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HE KOHA AROHA KI TE WHĀNAU: DELIBERATE SELF HARM AND MĀORI WHĀNAU

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for the degree of Doctor in Clinical Psychology
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Abstract

Deliberate self-harm (DSH) is a significant social problem facing young Māori (the indigenous people of New Zealand) today. Whānau, a concept meaning family and including extended family, is an essential factor in the well-being of Māori. Little is known about family members' reactions to a child's DSH or their needs following DSH, especially with Māori. Some research with non-Māori suggests that both the impact of DSH and consequent needs of family members may be considerable, yet often neglected. This study examined the impact of their children's DSH on Māori whānau, beliefs about the motives for the young person's DSH, and needs following the event. The whānau of ten young people, aged 10-18 years, presenting to a Child and Adolescent Mental Health Service following DSH were interviewed about the impact of the DSH, perceived motives for DSH and their needs. Five Māori clinicians were also interviewed about these topics. Interviews were recorded, transcribed, and subsequently analyzed using thematic analysis. Seven themes were identified from whānau ideas regarding motives for DSH: to communicate distress and seek help, to punish someone, to get relief from a distressing emotional state, due to the influence of others, as a response to feeling overwhelmed by difficult circumstances, to die, and the cultural influence of matakite. Clinicians presented similar motives; however, they did not mention matakite and included DSH being precipitated by social isolation. When discussing impacts of DSH, whānau reported that DSH had affected the entire whānau as well as having an effect on parents; including an emotional impact, an impact on parenting, and the concept of mental health was described as being difficult for parents to come to terms with. On the other hand, participants reported improvement in relationships within their whānau following DSH. Whānau also reported that DSH had resulted in practical difficulties. Themes derived from clinicians were similar; however, they did not discuss the effect of DSH on relationships. Whānau and clinicians both reported the need for greater levels of support and information. Implications are presented for the delivery of mental health services for young Māori and their families.

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Ehara taku toa i te toa takitahi, engari he toa takitini ke

My strength does not come from me alone but also from others

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CHAPTER ONE

Introduction: Te Whakatuwheratanga

Ma te mohio, ka hua ko te maramatanga

Only from the gaining of knowledge can there be understanding

This study is a qualitative research project that looked at the effects or impact of their children's deliberate self harm (DSH) on Māori whānau (a concept meaning family and including extended family). A related aim of this study was to examine the needs of families following DSH by their child. Needs are likely to be influenced by the effect or impact that DSH has on families, which in turn is likely to be influenced by family members' assumptions about the reasons for DSH. Therefore, it was considered important to explore perceived reasons for DSH, as well as impacts and needs.

Adolescent suicide and DSH are subjects of great concern in New Zealand (NZ) today. At a national level, there is concern about the high rates of youth suicide and youth presenting to hospitals following DSH. At a personal level, the young person and their family attempt to make sense of a behaviour that often seems incomprehensible. As noted above, this thesis aims to examine the impact of their child's DSH on Māori primary caregivers, and the needs of Māori primary caregivers following a child's DSH. The outcomes from the study may add to the body of knowledge held by those who provide services to Māori young people and their whānau following DSH. Consequently, recommendations will be made to child and adolescent mental health services (CAMHS) that will potentially aid them in better meeting the needs of Māori whānau following the DSH of their child. Whānau plays an important role in the mental health of

Māori, yet no research exists on the effects of DSH on Māori whānau and their needs or perceptions following DSH.

I have not had any direct experience with DSH or suicide within my family or social networks. My interest in the area of DSH was initially sparked when working as a community support worker in a rehabilitation-based mental health unit for adults with a diagnosis of borderline personality disorder. A large proportion of these adults engaged in DSH and I often wondered if, had they received appropriate help in childhood or adolescence, would things have turned out this way?

My interest grew while completing my clinical psychology Honours year. While learning about youth risk assessments I was surprised to find that, even in a psychologically educated population, a number of people considered DSH to be a form of manipulative attention seeking and nothing more. Furthermore, the published literature attributed a number of meanings or functions of DSH to individuals who engaged in this behaviour but only a small number of studies revealed the opinions of friends and family members. Literature examining DSH in a cultural context was also lacking.

As a person with Māori whakapapa (genealogy) I found literature including whānau notably absent. I belong to the Ngati Awa iwi (tribe) and Ngati Hokopu ki Wairaka hapu (sub-tribe), naming Mataatua as my waka (canoe). It was because of this that it was important for me to have a kaupapa Māori influence on my thesis. In order to help achieve this I began spending time with He Kākano, the Māori clinical team at Whirinaki CAMHS in East Tamaki. During this time I engaged in the process of whakawhānaungatanga (identifying and creating relationships, sharing of kinship and links) with the team and collaborated on a topic. Whakawhānaungatanga is an important part of Māori custom and of kaupapa Māori research, which will be discussed later in this chapter. The area of DSH in Māori youth was decided upon as an area of both importance and interest to many people.

My research includes a family impact aspect that I felt was important for research on DSH with Māori. This project focused specifically on Māori and had the ongoing support and cultural guidance of the taurawhiri (cultural advisors) at Whirinaki CAMHS and the He Kākano team, as well as the clinical guidance of Dr. Ainsleigh Cribb-Su'a and Professor Fred Seymour.

DSH and suicide by children and adolescents are highlighted as important targets in the national suicide prevention strategy (Associate Minister of Health, 2006). The needs of adolescents who present to hospital following DSH are emphasised by the NZ national guideline on self-harm (National Institute for Clinical Excellence, 2004; New Zealand Guidelines Group & Ministry of Health, 2003). Public concern and interest has also been increasing over the years and much effort has been put into developing the youth suicide prevention strategy (Associate Minister of Health, 2006).

DSH is encountered frequently in mental health settings. Suicide Prevention Information NZ (SPINZ) reported that in 2008 there were 2465 hospitalisations for DSH, equating to a rate of 151.7 per 100,000 people (SPINZ, 2010). DSH is found in a wide variety of people, including those with substance abuse, depressive, anxiety and eating disorders, as well as those with post traumatic stress disorder, schizophrenia and each of the personality disorders, especially borderline personality disorder (Haw, Hawton, Houston, & Townsend, 2001).

In 1994-2000 the Injury Prevention Research Unit (IPRU) reported suicide as being in the top ten leading causes of death in NZ for those in all age groups from 10-64. Suicide was said to be the second leading cause of death for those aged 15-24 and the third leading cause of death for those aged 10-14. DSH is noted as a major risk factor for completed suicide and this relationship will be discussed later in this chapter (IPRU, 2008).

It has frequently been noted that DSH and suicide rates among indigenous populations are high. Clear disparities have been shown to exist between the suicide rates of the indigenous people compared with that of the colonists in numerous countries including, NZ, Australia and the United States of America (USA).

As noted above, there are significant gaps in the literature on DSH with regards to Māori and family. Whānau may be especially important when working with Māori clients and yet, at the time of writing I was not aware of any studies in this area. In Māori models of mental health, such as Te Whare Tapa Wha (Durie, 1994), the moral order is clear: one cannot be healthy in isolation and therapy may not be effective if important relationships, such as those with whānau are not restored (Nairn, 2000). Furthermore, examining the needs of Māori clients fits with Te Tiriti o Waitangi (the Treaty of Waitangi) and Māori peoples ultimate aim of Tino Rangatiratanga (self determination) in regards to health services and delivery (Nairn, 2000). Māori may have different concepts of health and illness than non-Māori, and consequently, service providers using Western interpretations of psychiatric phenomena may form invalid opinions (Tapsell & Mellsop, 2007). This study may aid services in providing treatment that best reflects the needs, processes, beliefs and values of the tangata whenua (indigenous people).

The following chapter will provide a brief discussion of kaupapa Māori research, the importance of this study, as well as define DSH before looking briefly at its history. Attitudes to DSH will then be discussed, as well as the relationship between DSH and suicide. Next, the functions of DSH and its prevalence and incidence will be noted, followed by DSH in the familial context and then risk and protective factors. Finally, different methods for the treatment and prevention of DSH will be examined.

Before proceeding further, it is necessary to offer a word of caution in regard to the use of the word Māori, in discussion with taurawhiri the point was raised that care must be taken when using the world Māori, as generalisation is not that simple. Different iwi and hapu may have varying beliefs as well as differing dialects and practises.

Tribal connections, while discussed at the beginning of interviews, were not included in the research and may provide a limitation. The term Māori will be used through this research in a general context. This was decided with cultural consultation and was considered appropriate given that most participants used the word ‘Māori’ when describing themselves or their system of beliefs and this research aims to accurately portray the respondent’s sentiments.

However, it was felt that it was important to point out that Māori are not a homogeneous group, as generalisation may weaken iwi and hapu separations and also allow non-Māori to adopt unhelpful stereotypes. It is hoped that this is something the reader will consider throughout this thesis and beyond.

Kaupapa Māori Research (KMR)

KMR developed out of a much larger movement by Māori in an attempt to question “westernized notions of knowledge, culture and research” (Walker, Eketone, & Gibbs, 2006, p.331). ‘Ka piki te ora o te iwi Māori’; it has been said that anything that benefits Māori may be KMR (A. Herbert, personal communication, August 22, 2008). However, KMR is also not that simple. KMR is not only a methodological strategy; it is a philosophy, a system of beliefs and a form of resistance and agency (Walker et al., 2006). It is because of this that some authors suggest it is unwise to attempt to define KMR. Nevertheless, KMR is often described as research that is done by Māori, with Māori, for the benefit of Māori. There seem to be five main principals which make up the framework of KMR. They are Māori world view, Te Reo Māori (the Māori language), whānau (family), social justice, and Tino Rangatiratanga.

KMR gives full recognition to tikanga Māori (Māori customs and protocols), as well as Māori beliefs and values. It is therefore important that the researcher is competent in things Māori, as a special approach to knowledge is required. KMR aids the researcher in organising their research, and certain customs need to be applied to ensure that Māori protocols are adhered to (Walker et al., 2006). Whakawhānaungatanga is an important concept in the everyday lives of many Māori, as well as in research done by Māori, with Māori. Whakawhānaungatanga allows connections to be made between the researcher and the participants which permits the sharing of in-depth information (Walsh-Tapiata, 2003).

Ideally researchers should also have some understanding of Te Reo Māori, as KMR aims to promote its revival (Walker et al., 2006). Te Reo Māori is full of images and metaphors, and is useful in gaining information and perspectives that would otherwise be unobtainable. Māori language should be used when possible in KMR; however, in reality many researchers and participants are not fluent in Te Reo Māori and a mix of English and Māori languages may be used.

Māori are viewed as a collectivist culture and the idea of a collective is vital in understanding the concept of whānau. Whānau not only refers to immediate family but to extended family and tribal connections and helps to ensure that Māori have a shared vision of research, as it enables research to be directed and knowledge defined by the group (Walker et al., 2006). The practices of cooperation and reciprocity are also closely linked to the concept of whānau and it is important to remember these as a researcher (Jahnke & Taiapa, 2003).

The key concepts of social justice and Tino Rangatiratanga in KMR both emerge from the Te Tiriti o Waitangi. The principal of social justice strives to redress the power imbalances in research and health care and create concrete benefits for Māori (Walker et al., 2006). Tino Rangatiratanga is closely linked with this; it relates to the independence of Māori and is about a "Māori centred agenda where the issues and needs of Māori are the focus and outcomes of research" (Walker et al., 2006, p. 333).

The above has provided only a very brief attempt at describing KMR and is by no means meant as a comprehensive 'how to' guide. I felt it was important to describe my understanding of what KMR entails in order to give a context to my processes as a researcher. As a researcher and a Māori I have some knowledge of Te Reo Māori and of tikanga and am competent in research. However, I was constantly seeking research supervision, cultural advice and supervision, as well as attempting to improve my Te Reo by helping out at a local kohanga reo (Māori language preschool) and participating in a local kapa haka (Māori performing arts) group.

Whakawhānaungatanga is something that has always been important to me and as mentioned above, was something I sought to establish with the clinicians I worked closely with. It was also something I sought to achieve with participants by offering kai (food) or koha (a contribution or donation for their time) and by discussing my whakapapa (genealogy); this will be discussed later in the methods section. This project also fits with KMR in that the needs of Māori are the focus and the aims are to benefit the Māori community.

Understanding DSH and Suicide

Defining DSH

DSH is not an entirely modern concern; the behaviour of DSH is an ancient one. DSH is seen as early as ancient Greece, with Hippocrates humour theory stating that a person may rebalance themselves by the letting of blood (Favazza, 1998). DSH is also mentioned in the bible, with the Gospel of Mark making reference to a man who deliberately cut himself with stones (Mark 5:5, King James Version).

Favazza (1998) stated that the first published medical report of DSH appeared in 1846 and referred to a ‘manic-depressive’ woman who gouged her own eyes out after reading the Gospel of Matthew in the bible which mentions the removal of an offending eye. Reports of DSH in 19th Century literature mainly consist of eye removal and self-castration (Favazza, 1998).

Clinician and researcher interest in DSH, particularly wrist cutting, grew in the 1960’s. At first DSH was seen as a problem only affecting unmarried young woman and was focused solely on wrist cutting, excluding individuals who cut other parts of their bodies (Favazza, 1998). This idea changed in the 1980’s with considerations of other forms of DSH and the biological and behavioural influences being considered when describing and accounting for DSH. DSH started to be seen as something resulting from mental illness that affects men as well as women (Favazza, 1998). Pattison and Kahan (1983) also developed a model for something they called “self-harm syndrome”. It seems that this decade also witnessed the beginning of the debate over the definition of DSH. In modern times, DSH is not a recognised disorder in itself: its only mention in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychological Association, 2000) is as a symptom of other disorders.

Current knowledge of DSH is limited, especially with regards to culture. Understanding DSH is vital in order to provide effective treatments, a task that takes on more urgency as DSH appears to be increasingly common, as reported by research, as well as anecdotal evidence from clinicians at CAMHS (Fortune & Hawton, 2005).

DSH may mean different things to different people, thus it is important to have a clear definition of DSH at the outset of a project such as this thesis. Definition of terms is essential in facilitating communication and minimizing confusion among professionals working to understand and prevent suicide and DSH (O'Carroll, Berman, Maris, & Moscicki, 1996). Attempts have been made to generate classification schemes of suicidal behaviour (Fortune, 2003). However, DSH has been difficult to define, with little agreement on any one definition. DSH has been called a number of different terms including, self injury, self injurious behaviour, cutting, and self mutilation (Whitlock, Powers & Eckenrode, 2006). A review of the literature or a discussion with a colleague will draw attention to the interchangeable nature of such terms as DSH, self mutilation and attempted suicide.

There is particular disagreement as to whether the term DSH excludes those who have suicidal intention or ideation. Suicidal intent in adolescents is often complex and obscure and therefore difficult to determine (Hurry, 2000). Adolescents who engage in DSH are often ambivalent about their DSH, and occasionally their lives, and experience fluctuating mood states, making it difficult to obtain clear information regarding intent, particularly retrospectively (Fortune & Hawton, 2007). Wagner, Aiken, Mullaley and Tobin (2000) also noted that the aftermath of DSH may influence self-reported intent. For example, a young person may want to be discharged from hospital and therefore assures the assessor that the act was an accident, or they may be attempting to reduce the fear and anxieties of their parents by downplaying their intent to die (Fortune, 2003). Adolescents are also known to take part in activities that carry high risk and they may underestimate the lethality of their DSH (Fortune & Hawton, 2007). Conversely, adolescents may intend to die but choose a method that is relatively benign; for example, adolescents tend to have inadequate knowledge about the lethality of substances used for overdose (Fortune & Hawton, 2007). Largely, for these reasons, the World Health Organisation (WHO) prefers to exclude intent from definitions of DSH (Cantor & Neulinger, 2000).

The exclusion of intent to die becomes difficult, however, when considering culturally sanctioned self harm. DSH behaviours that are culturally sanctioned include body piercing and tattooing, body modifications in religious activities and rituals that maintain social order (Favazza, 1998). With some Māori the beating of the chest and scratching of oneself to the point of drawing blood is seen as acceptable displays of grief at a tangi (funeral). Such socially sanctioned DSH is unlikely to result in an admission to hospital or presentation at mental health units and is therefore not considered DSH in this thesis.

For the purpose of this research DSH will be defined as any self-injurious act that is not culturally sanctioned, with a non fatal outcome, including cutting, burning, self poisoning, hanging, jumping from a height and running into traffic (see also, Fortune & Hawton, 2007; Hawton, Rodham, Evans & Weatherall, 2002). Given the difficult nature of establishing intent, as well as the strong connection between DSH and suicide, intent was not considered in recruitment for this research.

Relationship between DSH and suicide

Several young people contemplate suicide at some point in their lives, many engage in DSH, some attempt suicide, and far fewer actually succeed (Fortune, Seymour & Lambie, 2005). Despite considerable debate regarding definitions most researchers agree there is a strong relationship between DSH and suicide.

DSH often leads to repeated DSH and occasionally to suicide (Cooper et al., 2005; Owens, Horrocks, & House, 2002). Individuals who carry out DSH make up one of the highest risk groups for eventual suicide (Harris, Hawton, & Zahl, 2005; Nock & Kessler, 2006; Owens et al., 2002). The rate of suicide for those who engage in DSH is said to be hundreds of times higher than that of the general population (Jenkins, Hale, Papanastassiou, Crawford, & Tyrer, 2002; Owens et al., 2002). Diekstra (1989) argued that as many as 10-14% of individuals who engaged in DSH could die by suicide. More recent literature shows that approximately 2% of individuals who injure themselves died as a result of suicide in the year following the initial act of DSH and after nine years as many as 7% had died (Owens et al., 2002). Whatever figures are used, the fact is young people who engage in DSH are at a much greater risk of suicide than the general population.

While recent evidence suggests that DSH and suicide co-occur, the nature of this relationship is unclear (Whitlock & Knox, 2007). A number of researchers suggest that suicidal behaviours operate on a continuum, ranging from suicidal ideation to suicide attempt (Fergusson & Lynskey, 1995). Some practitioners have proposed that DSH increases risk of suicide due to the fact individuals habituate themselves to the fear and pain associated with DSH, therefore gaining the capability to carry out actual suicide (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Whitlock and Knox (2007) point out that DSH and suicide “appear to share several important correlates" (p. 634). These include depression, substance abuse, and constriction of cognitions, as well as dysregulation of the serotonin system. They also note differences between acts of DSH and suicide, including the presence of intent to die, levels of hopelessness and lethality of methods. However, de Wilde (2000) argues that reported differences between those who engage in DSH and those who complete suicide have been overestimated.

Attitudes toward DSH and suicide

Societal and familial values and beliefs may inhibit or legitimize DSH and suicide (Bagley & Ramsay, 1997). These values and beliefs may also influence compliance with, and adherence to, treatment. Negative attitudes held by health professionals may also lead to a reduction in care (McCann, Clark, McConnachie, & Harvey, 2006).

The notion of suicide as a morally reprehensible act in Western culture is strongly influenced by prevailing Judeo-Christian beliefs (Fortune, 2003). Until as recently as the 1960's and 1970's suicide was a crime in most Western countries (Cantor, 2000). Laws are largely influenced by religious and moral beliefs, although less obviously in modern times. However, religious influences may still act as deterrents to suicide. In Christian religion, God is seen to both give and take life, thus taking one's own life is seen as a sin against God. Cantor reports suicide rates tend to be low in countries that adhere to orthodox teachings. Hirini and Collings (2005) mention in their work 'Whakamomori, a collection of contemporary views on Māori and suicide' the "increasing secularisation of society and the reduced influence of the Church and general codes of moral conduct" as a possible reason for the high rate of suicide among Māori (p.13).

Attitudes and beliefs regarding suicide appear to be changing, with differences occurring between generations. Bagley and Ramsay (1997) reported that younger people, in contrast to their parents, held views on suicide that are less judgemental, persecutory and stigmatized. These attitudes may influence whether or not a young person engages in suicidal behaviours, including DSH. The attitudes of parents may affect their likelihood of intervening, as well as the type of intervention taken or sought (Bagley & Ramsay, 1997).

As mentioned above, attitudes held by those in professional care-giving roles can influence the quality of service given, which may influence compliance with, and adherence to, treatment. Sanders (2000) showed that Accident and Emergency nurses hold negative attitudes towards certain types of patients, including those who engage in DSH behaviours. In an Australian study, McCann et al. (2006) showed nurses' attitudes towards patients who engage in DSH vary between undecided and somewhat supportive, suggesting attitudes may be becoming more tolerant. This study supports the general idea of changing attitudes to DSH and suicide. These changes may reflect increased education about DSH in nursing courses or greater public education regarding DSH and suicide.

Attitudes and beliefs regarding DSH have not been as widely researched as those regarding suicide. Favazza (1987) writes, "In the vast repertoire of human behaviours, self-mutilation ranks among the least understood and the most puzzling" (p. ix). DSH often defies comprehension and rationalization, and can elicit anger, disgust and fear (Favazza, 1987) as well as guilt, shame and embarrassment among family members and caregivers (McDonald, O'Brien, & Jackson, 2007). Although attitudes and beliefs toward both suicide and DSH appear to be slowly changing, they are said to still be in states of flux around the globe (Cantor, 2000).

Prevalence and Incidence of DSH and Suicide

The following section is divided into two parts. The first part presents data on suicide deaths and the second part, data on DSH. At the time of writing NZ statistics were available for 2008, having been printed in 2010.

For the purpose of this research NZ data on suicide and DSH was obtained from the Ministry of Health (MoH), which sourced some of its information from the NZ Health Information Service (NZHIS), and from the Youth 2000 survey (Adolescent Health Research Group (AHRG), 2004). The Youth 2000 survey is a national survey of health and wellbeing that was conducted with 9699 students from 133 secondary schools in NZ in 2001. Students completed the questionnaire by means of a computer assisted self interview. This study was the first of its kind in NZ and provides valuable information on the current functioning and wellbeing of NZ youth.

All deaths in NZ that are suspected of being a suicide are reported to a coroner, investigated by the police, and are subject to a coroner's inquest, reducing the chance for the death to be misclassified (Beautrais & Fergusson, 2006). According to the MoH, youth suicide covers those aged 15-25 years old. Difficulties in this definition must be noted, as it does not correspond with developmental definitions of adolescence, which generally span 12-18 years. It also does not relate to mental health and educational service definitions which end at 18 years.

In this section the definition of terms comes directly from a MoH report (MoH, 2010) where the term "number" refers to the actual number of people who have died by suicide and the term "rate" refers to "the frequency with which these events occur relative to the number of people in a defined population and a defined time period" (p. 69). Age-standardised rates refer to rates that have been adjusted to take account of differences in the age distribution of the population over time or between different groups; for example ethnic groups.

Suicide

Suicide results in approximately 500 deaths per year in NZ. This number is higher than the national road toll. In 2003 suicide was the ninth most common cause of death in the NZ population (MoH, 2006b). In 2008, 497 individuals died by suicide, compared with 483 in 2007. The age-standardised suicide rate for the total population of NZ in 2008 was 11.2 per 100,000 population, compared with 11 per 100,000 population in 2007. Figure 1 (below) provides a general picture of completed suicide trends in NZ. Figure 2 (below) provides age specific suicide rates for 2008. This figure demonstrates the high rates of youth suicide in NZ.

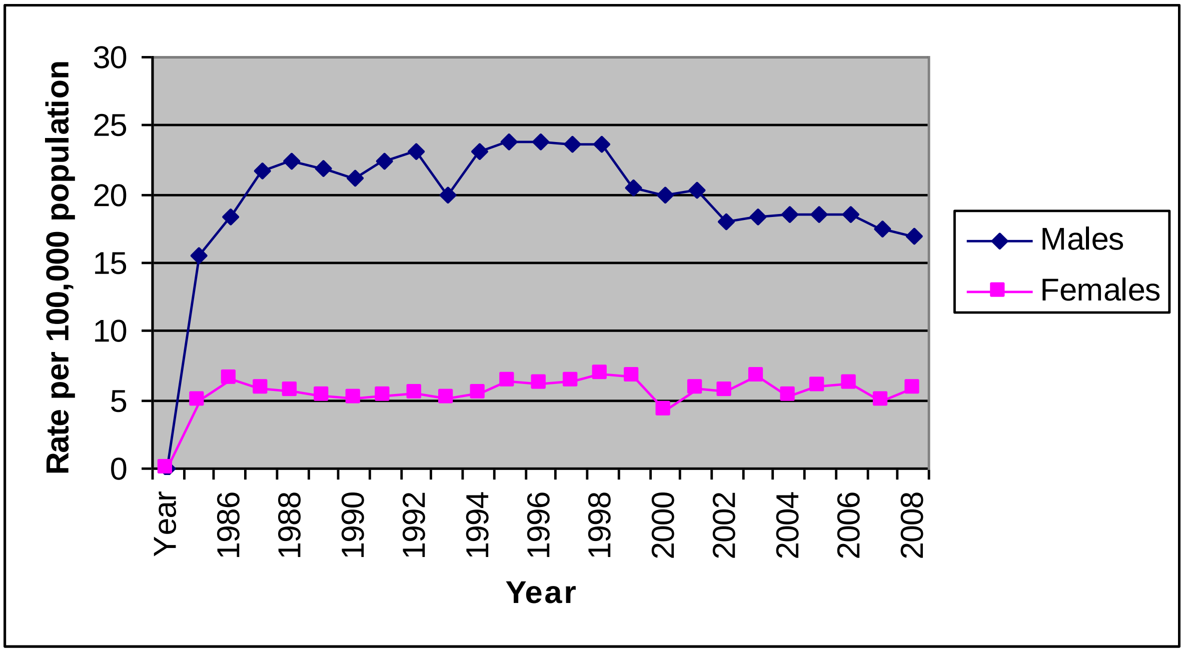

Figure 1. Age-standardised suicide death rate, by sex, 1985–2008 (MoH, 2010).

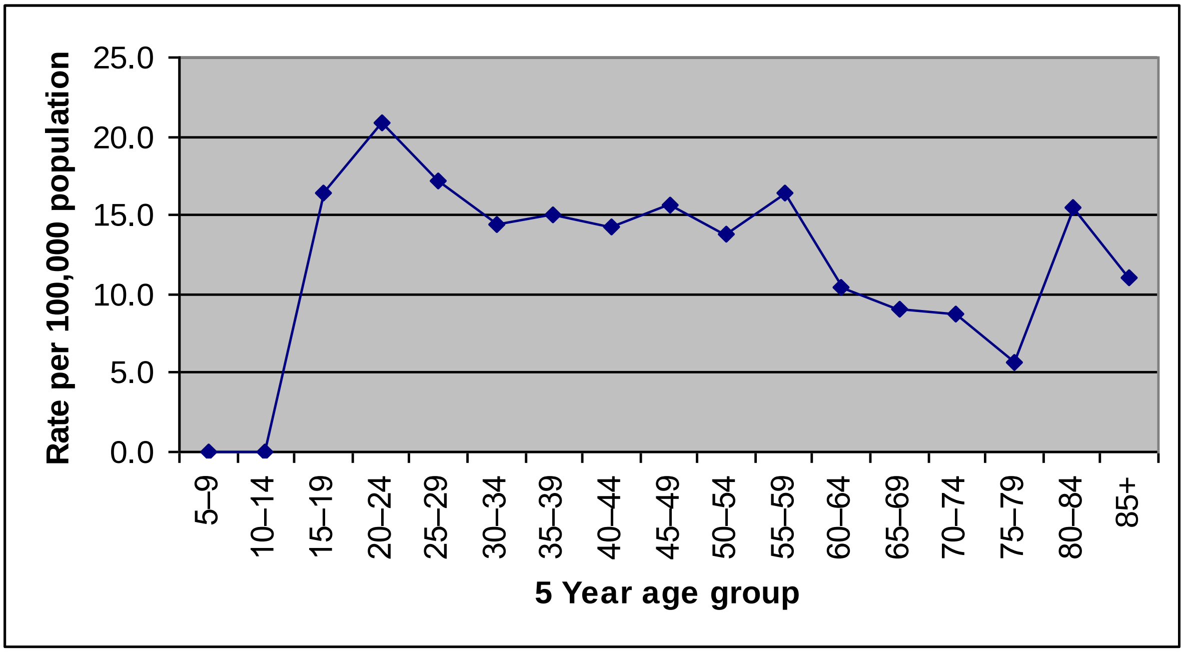

Figure 2. Suicide death rate, by age group, 2008, (MoH, 2010).

Suicide among children and adolescents

Thoughts of suicide are common among youth and although most students who took part in the Youth 2000 survey had not engaged in suicidal behaviours, some students were still considered to be at high risk of suicidal behaviours (AHRG, 2004). In this survey suicidal behaviours included, serious suicidal thoughts, making a suicide plan, deliberately harming or hurting oneself, and attempting suicide. The AHRG reported that in secondary schools those age 15 years had the highest rate of reported suicidal behaviours. Among 15 year olds who were interviewed, 33.9% of females and 20.2% of males reported thinking about killing themselves in the last 12 months, while 13.9% of females and 6.2% of male students reported engaging in acts of DSH in the past 12 months.

Of the 497 people who died by suicide in 2008, 118 were between the ages of 10 and 24 years old. In 2008, males aged 20-24 years old had the highest age-specific suicide rate in (MoH, 2006a). Traditionally suicide rates increase with age, however, NZ has shown a distinctive and disturbing trend with higher suicide rates in males aged 15-24 and females aged 15-19 than in most older age groups (Cantor, 2000).

Suicide among Māori

Suicide rates for Māori are unable to be compared prior to 1995 as a result of differences in the way ethnicity is recorded. Prior to 1995 Māori ethnicity was determined by the extent of an individual's Māori descent; however, since 1995 ethnicity has been based on self report, or whānau reports of the individual's self-identification in the event of suicide (Beautrais & Fergusson, 2006). It is likely Māori suicide rates were underestimated in the years prior to 1995 (Beautrais & Fergusson, 2006).

Among Māori, suicide is largely confined to those aged less than 35 years old (MoH, 2010). In the years from 2002-2004 the disparity between the average suicide rates of Māori and non-Māori was the widest it had been in the previous eight years. Māori young people have significantly higher suicide rates than non-Māori. Data suggests that young Māori males are almost three times more likely and young Māori females are almost twice as likely to die from suicide as non-Māori young people (Beautrais & Fergusson, 2006). The average total suicide rates for Māori males and females in 2008 were 18.9 and 8.4 deaths per 100,000 population respectively. The average suicide rates for non-Māori males and females were 16.4 and 5.1 deaths per 100,000 population respectively (Ministry of Health, 2010).

The population of NZ is approximately 4.4 million people. Of these, approximately 15% identify as Māori (Statistics NZ, 2003). As mentioned above there are significant differences between suicide rates of Māori and non-Māori. Māori make up 19% of the youth population aged

15-24 years but accounted for 35% of all youth suicides in 2002 (Statistics NZ, 2003). Possible reasons for the higher Māori youth suicide rate include the higher proportion of young Māori. Beautrais and Fergusson (2006) suggest societies with younger populations could be expected to have more problems than those with older populations. The higher Māori youth suicide rate may also reflect the disadvantaged status of Māori, evident in areas such as health care, education, welfare and justice (Beautrais & Fergusson, 2006). The high suicide rate may also reflect factors unique to Māori and their experience of colonization; for example, disconnection from culture, historical oppression, and identity confusion (Durie, 2001).

Māori are also more likely to commit suicide by hanging (Beautrais & Fergusson, 2006). The method of hanging is especially troubling, as it is easily available, difficult to restrict and more likely to result in death on the first attempt (S. Fortune, personal communication, July, 2008). Young Māori are also more likely than NZ non-Māori youth to have experienced unwanted sexual contact (24.6% compared with 17.6%) which increases the risk of suicide and DSH behaviours (Fanslow, Robinson, Crengle & Perese, 2007).

DSH

There were 2465 hospitalisations for intentional self-harm in 2008. This represents a steady decrease from 3030 in 1996. This significant reduction may reflect a real change in behaviour; however, it is also very likely that it has resulted from changes in medical practice and administration over the past decade. For example, the shift towards community-based mental health care likely reduces the numbers of people who may previously have been admitted to inpatient mental health services following DSH. There are also difficulties with hospital administration procedures as clinical coders may record the effect of the DSH rather than the action; for example, an overdose may be coded as abdominal pain (Hatcher, Sharon & Collins, 2009). Hatcher et al. also reported inconsistencies between District Health Boards (DHBs) and what may constitute ‘hospitalisation’, as some DHBs record everyone who presents to hospital while others record only those who are subsequently admitted.

DSH among children and adolescents

Contradictory to general statistics reported above, rates of DSH among youth appear to be rising, as is also reported in the international literature (Fortune & Hawton, 2007; Hawton et al., 2002; Rodham, Hawton & Evans, 2004; Whitlock et al., 2006). Furthermore, it is likely that the adolescents who present at hospital represent only a small proportion of those who engage in DSH. DSH is significantly underestimated and underreported, as those who self harm may not always seek treatment and only a small percentage may require admission to hospital (Fortune, 2006). A recent Australian study by McCann et al. (2006) estimated that as many as one in ten adolescents engage in DSH. DSH is common in psychiatric settings, such as CAMHS in NZ. A file audit of 100 clients at a CAMHS reported that almost half (48%) of the clients presented with DSH and a further 16% had suicidal ideation (Fortune et al., 2005).

DSH is particularly common in adolescence (Hawton et al., 2002; Fleming, Merry, Robinson, Denny, & Watson, 2007). In 2008 young people aged 15-19 years old had the highest number of hospitalisations for intentional self-harm and the highest age-specific rate (MoH, 2010).

DSH among Māori

As for suicide, there are distinct disparities for Māori youth. In the Youth 2000 survey 2,325 of the 9,699 participants identified as Māori (AHRG, 2004). Māori adolescents were more likely to have thought about suicide (17.4% vs.12.4%), made plans related to suicide (11.1% vs. 7.4%) and acted on these thoughts (6.9% vs. 3.6%) than non-Māori (AHRG, 2004).

Among hospitalisations for DSH in NZ Māori females had consistently higher rates of hospitalisation than all other groups. Māori males had higher rates of hospitalisation than non-Māori males. Māori females aged between 15 and 24 years old had the highest rate of hospitalisations for DSH in 2006 (SPINZ, 2008). In 2007 there were 75.3 Māori intentional self-harm hospitalisations per 100,000 people in 2007, compared to 61.6 per 100,000 for the non-Māori population. The DSH hospitalisations show no downward trend for Māori since 1996; in comparison, DSH hospitalisation rates for non-Māori have dropped markedly.

Risk Factors for DSH and Suicide

A large amount of literature exists on the risk factors for suicide and DSH and many different factors are said to increase the risk for both. A risk factor is said to be “a characteristic, variable, or hazard that increases the likelihood of development of an adverse outcome, which is measurable and which precedes the outcome” (Moscicki, 1997, p. 500). Some studies have found adolescents who engage in DSH are often unable to identify precipitating factors or give reasons for their behaviours (Beautrais, Joyce, & Mulder, 1996; Hawton et al., 1982; Kienhorst, de Wilde, Diekstra, & Wolters, 1995). Nevertheless, understanding risk factors is desirable to ensure effective treatment and prevention strategies for adolescents.

Family history and parental mental health

Having a family history of suicidal behaviours is associated with an increased risk of suicide and DSH (Beautrais, 2000a; Carr, 1999; Fortune et al., 2005). This may come about because of social learning factors, such as modelling of poor emotional regulation and distress tolerance skills, and an altered tolerance to DSH, as well as possible genetic factors.

Studies suggest that the rate of suicide and DSH is increased among adolescents who have been exposed to parental psychopathology, including depression, substance abuse disorders and antisocial behaviours (Beautrais, 2000a; Carr, 1999; Fortune et al., 2005). It has been suggested that families with parental psychopathology are characterised by high levels of conflict and low levels of communication and cohesion (Garber, Little, Hilsman & Weaver, 1998) which have also been linked with increased DSH. As mentioned above, this may be a result of social learning and the modelling of maladaptive behaviours and coping strategies (Carr, 1999).

Family problems

There is a well recognised association between family dysfunction and adolescent DSH (Agerbo, Nordentoft, & Mortensen, 2002; Miller, King, Shain, & Naylor, 1992; Sim, Adrian, Zeman, Cassano & Friedrich, 2009; Spirito, Brown, Overholser, & Fritz, 1989). A chaotic early environment is said to predispose individuals to psychological problems later in life (Carr, 1999). More specifically, conflict between parents and adolescents is a significant risk factor for suicide and DSH (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999). This view is supported by an Australian study which found more dysfunction in families of adolescents who engaged in DSH compared with those who did not (Tulloch, Blizzard & Pinkus, 1997). This study also found a strong association between inadequate parent-child communication and adolescent DSH. There is also recent evidence to suggest that rejection from parents affects adolescents more negatively than problems in peer relationships, and is more powerfully associated with suicidal behaviours than peer relationship difficulties (Fotti, Katz, Afifi, & Cox, 2006).

Childhood physical and sexual abuse

Childhood physical and/or sexual abuse has been associated with suicidal behaviour in adolescence (Dervic, Grunebaum, Burke, Mann, & Oquendo, 2006). A number of studies have examined the association between suicide or DSH and historical physical and sexual abuse (Beautrais, 2000a). For example, a cross-sectional study in Australia by Martin (1996) reported an increased risk of DSH in adolescents who report sexual abuse histories. Similar findings were found in a NZ study by Fergusson and Horwood (2001). Community based longitudinal research by Johnson et al. (2002) suggested that physical and sexual abuse increases the risk of DSH and suicide even when all other covariates are controlled for. Brent et al. (2002) also found that having a parent who reported a history of sexual abuse was associated with an increased risk of suicide and DSH among their offspring.

Childhood sexual abuse also places individuals at a higher risk of other risk factors associated with DSH and suicide, such as depression (Gladstone et al., 2004). Childhood physical and sexual abuse also tends to take place more frequently in families with higher rates of parental conflict and domestic violence (Gladstone et al., 2004), both of which place children at higher risk of suicide and DSH (Carr, 1999).

Socioeconomic status (SES)

A NZ study by Beautrais et al. (1996) demonstrated that those who engage in DSH are significantly more likely to come from lower socioeconomic groups, even when other risk factors have been accounted for. These finding were supported in the Christchurch, NZ longitudinal study (Fergusson, Woodward, & Horwood, 2000). Low SES may result in overcrowded and stressful situations, both of which are said to place young people at an increased risk of suicide (Carr, 1999).

Education

Numerous studies suggest that adolescents who report school based difficulties, perceived school environments as unsafe, had low educational achievement or had dropped out of school, have higher rates of suicide and DSH (Agerbo et al., 2002; Beautrais et al., 1996; Fleming et al., 2007; Fortune & Hawton 2007).

Psychiatric problems

Fergusson and Lynskey (1995) found that almost 90% of adolescents who had attempted suicide and 70% of those who reported suicidal ideation met criteria for a psychiatric disorder by the age of 16, compared with 30% of other adolescents. A study by Harrington et al. (2006) showed that 64% of individuals who engaged in DSH met the criteria for major or minor depression compared with 33% of the control group. The main disorders said to have a link with suicidal behaviours are depression, substance abuse, and conduct disorders as well as previous episodes of DSH. These disorders will be examined in the context of DSH and suicide below.

Depression: Previous studies have suggested a strong link between suicidal behaviours and depression (Fergusson & Lynskey, 1995; Goldney, Wilson, Dal Grande, Fisher, & McFarlane, 2000; Portzky & van Heeringen, 2007). This link is well-recognised in suicide research today (Allison, Roeger, Martin & Keeves, 2000). DSH is said to occur during or close to episodes of mood disorders such as depression (Greenhill & Waslick, 1997), with early onset depression being predictive of suicidal behaviour later in life (Kovacs, Goldston, & Gatsonis, 1993; Portzky & van Heeringen, 2007). Depression is the most common mental health disorder reported in adolescent suicide victims (Fortune, 2003) and as the severity of depression increases, so does the likelihood of DSH and suicide (Allison et al., 2000).

Substance abuse: Alcohol abuse is the second most common psychiatric diagnosis (after depression) identified in completed suicide (Haw, Houston, Townsend, & Hawton, 2001). Adolescents with substance abuse problems have higher rates of mental health disorders and DSH (Lubmen & Yucel, 2008). However, it can be difficult to distinguish if substance abuse occurs before or after mental health issues (Fortune, 2003). Previous research suggests that those who abuse drugs and alcohol have an increased risk of DSH and suicide (Beautrais, 2000a; Fortune et al., 2005).

Conduct disorders: Significant associations have been described between antisocial behaviours and risk of suicide and DSH (Beautrais, 2000a). Antisocial behaviours, such as conduct disorder are said to be more common in impulsive, risk taking individuals and impulsivity is reported as being a personality based risk factor for suicide (Carr, 1999). Several risk factors involved with conduct disorders are also risk factors for suicidal behaviours, such as family dysfunction, childhood abuse, and substance abuse (Apter & Fergusson, 2000).

Previous episodes of DSH.

As noted already, a past history of DSH is one of the strongest predictors of future DSH and of eventual suicide (Brent et al., 1999; Malone et al., 2000; Shaffer et al., 1996; Zahl & Hawton, 2004), with the greatest risk of repetition being in the first year (Roy, 2001). From the Christchurch longitudinal study, Fergusson, Horwood, Ridder and Beautrais (2005) found that adolescents who attempted suicide were almost 18 times more likely to make another attempt compared with adolescents without DSH behaviours. In a six year follow up study by Harrington et al. (2006), 30% of adolescents who engaged in DSH had harmed themselves again since leaving school.

It is suggested that once an adolescent engages in DSH they cross a behavioural threshold where they now have this behaviour in their behavioural repertoire and may now believe they are capable of suicide (Goldston et al., 1999). DSH is more likely to be repeated if the behaviour was reinforced, for example, by the individual experiencing relief from an undesirable feeling or if a positive and desirable change occurred in their lives due to the response of others. DSH therefore becomes an additional “tool” in the adolescent’s behavioural repertoire to be used in future situations (Fortune, 2003).

Sexual orientation

Studies have shown that homosexuals have higher rates of DSH and suicide than heterosexuals (Bagley & Tremblay, 1997; Russell & Joyner, 2001). A recent NZ study by Skegg, Nada-Raja, Dickson, Paul, and Williams (2003) demonstrated that both men and women who experienced same sex attraction have higher risks of DSH. Reasons for this disparity include the stress and isolation of the “coming out” process taking place in a homophobic society (Bagley & Ramsay, 1997) and exposure to serious social and personal stressors resulting from the homophobic attitudes of society (Beautrais, 2000a).

Media influence

A growing body of literature suggests that media exposure may increase suicidal behaviours in adolescents. It has been postulated that this is due to vulnerable adolescents modelling their behaviour upon the accounts of suicide, whether fictional or not, presented in the media (Beautrais, 2000a). Publicity may also lessen the taboo surrounding suicide and DSH by normalising these behaviours and making them seem like common and acceptable options for people who are suffering.

Precipitating factors and life events

Exposure to stressful and negative life events is associated with higher rates of completed suicide in adolescents (Beautrais, 2000a). The most common precipitating factors are reported to be relationship breakdowns and other interpersonal problems, disciplinary or legal crises, school related difficulties and financial difficulties (Beautrais, Joyce, & Mulder, 1997). Young people may consider DSH or suicide following rejection, conflict or loss (Fortune, 2003).

It is often difficult to ascertain the extent to which stressful life events that occur prior to suicidal behaviour are independent of, or caused by, negative pre-existing conditions such as sociodemographic status, childhood experiences, familial relationships, personality traits and psychiatric disorders, as described above (Beautrais et al., 1997).

Protective Factors

Substantial research has been done on what factors contribute to suicidal behaviour; however, less attention has been paid to what factors may protect adolescents from engaging in suicidal behaviours (Malone et al., 2000). Risk factors may be seen as opposites to protective factors, for example, if poor parent-child communication is a risk factor for suicidal behaviours then the experience of good parent-child communication may be considered a protective factor.

Protective factors that appear to be the opposite of risk factors include good social skills, problem solving and coping abilities, as well as the absence of familial discord and childhood abuse. These factors decrease the likelihood of problems including substance abuse, conduct problems and depression, and hence suicide (Beardslee, Schultz, & Selman, 1987; Beautrais, 2000a; Fleming et al., 2007). Reported individual protective factors include high self esteem and self worth (Wichstrom, 2000), religious influence and parental expectations (Rew, Thomas, Horner, Resnick, & Beuhring, 2001), as well as positive peer relationships and friendships (Beautrais, 2000a). Other possible protective factors for adolescents identified by Fergusson and Lynskey (1996) include higher IQ, lower novelty seeking, and fewer relationships with delinquent peers.

School factors have also been identified as protecting adolescents from engaging in suicidal behaviours. These include educational achievement and enjoyment as well as the feeling of being treated fairly (Fleming et al., 2007).

Although parenthood is at a low occurrence in adolescence it should be noted that parenthood may act as a risk or protective factor for women. Young mothers with several children, as well as women who failed to complete their pregnancy for any reason are at an increased risk of suicidal behaviours (Fortune, 2003). However, parenthood may also foster a sense of identity and feelings of responsibility to their children which may provide a reason for living (Cantor & Neulinger, 2000).

Cultural Factors and Māori Specific Risk Factors

Suicide and DSH are complex phenomena with numerous influences. These influences are said to include “the individual’s personality, biology, culture and social environment, as well as macroeconomic and political context” (McKenzie, Serfaty, & Crawford, 2003, p.100). As noted above, indigenous populations frequently have higher rates of suicide than non-indigenous populations and the under-reporting of indigenous suicides appears to be a universal issue (Hirini & Collings, 2005).

There are no traditional Māori cultural understandings of suicide and suicide appears to be a product of modern times (Durie, 2001). As mentioned already, colonial processes have resulted in a number of inequalities for Māori (Edwards et al., 2007). The undermining of the Māori language, along with land loss and urbanisation has had severe effects on the tangata whenua and may indirectly contribute to DSH, through racism and discrimination (Edwards et al., 2007) as well as through deculturation, insecure cultural identity and loss of autonomy (Durie, 2001).

Durkheim (1987) originally suggested that suicide risk is affected by societal and cultural contexts, including the idea of disconnection from social groups. This idea is particularly pertinent for Māori in today’s society. Māori may feel disconnected from not only their culture, but their hapu and iwi, due to the loss of traditional lands and the loss of recognition and use of their indigenous language (Hirini & Collings, 2005). Historical change within NZ has had dramatic effects on Māori social structure and functioning, resulting in increased individualism and loss of traditional support systems. Many Māori may also experience social and cultural alienation and loss of identity resulting in lower self-esteem, hopelessness and despair (Hirini & Collings, 2005).

Secondary risk factors associated specifically with Māori suicide have been identified. Critical variables said to be associated with Māori suicide include the influence of historical, political and social processes, as well as individual factors (Hirini & Collings, 2005). Māori experience higher rates of poor general health, marijuana usage, and the experience of interpersonal difficulties, including verbal, emotional, physical and sexual abuse, all of which may act as risk factors for suicide and DSH behaviours (Coupe, 2005). In the Youth 2000 survey Māori taitamariki (young people) were 1.5 times more likely to report sexual abuse or coercion than NZ non-Māori young people (AHRG, 2004). As a group Māori experience more social disadvantage in the form of lower educational achievement, higher unemployment rates, poverty and poor housing (Hirini & Collings, 2005), all of which place them at greater risk of suicidal behaviours.

It has been argued that for Māori, a feeling of connection with their culture and the presence of spiritual connections may act as a protective factor (Durie, 2001). Whānau support systems may also guard against suicidal behaviours by providing security and identity for young people (AHRG, 2004).

A Predictive Model of Risk Factors for DSH and Suicide

No single risk factor exists for DSH or suicide; it is likely that many risk factors act in collaboration. Knowledge regarding the sequence of, and relationship between, relevant risk factors for suicide and DSH is limited, making the development of a causal model difficult (Portzky & van Heeringen, 2007). Nevertheless, attempts have been made to describe risk factors from the best available information. One such model is that by Beautrais (2000a) presented below. This model incorporates biological, social, and psychological factors and demonstrates how these factors may directly influence suicidal behaviours, act indirectly or act on other factors in a manner which increases the likelihood of suicidal behaviours.

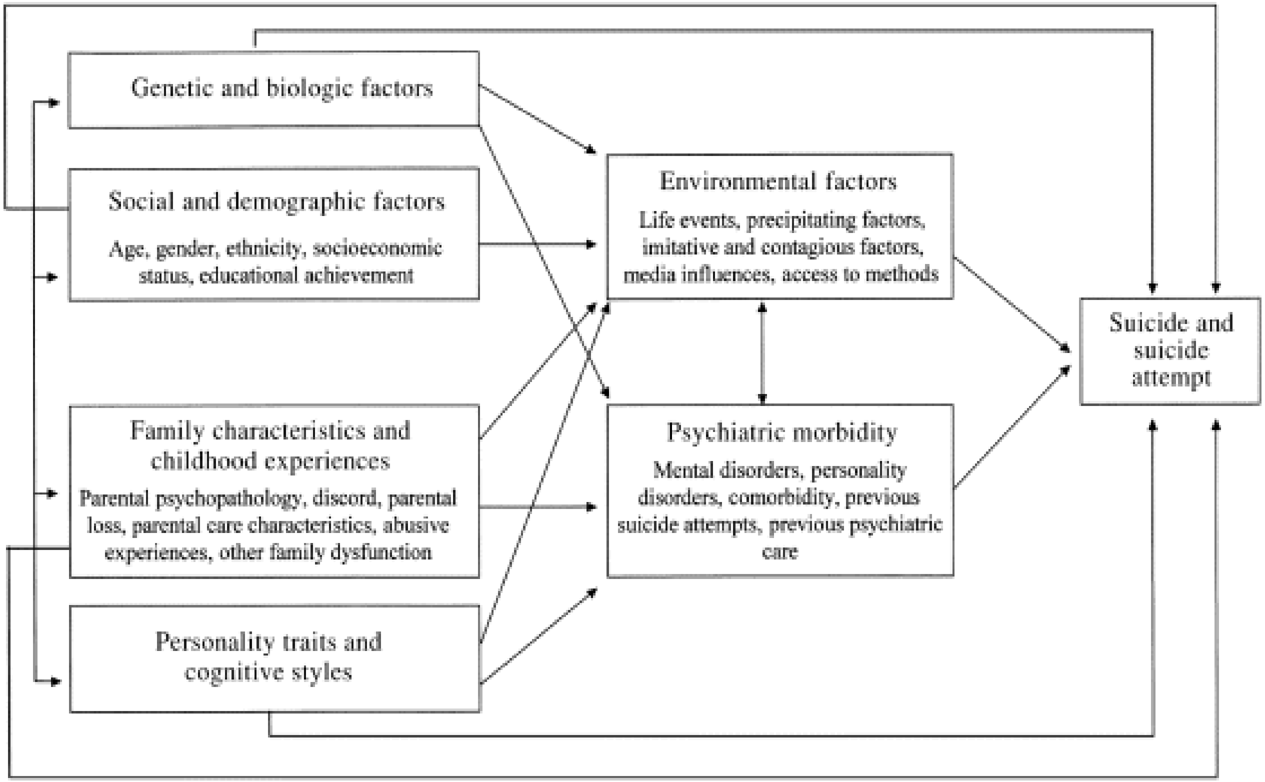

Figure 3. Conceptual model of domains of risk factors for suicide and suicide attempt (Beautrais, 2000a, p. 429).

Psychological Explanations of DSH

Psychological theories have provided another approach to the understanding of DSH. These theories potentially encompass risk factors; however, they pay stronger regard to psychological processes. Researchers have also attempted to examine the function or purpose of DSH. Relatively little is known about how adolescents explain their own DSH (Boergers, Spirito, & Donaldson, 1998). Nevertheless, numerous theories have been proposed as to why individuals self-harm. These include punishing oneself, to influence others, to see if someone cares, affect regulation and distress tolerance, to feel something, and to stop oneself from committing suicide. It must be stated however, that there is no single psychological explanation for DSH. Explanations of DSH may differ according to individuals, including their culture, psychological state, and situation. The following section provides only a brief description of these psychological explanations in order to demonstrate the numerous theories that exist and their complex nature.

Suyemoto (1998) provided a review of psychological models for DSH. These views were subsequently organised into six functional models. The models will be explained in more detail below.

Environmental Model (EM): The EM takes a largely behavioural stance and focuses on the interactions between the individual and their environment. The EM includes factors that may have started the behaviour, as well as maintained it. The EM proposes that DSH begins with familial modelling or through reinforcement (Suyemoto, 1998). An example of familial modelling is abuse which results in an individual believing DSH to be acceptable and linking pain with care. Reinforcement of DSH may be internal, such as feeling better after DSH, or come from the environment, such as receiving attention and care from others.

The Anti-suicide Model (ASM): The ASM is based on psychodynamic theory and attempts to understand DSH "as an expression or repression of life, death and sexual drives" (Suyemoto, 1998, p. 540). The ASM describes DSH as a way to avoid suicide by channelling destructive impulses into DSH, thus explaining DSH as a coping mechanism (Firestone & Seiden, 1990).

The Sexual Model (SM): The SM proposes that DSH provides sexual gratification as well as punishment for (or is possibly an attempt to avoid) sexual feelings or actions (Suyemoto, 1998). This model is said to be supported by the non-appearance of DSH before puberty, however, DSH has now been found to occur before puberty (Patton et al., 2007; Bergen, Martin, Richardson, Allison, & Roeger, 2003).

The Affect Regulation Model (ARM): The ARM appears to be the most popular among researchers. It states that DSH is an attempt to control, express, and externalize intolerable or overwhelming emotions (Klonsky, 2007; Suyemoto, 1998). It is often explained as the need to feel something other than emotional pain. It has been suggested that invalidating early environments teach poor coping strategies for dealing with emotional distress; these individuals may be less able to deal with their affect and are therefore more likely to use DSH as an affect regulation strategy (Linehan, 1993).

The Dissociation Model (DM): The DM is ingrained with self-psychology and focuses on the creation or maintenance of a sense of self (Suyemoto, 1998). The DM recognises DSH as a function of affect regulation but focuses on the experience of dissociation, characterising DSH as a response to episodes of dissociation (Klonsky, 2007). DSH serves as a function to either cause or end dissociation (Allen, 1995; Klonsky). DSH may aid in regaining a sense of self by shocking the system.

The Boundaries Model (BM): The BM has its basis in object relations and attachment theory (Suyemoto, 1998). It suggests that DSH results from the inability of individuals to adequately separate from their mothers, as well as an inability to differentiate the self from other (Noshpitz, 1994). DSH therefore acts as a definition of the boundaries of the self.

A recent review by Klonsky (2007) named seven functional models for DSH. The models were similar to these discussed above, including the Anti-suicide, Dissociation, Boundary and Affect-regulation models. However, Klonsky renamed and elaborated on the EM. He called it the Interpersonal Influence Model and emphasised that self-injury, either knowingly or unknowingly, is used to influence or manipulate others. This review also did not mention the SM but introduced two additional models. These were the Sensation-Seeking Model (SSM) and the Self Punishment model (SPM). The SSM views DSH as a way of producing excitement, in a manner similar to extreme sports. However, studies have shown only a small number of participants indicated DSH as a way to feel excitement (Nixon, Cloutier, & Aggarwal, 2002). The SPM suggests DSH is an act of anger towards the self (Klonsky, 2007). Linehan (1993) proposes that individuals who engage in DSH have learned to punish or invalidate themselves from early experiences.

Motives for DSH

Risk factors and psychological models may not reference what young people or their families have to say regarding the act of DSH. Some researchers have attempted to understand DSH from the perspective of the adolescent or their family; however, none with Māori. As noted already, this thesis is a new direction in suicide research.

Motives for DSH have important implications for the assessment and prevention of further DSH as well as in determining appropriate treatment options (Boergers et al., 1998; McAuliffe, Arensman, Keeley, Corcoran & Fitzgerald, 2007). Studies have shown that a number of motives are generally reported by those who engage in DSH, even those who also report a wish to die, possibly signifying ambivalence in intent (Hawton, Cole, O'Grady, & Osborn, 1982; Schnyder, Valach, Bichsel, & Michel, 1999; Scoliers et al., 2009).

Previous research suggests that both clinician’s and family members tend to interpret DSH differently from the person who has engaged in DSH (James & Hawton, 1985). This research also suggests that clinicians (especially doctors) and family members are more likely to attribute manipulative motives to acts of DSH and that this attribution of manipulative motives often results in participants being unsympathetic to the individual (Hawton et al., 1982; Hurry, 2000; James & Hawton, 1985). However, research with adolescents suggests the most common motives are to escape from terrible situations and painful experiences or thoughts, to obtain relief, and to die (Boergers et al., 1998; Hurry, 2000; James & Hawton, 1985; Scoliers et al., 2009). These motives are often described under the single category of intrapersonal or internal motives (McAuliffe et al., 2007).

There is no definitive list of motives for researchers to reference. Hawton et al. (1982) derived their list of motives from a larger list by Bancroft et.al. (1979) and it has been widely accepted and used in numerous research studies (Hjelmeland et al., 1998; James & Hawton, 1985; Rodham et al., 2004). Although not described as an explanatory model, this list of motives developed by Hawton et al. allowed adolescents as well as clinical assessors to attribute motives they thought applied to the act of DSH, as well as attributing suicidal intent. The research was conducted with 50 adolescents (aged 10-18) admitted to a general hospital following deliberate self poisoning and the member of the clinical psychiatric staff who first assessed them. Participants could choose as many motives as they thought applied. Adolescents most commonly reported DSH served to alleviate or communicate distress, while clinical assessors most commonly attributed DSH to punitive or manipulative reasons. Adolescents were much more likely than clinical assessors to report a desire to die.

Impact of DSH on Families

One important, but often neglected, aspect of DSH by children and adolescents concerns the impact this has on their families. The impacts of suicide are far reaching; it is not solely the loss of an individual but rather the loss of a part of a living network (Durie, 2001). Numerous articles report the important influence of family environments on all aspects of the development, health, and well-being of young people (Edwards, McCreanor, & Moewaka-Barnes, 2007; Fergusson & Horwood, 2001; Nada-Raja, McGee, & Stanton, 1992). It has been suggested that parents are the first to spot signs of DSH and therefore play a vital role in reaching children and adolescents in the community who are unknown to health services (Oldershaw, Richards, Simic, & Schmidt, 2008). The family context is also well known as an area where the well-being of young people can be enhanced (Edwards et al., 2007). A healthy family is essential in the well-being of young people but without appropriate supports for the family, its potential to nurture others is diminished (AHRG, 2004). However, less is known about the impact of suicide and DSH on family members. There is very little research on familial responses to DSH in any capacity, whether it is perceptions, reactions, impact or engagement with treatment, and no research exists on Māori whānau experiences of DSH.

In the USA, Wagner et al. (2000) interviewed parents of adolescent suicide attempters regarding their emotional reactions the day before, upon discovering, and the day after the suicide attempt. This study showed that parental reactions to DSH may include anger, fear, sadness and frustration. In an Australian study by McDonald el al. (2007), researchers interviewed mothers of children who had or were engaging in DSH and found parents may feel guilt, shame and embarrassment. It is also possible parents may be intimidated by the intensity of the DSH, which may complicate the parenting experience. Parents may, as a result, adopt greater restrictiveness in their parenting style, or alternatively retreat to a position of minimal limit setting, or try to transfer responsibility for their child to someone else (Hazell, 2000; McDonald et al., 2007).

How parents react to DSH may be influenced by factors such as the nature of the previous relationship with their child, the degree of perceived suicidal intent involved in the act and whether the DSH act was a first episode or a repeat (Wagner et al., 2000). The types of motives attributed to the act by parents, including whether the parents interpret the DSH as an act of manipulation, a sign of distress, or a definite attempt to die, may also be important (James & Hawton, 1985). As mentioned above, parents and clinicians alike are more likely than the adolescents themselves to attribute manipulative motives to acts of DSH. Cultural factors and the amount of social support available may also influence parental reactions.

In relation to the general population a small number of parents have expressed a need for more information about what to look out for and what to expect when caring for a child engaging in DSH (McDonald et al., 2007). These parents can feel alone and overwhelmed and may therefore be unable to help their children. Due to the dependant nature of young people, parents and whānau need to be healthy in order to aid their young people in being healthy. Appropriate treatment strategies must discover the needs of whānau in order to help them, and in turn help their children.

The impacts of DSH for Māori have not been looked at specifically and may differ from those previously reported. Parents of taitamariki who engage in DSH often comment that little help or support were made available for them (S. Fortune, personal communication, April, 2008). Virtually no information is available to indicate what their needs might be and/or whether they differ from other groups.

Interventions for DSH Behaviours

In response to the growing awareness of, and concern about, suicide and DSH, there has been a rise in the provision of interventions to prevent these behaviours. The following section will discuss and distinguish those interventions that are aimed at the general community (primary prevention), educational work with vulnerable populations (secondary prevention), and treatment based interventions at mental health services.

Restricting methods of suicide and DSH

The restriction of access to methods that may be used for suicidal behaviours is a key element in suicide prevention and is used in all national suicide prevention strategies (Beautrais, 2000b; Hawton, 2007). The restriction of methods is also recommended by the WHO in their steps for suicide prevention. These steps include the restriction of access to means of suicide (such as toxic substance and firearms), the identification and management of persons suffering from mental and substance use disorders, improved access to health and social services, and responsible reporting of suicide by the media (WHO, 2011).

Beautrais (2000b) reported that in the years preceding 2000 almost 80% of youth suicides in NZ were the result of hanging or vehicle exhaust gas, with hanging being the most popular method. As a method hanging is especially problematic and places severe limitations on the extent to which suicide rates may be reduced through the restriction of this method. Several authors have reported that there is no realistic or feasible way in which public access to means of hanging may be restricted (Beautrais, 2000; Cantor & Baume, 1998; Fortune, 2003). Carbon monoxide poisoning from vehicle exhaust gas is the second most common method of suicide among youth in NZ (Beautrais, 2000). Suggestions for restricting this method have been recommended, including detoxifying vehicle exhaust emission by fitting catalytic converters, the modification of exhaust pipes to make the capture of gas more difficult, and/or carbon monoxide sensors in vehicles, and automatic cut-out after a maximum idling time (Beautrais, 2000). Suicide prevention strategies in other countries, such as the USA and Canada have focused on restricting access to firearms (Fortune, 2003). However, in NZ the number of suicide deaths due to firearms is small and restricting this method would not significantly reduce the overall suicide rate (Beautrais, 2000).

Self-poisoning accounts for an overwhelming majority of hospital admissions in NZ (Beautrais, 2000b). Approaches to limiting DSH and suicide by this method include, limiting prescription sizes, safer packaging, means of encouraging disposal of out of date or unused medications and limited advertising (Beautrais 2000b; Cantor & Neulinger, 2000). Research has shown that a reduction in pack sizes and the number of packs that may be purchased at one time corresponded with a decline in rates of both suicide and DSH (Hawton et al., 2001).

Restrictions regarding media reporting of suicide and DSH

Suicide prevention strategies have often included media guidelines regarding the coverage of suicide (Sisask, Varnik, & Wasserman, 2005). The way suicide is presented or portrayed in the media, historically on television and in news papers, may trigger a suicide attempt in vulnerable individuals (Beautrais, 2005). In NZ heavy restrictions currently exist regarding the reporting of suicide in the media, these however do not apply to the internet, which is becoming increasingly available to young people and provides rapid access to information.

School based interventions

Recent literature suggests that adolescents consider school, family and peers as more important in preventing DSH and suicide than external agencies (Fortune, Sinclair, & Hawton, 2008). Prevention programmes which target students as helpers are based on this belief that adolescents turn to their peers for support rather than discussing their problems with adults (Fortune, 2003). Educational programmes in schools are aimed at teaching teachers and students about the warning signs for suicide and how to seek help (Burns & Patton, 2000).

Difficulties with the student helper school based interventions include concerns that not all peers would inform adults of a troubled friend and the fact that individuals most at risk are those who drop-out of school or have high rates of truancy, and these individuals would not be reached using school based programmes (Burns & Patton, 2000). Beautrais et al. (2007) states that the use of school based programmes such as those described above cannot be recommended as there is little evidence to imply they are effective and some suggestions that they may be unsafe. It has been proposed that students exposed to these programmes show no benefits or a decrease in desirable attitudes and behaviours and there are concerns that they may inadvertently normalise suicidal behaviour and promote imitation (Beautrais et al., 2007).

In order to overcome problems such as those mentioned above school based skill-enhancing and competency promoting programmes have been introduced. These programmes aim to enhance self-esteem as well as coping and problems solving skills and are based on the idea that these factors are thought to protect against suicidal behaviour and therefore enhancing them may protect vulnerable adolescents from engaging in suicidal behaviour or activities that put them at greater risk of suicidal behaviour (Beautrais et al., 2007). Research has shown an association between these school-based programmes and a reduction in suicidal behaviour among students (Eggert, Thompson, Herting, & Nicholas, 1995). Programmes have also been aimed at decreasing risk factors for DSH and suicide, such as depression. A NZ study by Merry, McDowell, Wild, Bir, and Cunliffe (2004) demonstrated the potential effectiveness of a school based depression prevention programme.

Support for family and friends bereaved by suicide

Individuals and families bereaved by suicide constitute a vulnerable population. The death of a loved one by suicide has been described as one the greatest stressors in life and can lead to mental health issues, placing friends and whānau at increased risks of suicidal behaviour (Clark & Goldney, 2000). Rates of suicidal behaviour have been shown to increase between two and six times in family members of those who engage in suicidal behaviours (Brent & Mann, 2005). Providing support to family and friends may decrease the likelihood of suicidal behaviours in this population (Beautrais et al., 2007). A small amount of literature exists in this area; little research has been done with family members bereaved by suicide and even less with family members of those who engage in DSH (Hawton & van Heeringen, 2000) and not much is known about what types of programmes may be effective in this context (Beautrais et al., 2007).

Therapeutic interventions targeting cognitions and problem solving

Cognitive behavioural therapy (CBT) is the most commonly used therapeutic intervention with adolescents suffering from depression and affective disorders (Burns & Patton, 2000) but has not yet been evaluated with DSH as an outcome variable in those with these disorders (Fortune, 2003). The use of CBT is based on the assumption that those engaging in DSH have deficits in problems solving skills, maladaptive coping strategies and cognitive rigidity (Raj, Antony, Kumaraiah, & Bhide, 2001). Controlled studies have demonstrated the efficacy of CBT in the treatment of depression, eating disorders and substance abuse disorders (Beck, 1995), hence, reducing risks involved with suicidal behaviour. CBT has also been shown to be effective in reducing depression and repetition of suicidal behaviours (Raj et al., 2001). Problem solving therapy has been noted as a promising area for further investigation (Fortune, 2003; Hatcher, Collins, Sharon & Blackett, 2011; Townsend et al., 2001) and it has been suggested that posing suicidal behaviours as a failure in problem solving is helpful to both adolescents and their families (Spirito, 1997a).

Most research surrounding treatment for adults engaging in suicidal behaviours has been with dialectical behavioural therapy (DBT) with promising results in clinical trials (Hawton & van Heeringen, 2000). Trails with female clients in the USA showed a reduction in repetition of

DSH in individuals who received this treatment (Hawton & van Heeringen, 2000). Further investigation is needed with male clients and adolescents.

Medication

Research investigating the use of antidepressant medication with young people has focused on those with major depression rather than suicidal behaviour (Hood, 2006). Gould, Greenberg, Velting, and Shaffer (2003) suggested that young people referred for suicidal behaviours are often prescribed selective serotonin reuptake inhibitors (SSRIs) and argued that these prescriptions may be a factor in the decline of youth suicide. However, Hawton et al. (1998) argued that there is no evidence to support the use of antidepressant medication in reducing DSH among young people.

Family based interventions

Research aimed at improving engagement in treatment with adolescents and their families is rare (Fortune, 2003). Treatments targeting or involving the family unit are often considered vital in interventions with and treatments of adolescent engaging in suicidal behaviours (Hood, 2006). This is based on the influence of familial factors, such as parental psychopathology, familial conflict and poor parent-child communication, on the risk of suicidal behaviours. Involving family may also be vital in the engagement and retention of adolescents in treatment. The familial factors described above have been suggested to impact adolescent engagement with treatment and treatment outcomes (Hazell, 2000).

Family therapy has been recommended as one of the most appropriate interventions with adolescents engaging in suicidal behaviours due to the fact that family issues are frequently implicated in the etiology of both suicidal behaviour and depression (Spirito, 1997b).

Barriers to effective therapeutic intervention with DSH and suicide risk

DSH is one of the strongest predictors of further episodes of DSH (Sakinofsky, 2000), including those that result in death (Beautrais, 2002; Hawton, Zahl, & Weatherall, 2003). The treatment of children and adolescents following DSH is an important element of suicide prevention (Burns & Patton, 2000; Hazell, 2000). The most effective form of treatment for DSH has yet to be identified, although some seem promising. CBT and problem solving therapies have been identified as therapies that show potential, with CBT being described as economic and relatively easy to teach.

Historically attendance at recommended treatment and aftercare for adolescents who have engaged in DSH is generally below 50% (Brent, 1997; Swedo, 1989), and can be as low as 20% (Spirito, Plummer, Gispert, & Levy, 1992). Significant and rapid dropout from treatment is frequently observed (King, Hovey, Brand, & Wilson, 1997). These dropout rates suggest that the treatment, or the way they are being delivered does not match the needs of young people or their family.

Family factors form part of the matrix of risk for adolescent suicidal behaviour and can be expected to influence adherence to treatment (King et al., 1997). Family factors are also important determinants of adolescents' engagement with treatment, and treatment outcomes (Hazell, 2000; King et al., 1997; Taylor & Stansfeld, 1984). The effect on engagement in treatment from family factors may vary according to type of treatment (e.g., medication, individual, psychosocial and family therapy) (King et al., 1997). In addition, families experiencing significant levels of psychosocial stress may be unable or unwilling to engage in therapy (Kerfoot, Harrington, & Dyer, 1995). Young people may rely on parents for transport to treatments, money for medications, or may be strongly influenced by parental opinions. It is therefore vital to consider families' needs and engage and include families in treatment plans.

Successful treatment approaches need to address the reactions and needs of parents, but almost no research has been conducted into how parents' reactions to DSH may influence the engagement of young people. This absence of research applies especially to young Māori in treatment.

Aims of the Study

The overarching aim of this study was to contribute to suicide prevention research by focusing on the effects on and needs of whānau following the DSH of their child. If appropriate support is given to a whānau in need it is hypothesised that the whānau will be better equipped to support their child or children. This study aims to examine the impact of their child's DSH on Māori whānau, their perceived motives, the needs of Māori whānau following a child's DSH, and the implications for treatment and outcome. It is hoped this study will advance understanding of Māori parents reactions following their child's DSH. It aims to examine emotional, cognitive and physical responses, aiding in a more comprehensive understanding of the impact of DSH on whānau.

By using qualitative measures the study will be able to investigate specific factors that influence these reactions, as well as how emotional, cognitive and physical responses interact and influence each other. The study fits with the Level 1 Priorities of the National Action Plan and it is hoped it will provide valuable information about the specific needs of Māori whānau who have experienced DSH by their child. In describing these needs it is hoped that more effective and supportive programmes may be designed to assist taitamariki and their whānau. This thesis aims to draw attention to an area of great importance for Māori that that is only modestly researched. It is also hoped that this will encourage future research.

CHAPTER TWO

Method: Te Tukanga

Tūranga mua, tūranga tika; tūranga muri, tūranga hē

To stand in front (of other people) is the right place; to stand at the back behind the people is the wrong place

Methodology

In this study qualitative methodology alongside a kaupapa Māori approach was considered an appropriate method to explore how Māori whānau experience and make sense of DSH by their child. It was hoped that this understanding would begin to inform both treatment approaches as well as bring awareness to an issue that may be widely occurring yet not commonly acknowledged.

I attempted to establish whakawhānaungatanga with members of the CAMHS prior to the start of the study and continued to do so during the study. Cultural consultation was also sought prior to and during the study. This involved identifying a research topic, study design and recruitment procedures. Matua Heemi Witehira and Whaea Miriama Scott, both taurawhiri (cultural advisors) at Whirinaki CAMHS agreed to this role. All procedures related to this research, including the recruitment process, participant information sheets and interview schedules, were discussed and devised in conjunction with taurawhiri and the Māori clinical team at Whirinaki CAMHS. It was important that this research was done by Māori for Māori, with the ultimate aim of benefiting the Māori people.

Qualitative methods were considered most appropriate for this research as it was exploratory in nature. The flexibility and richness of qualitative research allows an account of interaction effects which may occur in the social world that statistical methods do not; it is also more fully able to describe a phenomenon and supports the discovery of new information (Hoepfl, 1997). Purely statistical research runs the risk of ignoring information that while not statistically significant, may still be important (Hoepfl, 1997). Qualitative research is able to explore complex and dynamic phenomena, such as the meanings whānau prescribe to the DSH of their child (Larkin, Watts & Clifton, 2006).

Qualitative methods were also considered the most appropriate approach for Māori in this area. DSH and suicidal ideation have been described as states of mind, rather than "a quantifiable, biological phenomenon" (Hood, 2006, p. 47). This suggests that suicidal behaviours are best examined and understood in the words of those who experience them (Shneidman, 1997).

The qualitative analysis used in this study was thematic analysis (TA) (Boyatzis, 1998; Braun & Clarke, 2006). The process of analysis was guided by the description given by Braun and Clarke. TA was used in an attempt to understand the meaning of the experiences of Māori whānau, for example, the effects or impact of DSH by their child. TA allowed a detailed description of the needs of whānau following DSH by their child, as well as their perceived motives. I attempted to understand how whānau reacted to the DSH of their child both in their actions and emotionally, as well as how they made sense of this act and what their perceived needs were following.

According to Braun and Clarke (2006), TA should "be seen as a foundational method for qualitative analysis" (p. 78). TA, while rarely acknowledged, is a widely used qualitative analytic method. Boyatzis (1998) states that TA is used by scholars and researchers from several different fields while Braun and Clarke argue that a substantial amount of research that is analyzed is basically done using TA that is either reported as something else or not identified at all.

TA allows the researcher to identify, analyze and report themes within interview data. A theme may be described as a pattern found within the data that "at a minimum describes and organizes possible observations or at the maximum interprets aspects of the phenomenon" (Boyatzis, 1998, p. 4). Put simply, TA can organise and describe a data set in plentiful, yet complex detail.

One of the benefits of TA is the fact it may be used within different theoretical frameworks due to the fact it is not connected to any pre-existing framework (Braun & Clarke, 2006). The interpretive aspects of the analysis in this study were primarily from a critical realist perspective. A critical realist perspective has been described as acknowledging "the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'" (Braun & Clarke, 2006, p.5). A critical realist framework is reflected in this research as I aimed to give voice to participants and their opinions, but I acknowledge that I cannot represent what participants say absolutely. In a critical realist framework the researcher must interpret what is being said and thus it is acknowledged that they have an influence over what is reported. In this thesis I had influence in two main areas; one being the questions asked, and two being the analysis of information, or what is reported from transcripts and how it is represented.

Generally, in qualitative research it is recognised that the researcher plays a central role and the resultant themes may be influenced by their particular interpretations, biases and agendas (Potter & Hepburn, 2005). It is therefore important that the researcher be transparent and clear about any theoretical position they may have, as well as any personal or professional interests in the research or its outcome. As Māori, I have an interest in attempting to discover any and all impacts, needs and prescribed motives and making these heard. I also have background training in clinical psychology, and an intention to work in the mental health field with young people and their whānau. Thus, I have an interest in the implications of this research for therapeutic interventions, rather than, for example, primary prevention.

It is also important that the researcher's role is considered when undertaking research with Māori, as ideas may be misinterpreted by those who are not familiar with Māori customs or world views. All interviews and analysis for this research were carried out by the researcher who, as reported above, identifies as Māori. Themes were also discussed with a cultural advisor and a Māori clinical psychologist in order to identify any differences in opinion from a cultural perspective.

Overview of study

Interviews were carried out with ten whānau to gain qualitative data about the effects of DSH, their needs, and perceived motives. Background information regarding family composition, details of the DSH, and attendance at the CAMHS were from secondary sources, such as clinical notes and discussion with clinicians.

Interviews with five Māori key informants were carried out in order to gain insight into clinicians' perspectives of the effects of DSH by a young person on whānau, their needs following DSH episodes, and perceived functions or motives of DSH for Māori taitamariki. Key informant interviews were considered important as another perspective, as well as the fact they could speak from experience of a greater number of whānau.

This study was exploratory in nature, rather than testing a specific hypothesis in a strict sense. Nevertheless, data analysis included investigation of the following questions:

- What are the effects or impact of DSH of Māori whānau?
- What are the needs of Māori whānau following the DSH of a child? And what do they consider the needs of their child to be?
- What are the assumed motives of DSH by Māori whānau?

Ethical approval for this research was given by the Northern Regional Y Ethics Committee. Interviews were not carried out with adolescents as this was not permitted by the Ethics Committee upon submission. The focus of this thesis was also primarily on the impact of DSH on whānau.

The Setting

The study was conducted at Whirinaki CAMHS which comes under the jurisdiction of the Counties Manukau District Health Board (CMDHB). Multidisciplinary teams which may include clinical psychologists, psychiatrists, nurses, occupational therapists, social workers and cultural advisors work with young people and their families who represent the 3% of the population in the greatest need of psychiatric services. Young people up to the age of twenty years old (if they are still attending school) are treated using a combination of crisis intervention as well as family, group and individual therapy, and medication. As the census was cancelled in 2010 all statistics after 2007 are estimates and therefore the 2007 statistics are considered. The catchment area for this service had a total youth population of 486,200 which made up 36% of the total CMDHB population. Māori young people made up 21% of the youth population in the CMDHB in 2007.

He Kākano is the Māori child and adolescent mental health team at Whirinaki. They see only Māori young people aged 4-18 years old and their families. He Kākano is comprised of clinical psychologists, a psychiatrist, occupational therapists, social workers and nurses as well as a taurawhiri.

Participants

The study focused only on Māori whānau and clinicians. Participants were parents (or legal guardians and other primary caregivers/whānau) of young people aged 10–20 years, who presented to Whirinaki CAMHS following an episode of DSH. As noted above, ten families and five key informants were interviewed.

Whānau participants were excluded if they did not identify as Māori or were not identified as Māori by the CAMHS staff, lived outside the geographical catchment area of CMDHB, were in the care of Child Youth and Family Service (child protection service) and not placed with a whānau member, had no legal guardian residing in the area, and/or were thought to be experiencing psychosis. Participants needed to be able to communicate in English.

For the purpose of this research DSH was defined as a self-injurious act irrespective of intent with a non fatal outcome. This definition has been used in several previous research studies (e.g., Harriss, Hawton & Zahl, 2003; Hawton et al., 2002). This study included the threat of self harm or suicide which lead to distress for the whānau.

Initially recruitment was sought through individual clinicians who were asked to identify and refer suitable participants. However, recruitment proved more difficult than expected. Initially clinicians were asked to come forward with suitable participants via email, however, very few came forward. It is hypothesised that clinicians may have been too busy to consider the inclusion criteria and consult their case load. After discussion with clinical and cultural staff it was decided that potential participants would be identified by the Whirinaki CAMHS taurawhiri, who would also make the initial contact with participants. Taurawhiri are routinely informed of all Māori referrals to Whirinaki CAMHS and therefore had access to all potential participants. It was also decided that initial contact would be made by the taurawhiri, instead of the primary clinician, which would reduce the possibility of any perceived or actual coercion.

Eligible participants were identified upon referral to Whirinaki CAMHS, therefore limiting the number of eligible participants as existing clients were not contacted (unless put forward by the responsible clinician). Taurawhiri spoke with whānau and a brief explanation of the study was given, as well as an information sheet with the researcher's contact details (see Appendix IV). Whānau were asked for permission for the researcher to contact them.

I then phoned and whānau were given the opportunity to ask any questions, they were then asked if they would consent to participating. Whānau were given the option to think further after asking questions and I offered to call back the following day. Whānau then had the option of agreeing to participate and setting up an interview time.

Seventeen whānau were identified during the recruitment phase. This was only a small number of possible participants. Two of these whānau were excluded, one due to being cared for by a non-Māori family member and one due to age. Attempts were made to contact the other five whānau; however, this was not successful.

Information about client contact with clinical services was obtained from files and from discussion with the assigned clinicians. The information gained included whether or not a referral was made for on-going treatment following the initial meeting with the whānau, and if so, whether the adolescent or family attended any therapy appointments, how many appointments were attended, and whether treatment was completed.

Engagement with treatment was classified according to (i) *none/minimal* (zero or one contact), (ii) *some* (more than one contact, however, discontinued without professional recommendation; that is, the clinician believed further treatment was needed), or (iii) *complete.* These categories are the same as used by King et al. (1997). It must be noted that the rating of engagement with treatment is solely from the clinician's perspective. Anecdotal evidence suggests that clinicians and whānau may have differing ideas regarding the adequate period for treatment. For example, a clinician may feel a certain number of sessions covering certain topics or skills are needed and the family may only attend half of these, however feel that they have received what they needed.

It was initially anticipated that interviews would be with several members of the family together, as deemed appropriate by the family themselves, as they were invited to include whoever they felt was important. However, in each case only one member of the whānau was interviewed: this was either a mother or grandmother who was the primary caregiver. Information about participants and their treatment is presented in Table 1.

Table 1. Participant Information

ID	Relationship of interviewee to adolescent	Age of child	Self harm behaviour of child	Living situation	Gender	Engagement with treatment
P1	Grandmother	10	Suicidal ideation and threats	Maternal grand-Parents	F	Complete
P2	Mother	17	Overdose/ cutting	Parents and brother	M	Some
P3	Mother	16	Suicidal ideation and threats	Parents	F	Complete
P4	Mother	14	Attempted hanging	Parents and brother	F	Complete
P5	Mother	14	Suicidal ideation and threats	Parents and sister	M	Some
P6	Mother	17	Cutting	Parents and sister	F	None/Minimal (assessment only)
P7	Mother	14	Overdose	Parents	F	Complete
P8	Mother	15	Overdose	Mother, step father, 3 siblings and 5 nieces	F	Some
P9	Mother	11	Cutting	Mother and sister	F	Complete
P10	Mother	17	Cutting	Mother, father, 4 siblings	M	None/Minimal

Key informants were all Māori clinicians who worked as part of He Kākano, the Māori clinical team, and these clinicians only worked with Māori young people and their whānau. All clinician’s had worked for the service for at least two years and had been in their chosen field for longer.

Table 2. Key Informant Information

Identification	Designation	Gender
C1	Social Worker	F
C2	Taurawhiri	M
C3	Occupational Therapist	M
C4	Clinical Psychologist	F
C5	Psychotherapist	F

Procedure

As noted already, ethical approval for this study was obtained from both the Northern Regional Y Ethics Committee, as well as the Māori Research Review Committee. The staff at the CAMHS were familiar with research investigations, interested in the project and had expressed their full support. Participation in the study would in no way compromise the care or treatment offered to the young person or their parents/caregiver.

Following consent from whānau, whānau members were requested to give their child an information sheet with the researcher's contact details. Whānau were then asked if the young person consented to the researcher accessing their data or not. If they gave consent whānau were asked to get them to sign a consent form for the use of their data. All young people consented. Adolescents were also given the option to meet with the researcher and ask any questions they had; none chose to do this.

An interview time was made with whānau. This was arranged with the whānau to ensure the time and place were appropriate. Only one participant chose to be interviewed at the CAMHS and biscuits and beverages were offered to this grandmother. All other participants chose to be interviewed at their homes.

Following cultural protocol, karakia (prayer) was offered prior to starting the interviews, after which I gave a brief mihi (introduction) and offered participants the chance to do the same. This initial phase of the interview provided the researcher and participants the opportunity to get to know each other through the cultural process of whakawhānaungatanga. The research was then briefly explained as a reminder to participants and space was left for questions. Whānau were then asked to sign consent forms (see Appendix V and VI) before beginning questioning and turning on the tape recorder. Each interview with participants was approximately 1-1.5 hours, allowing them sufficient time to share their insights into the effects of DSH and explain their needs. Interviewees were given a $20 grocery voucher for their time.

A semi structured interview schedule (see Appendix I) was developed that would allow participants to speak freely, but to ensure that certain issues relevant to the research were addressed. The aim was to allow interviews to flow and to aid in establishing rapport. Areas covered were as follows:

Whānau perceptions of events: Whānau were asked to describe the events and their reactions using open ended questions, such as ‘Tell me what happened when [child’s name] hurt themselves?’

Parental needs following DSH: Questions were included that aimed at eliciting whānau needs following DSH. Open-ended questions were included such as “What help have you felt you might need as a result of [child’s name] self injury?”

Motives for DSH: Perceived motives may influence engagement with treatment, perceived needs of whānau as well as the effect of DSH on care givers. The whānau interpretation of the motives for the DSH act was assessed using the list of motives developed by Hawton et al. (1982) and used in research with adolescents (Hawton et al., 2002), adults (Hjelmeland et al., 1998), and with family members in response to DSH by their relatives (James & Hawton, 1985).

Three extra possible motives were added in order to take into account cultural factors, peer relationship and possible media influence. Parents were shown the list and asked to choose any motives that they feel applied to the DSH act. They were able to choose as many as they thought applied. It is acknowledged that inclusion of such a list differs to the approach taken in relation to the other topics. As a result of this it does not allow for the predominately inductive analysis that applies elsewhere and may limit or shape the responses given by participants. However, it was decided that a list of motives would be presented to whānau as this had been done in several other studies and would enable some comparison. The list also served as a prompt which occasionally lead to more in-depth dialogue. The motives were:

- She/he wanted to show how desperate they were feeling,
- She/he wanted to die
- She/he wanted to punish himself/herself
- She/he wanted to frighten someone
- She/he wanted to get their own back at someone
- She/he wanted relief from a terrible state of mind
- She/he wanted to find out if someone really loved them
- She/he wanted to get some attention

- She/he wanted to escape from an unbearable situation
- She/he was influenced by friends/family who were also self-harming
- She/he was influenced by cultural factors (e.g. possession by a spirit or god, because of a curse, etc)
- She/he was influenced by something he/she saw on TV or the internet.

Family functioning: The whānau perceptions of family functioning was measured using open ended questions such as ‘How close do you feel to your child?’ and ‘Describe the relationship you had with your child prior to and after the DSH?’ The purpose of these questions was to examine participants’ ideas about family factors that may have contributed to the DSH, but also to investigate any impact on family relationships.

As reported above, information regarding engagement and treatment was obtained from files and discussion with the assigned clinician.

Māori staff from the He Kākano team volunteered to be interviewed. As was done with participants, a semi structured interview schedule (see Appendix III) was developed that would allow clinicians to speak freely and also ensure that certain issues relevant to the research were addressed. All clinicians were interviewed at the CAMHS. Interviews were recorded digitally and took on average approximately 45 minutes.

Data Analysis

All interviews were tape recorded and transcribed verbatim for analysis. Recordings were listened to as often as necessary to ensure accuracy in the transcription.

In preparation for data analysis I read each transcript several times in order to familiarize myself with and immerse myself in the data, as recommended by Braun and Clarke (2006). Primarily this was done by reading and re-reading transcripts on a participant-by-participant basis. I then read each transcript through twice more while generating codes. This involved noting sections of the interview that related to the three broad topic areas outlined above and highlighting distinct statements that related to any of these topics. Data was sorted into these topic areas, regardless of whether the statement followed the direct question or not. Once all transcript data had been sorted into the topic areas, statements were then read and re-read to identify themes and subthemes within each topic area. Statements that expressed information in common, or were similar to one another, were given distinct colours. Colour coded documents were also created on the computer, and the 'cut and paste' function was used in to move information between initial draft themes as well as join themes together if necessary. Themes and subthemes were then examined and re-examined to identify appropriate names which subsequently became headings.

The following distinctions were used in organizing and presenting the interview data: "Topics" refer to broad areas described above in the interview schedule, and include perceived motives, effects or impact on whānau, and their needs. "Themes" refer to particular areas within each topic and "subthemes" refer to salient concepts that relate to a broader theme. For example, under the topic concerning the 'impacts of DSH', the theme 'DSH affects parents' emerged and the subthemes of 'emotional impact', and 'effect on parenting' were identified. Themes and subthemes were then reviewed by my primary academic supervisor, as part of the validation process, in the manner recommended by Braun and Clarke (2006). This was done several times throughout the analysis process. Changes were recommended in the grouping of themes as well as the naming of themes. When a theme or subtheme was thought to not accurately portray the participants' meaning, or the analysis was unclear, he challenged me to explain my thought process and rationale. Changes were made to theme and subtheme headings where necessary to ensure they reflected participants' meanings in a coherent manner.

At a second stage, cultural consultation and opinion was sought. One of the taurawhiri at the CAMHS, who was also a trained social worker, was given the transcripts, list of codes, themes and subthemes, and my initial draft commentary on the themes and subthemes. She offered written comments for my consideration and made herself available to discuss these comments. This process resulted in additional comments being made in order to more accurately portray the cultural perspectives in both the analysis and conclusions section.

Direct quotations are presented in the next chapter in italic font. In some instances quotations were edited in order to make them easier to read by removing repetitions and fillers, or joining two related sections without including discussion regarding a different aspect that occurred between sections. This was done very carefully in order to ensure the participants' meanings were not changed. Participants' quotes were also carefully edited to preserve participant anonymity; this involved removing names and locations.

While whānau participants' quotes are assigned to individuals, those from clinicians are not assigned as given the small number of staff at the CAMHS it was thought these clinicians would be easily identifiable, and they were guaranteed anonymity.

Loosely translated English words are in brackets following the use of any Māori words and a glossary is provided on page 118.

CHAPTER THREE

Analysis of Whānau Interviews: Ngā Whakaaro

Pihi kau ake te whakaaro pai, hauhake tonu iho

'When a good thought springs up, it is harvested'

Whānau Ideas Regarding the Motives for DSH

All of the whānau members who participated in this study had experienced DSH with their child within the previous six months. Whānau were asked to describe their ideas about why their child had harmed themselves. As a prompt whānau were given a list of motives and asked if they thought any of the listed motives applied to their child.

All participants chose more than one motive, consistent with previous research (e.g., Auliffe, Arensman, Keeley, Corcoran, & Fitzgerald, 2007). Participants often elaborated further on motives chosen from the list or spontaneously discussed motives elsewhere in the interview.

Seven themes were identified from the whānau ideas regarding the causes of DSH topic area. Further subthemes were identified and these are presented below under the theme headings.

To communicate distress and seek help

In the list of motives created by Hawton et al. (1982) 'to show how desperate he/she was feeling' and 'to get attention' are listed as separate reasons for DSH. Recent literature has seen these as linked under the theme 'cry for help' (Scoliers et al., 2009). Whānau members interviewed for this research also appeared to link these two ideas. It is, therefore, considered that showing how desperate one is feeling and aiming to seek attention, should be incorporated within a single theme. For example, one mother reported thinking that her daughter wanted to show her how distressed she was and therefore get her attention and assistance.

> *I'd probably go with the first one [she wanted to show how desperate she was feeling], yeah because I honestly don't believe that she wanted to die, I think she was just crying out for attention because I mean she could have just done it, and not said anything (P3)*

Seven out of the ten participants reported that they perceived attention/a cry for help as a reason for the DSH of their young person. All of these participants also reported other motives for their child's DSH, and it appeared that no participant felt attention seeking was the sole motive. Two whānau members pointed to the corresponding number on the list of motives (P1 and P10); while three gave the answer spontaneously (P2, P3 and P9) and one mother pointed at the corresponding number and elaborated further (P7).

> *A cry for help too (P9)*
>
> *Like my daughter said, mum he only wants attention (P2)*
>
> *One [to show how desperate she is feeling] definitely, I guess, why else would you sort of do that ... To get attention definitely (P7)*

The type of DSH in each of these young people appeared to be very different. Participants from the families where the two young people had made suicidal threats reported attention/a cry for help as a motive; along with those participants whose young people had cut themselves or taken a drug overdoses.

To punish someone

Two of the mothers interviewed felt that their child had engaged in DSH in order to punish/get back at someone else. One mother reported this was a 'possibility'; although she did not elaborate, she had spoken about relationships in their home being strained. Another mother spoke about not allowing her child to go out with her boyfriend and being accused of giving more attention to another daughter, who she had felt needed more of her attention at the time.

> *So because she noticed that I sort of didn't take any notice and I said no to her she took it upon herself to go into the room and take my tablets… I think it was her way of showing me that well if I don't get my way I'm going to play up (P8)*

A third mother reported that she felt her son had wanted to punish himself. She reported that he had been acting out and one episode of DSH occurred following him getting in trouble with the law. She spoke about how she had asked him why he had cut himself and stated that he had replied that he needed to punish himself for doing something that was wrong.

He wanted to punish himself (P2)

To obtain relief from a distressing emotional state

This perceived reason for DSH was also one of the list of motives developed by Hawton et al. (1982) and three out of the ten whānau members reported this. These participants assumed their young person must have been in a difficult place in order to have engaged in DSH. Participants did not report discussing this directly with their young person; rather it seemed that in order to make sense of DSH they held the belief that their young person must have been in a very distressed state in order to want, or need, to harm themselves and that DSH was a way to seek relief. One participant reported that her daughter was very sensitive and had been very low in mood.

> *And, I'd probably go with the third one down [she wanted relief from a terrible state of mind] she obviously got herself in a dark place (P3)*

Another mother also chose the motive from the list and read it aloud.

He wanted relief from a terrible state of mind (P2)

To die

Three mothers (P2, P7 and P10) reported that their young person's motive was to die. When asked why they felt their child had engaged in DSH all three responded by pointing to the corresponding prompt *"he wanted to die"*. One mother was hesitant and appeared unsure, stating *"maybe two [the corresponding number to the motive]"*. All three participants also chose other motives. It was not explored as to why these mothers felt their children wanted to die, as this research was exploratory and the researcher did not want to be overly intrusive but rather encourage spontaneous comment. However, it may be hypothesised that for one mother this perception resulted due to the method and frequency of attempts as this young man had attempted an overdose followed by cutting in secret with his door locked. For the other mother it may be that her son was very demonstrative of his distress and he also used cutting and threats of stabbing himself.

The above motives (relief from a dark state of mind or mood and to die) have been referred to in recent literature as the 'cry of pain' motive and studies state that these motives are more frequently reported by adolescents than externally directed motives (such as to gain attention or change someone else's behaviour; Scoliers et al., 2009). The 'cry of pain' motive may be interpreted with a more cultural perspective by considering DSH as an expression or manifestation of deep seated mamae (hurt) or pouri (sadness).

They were influenced by others

Seven out of the ten participants felt their young person had been influenced by others. Six out of these seven reported that their young person had gotten the idea of DSH from witnessing the behaviour in someone close to them, either at school or within the family.

One mother spoke about how her daughter was being bullied and had attempted to tell authority figures but was not listened to. She stated her daughter had witnessed a peer self harm in the past and had seen the "positive effects" for the other young person following this incident, which had given her the idea.

> *She sees that another girl had cut herself a couple of months ago and saw the attention she got, so she did it (P9)*

Other mothers spoke about the influence of peer pressure and how children were attempting to fit in with others and were influenced to engage in DSH in order to be accepted. In the words of one mother:

> *To me she was really copying what her friend was doing… I think too some of it is peer pressure (P7)*

Another mother spoke in particular about the "emo" (short for emotional) youth culture, known for its emotional state of mind, where young people often have dark hair covering their faces. The "emo" culture has most commonly been associated with white middle class teenagers. It was this participant's opinion that "emo's" engage in DSH and as her son became friends with this peer group he was encouraged or influenced to also engage in DSH.

> *He'd been kicking around with the emo's, and that's what the emo's do (P2)*

One mother spoke about her own DSH and how this impacted her daughter and influenced her DSH.

> *I didn't realise how much of an impact that [mother's cutting] had on her, my daughter felt that was the only way out, she believed, through me, that her only way out was to self harm, because that's what she's seen (P4)*

One mother reported her daughter may have been influenced by something on the internet, although she was unsure what that may be she felt her daughter had spent a large amount of time on the internet.

> *I think it could be the internet somehow, because she lives on that internet… yeah I'm thinking it could be something on the internet (P6)*

A response to feeling overwhelmed by difficult circumstances

Working in a CAMHS it is not uncommon to hear parents and caregivers speak about how their young person has 'more going on' or 'more to deal with' than they did at the same age. Caregivers' commonly report being concerned by exposure to violence, drugs and alcohol, as well as earlier sexual experiences and advances in technology. Advances in technology may also expose young people to other forms of harassment, such as text and internet bullying.

Three participants felt that a combination of negative events likely led to their young person feeling overwhelmed and unable to deal with numerous stressors at once. One mother, whose daughter had text her saying she was going to run into traffic, reported that her daughter had recently had difficulties with her boyfriend and has also been bullied by text message and on social networking sights, which her daughter had found very distressing.

> *…her ex boyfriend [contributed to her low mood] but then in saying that, that was only part of the problem… before that happened there had been problems at school where she was getting bullied at school, text bullied, bebo [a social networking site], people saying things… even just the bullying thing itself was really bad, and then with them [daughter and her boyfriend] breaking up that just sort of topped everything off, because it was within a couple of weeks of each other (P3)*

While participants reported that young people have a lot to deal with in their school and personal lives, family life also had major impacts. One mother spoke about relationship difficulties between her daughter and her boyfriend. This participant reported that the boyfriend had compromising photos of her daughter on his phone, which her brothers had seen. She stated the humiliation and betrayal her daughter felt, which coupled with family stressors (the mother herself was facing a court case) led to her daughter feeling overwhelmed and unable to cope.

> *Her boyfriend was involved as well [in causing her distress], and plus this court case and not knowing what was going to happen to me, it took a real thing [toll] on [her] (P4)*

One grandmother reported that her granddaughter was having difficulty coming to terms with not living with her mother (as her younger siblings were). She was also witnessing domestic violence when visiting her mother and was being told by her step father not to talk about it or tell her grandmother.

> *…she saw everything that was going on there; she was being told to keep quiet… she bottled it all up inside herself (P1)*

Three participants also reported that their young person was bullied prior to engaging in DSH and they felt this was a precipitating factor that may have contributed to DSH.

> *…there had been problems at school where she was getting bullied at school…it was really quite intimidating… (P3)*
>
> *Because she's actually been a little bit bullied a bit at school and things like that so we're having to deal with that as well with [her] (P4)*

One of these mothers reported that following DSH she had spoken to her daughter and her daughter had confessed to having a difficult time at school due to bullying. She reported that she was being verbally bullied by another young person and had spoken to a teacher, however nothing was done about it and the bullying continued.

> *She told me she was getting picked on and the teacher wouldn't do anything (P9)*

Two whānau members responded that they felt their young person engaged in DSH due to having a boyfriend or girlfriend break up with them. One mother described her son breaking up with a long term girlfriend in order to date another girl, when this relationship did not work out he attempted to reconcile with his ex girlfriend. She stated that the ex did not want to get back together and she noticed a change in her son’s mood.

> *He left a girlfriend of two years to go with this girl and I know when he did that and went back to the new girlfriend she didn’t want him (P2)*

Another mother spoke about her daughter experiencing a relationship break up and how this added to her difficulties.

> *…he broke the relationship off. That was when we noticed a big change in her, before that she’d been a little bit moody but that was when she text me and told me she way going to throw herself in front of a car (P3)*

In response to direct questions asked about what relationships were like prior to the discovery of DSH five of the participants reported difficulties in the relationship they had with their young person prior to DSH. This is consistent with research that reports difficulties in parent-child relationships and impairments in adolescent-parent communication are associated with an increased risk of suicide and DSH (Byrne et al., 2008; Fergusson et al., 2000).

> *She wouldn’t say much, she just went like a recluse into her room every day… she wouldn’t talk to me… I didn’t really have much time for my kids… I was working and the only time I had for them was sport, taking them to their sports (P9)*
>
> *It was very shaky; it wasn’t that close relationship that I would like to have had with her. We’ve had quite a rocky time over the previous two or three years (P7)*

Whānau appeared to believe that a lack of communication within their family had resulted in them not connecting as a family unit, may have made their young person vulnerable to DSH. One mother spoke about how a busy lifestyle had led to a change in the family’s routine. She stated that family members were ‘doing their own thing’ and would eat at different times and not together, which was a change from how things had been within their family.

He told other people that it affected him really bad [not talking unless we had to… doing our own thing] (P2)

Another mother spoke about the relationship difficulties between her son and his father prior to her son engaging in DSH. She reported difficulties in communication and disconnection between family members. She reported that after attending the CAMHS her son has spoken about how this impacted his life.

He said his dad never listened (P5)

Only three of the participants spoken to were mothers of young men who had engaged in DSH. Research suggests that same sex attracted young people are at a greater risk of self harm behaviours (Brown, 2002). One of the mothers reported that her son was gay and it was her opinion that this was difficult for him to deal with and may have lead to his emotional difficulties and DSH. It was not explored further as to why this mother reported sexuality as a factor in her son's DSH, it is therefore unknown as to whether the family had difficulty accepting this or if he was being harassed. As reported above this research was exploratory in nature and encouraged spontaneous comment.

And another one, sexuality, because he's gay (P10)

Cultural influences

Matakite is a cultural phenomenon that has been loosely translated as clairvoyance. It may involve seeing or hearing spirits or being able to see the future or past. In general Matakite is an accepted part of Te Ao Māori (Māori world view). However, as mentioned above, Māori are not a homogeneous group, and as in other cultures there are those who believe in this gift and those who do not. There are also those who embrace Matakite and those who are distressed by it.

Two of the mothers interviewed reported what appeared to be culturally specific factors as precipitating factors for DSH. Both of these related to seeing things that others could not. Neither of these young people had been diagnosed as psychotic and the agency had regarded both of these young peoples' experiences as within the accepted range of phenomena for Māori. One mother reported that her son felt cursed;

> *Sometimes he thought he was cursed…because he kept seeing things (P10)*

While the other stated that her daughter was always sensitive and was frightened by her "ability".

> *…even when she was little she used to say an old Māori lady was sitting there, she doesn't talk to her but she's there and its scaring her… that's playing on her mind too… I do believe that she does have psychic powers and she just doesn't know how to deal with it and it scares her… it [threats of suicide] could be because she doesn't know how to deal with it (P 3)*

The Impact of DSH on Whānau

Whānau members were asked about the effect or impact DSH had on them and their family. There is little information about how the reactions of parents influence their child's progress and adjustment after DSH. As with the needs of whānau, a small amount of research suggests that the impact of DSH on parents is significant and may be overlooked. Research has shown that parental reactions to DSH may include anger, fear, sadness, frustration as well as guilt, shame and embarrassment (McDonald et al., 2007; Wagner et al., 2000). Recent research suggests DSH is a traumatic event for parents and may have a 'ripple effect' on families (Byrne et al., 2008)

DSH had wide reaching impacts. Four themes were identified regarding effects and impact on whānau. These themes were, DSH affects the wider family, DSH has effects on parents (this theme had two parts or subthemes: emotional impact and the effect on parenting), and DSH results in practical difficulties.

DSH affects the wider family

Six out of the ten whānau members responded that the DSH of one young person affected their whole whānau, including other children in the home, as well as the extended family such as grandparents, aunts and uncles. One mother reported that the DSH of her son had had a negative impact on her younger children. She spoke about how his DSH was visible to his siblings and there were times when he threatened suicide in front of his siblings. It appeared that he modelled behaviours to his younger siblings (who began to experience acting out behaviours) as well as the fact their behaviour was affected by emotional stress within the family.

> *It affected all my kids; my older girls had to start doing counselling… the little ones were acting out heaps (P10)*

A grandmother spoke about the impact of their granddaughter's threats of suicide on her and her husband, she appeared to consider that DSH would not only be hurting her granddaughter but would also hurt both her grandparents; she stated that she told her granddaughter:

> *You're not only hurting yourself, you're hurting Nan and Pop (P1)*

Two participants reported that the DSH from one child had made them more aware and worried about others in the family. One mother was directly worried about her son attempting suicide, as she felt he had been through more and had more stress in his life than her daughter (who engaged in DSH). Her daughter's DSH had also made the possibility more 'real' to her.

> *I was a bit worried about my son too, because he's been through a lot of stress (P6)*

Another mother spoke about her siblings (the young person’s aunts and uncles) had favoured her other daughter (young person’s sister) and were often hard on the daughter who engaged in DSH. However, their behaviour towards her changed following DSH and they acted more caring towards her.

> *And after that they [her aunts and uncles] all changed their tune towards her… they didn’t pick on her any more (P9)*

DSH affects parents

The impact of their child’s DSH on parents appeared as a strong and consistent theme. This theme appeared to have two distinct parts to it: an emotional impact and the effect on parenting.

Emotional impact: The emotional impacts of their children’s DSH ranged across a number of emotions including worry and fear, confusion, guilt, disbelief and shock, anger; and the combined impact of this which was to leave them feeling drained and depleted. For most participants there was a mix of emotions. These emotions were often described as leading to certain behaviours or responses: some adaptive, some not so.

Eight out of the ten whānau members reported having a fear or worry that their child would harm themselves again. As a result, they reported being more vigilant with watching their young people, as well as keeping items that may be used for DSH, such as medications, in a place the young person could not access them. One mother whose daughter had attempted to overdose reported how as result of the DSH they took precautions to prevent further episodes involving medicines.

> *We didn't leave any pills around, we left our Panadol and stuff up in the cupboard there, cough medicines and stuff, but we actually put them away. We didn't leave them out any more for her to have access to (P7)*

Another mother whose son engaged in cutting and suicidal ideation also reported worry as a strong emotional response, and she held fears for his safety which kept her up at night worrying. She reported this fear caused her to take measures to hide anything that may be used for DSH, even if he had not done so in the past.

> *It was sleepless, it was like sleepless nights…you're restless, you're always checking, checking the medicine cupboards…just constantly, just checking twenty-four seven. You become obsessed (10)*

Consistent with Australian research by McDonald et al. (2007) six out of the ten participants spoke about feeling guilty and that in some way they had let their young person down, or failed as a parent. One mother spoke about how she felt she had failed in some way as a parent for her son to be feeling how he was and engaging in DSH.

> *Definitely a lot f guilt… you feel that you have failed as a parent (P10)*

Another said:

> *Something went wrong and I didn't recognise it (P8)*

While another mother spoke about guilt related to not seeing or recognising what was happening for her daughter. She reported she had been working long hours and had thought at the time that being able to provide financially for her children was most important. She spoke about the guilt she felt at not being there for her daughter when she needed it. She also reported that this had led to her cutting down to part time work and spending more time with both her children.

> *Yeah I felt guilty that I never saw it, I didn't really have time for them and yeah that I couldn't do anything for her (P9)*

Four whānau members stated they were in a state of disbelief or shock after learning their young person had engaged in DSH. Two mothers stated that they had thought DSH was not something Māori people do and that it was a Pakeha or non-Māori problem. This influenced their emotional reaction and they reported feelings of being shocked and confused. Both of these mothers had reported that their child was dressing in an “emo” way which they had also linked with DSH.

> *I’ve always thought yes, it’s the Pakeha that do that all the time, you know, why would a Māori bother to do that? You know it’s what I used to think before it actually happens to your own (P6)*

> *I’ve always thought it was a white thing (P2)*

When describing their emotional responses shock appeared to be a common theme. It seemed that this shock was related to the belief that DSH happens to other people and is not something that these participants had thought would ever happen within their families. It appeared that for most participants DSH was not something they had considered before and not something they worried about. It appeared that most participants were caught off guard by learning their child had engaged in DSH. In the words of one mother:

> *We were shocked when we heard; we didn’t really believe that something like this would happen (P6)*

Three participants talked about how they and other members of their family also felt angry at the young person for engaging in DSH. While the three mothers appeared to share the same emotional response there appeared to be differing reasons behind the emotion.

One mother reported that her son threatened DSH in front of his siblings and was ‘acting out’. She spoke about how this had gone on for a long period of time and it appeared to be emotionally taxing on the entire family. She stated that this behaviour impacted on his siblings and her older daughters became frustrated.

> *Yeah, definitely a lot of guilt and anger… They [his sisters] hated him; they resented him (P10)*

Another mother, whose perceived motive had been that her daughter was trying to get back at her, reported feeling so angry that she wanted to go into the hospital where her daughter was in a medically induced coma and hurt her.

> *All I wanted to do was go up there and hurt her for doing that, for hurting herself (P8)*

Most participants reported that they had felt a mix of emotions; one mother stated that her daughter had been having behavioural difficulties at school and she had been called in a few times so when she was called in for DSH she felt angry at being called away from her job again.

> *I felt angry because I had to come away from work again you know? (P7)*

Six participants also felt confusion and uncertainty related to a number of different aspects of DSH. Families reported feeling uncertain or confused as to the why their young person had engaged in DSH. One mother who had attended sessions at the CAMHS reported that she was still unable to understand why her daughter had engaged in DSH.

> *And even to this day I don't understand why she went along that path (P7)*

Most participants spoke about not knowing what to do or where to seek help for their young person. It appeared that they did not understand the behaviour and therefore did not know what to do to help their young person. This was expressed by some participants as a feeling of confusing regarding what to do about it or where to go for help,

> *I don't know what to do. I need help, what do I do? (P5)*

Some participants were confused about what triggered the young person, if it would happen again and how to prevent that. One mother spoke about how her daughter often experienced rapid changes in mood. It appeared that following the threat of suicide, each time her daughter's mood became low she worried that her daughter may feel suicidal or engage in DSH, which was not something she had previously considered.

> *What scares me is that she can be so happy and then all of a sudden really quickly she can be in that really dark place. And it's like, you just, don't know what some triggering her so quickly to go to that dark place (P3)*

For some whānau members DSH appeared to come out of the blue which left them feeling confused and concerned that if they did not notice it the first time, they may not notice it again. In the words of one mother:

> *She's already done it, you know, she could do it again (P6)*

Another participant echoed these thoughts and stated that at times she would check on her granddaughter and ask if she wanted to hurt herself, as she had not been aware of these feelings in the past, she appeared to be unsure of how she might tell if her granddaughter was feeling this way in the future.

> *We still have in the back of our heads that same question; you don't want to hurt yourself do you? And sometimes we ask (P1)*

Four whānau members spoke about the combined emotional toll that left them feeling drained or depleted of energy. They reported finding the emotional demands, as well as the practical demands of getting time off work and getting to appointments draining. One mother whose son had ongoing DSH spoke about the busyness of her days; she took the children to trainings and school as well as working full time and looking after the house. It appeared that the added stress of DSH along with the practical stressors of getting time off and attending sessions had taken a toll on her emotionally.

> *Umm yeah I think the most, I was really drained (P7)*

One mother spoke about meeting her son's emotional needs, as well as the constant worry about him and checking on him left her feeling drained. It appeared that her worry for his safety resulted in constantly checking the house for items which her son may have used to harm himself.

> *Just too constantly have that support for him, just to make sure he was safe… yeah, it was draining (P10)*

One mother whose son had threatened suicide reported feeling so exhausted and overwhelmed that she considered relinquishing custody of her son to the Child Young Persons and their Families Service (CYPFS). This mother was also working long hours and had reported a lack of communication in their family.

> *I was just more hurting and thinking ah who can help us, and honestly I was thinking of giving him to CYPFS (P5)*

When asked about the impact such emotional reactions had on them, two mothers reported that they turned to alcohol as a coping mechanism following the DSH of their young person.

I started drinking a lot more. That's how I dealt with it (P10)

I turned to drinking quite a bit… pretty much I just like to drink and forget about it (P5)

Effect on parenting: Eight out of the ten of participants spoke about the affect DSH had on their parenting in terms of setting and keeping to limits and boundaries. Some families reported a tightening of boundaries and adopting a more strict style of parenting. One mother spoke about how her husband had attributed their daughters DSH to the 'punk rock' or 'emo' culture which directly related to her fashion and appearance. She reported that her husband had become stricter in terms of how his daughter dressed.

> *When that happened he [her father] told her all those piercing have to come out, all the black eyeliner, all of it. He said, I don't want to see that stuff on you (P6)*

Another mother spoke about how her daughter was bullied prior to engaging in DSH, she also reported that they had a busy life style and she worked a lot, which meant she was not able to spend a lot of time with her children. She reported that following the DSH of her daughter she cut back her hours at work to spend more time with her children.

> *I wanted to be more protective of her... I finished my job and I made a thing to spend more time with my kids. I'm going back to work but I'm not going back to fulltime* (P9)

One mother also spoke about being aware of the desire to be more lenient because she did not want to upset her child and risk her feeling suicidal again, however she also recognised the need to parent and set limits.

> *…Sometimes it's a bit awkward, like you don't want to rock the boat because you don't know where her mind is at sometimes, but then I thought, no, she needs to know how worried we were about her (P3)*

Others spoke about a fear of setting limits or saying no to their young person for fear that would lead them to engage in DSH. One mother reported that the attention of the family shifted to focus solely on her daughter and do anything to improve her mood.

> *Whatever she wanted we'd bow down, we gave in; there was no rules, no boundaries, that had all gone. Whatever she wanted we gave her… yeah as a parent you will do anything to keep your child alive and if it means letting her go out where as normally you wouldn't then you would do that, um if she wants to see her boyfriend where you said no to, why this thing happened you said yes to that. Yeah things completely changed (P4)*

While many participants discussed the negative impacts of DSH on their parenting and relationship with their young person, positive impacts on the parent-child relationship were also discussed. Six out of the ten participants reported an improvement in their relationship following DSH. One mother reported that she had been focused on her career and making money for her child as she thought this would be best for them, however following DSH she stated that she now felt spending time together was the most important thing for her family.

> *I think that it drew me closer to my children and my thoughts after that was bugger making a lot of money if your kids aren't around to enjoy it, I'd rather be wearing rags than my kids mental health and everything suffering for it (P9)*

Two mothers reported that communication had improved and had resulted in more positive relationships and a more positive home environment.

> *After we were attending [CAMHS] it [relationship] did change. It changed for the positive, in a very positive way. For [daughter] and my husband as well… It [CAMHS input] seemed to help her, because our household, the whole lot of us changed and it was a better place to be, a better place for all of us, and we were all talking to each other instead of yelling and screaming at each other and actually listening to what [daughter] had to say… I could say we were the happiest we'd been in a long time (P7)*

We get on really well now, there's a lot more communication happening… His father's talking a lot more, that's changed. Yeah, he communicates now (P10)

Another two mothers spoke about how they and their daughters had gotten closer following DSH.

Oh absolutely yeah [the relationship has changed], I mean we've gotten closer, a lot closer, she's like, we were just sitting the other night and just sitting in the room and she said to me 'mum you're my right hand' and I said 'well you're my left'… but absolutely we've gotten closer, we've got an awesome relationship (P4)

…Probably if anything it's probably made us even closer (P3)

These particular participants appeared to have been strongly impacted by their child's DSH, which had noticeable impacts on their parenting confidence, causing them to be more wary and careful, as well as examine their parenting and relationships with their children. However, most of these family members appeared to have responded by emphasising the relationship and making positive changes, thereby strengthening their connection to their child.

Practical difficulties

Whānau members spoke about practical difficulties that arose following DSH. These included the getting time off from their employment, needing to organise care for other children and the financial cost of getting to appointments.

One mother spoke about the financial difficulties faced; she reported that the family lived on a strict budget and the extra petrol needed to get to appointments, as well as the time off work had come unexpectedly and therefore been difficult to manage financially.

> *...And it did put me out right of budget. Like, it cost me financially. You know, its, it put, it put us right out, like right out of food (P10)*

Two other mothers also reported taking time off work as well as getting to appointments had been a challenge.

> *I had to move on, to get myself ready and then organising this lot [young children] (P8)*

Needs of Whānau Following the DSH of their Young Person

Whānau members were asked to describe their needs following the DSH of their young person, and whether these needs were met or not.

Support and information emerged as the central themes when families were discussing their needs and the perceived needs of their child following DSH. Support encompassed five subthemes, support for the young person, support for family members (including parents), support for the whānau together, support from the school, and cultural support. Information encompassed two subthemes, knowing where to seek help, and having information about their child’s treatment.

There is a need for support

Support the young person: Seven of the ten participants reported that they would have liked or did like their young person receiving individual treatment. It is interesting to note that while generally Māori are viewed as a collectivist culture these whānau members also felt that in relation to DSH, individual work was needed. Five of those seven whānau members responded that in their perspective their child needed to talk to someone, and since they were not talking to people within the family, they therefore needed to be talking with someone outside the family.

> *I think she needed help at the time, someone to talk to, you know, if she can’t talk to her own parents. Someone else, but she had to want that sort of help. I thought it might have been helpful talking to someone else she doesn’t really know, you know, sometimes people can talk to people that they don’t know (P6)*

> *I actually wanted that to happen [individual counselling] because she wasn’t talking to me, I wanted her to talk to somebody because you know, I still wanted to know why, but she’s not going to tell me so at least if she can talk to someone she can get it out (P7)*

One mother also responded that she wanted her daughter to have professional help from someone who had experience dealing with DSH and low mood.

> *I think she needs to talk to somebody… someone with expertise in that area (P3)*

One mother felt that her child needed intense mental health support in the days following her attempted hanging that they did not get. This mother had her own history of DSH and the family were also facing a serious court case.

> *She needed intense counselling, I mean she needed to be like every day, it needed to be every day but it wasn't (P4)*

Support for family members: The second subtheme involved support for the family to cope. When asked what they believed the needs of their whānau were, most participants commented on the need for professional involvement or support, not only for their young person, but for themselves and/or their family as well.

Seven out of the ten whānau members also reported that they had needed (whether accessed or not) support for themselves and other family members. Participants differed slightly in the reason behind this need, some family felt the DSH had impacted other children, while others felt they as parents needed support to deal with the distress created, as well as learn skills related to managing their young person who had or was engaging in DSH.

One mother reported that her friends had been supportive during this time and that by letting them know what was going on she had been able to access support, which was helpful.

"The beauty about that [letting friends know] is that they were there to help me" (P8)

One mother spoke about how witnessing threats of DSH had affected her young children, she reported that when angry her six year old would say *"shut up or I'll kill myself"*. She stated that she and her family had needed more involvement from professionals and support to cope with the effects DSH had on them.

> *For the whānau, more whānau support with counselling and stuff I guess (P10)*

One mother who had attended sessions at the CAMHS reported that this support for the entire family provided a safe space to communicate which had been beneficial in helping her family as well as her son.

> *That was the biggest thing [having space to talk] and actually listening to what we were all saying for a change… and just saying how we felt (P7)*

Three participants reported that their needs were not met in this regard, either by not being offered, or by being offered and then not followed through with. They reported a lack of support for themselves and their families that they felt would have been helpful.

One mother spoke about how support was offered for her daughter only and not for her or her husband.

> *Yeah, it's been for the victim [of DSH; her daughter] and not actually for us [the family] (P3)*

One mother spoke about attempting to get support by calling crisis lines and not getting what she needed. She reported this experience left them feeling like they were *"not a family worth helping"* (P4). She reported being angry at the mental health advertisements on television as she felt the help was not there when people really needed it.

Another mother stated that she had been offered help but had received no follow up and was disappointed by this as she felt it was needed.

> *I felt really good, they said they were going to put me through counselling but never got back to me (P5)*

Two mothers also spoke about feeling high levels of stress following the DSH by their young person. They spoke about needing some time to themselves in order to manage stress levels and look after themselves. One mother had gone away on a planned woman's weekend which she reported finding very beneficial.

> *I just thought, I want to go away and by the time I left, I really needed it (P2)*

While another mother spoke about how not having any time out of the situation was a stressor.

> *I don't have a break, I don't get time out…it becomes stressful (P10)*

Only one participant spoke about not wanting to talk with anyone outside the immediate family due to shame and fear of judgement from others. She talked about how her daughter dressed in 'emo' fashion and how this was not a 'normal' thing for Māori to do. She felt that if they knew about the DSH then it would further alienate her daughter.

> *This is not something we need to tell everybody, because they already think she's a bit weird (P6)*

Consistent with Byrne et al. (2008) was the discussion of peer support. Support programmes for parents/caregivers have shown promise in recent research for decreasing parental distress as well as their ratings of their young person's distress (Power et al., 1998). Two mothers spoke about the benefits they felt peer support would or had offered them. One mother in particular verbalized wanting to share her experience with other whānau. Participants felt a group would have offered them the opportunity to learn from and support one another.

> *It would have been good to find out if any other parents had problems with their kids like that, see how did they deal with it and has there been any results, have they fixed themselves up or what… I just wish I had someone else to talk to you know, like some other parents who have had the same problem and see how they dealt with it (P6)*

While many of the participants spoke of needing or wanting help, some talked of the difficulty they had in being open to receiving help form a mental health service. Although not directly asked, two whānau spoke about how the concept of mental health and attending a mental health service was difficult to come to terms with given the prevalence of stigma associated with it.

One mother spoke about how her husband did not want to attend the CAMHS. The CAMHS and young person had a formulation that related directly to her husband and daughter's relationship, and even though she responded that she felt her daughter needed someone to talk to they did not access services due to her husband's refusal to attend.

> *[Dad] he didn't want to go, I think it's because of the mental health part (P6)*

Another mother spoke about the difficulty of explaining mental health services to family members, as well as being uncomfortable herself with the name as she felt it implied her young person was 'mental'.

> *I said to [CAMHS clinician], I don't like saying your name because I feel mental health you know, when I mention that they you know, my family, 'its alright mental health people are going to help me' 'is he mental?' 'No, no he's not!' (P10)*

Support for the whānau together: While speaking of their needs and discussing support for their young person as well as other members of the family four out of the ten participants commented on the need for individual work for the young person in combination with family work and support.

Both [individual and family support] I think, yeah that's what I was looking for- counselling, so yeah both (P6)

Consistent with recent literature (Byrne et al., 2011) families appeared to want psychoeducation around why young people self harm as well as how to manage DSH. One mother spoke about wanting to better understand what triggers her daughter to engage in DSH.

> *Both [individual and family work], I'd like her to be taken and then for us. She can get her help and then for us, we can know what triggers her or what to help her* (P9)

Support from the school: One mother spoke about wanting the school to be more involved, as she felt that a primary cause of her daughters DSH was bullying. She reported that her daughter had told a member of staff about the bullying and nothing was done, she then spoke about how when her daughter cut at school she felt that the school did not offer support but rather ‘attacked’ her by informing CYPFS without discussing it with her.

> *The only thing the school offered was CYPFS, I just felt like I was being attacked* (P9)

Cultural support: Two out of the ten whānau members reported wanting a more Māori specific approach to treatment. One mother reported speaking to the kaumatua (male Māori elder) at the CAMHS and felt like they were working in Māori specific with their clinician who was also Māori. She felt this was appropriate for her daughter.

> *…When we went to [CAMHS] we were able to speak to the kaumatua there… I think that's where we are going [Māori specific treatment] with [the clinician] because I do believe that whatever this is she can see is possibly putting her in that dark place (P3)*

One mother spoke about how they felt their Māori spirituality played a part in their life and how they were also open to trying anything for their young person, while one mother spoke about how Māori specific treatments were not offered to them and they were seeking it out on their own.

> *[my husband] seems to think nothings working, so we're going to take them back down to show them where they're from and [my husband] has an older brother there and they do a lot of spiritual healing there and we're going to try that (P2)*

Information is needed

Whānau spoke about not knowing how or where to seek help from for themselves and especially their young person. It appeared that they did not relate to the recent television commercials regarding mental illness, as they felt their young person was not “mental”.

Information regarding knowing where to seek help: Seven of the ten participants reported that they had not initially known where or how to access support services. The reported that they had needed more information on what services were available to help their whānau. Most families reported not knowing what services existed or how to contact them, some families were referred to the CAMHS by other agencies and stated they would not have known about this option if it was not presented to them.

> *You know, I wasn't too sure how to go about and help her… I felt that we had to deal with it ourselves, [we needed] mostly information, you know, or where can we go for help. Things like that you know, is there any help out there for our kids if they do something like that [DSH]? (P6)*

> *We didn't know who to turn to… if the school hadn't of told us about it [CAMHS]…. I wouldn't have known, I totally wouldn't have known, so yeah, I was just more hurting and thinking who can help us? And honestly I was thinking of giving him to CYPFS… I reckon there should be some sort of advertising for parents that need help (P5)*

Participants did not appear to reconcile the current mental health advertising campaigns with their children, it appeared that these campaigns were aimed too directly at adults or the problems represented appeared far more serious than what they considered their child was. It seemed that participants recognised their young person was struggling and also could not link that with labels used on campaigns such as “bipolar” and “depression”.

> *Yeah, I really didn't know what help is out there (P9)*

> *But it was us trying to think who do we contact? … We didn't really know where else to go and I mean, we've got the internet but we weren't even thinking about searching on there, it was just, for us it was yeah who can we go to? (P7)*

Information regarding their child's treatment: Three participants reported communication with other professionals involved in their young person's life had been useful and necessary. These professionals included school, the police, and the CAMHS.

> *Her teacher [has helped], she communicated more and would let me know straight away if anything was going on with her or if she had a bad day or was in trouble (P9)*

> *I found it helpful. They [police] kept in touch with me just to make sure that he's ok and what was going on (P10)*

All three also spoke about how lack of communication with professionals had been difficult, these professionals included the school and in particular school guidance counsellors (SGC), as well as the CAMHS.

> *Not knowing [made things harder], I mean, because [CAMHS] too, only let you know if they have to, if there's something serious, I do believe we need to know everything to help her (P4)*

One mother spoke about her frustration at the SGC; she reported not being included or kept up to date with her daughter's progress which left her feeling worried and excluded. This is a delicate issue for those working with young people 16 and over as one must balance confidentiality with making the whānau aware of risk issues.

> *…we were forever ringing the school and trying to make contact with them, the counsellors, and they kept saying "its private, its private" and I say "it's my daughter's life!" I just want to how is she doing and should you tell me anything I need to know? "It's private, it's private"… I needed them to help me to understand [her] because she was in intense counselling with them. But no it's all blocked… That's what we kept saying, that we're a whānau, that you know, we communicate and we need to know what's going on with our babies and yeah, when they cut you off like that well how am I meant to know, you know if my daughter shuts down from me yet she's telling you shouldn't I know this or be aware of it? (P4)*

CHAPTER FOUR

Analysis of Key Informant Interviews

Kaua e rangiruatia te ha o te hoe; e kore to tatou waka e u ki uta

Do not lift the paddle out of unison or our canoe will never reach the shore

Key Informants' Ideas Regarding the Motives for DSH

Most key informants spoke in general terms, and some gave examples of specific clients they had or were working with. Six themes were identified in key informants' ideas regarding the motives of DSH topic area. Further subthemes were identified and these will be presented below under the theme headings. Key informants did not report any motives they believed to be culturally specific. This may reflect a lack of willingness from whānau or clinicians to discuss cultural aspects, such as matakite, in a perceived Western setting (the CAMHS or a university-based thesis research project).

To communicate distress and seek help

Fitting with whānau reports, four of the five key informants reported that they perceived DSH to be a way for young people to draw attention to their difficulties or situation and gain assistance. In agreement with recent literature clinicians appeared to link attention seeking, communicating distress and help seeking behaviour together as a single 'cry for help' motive (Scoliers et al., 2009). They spoke about how it may be a young person's way of getting others, their family in particular, to notice their distress. Key informants did not appear to relate attention seeking with negative connotations but rather with help seeking and communication of distress.

> *They want things to be sorted out but you know, mum may be just sort of on another planet, dad doesn't care, siblings are all doing their own things, kids in the middle of just a whole lot of mess and wanting it to be sorted out, so yeah, just wants to draw attention to that so they draw attention to themselves in that sort of way*
>
> *Could be getting mum and dad's attention, or family's attention of doing it, umm yeah could be getting anyone's attention really, could be a cry for help*

One clinician spoke about DSH as a way for young people to get attention from someone else in order to have their needs met in a relationship. She spoke about a young woman who would use DSH as a way to get her partner to care more for her.

> *The example I think of is a girl wanting to get more attention from her partner, from her boyfriend or wanting to get him back in her favour or feeling really needy or feeling invisible in a relationship, either in your nuclear family or extended family or in your intimate relationship... it's a way of being seen, really important attention seeking*

To punish someone

Only one out of the five key informants reported DSH as a way for young people to punish their parents. This clinician spoke in particular about a young man whom he felt wanted his mother to take responsibility for something she had done to his father. This young man was close with his father and had a difficult relationship with his mother. He also spoke about the mother being controlling and felt the boy wanted to get back at her by engaging in DSH.

> *He didn't respect his mother at all, he loved his dad and just decided to cause her pain, cause her grief, by hurting himself and yeah she just fell over. It's almost cruel in a way; he wanted to make her feel what he was feeling about what she had done to him*

To obtain relief from a distressing emotional state

Key informants did not appear to discuss specific triggers but rather metaconcepts, such as a lack of emotion regulation abilities or poor problem solving capabilities. Two out of the five key informants spoke about DSH acting as a way to regulate emotion in some way. One clinician reported clients talking about the feeling of relief they have following engaging in DSH.

> *I think a lot of it is about that relief*

The other clinician spoke mostly about peer influence however also reported that:

> *...part of it is like a release of whatever*

A response to feeling overwhelmed by difficult circumstances

Three key informants reported that difficulty dealing with historical traumas lead to DSH. These key informants appeared to relate these traumas with a lack of distress tolerance skills which may possibly result in young people engaging in DSH in order to cope. These historical events have also been reported in literature as risk factors or precipitating events leading to DSH. These responses may reflect clinician's experiences, as well as knowledge of the literature, as research has suggested an association between DSH and physical abuse and a strong association between DSH and sexual abuse (Grossman et al., 1991).One clinician, while not talking about any specific client, stated:

> *There could be physical abuse, there could be sexual abuse*

While another reported:

> *It could be stuff that's happened in the past*

One key informant spoke about young people feeling particular pressure around school work and examinations. He reported this may lead to young people feeling overwhelmed and like they have failed, resulting in DSH.

> *...not achieving when they have got exams and just feel it's out of their depth and they're not going to get there. And of course as parents, a lot of parents expect a lot out of their children to achieve and so when they feel they're not achieving and they're failing*

They were influenced by others

All five key informants spoke regarding their perception of the contagion of DSH. One clinician reported that friends may discuss the benefits of DSH which would then lead others to engage in DSH, as it seems more appealing to them and has been endorsed by peers.

> *If your friends are doing it, you know, it only takes one person, one of your group of friends to start doing it and like you know, just kind of talking about it, and just saying how much release they feel when they cut*

Another clinician spoke about how knowing others who engage in DSH gives young people the idea that they may not have thought of and makes DSH an option for them.

> *A few of them have had other experiences of suicide within the whānau as well, I think I've had that with a few of my young people, maybe a cousin or an aunty or a friend at school, there has been someone else around them that has done this and it becomes a reality for them or an option for them*

Three key informants spoke about how they have noticed patterns in the community or within families that had led them to think the DSH by their client resulted from copying someone they knew. One clinician spoke about how she had worked with three generations of the same family who had all engaged in DSH. It was her opinion that witnessing or hearing about DSH made it more likely to occur, as it is something that is copied.

> *And it can be clan-ish as well, that groups can be doing it, which sometimes happens... I've had three generations in the room that were all self harmers, so the narrative gets replayed from generation to generation*

Another clinician said:

> *I think there has been a lot of completed suicide by copycat, where kids have hung themselves and known about that and seen that and tried to do that. I think there is a lot of copycat out there, where people are influenced by other people*

Several studies have reported a direct link between DSH and peer suicidal behaviours (Grossman, Milligan, & Deyo, 1991), as well as suicidal phenomena in family members (Evans, Hawton & Rodham, 2004).

One clinician reported that in her opinion DSH was not something that seemed a 'Māori thing to do' and therefore she would assume that young Māori would have gotten the idea from others who were non Māori.

> *I would suspect certainly being influenced by others who self harm, because I can be right off in saying this, but I think it's a really Pakeha thing to do*

However, this view was contrary to another key informant. Furthermore, statistics also suggest that this may not be the case as Māori have a high rate of DSH hospitalization, as discussed in the introduction of this thesis.

Two out of the five key informants reported that they felt young people engaged in DSH due to the frequency and manner in which it was portrayed on the internet and television. These key informants spoke about how this presented DSH as an option for young people, as well as the fact it made it seem like an acceptable option and perhaps something that was 'cool'. As one clinician said:

> *I think some of it is about what's the cool thing to do at the moment. And it's something that you hear about on Shortland St or through your mates at school or by celebrities or on the E channel and it's sort of glamorized in a way*

While another reported:

> *I mean there are influences with the internet, you know stuff like that, there are influences on the movies and on the programmes we have on these days*

Bullying, social isolation or 'not fitting in' precipitated DSH

Two of the five key informants discussed not fitting in or not having a sense of belonging as a precipitating factor for DSH.

> *Some kids who come in and are feeling alienated, at school, out of school, in the whānau even sometimes and they just feel like no one is there for them*

One clinician reported seeing a young man who came from a mixed race back ground and it was her belief that this lead to him feeling like he did not belong anywhere and was therefore not worth anything.

> *[He] doesn't feel like he fits anywhere and I don't think he would say that he's punishing himself for not fitting but it's kind of like, you are* nobody you need to hurt

Feeling lonely or not wanted was the most frequently report motive in an early study by Birtchnell and Alarcon (1971; as cited in McAuliffe, et al., 2007), however it does not appear to have been used as a motive since and may have been included in escape or communication motive in future research.

Only one clinician reported bullying as a possible factor for DSH. He spoke about how advances in technology had lead to more places where children and young people may be victimised by others. This clinician reported that this was not something he had considered until working with young people who experienced text bullying.

> *There could be bullying at school, there could be text bullying. When I first heard about text bullying I said you've got to be kidding, until we had a client that came in that actually was being text bullied and realized how dangerous that could be, where they*

> *were feeling unsafe to go to school and slowly dropped off from going to school because of those threats*

Bullying has been linked to suicidal thoughts and gestures in several studies and research suggests that youth who are bullied have an elevated risk of DSH (Hinduja & Patchin, 2010).

One male clinician queried sexuality as a factor related to DSH. He talked about not knowing the statistics or having a research base, however in his anecdotal evidence he felt that sexuality may make young gay men more vulnerable to cutting, as he equated this particular act of DSH with females.

> *But I think also for some it is about, actually I've got a couple of boys that I actually queried sort of identity issues and how they're fitting in and sexuality*

Research in fact does support this idea and several studies have suggested an increased risk of suicidal behaviour in gay, lesbian and bisexual adolescents (Bagley & Tremblay, 2000; Fortune & Hawton, 2005; Remafedi, French, Story, Resnick, & Blum, 1998).

Key Informants Ideas Regarding the Impact of DSH on Whānau

Key informants were asked to discuss their ideas regarding the impact or affect that DSH has on whānau. The themes appeared to be consistent with participant reports, that DSH impacts the wider family, parents and creates practical difficulties.

DSH affects the wider family

Two of the five key informants reported that they felt DSH affected the whānau, including extended family. One clinician spoke in general about the affect of DSH.

> *It affects not only the close family but uncles, aunties, umm grandparents, you know and so when people go through that for whatever reason and you know you start to wonder,*

> *I think that's the biggest effect, that it's not just the individual or the parents, it affects the whole whānau, right down the line*

Another clinician discussed an example of how when seeing a young man who had engaged in DSH she also worked with extended carers outside the immediate family.

> *I know that I've been working with a young man who self harms and he's come in here with his mother, his step father, his tohunga (expert, skilled and learned person), who he kind of refers to as his aunty because mum has a distant kind of connection with her,…his tohunga's partner and his tohunga's partners daughter, who's a kind of like extended caring person to this young person. Yeah and his self harm was affecting, obviously his whānau and his extended whānau*

DSH affects parents emotionally

Two key informants stated that families were caught off guard and surprised by DSH, this may relate to the idea that DSH is not considered a behaviour that is common amongst Māori. It may also speak to the busyness of family lives these days and the disconnection between whānau members. For Māori this may also represent the dynamics of adapting to a 'new' concept of whānau, with the shift from extended to nuclear family following the greater mobility of families in recent decades. One clinician referenced a particular client stating:

> *It was complete shock at the beginning*

While another clinician spoke in general about how some whānau are shocked which then leads to other emotions, such as panic.

> *You know sometimes it's completely out of the blue and then it's panic stations*

Three key informants spoke about how they perceived whānau to be very worried and anxious following DSH. This often related to worry that their child would continue engaging in DSH and how to manage that, as well as worry related to their child's mental well being.

> *They are very anxious*

One clinician stated that whānau he worked with often sought reassurance in regards to the safety of their young person.

> *They're looking for assurance that it won't happen again*

This is in keeping with findings from whānau members who reported worry that their child would continue to engage in DSH.

Four of the five key informants reported families often appeared confused following DSH, for various reasons, including not understanding the motives for DSH.

> *Consistently thinking why, you know why is my son or daughter thinking that they need to cut themselves or need to leave this earth or what's going on and that kind of thing*

As well as not knowing how to manage or tolerate DSH, what is the most appropriate approach to treatment, or where to seek assistance.

> *They don't know how to deal with it, who to go to for help on a lot of occasions and if they're getting help is it the right help, so all those questions are there for Māori I think.*

Three key informants discussed family members being affected by feelings of guilt and self blame. Guilt appears to be a natural response for parents and may be particularly strong for Māori, given the collectivist nature of the culture.

> *I mean a lot of our whānau are blaming themselves for a lot of things that have gone on, they don't feel like they've paid enough attention to some of the things that might have contributed to what's going on*

Another clinician spoke about how whānau appear to take responsibility for the DSH and view it as a reflection of themselves and their family unit.

> *Whānau seem to sort of blame themselves, there's something wrong with them, as a whānau, why their kid needs to act in that way to hurt themselves*

While one clinician reported that blame appeared to be especially pertinent for mothers of young people who engage in DSH.

> *Mothers I think tend to really personalize it as well, that is something about their mothering to cause this*

These key informant themes are consistent with both current research regarding the effect of DSH on family members, (Byrne et al., 2008) and the reports of whānau in this study.

Practical difficulties

One clinician spoke about the practical difficulties for families having to take time off work and not making money during that time. She reported this may lead to further difficulties for whānau relationships as it places extra stress on parents who may then look for someone to blame, often the young person.

> *Some of the whānau that come in here, their young person is going through stuff where whānau have to go in to session or whatever it is but because of the pressures of their work life, maybe they have to go to work, to make the money but if it's kind of critical that they have to keep coming in here then they get more pressured at work, , which kind of sometimes can turn to them blaming it on the young person, example, it's your fault if you weren't thinking so stupid you know I wouldn't get in trouble with my job*

This observation may be significant as these factors may act as a barrier to treatment for young people and their families. It may also be under reported as whānau may tend to report mostly emotional needs or difficulties to clinicians, as this is seen as appropriate for the service. Clinicians may not consider the practical impacts on families, such as time or money, as it does not appear to relate directly to what they work with or feel they can offer in terms of aid.

Key Informants Ideas Regarding the Needs of Whānau Following DSH

Key informants were asked their ideas regarding the needs of whānau following the DSH of their child. Two key themes emerged: these were support and information, consistent with participant perspectives. Further subthemes were identified and will be reported below. An additional theme was also reported by key informants; Māori find mental health a difficult concept to come to terms with.

There is a need for support

Support for whānau: One clinician spoke about the need for support groups within the communities. She reported that these groups may be more accessible to Māori whānau than a community mental health service and would also give whānau the opportunity to share with others, gain support, and lift the taboo related to DSH.

> *More groups I think in the communities, you know more groups in the communities to talk about this kind of stuff, like whānau groups, so that they can hear from others, because I think that in the Māori world it's kind of like, it's a bit of a taboo, even though it happens, but it's kind of like, they wouldn't do something like that, you know, 'we've got such a big family that they can come and talk to people around'*

Support for young people and their whānau: Three out of the five key informants spoke about the need for young people to have space to talk on their own as well as involving the whānau in treatment. One clinician spoke about the delicate balance between involving the family enough as well as giving the young person space. She reported that young people often have difficulty talking with family members as they are worried that person will then tell other members of the family. She also discussed the need to involve family so they know how to support their child and also feel involved in treatment.

> *[for the young person it is] kind of like well I don't want to talk to you because you might tell or you might tell, or you might tell. Sometimes they might want to come here to a stranger where they don't know any of my family, they won't say anything but that can also lead to the whānau thinking, 'oh well why do you want to go to there for, you've got us?' I think it's the way you handle the situation as the clinician, of explaining to the whānau, if they were to come and see me, plus you can support them this way, putting it together so the whānau know that yeah ok we're still involved in this child's life and also this other person is to and the young person will also know that they've got say me and they've also got their family*

This sentiment appeared to be echoed by both other key informants.

> *I think it needs to be both [seeing young person and whānau]; you can't do one without the other. If you're working with the individual, then the whānau needs to be aware of what to do and sometimes it's all a matter of feeling wanted by the whānau and sometimes they feel they're not wanted*

> *I do a bit of both. Umm I generally like to do a lot of whānau stuff, but I do a bit of both, depending on circumstances and what the young person would like*

Another aspect of the need for support theme reported by two out of the five key informants was the need for fathers' involvement in treatment as well as the need for all whānau members to be involved in treatment. One clinician stated that the best way to work with Māori who engage in DSH is by engaging both parents.

> *I think having parents and I mean both parents involved is a better way to treat Māori who self harm*

Two key informants reported that whānau and young people needed validation of their experience and their emotions. They spoke about how this enabled them to build a relationship with the whānau and was part of the work they would do.

> *What I see as important is acknowledging that there is some kind of distress here for this young person*

Another simply said:

> *I think it is all about validation*

Information is needed

Three of the five key informants reported that in their opinion families needed advice and information regarding the management of DSH and where to seek help. Clinician's appeared to think that these things would alleviate whānau distress and also encourage accountability and involvement of whānau.

> *[Whānau need] somebody that can give good advice and make sure that the advice that is given is structured, that they know what they are going to do if something like this happens, they know exactly what they are going to do, rather than just sit there and have no idea, who to call should this happen again, if it's in a weekend, if it's at night time, what can I do. I think those things are necessary for them [whānau] to know*

> *... when they are feeling like their young person might be wanting to do those sorts of things or possibly kill themselves, so I think that state of distress does actually get them to be a bit more responsive, they do feel like they want to be accountable and talk about options and risk and safety and things like that*

One clinician elaborated on this need for information, while she stated that whānau may require assistance with safety planning she also reported that education and awareness was a key need for whānau. She spoke about some whānau being in denial and the perception by Māori that DSH is a 'white' problem.

> *I guess more education on how to deal with, how to deal with the situation that your young person may be going with, but also thinking about you know where is this coming from, what's actually happening.... It's [SH and SI] happening now, to be realistic and I think the more education or the more educated the whānau are about, I guess that it [SH and SI] is here, well then, what can we do about it, would help because I just think,*

> *I mean sometimes some whānau can be in denial about it*

Māori find mental health a difficult concept to come to terms with

Clinician's spoke about the difficulties faced by Māori whānau when accessing mental health services. Two subthemes emerged from this discussion: difficulties due to associated stigma, and difficulties due to suspicion of western mental health services.

*Difficulties due to the associated stigma***:** Three of the five key informants spoke about the concept of "mental health" within a western framework and within a western setting, and how this may create a barrier for some whānau. They spoke about the stigma attached to mental illness and therefore mental health services and how this may act as an obstacle for accessing services.

> *I think that the whole concept of mental health for Māori is a really difficult concept to comprehend and I think that in general as a people we recognize that in actual fact the idea of a mental illness is based on very western concepts. I think as a people we generally know that, that mental health service is directed at putting people in a box that either fits with western norms or not and I think we do tend to recognize that a lot of what might be quite normal Māori cultural behaviours and ways of being are seen as quite abnormal and possibly indicative of mental disorder in western culture... some of the other issues are, you know, what does it mean and the stigma about accessing mental health services*

> *We're known as a mental health service and mental health; I guess out in the community means other things, like there's something wrong with you*

The issue of stigma related to accessing mental health services was endorsed by some of the whānau in the project and needs further investigation as it may act as a barrier to receiving treatment for some whānau.

Māori are suspicious of mental health services: All key informants discussed difficulty working with Māori within a non-Māori organisation. All five key informants spoke about Māori families being cautious and concerned when attending mental health services. The main subject identified was 'what are they going to do to me', key informants reported that this may be due to historical events and negative past experiences, as well as professions and terminology that do not fit with a traditional Māori view of health.

> *I don't know what's going to happen, you know, because mental health has usually got to do with nurses and doctors, going to give me a pill or am I you know sick? Yeah, there's a lot of caution and there's a lot of I don't know what's going to happen to me here*
>
> *I think umm the whole package of mental health care comes with psychiatrists and psychologists and all these big terms that, well they're not part of the Māori world, they don't fit with our terminology, we listen to those, we hear those terms and what the hell is that to us and what can they do for us? Typically non Māori, western paradigm, that's just not our experience, what we know, what we can trust*
>
> *There's this apprehension and cautiousness about, as I said, what are we going to do to them*
>
> *There's such a myth and negative connotations, people think of institutionalization, the effects of that and the mental health act, you know shock treatment and medicalisation of people's distress, absolutely that's an issues for Māori and some of them are, the previous generations have been through that, suffered from that, so it's not that far away from the story, of the parents or grandparents being institutionalized*

One clinician spoke about barriers for Māori accessing a Māori mental health service in particular. He reported that he has encountered Māori who have negative perceptions about the abilities of Māori services.

I think there’s a lot of Māori that are very suspicious of a Māori service, weather we have the right qualifications to deal with mental health, because sometimes I think that they think a Māori service isn’t giving a good enough service because of the fact that, sometimes we ourselves put ourselves down and say we’re inferior to other services

CHAPTER FIVE

Discussion: Te Whakamutunga

Whakapuputia mai o Manuka, kia kore ai e whati

Cluster the branches of the Manuka, so they will not break
(Unite with a basic philosophy and know which direction to go).

DSH is one of the most significant social problems facing young Māori today. The high rates of adolescent suicide and DSH demonstrate the need for ongoing research, particularly with Māori.

This thesis has started to explore the impacts of DSH by their child on Māori whānau, their needs following DSH by their child, the perceived motives attributed by whānau and the effects of DSH on whānau. Whānau are a key factor in the well being of children and adolescents and whānau plays a key role in the lives of Māori. To my knowledge, no research currently exists examining the experience of DSH by Māori whānau. In this research the views of ten Māori whānau members whose children or grandchildren had engaged in DSH were examined. In this chapter a summary is presented, along with further commentary and recommendations.

Summary of analyses

Seven themes were identified from whānau members' ideas regarding the motives for DSH: to communicate distress and seek help, to punish someone, to obtain relief from a distressing emotional state, to die, due to the influence of others, as a response to feeling overwhelmed by difficult circumstances, and the cultural influence of matakite. Five key informants identified similar motives; however, they did not mention matakite and included DSH being precipitated by bullying, social isolation or 'not fitting in'.

When discussing impacts of DSH whānau members reported that it had wide reaching impacts. Participants reported that DSH affected the whānau as well as parents. In terms of the affect on parents, participants reported emotional effects and impact on their parenting. It was also reported that DSH resulted in practical difficulties. Key informants identified similar motives for DSH and similar impacts.

Whānau and key informants both reported that there is a need for support. While key informants primarily reported a need for support for the young person with additional whānau involvement, whānau participants reported a need for individual support for the young person, as well as themselves and their whānau.

Both key informants and whānau participants also reported that information is needed. Key informants appeared to discuss this in terms of advice and acknowledgement of DSH as something that is prevalent, while whānau participants discussed the need for information regarding available services and as well as information and involvement regarding their child's treatment.

Key informants and whānau interviewed appeared to be consistent in the majority of themes identified on the topic of motives for DSH. One difference was that two whānau participants reported culturally specific causes; however culturally specific causes were not reported by key informants. This may be due to the fact key informants are more likely to formulate the function of a behaviour, rather than focus on events. For example, while a whānau member may attribute the cultural phenomenon of matakite to why their young person engaged in DSH, a clinician may report that a lack of distress tolerance skills resulted in DSH. Personality characteristics such as coping style have been linked to amplified risk of DSH (Fortune & Hawton, 2005). Studies have suggested that adolescent DSH is associated with poor emotion regulation capabilities (Sim et al., 2009). This fits with a model that appears to be most popular among researchers, the ‘affect regulation model’ (as described in the above introduction section), which states that individuals may lack coping strategies and therefore be less able to deal with their affect and more likely to use DSH as an affect regulation strategy.

The majority of key informants and whānau members interviewed reported seeing DSH as a way young people communicate distress and seek help, as well as something that was the result of being influenced by others. However, research has suggested that adolescents themselves may not identify these motives as frequently and are more likely to report DSH as a way to escape unbearable thoughts or situations or to die (McAuliffe et al., 2007). While some research has shown that adolescents reported DSH as a way to show others how desperate they were feeling (Rodham et al., 2004), it has also been reported that adolescents themselves rarely report engaging in DSH as a way to seek help (Hawton et al., 1982).

Research has suggested that both parents and clinicians are less likely to report intent to die than young people themselves (Hawton et al., 1998). It may be hypothesised that parents especially do not want to believe or acknowledge their child’s wish to die, or it may be that parents assume their child did not intend to die given their chosen method; however, young people may underestimate lethality and may consider their action an attempt to die.

Whānau members were more likely than clinicians to attribute negative events within the family as a precipitating factor. Studies have demonstrated that DSH is typically precipitated by relationship difficulties with family or friends, or disciplinary crises (Beautrais et al., 1997; Rodham et al., 2007). It is interesting that clinician’s did not so strongly identify family or systemic factors as motives for DSH, particularly given that family functioning is acknowledged as an important factor in Māori well being, and that there is an acknowledged connection between family dysfunction and adolescent DSH identified in previous research (Agerbo et al., 2002; Sim et al., 2000). Recent literature suggests that the high numbers of both males and females report family dysfunction as an underlying reason for DSH (Dieserud, Gerhardsen, Van den Weghe, & Corbett, 2010). These may include difficulties faced by other family members that impact on adolescents, as well as interpersonal difficulties between the young person and members of the family.

Whānau members were also more likely to view bullying as a contributing factor to DSH than key informants. Bullying is a widespread problem that may affect up to half of the adolescent population (Barker, Arseneault, Brendgen, Fontaine, & Maughan, 2008). Studies have suggested that victims of bullying have higher rates of mental health difficulties and increased rates of DSH (Barker et al., 2008). In a recent study on adolescents views on how to prevent DSH young people reported bullying as a stressor that needs to be addressed (Fortune, Sinclair & Hawton, 2008).

Peers have strong influence on adolescent behaviours (Brechwald & Prinstein, 2011). Studies have shown that knowing someone who engages in DSH is associated with increased rates of DSH (Claes, Houben, Vandereycken, Bijttebier, & Muehlenkamp, 2010; Deliberto & Nock, 2008). This may be an interesting dynamic for Māori and it is hypothesised that this peer/whānau dilemma has arisen following colonisation and the rural to urban shift. Culturally young people have been seen to belong to the whānau, not simply the parents, but the wider concept of whānau, including extended family. The rural to urban shift also exposed Māori to different attitudes and familial patterns, and perhaps has resulted in the peer group having greater influence over an individual’s behaviour than previously was the case.

Clinician’s reported the motive of social isolation or ‘not fitting in’ as related to DSH. It is possible that this motive relates to an escape motive, as feeling unwanted may then lead to young people wanting to escape an unbearable situation or thoughts. Birtchill and Alarcon (cited in McAuliffe et al., 2007) reported feeling lonely or unwanted was the most commonly selected motive for DSH by adolescents while McAuliffe et al. reported the escape motive (meaning, the desire to remove themselves from a situation or emotional state) as the most commonly selected, consistent with earlier research by Rodham et al. (2004). The idea of not fitting in may be of significance given the increasingly multi cultural nature of NZ and may represent a new difficulty facing many young people today and in the years to come. For example, one clinician spoke about a boy who was Māori/Indian and it was her opinion that not knowing where he fitted in - in terms of identity - had resulted in suicidal ideation. However, this was not something mentioned by participants in this research, and all reported their identity as Māori only.

The findings of this research suggest that the impact or effect of DSH on Māori whānau may be large, varied and wide reaching. This research suggests that DSH by a child or adolescent not only affects parents, but siblings, grandparents, aunts and uncles. The emotional effect on parents is considerable and may include guilt, shock, fear, uncertainty and anger. There also appeared to be a significant impact on parenting, primarily related to limit setting and boundaries. The majority of whānau participants reported that their parenting was altered in some way by the DSH of their child. DSH appeared to undermine parent’s confidence in their parenting abilities. Some whānau members spoke about becoming more rigid in their parenting, while others spoke about being afraid to ‘rock the boat’ and therefore became more lenient in their parenting. These findings are similar to those of Byrne et al. (2008) who reported that many parents had difficulties with boundary setting following DSH. Uncertainty may lead parents to either withdraw from their children or adopt a controlling stance over their behaviour (Byrne, 2008). Yet, for some whānau the aftermath of DSH – and perhaps the added influence of therapeutic intervention – was that parents felt closer to their young person.

The reported outcomes of DSH supports the need for whānau to have access to support and advice, specifically related to parenting a child who has engaged in DSH. However, the reports of both whānau members and key informants highlight the difficulty for many families in accessing services, including whānau feeling the service is for their child and not for them, stigma issues related to services being mental health related, lack of information about services, and practical difficulties in accessing services. Engaging with a mental health service often requires time away from work and other children; this can mean having to organize child care and a loss of wages.

This thesis may indicate the importance of Māori services and Māori teams, as well as the need for recognition of Māori healing and well being practises at a community, education and service level. The majority of whānau interviewed had chosen to be seen by the Māori clinical team. One whānau member reported the benefits of being able to speak with a kaumatua, while another whānau member stated that they had to find Māori focused services on their own.

A central point this thesis has raised is the visibility of services and the appropriateness of mental health campaigns. Most whānau members interviewed did not know what services were available or how to access them. In order to make services more accessible to Māori perhaps campaigns may also have a focus aimed at parents of youth (not *just* youth or *just* adults). It may also be beneficial for campaigns to take away labels and diagnoses that do not fit with Māori, as one mother spoke about seeing the television commercials and not relating them to her daughter as they appeared to be for people who are ‘mental’. This may also aid in taking away the shame and stigma of accessing mental health services. However, it would be naive to assume that years of negative experiences and connotations may be removed over night.

The majority of whānau and clinician's spoke about the need for professional involvement to allow the young person space to talk with someone outside the whānau. Both whānau and clinician's appeared to agree that young people often have difficulty talking with family members and there may be a need for them to discuss their difficulties with someone outside the family. It also appeared that key informants and whānau were in agreement regarding the need to involve whānau in treatment. It may be beneficial for non-Māori clinicians to note the importance of involving whānau even when doing individual work.

The majority of whānau responded that they felt professional support was needed for themselves and/or their other children. This theme was echoed by clinicians in terms of involvement with their young persons' treatment; however they did not report specific interventions or support for parents (other than support groups) or whānau. It is interesting to note that, while even though key informants recognised the impact of DSH on the whānau they did not include them in possible needs or treatment options. This may result from working within a government funded community agency that may treat the referred client only (siblings and other whānau members are not the identified client in most cases) and places an emphasis on cost effective treatment.

Most whānau participants spoke about how communication had been improved following the episode of DSH and attendance at the CAMHS, which resulted in improved relationships within their household. This appears to contradict recent literature (Byrne et al., 2008). However, this may not be a representative sample: it is a small group of volunteers whose willingness to participate in the research may have been because they saw their situation now as non-critical and improved. However, it also may reflect a cultural factor, as in Māori culture it is often emphasised that things must be discussed kanohi ki te kanohi (face to face). That way people are able to see the congruency between what one says and what one is saying with their body, as well as feel their āhua (spirit, appearance or presence of the other person). Perhaps DSH leads whānau to the realisation that there is a problem and therefore deal with it.

Comparison between Māori and non-Māori

Analysis of this research suggests that for the most part the effects of DSH on Māori and their needs following are similar to those reported for non-Māori in research that has been conducted in other countries. Similarities include the prescribed perceived motives, emotional impact, effect on parenting and the need for support for both young people and families. At the time of writing the researcher was not aware of any available research on non-Māori in NZ.

However, some culture specific differences were noted in both motives and impacts. This is of course a small number of informants. Two mothers spoke about matakite, as a possible precipitating factor to DSH that has not been reported in previous literature. While DSH has been reported to have a considerable effect on parents and immediate family, the effect on the wider family is not as commonly reported. While wider whānau were not interviewed for this research, participants spoke about the impact of DSH on their wider whānau, including grandparents, aunts and uncles. This may represent a culturally specific finding, as Māori may take a collective responsibility for young people in the whānau.

Little research exists regarding the practical difficulties following DSH, the degree of impact on families, and how to combat these issues. These practical difficulties relate to poverty, stigma and suspicion, which may all impact access and engagement with mental health services.

While suspicion may be Māori specific, given the political history for Māori and the Western setting and delivery mode of the CAMHS, poverty and stigma relates to all ethnic groups; nevertheless poverty may also reflect the disadvantaged economic standing of Māori. Participants discussed the financial and other associated difficulties of taking time off work in order to attend appointments at the CAMHS, as well as the associated transport costs.

Implications

This study makes a contribution to the work of clinicians in NZ by providing a foundation for research regarding DSH with Māori whānau as well as hopefully drawing attention to this important issue. It is also hoped this research will give clinicians information regarding possible treatment needs of Māori whānau as well as awareness of possible impacts on whānau. Although not an aim of the study, this report also touches on barriers to engagement for Māori that are recognised by Māori clients and clinicians alike. While both whānau and key informants spoke about the need for whānau and young people to engage with mental health services, both also verbalised the challenges associated with this and possible barriers to engagement.

The recognition and incorporation of Māori ways of healing into educational institutions and services may be of great benefit to Māori clients. At the very least it may be valuable if services made links within the community and with local iwi in order to have these more Māori focused services more readily available to clients. While not directly related to this thesis, this speaks to the need for more Māori focused training opportunities and will create the difficult task for services as to how to incorporate traditional Māori practices and also manage and hold risk issues. This does not negate the need for Western therapies, as finding from interviews conducted for this thesis demonstrate that whānau did see a need for individual work with their young person which is perhaps not considered a particularly ‘Māori way’ of doing things. It is noteworthy that most whānau believe their young person did need professional input and support. They expressed a preference for their young person to attend individual ‘counselling’ while they are still included in treatment discussions.

A key recommendation from this thesis would be more support and information for parents and families following the DSH of their young person. Obviously all whānau are not the same and whānau needs may vary. However, a number of participants spoke about the desire to speak with others who are experiencing, or have experienced, DSH as well as get advice on how to manage their child and keep them safe. This is similar to reports by key informants in this study and also consistent with other current research with families (Byrne et al., 2008). Perhaps support groups in the community or offered in services would fill this gap. Clinicians may also be aware that spending time with whānau discussing parenting strategies and skills, as well as safety plans may be beneficial.

A variation in advertising may also improve access to services for Māori young people and their families. Some participants did not appear to relate the current mental health campaigns with what was happening for their whānau. It may be useful to discuss symptoms (such as DSH), rather than label disorders (such as depression). However, further research is needed into what advertising may resonate with Māori.

Participants in this research did not appear to have a clear understanding of the particular community mental health service before referral. Anecdotally, this appears to be the case for many whānau attending the CAMHS. It appears that referrers do not clearly explain the mental health service or what is done there. It may therefore be considered that some whānau do not attend due to lack of knowledge or understanding, and others may attend without adequate knowledge or understanding of the service or why they were referred. Schools and GPs may be able to play a liaison role between families and their local CAMHS, posters and pamphlets may improve visibility and also allow families to self refer.

As culturally specific reasons were identified for motives and affects it is recommended that considerable attention continues to be paid to the continued development of Māori services as well as training in cultural competency. The prescribed motive of matakite, put forward by two participants, suggests a link between services and local kaumatua and iwi would be beneficial for the best possible treatment of Māori whānau and also aid clinicians in providing this care.

Limitations of the study

A limitation of this study relates to the specific characteristics of the participants. Whānau were drawn from a clinical population who had engaged with the CAMHS at least once. Given the sensitive nature of DSH as well as the lapse in time between the episode of DSH and the interview for some whānau, their reasons given and the recall of the immediate impact and effects may have been affected. Boergers et al. (1998) suggested that over time adolescents may gain insight into their DSH and its motives as a result of time passing or interventions. On the other hand, as time passes, these researchers suggested that young people's memories of DSH may fade and they may no longer remember events or cognitions which preceded their DSH. These may also apply for parents and other whānau members and therefore impact their responses.

While this thesis aimed to interview whānau, only mothers and grandmothers were interviewed. Therefore, it must be noted that fathers and other whānau perspectives are lacking. The small sample size also provides a limitation.

Directions for future research

Future research into effects of parenting changes and in particular boundaries on young people following DSH would shed further light on this topic. This is an important area as parenting style may impact parent-child relationships as well as treatment needs. Further research is also needed on how the impact on whānau and their perceived causes of DSH affects engagement with services and adherence to treatment.

It may also be beneficial for future research to also include fathers and other whānau members in order to gain their perspectives.

In order to improve visibility of services, research into what forms of advertising and the content of advertising that Māori relate to may be beneficial. While not directly discussed, this research does raise the question regarding treatment for Māori who engage in DSH and their whānau and what is most effective.

The internet has resulted in a new and increasingly available media source which offers both benefits and dangers. The internet may be used to disseminate cost effective and beneficial treatment options, however it may also be used to promote suicide and discourage help seeking (Fekete, 2002). While some studies have suggested the internet plays a notable role in suicidal behaviour, further investigation is needed (Sisask et al., 2005). As most participants reported the belief that their child was influence by others, primarily peers, further research into this effect, as well as the influence of the media on young Māori, would shed further light onto this phenomenon.

Given the small sample size of this research comparisons were not able to be made. Further research into the relationships between prescribed motives, impacts, needs and engagement with treatment should be investigated in order to provide appropriate follow up and treatment. In particular further research is needed in these areas: the relationship between prescribed motives for DSH and the impact on whānau, the relationship between prescribed motives and engagement with treatment, the relationship between impact on whānau and engagement with treatment, and if whānau particular needs affect engagement with treatment. As research with Māori is nascent, it is also recommended that further research be conducted with Māori taitamariki in order to investigate the motives prescribed by Māori young people themselves, as well as any relationship this may have to engagement with treatment.

Glossary

Āhua	Spirit, appearance of a person
Hapu	Sub-tribe
Hui	Meeting
Iwi	Tribe
Kai	Food
Kanohi ki te kanohi	Face to face
Kapa Haka	Māori performing arts
Karakia	Prayer
Kaupapa	Guiding principles
Koha	Offering
Kohanga Reo	Māori language pre-school
Kōrero	Speak, talk, discuss
Kaumatua	Male Māori elder
Mamae	Hurt
Māori	Ordinary, native people
Matakite	Calirevoyant
Mihi	Brief and informal Māori welcome
Pākeha	Non-Māori, European, Caucasian
Pouri	Sadness
Rangatahi	Youth, young person
Taitamariki	Young person
Tamariki	Children

Tangata Whenua	Indigenous people (people of the land), hosts
Tangi	Funeral (or to cry)
Taurawhiri	Cultural advisor
Te ao Māori	Māori worldview
Te Reo, Te Reo Māori	The Māori language
Tikanga	Practises and protocols (the right way of doing things)
Tino Rangatiratanga	Māori sovereignty or self determination, autonomy
Tohunga	Expert, skilled and learned person
Waka	Canoe
Whakapapa	Genealogy, ancestry, familial relationships
Whakawhānaungatanga	The process of making connections and establishing relationships, sharing of kinship and links
Whānau	Family (including all relatives)

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Appendices

Appendix I

Participant Interview Schedule

1. Welcome and offering of Kai. Mihi (introductions) and whakawhānaungatanga (building relationships). Introduce the study, confidentiality and sign consent forms. Do a genogram and ask about iwi, hapu and marae affiliations.

2. Can you tell me a little bit about your whānau, like whose working? Who lives with you? What's the daily routine like?

3. Can you describe the relationship you had with your child before to the DSH/Worries about hurting themselves?

4. Can you describe what the relationship is like now with your child? Has is changed at all?

5. How close did you feel with your child before the self-harm?

6. How close do you feel with your child now?

7. Do people in your whānau get along most of the time? How often do people in your family argue?

8. Can you describe for me what happened when (child's name) self-harmed/threatened to hurt themselves? How did you find out? What did they do? What did you do/how did you react?

9. Why do you think your child self-harmed (motives/meanings)? Do you think any of the following reasons relate to your child? :

(i) He/She wanted to show how desperate they were feeling

(ii) He/She wanted to die

(iii) He/She wanted to punish himself/herself

(iv) He/She wanted to frighten someone

(v) He/She wanted to get their own back at someone

(vi) He/She wanted relief from a terrible state of mind

(vii) He/She wanted to find out if someone really loved them

(viii) He/She wanted to get some attention

(ix) He/She wanted to escape from an unbearable situation

(x) He/She was influenced by friends/family who were also self-harming

(xi) He/She was influenced by cultural factors (e.g. a curse or was possessed, or possibly because of alienation from culture)

(xii) He/She was influenced by something he/she saw on TV / internet

10. What was the emotional impact of your child’s DSH on you? Can you describe your reaction, including what you thoughts and how you felt? *Prompt with: did you feel guilt, shame, anger, grief, fear, caring, sympathy, or embarrassment?*

11. Can you tell me how this has affected your/your whānau’s life or daily routines in anyway?

12. Have you ever experienced DSH or suicide before? If yes, with whom?

13. What needs did/do you and your whānau have following the DSH of your child? E.g. what support did/do you and your whānau want and need?

14. What help have you felt you and your whānau might need following your child’s DSH?

15. Who do you turn to for awhinatanga (support)?

16. Do you think your child needs help/treatment? If yes, what kind of help/treatment? What would be best for you, your child and your whānau?

17. What things have made it easier for you and your whānau? What would have made it easier for you and your whānau?

18. What things have made it harder / didn’t help you and your whānau following the DSH? (Separate out into things in the environment, family and things occurring in the services).

19. Is there anything else you’d like to say or anything you’d like to let us know?

Appendix II

List of Motives (Hawton et al., 1982)

(i) He/She wanted to show how desperate they were feeling

(ii) He/She wanted to die

(iii) He/She wanted to punish himself/herself

(iv) He/She wanted to frighten someone

(v) He/She wanted to get their own back at someone

(vi) He/She wanted relief from a terrible state of mind

(vii) He/She wanted to find out if someone really loved them

(viii) He/She wanted to get some attention

(ix) He/She wanted to escape from an unbearable situation

(x) He/She was influenced by friends/family who were also self-harming

Appendix III

Interview Schedule Clinicians

1. How do you think, or what do you think is different in the way Māori deal with Mental Health Difficulties or Problems?
2. How do you think, or what do you think is different in the way Māori deal with Mental Health Services?
3. What is different with engagement with Māori? What makes it more difficult and how do you aim to combat this and achieve engagement?
4. Can you tell me your perspectives on what the impact of DSH/Suicide attempt by their child is on Whānau?
5. Can you tell me what you think the needs of whānau are following this?
6. What do you think are the motives or functions of DSH by Māori, why do you think they DSH/attempt suicide?
    (i) He/She wanted to show how desperate they were feeling
    (ii) He/She wanted to die
    (iii) He/She wanted to punish himself/herself
    (iv) He/She wanted to frighten someone
    (v) He/She wanted to get their own back at someone
    (vi) He/She wanted relief from a terrible state of mind
    (vii) He/She wanted to find out if someone really loved them
    (viii) He/She wanted to get some attention
    (ix) He/She wanted to escape from an unbearable situation
    (x) He/She was influenced by friends/family who were also self-harming
    (xi) He/She was influenced by cultural factors (e.g. a curse or was possessed, or possibly because of alienation from culture)

(xii) He/She was influenced by something he/she saw on TV / internet

7. Do you think there is a different dynamic among Māori peers or way they relate?

8. Have you noticed any increase in DSH/Suicide attempts by Māori? Any changes in trends or the way young people self harm?

9. What are the particular demands on you as a Māori therapist when working with DSH than say when working with behaviour problems or anxiety?

10. How do you think DSH/Suicide attempts need to be dealt with, with Māori?

Appendix IV

Whānau Information Sheet

THE IMPACT ON WHĀNAU OF SELF-HARM BY THEIR CHILD: A STUDY OF RESPONSES, NEEDS, AND OUTCOMES FOR THE FAMILY

Researcher: Casey Wilson (Ngati Awa)

We are seeking your support to participate in a research project that I am undertaking as part of my Doctorate in Clinical Psychology at the University of Auckland. This project has the support of Whirinaki Child and Adolescent Mental Health Service and of the He Kaakano Māori team. This research will be used by Whirinaki to improve their service for families in your situation.

You have been identified by the staff at the Child and Adolescent Mental Health Service as a whānau that has recently experienced self harm or worries about your child's safety. We are interested in finding out more about the effects this self harm or worry had and has on your whānau as well as the needs your whānau had and have. We hope you will be able to help us to identify what has helped and what would have helped your whānau. All whānau responsible in the care of the child, as well as any support people you would like, may come along to interviews.

Background Information

Self harm is a significant problem for some young people in our community today. Very little is known about parent's reactions to a child's self harm or the needs of whānau following the self harm of their child. A small amount of research suggests that both the impact of self harm and consequent needs may be considerable, yet often neglected. There is also little information about how the reactions of whānau influence their child's progress and adjustment after self harm. Understanding the reactions of parents to self harm and the needs of whānau following self harm, will advance our understanding of how best to help families following this behaviour.

What would be involved?

I will be conducting interviews with parents or primary caregivers of young people who have recently self harmed or threatened to harm themselves. It is expected that each interview will take approximately one hour. Whānau will be given a $20 petrol voucher for their time.

Interviews will be conducted at Whirinaki, the Child and Adolescent Mental Health Service or at your home, depending on your choice. The interviews will be taped and then typed out so we have a copy of what has been said.

A second follow up interview will be conducted three months after the first interview.

We will also be asking to gain information about the young person from their primary clinician and file. If young people or the whānau do not want this information gathered, that is fine, interviews may still be conducted.

It is hoped the interviews will provide a positive opportunity for whānau members to explain what has made a difference for them during this difficult time and to describe their experience of self harm.

Your ideas could contribute to the development of more effective mental health services for young people and their whānau in the future.

It is possible that feelings of distress may be rekindled for whānau as a result of discussing the experience of self harm. If this happens to your whānau you will be given the numbers of appropriate people to contact.

Confidentiality

Everything you say in the interviews will be held in the strictest confidence. Tapes will be given code numbers and no names will be used in the written results. You will not be able to be identified from any part of the research.

Participation

Participation in the research is entirely voluntary and will not interfere with any clinical services or treatment for your child. You can withdraw from the study at any stage without giving any reason.

Further Information

Every participant will be sent a summary of the research findings if requested. If you have any further questions you may contact:

Casey Wilson on 0273280413 (text and I will call you back) or cwil131@aucklanduni.ac.nz
Or
Dr. Fred Seymour at the University of Auckland Psychology Department
Ph: 3737599 Ext: 88414

This project has been approved by the Northern Regional Y Ethics Committee.

Appendix V

Caregiver Consent Form

THE IMPACT ON WHĀNAU OF SELF-HARM BY THEIR CHILD:

A STUDY OF RESPONSES, NEEDS, AND OUTCOMES FOR THE FAMILY

I have read and understood the information sheet for volunteers taking part in this research project. I have had the opportunity to discuss the research and ask questions about it.

I understand that it is my choice whether or not I take part in the research and that I may withdraw from participating at any time, without having to give any reasons.

I understand that my participation is confidential and that I will not be identified in any way in the research reports.

Please tick
(   ) I agree to take part in this research project
(   ) I agree the interviews can be taped and transcribed

Name____

Signature____

Date____

This project has been approved by the Northern Regional Y Ethics Committee and the Māori Research Review Committee

Appendix VI

Parental Consent Form for Children Under 16

THE IMPACT ON WHĀNAU OF SELF-HARM BY THEIR CHILD:

A STUDY OF RESPONSES, NEEDS, AND OUTCOMES FOR THE FAMILY

Children under 16 years of age must have parental consent to participate in this research project. If your child is under 16 please complete the following consent form for them:

I_______________________________________(Name) as parent/caregiver give consent for _____________________________________(Child's Name) to take part in this research project.

Parent's Name____

Signature____

Date____

This project has been approved by the Northern Regional Y Ethics Committee and the Māori Research Review Committee

Appendix VII

Adolescent Consent Form

<u>THE IMPACT ON WHĀNAU OF SELF-HARM BY THEIR CHILD:</u>

<u>A STUDY OF RESPONSES, NEEDS, AND OUTCOMES FOR THE FAMILY</u>

I have read and understood the information sheet for volunteers taking part in this research project. I have had the opportunity to discuss the research and ask questions about it.

I understand that it is my choice whether or not I take part in the research and that I may withdraw from participating at any time, without having to give any reasons.

I understand that my participation is confidential and that I will not be identified in any way in the research reports.

Please tick

( ) I agree to allow researchers to use my information for the purpose of this research project

Name____

Signature____

Date____

This project has been approved by the Northern Regional Y Ethics Committee and the Māori Research Review Committee