

Ethnicity and deliberate self-injury: A review of the literature

Cate Wilson

The University of Waikato

Deliberate self-injury is a significant social problem affecting youth in New Zealand. Rates of hospitalisation for youth (aged 15 to 19) from deliberate self-injury approximate 225 per 100,000. It appears that 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). This paper draws upon both local and international literature to examine factors underlying this ethnic disparity.

There is a wealth of literature examining risk factors underlying suicidal behaviour as a whole. Deliberate self-injury is usually assumed to be an adjunct of youth suicide; prevention strategies are conflated. This paper argues that this assumption is untenable, and in particular, that prevention strategies designed for youth suicide are problematic in terms of deliberate self-injury. While prevention strategies are based upon studies that do not differentiate between these groups, results will be compromised.

More than one thousand people aged 15 to 24 are hospitalised as a result of non-fatal deliberate self-injury each year. The majority of these are Maori and women (Ministry of Health, 1996). Non-fatal deliberate self-injury has been the fifth leading cause of hospitalisation in young women (Department of Health, 1988). However, despite the prevalence of serious deliberate self-injury and the associated social costs, it has received minimal research. Rather, deliberate self-injury is assumed to be an adjunct of suicide. This assumption is questionable, and in particular, the prevention strategies designed for youth suicide are problematic in terms of deliberate self-injury. The literature suggests that youth who complete 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).

Until recently, as McKeown and colleagues (1998) point out, international literature on the prevention of deliberate self-injury and suicide 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. However, these researchers found that focusing on proximal factors may result in the important role of 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 approximately 25% of people who commit suicide have previously engaged in deliberate self-injury (Maris, 1981), the two groups have distinguishing characteristics. Furthermore, these characteristics can be linked to psychosocial factors such as unemployment, sexual abuse and gendered patterns of behaviour.

This paper discusses the literature on deliberate self-injury, with a particular focus on ethnic differences. There will be a particular focus on social and environmental issues and possible factors involved in 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 between these two phenomena. Due to the paucity of local literature on deliberate self-injury (as distinct from suicide), international material will be included. However, as McKeown and colleagues (1998) point out, few studies of self-destructive behaviour include substantial numbers of ethnic minority participants. An attempt will be made to examine the relevance of these studies to the Aotearoa/New Zealand context. There are very clear differences between those who do, and do not injure themselves, and these differences seem to be linked 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 non-fatal deliberate self-injury.

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). The term "deliberate self-injury" is used in preference to "attempted suicide" and "parasuicide" because it includes individuals for whom the intended outcome is unclear, but who, nevertheless, intended to cause serious harm to themselves. A major problem with these terms is determining people's intentions.

The term "self-injury" is used in this paper instead of "self-harm" because the latter may be taken to include relatively passive behaviours such as smoking, while the former is more frequently construed to describe active, deliberate or aggressive behaviour. However, it is acknowledged that some instances of self-injury will be overlooked because it is unclear whether injury was deliberate. For example, it has been suggested that this is the case in an important minority of motor vehicle accidents involving young men (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 injury to oneself, but there may or may not be an intent to die. However, if we think of self-injurious behaviour as a continuum with suicide at one end and relatively passive behaviour such as smoking at the other there are a number of points along the scale.

A set of behaviours that is outside the scope of this paper is that of high-repetition, low-lethality injury, such as superficial cutting. This type of behaviour is sometimes referred to as "self-mutilation" (Favazza, 1996; Walsh and Rosen, 1988). Early efforts to discuss self-mutilation and suicide emphasised their interrelatedness, leading to the concept of "parasuicide". More recent theories (Favazza, 1996; Ross and McKay, 1971; Walsh and Rosen, 1988) see self-mutilation as counter-intentional to suicide. There is often very little risk of dying, and no intent to die. Menninger (1938) discussed self-mutilation as an attempt at self-healing in which a suicidal impulse was focused on part of the body instead of the total body: "Local self- destruction is a form of partial suicide to avert total suicide" (Favazza, 1996, p. 271). In Favazza's view, self-mutilation is antithetical to suicide. Although

there are a number of similarities between self-mutilators and those who engage in the high-lethality, low repetition behaviour that is the focus of this paper (particularly in regard to risk factors), there also appear to be distinctions between them – and between these two groups and those who commit suicide.

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, the World Health Organisation defines "young people" as those aged between 10 and 24 years. However, "youth" are more frequently categorised as those aged 15 to 24 years, and this is the case in many reports and articles on this topic (for example, those by the Ministry of Health). Moreover, it appears that the ages of 15 to 24 are characterised by important developmental transitions, and deliberate self-injury is relatively rare in those aged under 15. For these reasons, for the purpose of this report, "youth" is defined as those aged 15 to 24.

Maori? Shifting definitions are also a problem in relation to ethnicity. The classification of ethnicity 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.

Interestingly, the change of definition has had a significant impact on statistics. Prior to 1996, an individual's ethnicity was recorded as Maori if they had a minimum of 50 percent Maori ancestry. From 1981 to 1993 Maori rates of hospitalization for deliberate self-injury were consistently higher than non-Maori rates. Since the definition of Maori was changed to self-identification, statistics indicate that Maori and non-Maori rates are similar, and, indeed, hospitalization rates for non-Maori females are higher than Maori.

Statistics:

Aotearoa/New Zealand has one of the highest rates of male youth suicide in the world. In 1994, the World Health Organisation ranked

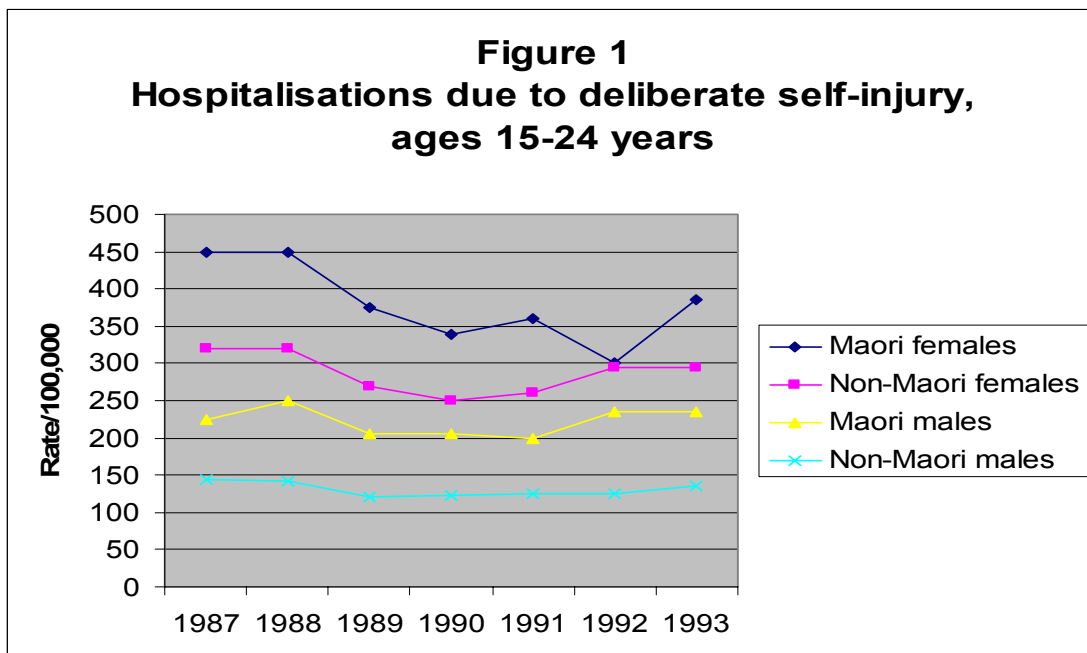
New Zealand highest out of 23 OECD countries, with 40 deaths per 100 000 population. However, completed suicide is only the “tip of the ice-berg” in deliberate self-injury. This is not to suggest that suicide is over-researched or undeserving of the focus of attention that it currently receives. Rather, the point is that non-fatal deliberate self-injury may in fact be an even greater problem than is currently recognised.

Up until age 12, hospitalisation for deliberate self-injury is very uncommon – less than 10 per 100 000 population each year. Between ages 12 and 14 the rate leaps to 400 per 100 000, increases to 500/100 000 by age 18 and remains relatively stable until age 24, at which point a decline in hospital admissions begins. By age 30, the rate is approximately 300/100 000 and by age 45 the rate has decreased to around 150. Data suggests that deliberate self-injury is the fifth leading cause of hospitalisation for young women (Department of Health, 1987). Maori are twice as likely to be hospitalised as non-Maori. 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 – an overall rate of 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.

The rate of hospitalization for deliberate self-injury represents only a fraction of incidents, as many incidents are dealt with by general practitioners and emergency departments without formal admission to hospital (Ministry of Health: Manatu Hauora, 1996). In addition the rates of both completed suicides and attempts are under-reported, due to the difficulty in determining intent, and the desire to avoid adding to personal distress by applying labels.

Coggan, Fanslow, Miller and Norton (1997) estimated the total economic cost of attempted suicide in 1992 at \$11,811,449. This figure was based on \$4,569 per victim and included counselling costs, emergency treatment, hospital stay and loss of productivity. Coggan et. al. suggest that this is likely to be an underestimate, as suicide attempters may not be identified as such by hospitals. In addition, this figure appears to relate only to those who are hospitalised.



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.

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 self-injure repeat the behaviour. Kerkhof and Nathawat (1989) argue that once people have injured themselves, they will be more inclined to see it as a feasible option. There is some suggestion that the attention received following an incident of self-injury becomes reinforcing, resulting in further incidents (Favazza 1996). In these cases the intended outcome of the behaviour is clearly not to die, but to seek support or attention.

According to Pritchard (1994), people who complete suicide (as opposed to the who self-injure) 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 and be socially isolated. Suicide is also more likely to occur in spring or autumn.

Conversely, people who engage in non-fatal self-injurious 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 incident is often made in an attempt to manipulate others or draw attention to their problems. 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.

In one of the few New Zealander studies of non-fatal suicidal behaviour involving young people, 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

Differentiating suicide from deliberate self-injury be slightly lower than usually reported. However, this sample may have been reluctant to divulge this information in an interview situation. These 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 was 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. As other New Zealand authors have suggested, young people, particularly young women, who are in contact with welfare services may be at greater risk of suicidal behaviour than others (Smith and Beautrais, 1999). This appears to fit with the pattern of characteristics presented by Fergusson and Lynskey above.

Table 1 synthesises the findings from the literature and makes use of New Zealand statistics (Ministry of Health: Manatu Hauora, 1996) in setting out some of the important differences between deliberate self-injury and suicide.

Table 1: Differentiating suicide from deliberate self-injury

| Suicide | Deliberate self-injury |
|--|--|
| Psychiatric illness – schizophrenia | 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, <i>and over 75</i> (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 |

Gender Issues

In 1992, females accounted for 59% of all individuals hospitalised for deliberate self-injury in New Zealand. As mentioned above, it is likely that many instances of deliberate 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 (e.g. 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 necessary. A study by the Wellington Hospital Board (1980) 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, lived in the inner city and were Maori. Again, this information was compiled from hospital admission records, so these trends may not be reflective of those who were not hospitalised.

Low self-esteem is an important factor in depression, and 90% of people who engage in self-destructive behaviour are diagnosable with an affective disorder, depression being the most common. Prior to adolescence, rates of depression in boys and girls are very similar

(Nolen-Hoeksma, 1990). However, with the onset of adolescence, female depression rates begin to increase rapidly. McGrath and colleagues (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 often decrease female adolescents' satisfaction with their bodies, while the reverse is the case for males (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 studies were confirmed by Gilligan, Lyons and Hammer (1989), who found that girls are harsher in their self-appraisals than boys, particularly in regard to physical appearance. Allgood-Merten, Lewinsohn and Hops (1990) 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.

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 are 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 and Linehan (1994) 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. 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).

Some of the literature discussed above¹ 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, possibly resulting in depression and a sense of hopelessness. One may argue that members of ethnic minority groups are at least as likely to be subject to these factors, which in turn, leads to other risk factors such as poor health, lower education levels, unemployment and other sources of stress, and less access to suitable health resources.

Ethnicity Issues

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. In these regards, 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-Maori². 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).

International studies suggest that colonised indigenous populations are at higher risk of self-injurious behaviour than the colonisers. McGrath, Keita, Strickland and Russo (1990) note that suicide is twice as high among Native Americans than among the general American population, and it is probable that the deliberate self-injury rate is similarly disproportionate. They suggest that poverty and lack of education are among the contributing factors. Similarly, these researchers 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 et al, 1996).

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, whose position they considered to be similar to that of Native Americans. Both have experienced extensive social disintegration as a result of colonisation.

The importance of risk factors seems to vary markedly between dominant and non-dominant groups. Neeleman and colleagues' 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. The researchers 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 that for them, unemployment may be less stressful than being in paid work.

The position of Maori

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.

Although it is clear that there is an ethnic disparity in the rates of deliberate self-injury, most local writers fail to adequately address the position of Maori. For example, a report by Coggan, Fanslow and Norton (1995) draws largely on American material for their discussion of prevention and intervention strategies. 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 no discussion whatsoever of the application of the articles of the Treaty of Waitangi or even of the principles. In fact there is little mention of the ethnic disparity in deliberate self-injury rates. The word "Maori" appears only once in the ten-page discussion of prevention and intervention, in an acknowledgement that suicides in custody make a substantial contribution to the Maori suicide rate, therefore "investigation of culturally appropriate interventions may be beneficial" (p. 104).

The Fergusson and Lynskey (1995) study referred to earlier was based in Christchurch is another example. Although there are fewer Maori living in the Christchurch area than the national average of approximately 12%, Maori still make up 7% of the population, with 6,582 Maori aged 15 to 24 living in Canterbury in 1996 (Statistics New Zealand, 1997). Given that approximately 65% of national deliberate self-injury hospitalisations are Maori, it seems reasonable to expect that a portion of their potential sample would be Maori. However, they are silent on this point. Similarly, Greenwood (1996) fails to even mention the ethnicity of her participants in her small qualitative study. Barwick (1992) does address the position of Maori asserting that it is feasible to generalise from international studies on acculturation through colonisation to the Maori situation. However, this hypothesis has yet to be tested. Similarly, Langford, Ritchie and Ritchie (1998) argue that deculturation and colonization have accentuated the risk for Maori. These factors, along with economic and social changes which have increased stress on families and

youth and led to increased rates of depression, substance abuse, aggressive behaviour, family violence and schooling difficulties were all considered to have contributed to an alarming increase in non-fatal suicidal behaviour in Aotearoa.

Lawson-Te Aho's work (1998) 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 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 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 their whanau.

With the important exception of Lawson-Te Aho's work (1998), overall, the literature pays little attention to the possibility that the long-term effects of colonisation are a factor in the disproportionately high Maori suicide rates. Assisting in the development of self-esteem and self-efficacy and establishing a context of support and collective responsibility among Maori are some of the avenues through which Aotearoa/New Zealand can begin to reduce the Maori suicide rate. However, in order to do this wider socio-political issues may need to be addressed.

Conclusion

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). We know, however, 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 individual's social environment points to the need for an examination of the socio-political context.

Although there is some local literature, much of it does not address the most relevant issues. The differences in rates of self-injury between Maori and Pakeha are clearly worthy of further investigation - yet the issue is still being dealt with as a mainstream issue. It is obvious that more attention needs to be given to reducing deliberate self-injury, not

only in the overall rate, but specifically in the Maori rate.

That a difference in rates exists points to a need for different ways of examining and thinking about the issue, and about interventions. It is evident that mainstream interventions are insufficient. 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 serious, but non-fatal, self-injuries. At the moment, the assumption seems to be that suicide prevention strategies will fix both problems. That is questionable.

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Notes

1. For example, McGrath et al, (1990).
2. However, 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, 1998b).

