Bicultural Issues

The National Standing Committee on Bicultural Issues
provides regular commentary on bicultural issues. It aims
to explain their implications for the activities of psychologists,
and for the practices and policies of the Society.

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In August 1999, the Maori and Psychology Research Unit (MPRU) based in the Psychology Department at the University of Waikato sponsored a graduate student symposium to mark the first 12 months of the MPRU's existence. The symposium was designed to showcase Maori-focussed graduate student work and attracted numerous papers spanning topics such as: gambling; epilepsy; parenting; ta moko; experiences as internship students; and accountability models for Pakeha practitioners. The papers presented at the symposium surveyed issues that deserve far wider dissemination. The NSCBI is pleased to support this process by publishing a sample of papers from the symposium in our regular Bulletin column.

The first paper on deliberate self-injury is by Cate Wilson. In my opnion, Cate has done well to survey the New Zealand based material on deliberate self-injury, and as such, provides a good resource for others working in the field. Notable is the absence of Maori-focussed research in an area where one would expect there to be more, especially given the high rates of self-injury and suicide among Maori. Cate has been rightly critical of this. As Cate intends to pursue this topic further for her Doctoral research, she would appreciate feedback on what is presented here, as well as contact with others conducting similar research.

Noho ora mai,
Linda Waimarie Nikora

Ethnicity issues in deliberate self-injury: A review of literature

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This article discusses the literature on deliberate self-injury, with a particular focus on ethnic differences. The current state of the literature is examined, both in regards to theories about our high rate of self-injury, and current prevention and intervention strategies. There will be a particular focus on social and environmental issues, and possible factors involved in the ethnic differences. In order to do this I will also discuss gender issues in relation to deliberate self-injury, in an attempt to illustrate the similarities and differences. Due to the paucity of local literature, international material will be included. An attempt will be made to examine the relevance of these theories to the Aotearoa/New Zealand context. There are very clear differences in those who do, and do not injure themselves, and these differences seem to clearly relate to gender and ethnicity. This is an important area for discussion, because it is frequently assumed that prevention strategies for suicide will also be suitable for deliberate self-injury.

Introduction

Deliberate self-injury is a significant social problem impacting youth in New Zealand. Rates of hospitalisation for youth (aged 15 to 19) from deliberate self-injury approximate over 1000 each year. The rates

for Maori and women are significantly higher. From 1987 to 1993, an average of 488 Maori women per 100 000 population have been hospitalised each year (Ministry of Health: Manatu Hauora, 1996).

Despite the prevalence of deliberate self-injury and the associated social costs it has received minimal research. Rather, deliberate self-injury is usually assumed to be an adjunct of youth suicide and prevention strategies are conflated. This assumption is untenable, and in particular, the prevention strategies designed for youth suicide are problematic in terms of deliberate self-injury. The literature suggests that youth who suicide and youth who deliberately self-injure are comprised of distinctly different groups, with characteristics that strongly suggest that different strategies are required (Maris, 1981; Pritchard 1994).

Literature on the prevention of deliberate self-injury has tended to focus on proximal risk factors; acute situations that may be construed as crises by adolescents, such as relationship break-up and school difficulties. McKeown et. al. (1998) found that focusing on proximal factors may result in the fundamental role of underlying environmental factors being overlooked. Blumenthal (1990) suggests that there are five overlapping spheres of vulnerability, (psychiatric disorders, personality traits, psychosocial, biology and family history), and it is the quality and interaction of these spheres that determines the risk for deliberate self-injury. The international literature suggests that although many people who commit suicide have previously engaged in deliberate self-injury, and a significant proportion of those who engage in deliberate self-injury go on to commit suicide, the two groups are distinguished by differing characteristics. Furthermore, these characteristics can be linked to psychosocial factors such as unemployment, sexual abuse and gendered patterns of behaviour.

Definitions

Deliberate self injury, attempted suicide or parasuicide?

Gauging a person's intent to die is problematic, and it is common for people to change their minds during the process

of committing suicide (Farberow 1991, Greenwood, 1996). I use the term 'deliberate self-injury' rather than 'attempted suicide' or 'parasuicide' because it includes individuals for whom the intended outcome is unclear, but who, nevertheless, intended to cause serious harm to themselves. In contrast, the other terms refer to people who intend to die. A major problem with these terms, is deciding what peoples intent was. This is a problem that comes up again and again, in the literature and in doing research.

The term 'self-injury' is used instead of 'self-harm' because self-harm is often taken to include relatively passive behaviours such as smoking, while self-injury is more frequently construed to describe active, deliberate or aggressive behaviour. However, it is acknowledged that some incidents will be overlooked because it is unclear whether injury was deliberate. It has been suggested that this is the case in an important minority of motor vehicle accidents involving young men, for example (Drummond, 1996). Unfortunately, there is no terminology available that can accurately capture this type of behaviour. Generally speaking deliberate self-injury in this context includes behaviour such as cutting and overdosing – there is an obvious intent to do serious injury to oneself, but there may or may not be an intent to die.

Young people?

The terms 'young people' and 'youth' mean different things to different people, and this is reflected in the literature. Although people often think of 'youth' as teenagers, in the literature 'youth' are more frequently categorised as those aged 15 to 24 years. This is the case in many reports and articles on this topic, such as those by the Ministry of Health. Also, it appears that the ages of 15 to 24 are characterised by important developmental transitions, and deliberate self-injury is supposedly relatively rare in those aged under 15. For these reasons in this seminar, when I talk about 'youth' I'm referring to the 15 to 24 age group.

There is another point to beware of: age-defined categories often assume a position of 'sameness' ie: that 'youth/young persons' are having to face or deal with the same issues as those in

another. This is clearly arguable.

Maori?

At this point it should be noted that the classification of ethnicity that is used in health statistics was changed in 1995. As a result more people are now categorised as Maori. This has obvious implications for data analyses – comparing data obtained pre- and post-1995 will lead to inaccurate results.

The Statistics

Aotearoa/New Zealand has one of the highest rates of male youth suicide in the world. In 1994, the World Health Organisation ranked New Zealand highest out of 23 OECD countries, with 40 deaths per 100 000 population. However, completed suicide is only 'the tip of the iceberg' in deliberate self-injury. This is not to suggest that suicide is over-researched or undeserving of the focus of attention that it currently receives. Rather, the point is made that deliberate self-injury may in fact be an even greater problem, deserving of attention.

Suicidal Behaviour is the fifth leading cause of hospitalization for women (Department of Health, 1988). Maori are twice as likely to be hospitalised as non-Maori for intentional self-injury. According to 1987 data, deliberate self-injury is the fifth leading cause of hospitalisation for young women (Department of Health, 1987). From 1981 to 1993, approximately 400 Maori females per 100 000 population were hospitalised, 300 non-Maori females, 250 Maori males and 150 non-Maori males – a total of up to 1250 young people per 100 000 each year (Ministry of Health: Manatu Hauora, 1996, 1999). See Figure 1 for a graphic illustration of these disparities. In addition, it is acknowledged that many people who engage in self-injury are not hospitalised, so the real figures are much higher. Also, it is likely that the actual rates of both completed suicides and attempts are higher than statistics suggest. Under-reporting is common due to the difficulty of determining intent, and the desire to avoid adding to the mourning family's grief by applying labels. Despite these statistics, there is little research on deliberate self-injury, particularly in Aotearoa/New Zealand.

Characteristics of those who complete suicide, vs. those who engage in non-fatal deliberate self-injury

According to White and Stillion (1988), deliberate self-injury is qualitatively different from suicide – deliberate self-injury is usually a 'cry for help'. Maris (1981) suggested that people who complete suicide and those who engage in non-fatal suicidal behaviour generally share some characteristics, such as depression and a sense of hopelessness, but differ in others. Moreover, those characteristics that are shared differ in their degree. For example: 75% of those who complete suicide make only one attempt (the successful one), while 58% of those who attempt but do not succeed go on to make further attempts. Kerkhof and Nathawat (1989) argue that once people have attempted suicide, they will be more inclined to see it as a feasible option. American studies (Blumenthal, 1990, for example) report that approximately 15% of these further attempts will result in death.

According to Pritchard (1994), people who complete suicide are less likely to have suffered early trauma, are unlikely to be frightened of death, and see death as a solution to their problems. They are more likely to suffer from a major affective disorder, schizophrenia or conduct disorder, a physical disability, illness and/or chronic pain or alcohol problems, and have often had a friend or relative who exhibited suicidal behaviour. They are also more likely to be male, from any social class and age group and socially isolated. Suicide is also more likely to occur in spring or autumn.

Conversely, people who engage in non-fatal behaviours are likely to have experienced early trauma (particularly abuse), have little sense of accomplishment, are young, view their social interactions negatively, and are more likely to abuse drugs other than alcohol. They tend to be of lower socio-economic status, living in overcrowded circumstances, and aged under 30. Their attempts are likely to be anger-based, and, according to Maris (1981), the first attempt is often made in an attempt to manipulate others or draw attention to their problems. Table 1 synthesises these findings, and makes use of New Zealand statistics (Ministry of Health: Manatu Hauora, 1996; Pritchard, 1994).

Farberow (1991) acknowledges that the distinctions between suicide, attempts, and other forms of deliberate self-injury are difficult to make, as attempts are usually preceded by threats and ideation, but nonetheless distinctions exist.

McKeown et. al. (1998) discuss two distinct groups of suicide attempters: a dysphoric, hopeless group who plan their attempts, and an impulsive group who make attempts without serious plans or intent, who exhibit less self-anger. They suggest that suicidal behaviours exist on a continuum, with increased risk for completed suicide being related to the increased number and severity of both proximal and distal risk factors. Given the low base rate of completed suicides and the difficulty in researching their precipitating factors, McKeown et. al. argue that concentrating on the more frequent non-fatal deliberate self-injury should prove more successful in developing accurate screening programmes.

As discussed above, people who engage in non-fatal deliberate self-injury appear likely to be survivors of trauma. Furthermore, there appear to be links with poverty, physical well-being (or the lack thereof), and depression. Statistics on the health and well-being of young Maori make grim reading. Young Maori are more likely than young Pakeha to live in circumstances generally associated with an increased risk to well-being. In 1996, over a third of Maori left school with no formal educational qualifications. Just over one-third of Maori aged 15-19 who were available for work were unemployed. As at 1995, Maori children were nearly four times more likely to be hospitalised for abuse than non-Maori[1]. In 1994, 51% of Women's Refuge clients were Maori, although Maori comprise approximately 13% of the total population of Aotearoa/New Zealand (Ministry of Health, 1998).

McGrath et. al. (1990) note that the mental health status of another indigenous group, Native Americans, is equally bleak. Suicide is twice as high among Native Americans than among the general American population, and it is probable than the deliberate self-

Figure 1. Hospitalisations due to deliberate self-injury, ages 15-24 years, by gender and ethnicity, 1987-1993
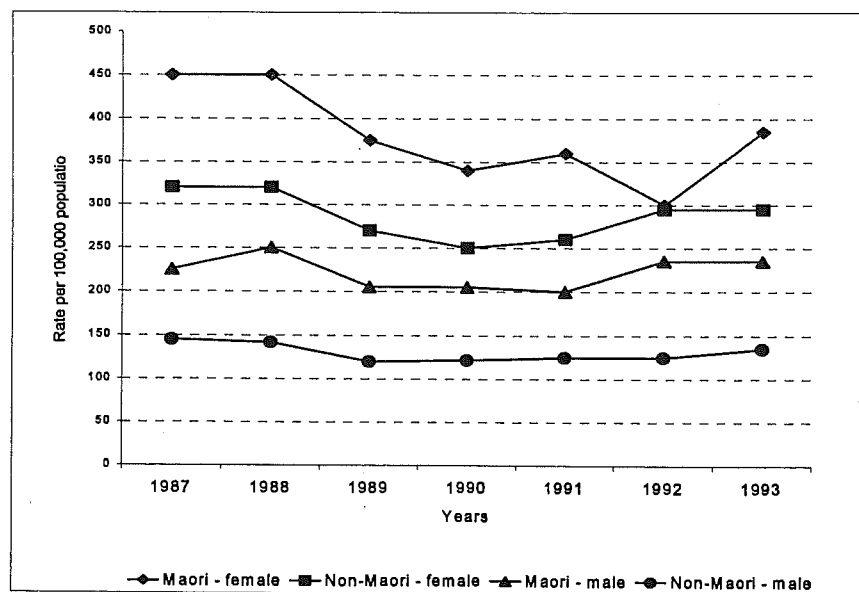
Adapted from: Ministry of Health: Manatu Hauora (1996). *Youth mental health promotion including suicide prevention: The public health issues 1995-1996.* Wellington: Ministry of Health: Manatu Hauora.

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1 Some of this differential may be due to the biases of hospital staff, who have been found less likely to confirm cases of abuse in non-Maori children (Ministry of Health, 1998).

injury rate is similarly disproportionate. They suggest that poverty and lack of education are among the contributing factors. In addition, a significant proportion of Native American women who come to the attention of mental health services have experienced sexual assault, and are at risk of self-medicating with alcohol and other drugs as a response to these stressors. Similarly, McGrath et. al. contend that African American/Black women are faced with a number of mental health issues as a result of their historical, cultural and structural position within American society. These issues are reflected in higher rates of ill-health and substance abuse. However, Black American deliberate self-injury rates are lower than white American rates (Neeleman, Jones, Van Os and Murray, 1996). However, as McKeown et. al. (1998) point out, few studies of self-destructive behaviour include substantial numbers of ethnic minority participants.

Exceptions to this include a British study by Goddard, Subotsky and Fombonne (1996) that compared a similar proportion of Black and White adolescents. They found that the rate of referrals to a psychiatric service for deliberate self-injury reflected the community composition, and the backgrounds, symptoms and circumstances of the two groups were similar, except that more social stress was reported by the Black group. In a study of Aborigines in South Australia, Clayer and Czechowicz (1991) found that there was a disproportionately high rate of suicidal behaviour among that population, which they considered to be similar to the position of Native Americans. They hypothesised that this as a result of 'anomie', a concept of social disintegration that fits the situation of tribal peoples under colonisation.

In addition, the importance of risk factors seem to vary markedly. Neeleman et. al.'s 1996 study of British-born Indian women provides a good example of this. The rates of deliberate self-injury in this group are 7.8 times higher than British-born white females. Neeleman, et. al. contend that unemployment is a much weaker risk factor amongst ethnic minorities in the United Kingdom. They suggest that members of ethnic minorities tend to be employed in less rewarding jobs, so

Table 1. Differentiation of suicide and deliberate self-injury.

Suicide	Deliberate self-injury
Psychiatric illness	Depression, personality disorder
Wants to die	Intent questionable
Males	Females
Alcohol / drug abuse	Alcohol / drug problems (less severe/likely)
Divorced	Divorced (less severe/likely)
Highest in 15 to 24s, and over 75 (for men)	Mainly under 25
Previous deliberate self-injury	Previous deliberate self-injury
Physical illness, chronic pain	Unusual
All socio-economic classes	Lower socio-economic groups
Unemployed (less likely)	Unemployed
Living alone, socially isolated	Over-crowded conditions
In spring and autumn	No seasonal variations
Previous abuse unlikely	High likelihood of previous abuse
Roughly equal numbers of Maori & non-Maori	Considerably more Maori hospitalisations

that unemployment may be a less stressful option.

Gender Issues

The literature examines deliberate self-injury and suicidal behaviour from a feminist perspective, arguing that all women may be directly or indirectly affected by discrimination, powerlessness and devaluation as a result of gender role stereotyping, leading to depression and a sense of hopelessness. We could argue that members of ethnic minority groups are at least as likely to be subject to these factors, which result in other risk factors such as poor health, lower education levels, unemployment[2], and other sources of stress, and less access to suitable health resources.

In 1992, females accounted for 59% of all individuals hospitalised for self-injury: 90.6 per 100,000 per year. As mentioned above, it is likely that many instances of self-injury do not result in hospitalisation, and this is particularly the case for females. Females tend to use less aggressive, slower-acting means of self-injury, for example drug overdose, than males, who are far more likely to use more lethal means such as hanging and shooting (Coggan et. al., 1995). As a result, women are likely to be discovered before hospitalisation becomes a neces-

sity. One of the few studies of non-fatal deliberate self-injury that went beyond merely gathering demographic data[3], is a study by the Corporate Planning Unit (1980). It showed that (in the Wellington area) people were more likely to engage in this behaviour if they were female, aged 15 to 24, unemployed, a sickness beneficiary or in a service occupation, lived in the inner city, and Maori. Again, this information was compiled from hospital admission records, so therefore may not be reflective of those who were not hospitalised, or those who were treated at the Accident and Emergency Department but were not admitted. Known drug users who overdosed were not included.

With the onset of adolescence, female depression rates begin to increase rapidly. McGrath et. al. (1990) argue that emerging gender role conflicts, fear of success and increasing devaluation of the female role are contributing factors. The normal physical changes of puberty decreased female adolescent's satisfaction with their bodies, while the reverse was the case for males, according to Dornbusch et. al. (1984). Furthermore, Lerner and Karabenick (1974) found that young women's self-esteem is closely related to satisfaction with one's body. These

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2 Young Maori women are more likely to be unemployed than Maori men of the same age, according to 1998 Ministry of Health statistics.

3 See also Fanslow and Norton, 1994.

studies were confirmed by Gilligan et. al. (1989), who found that girls are harsher in their self-appraisals than boys, particularly in regard to physical appearance, and Allgood-Merten et. al. (1990), who found that in a sample of 820 mid-upper socio-economic status teenagers, female adolescents reported more depressive symptoms, self-consciousness, stressful events and negative body-image, than boys. Moreover, what is presented clinically as depression may be a long-standing post-traumatic stress response.

When studied at age 18, 17.3% of females in the Christchurch Health and Development Study (Fergusson et. al. 1996) reported experiencing sexual abuse before age 16. However, it has been suggested that survivors in this age group are inclined not to report the abuse they have suffered (Ministry of Health, 1998). A study of 3000 Otago women aged 18 to 65 (Anderson et. al., 1993) reported 32% being sexually abused before age 16. 85% of the abusers were family members or 'friends', and only 5% of the abused women reported the abuse to social services or the police. For 10% of the survivors, abuse was inflicted over a period of three years or more. In addition, over the last 10 years, Maori girls aged under 14 have had far higher rates of hospitalisation for maltreatment than any other group, although in the last five years the gap between Maori girls and Maori boys has narrowed. However, from 1988 to 1995 hospitalisation rates for girls aged under 14 have varied from 60 per 100,000 to 240 per 100, 000, compared to 50 to 100 per 100,000 for boys (Ministry of Health, 1998).

Adults who have been victims of abuse as children report significantly greater symptoms indicative of depression, anxiety and self-abusive behaviour, and women whose experiences occurred within the family were at greater risk of disturbance than other women (Sedney and Brooks, 1984). Symptoms include trouble sleeping, nervousness, thoughts of hurting oneself and learning difficulties. Wagner et. al. provide confirmation of some of these findings, reporting that not only are women who have been sexually abused more likely to engage in deliberate self-injury, their behaviour is also more likely to be lethal than that of

women who did not report abuse.

Local Literature

Self-injurious behaviour is a significant public health problem in New Zealand, yet there is no comprehensive plan aimed at the reduction of the problem (Fanslow and Norton, 1994). In one of the few comprehensive studies of non-fatal suicidal behaviour involving young New Zealanders, Fergusson and Lynskey (1995) found that those who attempted suicide could be distinguished from those reporting suicidal ideation alone. The sample consisted of 954 sixteen year olds. By the age of 16, 15% of the sample reported having either made a suicide attempt or experienced suicidal ideation. (All those who reported making an attempt also reported suicidal ideation.) Of the attempts, approximately 20% required hospitalisation. The authors note that the prevalence of suicidal behaviour appears to be slightly lower than usually reported. However, this sample may have been reluctant to divulge this information in an interview situation. Their findings suggest that those engaging in deliberate self-injury are characterised by a greater burden of psychosocial risk factors, such as higher rates of psychiatric disorder, problems of adjustment, and exposure to family adversity. Fergusson and Lynskey suggest that suicidal ideation in the absence of other risk factors is not typically associated with an increased rate of deliberate self-injury. Perhaps the most interesting finding is that young people who self-injure often come from dysfunctional family circumstances, characterised by familial conflict and instability, parental substance abuse or offending, and economic disadvantage.

Although it is clear that there is ethnic disparity in the rates of deliberate self-injury, most writers on the topic appear to 'gloss over' this fact. For example, a report by Coggan, Fanslow and Norton (1995) draws largely on American material for their discussion of prevention and intervention strategies, despite acknowledging the ethnic disparity. They do not discuss the generalisability of American research to Aotearoa/New Zealand (other than questioning the relevance of further restricting access to guns). There is little

mention of the ethnic disparity in deliberate self-injury rates, however the authors do acknowledge that suicides in custody make a substantial contribution to the Maori suicide rate, therefore "investigation of culturally appropriate interventions may be beneficial" (p. 104). While the omission of discussion of ethnic differences in deliberate self-injury rates is common in the local literature (see also Fergusson and Lynskey, 1995; Greenwood, 1996;) the same cannot be said of the gender disparity. However, there have been some attempts to address the ethnicity issue.

Barwick (1992) asserts that it is feasible to generalise from these international studies on acculturation through colonisation to the Maori situation. However, this hypothesis has yet to be tested. Langford, Ritchie and Ritchie (1998) argue that the alarming increase in non-fatal suicidal behaviour is as a result of economic and social changes which have increased stress on families and youth, which in turn is linked to risk factors such as depression, substance abuse, aggressive behaviour family violence and schooling difficulties. In addition to these risk factors, they argue, Maori are subject to the additional issues of deculturation and colonization.

Keri Lawson-Te Aho, in her book *Kia Piki Te Ora o te Taitamariki. – the New Zealand Youth Suicide Prevention Strategy* (1998), argues that there is a clear relationship between culture and behaviour, and that this relationship needs to be recognised in the design of Maori youth suicide prevention strategies. However, a review of the New Zealand-based deliberate self-injury prevention and intervention literature revealed a wide variation in the way the issue is addressed. At one end of the spectrum Lawson-Te Aho's work (1998), which is clearly located within a Treaty of Waitangi framework and seeks to formulate specific preventions and interventions for Maori. It was commissioned by the Ministry of Youth Affairs and Te Puni Kokiri, and is explicit in its aim to provide the basis for a strategy for the prevention of Maori youth suicide. The strategies contained in the report are comprised of both government initiatives and community initiatives. Adherence to the principles of partnership,

protection and participation is explicit throughout the document, particularly in "Goal Four: Mainstream Responsiveness" (p. 15), which discusses the need for mainstream services to respond appropriately and effectively to the needs of Maori youth through the establishment of partnerships with Maori. Lawson-Te Aho argues that as Maori youth will have a lifetime of dealing with mainstream institutions, it is important that these institutions contain people, processes and performance standards that are capable of meeting the requirements of youth and the whanau. Unfortunately, much of the research lies at the other end of the spectrum.

Conclusion

It is obvious that more attention needs to be given to bringing about a change, not only in the overall rate, but specifically in the Maori rate. The differences in rates of non-fatal deliberate self-injury between Maori and Pakeha are indisputable - yet the issue is still being dealt with as a mainstream issue. That a difference in rates exists points to a need for different ways of examining and thinking about the issue, and interventions. It is evident that mainstream interventions are not working. Research that virtually ignores the Maori position clearly misses the point. In addition, it is important to find out more about the apparent differences in people who commit suicide and people who self-injure. At the moment, the assumption seems to be that suicide prevention strategies will fix both problems – that is questionable.

It appears that deliberate self-injury is linked to a number of social risk factors. Many of the risk factors are inter-related, such as unemployment, abuse and poverty. At times it is difficult to determine which factors are causes and which are effects. The fact that risk factors are embedded in an individual's social environment points to the need for an examination of the socio-political context.

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