouraged to talk freely of their experiences and opinions. Interviews took between 20 and 95 minutes and subjects were required to use a pseudonym to ensure anonymity. As a part of a larger study into drug-related risk behaviors, participants were asked about overdose patterns, blood-borne virus behavior, suicidality and attitudes towards death (Miller, 2002). They were specifically asked whether they had ever attempted suicide and were engaged in subsequent conversation regarding details such as level of intent, what they hoped to achieve, any triggering events and other contextual details.

Ethical approval was obtained from the Deakin University Ethics Committee and the Barwon Health Ethics Committee. All questions were read out during the interview to circumvent possible complications surrounding the interviewees' literacy levels.

Data analysis

The narratives in this article result from thematic categorization. Thematic analysis (or "narrative analysis") is an inductive design where, rather than approach a problem with a theory already in place, the researcher identifies and explores themes which arise during analysis of the data (Kellehear, 1993). In this analysis, once a theme became evident, all transcripts were re-analyzed for appearances of the theme. Categorization was not exclusive and some narratives appeared in many themes. Categories are added to reflect as many of the nuances in the data as possible, rather than reducing the data to a few numeri-

cal codes (Pope & Mays, 1995). All the data relevant to each category were identified and examined using a process called constant comparison, in which each item is checked or compared with the rest of the data to establish analytical categories.

Results and discussion

Sample characteristics Characteristics of the sample are shown in Table 1. The majority of respondents were male (60%), with the mean age of 28.1 years (range 15 to 51 years, median 26 years). Of the 60 interviewees, 58% (n=35) report having previously overdosed, which is comparable to previous research findings in Melbourne (55%, Jenkinson et al., 2004), South Australia (48%, McGregor et al., 1998), and Sydney (68%, Darke et al., 1996). The median number of life-time overdoses was 3 and ranged between 1 and 15 prior overdoses.

TABLE 1

Sample characteristics

<i>Item</i>	<i>Never attempted suicide</i>	<i>Ever attempted suicide</i>	<i>Total sample</i>
Number	43	17	60
Age (mean)	27	29	28
Standard Deviation	9.2	8.6	9.0
Gender (% male)	58	64	60
Education level %			
Primary	9	17	11
Secondary	76	52	70
Trade/tertiary	14	29	18
Unstable accommodation %	35	67	58
Unemployed %	58	64	60
Currently in treatment %	51	64	46
Overdoses (mean number)	1.6	3.4	1.9
Range	0-15	0-15	0-15

Suicide A substantial minority of the interviewees (28%, n=17) reported a previous suicide attempt and 45% (n= 27) reported having suicidal thoughts in the past. Interviewees reported a number of different types of suicidal behavior and responses have been classified into O'Carroll et al. (1996) categories (see Figure 1): Suicide attempts; Instrumental SRBs; Suicidal ideation and Risk-taking thoughts and behaviors. Results are also reported under the category of "Indifference."

Suicide attempts A minority of interviewees (5%, n=3) reported engaging in an acute suicide attempt defined by an increased intent to kill themselves. For example:

I bought \$160 [normal deal \$25] worth and mixed it all up-shot up my arm. Hoping that I would end up dead. Because I am fucking sick of it. And there is nothing to help us get off it. There is nothing at all. There is just no hope. And that's serious. People are just going to keep dying. I think I've had some depression most of my life. I had some problems growing up. I was pretty well discarded as a kid. I'd get depressed and would find that smoking dope doing something else would gratify, sort of, in some sense. Then you could just laugh things off. The great Australian "don't worry about it-she'll be right". Meanwhile, there's an underlying problem that are there all the time. It's why you do the drugs. People do overdose, for the reason that they think there's nothing, there's nothing really left. Unless they're quite happy leading the life of a prostitute. Doing it every day. Because that's really the only way. Selling themselves in one way or another. Otherwise I don't see how you can supply a heroin habit. (John, 39 years)

John's narrative is indicative of an archetypal form of suicide, often played out as an acute episode which was preceded by a period of major depression (Heale et al., 2003). In this case, John clearly wanted to end his life as he perceived that he had "nothing left" and saw no other options. Constant depression and the inability to achieve life goals are clear and well-known motivations for suicide (Shneidman, 1996). Such narratives are similar, to those of Rossow & Lauritzen, who found that "mortality in drug addicts is enmeshed in negative circles of risk-taking behavior, originating both in serious social incompetence and in deep-seated mental problems"

(Rossow & Lauritzen, 1999:271). John's narrative very clearly reports a high level of intent to kill himself and lethality and neatly fits within O'Carroll et al. categorizations.

*Instrumental
suicide related
behavior*

As outlined earlier, ISRB describes the situation whereby a person wishes to use the appearance of intending to kill himself or herself in order to attain some other end (for example to seek help, to punish others, or to receive attention) (Ashworth, 2001). Two interviewees reported engaging in behaviors which would fit this definition. For example:

What made me suicidal was the depression side of it. I got depressed with using, I couldn't find a way out, I heard all these stories that methadone was harder to get off, it's more addictive, so I didn't turn to methadone. Being from a very Christian family I didn't want to turn to any of my family. I just had no way out, you know. I thought I'll try overdosing, that was the first time. Somebody found me. It was really a way of asking for help, I suppose. I knew that by attempting suicide, eventually my parents would find out and eventually they'd approach me with the problem rather than me having to approach them. (Mark, 22 yrs.)

Mark's narrative demonstrates the importance of considering intent when classifying "suicidal behavior" and just how this may affect research results and clinical outcomes. Mark answered that he had attempted suicide, yet in reality, his behavior was not primarily aimed at terminating his own life. In this case, Mark's behavior had a very specific purpose and rather than being about depression, indifference or anger, Mark's behavior was clearly directed at communicating with his family, a pattern of behavior which is well-documented (e.g. Friedman et al., 2005; Veiel et al., 1988).

Suicidal ideation

Almost half of the interviewees (45%, n=27) reported having seriously considered suicide and most of these reported that if they were going to commit suicide, they would do so by using heroin. Indeed, many interviewees state that it is by far the most attractive type of death of which they are aware.

If I'm going to do it, I'm not going to blow my brains out, I'm going to stick a needle in my arm and go to sleep and feel good. (Damian, 29 years)

I always think that if I was going to kill myself heroin would be the best way to do it. (David, 35 years)

These narratives illustrate how the option of death and "going to sleep" is always close at hand for this group of people. Most particularly, the tools used to commit suicide are readily accessible and the actual act of suicide is also an easy extension of their current behavior. Previous research has demonstrated, in relation to firearms (Blumenthal & Kupfer, 1990) and paracetamol (Hawton et al., 2001), that access to the means of suicide can be an important factor in whether or not a person attempts suicide. Thus, access to the functional means of suicide also heightens the risk of self-harm and since IDUs are often in daily contact with large quantities of potentially lethal substances, it is perhaps not surprising that they would use heroin in an attempt to end their lives. It is also worth considering that research has demonstrated that the impulsiveness of suicidal behavior is often fueled by drugs and alcohol (Wyder, 2005). Yet, having a preferred method of dying is not uncommon in modern Western society and is usually related to people's favored activities (i.e. "he died doing what he loved"). Similarly, preferring to die painlessly is not necessarily suicidal in its own right. Thus, while much of the behavior described above clearly falls within the category of suicidal ideation, not all of this type of behavior should automatically be designated as SRB.

*Risk-taking
thoughts and
behaviors*

Using O'Carroll et al. (1996) nomenclature of suicide, risk-taking thoughts and behaviors can be placed into two categories; those with immediate risk (e.g., motocross, skydiving), and those where the risk is more remote (e.g., smoking, sexual promiscuity).

Immediate risk

The most common immediate risk faced by heroin users which might result in death is heroin-related overdose.

I think actually, if you're using heroin anyway, this is what I think, you're risking that anyhow and you are aware of the risks you're taking. I'm well aware, when I use, that this could be my last hit and I could die, but I take that risk anyway. (Lisa, 25 years)

I've OD'd twice and nearly died... Somehow, it doesn't like, phase me. I've seen that many people OD, but it doesn't put me off. (Fred, 27 years)

Well, I was happy not breathing, but they reckoned I needed to breathe. [laughs] Every time they've Narcaned me I've always gone off my head at the ambos, because it gives you the worst fucking headache you can imagine . . . I've always said to me friends and that "If I drop, just bloody walk away, go, leave me." But they won't. . . . Last year I would have dropped and been revived with the Narcan at least half a dozen times. The last time, I came to shackled to a bed in the hospital. That sort of worried me a little bit [laughed] . . . It's part of the game isn't it, guaranteed, you're born to die. How you die, who gives a fuck. I personally understand the risks and what the possibilities of it happening are, but I like to live on the edge of the road, so to speak, whether you're going to fall over or stay up. You've gotta have fun, because you just don't know what's goin to happen. I know the consequences of my actions, so if I'm to die tomorrow it's like "stiff shit, I've lived a good life, a happy life and I died happy. I did what I wanted to do." (Damian, 29 years)

Damian is clearly behaving in a very hazardous manner on a regular basis, placing himself at risk of death as well as apparently not wanting help when he is at risk. This narrative raises the issue of how important death is in comparison to other consequences. As Goffman points out, different people can have very different feelings about the same risk, or its consequences (1967:156). In Damian's narrative, it is clear that his behavior sits between risky behavior and indifference towards his own fate and gives an example of risky behavior which can be easily fitted within the spectrum of SRB.

Damian also demonstrates a considerable amount of bravado towards the dangers he faces. In his case it was clear that this had a great deal to do with his construction of his "self" and the "face" or persona he wishes to portray of the carefree risk-taker. This type of construction of the self has been well described in previous literature surrounding the presentation of the self to the world (Goffman, 1959). It has also been observed in a number of stoic reactions reported throughout the article. For example:

Why worry about it? It's just as likely that you'll have a good whack and then walk across the road and get hit by a truck. (Joe, 31 years)

Ultimately, all risk-taking behavior could also be interpreted as falling within society's behavioral norms. As Goffman points out, all risky behaviors have a degree of reward attached for the individual (1967:174), the real issue is the importance the individual places on the reward, something that varies between individuals. Risk, as well as being definable as a category of SRB, can serve a vast array of functions, from the supply of an endogenous "adrenalin rush" to helping individuals to define themselves both internally and socially. While the majority of research into risk behavior fails to address this, these findings are comparable to the notable exceptions such as Maher et al. (1998), Plumridge & Chetwynd (1998; 1999), and Moore (1993). Studies such as these have illustrated that there are number of activities which are attractive to users often because of their risk element such as the personal or vicarious risk of the heroin scene. Said risk-taking behavior can imbue attitudes of self-respect for those who take such risks. "They have a more or less secret contempt for those with safe and sure jobs and need never face real tests of themselves" (Goffman, 1967:182).

Another relevant concept in the context of this behavior is the notion of "A Hobson's choice" (Goffman, 1967). This is a situation where an individual cognitively reorganizes the consequences of behavior because the chance of adverse outcomes is very great.

"Given the practical necessity of following a course of action whose success is problematic and passively awaiting the outcome thereof, one can discover an alternative, howsoever costly, and then define oneself as having freely chosen between this undesirable certainty and the uncertainty at hand. A Hobson's choice is made, but this isn't enough to allow the situation to be read as one in which self-determination is central. Instead of awaiting fate, you meet it at the door. Danger is recast into risk; favorable possibilities, in to grasped opportunity. Fateful situations become chancy undertak-

ings, and exposure to uncertainty is construed as wilfully taking a practical gamble" (Goffman, 1967:171).

This is risk neutralization technique (as in the quote from Joe, above) has been described in both heroin using populations (Miller, 2005) and other drug users (Peretti-Watel, 2003) as having serious consequences for interventions designed to reduce drug-related harm. For example;

Remote risk Remote risk behavior also falls within the definition of SRB as being potentially self injurious behavior with some (nonzero) intent or instrumentality motivating the act. This type of behavior was most commonly observed in attitudes towards hepatitis C virus (HCV).

I'd say I've got it, because everybody has. (Lisa, 24 years)

Usually you don't care too much. You might ask if they've got Hep C. But you think, well if you've got hep C, I've got hep C, it doesn't matter. (Fred, 27 years)

[There] seems to be a lot more around. I suppose it's like roulette, you know. If you keep on pulling the trigger-you're going to get a cartridge sooner or later. (Peter, 28 years)

It is difficult to imagine that most of the interviewees saw this behavior is being fatal, though it may be, particularly in light of recent research showing a link to overdose death (Darke, 2006). It may also contribute to other fatal conditions in much the same way that smoking contributes to levels of cardiac disease. But the same behavior can lead to Human Immunodeficiency Virus (HIV) transmission and respondents reported very different responses to this disease. The high prevalence of HCV and the very mixed reports of consequences associated with the disease means that many of these IDUs do not regard contracting HCV as a substantial problem, particularly in comparison to other concerns associated with their lifestyle.

Indifference Individuals in this category show little or no intent in their actions, but expressed indifference about the consequences of their behavior. For example:

If you die you don't know about it. I know that sounds real stupid. You hurt everyone you know of, but the thing is, when you're a heroin addict, it's always in the back of everyone's head that there is the chance that you're going to overdose and die, you almost expected it. (Courtney, 20 years)

I'd rather not [die], you know. But sometimes it gets too much. Your broke all the time. You haven't got a roof over your head or you haven't got money for food. You just get sick of the lifestyle. It's a real bugger because it's something you love but you get discriminated against. You know, the way people treat you, even your family. It would be a good way to go, better than cancer. (Peter, 28 years)

You get to a stage where you're pretty much hanging out every day and you just don't care. Hanging out hurts so much, it wouldn't really matter if you died. Sometimes you just think, I'd be better off dead, you wouldn't have to put up with this all the time. (Dave, 22 years)

Much of the thinking expressed above can be described as being motivated by "unbearable psychological pain and frustrated psychological needs" (Shneidman, 1996). Many interviewees expressed hopelessness-helplessness and a cognitive state of indifference (individuals would be happy not to engage in risky behavior if they did not "have to"). Such characteristics have frequently been identified in heroin using populations (Plumridge & Chetwynd, 1999). These narratives lend weight to the proposal that the indifference towards death may turn out to be a rationally based response to "social isolation, meaninglessness and anomie, so characteristic of social life in the 20th century" (Kellehear, 1984:715). They illustrate that when society "dislodges individuals from the social fabric of society, thwarts their aspirations or drives them excessively, it may subsequently induce suicide" (Travis, 1990:238). Practices such as these manage the affective response associated with fatefulness, acting as the defense against feelings such as anxiety, remorse and disappointment.

Narrative responses showed that many interviewees (n=28) were either indifferent or fatalistic about death being the worst possible consequence of their actions.

Well, I surely don't want to die, but it doesn't make me not want to use. If it did I wouldn't use any more, because I've dropped a few times. It hasn't frightened me off enough. I know if I die, I'll just go to sleep any way, I just don't wake up. (Wayne, 51 years)

Wayne presents a typical response, reporting that while he is well aware of the consequences of his heroin use (having recently experienced overdose), he does not view death as being entirely negative. This narrative illustrates that while some interviewees did not wish to die, they are indifferent towards that outcome. However, it can also be seen that Wayne is only indifferent to what is a romanticized version of the type of death he would experience using heroin. Yet this romanticized version of an ideal death can be seen to increase the likelihood of SRB in this population as previous research has repeatedly demonstrated that people who have a decreased fear of death are more likely to commit suicide (Orbach, 2003). In the context of the lives described by many interviewees, suicide may not be an entirely irrational behavior, particularly when considering this aspect of overdose being "a nice way to go." It has similar overtones to religious notions of going to a better place and may fit within notions of "a good death."

However, some of the interviewees were focussed on the rewards they draw from their risk-taking behavior:

I reckon that was the best feeling, overdosing. The best feeling ever. The first time I ever felt so stoned. It was just the best feeling ever. There was a time when I was apparently dead. It was grouse [fantastic], I felt like I was asleep and I was just going through this full trippyness. It was the best feeling. (Casey, 15 years)

As with Damien's earlier quote, there may be elements of bravado incorporated within this narrative. Clearly, when the effect desired from drug use is on the verge of overdose/death, health promotion messages would appear to be of little relevance. Casey is also portraying herself in a heroic light as an adventurer and also seemed to enjoy shocking people because she was so young. While such attitudes

and behaviors can easily be pathologized, they are also within the range of normative behaviors observed in contemporary Western society. As Dubos proposes: "Man could escape danger only by renouncing adventure, by abandoning that which gives the human condition its unique character and genius among the rest of living things" (1987:281).

Occupational hazard

A specific discourse within the category of indifference was that death was an occupational hazard of heroin use. As with the previous discussion, interviewees identified that although they did not actively seek death, it was seen as a real possibility, or occupational hazard, in their daily lives.

I'd say that everyone is afraid of dying. Being a user, you're upping your odds a little bit. Not a lot of people think about that before using, they just want to get that taste into them. (Steve, 38 years)

Dropping is really an occupational hazard. When your number's up, your number's up. (Joe, 31 years)

Viewing death as an occupational hazard of drug use may be interpreted as SRB within O'Carroll et al.'s nomenclature of SRB because it is potentially self injurious and it could be interpreted that there is some (nonzero) level of intent. However, the line is clearly very thin in this category and individual cases may fall on either side of that line. While this attitude may be viewed as fatalistic, it can also be seen as a matter-of-fact response to the very high death rate among heroin users. Accepting risk as an occupational hazard may tacitly be denying any sense of agency towards risk behavior, thereby minimizing the degree to which someone engages in risk avoidance behaviors. However, the idea of an "occupational hazard" is common among other groups within Western society that engage in high levels of risk behavior (Albert, 1999) and the concept is employed widely to deal with situations which, on-the-whole, have little to do with the individual's behavior and are more related to societal norms which create risk environments (Rhodes, 2002). In the context of prohibition inhabited by these interviewees, heroin use ultimately creates an "unavoidably risk-laden nature" which

leaves the IDU no other option than to reasonably accept death as an occupational hazards of heroin use (Moore, 2004; Rhodes, 2002; Rhodes et al., 2003).

Realistically though, the dynamics outlined in the discussions above may not be only ones at play. Responses which report indifferent attitudes towards death may, in fact, be expressions of stoicism which is also a culturally recognized response to an impossible situation. It may well be that interviewees are presenting a stoic "face" in an attempt to maintain their presentation of the self in the face of a social and cultural environment which leaves the individual drug user with little self-respect or control. As Goffman proposes, "in social situations, then, ordinary risks and opportunities are confounded by expressions of make-up" (1967:168). Therefore, social situations (such as research interviews) become opportunities for introducing favorable information about oneself, just as they become risky occasions when unfavorable facts may be established. In contemporary Western society, healthiness imperatives have become social signposts of moral worthiness where labels of "risky" and particularly "unhealthy" equate to immoral and deviant (Peretti-Watel & Moatti, 2006; Petersen, 1996). In the context of an interview discussing such marginalized behaviors, interviewees may (not necessarily consciously) respond in a manner which allows them to construct and maintain a version of the self which they find attractive and acceptable to present. This stoic stance may allow the heroin user to preserve a heroic self-image in the midst of their reality in line with societal norms related to the presentation of the self. "It was a sense that, knowing the dangers involved, they were the type of person who could "hack it" and this set them apart from others who were too scared of the risk or worried too much about their safety" (Denscombe, 2001:172). In light of this, attributions of suicidality regarding indifference towards death require considerable reflection about the functionality of stoic and fatalistic responses.

The question remains whether the behavior described above is ultimately appropriate to incorporate into the spectrum of SRB. O'Carroll et al. (1996) distinguish between *zero* and *any* intent to kill oneself. Using this definition, it can be seen in the narratives above that it is reasonable to assert that interviewees are *not* exhibiting *zero* intent to die and are engaging in a lethal behavior. Yet it should be noted that indifferent attitudes also have a functional element, and may there be interpreted as being instrumental. Therefore, indifferent attitudes towards death should be included within a nomenclature of suicide under the category 2,B,i),(2)—Other ISRB (see Figure 1).

Summary It was repeatedly observed that many of the behaviors and attitudes reported by the interviewees fitted within the definitions of SRB. It is also clear that SRB can be distributed across a number of categories and that using the nomenclature outlined by O'Carroll et al. provides a promising structure for the description of SRB in heroin using populations. Indifferent attitudes towards death can be included within that nomenclature under the "Other ISRB" category (see Figure 1). However, the findings also demonstrate the importance of not being overinclusive when categorizing SRB. People who use heroin problematically have a unique relationship with death and SRB, both because of their social isolation and the pharmacological properties of their drug of choice and it is important that the ambiguity and indifference so often seen in this client group be acknowledged and documented. Conversely, not all the behaviors which might be seen as SRB are based on an intent to kill oneself and some represent a mechanism for dealing with the individuals' risk environment and maintaining their sense of self worth.

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Notes on contributors

SVETLANA POPOVA is a postdoctoral fellow in the Social, Prevention & Health Policy Research Department at the Centre for Addiction and Mental Health, 33 Russell St., Room T406, Toronto, Ont. M5S 2S1, Canada; Lana_Popova@camh.net). Her main research interests include addiction, mental health, and evidence-based regulatory policies in the areas of substance abuse and mental health. **JURGEN REHM** currently holds the positions of Professor and Chair, Addiction Policy, Public Health Sciences, Faculty of Medicine, University of Toronto, Canada; Senior Scientist and Co-head, Section Public Health and Regulatory Policy, Centre for Addiction and Mental Health, Toronto, Canada; and Director and CEO, Addiction Research Institute, Zurich, Switzerland. His main research interests are in addiction and public health, including economic aspects of addiction. **JAYADEEP PATRA** is a doctoral candidate at the Department of Human Development and Applied Psychology of the University of Toronto, and a research associate at the Centre for Addiction and Mental Health, Toronto, Canada. His main research interests center around addiction, drug intervention, public health, cost analysis, and methodology.

JESSICA PALM is a scientist at the Centre for Social Research on Alcohol & Drugs of Stockholm University (Sveaplan, 106 91 Stockholm, Sweden; jessica.palm@sorad.su.se). Her interest in the interplay of concepts and practices in alcohol and drug treatment systems is reflected in her recent dissertation, *Moral Concerns—Treatment Staff and User Perspectives on Alcohol and Drug Problems (2006)*, which included the present paper.

GRAZYNA ZAJDOW teaches sociology in the School of History, Heritage and Society at Deakin University (221 Burwood Highway, Burwood, Vic. 3125, Australia; graz@deakin.edu.au). She is currently undertaking research on the ways that people in drug treatment understand such concepts as freedom, autonomy, and choice in their lives. She is the author of *Al-Anon Narratives: Women, Self-Stories, and Mutual Aid (2002)*.

PETER G. MILLER is a health sociologist employed as Senior Clinical Research Worker at the National Addiction Centre, King's College, London (PO48 – Addiction, 4 Windsor Walk, Denmark Hill, London SE5 8AF,

U.K.; P.Miller@iop.kcl.ac.uk). He also acts as Addictions Advisor to the Pilgrim trust and the J. Paul Getty, Jr. Charitable Trust. His research interests include the social theory and the ethics of harm reduction, fear of death and suicidality, and the ethical, theoretical, and practical issues around implementing a prescription heroin trial.

KATE SENIOR is a medical anthropologist who is Head of Education and Training at the Menzies School of Health Research (PO Box 41096, Casuarina, N.T. 0811, Australia; Kate.Senior@menzies.edu.au). She has been working with communities in South East Arnhem Land for the past six years. Her work has focused on people's understanding of health and their health services, the lives and aspirations of young people in the community and substance misuse. **RICHARD CHENHALL** is a National Health and Medical Research Council Research Fellow and medical anthropologist at the Menzies School of Health Research, engaged in a study of best practice guidelines for evaluating indigenous residential alcohol and drug programs. He is the author of a forthcoming book, *Belong's Haven: Recovery from Alcohol and Drug Misuse in an Australian Aboriginal Residential Treatment Centre* (2007), and a co-editor of *Social Determinants of Indigenous Health* (2007). **DAPHNE DANIELS**, at the time of writing this article, was the assistant CEO of the Yugal Mangi Community Government Council. She is now working as a reporter on the local community newspaper, *The Ngukurr News*, and has been involved in research in her own community for the last six years and is also a member of the regional community-controlled health board.

BARRY GOETZ is an Associate Professor of Sociology at Western Michigan University (Kalamazoo, MI 49008-5189, U.S.A.; barry.goetz@wmich.edu), where he also teaches in the criminal justice program. His research interests include on social control issues related to policing organization and reform, drug control policy, and the links between white collar crime and social inequality. **ROGER E. MITCHELL** is an Associate Professor in the Department of Psychology at North Carolina State University. His research interests include the impact of psychosocial factors on health, as well as ecological factors influencing the implementation of effective health promotion programming. In particular, he has been interested in the role of community coalitions and community-based initiatives in implementing substance abuse prevention.