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**Reasons to Live:
NZ-Born Samoan Young People's
Responses to Suicidal Behaviours**

Jemaima Tiatia

**A thesis submitted for the degree of Doctor of Philosophy
University of Auckland
2003**

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CHAPTER ONE: INTRODUCTION

Suicidal behaviours amongst young people both internationally and in Aotearoa¹/New Zealand has been recognised as a significant public health² concern (Cantor & Neulinger, 2000a; Madge & Harvey, 1999; World Health Organisation, 1998). In 2000 in Aotearoa/New Zealand, epidemiological evidence indicated that for young people aged 15-24 years, males had the second highest rate of suicide (highest in 1999) and the fourth highest for females (highest in 1999) amongst selected Organisation for Economic Cooperation and Development countries (OECD)³ (Ministry of Health, 2002a; New Zealand Health Information Service, 2001). In addition, suicidal behaviours are a considerable drain on both primary and secondary health care resources worldwide (Schmidtke, Weinacker, Apter *et al.*, 1999).

Suicidal behaviours have been identified as contributing to the continuing poor health status of Pacific⁴ young peoples in Aotearoa/New Zealand (Ministry of Health, 1997a) yet there is a dearth of research-based evidence addressing suicidal behaviours amongst Pacific young peoples in this country (Tiatia & Coggan, 2001). More specifically, there have been no Aotearoa/New Zealand studies addressing suicidal behaviours amongst New Zealand born (NZ-born) Samoan young people. Evidence suggests that knowledge of factors which contribute to a range of suicidal thoughts and behaviours, is important for developing effective prevention efforts (Appleby, 1993; Coggan, 1995; Moscicki, 1993; Shaffer, Garland, Gould *et al.*, 1988). Given these gaps, the study described in this thesis is an attempt to address these concerns. This thesis is informed by a critical public health perspective and examines suicidal

¹ Aotearoa (land of the long white cloud) is the Maori (*tangata whenua* - the indigenous people of Aotearoa) term and is also recognised as an alternative in the language of mainstream New Zealand society.

² A public health definition may be described as an area of medicine dealing with safeguarding and improving community health through organised community effort, involving the prevention of disease, control of communicable disease, and health education (Beaglehole, Bonita & Kjellström, 2000).

³ OECD countries compared were Aotearoa/New Zealand, Finland, Australia, Canada, USA, Norway, France, Denmark, Sweden, Germany, Japan, UK and the Netherlands.

⁴ The term 'Pacific' in this research refers to the population with South Pacific ethnic origin from Samoa, Cook Islands, Tonga, Niue, Tokelau, Fiji, Tuvalu, Papua New Guinea, Vanuatu, Solomon Islands, and Kiribati - inclusive of NZ-born and overseas born.

behaviours amongst NZ-born Samoan young people.

In Aotearoa/New Zealand, the majority of public health examinations of young people's suicidal behaviours have primarily focused on Pakeha⁵ and Maori⁶ populations. In an attempt to provide relevant public health information specific to the Samoan population in Aotearoa/New Zealand, this thesis draws upon a wide range of research (including sociocultural) and will provide useful information to improve public health research, practice and policy.

This Introduction chapter sets the scene by briefly presenting an epidemiological overview of youth suicidal behaviours in Aotearoa/New Zealand. It describes the demographics of the Samoan population in Aotearoa/New Zealand and addresses the need for ethnic-specific information. The chapter then discusses my perspective in relation to why this study was undertaken and the remainder of this chapter is organised as follows: outline of research objectives; definitions of suicidal behaviours and the Samoan concept of health; the study rationale; epidemiology of suicidal behaviours and critical considerations; a summary of Western risk factors for suicidal behaviours and critical considerations; and lastly, the thesis outline.

Epidemiological Overview of Youth Suicidal Behaviours in Aotearoa/New Zealand

The total number of youth suicides in the year 2000, for the age range 15-24 years, in Aotearoa/New Zealand was 96 (an overall rate of 18.1 per 100,000) (Ministry of Health, 2002a). By comparison, the Maori youth rate was 25.7 per 100,000 (Ministry of Health, 2002a) and the Pacific youth suicide rate was 4.5 per 100,000⁷ (Ministry of Health, 2002b). Between 1993 and 1998, attempted suicide was the third leading cause of hospitalisations for all Aotearoa/New Zealand young people aged 15-24 years, accounting for 11 percent of all overnight hospitalisations (Coggan, Langley, Dawe *et al.*, 2000). In 1999/2000,

⁵ The term Pakeha refers to non-Maori Aotearoa/New Zealanders of European descent.

⁶ The indigenous people of Aotearoa/New Zealand.

⁷ Provisional 2000 NZHIS data, based on 1996 New Zealand Census data for the Pacific population in Aotearoa/New Zealand.

there were 356 male attempted suicide hospitalisations (a rate of 131.4 per 100,000) and 698 female attempted suicide hospitalisations (a rate of 268.3 per 100,000) (Ministry of Health, 2002b). In terms of hospitalisations in Aotearoa/New Zealand for Pacific peoples, in the years 1996-99, 44 percent were aged 15-24 years (New Zealand Health Information Service, 2002b) (see section 'Suicide Morbidity,' in this chapter for detailed Pacific hospitalisation data).

Demographics of Samoan Population in Aotearoa/New Zealand

Pacific ethnic classification is not routinely reported. The Samoan ethnic group is the largest Pacific community in Aotearoa/New Zealand. According to 2001 Census statistics, 115,017 Samoan people lived in Aotearoa/New Zealand - representing 50 percent of the total Pacific population. Almost all Samoan people in 2001 lived in urban centres (Auckland, Wellington, Waikato, Bay of Plenty, Manawatu-Wanganui and Canterbury) with populations of 30,000 or more. Generally, two-thirds of the Samoan community resided in the Auckland region (Statistics New Zealand, 2001).

Of those living in Aotearoa/New Zealand at the time of the 2001 Census, proportionately more were born in Aotearoa/New Zealand than in the Islands. The Aotearoa/NZ-born Samoan population accounted for 58 percent of the total Samoan population in 2001 compared to 49 percent in 1991 (Statistics New Zealand, 2001, 1998).

In Aotearoa/New Zealand the Pacific and Samoan ethnic groups have been described as a youthful population (Statistics New Zealand, 2001; Tukuitonga & Finau, 1997). For example, in 2001, 39 percent of Samoans were under 15 years of age, compared with 23 percent of the general population (Statistics New Zealand, 2003).

The Need for Ethnic-Specific Information

Overall, there is a dearth of literature addressing attempted suicide and suicide prevention specifically about NZ-born Samoan people in Aotearoa/New Zealand (Tiatia, Coggan, Hooper *et al.*, 2002). This may be partially attributed to the use of terms such as 'Pacific Islanders', 'Pacific Peoples' and 'Oceania', which homogenise Pacific groups and thus conceal ethnic differences (Tupuola, 1998). It is maintained that knowledge of cultural norms and differences are crucial in understanding the phenomenon of suicidal behaviours amongst different ethnic groups (Range, Leach, McIntyre *et al.*, 1999). Consequently, this thesis attempts to focus upon the Samoan young people's suicidal behaviours. Tukuitonga and Finau (1997) argue that ethnic-specific research and information is limited in Aotearoa/New Zealand. Ethnic-specific information relating to individuals and families is fundamental for improvement, monitoring and the evaluation of the health status and service delivery for Pacific peoples. Additionally, the health effects of social policy on minority⁸ groups have to be assessed with ethnic-specific information in order to be most effective. Furthermore, Tukuitonga and Finau (1997) argue that the present situation of a Pacific population needing "liberation from poor health" (p. 65) must be grounded in the approach of ethnic-specific information. It was further recognised by these authors that this ethnocentric approach would be heavily criticised, as it may be perceived as a form of "Hitlerism" (p. 65). Nevertheless, Tukuitonga and Finau maintained that much of this criticism stems from those of the dominant culture who seek to maintain the status quo.

The main focus of this thesis is to prioritise the NZ-born Samoan youth voice. It is envisaged that information from this thesis will be used to enhance health outcomes and inform future policy and service delivery for Samoan young people in Aotearoa/New Zealand and contribute towards improved mental health and wellbeing. Additionally, it is anticipated that this research will contribute to the long-term goal of reducing suicidal behaviours within this population.

⁸ The use of the term 'minority' in this context refers to a group that is different ethnically from a larger group from which it is part.

The Researcher's Perspective

I am a NZ-born Samoan woman, interested in the improvement of youth health and overall spiritual, mental and physical wellbeing - particularly amongst Samoan and Pacific young peoples in Aotearoa/New Zealand. Apart from personal associations with young people who had undertaken such behaviours, it was brought to my attention - after a comprehensive search of the literature about Samoan young people and suicidal behaviours - that what information there was, was predominantly written in the 1980s. Moreover, much of the literature regarding Samoan youth suicidal behaviours focused largely upon the population in Samoa itself. Consequently, questions arose - are the suicidal experiences of Samoan young people in Aotearoa/New Zealand any different? How relevant is the mental illness approach for Samoan young people? Are there in fact distinct cultural explanations?

It was for these reasons that I was driven to conduct research based at Auckland University's Injury Prevention Research Centre, as part of a three-pronged study of suicidal behaviours amongst Pakeha - 'The Risk and Resistance Project: Explorations of Pakeha/New Zealand European Young People's Suicidal Behaviours' (Coggan, Bennett, Adams *et al.*, 1999), Maori - 'Maori Case-Control Attempted Suicide Study' (Coupe, Durie, Coggan *et al.*, 2000), and Pacific youth in Aotearoa/New Zealand.

RESEARCH OBJECTIVES

The aim of this thesis was to investigate the perceptions of NZ-born Samoan young people (16-25 years)⁹ following a suicide attempt, as well as their reasons to live. In so doing, three fundamental questions needed to be addressed:

- ❖ What are the characteristics of Samoan young people who present to Emergency Departments (EDs) in the Auckland region as a result of a suicide attempt?

⁹ Refer to 'Rationale' in this chapter for justification of this age group.

- ❖ What issues contribute to suicide attempts amongst NZ-born Samoan young people in Auckland in Aotearoa/New Zealand?
- ❖ What are some of the reasons young NZ-born Samoan people who have attempted suicide believe would enhance their options to choose life and thus contribute towards their overall future wellbeing, be it physical, mental, spiritual, or emotional?

DEFINITIONS

Suicidal Behaviours

In this research, suicide refers to self-inflicted injury resulting in death (Coggan, 1995; Hider, 1998; Maris, Berman & Silverman, 2000). Attempted suicide may be interpreted along a continuum of severity, for example superficial lacerations to considerable lethality, where there may often be some doubts about the absolute intent of death by the person at the time of the event (Bowles, 1985; Hawton, 1986; Kessler, Borges & Walters, 1999; McKeown, Garrison, Cuffe *et al.*, 1998). Therefore in this research, attempted suicide includes a variety of incidents and intent, such as those actively intending to die or those engaging in attention-seeking behaviour (Coggan, 1995). Furthermore, official Aotearoa/New Zealand figures and publications refer to the term “attempted suicides”. Consequently, suicide attempters in this research have been defined as those presenting to an Emergency Department (ED) with an overdose, self-inflicted lacerations or self-inflicted injury by other means. It is recognised that this definition may include individuals with varying degrees of intent to die. It may also result in underestimates of suicide attempters who present by other means, including single occupant vehicle crashes.

Pacific and Samoan Concepts of Health

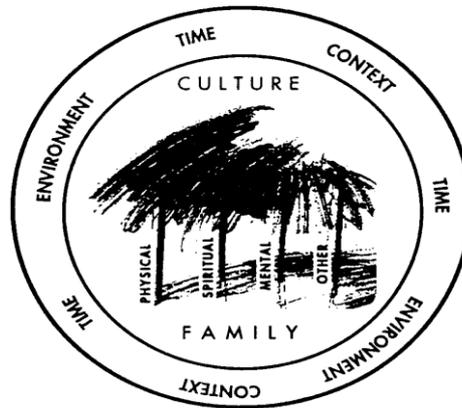
This research embraces the holistic approaches of both the Pacific and Samoan concepts of health (see figure 1). For instance, the World Health Organisation (WHO) suggests that health is best understood not just as the absence of disease, but as a state of complete physical, mental and social wellbeing (World Health Organisation, 2002a). The majority of Pacific populations believe that spiritual wellbeing is an equally important contributor to positive health and wellbeing (Ministry of Health, 1997b). Therefore the general Pacific concept of health may be defined as a state of complete physical, mental, social and spiritual wellbeing (Ministry of Health, 1997b; Tamasese, Peteru & Waldergrave, 1997).

It is imperative when discussing Samoan health to first define the Samoan-specific concept of health, which is expressed in the words -“*soifua maloloina*”. *Soifua* translates as 'life', or 'to live', and *maloloina* means 'a rest', 'health', or 'to recover from illness' (Laing & Miteara, 1994). To further illustrate, a Samoan model - the *fonofale* (meeting house) (see figure 1) which has been used in other disciplines prior to its use in public health, has been considered a framework for understanding the Samoan concept of health (Ministry of Health, 1997a).

The roof represents cultural values and beliefs, which is the shelter for life and may include both traditional and Western methods of healing. The foundation represents the nuclear family as well as the *aiga*¹⁰ *potopoto* (extended family). The *aiga* (family) provides the base which supports the four *pou* (posts): physical, spiritual, mental and other (other, being variables such as gender, sexual orientation, age and social class). Surrounding the *fonofale* is the social context in which health occurs and represents the time period and the environment - whether rural, village, or urban based (Ministry of Health, 1997a).

¹⁰ In this thesis the term *aiga* is used to encompass all relationships by blood, marriage, adoption or *tautua* (service) (Meleisea & Schoeffel, 1998; Mulitalo-Lauta, 2000). Therefore *aiga* has also been used throughout this thesis to include the *aiga potopoto* or extended family.

Figure 1: Fonofale



Source: Ministry of Health, 1997a.

RATIONALE

Why Suicide Attempts?

For the purpose of this research, attempted suicide rather than suicide has been the focus. This is based on the premise that the majority of previous international research has focused on the extreme cases of suicidal behaviours, that is, those resulting in death (Brent, Perper, Moritz *et al.*, 1993a; Shafii, Carrigan, Whittinghill *et al.*, 1985), or attempts resulting in hospitalisation for 24 hours or more both locally and internationally (Beautrais, 1999; De Wilde, Kienhorst & Diekstra, 1992; Morano, Cisler & Lemerond, 1993; Serafino, Somerford & Codde, 2000). Furthermore, it is believed that suicide attempts are also likely to contribute significantly to morbidity estimates (Beautrais, Joyce & Mulder, 1996). Yet there is little information about those who are not hospitalised for suicidal behaviours (Bennett, Coggan, Hooper *et al.*, 2002).

A substantial body of international evidence - both Western and non-Western - imply that young people who attempt suicide have an increased risk of repetitive suicide attempts and an initial suicide attempt is a frequent precursor to completion of suicide in the future (Diekstra, 1989; Aghanwa, 2000; Borowsky, Resnick, Ireland *et al.*, 1999; Cantor, 1994; Hezel, 1987; Kachur, Potter, Powell *et al.*, 1995; Schnyder, Valach, Bichsel *et al.*, 1999). It has been identified

internationally that as many as between 20-40 percent of youth suicide attempters will make a repeat attempt, and as many as 14 percent will eventually go on to die by suicide (Hawton, Fagg & Simkin, 1996; Kachur *et al.*, 1995). Thus, those who attempt suicide may have up to a 50-fold risk of subsequent suicide compared to those who have not attempted suicide (Cantor, 1994). It is argued that recognising those at high risk of repetitive suicidal behaviour should be the first step towards prevention (Appleby, 1993).

Why the Age Range 16-25 Years?

As statistical evidence confirms (see figures under morbidity section later in this chapter), the age group at highest risk of suicide attempts in Aotearoa/New Zealand are those in the age range 15-24 years (Ministry of Health, 2002b). For the purposes of this research young Samoans between the ages of 16-25 are the focus. Legal minors (15 years and under) were excluded from the research as parental consent was required for their participation. It was considered inappropriate, particularly amongst the study's youth cultural mentor group,¹¹ to consider including young Samoans 15 years of age and under even with parental permission. It was argued that most young Samoans tended not to disclose their risk-taking behaviours to their parents, thus reflecting the importance placed upon issues of confidentiality (Youth Cultural Mentor Group, 1999). Therefore obtaining parental consent would be considered problematic and potentially unsafe for the person who had attempted suicide. Beautrais (1996) in an epidemiological profile of child and young adolescent suicide in Aotearoa/New Zealand considers suicidal behaviours amongst young people aged 15 years and under to be rare. Beautrais recognises that this has however, increased during the last few years. Further evidence indicates that amongst Pacific children and young peoples aged less than 15 years, suicidal behaviours are uncommon (Beautrais, 2001).

¹¹ This group was established to work in an advisory capacity in the study. See also Chapter Three for further description of this group's role. It is also important to mention that although cultural mentor groups were involved in an advisory capacity, ultimately the final decision to

Why Emergency Departments?

Evidence suggests that attempted suicide is likely to result in considerable use of Emergency Departments (EDs) (Kapur, Creed, Feldman *et al.*, 1999; Taylor & Cameron, 1998). In most countries data suggests that rates of attempted suicide have been escalating since the late 1950s to early 1960s, and that amongst youth, suicidal behaviours have become one of the most important reasons for ED admissions and treatment (Diekstra, Kienhorst & de Wilde, 1985). In Aotearoa/New Zealand, estimates of the numbers of Samoan young people presenting to EDs as a result of attempted suicide are not routinely collected. For example, there is incomplete information collected for distinct Pacific ethnic groups presenting for treatment. This lack of data on ED presentations is a major hindrance in the planning of prevention strategies specifically catering for NZ-born Samoan young people. Moreover, as mentioned earlier, most research has focused upon suicide deaths (Brent *et al.*, 1993a; Shafii *et al.*, 1985; Appelby, Cooper, Amos *et al.*, 1999) or suicide attempts resulting in hospitalisations (Serafino *et al.*, 2000; Beautrais, 1999; Beautrais *et al.*, 1996). In contrast, the current research includes those with less medically acute suicidal injuries, that is - those presenting to EDs regardless of whether they are hospitalised or not, thus contributing to the knowledge base of Samoan young people in Aotearoa/New Zealand who attempt to take their lives.

Why Prioritise the Samoan Youth Voice?

To address the issue of suicidal behaviours, every effort has been made to prioritise the voices of young NZ-born Samoan suicidal attempters. This is primarily based on the view that too often in the past, public policy has either ignored young people in general or focused on them only when their behaviour has disturbed their elders (Burt, 1996). Similarly within the *fa'asamoa* (Samoan way), the youth voice has been somewhat covert as a result of cultural boundaries in which the young person is customarily taught to 'know' their place within the Samoan structure of gerontocracy (Taule'ale'ausumai, 1991; Tiatia, 1998; Tupuola, 1998; Chun, 2000; Mageo, 1998; Freeman, 1983; Vaoiva, 1999)

include or exclude advice was that of the candidate.

(see Chapter Two for in-depth discussion). Furthermore, it is claimed that in the investigation of suicidal behaviours, it is the suicide attempters themselves who are the most relevant source of information, as it is the perceptions of their experiences that are most vital (Hawton, 1986).

In light of these arguments, richness of information can only come from 'the source' not only in terms of sharing their difficult experiences, but also providing information which explores factors from the perceptions of NZ-born Samoan young people who have been encouraged to choose life and hence the need to ascertain factors which provide reasons to live.

Why Reasons To Live?

In addition to the views made above, according to the Education Review Office (ERO), positive mental health is a basic requirement for the social, academic and physical achievements of all young people (Education Review Office, 2000). The concept of 'reasons to live' may be closely linked with suicide prevention, and may also raise awareness of factors which may limit future suicidal behaviours (Linehan, Goodstein, Nielson *et al.*, 1983). This will be explored and developed throughout the thesis. An exploration of NZ-born Samoan young people's reasons to live contributes to existing public health information in the field of youth mental health promotion in Aotearoa/New Zealand. Additionally, factors identified by NZ-born Samoan young people to buffer against suicidal behaviours may potentially enable the planning and development of initiatives or services relevant for this population in Aotearoa/New Zealand, which in turn may minimise suicidal risk.

EPIDEMIOLOGY

Suicide mortality

International

According to the latest figures from the WHO, approximately one million people worldwide die from suicide annually (World Health Organisation, 2002b). Globally, suicide is the fourth largest cause of death amongst those aged 15-24 years (World Health Organisation, 2002c). This is a worldwide mortality rate of 16 per 100,000, or one death every 40 seconds (World Health Organisation, 2002b). The highest rates of youth suicide (more than 30 cases per 100,000) are found in Finland, Latvia, Lithuania, Aotearoa/New Zealand, the Russian Federation and Slovenia (UNICEF, 1996). By comparison, Japan and most Western European nations have low rates of youth suicide (fewer than 15 cases per year for every 100,000 young males). Almost four times as many young males as females commit suicide in industrialised nations (UNICEF, 1996).

It is acknowledged that comparing international rates of suicide is problematic, given that classification of suicide is culturally determined and that various methods are used to classify suicide. For instance, the quality of suicide mortality data is, to a considerable degree, associated with measures underlying the ascertainment of a suicide (Ministry of Health, 2002b; Morgan, 1979; Ruzicka, 1998).

For the selected Pacific populations of Fiji, Micronesia and Samoa, suicide data was extracted from police records, coroner reports and deaths in hospital (Aghanwa, 2000; Booth, 1999a; Bowles, 1985; Macpherson & Macpherson, 1985; Vivili, Finau & Finau, 1999) (see Table 1).

Booth's (1999a) description of suicide patterns by gender in Fiji and Samoa were limited to two periods 1982-83 and 1989-90 (Fiji) and 1981 and 1988-91 (Samoa). Booth reports that female and male rates within Pacific populations exceeded international gendered rates. For instance, according to Booth's (1999a) analysis, in global terms, it is assumed that youth suicide is predominantly a male phenomenon. Yet in the cases of the Indian population in Fiji and the population of Samoa, Booth states that females experienced slightly

higher suicide rates. During recent years, Samoan female suicides increased markedly. By the years 1988-91 in Samoa, 64 percent of suicides across all age groups were female (Booth, 1999a). Booth also notes that the relative frequency of different methods used in the suicides varied between the Fijian Indians and Samoan populations. For instance, hanging was the most common method amongst Fiji Indians in comparison to Samoa where the most common method of suicide was the ingestion of paraquat - a toxic herbicide (Booth, 1999a).

Table 1: Age-standardised suicide mortality rates in selected Pacific societies

Population	Year	Standardised Rate*	
		Males	Females
Melanesia			
Fiji			
Fijian	1982-83	3	3
Indians	1982-83	41	27
Micronesia			
Federated States of Micronesia	1960-1987	36	3
Chuuk State	1970-1985	57	4
Guam	1988-1992	24	4
Polynesia			
Samoa	1981	49	18

*WHO World standard, average annual rate per 100,000 person ¹². Source: (Booth, 1999b; Ruzicka, 1998).

¹² Statistics were subject to accessibility and current availability.

In the three year period 1981-83, there were a total of 106 suicides in Samoa (Bowles, 1985). The age range most at risk was the 15-24 year group. For example, the national rate over this three year period was 22.6 per 100,000 whereas for the 20-24 year age group, the rate was 75.7 per 100,000 (Bowles, 1985). The three leading methods used in youth suicide deaths were paraquat poisonings, hangings and gunshots.

Apart from the epidemiological review of suicides in Tonga by (Finau & Lasalo, 1985), the most recent review by (Vivili *et al.*, 1999) looks at suicide data for the period 1982-1997. There were 43 suicides documented for all age groups. The majority of Tongan suicide deaths were recorded for the age bracket 0-14 years. Records indicated that 91 percent were males for all ages, thus giving a male-female ration of 9:1. The incidence of suicide demonstrated that Tongan male youth were most at risk. Vivili and colleagues argue that the dominance of suicides amongst males is the result of diminished Tongan traditional support systems and is parallel to other Pacific experiences. The methods used in Tongan suicides were not documented.

There is epidemiological evidence which describes the suicide patterns of the Federated States of Micronesia (Hezel, 1987; Rubinstein, 1987; Booth, 1999b; Hezel, 1984, 1993). Generally such evidence indicates that in 1960, the male suicide rates for the overall Micronesian population had increased six times, from eight per 100,000 to 48 per 100,000 in the early 1980s (Hezel, 1993; Rubinstein, 1987). The female rate had also increased but remained relatively low in comparison to the male rate with a ratio approximately 12:1 (Rubinstein, 1987). The highest rates were in the age range 15-24 years. In most of Micronesia, in the period 1974-1983, suicide rates for young males were 100 per 100,000 annually (Rubinstein, 1987). The most common method used was hanging, which accounted for 85 percent of suicide deaths (Rubinstein, 1987). It is stated that Micronesian patterns of suicidal behaviours are culturally similar to those experienced in Samoa (Booth, 1999b; Hezel, 1989; White, 1985). For instance, Leacock (1987) stated that:

Like Samoa, Micronesia has experienced a tragic epidemic of youth suicide ... although rebuffs from parents, lovers, schools, or other sources trigger suicides, deep socio-cultural conflicts produce the malaise that has caused a sudden rise in the number of youth who respond to rebuff or punishment with this ultimate act of rage and despair (Leacock, 1987:184).

National

In a WHO comparison of selected Western world OECD countries, Aotearoa/New Zealand's 1996 youth suicide rate was the highest amongst young people in the 15-24 year age group (Disley & Coggan, 1996; World Health Organisation, 2002a). In 1999 (the most recent year for which coroners' data is available), 514 people died by suicide across all age and ethnic groups in Aotearoa/New Zealand (Ministry of Health, 2002b). Analysis of data across the life span indicate that young people in the 15-24 year age group had the highest rates for suicide (23.3 per 100,000 persons per year) (New Zealand Health Information Service, 2001). As stated earlier in this chapter, a total of 96 people aged 15-24 years, died by suicide in 2000 (Ministry of Health, 2002b). It is important to note that youth suicides represented 25 percent of all suicides despite youth comprising only 14 percent of the total Aotearoa/New Zealand population (Ministry of Health, 2002b).

Prior to 1995, ethnic classification in Aotearoa/New Zealand was defined as those possessing half or more Maori or Pacific blood. From 1996 onwards, ethnic classification was based on self-identification (New Zealand Health Information Service, 2001). However, there has been no commitment to identifying the ethnic diversity amongst Pacific peoples by statisticians (Ministry of Health, 2002b). Consequently this limits the obtaining of suicide data for the Samoan population in Aotearoa/New Zealand.

A study conducted by Rose and colleagues (1999) describe the population of those who had committed suicide between the periods 1989-97 in the Auckland region. During this period, a total of 1108 people in Auckland had taken their lives. This accounted for approximately one suicide every three days with a greater proportion of young people killing themselves in comparison to the general population. Findings indicate that there were 108 Pacific suicides, or that 9.7 percent of all suicides in the Auckland region were identified as Pacific

(Rose, Hatcher & Koelmeyer, 1999).

Recent New Zealand Information Service (NZHIS) data for the years 1996-98 indicate that suicide continues to be the second leading cause of injury amongst Pacific peoples across all age groups in Aotearoa/New Zealand (Coggan *et al.*, 2000; New Zealand Health Information Service, 2002a). A total of 54 Pacific suicide deaths were recorded for all age groups within this time period (see Table 2).

Table 2: Pacific Peoples Suicide Deaths in Aotearoa/New Zealand by Age Group and Gender, 1996-1998

Age Group	Female Numbers	Male Numbers
0-4	0	0
05-14	0	2
15-24	2	16
25-39	6	18
40-59	1	8
60-74	1	0
75+	0	0
Total	10	44

Source: New Zealand Health Information Services (2002a).

The 15-24 year age group made up 33 percent of the total. There were eight youth suicides reported for Pacific peoples in 1998 alone, six males and two females - all of which were hangings (Ministry of Health, 2002b). Although this number may not appear statistically significant, suicidal behaviours warrant further investigation as it is a strong indicator of negative mental health

(Coggan, Bennett, Hooper *et al.*, 2002; Beautrais, 2000b; Brent, 1995; Fergusson, Horwood & Lynskey, 1995).

Suicide morbidity

International

According to recent WHO data, annually 10-20 million people worldwide attempt suicide across all age groups (World Health Organisation, 2002a). Approximately three times more young people are hospitalised for attempted suicide than complete suicide annually, and nearly four times more young people will attempt suicide but never receive medical care (Hider, 1998). Not all suicide behaviours are intended to be fatal, as some may be considered a warning or 'cry for help' (Ruzicka, 1998). Furthermore, epidemiological evidence suggests that in most countries those who attempt suicide differ statistically by age and gender compared to those who actually die by suicide. Those who attempt suicide are predominantly female whilst nearly 80 percent of suicides are male (Moscicki, 1995).

For the selected Pacific populations (Fiji, Micronesia and Samoa as discussed under the section 'mortality') there was little hospitalisation data available, with only Samoa being the exception. In Samoa during the period 1988-91 and amongst those aged 15-24 years, females accounted for 46 percent of suicidal attempts with a gender ratio of 1:04 (Booth, 1999a). Reported data suggests that in relation to females in many other populations, Samoan female youth are under-reported in suicide attempts but over-represented in suicides (Booth, 1999a).

National

In Aotearoa/New Zealand, there are no accurate figures on all suicide attempts as records are only kept on people who have been admitted to hospitals as inpatients or day patients (Ministry of Health, 2002b). In addition, there is little consistency between hospitals regarding what constitutes an admission (Ministry of Health, 2002b). Statistics are not routinely collected on those

treated at public hospital EDs as outpatients, those people treated at private Accident & Emergency clinics (A & E), those who are treated by general practitioners, and those who do not seek medical treatment at all (Ministry of Health, 2002b). It is estimated that 50-80 percent of attempted suicides do not receive medical attention and therefore suicidal behaviours are likely to be more common than official data suggests (Cantor & Neulinger, 2000a). Furthermore, the data excludes cases of self-inflicted injury where there is no obvious suicidal intent as well as the likely misclassification of ethnicity. Therefore it is believed that accurately identifying the number of suicide attempts is more problematic than suicide deaths due to reporting inconsistencies (Serafino *et al.*, 2000).

Analysis of Aotearoa/New Zealand data for all ethnic groups and across the life span indicates that in 1999/2000, young people in the 15-24 year age group had the highest rates for attempted suicide (198.5 per 100,000 persons per year) (Ministry of Health, 2002b). Between 1993-98, suicide attempts were the third leading cause of injury hospitalisation amongst youth (15-24 years) (Coggan *et al.*, 2000). In 1999/2000, there were 356 male (rate of 131.4 per 100,000) and 698 female (rate of 268.3 per 100,000) hospitalisations for self-inflicted injury for the 15-24 year age group (Ministry of Health, 2002a).

With regard to Pacific hospitalisations for suicide attempts, more recent New Zealand Health Information Services (2002b) hospitalisation data (see Table 3), indicates that between the years 1996-99, there were 195 Pacific inpatient and daypatient hospitalisations for suicide attempts across all age groups. Forty-four percent of suicide attempts were in the 15-24 year age group (New Zealand Health Information Service, 2002b). From the years 1988-93, the highest rates occurred for Pacific females aged 15-19 (175 per 100,000) (Coggan, 1997). This pattern continues in the years 1996-99 (New Zealand Health Information Service, 2002b). Due to the limitations discussed earlier in relation to the collation of attempted suicide data, numbers of Pacific peoples making a suicide attempt may be underreported (Hatcher, 1997).

Table 3: Pacific Peoples Suicide Attempt Hospitalisations in Aotearoa/New Zealand by Age Group and Gender, 1996-1999

Age Group	Female Numbers	Male Numbers
0-4	0	0
05-14	12	3
15-24	64	43
25-39	17	39
40-59	52	10
60-74	2	3
75+	0	0
Total	147	98

Source: New Zealand Health Information Services (2002b).

Suicide Epidemiology: Critical Considerations for Public Health

(Diekstra, 1989) suggests that changes in suicide rates around the world are not simply a reflection of changes in classification procedures, but rather the result of sociocultural developments that remain obscure. Thus, given the abundance of epidemiological research in the field of youth suicidal behaviours on a global and national scale, the current research appears unique in that within a public health framework, it specifically focuses upon the sociocultural context of suicidal behaviours amongst NZ-born Samoan young people in Aotearoa/New Zealand.

Previous authors in this chapter also suggest that current epidemiological information relating to the Samoan community is severely limited (Coggan *et al.*, 2000; Tiatia *et al.*, 2002), and should therefore be augmented by other data

sources as Anae (2001) argues:

Statistical data should be combined with more finely grained analyses of culturally specific research to provide deeper insights into and cultural interpretations of the situation. Only then will problems be more realistically understood and appropriate solutions identified and implemented (Anae, 2001:117).

(Tatz, 1999) report to the Criminology Research Council investigating Aboriginal youth suicide in New South Wales, Australia, argues that youth suicide - whether Aboriginal, Maori, Pacific, or black African in South Africa - cannot be comprehended, let alone alleviated, by the statistics of suicidology. To rely on statistics alone can be limiting. For instance, it is necessary to recognise the cultural context surrounding the suicide attempt in order to understand the message that the attempt gives to the community (Counts, 1991). It is for this reason the current research focuses primarily upon the Samoan community in Aotearoa/New Zealand, thus seeking to provide information 'by Samoan, for Samoan' and is of relevance to this community.

RISK FACTORS

Within the field of public health there are extensive investigations into risk factors for suicidal behaviours amongst young people, conducted mainly through psychological autopsy studies, clinical case-control studies, longitudinal investigations and epidemiologic surveys (Beautrais, Joyce & Mulder, 1998b; Fergusson & Lynskey, 1995a; Hawton, Harris, Hodder *et al.*, 2001; Williams, 2001). The dominant finding of these studies suggests that the development of mental disorders is the strongest contributing risk factor in youth suicidal behaviours. Furthermore, amongst those making suicide attempts, a majority have been argued to possess a recognisable psychiatric disorder (Beautrais, Joyce & Mulder, 1998a; Fergusson & Horwood, 2001; Johnson, Brent, Bridge *et al.*, 1998; Hider, 1998).

Reviews of current public health knowledge about risk factors for suicidal behaviours amongst young people have been broken down into six general domains of risk factors, all of which may be interrelated (Beautrais, 2000b;

Hider, 1998). These domains include: social risk factors; family characteristics/childhood background; personality and cognitive attributes and sexual orientation; biological factors; psychiatric morbidity; and stressful life events and adverse life circumstances. These domains are briefly described in the following.

Social Risk Factors

A recurrent finding in the literature is that suicidal risk is increased amongst youth from socially disadvantaged backgrounds which are characterised by low socio-economic status and poor academic achievement (Beautrais *et al.*, 1998b; Fergusson & Lynskey, 1995a; Hawton *et al.*, 2001; Williams, 2001). It is recognised that there are different connotations associated with the term 'disadvantaged'. General understandings of the term disadvantaged include, for example, family dysfunction, poor family relationships, poor mental health of parents, school failure, poor socio-economic status, low personal or family income and psychiatric disorders (Beautrais *et al.*, 1998b; Fergusson & Lynskey, 1995a). It is also a predominant finding in Western literature that unemployment is a contributing risk factor toward suicidal behaviours (Jones, Forster & Hassanyeh, 1991; Lester, 1991; Morgan, Burns-Cox, Pocock *et al.*, 1975; Morrell, Taylor & Kerr, 1998; Stack, 2000).

Family Characteristics/Childhood Background

A substantial number of diverse study designs conducted in various countries (for example, the United States, Aotearoa/New Zealand, the Netherlands, Canada, Sweden and Australia) examine the magnitude to which young people's exposure to dysfunctional, abusive or difficult child circumstances increases their risk of suicidal behaviours (Hider, 1998). For instance, both national and international evidence suggest that there are strong correlations between suicidal behaviours and the following situations: parental loss (by death, separation or divorce) (Beautrais *et al.*, 1996; De Wilde *et al.*, 1992; Gould, Schaffer, Fisher *et al.*, 1998; Maris, 1997); exposure to parental

psychopathology (Brent, 1995; De Wilde *et al.*, 1992; Fergusson & Lynskey, 1995a; Shafii *et al.*, 1985); a family history of suicidal behaviours (De Wilde *et al.*, 1992; Gould, Fisher, Parides *et al.*, 1996; Johnson *et al.*, 1998; Roy, Rylander & Sarchiapone, 1997; Shafii *et al.*, 1985); poor parent-child communication (Beautrais *et al.*, 1996; Fergusson & Lynskey, 1995a; Gould *et al.*, 1996; Morano *et al.*, 1993) and physical and/or sexual abuse (Beautrais *et al.*, 1996; Brown, Cohen, Johnson *et al.*, 1999; De Wilde *et al.*, 1992; Dube, Anda, Felitti *et al.*, 2001; Garnefski, Diekstra & de Heus, 1992; Kienhorst, De Wilde, Diekstra *et al.*, 1992). Any of these situations may also act as distal or proximal risk factors (Moscicki, 2001). Family characteristics and childhood background factors will be discussed in further detail in Chapters Two, Five and Six, particularly focusing upon Samoans in relation to poor parent-child communication and physical discipline or abuse.

Personality and Cognitive Attributes and Sexual Orientation

Considerable research, both nationally and internationally, has focused on the extent to which various personality and temperamental factors contribute to youth suicidal behaviours. Various personality traits such as low self-esteem; hopelessness; aggression; introversion and impulsive violence are but a few of the associated traits in suicidal behaviours amongst young people (Beautrais, 2000a; Brent, Johnson, Perper *et al.*, 1994; De Wilde *et al.*, 1992; Johnson *et al.*, 1998; McLaughlin, Miller & Warwick, 1996). Chapters Two and Six focus upon certain personality traits - particularly anger and shame - and discuss the social-emotional implications of these traits in relation to NZ-born Samoan young people's suicidal behaviours.

The association between cognitive styles (the way in which an individual perceives, mentally organises and understands life experiences) also appears to be a contributing risk factor in suicidal behaviours amongst young people. For instance, there are a number of studies investigating the inability to think in a flexible manner, an outlook of negativity and hopelessness, and poor problem solving which have been identified as having a cognitive influence on young people's suicidal behaviours (Atha, Salkovskis & Storer, 1992; Dexheimer-

Pharris, Resnick & Blum, 1997; Resnick, Bearman & Blum, 1997; Donaldson, Spirito, Arrigan *et al.*, 1997; Hall, Platt & Hall, 1999; Jordan, 2000; Suominen, Isometsa, Henriksson *et al.*, 2000; Velting, 1999; Zechetmayr & Swabey, 1998).

Most national and international literature has also identified sexual orientations (gay, lesbian and bisexual) as having a positive correlation to increased risk of suicidal behaviours in young people (D'Augelli, Hershberger & Pilkington, 2001; Garofalo, Wolf, Wissow *et al.*, 1999; Moscicki, 2001; Remafedi, French, Story *et al.*, 1998). Some authors contend that the stigmatisation surrounding gay, lesbian and bisexual young people increases their likelihood of engaging in suicidal behaviours (Beautrais, 2000b; Garofalo *et al.*, 1999). In addition, the literature suggests that young people may engage in suicidal behaviours when in a state of confusion or depression over an emerging gay identity in a climate of homophobia (Bagley & D'Augelli, 2000).

Biological Factors

Genetic factors or biologic neuroendocrine¹³ underpinnings have been identified as increasing the risk of suicidal behaviours amongst young people. For instance, there is some evidence that suicidal behaviour and severity of lifetime aggression are both associated to reduced levels of serotonergic¹⁴ activity (Placidi, Aouendo, Malone *et al.*, 2001). It has been identified that significant abnormalities are present in the serotonergic system in suicide attempters and completers (Mann, Brent & Arango, 2001).

Twin studies suggest that suicidal behaviours may be genetically transmitted. For example, twin studies indicate approximately sixfold greater concordance for suicidal risk in identical twins who come from one egg in comparison to fraternal twins who come from two eggs (Maris *et al.*, 2000). In addition, adoption studies are considered the strongest evidence for the presence of

¹³ Having to do with the interactions between the nervous system and the endocrine system, which secretes (produces) hormones. Neuroendocrine describes certain cells that release hormones into the blood in response to stimulation of the nervous system (Phoenix5, 2002).

¹⁴ A hormone present in the brain, intestinal tissues, and blood platelets (Academic Press, 1996).

genetic factors in suicide (Maris *et al.*, 2000) as these studies separate environmental factors from biological variables.

Psychiatric Morbidity

A wealth of evidence suggests that those who suicide or attempt suicide suffer from a psychiatric disorder (Brent, Perper, Moritz *et al.*, 1993b; Appelby *et al.*, 1999; Appleby, 1993; Beautrais *et al.*, 1998a; Fergusson & Horwood, 2001; Haw, Hawton, Houston *et al.*, 2001; Houston, Hawton & Shepperd, 2001; Johnson *et al.*, 1998; Neame, 1997; Shaffer *et al.*, 1988; Shafii *et al.*, 1985). It is argued that an individual's psychiatric state in relation to social, familial, individual and environmental risk factors is the strongest correlate to suicidal behaviours (Beautrais, 1999; Fergusson, Woodward & Horwood, 2000).

Substance use disorders have been diagnosed as a psychiatric disorder and have been linked with suicidal behaviours in young people (Beautrais, 1999; Gould *et al.*, 1996) as well as contributing substantially towards the youth suicide rate (Brent *et al.*, 1993a). Brent and colleagues (1993) reported that substance abuse and suicide risk in young people was 8.5 times higher in young people with substance abuse disorders than in control subjects.

Stressful Life Events and Adverse Life Circumstances

In general terms, young people's susceptibility to suicidal behaviours is elevated by stressful life events (Brent, Perper, Moritz *et al.*, 1993c; De Wilde *et al.*, 1992; Kienhorst *et al.*, 1992) - particularly interpersonal conflict, interpersonal loss, and legal and disciplinary issues (Brent, 1993c; Kienhorst, 1992). It is also acknowledged that these events may act as precipitators for suicidal behaviours amongst youth who may often have other underlying risk factors (Beautrais *et al.*, 1998a; Brent *et al.*, 1993c).

RISK FACTORS: CRITICAL CONSIDERATIONS

Illustrated throughout the previous section of this chapter, it appears that much of the public health literature in developed Western societies is dominated by the mental illness model when describing the aetiology in youth suicidal behaviours (Appelby *et al.*, 1999; Beautrais *et al.*, 1998a; Beautrais *et al.*, 1996; Brent, 1995; Fergusson & Lynskey, 1995b; Gunnell, Peters, Kammerling *et al.*, 1995; Haw *et al.*, 2001; Houston *et al.*, 2001; Velting, 1999). For example, suicidologists often quote that 90 percent of all suicides and attempted suicides are the result of a psychiatric illness (Beautrais, Joyce & Mulder, 1997; Bugental & Happaney, 2000). Moreover, Western diagnoses are primarily informed by diagnostic categories which have derived from research amongst Caucasian populations, particularly those in hospitals or psychiatric clinics (Beautrais *et al.*, 1997; National Institute of Mental Health, 1999).

The findings of Anderson and colleagues (2000) indicate that whilst mental illness may be considered a factor in some young people's suicidal behaviours, particularly in cases where diagnosis of a mental illness has been established, it does not necessarily support the myth that a young person who engages in suicidal behaviours is mentally ill (Anderson, Standen, Nazir *et al.*, 2000). Therefore, a broader conception is needed which goes beyond this mental illness approach and, as Sligo and Jameson (2000) suggest, should be:

based on a holistic understanding of the patient's [sic] life world that comprises social and cultural norms of health and wellness (Sligo & Jameson, 2000:860).

Similarly, (Disley, 1997) suggests that not all suicidal behaviours are associated with mental illness and argues that there is some association between the event and the level of mental distress in the community as a whole. For instance, Lester (1998a) contends that when the quality of life is good, young people have fewer external sources to blame for their unhappiness and so then may engage less in suicidal behaviours. Lester suggests that in the milieu of contemporary society, there appears to be an increase in the "me-generation" (p.502), therefore those who fail to achieve are likely to blame their failure on their own inadequacies. Lester (1998a) continues:

If adolescent suicide rates increase as the quality of their lives improves, then proposals to reduce adolescent suicide rates by increasing the quality of adolescent life are misguided. This new perspective requires that we examine individual adolescent suicides, not as the inevitable result solely of individual psychiatric disorder, but rather as deviant behaviours in the context of a society with particular values (Lester, 1998a:502).

Within an indigenous context, Tatz's (1999) investigation of suicidal behaviours amongst the Aboriginal people of Australia claimed that until a critical examination of the contexts within which these suicidal behaviours occur are undertaken and incorporated into intervention strategies, the present medical 'mental illness' approach, which seeks to 'pathologise' Aboriginal youth suicide, is unwarranted. This follows on from the argument that suicide research which addresses cultural diversities, is required primarily based on the view that it has often been too impersonal (Leenaars, 1996). Furthermore, suicidal behaviours have been recognised as a multi-faceted events and is therefore also open to multi-disciplinary research (Leenaars, 1996).

Much of the 'mental illness' approach dominates public health literature (Beautrais *et al.*, 1998a; Brent *et al.*, 1993a; Neame, 1997; Thomas, Read & Mellisop, 1992). However, this may appear to be inappropriate for all Samoan young people in Aotearoa/New Zealand as the 'mental illness' school of thought may be limiting. For instance, some Samoans consider that 'mental illness' is "a condition originating within, and totally confined to a person exhibiting certain types of disturbed behaviour" (Bathgate & Pulotu-Endemann, 1997:106). Some Samoans believe that mental, emotional, physical and spiritual wellbeing can be greatly affected by familial events - particularly with the illness known as *fa'anoanoa* (sorrowful, mournful, regretful), which can occur if there is a disturbance to, or disharmony within, the *aiga* (family) (Bathgate & Pulotu-Endemann, 1997). Bathgate and Pulotu-Endemann (1997) argue that when a person suffers *fa'anoanoa* they are influenced by the idea that no one loves them, and/or they feel compelled to isolate themselves and seldom speak (in other words, portraying *musu* (sulkiness, withdrawal). Bathgate and Pulotu-Endemann (1997) further highlight that, in its extreme form, *fa'anoanoa* induces bad thoughts which may then be manifested in suicidal behaviours. Although I

acknowledge that there are extensive writings alluding to the association between *musu* and Samoan youth suicidal behaviours in Samoa, this concept remains absent from Western public health literature or from any investigations of Samoan youth suicidal behaviours in the context of Aotearoa/New Zealand. This is discussed in more detail in Chapter Two.

It is evident that NZ-born Samoans' beliefs, views and practices cannot be understood or be made to 'fit into' a Western mental illness framework. Furthermore the danger, as (Turton, 1997) argues, lies in disregarding the richness of cultural cognitive frames of reference in health research which may not only decontextualise findings, but also force a recontextualisation of data into an inconsistent framework where distinctions, overt contradictions, and other misleading interpretations may result. So it may seem that apart from anecdotal evidence, there is little known about contributing factors to suicidal behaviours and possible suicide prevention strategies relevant for NZ-born Samoan young people and their *aiga* in Aotearoa/New Zealand. Given these gaps, this current research is an attempt to recontextualise youth suicidal behaviours in this population.

THESIS OUTLINE

With a sociocultural basis, Chapter Two discusses the literature about suicidal behaviours and explores contributing factors as well as the various debates around suicidal behaviours amongst Samoan young people. Additionally, this chapter explores young people's reasons to live on the premise that it is equally important to discuss this in conjunction with risk factors. For instance, the former identifies the problem and the latter detects factors for intervention with the overall aim of improving life choices for NZ-born Samoan young people. In doing so, this chapter first provides a theoretical overview of the research objectives and processes with the intention of shifting away from a Western scientific, mental illness framework. It then discusses the literature around *aiga* and emotions and its impact upon Samoan youth suicidal behaviours. Lastly, this chapter addresses the literature around suicide prevention and intervention strategies, exploring their relevance for the Samoan community in

Aotearoa/New Zealand.

Chapter Three provides a methodological description of the research. The study aims and a description of the study participants are also presented. The two phases for data collection and analysis are detailed. The first phase involved a 12-month medical record review of all Samoan young people (16-25 years) who presented to public hospital EDs in the Auckland region. As this phase is limited to an investigation of what is included in the medical records, it is written in a 'case study' format as a stand alone chapter. A public health perspective informed the development and analysis of this phase. Phase two of the research involved a series of in-depth, face-to-face interviews with Samoan young people who had presented to public hospital EDs in the Auckland region following a suicide attempt. An outline of data collection and data analyses is also discussed.

Chapter Four is the first findings chapter for this thesis. This chapter presents the findings for phase one of the research and briefly discusses some of the implications these findings may have for Samoan youth suicidal behaviours and overall mental health and wellbeing from a public health perspective. Further discussion of implications is included in Chapter Eight. The chapter then concludes with an outline of the limitations to this phase of the study.

Chapters Five to Seven are based on phase two of the research findings, and attempt to place into context suicidal behaviours amongst NZ-born Samoan young people in relation to the themes of the '*aiga*', 'Emotions' and 'Reasons to Live: negotiating Samoan youth wellbeing'.

Chapter Five addresses the importance of the *aiga* and its traditional Samoan core values. Based on research findings, it explores the unspoken complexities within some *aiga* in relation to the importance of obligation¹⁵, the role of the eldest sibling¹⁶, parent-child communication, (particularly with regard to the withholding of private experiences and feelings), physical discipline and

¹⁵ Obligation in this context is the fusion of self and the rights and duties of a person (Holroyd, 2001).

¹⁶ The 'eldest sibling' in this thesis refers to a young person who may not necessarily be the first-born, but is the eldest 'child' residing within the family home.

intergenerational misunderstandings. It then explores the *feagaiga*¹⁷ (or brother-sister covenant) and its potential for strengthening communication within the *aiga*. This chapter attempts to unravel these intricacies in light of the mental and overall health and wellbeing of NZ-born Samoan young people and their suicidal behaviours.

Chapter Six discusses how social-emotional factors - particularly anger and shame - provide for some understanding of the type of emotions (most often provoked by conflict with a member of the *aiga*) are seen to precipitate suicide attempts amongst NZ-born Samoan young people. This chapter reinforces that there are certain types of emotion which may be culturally determined and have been absent from Western medical and clinical models. Predominant themes to emerge were emotions of anger, shame, putting on a 'mask' and - to an extent - depression. These themes are discussed in this chapter as contributing factors to participants' suicidal behaviours.

Chapter Seven explores participants' subsequent reasons to live following their suicide attempt. The analyses investigate the concerns of participants in relation to the breakdown in communication within the *aiga*, followed by what participants consider would work in terms of their spiritual experiences, and identified alternative coping strategies. This chapter describes participants' perceptions of appropriate, relevant and effective strategies for NZ-born Samoan youth suicide prevention via advice and words of encouragement, which they feel, would discourage others from undertaking suicidal behaviours.

Chapter Eight provides concluding comments, recommendations and discusses the implications for policy and practice. It also includes a discussion of the research process from the perspective of the researcher. Based on research

¹⁷ The *feagaiga* is both a formal and informal contractual agreement between two parties and is usually referred to with regards to religion and kinship (Schoeffel, 1995). Within the religious context, the *feagaiga* relates to the association between the pastor, his/her congregation and the biblical New Testament. In terms of the kinship, the *feagaiga* refers to the relationship between brothers and sisters and between kin groups defined as the descendants of sisters and brothers (Schoeffel, 1995). In this thesis the *feagaiga* focuses on the brother-sister covenant or relationship. It is also recognised by the candidate that the concept of the *feagaiga* encapsulates a spiritual bonding, immense responsibility, commitment and respect for each other. However, it is beyond the scope of this thesis to closely examine this relationship. For the purposes of this thesis, the *feagaiga* is addressed in relation to communication between brother and sister.

findings from both phases of the research, several suggestions for improving policy and practice in relation to suicidal behaviours amongst NZ-born Samoan young people are presented. These include: providing assistance to NZ-born Samoan young people to solve their interpersonal conflicts; facilitating meaningful follow-up care for those who present to EDs following a suicide attempt; exploring the role of the *aiga* further as an initial prevention strategy for suicidal behaviours; enhancing coping mechanisms including anger management strategies and problem solving; promoting help-seeking behaviour; recognising the importance of spirituality¹⁸ as a potential resource for suicide prevention; and increasing youth suicide awareness amongst the Samoan community by encouraging more dialogue

¹⁸ It is recognised that spirituality has various meanings. Yet for the purposes of this thesis, spirituality is defined as delving deep into the inner domain of self to connect with God. It is also acknowledged that spirituality and religion, or religiosity, may be defined as overlapping concepts that involve subjective feelings, thoughts, and behaviours in the search for the sacred. No consensus has been reached in the literature regarding the relationship between 'spirituality' and 'religion' (Holder, Durant, Harris *et al.*, 2000). Religion broadly is the study and following of what is laid down in the Bible for the Christian to improve upon the level of life and to live a life full of moral values and ethical practices (Kumar, 2000). However religiosity implies an association with an identifiable group (Kim & Seidlitz, 2002). Spirituality on the other hand, is often reflected through a pursuit of a personal relationship with a higher force like God (Batten & Oltjenbruns, 1999). Therefore in the context of this thesis, spirituality refers to a subjective experience with God, whereas religion will refer to the communal obligation to a set of institutionalised beliefs (Holder *et al.*, 2000).

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

This chapter discusses various debates surrounding suicidal behaviours amongst NZ-born Samoan young people using both sociocultural and public health literature. It explores contributing factors as well as discussing those elements which may buffer against youth suicidality. This chapter first provides a theoretical overview of the rationale for the research objectives. It then discusses the *aiga* and emotions within a sociocultural context and their impact upon NZ-born Samoan youth suicidal behaviours. It then concludes by addressing the discussions around suicide prevention and factors which may discourage youth suicidal behaviours and its potential relevance for NZ-born Samoan young people.

RATIONALE FOR RESEARCH OBJECTIVES

This research seeks to divert attention away from those who have spoken on behalf of NZ-born Samoan young people. That is, older Samoan people and people from other ethnic groups (Anae, 1995; Rivlin, 1993; Tupuola, 1993b; Tiatia, 1998). Without documentation of NZ-born Samoan young people's experiences in relation to suicidal behaviours, assumptions may continue to be made within a traditional Western medical model. White (1985) - an anthropologist who worked extensively in Pacific societies - argues that suicidal behaviour is a social event which is shaped in complex ways by culture - that is, by shared beliefs and practices which give meaning to social life. White implies that research on suicidal behaviours should go beyond the explanation of a pattern of mortality and morbidity to a concern with the cultural fabric of social life and some of the most critical points at which that fabric may be torn by conflict and change. White maintains that any attempt to address the difficulties of social change should begin within the frame of reference or culture of the people affected. If this is neglected, White contends, potential social changes run the risk of being futile because of the severance from the values people use to organise their lives and respond to problems stemming from cultural contact. White further suggests that often there has been a misinterpretation of suicidal

behaviours amongst Pacific populations due to its application to Western psychological diagnoses. For instance, the Western-trained clinician might be expected to look for, and possibly find, depression amongst suicidal clients. Furthermore, this author emphasises that cultural meaning cannot be seen as separate from medical or public health concerns with regard to suicide prevention. It was suggested that neither research nor prevention measures are likely to be effective without an understanding of local conceptions which shape suicide attempts and responses to them.

Counts' (1991) anthropological work in Papua New Guinea in relation to suicidal behaviours indicates that if one fails to comprehend the unique experiences and culture of a population, one may then risk the error of applying Western psychosomatic concepts to their behaviour, thereby misunderstanding what suicidal behaviours mean to this population. Similarly De Leo (2002), who has a psychiatry background, recognises that the various rates of suicidal behaviours worldwide illustrate that "social and cultural variables amplify any biological and psychological predisposition a person may have" (p. 23). De Leo argues that most of the existing research has focused on tangible factors such as the presence of a given psychiatric disorder, rather than less clearly definable aspects like, for example, the effects of social support. This author suggests that for more effective suicide prevention, the examination of those conditions which may buffer suicidality needs to be rapidly developed.

Joseph's (1997) research in the discipline of psychology examines Maori youth suicide in Aotearoa/New Zealand and argues that very few reviews of youth suicidal behaviours have addressed culture and ethnicity in such a way that it is central to the research. This is reinforced by official data which has suggested that there are different rates of attempted suicide amongst Pakeha, Maori and Pacific peoples in Aotearoa/New Zealand, thus implying that underlying influences of culture may exist (Coggan, 1997). Joseph (1997) also contends that by neglecting to address suicidal behaviours in the context of the community it directly impacts - in Joseph's case, the indigenous people of Aotearoa/New Zealand - potential differences between social and cultural explanations of youth suicide may be lost (Joseph, 1997).

One aspect absent from the Western mental illness model is the component of spirituality. (Wright, Frost & Wisecarver, 1993) suggest that health professionals interested in implementing youth programmes might benefit by involving local religious and spiritual leaders. The authors argue that community churches would not only provide fellowship, but also a “purpose for living” (1993, p. 567). Chapter One mentioned spirituality as being fundamental for most Samoan people. Thus the inclusion of spirituality in this current research is to remain consistent with the Samoan concept of health. Therefore it seems appropriate that spirituality be addressed in this section particularly in terms of its potential for suicide prevention for the Samoan community. It may be fitting to first identify the importance or not, of spirituality in the lives of NZ-born Samoan young people who have engaged in suicidal behaviours. In other words, ascertaining whether spirituality has any relevancy in the lives of these young people in contemporary Aotearoa/New Zealand who have on the contrary performed acts which contradict the values of the whole spiritual experience.

Tamasese, Peteru and Waldergrave’s (1997) study participants identify the importance of preventing mental health illness through the strengthening of critical cultural concepts and structures. In particular, the emphasis is placed upon strengthening spiritual and relational arrangements within the *aiga*, in recognition that the *aiga* is the first place of relational harmony, belonging and identity. Furthermore, the investigators suggest that in cases of mental unwellness, it is important that the church play a pivotal role in providing spiritual support and strength.

Many counsellors - professional and lay - social scientists, social workers and community workers have been trained within a Western paradigm of health and illness (Siataga, 2000). Training problems often perpetuate negative stereotypes of spirituality and religious practice and beliefs within the mental health profession (Siataga, 2000). Siataga further argues that “the mental and health professions have tended to have a ‘low’ view of religious experience and spirituality“ (2000:8).

Spiritual people tend to experience feelings of fulfilment and deep communion with God (Kim & Seidlitz, 2002). These experiences may provide inner strength and solace that combat feelings of anxiety and despair (Kim & Seidlitz, 2002). Research by Pardini, Plante, Sherman and Stump (2000) explores spirituality in relation to substance abuse recovery and its impact upon mental health benefits. They argue that spirituality's inclusion in recovery treatment is effective in those with substance abuse disorders as it "provide[s] recovering individuals with an optimistic life orientation, greater social support, and a buffering against stress and negative emotionality" (2000 p.348). It has been suggested that higher spirituality is associated with increased coping, greater resilience to stress, optimistic life orientation, greater perceived social support, and lower levels of anxiety. It may be of benefit to include this view in relation to suicidal behaviours (Pardini, Plante, Sherman *et al.*, 2000). Furthermore, spiritual interconnectedness is considered an important coping mechanism for young people (Early & Akers, 1995; Holder *et al.*, 2000; Hovey, 1999; Kim & Seidlitz, 2002).

Research conducted by (McGeorge, 1996) with regard to young Pacific people's self-esteem, found that the role of religion in the lives of study participants had four distinct effects being that: a) religion has a detrimental effect on the self-esteem of young Pacific people because of the "fire and brimstone" approach; b) the move away from religion is considered detrimental to self-esteem because some Pacific young peoples depend on God for support; c) the move away from religion is detrimental to self-esteem because it is often accompanied by isolation from the family; and d) because spirituality or religion plays a central role in the lives of most Pacific young peoples, to deny its existence over a long period of time would be a psychological battle for the young person and as a result would directly impact upon their self-esteem.

There is also a need to look beyond solely academic research for social and cultural descriptions of NZ-born Samoan youth suicidal behaviours in Aotearoa/New Zealand. For instance, as Schreiber (2000) contends, academics tend to take an elitist position on what appropriate source documentation looks like. Consequently, this places researchers of understudied groups at a disadvantage since they only have a limited literature base to work from. This

author argues that acceptance to mainstream journals may also prove difficult therefore, “any data source which can lend insight to the communicative behaviours of cultural groups should be explored” (Schreiber, 2000:665).

In the context of Aotearoa/New Zealand, it seems that an appropriate and effective example of promoting suicide prevention messages is that of the Family Life Education Pasefika (FLEP). FLEP is a group that works with Pacific communities, primarily in South Auckland, with the objective of promoting a positive view of sexuality. Its mission statement includes: a) working with adults and young people to increase understanding about personal relationships within their families and communities; and b) acknowledging and respecting the values, beliefs, cultural protocols and mannerisms of each Pacific ethnic culture and other ethnic groups. What is unique about this service is that it works alongside the community to design a tailor-made programme relevant to that group. It uses Pacific drama, role plays, music and movement, comedy, dance and group discussions to address sensitive issues. These modes appear appropriate and are considered an effective way of delivering messages to Samoan and Pacific communities.¹⁹

It appears evident that suicidal behaviour is not generic across cultures. This current study has adopted a sociocultural approach and, on the basis of arguments made by White (1985), Counts (1991), De Leo (2002) and Joseph (1997), similar perspectives are addressed in more depth throughout this chapter.

Contributing factors for suicidal behaviours within the Samoan community in Aotearoa/New Zealand have been argued to be spurred by unresolved family conflicts, the inability to meet family and social obligations, shame resulting from misdeeds, sexuality and sexual conduct, failure to meet unrealistic expectations, low self-esteem, abuse, conflict between traditional ways and the new ways, and constraints or demands placed by church (Bathgate & Pulotu-Endemann, 1997). In response to this view this current study examines

¹⁹ It has been beyond the scope of this thesis to explore popular culture in further depth. However it is acknowledged by the candidate that there exists contemporary tools of expression such as drama, music, short film, poetry, skits (short plays) and so forth which allow for young Samoan people to communicate messages in Samoan and Pacific contexts.

sociocultural forces with particular attention paid to the *aiga*, emotional states, and reasons to live in order to explain the context of both suicidal and resilient behaviour amongst NZ-born Samoan young people in Aotearoa/New Zealand. From the point of view of suicide prevention, identifying sociocultural factors associated with suicidal behaviours for NZ-born Samoan young people in Aotearoa/New Zealand could be amenable to interventions. These are discussed in the following section.

THE AIGA

In the context of Aotearoa/New Zealand, shared households are common within the Samoan community (Statistics New Zealand, 1998). According to the 2001 Census, 20 percent of Samoan people living in a family household share a household with other *aiga* or individuals in comparison to 5 percent of the general population in Aotearoa/New Zealand (Statistics New Zealand, 2003). Households with more than one family often consist of *aiga potopoto* (extended family), where related parents, grandparents, children or siblings, live together (Statistics New Zealand, 1998). In 2001, 30 percent of Samoan people live in *aiga potopoto*, compared with 29 percent of all Pacific peoples, and eight percent of all Aotearoa/New Zealanders (Statistics New Zealand, 2003).

This section focuses on what is considered by most Samoans to be a valued entity of Samoan society - that is, the *aiga* or family. *Aiga* is the core of the *fa'asamoa* (Samoan way). It provides love, offers support, nurtures cohesiveness, and encourages reciprocity and service to one another (Anae, 2001; Côté, 1994; Graves & Graves, 1985; Mageo, 1988; Mead, 1928; Meleisea & Schoeffel, 1998; Mulitalo-Lauta, 2000; Tupuola, 1998). Thus, it is appropriate to pay particular attention to the role of the *aiga* and its impact upon young NZ-born Samoan people's suicidal behaviours. The purpose of this section is to explore the *aiga* in terms of the value Samoans place in it, the types of relationships between its members, the obligatory roles of its members, - in particular its young people - parent-child communication, and lastly, its transforming and contemporary structure. All of these facets are discussed in relation to the impact they may have upon Samoan young people's suicidal

behaviours. This section also explores the issue of whether or not the disintegration of the *aiga potopoto* has impacted upon suicidal behaviours for NZ-born Samoan young people.

The Pacific concept of family is seen as the foundation for socialisation and is recognised as the main entity in which Pacific children learn and grow (Finau, 1982; Graves & Graves, 1985; Holmes, 1958; McDade, 2001; Ministry of Health, 1997b; Pitt & Macpherson, 1974; Sua'ali'i, 2001; Tau'le'ale'ausumai, 1994). Irrespective of living arrangements, 'family' to Samoans typically means extended family (Ministry of Health, 1997b). The *aiga potopoto* continues to be the fundamental means of interaction in which religion and reciprocal obligation are considered the primary vehicles for solidarity (Macpherson, 1999; Silipa, 1999a). *Fa'aaloalo* (respect), *aiga* (kinship), *lotoalofa* (love, compassion), *fealofani* (living in harmony), *tautua* (service) and *to'aga i le lotu* (commitment to Christian faith and the church) are seen as the central symbols for Samoan public identity and culture (Anae, 1998b; Tupuola, 1998).

Holroyd's (2001) research examines Hong Kong Chinese women and their cultural and family obligations, and is used in this context as it seems the cultural tenets for Hong Kong Chinese - which include hierarchy, reciprocity, obligation, service, respect for elders and prioritisation of family - can be likened to the cultural tenets of the *fa'asamoa*. Holroyd suggests that the fusion makes kin boundaries idiosyncratic from the boundaries of others, in that it addresses "permanence" (p. 1130) on a personal level. Subsequently the "permanence" and "durability" (p. 1130) of kinship provides a social place that delineates one's personal identity. In the same way, it is on the basis of such values as *fa'aaloalo* (respect), *aiga* (kinship), *lotoalofa* (love, compassion), *fealofani* (living in harmony), *tautua* (service) and *to'aga i le lotu* (commitment to Christian faith and the church) within the *fa'asamoa* which sets it apart from Aotearoa/New Zealand's dominant Westernised environment. In particular, there is an emphasis on the importance of the *aiga* as the main unit within the *fa'asamoa*, rather than the individual (Chun, 2000). Traditionally, it is believed that the bond between a Samoan individual and their family is a powerful one, fashioned early in one's life (Anae, 1998b; Meleisea & Schoeffel, 1998; Schoeffel, 1979).

As in Holroyd's (2001) research amongst Hong Kong Chinese women, most Samoan children are taught that their personal identity and status is, without reservation, connected with that of their *aiga* (Schoeffel, 1979). Some Samoan children are also taught that their conduct can enhance or decrease their family's prestige and power, and there is pressure on individuals to consider the consequences of their conduct for their family (Holt, 1999; Macpherson & Macpherson, 1985). It therefore seems important to include the role of the *aiga* in the analysis of suicidal behaviour amongst NZ born Samoan young people.

The Changing Nature of the Aiga and its Impact on Suicidal Behaviours

A large body of national and international Western public health literature has indicated that a breakdown in the nuclear family unit resulting from parental divorce or separation is a strong contributing factor for youth suicidal behaviours (Beautrais, 2000b; Beautrais *et al.*, 1996; Borowsky, Ireland & Resnick, 2001; Brent, 1995; Fergusson *et al.*, 2000; Fergusson & Lynskey, 1995a; De Vanna, Paterniti, Milievich *et al.*, 1990; Frederick, 1985; Gould *et al.*, 1998; Hawton *et al.*, 1996).

In the context of Aotearoa/New Zealand, the structure of the *aiga* is transforming and the gradual disintegration of the *aiga potopoto* is becoming more commonplace. For instance, in the 2001 Census, only 30 percent of Samoan people were living in extended family situations. This is a decrease from 36 percent in 1996 (Statistics New Zealand, 2003).

According to the 2001 national Census, 83 percent of Samoan people lived in a family. A two-parent family with children remains the most common family type for Samoan people. Of those living in a family in 2001, just over two-thirds (67 percent) were living in a two-parent family. This is a drop of six percent since 1991. In 2001, the overseas-born Samoan population (23 percent) was more likely to live in households with two or more families than NZ-born Samoans (18 percent) (Statistics New Zealand, 2003). Just over a quarter (26 percent) of Samoan people living in a family were in a one-parent family. By comparison, 28 percent of the Pacific population and 17 percent of the Aotearoa/New

Zealand population were living in a one-parent family in 2001 (Statistics New Zealand, 2003).

It has been argued that since the 1960s, the main contributing factor in Pacific youth suicidal behaviours is the breakdown in the traditional extended family structure amongst most Pacific communities (Hezel, 1993, 1994). With regards to the Pacific literature in relation to suicidal behaviours, the disintegration of the extended family structure is not a new concept. In this context, the term 'breakdown' is used to express a lack of support, communication and types of conflict within the Samoan *aiga*. The disintegration of the *aiga potopoto* is argued to be the greatest single cause for the suicide epidemics of the past three decades for some parts of the Pacific (Hezel, 1994, 1993). Hezel (1993) argues that:

The nuclear family is now the last line of resistance. When that breaks down, the results can be disastrous. We are moving from a multi-parent family to a two-parent family, but in some circumstances the two-parent family has become a single-parent family ... troubled or delinquent children are often the result, as many of us have noticed in Micronesia. Hence, what is so often called the 'youth problem' actually stems from the inadequacy of present-day families to do all that is expected of them (Hezel, 1993:4).

Hezel argues that while there are some Pacific young peoples who are able to endure hardship within the family and survive the tensions, this however, is not to say that they are any less at risk. Hence, the transformation in the size and shape of the family is one of the most important changes occurring in the Pacific (Hezel, 1993, 1994).

Similarly, Rubinstein (1994) believes that the high rates of suicide amongst young men in Micronesia were related to the dissolution of their social support systems. Vivili (1999) and his team reviewed Ministry of Police reports in Tonga for the period 1982 to 1997 and similarly reported that suicidal behaviours (particularly in males) may be attributed not only to youth exposure to westernisation, but also to the diminishing state of traditional support systems.

Therefore, what relevance does the changing nature of the *aiga* have for NZ-born Samoan young people in relation to the impact upon their suicidal behaviours, particularly with regard to the disintegration of the traditional

extended and nuclear family structures?

Obligation in Light of Suicidal Behaviours

Mageo (1998) proposed that all cultures cultivate a type of dependency, where trust presumes stable dependencies; dependencies that are meant to last a lifetime and can be relied upon. Mageo's work focused upon Samoans in the Islands and went on to suggest that the reliance or interdependence most Samoan's place on their *aiga* can be compared to the "absolute reliance" (p. 46) most place on their mothers. Mageo's viewpoint is, of course, based on the assumption of a mother's unconditional love. It is seen as imperative to have a reputation within the *aiga* that members can rely on you and your willingness to *tautua* (serve) (Anae, 2001; Tupuola, 1998). Underlying the value of *tautua* is the virtue of *alofa* or love toward one's *aiga*, which in most circumstances often requires putting one's personal needs aside. This is best illustrated in the following excerpt from Figiel's (1996) novel:

Alofa. The virtue that makes you forget about you and you think of others first. Whether it's your mother-father-sister-brother-grand-mother. All members of your aiga. Of the sacred 'we'. The aiga. The nu'u [village]. The itumalo [district]. The whole of Samoa (p.12).

Within the *fa'asamoa*, a person's path to authority and elevation is through his or her service to the *aiga* and the community (Anae, 1998b; Mulitalo-Lauta, 2000; Tupuola, 1998). Samoan youth are trained from an early age in areas of enculturation such as responsibility toward the *aiga*, service to the community and personal sacrifice (Duncan, 1994). This is best articulated in the eminent Samoan expression "*o le ala i le pule, o le tautua*" (the road to authority, is service). Central to the *fa'asamoa* (Samoan way), is service (*tautua*), which is a synonym for humility and a way of showing inhibition (Anae, 1998b; Holt, 1999). Samoan young people learn reticence through obedience, *tautua*, financial contributions and looking after younger siblings (Tupuola, 1998; Anae, 2001; Silipa, 1999a).

The question may then be asked - How important is the *aiga* for NZ-born young people and is this "absolute reliance" (Mageo, 1998:46) still applicable in the

context of Aotearoa/New Zealand?

This section examines the concept of obligation primarily because, for some Samoans, it is implicit that health and wellbeing is achieved when one fulfils obligations, be it to their *aiga* and/or church. Yet how relevant is this for NZ-born Samoan young people in terms of this absolute reliance and its impact upon suicidal behaviours. It is important to note that this focuses upon those NZ-born Samoans who have an association with things traditionally *fa'asamoa*.

Macpherson and Macpherson's (1985) observations in Samoa consider that the young Samoan person's place within the structure of their *aiga*, and the many pressures placed upon the young people in the name of Samoan 'culture' contributed to the continuing and high rate of Samoan youth suicidal behaviours. Similarly Bourke (2001), in a critical consideration of the *State of Pacific Youth 1998 Report by UNICEF*, reported that the underlying reason for suicidal behaviours amongst Pacific young peoples was a feeling by the young person that there was no one to turn to or discuss emotions - whether broken love, alienation, anger or frustration. Bourke also comments on the stresses of social change - which are occurring in various degrees for the young people of the Pacific, as well as the belief that traditional culture only listens to the voices of elders. The different forms of pressure that young people are seen to encounter include peer pressure, study, family pressures and religious and cultural pressures. It is suggested that pressures are imposed on young people by expectations of families, teachers, society and personal ambitions. Bourke acknowledges that sometimes these pressures are not as great as the weight of disappointment that follows when an individual is unable to achieve their goals. The question may be asked, is this so for Samoan youth in the context of Aotearoa/New Zealand?

Thus far, it appears that the nature of the relationship which develops between individuals and their kin group or *aiga* is central to an understanding of suicide in Samoa as well as suicidal behaviours amongst NZ-born Samoan young people (Bathgate & Pulotu-Endemann, 1997; Macpherson, 1999; Wendt, 1999). Whilst the *aiga* is of importance to most Samoans (as discussed throughout this chapter), the contradiction is that in some instances *aiga* may equally contribute

to NZ-born Samoan young people's demise by placing them in compromising positions (Tupuola, 1998, 1993b; Tiatia, 1998; Silipa, 1999a; Mulitalo, 2001). For instance, *aiga* expectations exert a number of cultural demands and unrealistic expectations upon the NZ-born Samoan young person, who is then obligated to demonstrate *tautua* (service), normally with an unquestioned obedience (Holt, 1999; Tupuola, 1998; Tiatia, 1998; Vaoiva, 1999). The importance of the *aiga* and its contribution to suicide rates may illustrate that the young person is caught in the conflicting values of Samoan and Western cultures as well as - for some - multiple ethnic identities.

Silipa's (1999) research conducted in Aotearoa/New Zealand involves a critical analysis of Samoan students' performances at secondary school. Silipa's focus is an examination of the interrelationship between Samoan students' socialised dispositions and their learning strategies. Silipa recognises that the influential nature of the *fa'asamoa* is embedded within the study participants as passed down from their forebears to parents and members of the *aiga potopoto* (extended family). This author concludes that study participants feel obligated to attend church activities, often against their will, and attend to familial obligations at the same time as complying with the realities of educational norms and regulations. Silipa (1999) argues that:

With this frame of mind they had to put up with different coercion in terms of morality from both ends (home and school), as they struggled to maintain and sustain a balance between the two (Silipa, 1999a:5).

However, despite the daily pressures of working in - and between - the values of both home and school environments, as Silipa has illustrated, most participants in this study agree that the obligations of the home take precedence. This implies that some NZ-born Samoan young people may continue to have strong cultural beliefs concerning obligation to their *aiga* in Aotearoa/New Zealand. It is argued that such pressures, coupled with high parental expectations, for some NZ-born Samoan young people impact negatively upon their overall mental health and wellbeing (Tamasese *et al.*, 1997).

In the *fa'asamoa* it is believed that by fulfilling all these obligations, one is displaying *osi aiga* and paying respect to the codes of conduct by meeting core expectations of the *fa'asamoa* (Tupuola, 1998; Mulitalo-Lauta, 2000). *Osi* means 'embrace' or 'conform' to the influence of *aiga*. *Osi aiga* therefore refers to one's obligation to meet familial demands and support family projects at any cost (Mulitalo-Lauta, 2000). The philosophical basis of *osi aiga* derives from the principles of *tautua* (service), *alofa* (love) and *fa'aaloalo* (respect) that one performs to the *aiga*.

The challenge for NZ-born Samoan young people is that any ignorance shown about the central premises of the *fa'asamoa* on their part may incur scepticism by Samoan peers of whether or not one is behaving as a 'true' Samoan (Anae, 2001; Macpherson, 1999; Tiatia, 1998). Traditional and contemporary expectations strongly indicate that the needs of the *aiga* must take precedence over the young persons' time and energy (Macpherson, 1999; Silipa, 1999a; Tupuola, 1998; Anae, 1998b). However some NZ-born Samoan young people often find themselves in unmanageable situations when unable to successfully achieve these expectations as discussed earlier in Silipa's (1999) research. In relation to suicidal behaviours, the question may be asked - Do familial pressures of obligation impact in any way upon NZ-born young people's self-destructive behaviours?

Both Tupuola (1998) and Taule'ale'ausumai (1997) argue that the expectation of a fervent allegiance to *aiga* has been described as an overbearing pressure. It is this "overbearing pressure" (Taule'ale'ausumai, 1997:229) or "claustrophobia" (Tupuola, 1998:138) primarily associated with satisfying onerous *aiga* expectations, which may have contributed to suicidal behaviours amongst Samoan young people. The complex issue is that some NZ-born Samoan young people are caught in a dilemma of dual expectations between the traditional expectations of the *aiga* - expressed in the 'we', and contemporary expectations of Western individualism - or the 'I'. For some, this dilemma appears unrealistic and produces negative effects on their physical, mental and spiritual wellbeing and contributes to NZ-born Samoan young

people's risk-taking and self-harming behaviours. This is reinforced in the following excerpt:

Young Samoan people are caught in a bind ... some of the consequences I have witnessed include running away from home and being disowned by parents, drug and alcohol abuse, an inability to deal with instant freedom, a total disregard for religion, teenage pregnancies which are sometimes accidental and sometimes a ticket to freedom, arranged marriages, eloping, and ultimately suicide as a final escape (Taule'ale'ausumai, 1997:230).

It may seem apparent thus far, that the pressure to 'succeed' is an additional onus upon Samoan young people with regard to saving face so as to avoid public scorn. Taule'ale'ausumai (1997) notes that Samoa has one of the highest international suicide rates and has attributed this high rate to unrealistic familial expectations and the emphasis upon 'success' for Samoan young people. Taule'ale'ausumai argues that in the context of Aotearoa/New Zealand, some parents envisage their children as future ministers, doctors and lawyers with the expectation that this be fulfilled with an unquestioning obedience. Consequently, according to Taule'ale'ausumai, this often subjects Samoan young people to a "sense of powerlessness" (p. 229) as the *fa'asamoa* revolves around the notions of honour and pride. This "sense of powerlessness" develops from having to fulfil *aiga* and cultural commitments in conjunction with the 'burden' of honour, and may be onerous in a shame-based culture such as Samoa. Taule'ale'ausumai (1997) maintains that:

The fa'asamoa can become claustrophobic, even to the extent that one tries to please all parties to whom they have a responsibility so much so that trying to please both friends and parents, or church and peer group, may cause some to live lives bordering on schizophrenia. There is much within the fa'asamoa which generates obligation, whether in works or in monetary or other heavy responsibility. The effect this can have on many young people has resulted in the high suicide statistic[s] (p. 229-230).

Taule'ale'ausumai (1997) is concerned with the obligatory demands of the *fa'asamoa* and considers that failing to respond to these responsibilities may have contributed to Samoan youth suicidal behaviours. Similarly, Bowles (1985) states that a:

Suicide attempt is frequently recounted by the person as a flight or escape from an intense and intolerable situation, with death not always the well-formulated goal (p. 18).

Taule'ale'ausumai (1997) illustrates that the sometimes onerous demands of the financial commitments towards *aiga*, church and cultural obligations have placed some NZ-born Samoan young people under considerable strain (Tau'le'ale'ausumai, 1994; Tiatia, 1998). A financial obligation to the *aiga* and its impact upon the mental health and overall health and wellbeing of NZ-born Samoan people is an issue which needs to be addressed. This is further examined in Chapters Four and Five of this thesis.

With regard to gender roles, potential pressure escalates for some NZ-born Samoan women who must fulfil the obligatory cultural codes of *alofa* (love), *fa'aaloalo* (respect) and *tautua* (service) even more than their male and older counterparts (Tupuola, 1998). For some young Samoan females it is said that there is also a sense of powerlessness, restriction and discipline, which has been associated with suicidal behaviours (Booth, 1999a; Mageo, 1988). It is acknowledged that not all young NZ-born Samoan females share this view.

Mageo (1988) maintains that the burden for young single Samoan females to live an honourable lifestyle is, in itself, restrictive. She argues that despite, or because of, a Samoan female's status as sister and upholder of family honour, it results in her being powerless. Mageo (1988) further concludes that issues of powerlessness, cultural restriction and being subjected to physical reprimand would be inevitable determinants for suicidal behaviours in this specific population. Booth (1999a) claims that powerlessness is the lack of acceptability in the face of social change. Booth writes:

It is the perception of powerlessness that leads both male and female youth to challenge existing power structures. The result is intergenerational conflict, both furthering perceived powerlessness and contributing to suicide (p. 61).

The difficulty with conducting traditionally expected *tautua* (service) and meeting the expectations of education or society at large has been identified as another source of pressure for young Samoan or Pacific women whose *aiga* have not

modified their demands on her (Sua'ali'i, 2001; Leacock, 1987; Pulotu-Endemann & Peteru, 2001; Tupuola, 2000a). It has also been claimed that in a context of social change and demands for greater freedom, cultural restrictions placed on young Samoan females form the basis for intergenerational conflict leading to their suicidal behaviours (Booth, 1999a; Tupuola, 1998). The expectation to be the 'right kind' of woman places Samoan female youth in compromising positions. For instance, in some *aiga*, youth behaviour is strongly influenced by maintaining family honour, the fear of shame and the disapproval by family members concerning female sexuality and sexual development (Leacock, 1987; Tupuola, 1998, 1993b). Moreover, in the context of Aotearoa/New Zealand, some women feel resentment toward the *fa'asamoa* and the choices made for them by their *aiga* (Tupuola, 1998). Tupuola (1998) aptly comments that young women's predicaments are unspoken because of the dilemma of expressing conflicts due to fear of dishonouring their parents, being physically reprimanded or being shunned by the *aiga*. As a result Tupuola found that:

Some of the women in this study considered suicide, as they understood it, to be a form of escape from what they described as the 'claustrophobic' nature of fa'asamoa ... tendencies of suicide appear to be a form of solution for some young women of Samoan backgrounds because they seem to perceive it as an escape from their constant battles and conflicts (cultural, psychological and gender (p. 138-39).

AIGA COMMUNICATION

There is an abundance of Western and non-Western writers who have concluded that there is a lack of communication within some families - particularly between youth, parents and their elders - and it is this breakdown in communication that is perceived to be a risk factor for youth suicidal behaviours in many cultures (Adam, Bianchi, Hawker *et al.*, 1978; Borowsky *et al.*, 1999; Brent, 1995; Chastang, Rioux, Dupont *et al.*, 1998; Hezel, 1984, 1989, 1993; Johnson *et al.*, 1998; Koopmans, 1995; Maris, 1997; Peck, Faberow & Litman, 1985; Rubenstein, Heeren, Housman *et al.*, 1989; Rubinstein, 1994; Vivili *et al.*, 1999). Similarly, this has also been argued to be the case for some *aiga* in Samoa (Booth, 1999a; Bourke, 2001; Macpherson & Macpherson, 1985):

Youth are not entitled to challenge the existing distribution of power, or the means by which it is obtained, which may heighten their sense of disillusion with their society and their place in it (Macpherson & Macpherson, 1987:312).

According to Schoeffel's (1979) observations in Samoa, suicidal behaviours amongst young Samoans are motivated by what were described as 'seemingly trivial' events as a result of a parent-child dispute. Triviality in this context relates to both Rubinstein (1987) and Schoeffel's (1979) investigations which imply that the predominant pattern found in most Micronesian and Samoan youth suicides is that the suicidal behaviour is a result of a scolding by a parent or elder, or the young person being refused a request made to their parents. Rubinstein (1987) also suggests that suicidal behaviours seem out of proportion with the triviality of the precipitating event. Consequently, what may be a seemingly trivial event to an observer may be of major symbolic significance to those more closely involved. Schoeffel (1979) therefore maintains that restricted communication between young people and their elders denies young people the right to dispute, which may then produce extreme frustration and lead to suicidal behaviour in young people when their desires are thwarted.

In terms of Samoans in Aotearoa/New Zealand, further exploration is needed to examine how a lack of communication within the *aiga* may prohibit some NZ-born Samoan young people from turning to someone in the *aiga* in a time of crisis.

Within Aotearoa/New Zealand, Bathgate and Pulotu-Endemann (1987) noted that discord between *aiga* or community members frequently lead to suicidal behaviour amongst Pacific young peoples (including Samoan young people). In addition, Taule'ale'ausumai (1991) believes that in the context of Aotearoa/New Zealand, the lack of communication within some *aiga* has led to Samoan youth suicidal behaviours.

Within the gerontocratic structure of Samoan society, the status of young people is relatively subordinate in comparison to those of seniority, primarily in relation to the deference some Samoan young people have been taught to show toward their elders (Tupuola, 1998; Anae, 1998b; Chun, 2000; McGeorge,

1996; Tiatia, 1996; Tiatia, 1998; Vaoiva, 1999; Tupuola, 1993b). For most Samoans, to act promptly upon commands is to *fa'alogo*, which means both 'to obey' and 'to listen' (Mageo, 1989). Within the *fa'asamoa* this would be a demonstration of *tautua* (service) and may, at times for some, be the antithesis of expressing oneself. In Samoan childhood, to express a desire for dominance is considered *tautalaitiiti* (cheeky), signifying that one is talking or behaving above one's age and therefore is failing to take one's proper place within the *aiga* (Meleisea & Schoeffel, 1998; Mulitalo-Lauta, 2000; Schoeffel, 1979). It is also believed that a young persons' obedience demonstrates a readiness to listen and to put into order or *teu teu le amio* their own subjective reaction towards their elders (Mageo, 1989). Thus communication between parents/elders and young people is often limited. The requirement of an unquestioning obedience and knowing one's place within the hierarchical structure of the *aiga* and the *fa'asamoa* in general, ensures that the youth voice in most cases will remain 'muffled' (Mageo, 1998; Tiatia, 1998). Consequently intergenerational communication will remain problematic and, from a public health perspective, may be detrimental if young people choose not to confide in their *aiga* at a crucial time in their lives (Coggan, 1997). This has the effect of some young Samoan people becoming embittered with their place in society.

Another factor worthy of consideration in the context of Aotearoa/New Zealand, and in particular in relation to the lack of parent-child communication, is that of the language barrier. Intergenerational misunderstandings of language and the sometimes incongruent experiences of NZ-born Samoan young people and their Samoan-born parents may impact upon parent-child communication (Tiatia, 1996; Tiatia, 1998; Anae, 1998b; Hunkin-Tuiletufuga, 2001). For instance, 52 percent of NZ-born Samoans do not speak Samoan (Statistics New Zealand, 2003). Hunkin-Tuiletufuga (2001) maintains that the preservation of the Samoan language in Aotearoa/New Zealand is essential for the retention of cultural identities. The author argues that languages reinforced "unity" (p. 200) and intergenerational communication amongst *aiga* both in Aotearoa/New Zealand and in Samoa. Furthermore the underlying values, norms, mores and the belief systems of a culture are transmitted within the language (Niulevaea, 2001; Tamasese *et al.*, 1997). The fact that NZ-born Samoans understand but

do not speak their parents' languages creates a language barrier between children and their parents and grandparents (Hunkin-Tuiletufuga, 2001; Tiatia, 1998).

There are extensive writings which explore the issue of intergenerational misunderstandings between NZ-born Samoan young people and Samoan-born elders within the context of the *aiga* and beyond language barriers in Aotearoa/New Zealand (Anae, 1998b; Macpherson, 1999, 2001; Macpherson, Bedford & Spoonley, 2000; Ritchie & Ritchie, 1979; Taule'ale'ausumai, 1991; Tiatia, 1998; Tupuola, 1993b, 1998; Utumapu, 1992). However, there appear to be few in-depth accounts of intergenerational misunderstandings in relation to suicidality amongst NZ-born Samoan young people - with the exception of Tupuola (1998) whose findings suggested that for some Samoan females, suicide was thought to be an alternative method of evasion, particularly from physical discipline and/or exclusion from their *aiga*.

Such views may suggest that there is growing tension between the modern emphasis on self and the *fa'asamoa* image of dutiful children and self subordination which, in turn, may limit effective communication within the *aiga* and between parents and their children.

This next section discusses the *feagaiga* (brother-sister covenant) relationship focusing on the traditional code of separation and how this may impact upon *aiga* communication.

In traditional Samoan society it is believed that the most important relationships within the household, and those which most influence the lives of young people, are the relationships between boys and girls who call each other *tuagane* (brother) and *tuafafine* (sister), whether by blood, marriage or adoption (Liu, 1991; Meppen, Zunino, Mercier *et al.*, 1993; Schoeffel, 1979, 1977). It is a sacred relationship where it is the brother's role and responsibility to ensure the safe welfare of his sister(s) (Tamasese *et al.*, 1997; Schoeffel, 1995). As documented by Shore (1982), traditionally the *feagaiga* prescribes that:

A brother does not indicate his respect for his sister in any direct contact between them, since brothers and sister generally avoid intimate contact and are commonly ma (ashamed) in each other's presence [this] testifies to the power of this traditional avoidance in

Samoan culture. Rather a brother must dignify (fa'amamaluina) his sister and honour (fa'aaloalo) her in the service or care (tautua) that he performs for her welfare (p. 233).

Within some Samoan households, and within a more contemporary context, Sua'ali'i (2001) claims that these distinct gender roles within the *feagaiga* continue to be observed after migration to Aotearoa/New Zealand. Traditional practices continued within Aotearoa/New Zealand include not being able to form platonic relationships with members of the opposite sex, at least until after marriage; not being able to sleep in the same room as brothers; not being able to wear brothers' clothes or vice versa; not being able to make any sexual inferences during a conversation, or watch sexual scenes on television when a brother is present, and vice versa (Holmes, 1958; Sua'ali'i, 2001). These practices signal a social ban on incest (Ritchie & Ritchie, 1979). Sua'ali'i (2001) mentions that "many of these incidences were not uncommon to my own experience growing up in New Zealand" (p.176) and it is within the practices of these gender codes that the significance of the *feagaiga* (brother-sister covenant) is practised in the context of contemporary Aotearoa/New Zealand. It may be important to include this relationship in the examination of the dynamics within the *aiga* and communication. If this separation still exists today as suggested by Sua'ali'i (2001), then what impact will this have upon NZ-born Samoan siblings who have little communication with their parents? Who then can one turn to? Chapter Five examines this relationship in more depth with regards to communication within the *aiga*.

Physical discipline

There is Western evidence both nationally and internationally indicating that physical abuse within the home is a contributing factor to youth suicidal behaviours (Beautrais *et al.*, 1996; Brodsky & Stanley, 2001; Brown *et al.*, 1999; Fergusson *et al.*, 2000; Fergusson & Lynskey, 1995a; Grossman, Milligan & Deyo, 1991; Thakkar, Gutierrez, Kuczen *et al.*, 2000).

Providing culturally sensitive definitions of physical abuse can be problematic, as perceptions of what constitutes abuse vary amongst communities (Collier,

McClure, Collier *et al.*, 1999). Thus, whilst physical abuse is partly a subject of definition and perception, what is measured as abuse is also determined by community attitudes which reflect cultural values and priorities (Schultz, 1995). The term physical discipline has therefore been used in this thesis.

By using the broad and culturally sensitive term 'physical discipline' it is not uncommon to find cultural tolerance of physical discipline in the Pacific (Schultz, 1995). Physical discipline of children in most Pacific societies has been regarded the norm where parents claim the right to punish their children on cultural and religious grounds (Schultz, 1995; Collier *et al.*, 1999).

Ritchie and Ritchie (1979) argue, in reference to Samoan and Tahitian young people and physical discipline, that although these young people clearly understand their cultural expectations, it is the intense nature of adult authority, status and due respect in these societies that has impacted upon these young people most and which contributes to the frequent occurrence of suicidal behaviours within these two Pacific societies. Yet how realistic is this for NZ-born Samoan young people? This section first explores the historical and 'cultural' beliefs of physical discipline within Samoa, and then addresses this issue in relation to the context of Aotearoa/New Zealand.

Freeman (1983) states that Samoan beliefs, which were integral to the pagan culture of Samoa, have been powerfully reinforced since the mid-nineteenth century by the biblical teachings of King Solomon who wrote:

He that spareth his rod hateth his son: but he that loveth him chasteneth him betimes (Proverbs 13:24).

Foolishness is bound in the heart of a child; but the rod of correction shall drive it far from him (Proverbs 22:15).

Train up a child in the way he should go: and when he is old he will not depart from it (Proverbs 22:6).

Samoans have long taken to heart such instructions, and when asked why they punish children indicate that it is believed that this is the best way to teach young people what they must do (Freeman, 1983; Holt, 1999). Physical

discipline is a form of social conditioning to remind Samoan youth of their place, and to promote good behaviour and self-control at all times (Duncan, 1994; Fairbairn-Dunlop, 1999). As mentioned throughout this chapter, Samoan society is characterised by a hierarchical system, which explains why *fa'aaloalo* (respect) for rank is regarded by Samoans as the most fundamental of all virtues. The following extract describes the importance of *fa'aaloalo* which is imparted in the lives of some Samoan youth:

There is probably no greater shame than inadvertently to be disrespectful. Teaching respect is a parental preoccupation. Giving respect may shut one's mouth. ... Respect may seem to a Westerner to be shyness, withdrawal, sullenness even, but it is respect, just respect (Ritchie & Ritchie, 1979:86).

Some Samoan parents believe that severe physical corrective techniques are the most effective mechanism for teaching respect and personal abasement (*lotofa'amaualalo*) for those deemed too young to understand otherwise (Mageo, 1998; Sua'ali'i, 2001). Mageo (1998) suggests that reprimand and status are intimately connected in Samoa where status strongly conditions child-parent relationships, rendering them proper and reserved. There is the belief in the unique effectiveness of pain as a means of training where physical discipline is necessary to achieve *fa'aaloalo*²⁰ (respect) and ensure children will be well behaved (Gerber, 1975). Mageo (1998) argues that Samoan punishment aims to produce submission and plays upon the "dominance/submission motif" (p.66) which implies hierarchy. Consequently, young people come to avoid affirming their own desires in relation to their elders (Hezel, 1993, 1994). It is contended that, as such, many Samoan youth difficulties specifically in relation to suicidal behaviours have been precipitated by conflict with authority, and in some cases as a result of physical discipline by authority figures (Freeman, 1983; Gerber, 1975; Herdt & Leavitt, 1998; Mageo, 1988; Rubinstein, 1987). This suggests that such behaviour within some *aiga* is not tolerated by young people.

²⁰ *Fa'aaloalo* is respect for status where the *aiga* is the training ground for *fa'aaloalo*. It is also the Samoan synonym for proper behaviour and is demonstrated by deference (Mageo, 1991; Booth, 1999b; Hezel, 1984, 1989; Leacock, 1987; Macpherson & Macpherson, 1987; Rubinstein, 1994; White, 1985).

In Aotearoa/New Zealand, it is also contended that the effects of extreme physical discipline on Samoan and Pacific children and young peoples can be extensive and multi-dimensional and can negatively impact upon their personal growth, their mental health and their potential (Ministry of Social Development, 2002). Studies indicate that young people who experience violence in families are more likely to develop severe cognitive and behavioural problems, to become violent in adulthood, and to perpetuate the cycle of violence in adulthood (Ministry of Social Development, 2002). In Aotearoa/New Zealand, violence has been recognised as a priority area for Pacific injury prevention (Tiatia *et al.*, 2002).

Physical discipline within the home is an under-researched area for Pacific populations, particularly in families. This discipline may seriously affect the wellbeing of Samoan and Pacific peoples, whether they witness it on others or have been subjected to harsh methods of physical discipline themselves (Ministry of Social Development, 2002).

(Fairbairn-Dunlop, 1999) argues that Pacific peoples are experiencing the consequences of harsh child-rearing practices. This is reflected in youth involvement in anti-social behaviours and crime; parents fearing youth; youth feeling they cannot discuss sensitive issues with parents; and some youth despising or rejecting the *fa'asamoa* (Samoan way) as they associate this with "physical violence, inflexibility and unrelenting calls to obey" (p. 2). Fairbairn-Dunlop also goes on to suggest that Samoans most often use religious grounds to justify their behaviour, yet recognise there is an increasing number who oppose this behaviour and regard it as the antithesis of the traditional *fa'asamoa*. It is the latter group, Fairbairn-Dunlop notes, who perceive physical abuse or discipline as a consequence of urbanisation, the breakdown of the *aiga potopoto* (extended family) and poor socio-economic conditions.

It seems there is particular irony in that the strict observance of *fa'aaloalo* (respect), is compromised when some homes debase its meaning by use of severe physical discipline (or abuse as the case maybe) which has, in turn, negatively affected Samoan youth health and wellbeing.

Aiga: A Buffer Against Suicidal Behaviours

It is suggested that there is no single approach to an individual at risk for suicidal behaviours, but common to all approaches is the development of a working rapport between the key parties (Durie, 2001). As previously discussed, one key party in the case of some Samoan youth, is their *aiga*. While the primary relationship is between the helper and the distressed youth, *aiga* involvement and the involvement of other key figures in the community should be equally positive. It is argued that this does not mean a vast array of experts but rather a circle of concerned family and friends able to respond in a consistent manner (Durie, 2001). Hezel (1994) recommends that the community must cultivate activities to strengthen and develop the young peoples' competence to raise their self-esteem and confidence. Hezel's argument is that, in its entirety "the best means of prevention is strong and healthy families" (Hezel, 1994:62). Moreover, from a public health perspective, positive friendships have been considered an important component to resilience. For example, Coggan, Patterson and Fill (1997) find that young people often turn to their peers and friends if they are feeling suicidal and argue that this has important implications towards the planning of suicide prevention strategies. Additionally, for instance, Marrone (1999) argues that communication about problems with friends or family is more effective in reducing the probability of a suicide attempt than looking to decrease risk factors. In relation to considerations for prevention, the author argues that there should be a focus on promoting these protective factors. Furthermore, (Smokowski, Reynolds & Bezruczko, 1999) find that having positive relationships with siblings is often reported amongst young people. These authors conclude that a blend of optimistic future expectations, realistic appraisal of one's strengths, having personal goals, and avoiding the initial excitement and subsequent danger involved in risk situations were solutions for many young people to 'keep on track'. It is important to examine how pragmatic these views are for NZ-born Samoans in terms of their experiences.

A large body of public health literature has indicated that family cohesiveness across cultures is a protective factor from suicidal behaviours (Cohen & Wills, 1985; Mitchell, 2000; Rubenstein *et al.*, 1989; Kirmayer, Boothroyd & Hodgins,

1998; Calvert, 1997). Family caring and connectedness is perceived as the most powerful protective factor associated with emotional wellbeing for young people (Cummins, Ireland, Resnick *et al.*, 1999). Resnick (2000) suggests that a strong sense of social connectedness amongst young people is a salient protective factor from health endangering behaviours. Heikkinen and co-investigators (1994) also maintain that supportive social networks and strong interpersonal relations provide a feeling of necessity and a meaning for living by providing a buffer against the effects of adverse life events and subsequent suicidal behaviours. Additionally, it has been identified that the importance of family therapy is vital (Jobes & Mann, 1999).

A study conducted by (Paproski, 1997) investigates British Colombian First Nations Women, in relation to suicidal behaviours. Motives which inhibit some women from making an attempt on their lives and increase their desire to live include having a sense of connection and responsibility - particularly towards family - as well as conceiving of the impact their act would have upon family members. How relevant are these claims for NZ-born Samoan young people and their *aiga*? For instance, *aiga* is central to most Samoans, yet the implication is that the *aiga* may be a young person's only unit of support, even if it may be a harmful environment. Thus the social support provided by the extended family has been considered a buffer against oppression, other negative life circumstances, and suicidality (Range *et al.*, 1999).

Schuster (2001) maintains that "contemporary counselling" (2001, p. 194) in Samoa is posed as a threat to the *fa'asamoa*. Contemporary counselling is described by the author as the practice which begins with the individual as the first point of intervention. Although the intervention process may involve other people, the initial focus is that of the needs of the individual. This intervention strategy promotes 'healing' the individual and enabling them to either reorder or adjust to their environment.

Schuster (2001) argues that traditionally, the roles of the *matai* (chief), family elders and church ministers are considered to be the “community counsellors” and usually define the problems for individuals. The role of the individual is to participate in the counselling, irrespective of their willingness to do so. Schuster goes on to suggest that this is the first example of how contemporary counselling contradicts traditional Samoan expectations - where the individual’s perception of the problem is above that of “community counsellors”. Consequently, in Samoa this counselling approach has struggled due to the criticism that it is not considered to be the Samoan way (Schuster, 2001). Yet, in the context of Aotearoa/New Zealand, would this too be the case for NZ-born Samoan young people?

In relation to service delivery it seems there is a mismatch between those who need help and those who utilise the services (Williams, 1997). This is an obstacle along the path to suicide prevention. A study by Nisbet (1996) who looks at protective factors for suicidal black females finds that social support availability operates as a safeguard against attempting suicide. Therefore, to strengthen this safeguard, resources for social and emotional support need to be perceived as being more readily available and accessible. Nisbet suggested that the availability of support from friends and familial ties is a stronger safeguard against attempting suicide than is the availability of professional support (Nisbet, 1996).

Bathgate and Pulotu-Endemann (1997) suggest that the best prospects for mental health promotion in Aotearoa/New Zealand are those that are achieved with, and through, Pacific organisations (churches and other groupings). However contrary to this, as is the argument made earlier by Schuster (2001), and the research findings by Coggan and co-investigators (1997) who find that Pacific youth study participants do not consider seeking help from an elder or minister within the church. This is based on the suspicion young Pacific peoples hold that the whole church community would find out (Coggan, Patterson & Fill, 1997). However, an evaluation by Coggan, Patterson and Tiatia (1999) which looks at the provision of health services in secondary schools in Auckland finds that many Pacific students feel Pacific health workers are the most effective in identifying their mental health concerns and are also the most capable of

working with their *aiga*. Furthermore, trust is identified as one of the essential components for young people in order to comfortably open up with private and painful issues (Coggan, Patterson & Tiatia, 1999; Zechetmayr & Swabey, 1998).

In addition to the *aiga*, emotions are an important sociocultural factor that has been identified as having a major role in Samoan youth suicidal behaviours. Consequently, understandings of emotions, which are informed by a critical Samoan perspective, are therefore required.

EMOTIONS

White's (1985) anthropological writings of Pacific peoples' emotions and the concept of self in relation to suicidal behaviours argues that Pacific peoples perceive, discuss and experience emotion in culturally distinct ways. The author concludes that this must be considered in any attempt to make sense of suicidal behaviours in these populations.

Chapter One discussed the dominant belief in Western public health literature that major mental disorders are a prominent contributor to youth suicidal behaviours (Appleby, 1993, 2000; Beautrais *et al.*, 1998a; Brent *et al.*, 1993a; Brent *et al.*, 1993b; Fergusson & Horwood, 2001; Haw *et al.*, 2001; Houston *et al.*, 2001; Johnson *et al.*, 1998; Neame, 1997; Shafii *et al.*, 1985; Shaffer *et al.*, 1988). However, this view is contradicted by other studies which maintain that major mental disorders cannot be assumed to be the sole explanation (Anderson *et al.*, 2000; Bathgate & Pulotu-Endemann, 1997; Disley, 1997; Lester, 1998a; Sligo & Jameson, 2000; Tatz, 1999). The focus of this section reinforces how suicidal behaviour amongst Samoan young people cannot solely be conceptualised through the lenses of Western psychological concepts. Additionally, this section examines the 'personality and cognitive' risk factor domain for youth suicidal behaviours as outlined in Chapter One, with a particular emphasis upon Samoan young people's emotional states prior to a suicide attempt.

This section is structured as follows: firstly it addresses the Samoan source of all emotion - the *loto*; secondly it discusses issues of anger as well as the Samoan youth retreatist form of anger or withdrawal (*musu*); thirdly it explores youth emotional repression as a culturally appropriate stance which is potentially detrimental to Samoan young people's wellbeing; and lastly this section explores the relationship between shame and suicidal behaviours within Samoan *aiga*.

It is believed that suicidal behaviours are a desperate expression of thoughts, emotions and hopes, rather than merely a physical act (Tuzan, Polat, Vatansever *et al.*, 2000). The primary message the suicidal person conveys is a sense of hurt and anger (Rubinstein, 1994). An investigation of emotions either precipitating, or immediately after a suicide attempt, may provide for some cultural understanding of the emotional state which may prompt a Samoan young person to undertake suicidal behaviours.

In Samoan society, the *loto* (inner self) is regarded as the source of all emotions (Gerber, 1975; Mageo, 1991). The *loto* is the depths of an individual's personal thoughts, feelings and desires and it inspires all manner of sentiments - from arrogance, to envy, to periods of grief - which may not be accounted for by social roles (Mageo, 1998). The marriage of Samoan emotions and suicidal behaviours will be explored with reference to the Samoan expression - "*teuteu le amio*" (to put one's feelings in order) and will be the basis of this section and further investigated in Chapter Six's 'Emotions'.

Most Samoans understand their roles with reference to other people and believe that one must, above all else, play the appropriate part (Meleisea & Schoeffel, 1998; Mulitalo, 2001; Mulitalo-Lauta, 2000; Silipa, 1999a; Tamasese *et al.*, 1997; Tupuola, 2000a). However, this 'social acting' does not necessarily mean that behaviour is insincere. Shore (1982) states that the emphasis is on "the internal ordering of one's own actions in the face of a shame-producing or punishing threat" (p. 159) where *teuteu le amio* stresses a type of self-control. Therefore, *teuteu le amio* most often places cultural restrictions on overt expressions of emotion and it is these restrictions which will be examined in terms of their impact upon suicidal behaviours amongst NZ-born Samoan young

people. The extreme antithesis is engaging in suicidal behaviours as a means of vengeance which in this thesis refers to two secondary goals: a) the symbolic behaviour of convincing the offender that a particular type of behaviour will not go unpunished; and b) vengeance spurred by the goal of saving face whereby the offender is lead to believe that the offended should be respected and not treated in the same way again (McCullough, Bellah, Kilpatrick *et al.*, 2001).

Mageo (1991) documents three practices which are believed to be the means by which some Samoans may structure emotion, behaviour and a communal mindset. Underpinning Mageo's three practices is the concept of *teuteu le amio*. They are:

1. Structuring emotion: parental distancing is used within some Samoan *aiga* to regulate strong interpersonal affection. To lavish love and care upon a child is, for some, inappropriate for growing children, as it infers spoiling the child (Mageo, 1991).
2. Structuring behaviour: in Samoan society most parents communicate with authority to teach the child *fa'aaloalo* (respect) which is regarded as proper behaviour. Consequently, Mageo (1991) argues, the Samoan young person's subservient role encourages the desire to attain a dominant position.
3. Structuring identity: Samoan children are taught to identify with the group, not as individuals. Thus, young people are discouraged from distinguishing themselves (Mageo, 1991).

It seems that these three practices thwart overt expressions of emotion. How would Mageo's (1991) identified practices relate to NZ-born youth's suicidal behaviours? With regard to practice one, communication may be limited between parents and their children creating the dilemma of whom NZ-born Samoan young people can turn to in times of distress if this affective distancing still exists? Practice two infers that the strict observance of *fa'aaloalo* (respect) and knowing one's place may mean that things of a 'sensitive' nature are better left unsaid. To remain within cultural boundaries is to uphold social order and is most often expressed in the Samoan proverbial expression -"*aua le to'ia le va*" (do not step over the gap). Mageo's notion that young Samoans desire to attain

a dominant position due to their structured behaviour in the hierarchical order may be a huge generalisation. For instance, Aotearoa/New Zealand researchers acknowledge truth in the assumption that every Samoan young person should know their cultural boundaries and their position within the *aiga* and community (Tupuola, 2000b; Vaoiva, 1999; Mulitalo, 2001). However in relation to Mageo's practice two, NZ-born Samoan young people who are challenging aspects of the *fa'asamoa* are criticising such cultural restrictions rather than desiring domination (Tiatia, 1998; Tupuola, 1993b, 1998). According to Tupuola (1998), there are some Samoan young people who begin to resent the *fa'asamoa* and often conceal this conflict for fear of disrespecting their parents, physical reprimand and rejection from the *aiga*. Practice three may relate to the complexity some NZ-born Samoan young people have in relation to balancing the Samoan value placed on communalism and the Western emphasis upon individualism, particularly in relation to the impact it may have upon suicidal behaviours. With regard to Mageo's practice three, Tupuola's (1998) work concludes that for some NZ-born Samoan young people, there is conflict between the public Samoan and private life. Tupuola suggests that on the overt level one may be hesitant to search for a sense of 'self' and on the covert level may appear to obscure desires of independence. As such, some NZ-born Samoan youth are seen to be in a cultural bind. Consequently, Tupuola (1998) adds, suicidal behaviour is then considered the most realistic option as a means of distancing themselves from the *aiga*.

To express anger towards elders would indicate that a Samoan person sees themselves above their 'proper' station within the hierarchy which may be described as "lawlessness" (Mageo, 1989:389). Thus, it is then best to *teuteu le amio* (to put one's feelings in order). Subsequently, a Samoan young person may then be led to a 'breaking point' due to constructs of gerontocracy and the preservation of emotional discontent (Tupuola, 1998; Fairbairn-Dunlop, 1999).

Between Samoan and Micronesian societies there is shared knowledge of a term used in Truk (one of four States of the Federated States of Micronesia) - *amwunumwun*, and in Samoa - *musu*, in relation to suicidal behaviours in these populations. A state of *musu* is to sulk, to be sullen, withdrawn, stubborn, uncooperative and the refusal to communicate with others (Macpherson &

Macpherson, 1985; Mageo, 1998). It is argued that the predominant pattern leading to suicidal behaviours in both societies may be attributed to the parent or family authoritarian who scolds the young person, or perhaps refuses some minor request from the young person. From this event, the young person withdraws (Macpherson & Macpherson, 1985; Rubinstein, 1987). This kind of withdrawal is *amwunumwun* or *musu*. Both strategies of withdrawal or self-abasement are used to show that one must continue to stay within the cultural boundaries and without breaching the norms of *fa'aaloalo* (respect) (White, 1985).

The term '*musu*' was recorded as early as 1832 by the pioneering missionary, John Williams and is believed to have no exact equivalent in English (Freeman, 1983). Samoan young people who continue to express discontentment with a particular outcome may become *musu* and will treat a particular person with disinterest to accentuate their discontent (Macpherson & Macpherson, 1987). Typically this motivates others to try to restore the relationship (Macpherson & Macpherson, 1985). It is argued that when an individual is *musu*, and his/her expectations have not been met, s/he has three options: a) to simply accept the annoyance and wait for the tables to turn and his/her time comes around; b) flee to the comfort of others; and finally, c) allow him/herself to be moved to strong anger (Gerber, 1975; Macpherson & Macpherson, 1985; Shore, 1982). *Musu* has social-emotional implications providing some Samoan young people with a standard script for communicating about and, possibly, resolving conflict (White, 1985).

The notion of musu specifies a culturally appropriate way for children to demonstrate dissatisfaction vis-a-vis parents. It is a stereotypic form of withdrawal, which signals displeasure with someone in a position of authority (White, 1985:7).

It appears that *musu* may be associated with Samoan youth suicidal behaviours (Howard, 1986). Therefore, *musu* involves an entire branch of understanding about conflict and resolution primarily within the *aiga*. *Musu*, like *amwunumwun*, is a retreatist anger and is deemed a culturally characteristic Samoan youth response (Macpherson & Macpherson, 1987; Rubinstein, 1992).

International literature from Western developed countries suggests that there is a strong correlation between anger and suicidal behaviours within families (Goldney, Winefield, Saebel *et al.*, 1997; Johnson *et al.*, 1998). It is argued that affective states such as anger - as well as depression, anxiety and loneliness - serve to trigger various impulsive behaviours (Milligan & Waller, 2001). Such is the case for some Samoan young people and their suicidal behaviours. Drawing upon Micronesian suicide literature, the peoples of Truk - as in many other Pacific societies, have built complex social structures as a means of minimising outbreaks of hostility, with the intention of maintaining 'tranquillity' within the community (Hezel, 1987). In both Trukese and Samoan societies one of the cultural understandings is the restriction upon verbalising anger towards one's elders. In so doing, it is believed that arguments may be reduced. Hezel (1984) has identified that the cultural patternings of youth suicide amongst the Micronesian group of Truk have similarities to Samoan cultural patternings, beliefs and practices. In the examination of Trukese suicidal behaviours, Hezel concludes that the cultural confines upon overt expressions of anger and their purpose must be understood. Hezel postulates that Western mental health professionals are inclined to assume suicides are of a pathological nature thus ignoring the reality that such behaviours stem from a culture which discourages the venting of strong negative feelings towards parents and elders. Furthermore, Hezel suggests that suicidal behaviours are typically led by the emotion of anger, particularly towards those whom negative feelings should be avoided (that is, for example, elders and prominent people).

It appears that the cultural expectation of emotional repression imposes a negative impact upon Samoan young people thus contributing to their suicidal tendencies. For instance, as Mageo contends, (Mageo, 1991; see practice number two), forced submissiveness in childhood may lead to aggression and a strong desire for Samoan young people to dominate in later life. It seems apparent that the denial of the right for Samoan youth to express their concerns may often produce extreme emotional tension, and as a result, suicidal behaviours are triggered by seemingly inconsequential events (Rubinstein, 1987; Schoeffel, 1979). As mentioned earlier in this chapter, what may be considered a seemingly insignificant incident by an observer may have major

symbolic importance to a suicidal person (Rubinstein, 1987; Schoeffel, 1979). So whilst suicidal behaviours may seem entirely out of proportion with the triviality of a precipitating incident, it is the emotional reaction to these incidents which needs to be understood within the context of relations between the Samoan young person and those whom they must revere - more specifically, their elders.

Emotional expression amongst Samoan young people appears complex, whereby the gerontocracy of Samoan society and the strict observance of *fa'aaloalo* (respect) may compel some to become *musu*. Therefore in view of the literature, the question may be asked - is *musu*, being a form of emotional withdrawal, a danger to Samoan young people? Considering the cultural constraints upon overt emotion, how may a Samoan young person vent their frustrations? Schoeffel (1979) agrees that emotional restraint not only encourages Samoan young people to yearn for independence, but can also become a source in their undertakings of other risk-taking behaviours such as drug and/or alcohol abuse, and teenage promiscuity. It is these complexities which reinforce the need for an awareness of cultural understandings of the emotions surrounding Samoan youth suicidal behaviours and, as White (1985) argues:

May produce insights, which will also prove useful in understanding other social problems such as alcohol abuse, violent or mental disorder (p. 1).

Shame

Within the Samoan world, it is believed that the association between shame and suicide is not coincidental as "Samoans hold to be appropriate a person's conduct which may cause serious and lasting damage to his/her kin group" (Macpherson & Macpherson, 1987:316). Macpherson and Macpherson (1987) offer examples of the types of events which induce shame and thus lead to suicidal behaviours amongst Samoan young people. For example, these events include: the discovery of offences of sexual immorality; lost virginity; adultery in prominent *aiga*; incest; and an inappropriate relationship or marriage. The following section attempts to explore shame and its correlation with suicidal

behaviours amongst Samoan young people. It may be important to note that whilst the literature focuses on Samoan youth in Samoa, there are similarities pertinent to Samoan young people in the context of Aotearoa/New Zealand.

Shame has been regarded as having a strong correlation with suicidal behaviours (Lester, 1998b). The conceptualisation of shame may be regarded as a desire to hide from public response more than dealing with indiscretion of private principles, as caused by the acts of others (Kalafat & Lester, 2000). Shame in this thesis refers to feelings of inhibition where inhibition is fixed to anxiety about the responses of others to the self. Hence, in this thesis, shame may be characterised as the fear of facing those who know of our unworthiness, and where some, under certain conditions, seek the ultimate withdrawal by partaking in suicidal behaviours (Kalafat & Lester, 2000).

In Samoan society, a person who acts without concern at the cost to their *aiga*, is compelled to feel ashamed and guilty for having lowered the *aiga's* name into disgrace (Holt, 1999; Tupuola, 1998; Tiatia, 1998; Anae, 1998b). It seems apparent then, that to avoid bringing shame upon the *aiga* the expectation is to succeed, and with this success comes the consequent elevation of the family name. As Schoeffel (1979) articulates, with regard to Samoans and the value placed on 'success', that:

Good deeds, innovations and precocious achievements are highly valued, but the pursuit of public approval and recognition via personal achievement is also clouded by a widespread fear of failure and of public mockery (p. 122-123).

Moreover, the concern by some Samoans to keep others oblivious to their business is a reminder to children that their conduct can either improve or undermine the prestige and power of the *aiga* (Mulitalo, 2001; Meleisea & Schoeffel, 1998). Therefore, there is enormous pressure on individuals to consider the consequences of their conduct for their *aiga* (Chun, 2000).

Many writers have addressed the shift toward, or desire for, independence by NZ-born Samoan young people (Anae, 1998b, 2001; Faumui, 1996; Holt, 1999; Chun, 2000; Macpherson, 2001; Niulevaea, 2001; Tupuola, 1998; Tiatia, 1998; Tupuola, 2001; Vaoiva, 1999). It is often argued that due to the emphasis upon

filial allegiance, some Samoan parents or caregivers are resolute about their children's life choices which inevitably (in some cases) places huge pressures upon the NZ-born Samoan young person (Anae, 1998b; Chun, 2000; Silipa, 1999b; Tiatia, 1998; Tupuola, 1998, 2000a). Therefore, as echoed in the words of Mead (1928), what has developed for some, is a form of *aiga* administration which harnesses the emotional life, and distorts and confuses the growth of Samoan young people attempting to live independent lives.

Shame and its role in Samoan youth suicidal behaviours are closely linked with marring the family name and may fit into Mageo's (1991) practice three which prescribes that Samoan young people should not be encouraged to distinguish themselves (refer p. 63 in this chapter). Furthermore, the extent of shame may make some Samoan young people feel excluded and isolated from their own community (Holt, 1999). Donald and colleagues (2001) argue that shame becomes an expression for interpersonal conflict, indicating continuing disruption in close relations and encouraging their restoration. Shame, then, may be considered adversative to the very relations that maintain community cohesiveness and 'harmony' and so must be alleviated by somehow reinstating those relations (White & Watson-Gegeo, 1990).

Masking

*...I fit your plans and schemes for the future.
You cannot see the real me
My face is masked with pretence and obedience
And my smiles tell you that I care
I have no other choice (Thaman, 1974:13).*

The term 'masking' refers to the concealing of one's true feelings and is aptly described in an excerpt from Thaman's (1974) poem entitled 'You the Choice of My Parents'. This excerpt alludes to traditional parental expectations placed upon a Pacific young woman. Similarly, Tupuola (1998) finds that whilst some of her Samoan female study participants abide by *aiga* expectations, that does not necessarily mean they accept them. Tupuola argues that some mask their inner conflicts in order to fulfil these parental expectations often negating their

yearning for a sense of 'self' (Tupuola, 1998). In some cases, masking may be used to hide weaknesses for face-keeping/saving purposes (Macpherson & Macpherson, 1985; Tatz, 1999; Holt, 1999). The 'art' of masking may also be considered a method of maintaining self-control toward *aiga* and another mechanism or 'wall' to hide one's *loto*. It is perceived that while a person remains smiling, unsettled and painful emotions may be beneath the surface (Goodman, 1990). Thus masking *per se* is not so much an emotional state, but rather a response and seems important to include as part of the *teuteu le amio* - putting one's feelings in order. In addition, masking may also be used in some cases to illustrate courage or to be *lototele* irrespective of the fear that may be mounting within. Mageo (1991) describes what it is to be *lototele*:

Samoans compensate for the tendency toward emotionalism by telling those who suffer strong emotions to be lototele. ... Lototele represents a reversal of the tendency toward grief and fear ... those who successfully struggle with these inclinations ... are brave in the sense that they have the strength to act appropriately (p. 409).

Aune & Waters (1994) examined variance in motivations for "deception" (p. 159) spurred by cultural differences inherent in communal and individualistic cultures. They collected data in North America and American Samoa and found that Samoans are more likely to attempt deception on occasion, in order to satisfy an authority figure. It is contended that a NZ-born Samoan young person learns early in life to comply overtly with parental and elder dictates while concealing their true feelings and intentions in order to please those in authority (Chun, 2000; Mulitalo, 2001). Subsequently, some Samoans soon become adept at assuming an outward demeanour pleasing to those in authority. For instance, by the time a Samoan young person has reached adulthood, they may have acquired the ability to hide their true feelings behind an almost impregnable mask. This masking may be seen as a survival strategy for the Samoan youth as well as a demonstration of *fa'aaloalo* (respect) towards the *aiga* (Tupuola, 1998; Holt, 1999).

Another emotion that deserves further attention is depression. It will first be discussed in relation to popular public health perceptions before moving onto Pacific and Samoan perceptions.

Depression

The term 'depression' is generally used to describe both a frequent human emotion as well as a disorder or illness (National Health & Medical Research Council, 1997). Much of the suicide literature has identified depression as an important underlying factor in youth suicidal behaviours (Adcock, Nagy & Simpson, 1991; Andreasen & Grove, 1982; Beautrais, 2000b; Beautrais *et al.*, 1996; Beautrais *et al.*, 1998a; Chastang *et al.*, 1998; Donald, Dower, Lucke *et al.*, 2001; Herman-Stahl & Peterson, 1996; Hovey, 2000; Kaltiala-Heino, Rimpela, Marttunen *et al.*, 1999; Mazza & Reynolds, 1998; McLaughlin *et al.*, 1996; Rihmer, Rutz & Pihlgren, 1995; Rubenstein *et al.*, 1989; Sullivan & Bulik, 1997). It is also argued that adverse life events may contribute to feelings of depression and suicidal behaviours (Beautrais, 2000b; Beautrais *et al.*, 1996; Fergusson *et al.*, 1995; Placidi *et al.*, 2001; Rubenstein *et al.*, 1989). In addition, ineffective coping has been identified as a risk factor for depression (Donald *et al.*, 2001; Sadler, 1991).

Depression has been used to refer to a broad range of negative feelings, cognitions and behaviours of varying severity and duration (National Health & Medical Research Council, 1997). As a result, it is difficult to diagnose and categorise the prevalence of depression (Donald *et al.*, 2001; Sadler, 1991). The Australian National Health and Medical Research Council outlined three principal categories to define depression. They are: a) depressive mood, which includes sadness, unhappiness or blue feelings and has been estimated to affect two-fifths of young people; b) depressive syndrome, which is a combination of feelings such as loneliness, anxiety and worthlessness, as well as depressive mood; and c) depressive disorder which refers to standard clinical classifications - most commonly, the Diagnostic and Statistical Manual of Mental Disorders, and the International Classification of Diseases (ICD) - 10 Classification of Mental and Behavioural Disorders (National Health & Medical Research Council, 1997).

It is recognised by the author that various Western instruments are used to measure depression in an individual (Beck Depression Inventory (BDI), Hopelessness Scale (BHS), Clinical Anxiety Scale, Multiscore Depression

Inventory for adolescents and adults (MDI) to name a few). However, for the purpose of this research the primary objective has been to project the youth voice, hence the reliance upon participant perceptions.

(Nordstrom, Schalling & Asberg, 1995) agree that attempted suicide is a common clinical psychiatric dilemma, however they find that hopelessness is more closely linked with suicidal intent than the severity of depression, thus suggesting that hopelessness may be considered a causative factor in suicidal behaviours. Tuzan and colleagues (2000) also discovered in their investigation, that hopelessness accounts for just over 40 percent of cases, with just over 19 percent being diagnosed with mild depression. Tuzan and colleagues however acknowledge that there is a close relationship between depression and hopelessness.

There is no exact equivalent term for major depressive disorder in Pacific cultures, yet it may be described in the dimension of spirituality (National Health Committee, 1996; Tamasese *et al.*, 1997). In most cases, it is suggested that major depressive disorder is often the symptom of altered states of wellness in the other dimensions - especially those of family - which impact upon the mental, the physical, and cultural dimensions (National Health Committee, 1996). Issues of traditional values and beliefs versus NZ-born values and beliefs also impact upon spirituality (National Health & Medical Research Council, 1997; Bathgate & Pulotu-Endemann, 1997; Tamasese *et al.*, 1997). Signs and symptoms of depression vary between Pacific communities, therefore it cannot be assumed that what may be defined as a state of depression for one person in one culture is necessarily the same for someone in another culture (National Health Committee, 1996). Furthermore, amongst symptoms identified in depression, it is argued that the parameters of shame and guilt further complicate the clinical model (National Health Committee, 1996). Information about depression amongst Pacific peoples is believed to be "essentially non-existent" (Sullivan & Bulik, 1997). Little is known about the prevalence of depression in these populations or about the role of culture and depression (Sullivan & Bulik, 1997). This area is in need of further investigation.

REASONS TO LIVE

It seems equally important to this research that factors which buffer against suicidality for NZ-born Samoan young people are also addressed. The investigation of both contributing factors and reasons to live may provide a better understanding of why Samoan young people are harming themselves and how best this type of behaviour may be prevented. This section primarily focuses upon public health literature - particularly in relation to protective factors which may contribute to a young person's reasons to live. This section reviews the relevancy, or not, of these protective factors for NZ-born Samoan young people.

Lineham and colleagues (1983) developed The Reasons For Living Inventory which aimed at measuring a range of life-oriented beliefs potentially as reasons for not engaging in suicidal behaviours. They discovered that the importance of family and children, religious values, our beliefs in our own capabilities and the value of living, as well as fears of what others would think and about the pain involved in a suicidal act, may be crucial considerations for anyone contemplating suicidal behaviours. They suggested that in the movement towards a reduction in the incidence of suicidal behaviours, the suicidal person may benefit if taught to believe in, and give importance to the beliefs in the Reasons To Live Inventory. The question may be asked, 'could any one of these measurements as suggested by Lineham and colleagues, be of relevance for NZ-born Samoan youth?' They may very well, yet it may be potentially beneficial if Samoan or Pacific inventories of a similar nature were developed.

In light of the traditional association between suicidal behaviours and mental illness, suicide prevention largely consists of recognising and treating those with mental illnesses, such as depression, schizophrenia and anxiety disorders (to name but a few), which ultimately lead to suicidal behaviours (Rosenberg & Mercy, 2000). Maris, Berman and Silverman (2000) however claim that suicide prevention should encompass the concepts of risk reduction and resiliency. The authors go on to suggest that suicide prevention may then contribute toward reducing the prevalence of known vulnerabilities or increasing protective factors. It is claimed that most research has focused on risk factors associated

with suicidal behaviours rather than potentially protective factors like resiliency (Royal New Zealand College of General Practitioners, 1999; Willis, Coombs, Cockerhame *et al.*, 2002). By focusing on both risk and protective factors in research, it is believed that more effective intervention measures can then be designed (Willis *et al.*, 2002).

The emerging public health literature on protective factors in the lives of young people has redirected the focus from a traditional pursuit of pathology to a pathway of understanding successes, resistance and resilience (Resnick, 2000). The most common protective factors include: a strong sense of connectedness to parents, family, school, community organisations, adults other than family, the development and enrichment of academic and social competence, and involvement in extra-curricula activities which foster multiple friendship networks (Resnick *et al.*, 1997). It has been recommended that in order to help these young people improve their odds, one must:

Understand those factors that protect from harm and then build intervention to strengthen the protective factors. Clearly, in family, school, and community reside some of the secrets to success (Cummins et al., 1999:243).

Resilience may be conceptualised as a person coping better with stress than expected. It is understood that resilient individuals have developed protective mechanisms to risk factor vulnerability (Royal New Zealand College of General Practitioners, 1999). Some dispositional attributes for resilience in young people include: a 'good fit' between the young person's temperament and their environment (family, culture); having an internal locus of control - that is, having the feeling of being able to control one's own destiny; good self-esteem, self-image, self-confidence and self-efficiency; intelligence and problem solving abilities; and gender. In addition to the concept of resilience are external support systems and resources which may comprise of an available, adequate, emotional relationship with a significant other in the family. For most Maori, having *whakapapa* (genealogy) which binds them to a potentially caring *whanau* (family) and community; having an optimal level of social support via social networks (extended family and common groups); having a personal spiritual

faith; being in therapy; positive school experiences; and external interests and affiliations are considered to develop resilience (Royal New Zealand College of General Practitioners, 1999). In the same way these factors may seem appropriate for Samoan young people in Aotearoa/New Zealand.

There is the view that a better understanding of factors which protect against suicidal behaviours amongst young people is needed to identify adaptable factors and develop culturally appropriate suicide prevention and intervention strategies (Borowsky *et al.*, 2001). Within a public health framework, the most functional protective factors are those which are both responsive to intervention and likely to be useful and accessible to all young people, irrespective of being at risk or not, to buffer against self destructive behaviours (Hojat & Resnick, 1998).

A public health focus on suicide prevention means that the ultimate objective is to prevent suicides in the future and is measured by reductions in the suicide rate. Rosenberg and Mercy (2000) describe the value of the public health approach towards suicide prevention with the three underlying principles of the public health approach being: the focus on prevention; a basis in science; and an inclusive scope. The authors argue that a public health approach to suicide prevention takes an 'activist' stance, that suicide prevention works within a "cause and effect world" (p.277), and that:

*if we can understand the causes, we can then affect the outcomes.
As a result, if we understand the causes of suicide, we can prevent suicides in the future (p. 277).*

Secondly, the scientific approach comprises four layers - What is the problem? Who are the people involved? What methods are used? And finally, when and where does it happen? Epidemiological data is often used to address these questions. Rosenberg and Mercy describe how one takes what is learned about patterns of the problem and the causes and then generates and critically evaluates interventions. A public health approach to suicide prevention as outlined by the authors focuses on the implementation of prevention programmes. It explores how this is achieved in terms of the organisation of resources at local, state, national, regional and global levels to put interventions

in place and maintain them over time. This step requires the knowledge of being able to mobilise the 'political will' to communicate scientific information about suicide prevention and to amalgamate a wide array of suicide prevention and support services multi-sectorally (Rosenberg & Mercy, 2000). For instance, an effective approach to suicide prevention requires the collaboration of individuals in public health, mental health, medicine, education and social services in both the public and private sectors (Rosenberg & Mercy, 2000).

Unlike the clinical paradigm which rests primarily on a mental illness model and most often involves tertiary prevention, the prevention paradigm is founded on a public health model and primary prevention (Rosenberg & Mercy, 2000). There is the view that risk factors for suicidal behaviours have no universal authority (De Leo, 2002). Therefore, suicide-prevention strategies need to be tailored to the local culture and cannot be simply exported or reproduced from one country to the next (De Leo, 2002). In other words, suicide prevention strategies cannot merely be carbon copied to different cultures - even within the same country. It is considered that suicide prevention and interventions are more likely to be successful if they are conducted at a community level, on the initiative of the members of that community, and enable full ownership (Clarke, Frankish & Green, 1997).

A lack of knowledge around suicidal behaviours and access to (and the utilisation of) existing services/resources are major barriers for young people in general (Coggan, Patterson *et al.*, 1997). It was suggested that health promotion awareness campaigns should provide information where young people could access help (Coggan, Patterson *et al.*, 1997). This area, and the focus of this section, are in need of further investigation in terms of what would be most appropriate and useful for Samoan young people in Aotearoa/New Zealand.

One response is the '*Ola Mautinoa*' Project, which is a community-based Pacific youth suicide prevention initiative - operating within South Auckland's Papakura community, which has a high representation of Pacific peoples. Through the *Ola Mautinoa* experience four major contributing risk factors for suicidal behaviours have been identified. They are:

1. Powerlessness:
low expectations of controlling Pacific young people's lives and achieving goals;
2. Meaningless:
lack of connection between past and present;
3. Confusion with the connection between culture/society and educational futures;
4. Normlessness:
perceived conflict norms between parental expectation and society/social pressure;
5. Social estrangement:
separation or refusals to integrate into peer networks.

The *Ola Mautinoa* suicide prevention outcomes towards resilience development include: improved ability to connect; life coping and problem solving skills; the ability to learn from mistakes; 'intelligence'; hobbies/creative interest/talents; increased ability to access resources and key Pacific peoples; capacity for empathy and self-monitoring; a sense of personal efficacy; increased cultural and spiritual beliefs; ability to appraise a given situation or environment; a sense of purpose of mission in life; and a greater knowledge base of the Pacific profile. The project's approach is illustrated in figure 2 (see appendix). It is also suggested that another aspect of developing resilience is that of 'building heart'. Heart creates a goal to live for and helps develop the conviction of one's right to survive (Bell, 2001). Building heart is considered a preventative public health strategy designed to inoculate against the potentially negative effects of stress and trauma (Bell, 2001).

Borowsky (1999) contends that in relation to suicidal risk, focusing on protective factors such as parent-family connectedness and emotional wellbeing is just as important, or more effective, than decreasing risk factors.

Jobes and Mann (1999) contend that life-oriented beliefs and expectations may alleviate and prevent suicidal behaviours. Life-oriented considerations in relation to suicidal behaviours are referred to as the 'reasons for living' approach. Jobes and Mann conclude that strong family influences and a future

outlook including plans and goals are reasons why their sample of suicidal outpatients choose to stay alive.

Research conducted by Bennett (2002) identifies techniques which may be helpful for young people. Techniques include: active help-seeking from professionals and peers; practical problem solving abilities; thinking positively; and rediscovering reasons to live. Bennett (2002) finds that many of the study participants emphasise that 'thinking positively' about their lives and concerns is a useful element of problem solving. In addition, the study also finds that positive thinking functions as an effective hindrance to future suicidal behaviours amongst youth.

Problem solving involves the recognition and admission that a problem exists; being able to communicate this to appropriate others; the generation of alternative solutions other than suicide; the implementation of a solution; and assessing the outcome (Morgan, Coleman, Farrar *et al.*, 1994). Williams (2001) argues that what has proved most helpful is to allow the person to see their moods as normal, rather than as evidence of their inherent deficiency as a person. Additionally the author recommends that by encouraging the person one should not ask, 'How can I make everything different?' but rather, 'How can I take care of myself right now?' In short, Williams adds, the person is encouraged to be gentle with themselves.

In conclusion, it is argued that shame, guilt and the stigmatisation traditionally associated with suicidal behaviours prevents extensive study of the subject, which is often deemed taboo within some communities (Haynes, 1997; Lester, 1988). However, exploring the nature of this taboo amongst Samoan young people in Aotearoa/New Zealand may provide some understanding surrounding the nature of attempted suicide. Additionally, exploring reasons to live may divert attention away from the stigma attached to suicidal behaviour and promote appropriate channels towards health and wellbeing for Samoan young people. Both contributing factors and reasons to live are equally important where the former identifies the problem and where the latter can identify points for intervention with the overall aim of improving life choices for Samoan young people.

CHAPTER THREE: METHODOLOGY

INTRODUCTION

This chapter describes the methods undertaken in this research by providing an overview of the research objectives, the research design, processes of data collection and the analyses. Initially this chapter reiterates the research objectives previously outlined in Chapter One. It then discusses the research design, and emphasises that a traditional Western scientific approach in the exploration of youth suicidal behaviours is not necessarily the only means by which an investigation of suicidal behaviours amongst Samoan young people may be conducted. Thirdly, this chapter provides an overview of the research methodologies adopted for both phases of the study. Phase one includes a description of the procedures of data collection and data coding. This is followed by a description of the methods employed for phase two's in-depth interviews with young people who have attempted suicide as well as presenting their profiles. This chapter then discusses the analyses used for both phases. The chapter concludes with a description of the researcher's role, presents the study timeline and provides a personal perspective.

RESEARCH OBJECTIVES

As previously outlined in Chapter One, the primary objective of this research is to investigate the perceptions of Samoan young people following a suicide attempt, as well as their reasons to live. In order to achieve this, three fundamental questions need to be addressed:

1. How many Samoan young people present during a 12-month period to EDs as a result of a suicide attempt, and what are the characteristics of this population?
2. What issues contribute to suicide attempts amongst NZ-born Samoan young people in Aotearoa/New Zealand?
3. What are some of the reasons young NZ-born Samoan people who have attempted suicide believe would enhance their options to choose life and

thus contribute towards their overall future wellbeing, be it physical, mental, spiritual, or emotional?

In an attempt to answer these questions, this research was designed to:

- ❖ account for the number of Samoan young people, during a 12-month period, treated at Auckland regional public hospital EDs as a result of a suicide attempt and to describe this population;
- ❖ explore young NZ-born Samoan suicide attempters' perceptions of the event and the contributing factors;
- ❖ identify and describe NZ-born Samoan suicide attempters' reasons to live with the expectation that it may provide information for Samoan young people to choose healthier lifestyles; and
- ❖ provide information which may help in the planning of prevention strategies for agencies, and community organisations dealing with NZ-born Samoan youth affairs in Aotearoa/New Zealand.

It is envisaged that addressing such key areas may contribute towards the planning of Samoan, and possibly Pacific, youth suicide prevention strategies which are most relevant and appropriate for these communities.

RESEARCH DESIGN

There are two phases to this research. The first phase includes a medical record review for the purpose of collecting routine data on the number and characteristics of Samoan young people presenting to Auckland EDs as a result of a suicide attempt during a 12-month period. The second phase involves in-depth, face-to-face interviews with NZ-born Samoan young people who have attempted suicide to provide a qualitative and sociocultural approach to an investigation of contributing factors to suicidal behaviours and to explore reasons to live. A quantitative description and qualitative approach was used in this thesis.

It has been argued that multiple methods of research is a practice which needs to become more commonplace (Samiee & Anthanassiou, 1998). Both conceptually and methodologically, research based on multiple methods leads to more meaningful results than that which is dependent on a single method (Samiee & Anthanassiou, 1998). A multi-method approach is believed to be advantageous, as quantitative data provides a skeletal framework for understanding social phenomena, and qualitative data is the substance for understanding the inner-workings of human systems, so together they provide an holistic impression of reality (McGregor, Minerbi & Matsuoka, 1998). Furthermore, as (Pope & Mays, 1995) suggest, for research to be most effective, the relationship between qualitative and quantitative methods should be characterised as complementary rather than exclusive. The descriptive quantitative component of this study is complemented by the qualitative investigation of the experiences and understandings of NZ-born Samoan young people in relation to their suicidal behaviours. This qualitative strand is based on the premise that:

Statistical data should be combined with more finely grained analyses of culturally specific research to provide deeper insights into and cultural interpretations of the situation. Only then will problems be more realistically understood and appropriate solutions identified and implemented (Aae, 2001:117).

Towards a Samoan Methodological Research Approach

Range and Leach's (1998) writings in the field of feminist research and suicidal behaviours contends, that with regard to suicide research literature, it:

Is replete with studies using traditional scientific methods to the exclusion of alternative methods (Range & Leach, 1998:25).

Range and Leach agree that, from a traditional research point of view, scientific approaches are robust because of their experimental, laboratory-based and rigorous design. However, the authors argue that the underlying assumptions of the scientific approach include reductionism (omitting context), objectivism

(viewing data from a purely “rational” (p. 26) perspective, and linearity (expecting a direct cause-and effect relationship). They suggest that there are a number of concerns regarding the scientific research process. For instance, they argue that contributors are often treated as objects rather than as participants; experimenters often distance themselves from participants, presenting themselves as objective experts rather than probing collaborators; and that the laboratory design ignores context and presents a situation unlike the typical life experiences of participants. So, the question may be asked - what is an appropriate research process for the Samoan community in the investigation of young people’s suicidal behaviours? This thesis is an attempt to address this question.

It is argued that attempts to understand realities of non-Western communities - with the intention of providing appropriate frameworks - is often seen as a self-defeating exercise (Tamasese *et al.*, 1997). This is believed to be the result of prevailing Western scientific thought which has often undervalued the culture of minority or non-Western cultures as a premise for theoretical development (Tamasese *et al.*, 1997).

A Samoan methodological research approach may best be described in relation to Schreiber (2000) who looks at the application of Afrocentric epistemology and methodology in intercultural research. Schreiber uses the imagery of a mountain summit where, upon reaching the summit, one is then able to see the entire world with clarity. However, standing at the top of the mountain gives only a partial view of the surrounding mountains and only a glimpse of mountain peaks farther away. This metaphor, Schreiber argues, is representative of the Afrocentric perspective which suggests that:

We cannot develop a deep, multifaceted understanding of culture by standing at the top of a distant mountain. Cultural knowledge originates from a culture’s center, or worldview (Schreiber, 2000:652).

Afrocentrism therefore, focuses on African ideals, values and history and posits that these must be the center of any analysis of African American or Africans. Afrocentricity, in fact, challenges the status quo. The point here is not to detail the controversy surrounding this approach, but rather to illustrate that some of

its facets may be relevant towards the development of a contemporary Samoan methodological approach in the investigation of youth suicidal behaviours.

Tupuola's (1993a) statement in the following extract appears to be an appropriate starting point. Tupuola asserts that Samoan research must be embedded within a culturally appropriate framework:

Research frameworks on Samoan people must prioritise their 'holistic' perception of knowledge and scholarship, oral communication style and protocol of consensus and respect. For too long we have had to express our thoughts within a Palagi [European or Western] framework. The time has come for Samoan research to be processed and written within a Samoan context (Tupuola, 1993a:179-180).

Finau (1995) also makes a compelling and similar statement - one which underpins the debate that research should be conducted by Pacific peoples, for Pacific peoples. In this current research this may be translated as, 'by Samoans, for Samoans'. Finau argues that Pacific people's perceptions of themselves has often been predetermined by dominant ideas. He concludes that if Pacific peoples are to be self-determining then they must be the "custodians of knowledge and information about themselves" (Finau, 1995:16). Furthermore it is maintained that more documentation and appreciation of knowledge associated with Pacific cultures and settings, as well as the acceptance of alternative research methodologies as legitimate areas for inclusion, is needed in the world of academia (Thaman, 2002).

Therefore, in light of these perspectives, it appears that for the Samoan community, a Western scientific approach may be considered problematic. Tamasese and colleagues (1997) maintain that whilst theories are the constructions of unique worldviews, the theoretical framework - if it is to be dedicated to the context of its participants' contributions - must have as its foundation, a method that is reflective of the cultural values and meanings of its research community (Tamasese *et al.*, 1997). It appears therefore, that a Western scientific approach does not cater to this. This research attempts to emphasise NZ-born Samoan young peoples' lived experiences and is thus developed within a Samoan cultural youth context.

It is argued that future research on suicidal behaviours should enable the population to drive the questions, for example, asking interviewees in open-ended format how their experiences have either been intensified or diminished (Range & Leach, 1998). It is suggested that allowing people to share their own insights, rather than merely responding to someone else's questions, enables more participation in the research and enables the possibility for changes in the goals and the design from what the researcher initially intended (Range & Leach, 1998). Therefore it is important to the current research process that the relationship between the researcher and the participant be fairly open and flexible.

Additionally, this research deliberately moves toward the development of a contemporary Samoan research methodology. The core of this contemporary Samoan research methodological approach is that it challenges the traditional Samoan gerontocratic structure and is the antithesis of a 'top-down' approach by promoting the NZ-born Samoan youth focus. It is essential that the Samoan cultural context, as perceived by NZ-born Samoan young people, needs to be explored because as Tamasese and colleagues (1997) argue, it "faithfully interprets" (p. 9) their realities, where value must be given to the individuals, their communities of people, and their respective protocols and etiquette. In other words, this facilitates the emergence of their traditions and culture, their language, and the historical and genealogical dimensions that Samoan youth originated from and in and through which they now exist (Tamasese *et al.*, 1997). This contemporary Samoan research methodology is supported not only by the focus on Samoan young suicide attempters' perspectives, but also the youth cultural mentor group's involvement in guiding the research process. This process has also been strengthened by the support of an adult cultural mentoring group, exemplifying the Samoan - and, in most cases, Pacific - appreciation of communalism and also characterising the importance of the extended family or *aiga potopoto* to inform this contemporary research approach.

Cultural Mentor Methodological Issues and Recommendations

In order to maintain a Samoan framework of research to assist with the research design, youth and adult cultural mentor groups were established to guide and ensure that research processes were relevant for Samoan young people and, possibly, Pacific communities in Aotearoa/New Zealand. This approach is supported by (Mara, 1999) who states that:

The contributions of an advisory committee, a critical colleague or colleagues and cultural mentors cannot be underestimated, particularly in the development and implementation of methodology (n.p).

Members of the youth cultural mentor group were identified through personal community networks. The criteria for selection was that: they were to be of Samoan or Pacific origin; aged between 16-25 years; and agreed to be committed for the entire duration of the research. Adult cultural mentor group members were also identified through community networks. The preferred criteria for inclusion was based on work-related experiences with NZ-born Samoan young people; familiarity with non-Western research methodologies; and expertise in youth health issues. This adult cultural mentoring group consisted of Pacific health researchers, a Reverend, church youth leaders, youth health professionals, medical doctors, social workers, a youth aid police officer, and injury consultants. This group contributed valuable knowledge, expertise and skill to guide and shape this research by advising on the most appropriate methods and processes. Both cultural mentor groups were involved throughout the entire duration of the research.

At the outset of this research, adult cultural mentors were most concerned with safety issues for the participants and the interviewer. To ensure ethical integrity and safety for participants, cultural mentors suggested a Samoan mental health professional, who had worked with suicidal young people in a professional capacity, be available for the participants immediately following an interview. Furthermore, it was recommended that male participants be offered the opportunity to have a male interviewer conduct the interviews.

Given the sensitive nature of this research, care was taken: i) to ensure

confidentiality was preserved and that all information accessed was stored securely; ii) that interviews were only conducted after full training for the male interviewer had been provided; iii) that debriefing sessions for each interview were held between the interviewer and a mental health professional, and on a separate occasion, with the primary supervisor and/or other advisers; and iv) provided participant consent was given, primary caregivers of each of the participants to be interviewed were informed of their patient's involvement in this research.

There was further concern by youth and adult cultural mentors for the interviewer's personal safety. It was suggested that if the participants attempted to harm themselves during the interview it was the interviewer's obligation to be suitably prepared. Therefore, the interviewer was to notify senior staff at the Injury Prevention Research Center (IPRC) of the time and location of each interview. The interviewer was required to carry a cell phone into each session in case of an emergency and was also expected to give notification at the end of each session.

THE RESEARCH PROCESS

Ethical Approval

Health Funding Authority Ethics approval was obtained for this research (reference number 99/165). In addition, management approval to conduct this research at the participating hospitals was also obtained.

Consent to participate was obtained both verbally and in written form (see appendix). The research was explained three times to the participant: i) following initial approach by ED staff or a member of the Psychiatric Liaison team; ii) by the researcher when first contact by phone was established; and iii) face-to-face before beginning the interview. If required, an interpreter was made available for those participants who wished to conduct the interview in the Samoan language.

Reflections of the Pilot Phase

The format for the question zones of interest to be used in the interviews was developed by the researcher, reviewed by supervisors and distributed amongst adult and youth cultural mentors. After general discussion, all agreed that the suggested format was appropriate.

Adult cultural mentors recommended that three meetings (an introductory session and two interviews) be scheduled with potential participants to allow for rapport to be established between the interviewer and interviewee. It was suggested that a 'one-off' interview would be inappropriate for the participant. However, during the pilot phase, all participants were reluctant to meet for three sessions and preferred the one-off interview. Primary reasons were lack of time and a need to move on with their lives as quickly as possible.

The youth and adult cultural mentor groups and the researcher recognised that the inclusion of a male interviewer was crucial to the interviewing process. In maintaining cultural and ethical obligations all male participants were given the option of having a male researcher conduct the interview. However, all male participants during the pilot phase declined the opportunity of being interviewed by a male interviewer and willingly agreed to be interviewed by the NZ-born Samoan female researcher (the candidate).

It seemed appropriate for the researcher to include Samoan mental health professionals in debriefing sessions immediately after each interview to ensure an ethically safe environment was guaranteed for participants as recommended by the adult cultural mentor group (see under section 'Cultural Mentor Recommendations and Methodological Issues'). A group of Pacific mental health workers agreed to offer their services which allowed for flexibility between the researcher and mental health professionals, being mindful of course, that the interview time and location with the participants would not be confirmed until the availability of a mental health professional was ensured. The adult cultural mentor group suggested that mental health professionals should also be present in the interview. This was tested on two occasions and proved to be a distraction in the interviewing process. For example, both participants would often look to the health professionals throughout the duration of the

interview for the 'right' answers and as such seemed to withhold information. In both sessions there were periods when mental health professionals left the room and during this time, participants became more vocal and appeared a lot more relaxed.

Initially this research endeavoured to recruit two sample groups: Samoan young people who presented to EDs as a result of an attempted suicide; and Samoan young people who had engaged in suicidal behaviours but did not seek ED treatment. However, there were major concerns raised by cultural mentors, funding assessors and reviewers, and the Ethics Committee in relation to the recruitment of a community sample. It was considered that the community sample would be recruited using the snowballing technique via the researcher's personal community networks. Yet, the general consensus amongst cultural mentor groups, on the grounds of ethical and safety concerns for the participants, was that this was inappropriate and that the community sample should be discarded.

There was also lively debate between adult cultural mentors and the researcher as to whether the research should encompass all Samoan young people (both NZ-born and those born in Samoa). It was emphasised by the researcher that the research sought to emphasise the voices of NZ-born, particularly on the grounds that six in 10 people of Pacific ethnicity were born in Aotearoa/New Zealand (Statistics New Zealand, 2001). However, it was the collective view that all Samoan young people be included in the sample. Therefore, to compromise, the research sought to include both those Samoan young people born and raised in Aotearoa/New Zealand, and those who were born in Samoa but spent the majority of their educational lives in Aotearoa/New Zealand.

It was a further requirement of the Ethics Committee that an ED or other hospital staff member make initial contact with the potential participants to obtain written consent for the researcher to contact them. Once consent had been obtained the researcher would then be permitted to phone the potential participant for a brief introduction and to establish a time and location to further introduce the study and obtain written consent to be interviewed. Contrary to this proposed process, both the youth and adult cultural mentors objected to

this process of obtaining written consent from participants. It was believed that this was not the Pacific or Samoan way and was regarded to be inappropriate on the premise that most Pacific peoples prefer to give verbal consent and therefore should not have to accommodate *Papalagi* (European or Western) protocols of “signing bits of paper” (Adult Cultural Mentor Group, 1999). Nonetheless the research was constrained by ethical research guidelines, which required written consent of potential interviewees.

During the pilot phase, the exclusion of participants from EDs who either absconded or were not approached about the study proved to be problematic. For instance, due to the high staff turnover in an ED setting, not all staff were informed of the study. In addition, due to the high workload in the ED setting itself, recruitment may have been inappropriate at the time. To counter this, the researcher liaised with Central, North-West and South Auckland Pacific mental health services, all of which were sub-establishments of Middlemore, Auckland and North Shore public hospitals. Mental health professionals within these units approached potential participants who had presented to an ED and were referred to their service for an interview. If the participant agreed, the health professional would then inform the researcher that contact was permitted.

Selection of Participants

Estimates of the number of participants for recruitment were based on recent New Zealand Health Information Service (2002b) hospitalisation data which indicates that between the years 1996-99, there were 195 hospitalisations for suicide attempts across all age groups, of which 44 percent of suicide attempts were in the 15-24 years age group (New Zealand Health Information Service, 2002b). Therefore, all Samoan young people presenting to EDs following a suicide attempt were invited to participate in the research from the 12-month recruitment period (refer also to section ‘The Participants’). Potential participants for interview were identified from the sample of all those who met the following criteria: had received treatment at EDs - either Auckland, Middlemore or North Shore public hospitals - as a result of attempted suicide during the study period; were diagnosed by ED staff as presenting with an

overdose, self-inflicted lacerations or self-inflicted injury by other means; identified themselves to be of Samoan origin; were aged between 16-25 years; resided in the Auckland region; and gave their consent to participate in the research.

DATA COLLECTION

Medical Record Review (Phase One)

Two research nurse assistants were employed to undertake record reviews at Auckland, Middlemore and North Shore public hospital EDs for phase one of the research. They were responsible for reviewing the day registers one day per week for the 12-month data collection in the period 1 January 2000 to 31 December 2000 inclusive. They were also required to keep in close contact with ED staff and Psychiatric Liaison teams at the participating hospitals to identify potential participants. The study population included all Samoan young people (16-25 years) who were treated at Auckland, North Shore and Middlemore public hospital EDs during that period. The study population was identified following review of all ED and Psychiatric Liaison databases, and (where available) self-harm registers at the participating hospitals. The databases were initially searched for key words, (e.g., “drug overdose”, “lacerations”) indicating self-harming behaviours. All identified medical records were reviewed for injuries classified within International Classification of Diseases (ICD) codes E950.0 to E959.9 for attempted suicide. All records were also reviewed to identify those whom Psychiatric Liaison teams considered had suicidal intent at the time of their presentation for self-harming behaviours. Only patients who were alive on presentation to the ED were included in the study. Furthermore, classification of ethnicity was by self-identification.

An ED medical record data collection form (see appendix) was used to gather information on: age; gender; ethnicity; occupation; housing situation; admission data; primary diagnosis for current visit; previous ED visits for injuries, and medical or psychiatric conditions; circumstances and description of the event; preceding factors as described by the Samoan young person; involvement of alcohol and other drugs as indicated by clinical notes in the medical records; and discharge

data.

Data Coding

Each identified case was assigned a study number. Against this study number variables were entered onto EPI-INFO, determining the total number of cases who were treated following a suicide attempt during the review period. The number of previous admissions to an ED for psychiatric conditions, injury, or other medical conditions were summed to create a new variable for use in analyses. Due to small numbers in some categories of the method used, the 'method' variable was regrouped into three categories 'drug overdose', 'cutting and piercing', and 'hanging'. As age was not normally distributed, this variable was re-coded into two groups: 16-19 years and 20-25 years. Following multiple readings of the medical records, there were four common themes to emerge from Samoan young people's descriptions of events preceding their suicide attempt. These were grouped into four thematic categories: 'mental health problems', 'family conflicts', 'conflicts with partner (which also included relationship break-ups)', and 'other' (including multiple causes, bereavement, and other stressors including bullying).

In-depth Face-to-face Interviews (Phase Two)

As mentioned earlier, the initial approach to potential participants for interviewing was made either by ED staff or a member of the Psychiatric Liaison team, depending on the availability of personnel at the time of the young person's presentation. Staff were required to present the eligible participant with an information pamphlet (see appendix) seeking the individual's consent to be contacted by the researcher. When consent had been obtained, the researcher was then permitted to contact the person, explain the study aims, discuss a time and location for the interview and to seek full written consent for participation in the research. The procedure for identifying potential participants was piloted and was in accordance with Health Funding Authority ethical guidelines (see earlier description under 'Ethical and Safety Considerations').

Face-to-face in-depth interviews were conducted at a time and location convenient to the participant. Participants were given the option of either having the interview scribed by the interviewer or writing down their responses themselves to avoid any discomfort with being audio taped.

Interviews ranged from 90-120 minutes in duration. During this time, as part of the interview, research aims were explained, their role as a participant was clarified, and time was allowed for questions concerning the research to be raised. The interviews explored issues (see appendix for Question Zones of Interest), around *aiga*, relationships, perceptions of attempted suicide, reasons to live and coping strategies. All interviews were transcribed.

The Participants

Of the 27 potential participants approached by hospital staff during the 12-month recruitment period, 20 completed interviews with the researcher were conducted. Four refused, two were considered by mental health professionals as being unable to give informed consent due to their current mental health status, and one was unable to be contacted as they had been dispatched 'home to Samoa'. The background profiles for study participants were uplifted from notes recorded in their medical records and, in some instances, included some additional information which emerged from the interviews. Using pseudonyms a description of the participants follows:

Michael is a 22 year old Samoan male. He is a reformed alcoholic and compulsive gambler. He was born in Aotearoa/New Zealand and is now a chef by profession. He comes from a family of 12 and is in the middle order of siblings. His older siblings were born in Samoa and the whole family came to Aotearoa/New Zealand for a 'better' education. He is now considered the eldest sibling in his *aiga* as all the older ones have left home. He presented to an ED as a result of a laceration to his wrist. He was interviewed two months after seeking ED medical attention following a suicide attempt and six months after ending a longstanding relationship with his non-Samoan partner. He is deeply committed to his *aiga* and much of his time and financial support is devoted to

duty and obligation, or in Samoans terms, *osi aiga* (family support) (see Chapter Two). Michael's parents rely a great deal upon his financial contribution towards settling arrears in bill payments, the church and being the son of a *matai*, contributing to *fa'alavelave* (special occasions like weddings, funerals, birthdays etc).

Thomas is a 19 year old male of both Samoan and Jewish heritage. He was born in Aotearoa/New Zealand. He is a student living with his family and is the eldest of his siblings. He had attempted to hang himself. He had started drinking alcohol at the age of 14 years, was attending anger management courses and has been under a probation officer for stealing cars and fighting. His father has gang affiliations. He took care of his father and felt he had missed out on his own childhood and now feels 'emotionally immature'.

Fatu is 20 years of age, lives with family and has two jobs. He presented to an ED as a result of an overdose of painkillers. He had an argument with his mother and older brother and felt "stressed out". He is working towards a Bachelor of Arts degree. Very few in his *aiga* have reached higher educational levels. He is also a provincial representative rugby player. He was born in Aotearoa/New Zealand.

Solomona is of Samoan and Hawai'ian heritage, employed full-time, was born in Aotearoa/New Zealand and is 20 years of age. He lives with family and is the eldest male of six children. He had broken up with his girlfriend a week prior to his suicide attempt and cut his wrists as a consequence.

Joe is a 19 year old male of Samoan and Tongan descent. Joe was born in Aotearoa/New Zealand. He lives with family and is the eldest sibling. He had presented to an ED with lacerations to his wrist. He was angry at the time and "wanted to end it all". This was his second attempt.

Timo is a 22 year old male, employed full-time and lives with his parents, older brother, his brother's wife, and his two younger siblings. He was born in Samoa and had come to Aotearoa/New Zealand at 10 years of age. He described his parents' as having high and unrealistic academic expectations particularly during his senior secondary schooling. He was an above average student. He

presented to an ED as a result of an overdose of analgesics. He had been in a 10-month relationship with his girlfriend. His girlfriend ended their relationship two days prior to his suicide attempt. He threatened his girlfriend many times that if she ended their relationship he would commit suicide. He had also informed his work colleagues that he wanted desperately to reconcile with his girlfriend and made them aware of his plans to end his life. In addition, his parents were constantly lecturing him and asking him to contribute financially towards the family, which he felt was an added “burden”.

Zarnia is 21 years of age and lives at home. She was born in Aotearoa/New Zealand. She had attended a party with her boyfriend who had left her and went home. She later went home and stabbed herself in the abdomen in front of her mother.

Aniva is 21 years of age, is employed full-time and lives with her female partner and partner’s mother. Aniva was born in Aotearoa/New Zealand. She presented to the ED with lacerations. She was at home with her partner and felt despondent and angry about their relationship. Her partner then phoned the ambulance.

Satia is employed and is 17 years of age and was born in Aotearoa/New Zealand. She has two brothers, one older and one younger. She lives with family and is of Samoan and Tongan heritage. She lacerated her wrists after a family dispute and wanted “to end it all”. Her suicide attempt was related to high family expectations. She had made two previous suicide attempts. She considers herself to be in a serious relationship.

Pologa was born in Aotearoa/New Zealand, is unemployed, is 19 years of age and lives with friends. She had used a razor to cut her wrists after a dispute with her boyfriend of five months. Her lacerations to both wrists were to show her boyfriend how angry she was. She is of Samoan and Niuean heritage. Throughout her childhood and youth she suffered physical and sexual abuse by members of her family.

Kim was born in Aotearoa/New Zealand, is 22 years of age, and is unemployed. She lives with family and ingested analgesics as a consequence

of unresolved grief for her mother who had died a few months prior to her suicide attempt. She felt “distressed” that night.

Ana lives with friends and is 24 years of age. She too was born in Aotearoa/New Zealand. She attempted to hang herself with a *lavalava* (wrap-around attire) in her hotel room. The night before her suicide attempt she had a fight with her boyfriend and he had punched her.

Saeni is a student who was born in Aotearoa/New Zealand. She lives with her boyfriend and their two-and-half-year old daughter and is 22 years of age. She had ingested analgesics as a result of being depressed that morning.

Nofoa lives with family and is 19 years of age. Nofoa was born in Aotearoa/New Zealand. After an argument with her parents concerning her boyfriend she ran to a cemetery followed later by her friends and cut both her wrists as well as ingesting analgesics. Her family believes she has brought shame to the family. She has had school counselling and two years ago had overdosed three times.

Talia is 22 years of age and lives with friends. She is the second eldest of five siblings. She was born in Aotearoa/New Zealand. Talia was diagnosed with depression and is seeing a psychiatrist. Prior to her suicide attempt, her family had lost their home four years earlier and her boyfriend had committed suicide two years prior. She presented to an ED with lacerations to both her wrists and forearms.

Louise is a hairstylist by trade and is 22 years of age and lives with family. She is the middle child of five and was born in Aotearoa/New Zealand. She had ingested a poisonous substance, as she felt afraid of what her parents would think of her if they were to find out about her first sexual encounter with her boyfriend. Her boyfriend had been seeing another girl and had made her pregnant. Louise desires to run away with her boyfriend but finds that she is unable to do so because of her strict parents. Her parents oppose her relationship.

Sesilia is on the sickness benefit, was born in Aotearoa/New Zealand, is 22 years of age and lives with family. She was upset with her mother and was unable to cope with problems at home so took an overdose of analgesics. She

is of Samoan and Cook Island descent, is the eldest sibling and has three children of her own, all under the age of five years.

Otila is employed, 22 years of age and is of Samoan and Tokelaun descent. She was born in Aotearoa/New Zealand. She felt lonely and depressed and called a crisis line. It proved unhelpful so she slashed her wrists and took an overdose.

Samuelu is employed and is 23 years of age. Samuelu was also born in Aotearoa/New Zealand. He had an argument with his girlfriend, drank copious amounts of alcohol and then lacerated his wrists. His family had refused psychiatric referrals to help with his follow-up. He was incarcerated for aggravated robbery, two years prior to this interview. His co-offender, a close friend, hanged himself shortly after being apprehended. He is currently unemployed and he and his partner have a child together. His suicidal behaviour occurred immediately after a disagreement with his partner. Samuelu resides with his father as a result of parental separation. His mother and siblings live overseas.

Loleta is a 17 year old secondary school student of Samoan and Papua New Guinean descent. Loleta was born in Aotearoa/New Zealand. She had cut her wrists as a result of school bullying.

ANALYSIS

The Medical Record Review

For phase one of this research, data analyses of medical record reviews were analysed in SAS (version 8.1). Chi-squared analyses were used to examine univariate associations between variables, and non-parametric methods were used to analyse length of hospital stay.

The Interviews

Narrative analysis was selected for interpretations of phase two's in-depth interview data. Narrative analysis has been described as understanding human motivations, perceptions, and behaviours by interpreting the stories people tell of themselves and their experiences (Riessman, 1993). It allows for the systematic study of personal experience and meaning and how events have been constructed by active participants (Riessman, 1993). Narrative analysis in this research allows for participants to present their life stories, highlighting the multiple truths and beliefs they hold about attempted suicide and the circumstances surrounding their experiences. (Clandinin & Connelly, 2000) consider human experience a key concept and argue that it is narrative analysis that best epitomises this. For example Clandinin and Connelly state:

For us, narrative is the best way of representing and understanding experience. Experience is what we study, and we study it narratively because narrative thinking is a form of experience and a key way of writing and thinking about it (p. 18).

It is also claimed that a narrative analysis approach provides access to the intricate ways in which elements of culture are woven into the explanation of individual experience. In other words narrative provides for the opportunity to view the cultural worlds of others (Hanninen & Kosiki-Jannes, 1999). It is also suggested that, as with other narrative research, the detailing of participants' experiences enables a critical reflection of the cultural and social contexts and functions of the constructed narratives (Mishler, 1995).

Mischler (1995) suggests that there is no single method of narrative analysis, but a variety of approaches to texts that take narrative form. For instance, Anae and colleagues (2000) use focused life stories in their study which investigates the roles and responsibilities of Samoan men in reproduction. The investigators consider this approach to be appropriate for a sensitive topic like sexual reproduction as it encourages:

A reflective, narrative style where the research participant sets the pace, and the interviewer listens, clarifies, probes and eventually brings up any topics which need to be covered in the interview that have not arisen spontaneously in the course of conversation (Anae, Fuamatu, Lima et al., 2000:8).

Similarly, as is the case in the current research, the narrative approach used by Anae and co-investigators is not so much an attempt to explore all aspects of a person's life. Rather, it is an effort to place an emphasis upon a focal point (Samoan male reproduction) by which other aspects are seen as valuable context within which the focal point is to be understood.

Tamasese, Peteru and Waldergrave's (1997) qualitative investigation into Samoan perspectives on mental health and culturally appropriate services, contends that methodological frames should be more sensitive to their participants' cultures without compromising the inherent beliefs and values that sustain those communities. This also follows on from Hawton's (1986) argument where suicide attempters themselves are considered the most relevant source of information, as it is their experiences that are most vital. Thus, as Hawton suggests, in the current research, richness of information can only come from 'the source' not only by documenting young Samoans' struggles, but equally providing information, which they feel, may promote the message of life. These views indicate that the narrative approach is an appropriate analytic tool. It has the potential to delve into the worlds of young NZ-born Samoans in relation to their suicidal behaviours, thus developing information previously unknown.

Following verbatim transcribing of all interviews, multiple readings of the participants' narratives will allow for the emergence of multiple levels of analysis, thereby allowing an exploration of the many voices and levels of influence embedded within the narrative. This type of analysis can shed light on aspects of the participants' worldview that may be currently unknown or misunderstood (Riessman, 1993).

Analysis of the in-depth interviews involves close and repeated readings of verbatim transcripts by the researcher to become more familiarised with the

content. This is in order to develop an understanding of the common ‘themes’ and to be guided by the specific aims of the research, remaining mindful that:

Close and repeated listenings, coupled with methodic transcribing, often leads to insights that in turn, shape how we choose to represent an interview narrative in our text (Riessman, 1993:60).

Moreover, while the features of a participant’s narrative account have been chosen by the researcher, as Riessman (1993) claims, linking them to the evolving research question and the theoretical/epistemological positions of the researcher, this - more often than not - also reflects the researcher’s personal biography.

A qualitative software package (Nvivo) was used to assist in the management and synthesis of these common themes. Finally, participants were given pseudonyms.

THE RESEARCHER’S ROLE

The researcher had primary responsibility for all aspects of the study. It included designing, developing and piloting the study methodology, in-depth interviewing, and editing and analyses of the data. A study timeline is presented below detailing the researcher’s activities:

Study Timeline

Establishment of Cultural Mentor Groups	April 1999
Mental health professionals confirmed	May 1999
Ethical approval obtained	August 1999
Nurse researchers confirmed	August 1999
Hospital management approval given	September 1999
Liaison with hospital Psychiatric teams	September 1999
Liaison with hospital cultural units	September 1999

Liaison with Emergency Department directors	September 1999
Obtaining access to hospital self-harm databases	September 1999
Data collection form developed	October 1999
Liaison with Pacific community mental health services	October 1999
Pacific representative for Suicide Prevention Information New Zealand (SPINZ) reference group	1999-current
Data collection form pilot tested and revised	Nov-Dec 1999
Participant recruitment and pilot interviews	December 1999
Data collection commenced	January 2000
Funding confirmed	May 2000
Data collection completed	December 2000
Participant recruitment and interviews	Jan-Dec 2000
Analysis of record review data	2001
Preliminary analysis of interview data	2001
Ministry of Health Pacific representative for development of Youth Suicide Toolkit for District Health Boards	May 2001
Pacific representative for Ministry of Youth Affairs	
Youth suicide prevention external reference group	June 2001-current
Final analysis of interview data and write-up	Jan-Dec 2002
Completion of PhD	2003
Submission of PhD	April 2003
Preparation of journal articles	2003
<u>Dissemination activities:</u>	
❖ Presentation at Suicide Prevention Australia Conference	April 2000

- ❖ Presentation to Pacific communities,
Pacific organisations and students March-Nov 2001
- ❖ Presentation at New Zealand Public Health
Association Conference July 2001
- ❖ Presentation at Injury Prevention Network Conference Oct-Nov 2001
- ❖ Presentation at SPINZ Symposium August 2002
- ❖ Presentation at HRC Pasefika *fono* September 2002
- ❖ Workshop presentation for Pacificare Trust/Like Minds,
Like Us Project November 2002
- ❖ Keynote Address 1st Asia-Pacific Injury Prevention
Conference March 2003

A PERSONAL PERSPECTIVE

I am a NZ-born Samoan woman. My father comes from the village of *Taga* on the Island of *Savai'i* in Samoa and my mother, whose parents both originated from Samoa, was born in Mangakino in the province of Waikato, Aotearoa/New Zealand. I have found, as a NZ-born Samoan researcher, that there are a host of complexities. At one level, there are high expectations to produce research within the constraints of Western academic requirements, which may often contradict non-Western approaches. In my own experiences some of the traditional scientific and mental illness approaches to the investigation of youth suicide attempts, are far from my own realities. In addition:

- ❖ The *fa'asamoa* (Samoan way) requires me to receive without question whereas, the world of the *fa'apapalagi* (European way) requires me to critique (Tiatia, 2000).
- ❖ The *fa'apapalagi* tells me to look out for the 'I' and 'me', whilst my *fa'asamoa* tells me to look out for the 'we' (Tiatia, 2000).
- ❖ My *fa'asamoa* asks me to speak to enable 'us' to understand. Whereas the *fa'apapalagi* asks me to write within a Western paradigm along with all those fancy words to make 'them' understand (Tiatia, 2000).

On another level, it seemed that during interviews my “shared positionality” (Mullings, 1999:345), as a person of Samoan and Pacific descent, allowed me to “partially” and “temporarily” (1999, p. 345) inhabit the space of an insider.

It is argued that prior to a research idea being formulated, the researcher’s ontology and epistemology start to influence the choice of group for analysis, the types of questions asked, and the means by which to answer those questions (Schreiber, 2000). The research process and presentation of findings are influenced by the researcher and the research community of which s/he is a part, as well as being fashioned by the ‘subjects’ of the research and the historical, economic, political and social contexts in which they are entangled (Schreiber, 2000). The difficulty, Schreiber (2000) argues, lies in examining one’s own assumptions, expectations, emotions and intellectual position and the ways these personal characteristics reflect and refract our academic alternatives and interpretations.

There is also the issue of accountability, which is best depicted in the following statement:

Research has been described as a tool of interpretation, and definition of knowledge deemed to be responsible to its various sponsors and stakeholders. It also seeks to maintain its ethical obligations to its participants and their communities (Tamasese et al., 1997:24).

The complexity is finding that middle ground between the Samoan community and the requirements of academia. For example, Schreiber (2000) maintains that matters may be complicated for young scholars when “there is the pressure to be productive in order to be granted tenure” (2000, p. 664). Reaction to this pressure restricts much research creativity - particularly if it is to be appropriate and relevant to the community being researched.

In undertaking the current research, through constant dialogue and debate with my Pacific youth and adult cultural mentor groups, my academic *papalagi* (European) primary supervisor (Associate Professor Carolyn Coggan), my Samoan academic secondary supervisor (Dr Anne-Marie Tupuola) and my

academic *papalagi* co-secondary supervisor (Dr Sara Bennett), I was able, I believe, to remain respectful to the narratives of participants.

CHAPTER FOUR: MEDICAL RECORD REVIEW

INTRODUCTION

This chapter is the first findings chapter for this thesis. It presents the medical record review findings for phase one of the research. This first phase involves a 12-month medical record review of all Samoan young people (16-25 years) who presented to public hospital EDs in the Auckland region. As mentioned in Chapter One, a public health perspective informs the development and analysis of this phase. This chapter is organised as follows: i) introductory section; ii) background; iii) findings from the medical record review findings; iv) discussion of these findings; v) limitations of the medical record review. With the exception of the methods section (included in Chapter Three), this chapter is written in a 'case study' format as a stand alone chapter, as the information is limited to an investigation of what is included in the medical records. This chapter provides previously unknown information in the area of public health related to Samoan young people (16-25 years) who presented to EDs at any of the three Auckland public hospitals following a suicide attempt, and the trends and patterns of these presentations.

BACKGROUND

In Aotearoa/New Zealand, the numbers of Samoan young people presenting to EDs as a result of an attempted suicide are not routinely collected (Tiatia & Coggan, 2001). Previous research has supported the feasibility of ED-based investigations of attempted suicide, and has indicated that such studies can be used to examine trends and identify groups at high risk for suicide attempts (Bennett *et al.*, 2002; Birkhead, Galvin, Meehan *et al.*, 1993; Tiatia & Coggan, 2001). A review of the current public health literature suggests the need for further research of ED presentations following a suicide attempt by young people (Bennett, 2002). In particular, current gaps in the literature include: a lack of comprehensive epidemiological data regarding the extent of the problem for Samoan young people; the characteristics of Samoan young people who have presented to an ED following a suicide attempt; and the follow-up care offered for these young people.

International public health literature suggests that suicide attempts by young people are a familiar presentation in most EDs world-wide (Kapur *et al.*, 1999; McManus, Kruesi, Dontes *et al.*, 1997; Taylor & Cameron, 1998). With regard to the Samoan population, primary healthcare services are under-utilised by many Pacific peoples and this subsequently leads to higher hospitalisation rates (Young, 1997; Finau & Tukuitonga, 1999).

It is recognised by the candidate that there are limitations to the accuracy of routinely-collected NZHIS hospitalisation suicide attempt data. For instance, records are only kept on those who are admitted to hospital as inpatients or daypatients. Therefore, by not recording those who do not report to hospitals at all, the exact extent of the problem is difficult to establish. Furthermore, in the context of this current study, it is important to acknowledge that this research could not determine either the numbers of Samoan young people who had been treated in private Accident & Emergency clinics (A&E) as outpatients, those treated by General Practitioners (GPs), those who did not seek medical treatment or those cases that were classed as motor vehicle crashes or drownings (Ministry of Health, 2002a). Moreover, the advancement in treatment practices makes comparison across years problematic. For instance, for those who had overdosed, the improvement in treatments means more people are treated as outpatients and therefore will not appear in the statistics (Ministry of Health, 2002a). Subsequently, given these limitations, the numbers of Samoan youth suicide attempts are likely to be under-reported. Additionally, the official data is often classed into two distinct categories - Maori and non-Maori and there is also the tendency by statisticians to homogenise Pacific groups. Thus a breakdown of Pacific ethnic groups in statistical data is absent.

Prior to 1995, ethnic classification in Aotearoa/New Zealand was defined as those possessing half or more Maori or Pacific blood. As stated in Chapter One, from 1996 onwards, ethnic classification was based on self-identification (New Zealand Health Information Service, 2001). However, there has been no commitment in official health statistics to identifying the ethnic breakdown amongst Pacific peoples in Aotearoa/New Zealand (Ministry of Health, 2002b). The concern for Samoan, and ultimately for most Pacific peoples is that these shortfalls are a handicap toward the planning of prevention strategies

specifically catering for Samoan young people (Bennett *et al.*, 2002; Tiatia & Coggan, 2001). Given these deficiencies in the data, it is important to gain some degree of insight into the extent and nature of suicidal behaviours in the Samoan population (Booth, 1999b). Furthermore, and as discussed in Chapter One, the development of ethnic-specific information and research capability amongst Pacific peoples is needed (Finau & Tukuitonga, 1999). Consequently, ethnic-specific research allows for accessible information, for the improvement, monitoring and evaluation of the health and services catering to Samoan individuals and their *aiga* (Tukuitonga & Finau, 1997). The candidate recognises that there are those Samoan and Pacific young peoples who may identify with multiple ethnicities. However, it has been beyond the scope of this current thesis to explore multiple ethnicities amongst Pacific young peoples and the impact this may have upon suicidal behaviours. This is an area in need of further investigation.

FINDINGS

During the study period, 27 young people who self-identified as Samoan presented to the participating hospital EDs following a suicide attempt, representing 27 incidences of suicide attempt. Six of these also identify with other ethnic groups; Hawaiian (n=1), Niuean (n=1), Papua New Guinean (n=1), and Tongan (n=3). Table 4 describes demographic details of the sample.

As indicated in Table 4, the majority of ED presentations were by young women. The majority of people presenting were over 20 years, were employed, and living with *aiga* at the time of the attempt. Most suicide attempts took place at home and a family member or partner accompanied the majority of participants to the ED. Most suicide attempts occurred on a weekday, outside office hours and were seen within an hour of presenting to the ED. Although not presented in Table 4, findings also indicated that there was no difference of statistical significance in the month of presentation.

Table 4: Demographics of sample

Variable		n	%
Gender	Male	10	37
	Female	17	63
Age group	16-19 years	11	41
	20-25 years	16	59
Occupation	Employed	16	59
	Student	4	15
	Unemployed/Other	7	26
Living arrangements	Living with family	15	56
	Flatting or living with friends	7	26
	Boarding	2	7
	Living alone	0	0
	Not stated	3	11
Who accompanied patient to ED?	Family/partner	14	52
	Friends	2	7
	All other	8	30
	Not stated	3	11
Venue of suicide attempt	At home	18	67
	Other venue	8	30
	Not stated	1	3
Hospital presented to	Auckland	6	22
	North Shore	6	22
	Middlemore	15	56
Day of presentation	Week day	18	67
	Weekend (Friday midnight-Monday 6am)	9	33
Time of presentation	During office hours (8am-5pm Monday-Friday)	8	30
	Outside office hours	18	67
	Not stated	1	3
Time spent waiting for medical assessment	Up to one hour	16	59
	Up to two hours	5	19
	Two hours or more	2	4
	Not stated	4	18

Table 5 provides a breakdown in occupation by gender for these young Samoan suicide attempters.

Table 5: Gender by Occupation

Occupation	Female		Male	
	n	%	n	%
Employed	9	53	7	70
Unemployed	4	23	2	20
Student	3	18	1	10
Other	1	6	0	0
Total	17	100	10	100

As indicated in Table 6 the most common method used for a suicide attempt was a drug overdose. Table 6 also illustrates that males and females did not differ significantly in the methods used to attempt suicide.

Table 6: Methods of attempted suicide

Method	Male		Female		Total	
	n	%	n	%	n	%
Drug overdose (OD)	4	40	6	35	10	37
Cutting and piercing	3	30	6	35	9	33
Drug OD and cutting & piercing	2	20	4	24	6	22
Hanging	1	10	1	6	2	8
Total	10	100	17	100	27	100

The following Tables (7 and 8) illustrate the body site for the suicide attempt and the types of products used in the event. Table 7 indicates that the sites of injury showing the highest numbers were the wrist area and ingestion. This corresponds with figures in Table 8 which show that the products involved included analgesics, razors, alcohol and knives.

Table 7: Site of Injury

Site of Injury	n	%
Wrist	11	41
Neck	2	7
Ingestion	10	37
Other	4	15
Total	27	100

Table 8: Product Involved

Product involved	N	%
Analgesics	8	29
Razor	2	7
Alcohol	4	15
Knives	5	19
Unspecified	5	19
Other	3	11
Total	27	100

Of those patients who overdosed (n=16), half ingested prescribed medications, and half ingested over-the-counter medications only. A quarter of all overdoses of suicide attempters included some form of paracetamol. Findings in this

current phase of the study indicate that young people aged 20-25 were less likely to ingest prescribed medications (45%), compared to those aged 16-19 (60%), although this difference was not statistically significant.

Nineteen percent of youth that attempted suicide were hospitalised for one night or longer following presentation to an ED. Hospitalised patients spent an average of 3.6 days in hospital (longest stay = 13 days). The likelihood of admission did not differ significantly by method used.

NZ-born Samoan young people's self-reports of events preceding the suicide attempt were included in the medical records in 100% of the cases. The most common preceding event was 'partner conflict' (41%), 22% reported 'family conflicts', and 22% reported 'mental health problems'.

Table 9 indicates that one-quarter (n=7) had presented to EDs with the presence of alcohol at the time of the attempt or at the time of presentation. However the majority did not report either the presence of alcohol at the time of the attempt, or at the time of the presentation.

Table 9: Influence of Alcohol and Drugs

	No (%)	Yes (%)	Unspecified (%)	Total (%)
Influence of alcohol at admission	19 (70)	7 (26)	1 (4)	27 (100)
Alcohol definitely involved	19 (70)	7 (26)	1 (4)	27 (100)
Other drugs involved or suspected	19 (70)	7 (26)	1 (4)	27 (100)

The medical records indicate that seven patients had at least one previous admission to any participating hospital for a suicide attempt. However, no other information was available due to small numbers, and thus no other analysis was undertaken.

Based on hospital medical notes, the majority of patients (59%) were given medications while in the ED. Nearly all Samoan young people who attempted suicide were seen by the Psychiatric Liaison team (93%). However, only 11% were given a psychiatric/mental health assessment, and none of the patients were assessed by a social worker. A small number of youth (7%) absconded or refused services prior to final discharge.

Fifty-nine percent of Samoan young people in this current phase of the study have evidence in their medical records of a post-discharge treatment plan, and 56% of the medical records include evidence of a specific referral for post-discharge follow-up care. The majority of referrals are to community mental health services (60%), 13% were referred to a GP, 13% were referred to 'other services', and 13% do not state who the patient was referred to. Patients admitted overnight to hospital were more likely to have evidence in their medical records of referrals for post-discharge follow-up care (100%), than those not admitted (77%), although this difference is not statistically significant.

DISCUSSION OF MEDICAL RECORD REVIEW

In line with national data and with research investigating presentations to EDs by Pakeha youth in Aotearoa/New Zealand (Bennett *et al.*, 2002), most Samoan young people who attempt suicide live with their *aiga*. In addition, interpersonal conflicts with family members/partners are almost always a preceding event to a suicide attempt. This is consistent with national studies which suggest that stressful life events and circumstances such as interpersonal conflicts are related to the onset of youth suicidal behaviours (Beautrais *et al.*, 1998b; Fergusson *et al.*, 2000; Bennett *et al.*, 2002). Whilst the findings of phase one in the current study suggest that serious mental health problems are only one indicator of risk of suicidal behaviours by Samoan youth, further consideration should be given to other factors, particularly interpersonal conflicts. This is reinforced by (Yip & Chiu, 1998) epidemiological examination of youth suicide attempters who had presented to EDs in Hong Kong. Their study finds that for 87% of this population, interpersonal difficulties are precipitating factors to suicide attempts.

As Table 4 illustrates, just over half of the cases of Samoan youth presented to the Middlemore hospital ED. This is reflective of the high proportion of Samoans who reside in the South Auckland area. Furthermore Table 6 is representative of not only other national data sets (New Zealand Health Information Service, 1999, 1997, 2002b, 2001), but also the medical record review for Pacific young peoples whereby the most common method used for a suicide attempt was a drug overdose (Tiatia & Coggan, 2001).

When considering those who had presented to the ED with the presence of alcohol at the time of the attempt or at the time of presentation (n=7), the numbers support previous studies which identify substance abuse as a risk factor for suicidal behaviours (Borges & Rosovsky, 1996; Brent, 1995; Gould *et al.*, 1996). Furthermore, some authors have argued that alcohol consumption prior to self-harm may be a more important risk factor than habitual consumption (Bennett *et al.*, 2002; Borges & Rosovsky, 1996).

It is maintained that presentation to a hospital ED may offer the single best opportunity for intervention with youth following suicide attempts (Hurry, 2000; Bennett *et al.*, 2002; Kruesi, Grossman, Pennington *et al.*, 1999; McManus *et al.*, 1997; Silburn & Zubrick, 1995). This is particularly relevant for Samoan people who, as mentioned earlier in this chapter, are more likely to access tertiary care providers rather than primary health care providers (Finau & Tukuitonga, 1999; Young, 1997).

Analyses of hospital medical records during the course of the study identify two groups of particular concern. Firstly, findings indicate (see Table 4), that the occupational status of Samoan young people contradicts Western research, which suggests that the unemployed have a higher risk of engaging in suicidal behaviours than those who are employed (Jones *et al.*, 1991; Lester, 1991; Morgan *et al.*, 1975; Morrell *et al.*, 1998). It is apparent in this current research, that young Samoans who are employed may have an increased risk of suicidal behaviours. This is consistent with the Pacific young people's ED medical record review of suicide attempters in Aotearoa/New Zealand (Tiatia & Coggan, 2001). This could be attributed to the frequent and often substantial financial contribution towards *aiga*, church and cultural obligations some young Samoan

people are committed to. This has, for those in paid employment, placed them under considerable strain (Tau'le'ale'ausumai, 1994; Tiatia, 1998; Silipa, 1999a; Meleisea & Schoeffel, 1998). This issue is further discussed in Chapter Two.

Secondly, findings indicate that management of young people presenting to EDs following a suicide attempt is not all together straightforward - particularly when judgements of intent, ongoing risk, and other considerations have to be made in the milieu of a busy ED setting (Bennett *et al.*, 2002). Some authors suggest that people who present with attempted suicide to an ED are more likely to be marginalised by healthcare providers (Bennett *et al.*, 2002; Niruni & Chenoweth, 1999). This is based primarily on the view that taking one's life contradicts the professional aspiration of saving lives (Pallikkathayil & Morgan, 1988). This may then have an impact on an individual's likelihood of admission, treatment and consequential access to follow-up care.

At one level, findings from phase one of this current research are relatively positive compared to international findings. For instance, Samoan young people in Aotearoa/New Zealand are more likely to present to EDs accompanied by family members than young people in the United Kingdom - thereby facilitating a more comprehensive assessment (Nadkarni, Parkin, Dogra *et al.*, 2000). This is consistent with the findings of Tiatia and Coggan's (2001) investigation of Pacific youth presenting to an Aotearoa/New Zealand ED following a suicide attempt, as well as Bennett and colleagues' (2002) findings of Pakeha youth presenting to an Aotearoa/New Zealand ED following a suicide attempt. Furthermore, the relatively low level of those absconding or refusing treatment is positive, given that those who discharge themselves from EDs before completing an initial assessment, and consequential linkage to follow-up care have three times the rate of repetition of self-harming behaviours compared to those completing an initial assessment (Crawford & Wessely, 1998).

Phase one of this research indicates that suicide attempts by Samoan young people are a persistent public health concern particularly in Auckland. A similar finding has been reported in relation to suicide attempts by youth generally in Aotearoa/New Zealand (Langley, Nada-Raja & Alsop, 2000). Findings from the current study, however, suggest that Samoan young people in Auckland are

more likely to be admitted to hospital following a suicide attempt than their counterparts elsewhere. These findings are possibly indicative of widespread awareness and concern regarding Samoan youth suicide amongst healthcare workers in Aotearoa/New Zealand. It is believed that access to follow-up care and other support services is crucial as a means of decreasing risk of further attempts or eventual death by suicide for young people who have already made one attempt to end their life (Hatcher, 1997). It is further argued that this may be particularly relevant for those young people who are not admitted to hospital, but who are discharged with unknown levels of minimal follow-up care (Bennett *et al.*, 2002).

It seems essential to ensure that follow-up care options are available and offered for all youth who present to EDs following suicide attempts, although it is readily acknowledged that arranging care options is not the same as arranging compliance with a proposed care plan (Bennett *et al.*, 2002). While it is commendable that the majority of Samoan young people are seen by a member of the Psychiatric Liaison team as part of their ED-based care following a suicide attempt, opportunities for further improvements remain. For example, ensuring that follow-up care services are also accessible for Samoan young people who are not admitted to hospital. In addition, services need to be appropriate and relevant for Samoan young people. Furthermore, changes to hospital policy and practice to enable integration of suggested follow-up and other care services with various community (and in this case, Pacific and Samoan) support services, in addition to community mental health services, is required.

Phase One Limitations

There are a number of limitations that may compromise the reliability of the data of Samoan ED presentations following a suicide attempt. Firstly, a 12-month period may be considered too restricting. Yet, for the purposes of the current study, a one year data collection period was considered appropriate by both cultural mentor groups and allowed for the feasibility of working within funding and time constraints for this particular phase of the research. Secondly,

reliability of the data recorded is dependent upon the diligence of record keeping. It is likely that medical records will have missing information, particularly regarding: the reporting of depression; previous attempts where presentations may have been made to different hospitals during the study period, or to hospitals outside the Auckland region; where information is a result of incomplete record keeping; where there are lapses in the information gathering process; or simply where details were considered unimportant. It became evident during the course of this study that quality of data varied considerably amongst participating hospitals, and therefore some presentations for attempted suicide may not have been included in the review. Furthermore, while the available data reveals factors that are associated with suicide attempts, the descriptive study design is unable to establish cause and effect relationships between various risk factors and causes of suicidal behaviour (Bennett *et al.*, 2002).

CHAPTER FIVE: AIGA

E leai se aoga e tele ai au mea, ae leai ni ou aiga

INTRODUCTION

This Samoan proverb defines the importance of the *aiga* and is the basis of this chapter. Loosely translated, it suggests that it is of no use for one to possess everything (riches, fame or success) of the world but have no family.

This chapter is arranged under key themes, which have emerged from interview data. It describes the complexities in relation to the importance of the *aiga* and obligation, the role of the eldest sibling and obligation, parent-child communication (particularly with regard to the withholding of private experiences and feelings), physical discipline, and intergenerational misunderstandings. Lastly this chapter explores the *feagaiga*, or brother-sister covenant, and its potential to strengthen communication within the *aiga*. The discussion of each of these themes, the appropriate way to present narrative findings, attempts to unravel these intricacies and to explore their impact upon the mental wellbeing of NZ-born Samoan young people and their suicidal behaviours.

ANALYSIS AND DISCUSSION

The Importance of Aiga and Obligation

The core values of the *aiga* are *fa'aaloalo* (respect), *loto alofa* (love, compassion), *fealofani* (living in harmony), *tautua* (service) and *to'aga i le lotu* (commitment to Christian life and the church) (Mulitalo-Lauta, 2000). *Aiga* is considered by most Samoans to be a core feature in the *fa'asamoa* (Samoan way) (Meleisea & Schoeffel, 1998). It provides love, offers support, nurtures cohesiveness, and encourages reciprocity and service to one another (Anae, 2001; Côté, 1994; Graves & Graves, 1985; Mageo, 1988; Mead, 1928; Meleisea & Schoeffel, 1998; Mulitalo-Lauta, 2000; Tupuola, 1998).

The narratives of three participants (Joe, Nofoa and Thomas) are presented in this section to highlight the complexities of the interconnectedness between the importance of the *aiga* and obligation. As seen by their narratives, below, there is a suggestion that perceived failings or burnout in order to meet *aiga* obligations and expectations have contributed to these participants' suicidal behaviours.

Most participants consider the *aiga* to be a significant aspect in their lives. In the following comments there also appears to be an appreciation for *aiga* cohesiveness and honour. This is illustrated in Joe's extract.

I find that the most important thing about our family, is that even though people have moved away, we tend to come together when it's important issues like if there's a death in the family or a wedding or a birthday no matter where we are we travel and just come as one underneath the one roof, which I like because when the family meeting is on you get that real wholesome, real Samoan feeling. Samoans tend to have big families and when your family is all around you, you know, you feel protected and as one.

When asked to describe his *aiga*, Joe claimed they made him "feel protected" and "as one". Additionally, his comment reinforces *aiga* cohesiveness, which gave him a "real wholesome, real Samoan feeling". It may also appear that Joe's view is reflective of the Samoan belief that the *aiga* is the hub of the *fa'asamoa* (Samoan way) and the essence of Samoan public life (Anae, 2001; Macpherson, 1999; McCallin, Paterson, Butler *et al.*, 2001; Meleisea & Schoeffel, 1998) and personal identity. With regard to Samoan youth suicide attempts, this raises a crucial question - if the *aiga* is the primary support structure for its young people and the very essence of their being, why is it perceived by some to be a contributing factor for suicidal behaviours? The following narratives give account to this dilemma.

Whilst Joe in his earlier comment acknowledges that his *aiga* is crucial to his livelihood, later in the interview he mentions that the pressures of *osi aiga* (family support) had influenced his decision to end his relationship with his partner.

However supported and “protected” Joe declares his *aiga* had been, he does not discount the fact that family responsibilities contributed to his suicidal behaviour.

My relationship with her [partner] was pretty good, had our ups and downs as normal relationships do just certain things that came like I couldn't come to like say a party or something because my parents wanted me to do this. She'd be annoyed at first but I'd say 'you don't come first it's my parents that come first and you gotta understand this in our culture, I can't drop everything at a drop of a hat and just come out over there and see you'. She gradually started to understand it but she still wouldn't accept it... Yeah we ended it and then I found I couldn't cope and I also couldn't hack all the pressure so I just thought why not get rid of all the hassles?

It seems Joe's earlier description of his *aiga* is partly contradicted by the above response. Joe's comments reinforce the preservation of *aiga* cohesiveness and the social sacrifices made as a result of *osi aiga*. From his comments, his conduct of *osi aiga* means that both his and his partner's needs are considered after those of his culture. Nevertheless Joe's comment that “you don't come first it's my parents that come first and you gotta understand this in our culture, I can't drop everything at a drop of a hat” reinforces the notion that prioritising *aiga* obligations for some is accepted as part and parcel of the *fa'asamoa*. This is not surprising considering that for most Samoans, maintaining solidarity and lifelong dedication to the *aiga* takes precedence (Anae, 1998a; Silipa, 1999a; Tupuola, 1998; Graves & Graves, 1985; Macpherson, 2001; Meleisea & Schoeffel, 1998; Mulitalo-Lauta, 2000; Sua'ali'i, 2001). Subsequently, Joe ended his relationship with this partner and found that he “couldn't cope”. This supports evidence across different cultures, which indicate that a relationship break-up is a common contributing risk factor for suicidal behaviours (American Academy of Pediatrics, 2000; Brent *et al.*, 1993c; Hawton, 1986; Marttunen, Aro & Lonnqvist, 1993). The complexity for Joe appears to be in the clash between the *fa'asamoa* and *fa'apapalagi* (European or Western way), in terms of shunning personal desires in place of satisfying the collective, in place of *osi aiga*, and in place of forfeiting that “real wholesome, real Samoan feeling”. Joe's statements support Holroyd's (2001) definition, made earlier in Chapter Two,

where obligation denotes “permanence” (p.1130) and “durability” (p.1130) of kinship, thus creating a social place, which defines one’s personal identity.

Nofoa speaks of the complexity involved in her commitment to the *aiga* and claimed with regard to her suicide attempt that she, “couldn’t balance everything at once, so I just did what I did.”

Family is really important, you know without them you’re nothing and they’re always there for you at the end of the day, but man! Can they just give us a break! Oh you know! Drive them here, there, pick up so and so and you know pay for this and that, look after the kids and it just gets too much and it hit me one day; you know all the bloody pressure. But you can’t win cos if you don’t do it you feel guilty for the whole day or week. ... In the end I couldn’t balance everything at once, so I just did what I did - like you know, just kill myself or basically just wanting to escape.”

Although it seems Nofoa was fulfilling the core values of the *aiga* - primarily *fa’aaloalo* (respect), *loto alofa* (love, compassion) and *tautua* (service), and her acknowledgement of how important *aiga* is to her and the errands she performed for them, she began to rethink her energy given to the *aiga* - “Can they just give us a break! ... it just gets too much.”

Nofoa’s account signifies the complexity that on the one hand she shares an inherent understanding of the Samoan expression presented in the opening of this chapter in her response - “without them you’re nothing”. Whilst on the other hand, she has to cope with the “pressure” afforded to family obligation or *osi aiga* which she claims contributed to her suicidal behaviour.

Nofoa asserts that her suicide attempt was a means of “escape”. This reinforces Tupuola’s (1998) findings where suicidal behaviours amongst young Samoan females is seen to be a release, free from the “claustrophobic” (p.138) nature of the *fa’asamoa*.

Nofoa’s comment “But then if you don’t do it you feel guilty for the whole day or week” implies that her commitment to *osi aiga* is more about personal conviction. Nofoa’s guilt may manifest itself in different forms. For instance, as addressed in Chapter Two, there is the belief that within some *aiga*, one must

have the reputation for reliability, where members can rely on you and your willingness to *tautua* (serve) (Tupuola, 1998; Anae, 1998a; Graves & Graves, 1985). It is claimed that meeting familial demands and supporting family projects at any cost is a display of *osi aiga* (Mulitalo-Lauta, 2000). The basis of *osi aiga* derives from the principle of *tautua* that one performs to the *aiga*. Therefore it may appear that by ignoring the principle of *osi aiga*, one fails to *tautua*. In addition, for some Samoan young people there is the perception that they have to protect their parents from hardship (Tau'le'ale'ausumai, 2000). In other words, some youth desire to fulfil their parents' hopes, dreams and familial obligations despite the personal grief it may cause some in doing so. Another contributing factor to Nofoa's guilt may be considered whereby, the commitment to *aiga* obligations may have been performed to avoid criticism or scrutiny by other family members about her display of true "Samoanness" (Macpherson, 1999:4) had she turned her back on her family's expectations.

Thomas' perception was different in comparison to all other participants as his definition of *aiga* also included his family's gang affiliations. His comments provide an alternative and contemporary perception of the *aiga*.

It means a lot you can always come home again [laugh] you know if you like step out into the big wide world you can always come back. Also I'm related to half of the gangsters around here with my dad's cousins. My dad's been in a gang for like 25, 26 years. And it's like an extended family you go out and bash people. We have big get togethers, oh it's just like another family I reckon. ... I was pressured with everything, like making my mark with them you know with the car theft, making heaps of trouble and stuff like that, it wasn't me for real man. I was feeling really stink but you know you just need somebody, you know just to stick along with you. ... The pressure can really get to you ... and there's no-one to talk to really cos if I said anything then I'd look weak aye and that's not good. ... The pressure of trying to be 'the man' and the guilt of all the bad shit you've done can cut deep and all I could think of was to hang myself - it was the easiest thing to do.

Thomas viewed his gang as an extended family, which is not uncommon amongst gang members (Decker & Curry, 2000). Moreover, his father's long-standing gang membership supports evidence that having family ties or having a primary family member within a gang is a possible element of why he

considered it to be an additional family unit (Decker & Curry, 2000; Lynch & Krzycki, 1998).

Thomas was torn between “feeling really stink” about his involvement in criminal activity, and achieving a sense of belonging and security -“you just need somebody ... to stick along with you”. His perception is similar to Joe’s response in that although his family provided “security” it did not hinder his decision to take his life.

As mentioned earlier, with matters regarding the *fa’asamoa*, to turn one’s back on any one aspect of it puts into question one’s true “Samoanness” (Macpherson, 1999, see Chapter Two). In the same way, although making no direct reference to the *fa’asamoa*, Thomas associates the pressure he was under with “trying to be ‘the man’” and making a name for himself, which ultimately contributed to his suicide attempt. As mentioned in Chapter Two, young people acquire an esteemed reputation by fulfilling most, if not all, *aiga* expectations (Tamasese *et al.*, 1997) and in Thomas’s case this includes engaging in criminal activity.

Thomas raises a crucial point which may have relevance for suicidal behaviours amongst NZ-born Samoan youth. He claims there was “no-one to talk to” for fear of being looked upon as “weak“, or in the Samoan sense, *lotovaivai*. These statements follow on from Mageo’s (1991) description of *lotovaivai* in Chapter Two. Therefore, to be *lototele* (courageous) in most cases, may at times mean keeping up appearances - “if I said anything then I’d look weak aye and that’s not good”. In the statement “the pressure can really get to you ... and there’s no-one to talk to” suggests that his options of seeking a confidant within the group are limited. It then seems apparent that the only real options for Thomas are to either continue in his misdemeanours or to engage in suicidal behaviour. For him, the latter was the chosen option.

Joe, Nofoa and Thomas are each the eldest child within their respective *aiga*. Given this fact, the question may be asked - is the eldest sibling required to display more *osi aiga* (family support) than younger members within the *aiga*? If so, is the “pressure” of obligation greater, thus increasing their risk of undertaking suicidal behaviours? The following section attempts to investigate

whether being the eldest child in the household in relation to roles and responsibilities, has any bearing upon suicidal behaviours.

The Role of the Eldest Sibling and Obligation

I am the oldest so my father expect me for to pass everything and be the good example to the young ones. But here I am the failure. Perhaps I shall go and hang myself like that other boy in Salamumu I read about in the Samoa Times. Perhaps I shall go and drink the poison weed-killer like that other boy in Vaivase who I read about too. But there is still hope in the prayers. I'll keep praying to God for to enter into my father's heart and make him forgive me when I tell him about my failure (Wendt, 1999:168).

This extract taken from Wendt's (1999) short story entitled 'Exam Failure Praying' seems to be an appropriate opening for this section. For instance, it provides a clear example of the role of the eldest sibling and the parental expectations that accompany this rank. Potentially this may be characteristic of some *aiga* which in the case of this character, had impacted upon his decision to engage in suicidal behaviours as a reaction to pressures and the belief that he had 'failed' to meet his father's expectations. This raises the question - 'do the participants in this current research react in much the same way? This section attempts to explore the role of the eldest sibling in relation to obligation and how this relationship impacts upon some Samoan young people's suicidal behaviours.

Like most societies, within the traditional structure of the *aiga*, the eldest sibling has additional roles and responsibilities, which primarily focus on being a good example and closely supervising younger siblings (Ritchie & Ritchie, 1979). Ritchie and Ritchie (1979) maintain that the socialisation process carried out by the elder children in most Pacific societies is considered a "great gift to the literature of child development" (p. 66). This section explores the added responsibilities, duties and associative pressures for the eldest sibling and the impact this has upon suicidal behaviours. Participant perspectives in this following discussion highlight the correlation between being the eldest and the increase in familial expectations.

Michael, in this next extract, describes how his older sister's decision to leave home means he would be her successor. Michael mentions how he and his sister have a close relationship, which again reinforces the notion that the *feagaiga* (brother-sister covenant) effectively operates within some contemporary *aiga* and will be discussed later in this chapter. Michael's sister reminded him of the leading role he would inherit in the *aiga* where certain responsibilities would then ensue. He states:

With the youth, the most affected in terms of a suicide attempt in Samoan families would be the eldest. They have to set a path for their younger siblings and if they see you go wayward your parents will expect and think that your younger siblings will go towards where you're going. [I: yeah]. I'm the eldest son; I'm close with the eldest daughter. Just before she moved outta home she said 'you're gonna have to lead the family and it will all rely on you' and I'm like, ohhh man the pressure, it's the pressure just stressing you out.

Michael's view that the eldest within the *aiga* may be more susceptible to suicide attempts is supported by the statement -"with the youth, the most affected in terms of a suicide attempt in Samoan families would be the eldest". He justifies this by alluding to his family's belief that the eldest is required to set a benchmark for younger siblings and to do so admirably and without question. Before Michael had even taken up the elder sibling role he was convinced that there would be increasing "pressure" - "she said 'you're gonna have to lead the family and it will all rely on you' and I'm like, ohhh man the pressure, it's the pressure just stressing you out". It appears his only strategy to deal with the pressure is to engage in suicidal behaviour.

Timo is the eldest in his *aiga* and echoing Michael's response, was reminded of his duty to set an example for younger siblings.

I'm the eldest and my parents expect me to do well. They would have all eyes on you, you know, everyone is looking at you to do well and when you fail, they all go ooh what a waste. My parents, when they went to our prize givings they expected us to get a prize and if there was no prize then you better watch out when you get back in the car because they'll not only just give you an ear bash but you'd also get a few whacks on the head and ask - 'Why didn't you get a prize?' The parents expect

our generation right now to do so well, to perform. It's just so repetitious that it gets stuck in your head and then you try and strive and strive, and when you find out you didn't live up to their expectations you think of the option to commit suicide. If you can't reach parents' expectations, you think you're letting them down, and they think you're letting down the family name. And then we [Samoan youth] tend to side toward suicide ... It [suicide attempt] was just a faster way to get out of it, a faster way to get out from you know, from all the stress.

At the outset of his narrative, Timo speaks of the connection between being the eldest and high achievement. He attributes this to his accountability to the *aiga* - "everyone is looking at you to do well". He feels the disgracing of the family name is not acceptable to his *aiga* and equally is discouraged within the *fa'asamoa* (Samoan way) (Tupuola, 1998; Macpherson & Macpherson, 1987; Holt, 1999). It seems apparent that in the context of Aotearoa/New Zealand, a high regard in honouring the family name continues to be upheld. It is evident in this case that the pressure of being the eldest is also associated with setting an example, as others would potentially follow his lead. It seems the overarching concern is his attempt to please his parents, "you try and strive and strive," and then he was made to feel as if his efforts were insufficient. This in turn encouraged his suicidal tendencies - "when you find out you didn't live up to their expectations you think of the option to commit suicide".

Timo uses the collective terms 'our' and 'we' implying that his case is not exclusive, but rather experienced by NZ-born Samoan young people who may share similar experiences. He maintains that the emphasis upon success leaves no room for 'failure' and claims that, as a result, Samoan youth tend to "side" towards suicidal behaviours. Additionally, it seems Timo underwent multiple stressors such as his role as the eldest sibling, fulfilling parental expectations, and honouring the family name, which all contributed to his suicide attempt and, like Nofoa, presented earlier in this chapter, regarded it as a means of escape.

In this next account, Joe recalls his secondary school experiences, and speaks about familial restrictions, which he considered denied him opportunities to seek self-determination. His narrative shares similarities with both Nofoa and Timo's

perspectives.

When you're younger like in high school and that, everything's forced; you sort of have to do everything. You always think, you don't get to do things you'd like to do and then they [parents] compare you to everyone else at church, but as you grow older you feel obligated because they drop those hints, especially being the eldest ... the pressure and responsibilities ahh! It can really tear you down.

The conflicting nature of the collectivist and interdependent nature of the 'we' versus the individualistic and independent 'I' is an ongoing challenge in the lives of some NZ-born Samoan young people in Aotearoa/New Zealand and is addressed in Chapter Two. For instance, Joe feels that fulfilling his parents' expectations is denying the self - "you don't get to do things you'd like to do", which is reflective of the nature of the 'I', common to Western dominant society as opposed to the 'we' of the *fa'asamoa* (Aune & Waters, 1994; Tiatia, 2000; Tupuola, 2000b; Meleisea & Schoeffel, 1998).

Joe reveals that his parents frequently compare him to his peers which, in the literature, is not uncommon for some within the Samoan community (Taule'ale'ausumai, 1991; Tiatia, 1998). Parallel with Nofoa's feelings of guilt, Joe considers how, as he matured, he was no longer being forced but rather felt compelled to meet *aiga* obligations - "but as you grow older you feel obligated because they drop those hints". This view supports Holroyd's (2001) investigation of Hong Kong Chinese females. Holroyd suggests that the need to emphasise familial commitment as a distinct duty within some families has decreased, but that young people were becoming more obliged because of the bond they have with their parents. Holroyd adds that this feeling of entitlement and reciprocity creates motivation where individuals eventually find themselves in an "emotionally binding relationship" (p. 1133). Similarly Taule'ale'ausumai, (2001) in personal communication, claims that for some Samoan youth, and as highlighted in Nofoa's earlier narrative, the cultural requirement of personal obligation may also be to "protect their parents from struggles". Moreover, Joe believes that being the eldest incurs further responsibility which, he states, "can really tear you down". Joe reveals, earlier in this interview, that the pressure of

aiga obligations contributed to his suicide attempt.

Parent-child Communication

This section discusses the complexities of communication within the *aiga*, particularly focusing upon the parent-child relationship. Narratives are presented in this section to emphasise issues of concealing the unspoken and the private. Parent-child relationships take on various forms and in this discussion have been addressed in relation to parent-child communication and the withholding of personal matters; physical discipline as a parental communicative method; and the relationship between familial communication and intergenerational misunderstandings. These issues will be explored in relation to their impact upon NZ-born Samoan youth suicide attempts.

Participants were asked why they thought suicidal behaviour was not generally discussed amongst the Samoan community. Samuelu's response, below, addresses this concern. He addresses the issue on the level of the *aiga*, rather than the Samoan community as a whole. He expresses the view that limited discussion regarding suicidal behaviours is associated with the restrictive relationship between some parents and their children.

Kids can't communicate with their parents cos it's a cultural thing. I know that my parents in Samoa weren't allowed to talk to their parents and stuff like that, and that's sort of come down to us. I think it might help if our parents could recognise that problem. We need to break out of that especially for future generations then it won't be so hard for the kids to communicate with parents.

The reluctance to discuss the issue of suicidal behaviour amongst Samoan families is, in Samuelu's view, a communication breakdown between parents and their children. He regards this a "cultural thing" and associates this to common traditional practices in Samoa, and claims it needs redress - "I think it might help if our parents could recognise that problem". By this statement he may be subtly implying that within this 'new' environment (Aotearoa/New Zealand) this breakdown should not be perpetuated. However, it is contended,

that “cultural guidelines exist in the dominant ideas and rhetoric of a particular society” (Holroyd, 2001:127). Therefore within the *fa’asamoa*:

The reluctance to discuss or pursue purely private experiences may then be considered understandable, primarily in light of the largely relational identities Samoans develop (Shore, 1982:147).

Samuelu places the onus upon parents to address this lack of communication in order to avoid its recurrence for future generations. In the same way, the following narrative reveals some reluctance to discuss personal matters amongst *aiga* as a result of inherent cultural beliefs.

Loleta indicated earlier in this interview that communication between her, her parents and her five siblings was limited.

I think it’s because they feel alone and parents are like the last people you want to talk to about anything, especially some parents because you’ll get a wasting [beating] ... [laughter]. You just feel shame or like they’ll embarrass you and think you’re an egg. It’s just; you wouldn’t go to your parents for anything let alone telling them what you’ve done [suicide attempt].

When asked why young Samoan people engaged in suicidal behaviours, Loleta believes that it is the effects of loneliness - “I think it’s because they feel alone”. Her view supports findings which suggest that loneliness increases the risk of suicidal behaviours (Guertin, Lloyd-Richardson, Sprito *et al.*, 2001; Stravynski & Boyer, 2001). In addition, it reinforces the views of Shore (1982) and Goodman (1990) who contend that Samoans tend to avoid situations of social isolation. The candidate acknowledges that this does not account for all Samoans.

Loleta’s comments that “you just feel shame” and parents would “embarrass you” and “think you’re an egg” are seen to impede any discussion of suicidal behaviours or other subjects considered taboo amongst *aiga*. In other words, it seems that the characteristic nature of ‘shaming’ for some *aiga* prohibits increased parent-child communication and may also affect interpersonal communication. Loleta’s view also supports Mageo’s (1998) writings, which suggest that “teasing” (p. 60) by some parents or guardians makes children feel dull-witted. Teasing suggests that a child’s ‘bad’ behaviour should be

discouraged rather than accepted. The author contends that the goal is to undermine the feeling that the self is acceptable which may be deemed by some *aiga* as conceited. This shaming mechanism has the effect for some NZ-born Samoan young people, of withholding any discussion concerning matters of 'the heart' within their *aiga*. The dilemma is that the *aiga* which is generally perceived as a primary means of support for its members is, also in contradiction, the very reason support is needed. The concern has arisen - What has happened to the central symbols of *fa'aaloalo* (respect), *lotoalofa* (love, compassion) and *tautua* (service)?

Aniva, like Samuelu, highlights that within her *aiga* there is limited communication and suggests that members simply "never learnt how to communicate".

We don't really talk. My parents have always like worked really hard, and most of the time they weren't around so really we don't even talk, the most we ever say is hi and most of the time we don't even say hi. We never learnt how to communicate because most of the time they weren't around. They were at work and by the time my dad got home, you know, we'd be sleeping and, with my mum she always working late hours at night.

The complexity is that the lack of communication within Aniva's *aiga* is attributed to her parents' long working hours and the view that they "weren't around" thus enabling little opportunity to "talk". This leads to her belief that the skills needed for communicating were not taught. In addition, her comment is an example of how the notion of '*aiga*' may sometimes be misconstrued. For instance, there is generally the assumption that because young Samoans are living in large family units they also share a communal and collective lifestyle. However, Aniva's narrative suggests an alternative perspective. Her view is consistent with Tupuola's (1998) findings which reveal that in some cases, 'adolescence' does not appear to encompass extended family or *aiga potopoto* and communal relationships or social norms characteristic of the *fa'asamoa*. Tupuola addresses the unspoken commitment which some parents make to better their children's lifestyles, although at a cost, and in this case, the cost of sacrificing the traditional concept of *aiga*. It therefore seems apparent that

socio-economic factors are also involved in her experience, which have shaped the dynamics of her *aiga* and instigated the deterioration of parent-child relationships and communication.

Zarnia similarly comments that “what I really wanted was just their time,” suggesting that her parents’ time away from the *aiga* affected parent-child communication. As in Aniva’s case, it also appears that the breakdown in family communication involves socio-economic implications.

Islanders don't really show affection and things like that. Their way of showing love was like working really hard and providing, food on the table and a nice house to live in, and things like that but you know what I really wanted was just their time, [I: yeah] Yeah you know, to do things, with the family and things. We always did things separately.

Zarnia’s narrative suggests that “Islanders don’t really show affection”. The candidate acknowledges that this is not reflective of “Islanders” in general. However, this apparent lack of affection is also discussed by Mageo (1998) who uses the term “affective distancing” (p.48). Mageo suggests that although some Samoan parents do not dismiss emotional responsiveness, there is the notion that “to lavish love and care upon a child - *fa’apelepele*, literally ‘to make dear’ is believed to be bad for growing children” (p. 48). The author adds that the irony is that the distancing of children rather than “making dear” is principled by *alofa* (love). *Alofa* is demonstrated by *tautua* (service) to others. Zarnia recognises this and recounts that her parents’ display of *alofa* was “working hard” to provide necessities for the *aiga*. According to Zarnia, this is difficult to accept. Yet it is believed that within some *aiga*, for parents to “lavish” *alofa* potentially sends signals to their children that they may be of a higher status than their elders (Mageo, 1998). Mageo (1998) concludes that this creates confusion amongst some Samoan young people of the social hierarchical boundaries.

The complexity then exists that for some NZ-born Samoan young people, they may appear to be caught in a world of privacy and secrecy. Therefore, in times of distress, to whom can these young people turn to? If they can’t “talk”, let alone be heard in some cases, what other mechanism is available to them to communicate other than self-destructive behaviours?

This next section addresses this dilemma where it appears that some NZ-born Samoan youth perceive deliberate self-harming to be an alternative communicative signal.

Maris, Berman and Silverman (2000) argue that suicidal behaviour is both a communication in itself as well as a result of failures in more adaptive efforts to communicate. The following responses by Fatu and Pologa illustrate that their suicide attempts were forms of communication. Both reveal that their behaviours were a means of channelling their pain and frustration.

Fatu refers to the expectations his mother places on him, and claims his suicidal act was in response to this “pressure”.

I wanted to die because of my mum, she just puts too much pressure on me to be the sporty and brainy son and this was my way of telling her to shut-up.

Fatu’s statement - “this was my way of telling her to shut-up,” conveys the message that in order to deal with the pressure, his only likely alternative to communicate is to harm himself. In the same way, Pologa’s suicide attempt was, as Maris, Berman and Silverman (2000) argue, a communication that serves as a proverbial ‘red flag’ signalling to others that there is potential risk for a more lethal suicide attempt or at least calls attention to others of her discontent.

Pologa’s partner had not spoken to her for three days as a result of a disagreement. This had become the precipitating factor to her suicide attempt. In the first of two extracts presented here, Pologa describes how her efforts to communicate placed pressure upon her *aiga* and partner to respond in some way. A similar scenario is referred to in the writings of Bowles (1985). Pologa’s second and third responses regarding parent-child communication address her role as a young Samoan female, who is expected to “keep [her] mouth shut”.

I tried to write a final letter and my tears were flowing and I was writing in anger. I’d read through it and suddenly realised that what I was doing was quite silly, and um, also thinking of everybody that I’d be hurting, because there were a few people that I actually wanted to hurt over killing myself like, basically

my family, I wanted them to see that the pain that they put me through caused me to do this.

Pologa initially perceived that her behaviour “was quite silly” in the short time prior to her suicide attempt. She intended for her *aiga* “to see...the pain”. In relation to suicidal behaviours it has been suggested that the desire to afflict others invokes communicative expression (Lester, 2001) and appears to be a form of rebellion. Considering that the *fa’asamoa* stresses *fa’aaloalo* (respect) for seniority, Pologa’s act may then well be considered disrespectful.

It appears in Pologa’s comment that verbal communication is difficult within her *aiga*. It therefore seems that her suicide attempt supports public health findings that suicidal behaviours are a communicative form of expression and are sending a message alerting help (Bonnar & McGee, 1977; Handwerk, Larzelere, Friman *et al.*, 1998; Lester, 2001; Maris *et al.*, 2000; Marshall & Yazdani, 1999).

Pologa’s history of sexual and physical abuse raises some contextual factors. This is consistent with previous findings on the effects of sexual and physical abuse which increases the likelihood of suicidal behaviours (Beautrais, 2000b; Brown, Overholser & Spirito, 1991; De Wilde *et al.*, 1992; Fergusson *et al.*, 2000; Suyemoto & MacDonald, 1995).

Where then, in Pologa’s situation, is the essence of what *aiga* encapsulates? Where is the essence of *fa’aaloalo* (respect), *loto alofa* (love, compassion) and *tautua* (service)? This reinforces the argument made throughout this chapter that the *aiga* may often be the demise for some NZ-born Samoan young people.

Pologa’s second narrative reaffirms the notion that the youth voice is not very often heard, particularly in light of the cultural restrictions prescribed of Samoan females (Booth, 1999a, 1999b; Tupuola, 1993b, 1998, 2000a).

I was taught not to speak out and the [laughs] worst part was I had guy cousins that were my age, like there were three of them, and they would always play and I would always get the hiding for it, being female and that. So I just went home and cooked, you know cleaned for everybody and all that stuff. I thought that was normal, you know, for females to actually stay home, keep your mouth shut, do the dishes and tea and that ... I feel Samoan women are basically more at risk [suicide

attempts] because, you know they're told to keep quiet and everything and to do as they're told. It is basically really hard for them to go through, whereas the guys can basically get away with anything. In my experience with my boy cousins, they got away with whatever, they could talk back to their parents and everything, as for me if I was to get smart, the wooden spoon would come.

Pologa alludes to the repression of the Samoan female voice expressed in the comments, "I was taught not to speak out", "keep your mouth shut" and "they're told to keep quiet". Subsequently, to step outside cultural boundaries she would "get [a] hiding for it" or "the wooden spoon would come" and she accepts it as common practice - "being female and that." Therefore, in light of these views, it may seem explicable that Samoan females or "women" are more susceptible to suicide attempts. This is supported by the findings and discussion made in Chapter Four, which suggests that females, as most international and national data confirms, are at greater risk of making a suicide attempt than their male counterparts (Booth, 1999a; Khan & Reza, 1998; Ministry of Health, 1999; Nisbet, 1996; Oregon Vital Statistics, 1996; Range & Leach, 1998; Vannatta, 1997; Wannan & Fomborne, 1998; World Health Organisation, 1998). Pologa also addresses the relative 'freedom' male family members have in comparison and is indicative of the double standards which exists within Samoan culture (Booth, 1999a; Leacock, 1987). However with regard to the male participants presented in this chapter so far, the contradiction exists that this is not necessarily a reality for all Samoan males. For instance, it is apparent in this current research that male participants do not get these privileges Pologa refers to.

It seems apparent that parent-child communication is a complex issue - particularly in relation to some of the cultural factors surrounding it. This next section will continue to explore these complexities in light of the debate around physical discipline and, in some instances, abuse which in public health literature has contributed to young people's decisions to take their lives (Beautrais *et al.*, 1996; Brown *et al.*, 1999; De Wilde *et al.*, 1992; Dube *et al.*, 2001; Garnefski *et al.*, 1992; Kienhorst *et al.*, 1992).

Physical Discipline

Factors warranting study are the communication patterns between parents and young adults [and] the heavy and frequent use of punishment at the family and village level as virtually the only means of controlling behaviour (Va'a, 1982:17).

There is a Samoan proverbial expression - 'o au o matua fanau' which loosely translated means 'children are treasures to their parents'. This appears far removed from Va'a's statement thus indicating an immense contradiction. This contradiction is apparent in the current research where the frequent use of physical discipline within some *aiga*, has contributed towards young people's suicide attempts. This is consistent with the observations of young people in Samoa (Freeman, 1983; Gerber, 1975; Mageo, 1988). This finding is also congruous with Western literature, which suggests that a history of harsh reprimanding during childhood increases the likelihood of a suicide attempt three-fold (Brent *et al.*, 1993c; Brown *et al.*, 1999). This next section will explore the relevance of this issue for young NZ-born Samoans in Aotearoa/New Zealand.

It appears Pologa's upbringing was physically harsh as illustrated in her comments - "giving us a hiding", "leaving us black and blue" and "being beaten up". Like Va'a's (1985) opening statement, her perception is that Samoan elders often resort to physical rebuke as a form of reprimand.

The elders - you know Aunties and Uncles they should sit down and talk to us, because half the time we don't even know why they're giving us a hiding. They could have learnt to sit down and explain you know 'I didn't like what you done'. It's just a quick reaction, giving us added anger [laugh] leaving us black and blue [laughter] and sore. I reckon it's gonna take a while, at least another 10 generations, before this thing gets wiped out...With me now, I sit with my partner and we compare our notes with, you know, being beaten up, like 'Were you hit with the cord?' and he'd say yeah. I mean, I've basically been beaten up every where I've been I was even beaten up in Niue, I was beaten up basically everywhere [laughter].

Pologa suggests that effective communication would be achieved if there was dialogue, because "half the time we don't even know why they're giving us a

hiding". Despite Pologa's recollection of her experiences of physical discipline, she used laughter to tell her story which Goodman (1990) claims, may act as social "grease" (p. 137) to eliminate friction and that although a person continues to smile, there is unsettled pain and emotions lurking behind the surface (Aune & Waters, 1994; Tatz, 1999; Thaman, 1974; Goodman, 1990).

The next participant shares a similar experience with Pologa. When asked what had been the precipitating factor to her suicide attempt, Talia recalls that it was "getting a wasting" by her mother for coming home late from school.

Just the same ole story you know getting a wasting [a beating] for doing the littlest thing - I came home late from school... You see that's how they communicate with us kids - those slap the mouth ones, or a flying punch here and everywhere. I was just sick of it I suppose.

Central to Talia's story is her parents' corrective response to her misconduct by way of "slap the mouth" and "a flying punch here and everywhere". Such parenting styles are problematic to the extent that in Talia's case, it was a proximal factor to her suicidal behaviour - "I was just sick of it".

Similarly, in this next response Sesilia had also experienced episodes of harsh physical discipline - "I wouldn't do it and would just get a massive beating". She places physical discipline in a context which made sense to her. This is illustrated in the statement that physical discipline is the "Samoan way". When asked what issues she feels NZ-born Samoan young people face in today's society, she responds:

Beatings from the island way, the Samoan way... I was the eldest and always hated to do the things I was meant to do and what my dad told me to. Sometimes I wouldn't do it and would just get a massive beating. That's when I was younger but as I started growing older, I grew closer to him and learnt his ways of being a hard Samoan and that.

Sesilia "hated" responsibility, particularly being the eldest, which strengthens the argument that there may be added pressure for those in comparable positions (see for instance 'the role of the eldest sibling' earlier in this chapter).

Yet Sesilia mentions that the lesson learnt was to be a “hard Samoan”. She had learnt the ways of her father and adopted ideas of what it is to be a “hard Samoan”.

With regard to the findings thus far, it appears that Sesilia is impacted by multiple stressors which contributed to her suicide attempt. For instance her responsibility as the eldest sibling as well as being subjected to intense physical discipline. Although not presented in her response, during the course of this excerpt, Sesilia revealed that the frequent occurrence and severity of physical discipline within her *aiga* had contributed to her suicide attempt.

Intergenerational Misunderstandings

As discussed in Chapter Two, the literature suggests that intergenerational misunderstandings - particularly between NZ-born young people and Samoan born elders - may impact upon parent-child communication (Anae, 1998a; Bathgate & Pulotu-Endemann, 1997; Macpherson, 2001; Macpherson *et al.*, 2000; Mulitalo, 2001; Mulitalo-Lauta, 2000; Silipa, 1999a; Taule'ale'ausumai, 1991; Tiatia, 2000, 1998; Tupuola, 2001; Tupuola, 1998; Utumapu, 1992; Chun, 2000). This section - and the two following narratives - focuses upon intergenerational misunderstandings in terms of language and the sometimes incongruent experiences of NZ-born Samoan young people and their Samoan born parents. This discussion is explored in relation to the breakdown in communication and the subsequent impact this has upon young Samoans' suicidal behaviours.

The first of these narratives is Samuelu who, as mentioned earlier in this chapter, does not communicate much with his father. It was at this point he reveals that he is not proficient in *gagana Samoa* (Samoan language).

My mum's good but they're all gone, the whole family have gone. It's just me and my dad here. My mum's got two sisters and a brother living in Australia and they've all gone there to live. My parents split up. It's hard to talk to my dad anyway because he doesn't understand. He speaks in Samoan, but I can't speak Samoan so we just don't talk at all.

Samuelu's comments illustrate one aspect of how intergenerational misunderstandings affect communication. His response supports the argument made in Chapter Two that language barriers impact upon parent-child communication. For example, the issue for Samuelu and his father is that his limited knowledge of the Samoan vernacular means that they "just don't talk at all". In addition, what is also critical is his comment about his home situation - his parents separated which leaves him and his father in the family home. This is indicative of the changing nature of the *aiga* for some Samoans.

Intergenerational misunderstandings are also prevalent in this next participant's account. Ana recalls the experience between her and her Samoan born mother. Her response is the description of a follow-up session she and her mother attended with her clinical support worker.

When X [clinical support worker] came over and visited us last weekend we were talking about something totally different but mum brought up something else about herself and I was thinking 'we're not talking about that sort of thing' and X explained to me that that's her way and that she uses abstract ideas. She [mum] puts things in a different way and that's where I went a bit clueless like I'm sitting there going, but we're not talking about that mum and that's when arguments would arise and I'm like, you don't even understand what I'm about. There's a big miscommunication there, because I was brought up here and she was brought up in Samoa and it was a different upbringing but basically what she [mum] was trying to tell me was to be strong. You know I was like that's not helping me at all but I didn't think she was actually trying, she was just putting it in a different way and here I was thinking 'ok she doesn't understand me at all.'

Ana states there was "a big miscommunication" between her and her mother and attributes this to their "different upbringing[s]". She acknowledges her mother's efforts to offer advice yet claims that disputes often arise due to the unintentional misunderstandings of a parent and the 'limbo' state of the child - "She [mum] puts things in a different way and that's where I went a bit clueless like I'm sitting there going, but we're not talking about that mum". This account is an example of how talking past each other frustrates some parent-child communication patterns. In addition, Ana seems to contradict the argument

made in Chapter Two regarding voice suppression, knowing one's place and withholding any thoughts or words which may compromise the status of seniority (Tiatia, 1998; Tupuola, 1998; Sua'ali'i, 2001). In her statement "but we're not talking about that mum and that's when arguments would arise and I'm like, you don't even understand what I'm about" indicates that Ana takes the opportunity to voice opposition, which is not reflective of the traditional view where a Samoan youth is required to remain silent.

As is the common thread in both Thomas and Sesilia's cases, Ana is also told "to be strong" - reinforcing the value placed on *lototele* (courage). Whilst Ana considers both her and her mother's experiences to be distinct, it seems she is still expected, in a time of crisis, to remain "strong". Such perceptions suggest that showing any sign of weakness or *lotovaivai* should be avoided. The concern is that some young people do not have the understanding that it is okay to feel apprehensive or vulnerable at times.

It appears evident that such factors that have contributed to the lack of communication within some *aiga* - particularly between youth, parents and their elders - have in some way impacted upon NZ-born Samoan youth suicidal behaviours. The implication is that NZ-born Samoan youth may be avoiding help-seeking either within their *aiga* or in the wider community due to perceptions of being misunderstood or misinterpreted. The question may then be asked - if the *aiga* is seen as the primary support structure for most, to whom in the *aiga* may one turn to in times of crises? Research findings indicate that the brother-sister relationship may strengthen the communication and support structure within *aiga*. The next section explores this supposition further.

Brother-Sister Covenant

The following participants indicate that the *feagaiga* (brother-sister covenant), a traditional bonding between brother and sister, continues to operate within some *aiga*. It seems this may be effective in terms of strengthening communication within *aiga*. (Figiel, 1996) provides an apt description of the significance of this covenant:

The seven brothers guarded their sister not only with the strength of their bodies. But also with their very souls. For she was to be the sky of their eyes. The source of their strength. They were to serve her until their souls were ready to leave their bodies for pulotu [place in ancient Samoa where souls go to rest]. Through old age. Sickness. Accidents. Or some other way that was not self inflicted. This was their duty. This is what they called the feagaiga between themselves and their sister i.e., the covenant (p.68).

It is believed by most Samoans that the brother (or male relative's) role within the *aiga* is to protect the chastity of his sisters and female relatives. This is embodied in the *feagaiga* and is central to the construction of distinctly separate male and female roles and responsibilities (Sua'ali'i, 2001). In the context of Aotearoa/New Zealand, it appears the traditional facets of the *feagaiga*, such as the brother's protection over his sister, honouring her and *tautua* (service) to her are still observed. However, closer examination of the current research findings highlight that the traditional aspect of avoidance prescribed by the *feagaiga* has changed for some NZ-born Samoan youth.

Of all the participants Louise best describes this covenant or "bond". Her description reiterates the importance of this relationship. She has revealed in the interview that she has a strong relationship with both her parents and other siblings, but prefers to confide in her younger brother.

It's great, I get on with my sisters, but I find me and my brother are closer. We have this special bond, he looks after me especially when it comes to other boys, he doesn't like me talking with boys when he's around. It looks like he wants to give them a hiding. I share everything with my brother even though he's four years younger, it's just that we have so much in common and he knows my darkest secrets and vice versa. One time we both said that we would walk through fire for each other. So yeah he's really the only one I can confide in about intimate stuff. When I did what I did, he was the one I poured my heart out to after I came back from the hospital - he was pretty pissed that he wasn't around at the time and blamed himself - it wasn't his fault though.

Louise describes her relationship with her brother as having a "special bond" thus enabling her to share with him her "most darkest secrets". This contradicts

the traditional structure of the *feagaiga*, which prescribes the avoidance of 'close' contact between brother and sister (Schoeffel, 1995; Shore, 1982). Although Louise reveals that her brother is the only one she can "confide in about intimate stuff", it does not dismiss the fact that she engaged in suicidal behaviour. Yet she recalls that after her ordeal "he was the one I poured my heart out to" suggesting that her brother is an effective sounding board and means of support.

Similarly, Satia's description of the brother-sister relationship also indicates that the traditional avoidance originally prescribed of the *feagaiga* has transformed. Although not illustrated in this extract, Satia reveals that her time spent sharing with her brother about her partner was beneficial to her emotional well-being. She adds:

Mum and Dad brought us up, like to share this and share that, and don't go anywhere without your sister or brother, don't go here or there and leave your brother here. Me and my older brother are the closest. He's the one that I can confide in, he's the one that I run to, and, yeah, wherever my older brother went I had to be with him, I have to, have to. He's my security, he's everything, he's just like a best friend, yeah. He understands me more than anyone in my family and he just knows what's best for me, he knows what to say he knows what to do. He's my protection.

Satia reveals that within her household the brother's protection over the females is traditionally the role of the male in terms of the traditional structure of the *feagaiga*. Satia, in the same way as Louise, regards her brother as her primary confidant - "He's the one that I can confide in", her "tower of refuge" - "he's the one that I run to ... he's my security", and, as illustrated in Figiel's (1996) excerpt presented earlier in this discussion, her whole being - "he's everything". One cannot help but speculate whether Satia's 'moments' with her brother are merely fortuitous. For instance, would her suicide attempt have been prevented had she sisters to rely on? Furthermore, although her description of the relationship with her brother is reflective of the *feagaiga* and includes most of the tenets prescribed of this relationship - "He's my security", "He's my protection" and "don't go anywhere without your sister or brother", it is

contradicted by the fact that she still opted to take her life, when after all, she could have initially turned to her brother for help.

Thus far, female narratives have dominated the description of the *feagaiga*. It may be important to explore a male participant's view and to examine whether this view of this type of relationship is shared. The following is a male perspective.

Earlier in the interviews Solomona made a comment that his parents had little spare time for their children due to work and church commitments. Subsequently, it appears in his response that there is little communication between him and his parents. So he confides in his sisters with whom he feels "comfortable".

I hardly communicate with my parents, my brothers are cool to go out we have fun with the mates, but my two sisters are the ones I feel comfortable with, with all personal stuff. They give good advice and we know that I've got their backs and they've got mine.

Once again, as in Louise and Satia's narratives, the traditional tenet of direct avoidance - is not observed in this instance. The changing face of the traditional *feagaiga* has, as Shore (1982) puts it, moved beyond the "power of traditional avoidance" toward a contemporary dialogue of intimacy - "but my two sisters are the ones I feel comfortable with, with all personal stuff".

These comments suggest that there are positive relationships within the *aiga* - specifically, the sibling relationship between brother and sister. Responses have suggested that the strengthening nature of the brother-sister relationship may be a starting point in terms of promoting dialogue within the *aiga* and ultimately early suicide intervention and prevention.

CONCLUDING COMMENTS

This chapter illustrates that the *aiga* plays a significant part in the overall health and wellbeing of NZ-born Samoan young people. It has attempted to unravel the intricacies within the *aiga* which impact upon young Samoan suicidal behaviours. In so doing, it has addressed the complexities of the allegiance to *aiga* and its associative 'pressures' of obligation. It has also explored the unspoken complexities of the obligatory role of the eldest sibling, the lack of parent-child communication - particularly in relation to unspoken hurts and frustrations, the dilemma of physical discipline as a communicative style and the adverse effect on mental health, and the breakdown in communication as a result of intergenerational misunderstandings. It then moved its focus toward the relevance of the brother-sister covenant or *feagaiga* and its potential to fill the void in 'weak' or non-existent parent-child relationships.

CHAPTER SIX: EMOTIONS

INTRODUCTION

This chapter depicts how social-emotional²¹ factors - particularly with regard to anger and shame - provide some understanding of the type of emotions which may precipitate suicide attempts amongst NZ-born Samoan young people in Aotearoa/New Zealand. This discussion does not endeavour to probe entirely into the psyche of Samoan young people. Rather, it argues that there are certain types of emotion which may be culturally distinct and form part of a culture's socialisation process, which have been absent from Western medical and clinical models that have examined risk factors for suicidal behaviour (White, 1985). Moreover, as detailed in Chapter Two, if one fails to comprehend the cultural experience of emotion in suicidal behaviours, one may then risk making the error of applying Western psychological concepts to their behaviour, thereby misunderstanding what suicidal behaviours mean to certain cultures (Counts, 1991).

This chapter is arranged under key themes which have emerged from interview data. It discusses participants' perceptions of their emotional states prior to their suicidal behaviours drawing upon themes of anger and emotional repression, shame, masking and to an extent, depression. These themes are explored in terms of the interconnectedness between emotion and the timing of suicidal behaviours amongst NZ-born Samoan young people.

²¹ The candidate acknowledges that there are numerous works around shame, the marring and honouring of the family name, masking, and anger in relation to NZ-born Samoan youth. However, for the purposes of this thesis, these emotions have been restricted to a public health focus in relation to Samoan youth suicidal behaviours.

ANALYSIS AND DISCUSSION

Anger and Emotional Repression

Chapters Two and Five have discussed how, within Samoan society, overt expressions of anger by young people are discouraged in order to maintain harmony (Hezel, 1987), to keep young people within cultural boundaries, and to teach young people *fa'aaloalo* (respect). Consequently, the cultural expectation of emotional restraint in relation to Samoan youth suicidal behaviours for some becomes internalised anger and resentment (Schoeffel, 1979; Shore, 1982; Watson-Gegeo & White, 1990). It seems also from participant narratives that emotional repression manifests itself to the point of self-destructive behaviours. Within Samoan society supposedly, there are culturally appropriate emotional mechanisms for young people to adhere to. For instance, *musu* (sulking, withdrawal) as a form of emotional restraint is considered a culturally appropriate and accepted form of Samoan emotional expression - particularly amongst young people (Macpherson & Macpherson, 1985; Mageo, 1998; Rubinstein, 1987). The following participant narratives are indicative of the way Samoan young people may perform *musu*. However, in light of their suicidal behaviours, this has been taken to the extreme. The selections of three participants' narratives illustrate how anger, primarily aimed at a significant other, is internalised and redirected upon the self.

The first participant, Samuelu, mentions during his interview that he had made a previous attempt on his life. When asked to describe this event he states:

Oh just on a motorbike, the same thing [referring to both his attempts being the result of partner conflict]. Me and my girlfriend were arguing. She wanted to go to her mother's and I didn't want her to go to her mother's but she went to her mother's anyway and I just buggered off, I was pissed as [angry] then just being a clown, a clown yeah, driving a motorbike, just driving along and I crashed it - biggest mistake that was [laugh].

Samuelu's objective in his recollection of a previous suicide attempt is unclear. For instance, it is difficult to make the distinction in his actions between

vengeance (McCullough *et al.*, 2001) and *musu*. Yet what is important in this context is that he was angry - "pissed as" and of equal concern is his reaction to what may appear to be an inconsequential event. This supports Rubinstein (1992) and Schoeffel's (1979) belief that a young person's suicidal response is usually precipitated by a "trivial incident" (Rubinstein, 1987:143) - most often following an argument with a significant other. In addition, Samuelu believes that his actions were a "mistake", yet it did not prevent him from repeating this self-destructive behaviour. The potential danger for Samuelu, and possibly many other repeat suicide attempters, is his vulnerability to death by suicide. This reinforces public health evidence that young people who attempt suicide have an increased risk of repeating this behaviour (Diekstra, 1989; Aghanwa, 2000; Borowsky *et al.*, 1999; Cantor, 1994; Hezel, 1987; Kachur *et al.*, 1995; Schnyder *et al.*, 1999). As is discovered in Chapter Four's medical record review findings, Samuelu's account has confirmed that partner conflict is a precipitating factor to Samoan youth suicidal behaviours. This also strengthens Western international public health literature, which has identified partner or interpersonal conflict as a contributing factor to young peoples suicidal behaviours (Marttunen *et al.*, 1993; Brent *et al.*, 1993c; Davidson, Rosenberg, Mercy *et al.*, 1989; Mercy & Rosenberg, 2000; American Academy of Pediatrics, 2000).

Similarly, both Thomas and Saeni in the following responses confirm arguments made by national and international authors regarding interpersonal conflict and the onset of both Pacific and Samoan youth suicidal behaviours (Bathgate & Pulotu-Endemann, 1997; Booth, 1999a; Freeman, 1983; Herdt & Leavitt, 1998; Macpherson & Macpherson, 1985; Mageo, 1988; Rubinstein, 1987; Tupuola, 1998; White, 1985). This evidence suggests that interpersonal conflict is often a catalyst to Samoan youth suicidal behaviours. Thomas states, during the interview, that he attributes his suicidal behaviour to a disagreement he had with his partner. When asked to elaborate Thomas shares:

I just like wanted to finish it [life] you know? No more getting jealous, no more getting angry and no more getting pissed off at little things, niggly little things with the old lady [partner] and then when I woke up and it was - daaamn what have I done?

Thomas confirms that partner conflict was a contributing factor in his choice to attempt suicide. Additionally, in the statement - “daaamn what have I done?” he, like Samuelu, realised the seriousness of his actions and had subsequent regrets. It appears Thomas’s recollection conveys emotional frustration. This is illustrated in his use of the words, “jealousy ... getting angry ... getting pissed off”. It seems that his suicide attempt was a means of responding to his partner’s “niggly things”. It also appears evident that Thomas has no other alternative in coping with his emotions, which is characteristic of all other participant narratives presented in this chapter. Instead Thomas has found suicidal behaviours to be his mechanism for coping.

Although not presented in the following excerpt, Saeni shared during the interview that during her counselling sessions she openly spoke of her anger towards her *aiga*. Saeni’s anger is a result of interpersonal conflict and seen as a contributing factor towards her suicide attempt. She states:

Sometimes at nights, she [her baby] stresses me out you know when she doesn’t go to sleep and like I need some time out and I’ve started this counselling but its not really helping because like a lot of the anger is still there. I’m still angry, especially with my mum and his mum and him [ex-partner] and my sister.

In the opening of Saeni’s statement, parenting factors are considered an issue. However underlying, and of relevance to this discussion, is her description of deep-seated anger towards her *aiga* and its impact upon her decision to attempt suicide - “I’m still angry, especially with my mum and his mum and him [ex-partner] and my sister”. This is reflective of the emotional concept of *musu* as discussed in Chapter Two because, as mentioned, it was not until this interview, other than her counselling sessions that she openly expressed her emotions. It seems she had withheld any negative emotions towards *aiga*. As previously discussed, *musu* is a form of emotional restraint and consequently, as in Saeni’s case, it may have been difficult to seek an appropriate means of venting this anger and hurt.

All participants were asked how they were feeling at the time of the event. The majority felt anger and considered it to be a principal and immediate contributor

to their suicidal behaviours. Thomas and Loleta's narratives are two examples:

I wasn't thinking. Just my anger aye, it just got in the way and it makes thinking properly difficult. Anger, I think I was just more angry that my girl was gonna leave me and stuff.

Nothing made sense to me. I walked around and wouldn't talk to people. I don't think I was depressed, I was angry, just angry.

Thomas attributes his anger to the possibility that he would lose his partner, as opposed to Loleta who remained ambiguous as to how her anger cultivated. Their comments reinforce the argument made in Chapter Two which suggests that suicidal behaviours are believed to be typically led by the emotion of anger - particularly towards those whom negative feelings should be avoided (Hezel, 1984). Whilst depression had been identified as a contributing risk factor for some participants, of concern is how the majority considered the emotion of anger to be the primary catalyst to their suicide attempts.

Zarnia: *When you harm yourself oh gosh it's hard to explain! Um you don't see anything else, all you feel is that you've got a lot of anger inside you and the only way you can bring it out is to harm yourself, you know to have open wounds - that would help. Deliberate harm or suicide is, I guess your negative approach to thinking that does it for you, it's not you, it's the pain that does it for you.*

Zarnia's portrayal underpins arguments made in Chapter Two which refer to the development of resentment due to the cultural expectation of emotional restraint amongst some Samoan youth which then leads to internalised anger (Gerber, 1975; Tupuola, 1998). In the same way, Zarnia's actions support judgements made in Chapter Two whereby the stringent cultural expectations of knowing one's place and acting accordingly may produce internal resentment and stress within the Samoan young person (Tupuola, 1998; Freeman, 1983; Mulitalo, 2001). This, for some, may lead to *musu* (withdrawal, sulkiness). Freeman (1983) maintains that a person in this state, is "very near the breaking point" (p. 219) and may consequently engage in suicidal behaviours. Both Tupuola (1998) and Taule'ale'ausumai (1991) also consider that in the case of some NZ-born

Samoan young people, rigid cultural expectations impact upon suicidal behaviours.

Zarnia's description of her suicide attempt was a means of expressing or emitting her anger. She suggests that negative thinking triggered her anger and sought self-destructive behaviour as her relief. As highlighted by Tupuola (1998), this reaction is not uncommon. The act of suicide was perceived by Tupuola's respondents as a means of releasing stress and pressure and escaping cultural constraints. Furthermore, Zarnia's allusion to "open wounds" is considered a method of coping with her internalised anger.

Otila also addresses emotional repression and describes how her *aiga* tended to avoid "deep conversations". She states:

I've always noticed that I've been closer to my dad than my mum. I find it hard to share things with my mum ever since we were small. I never really shared feelings about things that went on with any one in my family, even with my older sister. We didn't share anything we weren't close. I think it was just me. I find it hard to talk about my deep emotions and stuff. I prefer to keep it in. Yeah, and I know that sometimes that's not good, but I don't know, it's just, I feel weird or uncomfortable sharing them and so I never really had those deep conversations with my mum [laugh] or my sister or anything.

Otila finds it difficult to share her feelings with members of her *aiga* and claims that 'healthy' relations between her and other female members of the *aiga* are minimal - "We didn't share anything we weren't close". When asked to clarify what she meant by a lack of communication being a fault of her own, she attributes this to not being able to 'open up' - "I find it hard to talk about my deep emotions." She considers it awkward - "I feel weird or uncomfortable sharing them". Subsequently, this means dialogue between family members is restricted and seems a challenge for her to talk about her "deep emotions". Otila's response regarding emotional repression thus contradicts the concept of *teuteu le amio*, or putting one's feelings in order, which is a type of self-control and is perceived to maintain peaceful relations (Shore, 1982). Instead Otila's emotional repression is one of personal choice.

The comments made by both Zarnia and Otila imply that their suicidal behaviours were methods of releasing the 'pain'. Their narratives also reinforce insights whereby young Samoan females are subjected to cultural constraints - more so than their male counterparts (Schoeffel, 1979; Tupuola, 1998; Anae *et al.*, 2000). Subsequently, this may insinuate that some young Samoan females may have the least opportunity to express anger or hostility.

It seems that emotional suppression builds 'walls' and it is these 'walls' that are proving self-destructive for some NZ-born Samoan youth. There may also be the additional challenge for some NZ-born Samoan young people to not only keep their feelings in order - *teu teu le amio* - but also maintaining a controlled outward appearance. As a result this may have bearing upon the emotions of shame and masking that have been emotional tools which have helped some cope with the cultural constraints of overt emotional expression. These concepts are examined in the following sections.

Shame

Suicides cut themselves off from their families. From the village. They bring eternal shame to everyone. To their mothers especially ... because they have no place to belong suicide souls wander. Always (Figiel, 1996:6).

The findings thus far have suggested that the lack of discussion around suicidal behaviours within the *aiga* and the Samoan community is ascribed to the potential shaming of the *aiga* as expressed by Figiel, above. For instance, findings in Chapter Five indicate that for some NZ-born Samoan youth, the high expectation of honouring the family name contributed to their suicidal behaviours. In addition, Tupuola (1998) and Macpherson and Macpherson (1985) speak of the association between shame and Samoan youth suicidal behaviours.

Participants were asked to share their thoughts about why they believe some *aiga* in Aotearoa/New Zealand tend to avoid the discussion of suicidal behaviours. Louise and Loleta attribute this to shame. It appears in Louise's

response that the reservation about discussing suicide attempts amongst the Samoan community is associated with the potential marring of the *aiga* name.

Why aren't they talking about it? They don't want it to happen to them. They don't want to be involved in such a thing. I think it's just that they're stubborn and I think it's because of embarrassment. They don't want to talk about it because they're embarrassed to talk about it because some of them have gone through that phase and they probably don't want to talk about it because they don't want to put shame upon their families.

Louise suggests that some families may have encountered suicidal behaviours amongst their own members and so tend to avoid any discussions around it. Moreover, if an individual undertakes suicidal behaviours, this may result in a negative judgement about that individual and perhaps about their *aiga* (family). The stigma of suicide spreads to those involved with the deceased or with those who have attempted to take their lives (Lester, 1998).

The following three narratives depict the interweaving of *aiga*, suicide and shame. When asked to reflect upon *aiga*, suicide attempts and shame the participants state:

Loleta: *Oh man they're so into that they're like - 'you have to keep the family name clean you know, don't go off and do this and don't go off and do that' and to me that's just like pressure as well as expectations. It's just a whole lot of things and that's one of the reasons why you find other kids you know, becoming bad and stuff and kids like me trying to finish it.*

Loleta confirms Chapter Five's discussion that family "pressures" and "expectations" contributed to her suicidal behaviours - "trying to finish it". She believes that familial strains are brought about by having to uphold family honour and in saying this, assumes that this compelled Samoan young people to participate in other risk-taking activities - "and that's one of the reasons why you find other kids you know, becoming bad and stuff". Her point of view also reinforces Tupuola's (1998) findings where tendencies of suicidal behaviours are perceived by study participants as an escape from their "constant battles and conflicts" (p. 139).

The findings so far illustrate that the notion of shame, coupled with the fear of disgracing the family name is an area of concern. Such perceptions are reinforced in the next two narratives. Michael's response illustrates how he perceives Samoan young people feel about 'letting down' the *aiga*. During the course of the interview Michael had used the term *ma* (shame) in reference to fulfilling family obligations and expectations which had subsequently impacted upon his suicide attempt. When asked to define what being *ma* means to him, he answers:

Um, well it was shame when I failed rugby and shame that I got a duck at cricket. You start becoming picky with the things you do. Because I brought a lot of shame to the family, I didn't want to go and try something new you know, and so I started to be very picky - yeah, I'm gonna go over here because I know I can do that properly and I know I won't bring shame to my family.

Being *ma* for Michael has negative connotations. His view reinforces the notion that personality factors impact upon youth suicidal behaviours - particularly those factors of lowered self-esteem and confidence (Beautrais, 1999; Cummins *et al.*, 1999; Velting, 1999) It seems apparent that being *ma* perpetuates these factors. Michael also makes the connection between shame and the honouring of the family name. His fear of failure and the potential 'damaging' of the *aiga* reputation means his life choices are limited. Therefore, to avoid shaming his *aiga* it seems Michael chooses to 'play it safe'.

Solomona, in the next narrative, makes a similar connection with regard to the importance placed on honouring the family name. Although not included in this extract, he too shared during the interview that familial pressures directly impacted upon his decision to take his life:

Oh they're always praising each other you know the family name and things yeah and getting worried if you know one of us kids did something wrong that other families are going to turn around and say 'oi va'ai leaga tele...blah blah' [look, very bad] and their family is just this and that. Oh they're just too worried about what people say to them.

Solomona reinforces that one's conduct can either improve or demoralise the prestige of the *aiga*. Thus Solomona confirms that some individuals undergo considerable pressure in order to observe the consequences their conduct may have upon the status of the *aiga* (Chun, 2000).

So far, it seems that upholding the family name is paramount for these participants - where Michael, Loleta and Solomona believe that the wrongdoing inside the *aiga* would attract negative judgement by the Samoan community. The complexity for these NZ-born Samoan young people is determining what is more face-saving - to be alive, or to be dead. This dilemma bears out the perception by some within the Samoan community that "it is worse to lose your face, than lose your life" (Tatz, 1999).

Shame, in light of participant narratives, has varying facets: shame associated with the lowering of the family name; shame associated to non-successes or 'failures'; and the shame involved in a suicidal act committed by a member of the *aiga*. As such, 'keeping face' puts pressure on the young person and may hinder any open discussion around suicidal behaviour amongst some *aiga*. For example, as illustrated in Louise's and Loleta's narratives, "They probably don't want to talk about it because they don't want to put shame upon their families" and "you have to keep the family name clean ... and that's one of the reasons ... like me trying to finish it".

In the next section 'masking' is the third theme to emerge from participants' narratives as an important mechanism for defence that equally impact upon their suicidal behaviours.

Masking

Imprison/protect/cut off/shield
Walls hide/keep in secrets/keep
Out marauders
Walls frame our seeing
Walls don't happen
We grow them...

(Cited in Wendt (1995) an excerpt from The Wall).

This excerpt from the piece entitled - 'The Wall' by Albert (Wendt, 1995) is an apt description of the suppression of one's true feelings or, in other words, 'masking'. For participants in the current research it appears that such walls have been a means for them to "protect/cut off" and "shield" themselves. Masking, like *teuteu le amio*, may be considered another type of denying one's inner feelings (Aune & Waters, 1994). As discussed in Chapter Two, masking may be used by the young person to satisfy an authority figure. This most often means that one's feelings are concealed (Thaman, 1974; Aune & Waters, 1994; Tupuola, 1998). Consequently, masking may discourage some young Samoans from seeking help or talking about their problems during times of distress, thus promoting the decision to undertake suicidal behaviours as almost a natural one.

Ana, in the following narrative, reinforces the perception that masking is a tool used for hiding "true emotions." Ana's account also illustrates the various personas adopted in order to achieve this.

There were the pressures of going to church and putting on a happy face and coming home, knowing that I wasn't happy at all. I'm not the happy person that everybody thinks I am because I put up a mask and just talk to everyone. I'm pretty good at hiding my true emotions. I've learned that way before school, before primary school. Everybody expected me to be a happy person, when after getting a hiding they expected me to wipe those tears and you know, be happy again, and if I showed any other emotion like anger I would get another hiding, or if I continued crying. So I guess, yeah, that's where the mask came from, just good at hiding it all.

Ana reveals that putting on a "happy face" or mask is becoming a challenge as it contradicts her true emotions. She makes the statement - "that's where the mask came from, just good at hiding it all." During the interview Ana was asked to elaborate upon her use of the term 'mask'. She speaks of this term in relation to the constraints of emotional repression - "after getting a hiding they expected me to wipe those tears and you know, be happy again". This enables her to 'control' her emotions - particularly with regard to the overt expression of anger - "if I showed any other emotion like anger I would get another hiding ... so I

guess, yeah, that's where the mask came from, just good at hiding it all." This supports literature in Chapter Two which details the unacceptability of overt emotional expression by Samoan youth, particularly if it is in relation to one's elders (Chun, 2000; Mulitalo, 2001; Tupuola, 1998; Gerber, 1975). It also reinforces the claim made in Chapter Two that from early socialisation, a Samoan person learns the art of concealing their true feelings (Aune & Waters, 1994; Freeman, 1983). Ana also alludes to the enforced emotional repression for some young people in 'holding back the tears' - "after getting a hiding they expected me to wipe those tears and you know, be happy again". This confirms *teu teu le amio* that emphasises the internal ordering of one's actions, feelings and self-control (Shore, 1982). It is therefore evident that the stringent cultural observance of self-control and *fa'aaloalo* (respect) by most NZ-born Samoan young people, as well as the expectation of knowing their place in the hierarchy, reinforces this masking behaviour.

In the context of this next narrative, Kim implies that masking is used both as a "cover up", a way of avoiding people's sympathy, and as a method of coping.

I don't care about myself basically, I don't love myself enough to think positive like I'm getting there slowly but at the moment it's all like a cover up when I'm all cheerful and stuff but basically, really I'm feeling down. But that's just 'a trying to get through it' I suppose. Always trying to be happy and stuff but I want to actually feel it, feel happy not faking it. [I: Why do you fake it?] Only so people won't keep saying - 'are you all right?' and stuff like that. I don't want to be a burden to anybody basically.

Kim shows a sense of hopelessness which is similar to Michael's comment made in the previous section and, as suggested by Goodman (1990) and Shore (1982), increases her negative expectancies. It seems that her attempt at masking forms a multiplicity of personas: the repressed persona - "don't want to be a burden to anybody;" the happy and dejected personas - "I'm all cheerful and stuff but basically, really I'm feeling down", and the persona of despair - "I don't care about myself basically, I don't love myself enough". Kim's perspective confirms that masking may not be uncommon for some NZ-born Samoan young people - particularly if it is a means of maintaining self-control, honouring the family name, and concealing one's true feelings (Goodman, 1990; Tupuola,

1998). Moreover, it may be important to note that in relation to the *fa'asamoa*, some NZ-born Samoan youth may use masking as a means of complying to the cultural code of *fa'aaloalo* (respect) towards their elders.

Depression

If the problem involves the adolescent's security, safety or acceptability to others, the conviction that no coping action is possible can lead to an emotion some might call the depression of hopelessness. This state can motivate a suicide attempt (Kagan, 2001:798).

Depression is often used to explain both a frequent human emotion as well as a disorder or illness (National Health Committee, 1996). As previously outlined in Chapter Two, there is little known about depression amongst Pacific peoples in Aotearoa/New Zealand (Sullivan & Bulik, 1997). Furthermore, there are gaps in public health literature regarding the connection between depression and young Samoan people's suicidal behaviours.

During the course of all interviews, participants were asked if they felt they were depressed at the time of their suicide attempt. A small number identified as being depressed with a subsequent impact upon their suicidal behaviours. This partially confirms Western public health research which suggests that depression is associated with young people's suicidal behaviours (Adcock *et al.*, 1991; Andreasen & Grove, 1982; Beautrais, 2000b; Beautrais *et al.*, 1996; Beautrais *et al.*, 1998a; Chastang *et al.*, 1998; Donald *et al.*, 2001; Herman-Stahl & Peterson, 1996; Hovey, 2000; Kaltiala-Heino *et al.*, 1999; Mazza & Reynolds, 1998; McLaughlin *et al.*, 1996; Rihmer *et al.*, 1995; Rubenstein *et al.*, 1989; Sullivan & Bulik, 1997). The participants who admitted to being depressed at the time of their suicide attempt were asked to describe, in their own words, what the term 'depression' meant to them. Definitions such as -"I'm in a black hole", "a deep hole", "a dark cloud just over your head", "raining hard out on you" and "you look outside, it's just grey to you" were used; these are depicted in Pologa's and Talia's narratives in the following:

Pologa: *Depression, oh! I wish it would just go away. Um, it's worse than being sad, you know, it's something that's always there. It's like a dark cloud just over your head all the time and it's basically raining hard out on you, you know rain and hail. Um, even when it's a sunny day you look outside, it's just grey to you, you don't see it, and when people say 'oh yeah it's a lovely day today' and stuff like that, you're like 'yeah it is isn't it?' but really inside my head I'm going, no it's not. It's a suckful day sort of thing. You don't see the goodness you know, like when you walk by and you see a daisy, people stop and notice it but for me I just walk straight past and not notice it, I don't care. I have one of those real ignorant attitudes towards what's good in life, you know, the sun is shining now but I'm like, mm, still looks grey to me.*

Talia: *Put it this way, like for myself, I feel like I'm in a black hole or in a deep hole and I'm trying to get out but can't get out of it yeah, that's how I can explain it.*

It appears in these narratives that the emotional pain experienced by these participants leaves them in a state of increased vulnerability in relation to their emotional and mental wellbeing. These views seem to be consistent with the Western notion of depression. For instance, an Aotearoa/New Zealand-based study by (Dickinson, 2000) finds that Pakeha (European New Zealanders) young people's depressive symptoms are bought on by change and loss situations and increased isolation which potentially increases their risk of suicidal behaviours. In addition, the participants in the current study who identified as being depressed, confirm much of the Western public health literature which suggests that depression is a contributing factor in youth suicidal behaviours (Adcock *et al.*, 1991; Beautrais *et al.*, 1998a; Haw *et al.*, 2001; Mazza & Reynolds, 1998).

Pologa's definition regarding her state of depression as being "worse than being sad" may be reflective of a depressive syndrome, that is for her, the combination of feelings of anxiety and worthlessness, as well as depressive mood (sadness, unhappiness) (National Health & Medical Research Council, 1997). Her description also seems to reflect a sense of hopelessness.

There is the argument that depression may be brought about by young people's inability to identify effective coping strategies in times of distress (Herman-Stahl & Peterson, 1996; Kagan, 2001). Of particular concern in Talia's account is her description of depression which she likens to being in a "deep hole", a hole she believes she cannot "get out of". This belief supports the argument that depression and ineffective coping go hand in hand. Most participants who identified with being depressed share a similar view. Joe's response is an example:

I have my own stuff happening for myself in here. Um trying to handle depression, trying to juggle with depression.

Other descriptions of depression are similar to Pologa's feelings of loneliness and worthlessness:

Kim: *Depressed, hmm I guess a lot of it was just looking down on myself. I had real low self-esteem, which couldn't make it any easier, you know, yeah, it just turned to that. The lowest point of my life, nothing was going to stop, or nothing could, I could feel there's nothing out there and there was nothing more that's gonna help me. I was like the loneliest, my loneliest point in life.*

Otila: *My depression was from, the fact that I didn't have any work, had no qualifications, had no one, no family around me. Cos even though they live out in X [place], I just wanted to know that I can still go back and be normal, but I knew that if I was to go back, they wouldn't treat me the same, like they would probably step away from me and I'm the type of person that likes everybody around me. Just having no one to talk to that basically depressed me quite a bit and just remembering the things that my family used to say you know, I was dumb, I'm stupid and all that stuff so, yeah, just everything, everybody was saying to me put me in a big depressed world.*

Pervasive themes to emerge from these comments appear to be loneliness, having no one to talk to, and a sense of hopelessness. This sense of loneliness supports the view in Chapter Two that some NZ-born Samoans tend to avoid situations which may leave them in social isolation. It also supports the Western

public health perspective that loneliness may trigger youth suicidal behaviours (Milligan & Waller, 2001). Kim's and Otila's responses also reaffirm (Harris & Morlock, 2000) argument that young people's perceptions of their futures are influenced by negative expectancies, which in turn may play a significant role in their suicidal behaviours. Furthermore, feeling "normal" around her *aiga* is an issue for Otila. She assumes her *aiga* would avoid her - "they would probably step away from me" and recalls the negative remarks they would say like, "I was dumb" and "I'm stupid". This, she feels had contributed to her depression and subsequent suicide attempt.

CONCLUDING COMMENTS

In conclusion, this chapter raises a number of issues for Samoan young people, in particular, the cultural expectations of emotional reserve which has impacted upon their suicidal behaviours. This chapter argues that most often, interpersonal conflicts trigger this anger and subsequent suicidal behaviours. Shame and masking are discussed in terms of the interweaving of *aiga*, keeping face, remaining within cultural boundaries and suicide attempts. Furthermore, there is the issue of Samoan young people's inability to identify coping strategies, primarily in relation to their depressive states. It seems that NZ-born Samoan young people's states of depression are better explained in terms of Western public health perspectives. A more in-depth discussion of these implications and potential strategies are detailed in Chapter Eight.

CHAPTER SEVEN: REASONS TO LIVE: NEGOTIATING SAMOAN YOUTH WELLBEING

Fatu: There are times when you do come across down stages. I pick myself up now, whereas before I used to just let my family take its toll on me like having to do what they wanted me to do all the time and just going with it. I've learned to accept what I'd done and am letting it go. I keep thinking of all the reasons of why I should go on living and to be quite honest, it's mainly for my family. You see I lost a bit of myself when I tried to kill myself, and now I want to reclaim my life back.

INTRODUCTION

In previous chapters a predominant theme to emerge was the pressure of *aiga* expectations and obligations placed upon young people, which are believed by some to have contributed to their suicidal behaviours. Fatu, in the above extract, reinforces this in the mention of his responsibilities to the *aiga* which he considers had taken “its toll”. As with other participants, Fatu refers to the contradictory nature of the *aiga*. However, what is significant in his response, and in the context of this discussion, is that the *aiga* is also perceived to be a reason to live. It appears that the *aiga* is perceived as having the potential for strengthening the mental, emotional and spiritual wellbeing of its young Samoan members. Fatu’s perception supports empirical public health research which has linked youth happiness and mental health wellbeing to family cohesion (Calvert, 1997; Clarke, Harnett & Shochet, 1998; Harris & Morlock, 2000; Resnick, 2000; Resnick *et al.*, 1997). Public health knowledge suggests that family cohesiveness and support are seen as buffers against suicidal behaviours (Jobes & Mann, 1999). Therefore, it appears that a strong supportive family as well as future plans (as in Fatu’s case) may mitigate suicide risk (Jobes & Mann, 1999).

This chapter focuses upon what participants considered would best work for them in terms of promoting an incentive to live. It would seem that participant responses, in line with Jobes and Mann’s (1999) argument, create opportunity to support and reinforce specific reasons to live while simultaneously

addressing a decrease in competing reasons for dying. This chapter explores the reasons Samoan young people give to promote the message of life. This information will be a useful contribution to the development of possible strategies for suicide prevention. For instance, as Fatu illustrates, *aiga* is a convenient starting point.

In Chapter Two I addressed the matter of culture where, “Suicide prevention strategies need to be adapted to the local culture and cannot be simply exported or copied from one country to the other” (Rosenberg & Mercy, 2000:29). This chapter attempts to investigate suicide prevention strategies relevant for Samoan youth in Aotearoa/New Zealand by exploring their reasons to live. Participant narratives have been organised under key themes which have evolved from interview data. These key themes include: reasons to live; social support; spirituality; and service delivery considerations.

ANALYSIS AND DISCUSSION

The public health approach, discussed in more depth in Chapter Two, emphasises prevention and identifies protective factors in the family and the community (Resnick, 2000; Smokowski *et al.*, 1999). Protective factors are often seen to facilitate the process of overcoming adversity (Calvert, 1997). The conceptual role of protective factors helps to explain how many young people, despite adversity and the pressures of negative life events, rise above these negatives (Calvert, 1997). Such factors will be explored in the following analyses.

Reasons To Live

Participants were asked what advice or action would they take to convince other Samoan young people that life was worth living. Most participants agree that talking through problems with people with whom they could relate to, as well as restructuring negative thought patterns, would be the first solution.

Kim: My advice would be for the youth to not think negative things. You have to pull yourself out of that state of mind. You can't stay in the same circle you've always been in. Most of the time it's about having somebody there, even if they're silent, its just having somebody there to comfort you, that's all. You deserve to live, you don't deserve to die. I keep saying to myself that before I met him [partner] I lived without him, so I can live again without him. It will get better. I have faith in that. There's so much to live for like family and my future career. I want to be an achiever that's the main reason, yeah that's my motivation to move forward you know wanting something for myself, not for anyone else. Living my life the way I expect it to be, not the way that people expect me to be. I also feel that when it comes to preventing suicide it's important to instil your culture wherever possible.

Kim claims that negative thinking has to be discouraged amongst Samoan young people who are suicidal and that someone has to be “there” for them. This supports Bennett's (2000) findings whereby positive thinking is found to be a useful component of problem solving. Kim also concludes that optimistic life orientation and recognising the value of *aiga* are both compelling reasons to live.

It is interesting to point out that Kim has negotiated the traditional Samoan view of identifying herself in the ‘we’ or the collective. Instead it appears that she had adopted the Western “I” or individualistic view - “wanting something for myself” and “living my life the way I expect it to be”. It seems she is challenging the expectations of the *fa'asamoa* by having the desire to become independent and taking control over her own life. This is consistent with the findings of Tupuola (1998). Subsequently she maintains that this has heightened her incentive to live - “that's my motivation to move forward you know wanting something for myself, not for anyone else”. The predicament for some, not all, is that when a Samoan young person behaves or thinks independently, rather than obeying his/her elders, they may be called *fiapoto* (acting smart), may be accused of *fiasili* (acting like the best) or even dubbed *fiapalagi*, (wanting to be a European) (Macpherson & Macpherson, 1985; Tupuola, 1993a, 1998). The Western emphasis on personal autonomy can thus be problematic for the Samoan

young person in Aotearoa/New Zealand as the concepts of self and individualism are not universal prerequisites in Samoan culture. For instance, the individual's experiences and lifestyles are predominantly shaped and determined by their community, *aiga*, and social and cultural norms. Furthermore, theories that emphasise personal independence seem to show little awareness of hierarchical structures where for some, choice is not determined by the individual but rather dependant upon their status in the community, gender and/or age (Macpherson & Macpherson, 1985; Thaman, 1974; Tupuola, 1993b, 2000a, 1998; Silipa, 1999b; Tiatia, 1998; Fairbairn-Dunlop, 1999).

Samuelu also implies that altering one's negative thought patterns would promote the message of life for Samoan young people. He states:

Talking about it will help, talking your way through problems releases you. If you run into a problem you can solve it a bit better instead of thinking 'I deserve it'. The best decisions are the hardest ones to make even though you hurt, but you'll get over it, and takes a bit of time, and you've gotta be patient with it. Sure enough, you'll go through a rough time but then there is a time when good comes to you as well. You've got to just keep up the will to live and the best way I think is talking about it. Also the Samoan people need to know that suicide is real and not to just keep it hidden all the time that way we as a people can pick out the positives and build up the reason to live for the younger generation.

Samuelu believes that talking through issues is the "best way" in terms of keeping "up the will to live" for Samoan youth. He also suggests that raising awareness within the Samoan community would allow for positives to be extracted and then developed.

The next narrative also appears to illustrate the negotiation of traditional Samoan values. For instance:

Joe: *I would like to go around schools and get a group of kids together who feel they are in the same situation as me and start talking to them about what happened and giving them advice, and drilling into their minds that suicide is not good. Because we didn't have that when I was in school. It would've been cool if we had people who had gone through our experiences, come*

and talk to us. Samoan young people need to talk about when they're upset, like with their family problems, and to learn to go up to whoever they're angry with and talk to them about how they feel but at the same time I know this is hard for Samoans, but it has to start somewhere.

It appears Joe was oblivious to the traditional Samoan prerequisite that a young person must display *fa'aaloalo* (respect) and remain non-confrontational toward elders at all times, irrespective of who may be in the wrong. As mentioned in Chapter Two, for a young Samoan person to do this indicates that s/he is overstepping cultural boundaries which would, in turn, be a negative reflection upon their *aiga*. Joe's advocacy for overt expressions of discontent amongst Samoan youth appears "non-Samoan" in that he challenges the Samoan notion of *teu teu le amio* (to put one's feelings in order). However, he feels that, in terms of suicide prevention and promoting reasons to live for young Samoans, there needs to be opportunity for young people "to go up to whoever they're angry with and talk to them about how they feel". He puts forth the idea that Samoan young people need to rethink their positions. Both Joe and Kim highlight challenges some NZ-born Samoan young people may face.

Social Support

We have heard time and time again if we're going to nurture successful young leaders, we navigate to the millennium, supportive relationships. ... Young people today they need our support ... relationships is about building positive relationships to meeting youth needs (Taufua, 1999:n.p).

A generalised beneficial effect of social support is that it may provide a type of support which could be related to the overall wellbeing of an individual because it provides positive effect, a sense of predictability, and stability in one's life situation, and a recognition of self-worth (Cohen & Wills, 1985). This section explores some of the gaps participants identified in relation to their current social support structures. The narratives also suggest support mechanisms that may be helpful during times of suicidal crises.

One participant, Thomas, when asked to consider why he thought Samoan young people turned to suicidal behaviours states:

I think, the young people have got no one to talk to at that moment, when they've got problems. They just can't handle it, and I think they're frustrated and don't know what to do. So they just want to hurt themselves, like what I did. There's just no one to turn to, like with some Samoan families the young people can't talk to them, especially when it comes to private things.

Thomas believes suicidal behaviours amongst “young people” was the result of not being able to “handle” their problems. His view implies that Samoan young people are unfamiliar with any coping strategies to draw upon in times of distress and because of this, Thomas considers, suicidal tendencies are the only option for many Samoan young people. His view supports those narratives presented in Chapter Five, which suggest that with some *aiga* staying within cultural boundaries often means that young people are prevented from expressing their deepest hurts, frustrations and anger. In addition, Thomas raises the issue that there is the tendency by some *aiga* to avoid discussions around things of a private nature. This may be reflective of the way most Samoans live their lives in a public arena and where the more private aspects of experience are strongly discouraged (Shore, 1982).

Friends

Some participants consider that talking to friends is a factor which would inhibit suicidal behaviours. This is depicted in the following narratives:

Aniva: *I've got really good friends, like a little group of friends from high school and we still keep in touch. I can share with them because they can relate to what I go through. It's just them that I can really open up to. After talking with them I knew things would be right. I guess once you isolate yourself it makes it worse. I tried to get a hold of a few of them before I slashed myself, cos I knew they would have talked me out of it, but none of them were home and that made it easier for me to harm myself.*

Aniva considers peer support to be her strength. “Offloading” is made easier due to shared experiences amongst her group of friends. Her comment about isolation and making a situation “worse” supports the argument in relation to Samoans in the islands during the 1980s where most tended to avoid situations which may have left them in social isolation (Shore, 1982). It seems that for some NZ-born young people, this fear of social isolation may still be relevant. In the same vein Solomona, when asked whom he would talk to when he felt pressured, also identifies the support of friends:

Yeah I have a bunch of mates that I used to kick it with [hang-out] and we talk heaps but I share more with one of them. He’s like my best mate. It’s good to know you have that kind of support. It eases the load.

Both Aniva’s and Solomona’s views reinforce the recommendations of various authors, who suggest that friends and peer groups should be recognised as fundamental in the planning toward suicide prevention strategies (Borowsky *et al.*, 2001; Calvert, 1997; Cummins *et al.*, 1999; Evans, 2000; Gibbs, 1997; Heikkinen, Aro & Lonqvist, 1994; Nisbet, 1996; Resnick, 2000; Resnick *et al.*, 1997; Rubenstein *et al.*, 1989; Smokowski *et al.*, 1999). This also supports the notion that positive friendships are an important component to resiliency (Heikkinen *et al.*, 1994; Smokowski *et al.*, 1999). Furthermore, Aniva’s and Solomona’s views also illustrate that fear of social isolation continues to be a factor for NZ-born Samoan young people.

Aiga

Contrary to Chapter Five’s discussion of the intimate correlation between *aiga* pressures and suicidal behaviours, this section focuses on some of the strengths of the *aiga* which may be considered a starting point for effective and appropriate suicide prevention strategies specifically targeting Samoan young people. Although the *aiga* has been recognised as a pervasive environment of risk for some participants (as discussed in previous chapters), it appears that the *aiga* continues to play an integral part in the lives of most participants’ lives.

It also seems that some recognise the motivational support the *aiga* provides. This is emphasised in the following narrative.

Timo: *They've just been there through the worst times. They have never subsided for me, they've always comforted me and they've always encouraged me to do this and that and never looked at me differently. They've never talked bad about me and regardless of what I did and how much trouble I've put them through, they've never looked at me negatively but always thought of me as me. They've been there for me after my ordeal. So yeah, they're helping sort things out big time!*

Although Timo has attempted to take his life, it seems his ordeal has helped him come to the realisation that his *aiga* has “been there.” His description appears to support a plethora of literature which suggests that family cohesiveness is a leading protective factor for young people (Calvert, 1997; Clarke *et al.*, 1998; Cohen & Wills, 1985; Harris & Morlock, 2000; Mitchell, 2000; Range *et al.*, 1999). Furthermore, social support provided by the extended family may serve as a buffer against suicidality, oppression and negative life circumstances (Range *et al.*, 1999). Timo’s narrative illustrates that his *aiga* encapsulates the concept of *loto alofa* (compassion) and that he finds hope there. Their positive reinforcement, tolerance and being “there through the worst times” helped him “sort things out”.

Sesilia’s narrative sheds light on the need for role models within the *aiga*.

My brother has been my motivation to stay alive and it's not fair on him. I mean he's had a pretty jacked up life as well and I know that if I was to kill myself it would stuff up things for him even more and I love him too much to do that to him. So even though I'm so desperate to do it again I think of him and it's like oh nah, forget it. I have to set a good example.

Sesilia’s reasons to live may be comparable to the responses given by study participants in Paproski’s (1997) investigation of British Columbia First Nations Women and their suicidal behaviours. Like Paproski’s participants, Sesilia’s motivation to live is primarily based on being mindful of the negative impact her act would have upon a member of her *aiga*. Sesilia’s narrative depicts the high expectations she places upon herself in order to live up to her brother’s. Yet her

response seems to emphasise the value of *loto alofa* (love, compassion) towards her sibling - "I love him too much to do that to him" which is reflective of one of the core values. It also reinforces the bond a brother and sister share as prescribed by the concept of the *feagaiga*.

Feagaiga

It seems appropriate that the *feagaiga* be addressed in this section, as it may be considered an effective starting point for promoting dialogue within the *aiga*. Moreover, the concept of the *feagaiga* as a potential strategy for suicide prevention is a novel one in terms of its relevancy for NZ-born young people and their inhibitions towards suicidal behaviours. The following two narratives support this and suggest that the *feagaiga* relationship may be considered a social support structure in terms of enabling brothers and sisters to turn to each other in times of distress.

Joe: *If I feel like sharing something which is really pulling me back I usually share it with my sisters. They understand, they lend a shoulder and lend an ear to listen. Usually what they say calms me down and relieves me from my stress. It was a pity that at the time, I didn't turn to them. I guess I knew they'd talk me out of it.*

Timo: *My sisters have a real Christian base and they're someone to call upon for advice because they have a clear mind and they respect life. I'm comfortable with my sisters and I like to turn to them. They pick me up when I'm down and share their point of view from their Christian side just to calm things down you know, if you're feeling uneasy or a bit timid and a bit stressed at times.*

It is apparent that the *feagaiga* is a relationship which offers comfort and support for siblings. Just as peers and friends have been recognised as appropriate support systems - not only for these participants but also within the discipline of public health - for some NZ-born Samoan young people, the *feagaiga* is at least as much an essential component to consider in the planning of Samoan youth suicide prevention strategies. Taken from Joe's and Timo's

narratives, the *feagaiga* seems to be a relationship which may for some Samoan young people, in times of distress, provide them with “an ear to listen”; “advice”; a “comfortable” environment; a “pick me up”; and is a relationship that “calms” one down. It must be noted that the *feagaiga* does not exclusively work for males. For instance, Louise and Satia in Chapter Five provide sisters’ perspectives.

The narratives presented in this section strengthen the argument made in Chapter Two that supportive social networks and close interpersonal relationships may act as protective factors and are applicable to the lives of some NZ-born Samoan young people.

Spirituality

The exercise of faith and the acceptance of an order beyond our control does not mean we concede our free will, or relinquish our desire to be in control. In a sense, we achieve our greatest control over our living when we choose to exercise our faith (Marrone, 1999:505).

This next section focuses on spirituality, which has been described as an experience which may provide internal strength and peace for an individual, thus buffering feelings of anxiety, despair and other negative life circumstances (Kim & Seidlitz, 2002; Range *et al.*, 1999).

It has been argued that a strengthening of spiritual connectedness with God - particularly within the *aiga* - may be considered vital if adverse events are to be managed amongst Samoans (Tamasese *et al.*, 1997). Whilst the majority of literature addressing the spiritual or religious concerns of the Samoan community appear to speak for most Samoans, this discussion explores the relevance of spirituality for Samoan young people in the context of Aotearoa/New Zealand.

Participants were asked about the place of spirituality in their lives in the contemporary context of Aotearoa/New Zealand. Their responses are presented in the following narratives.

Pologa: *Spirituality is very important. Our family is a very religious family. I didn't really believe there was a God. But ever since my break up with my boyfriend, I go to church nearly every two days and have prayers at home every day; it has been a must for me. I've made it a priority and that has been what's picked me up again. I have chosen to live cos God gave me another chance to live. My faith has helped me get back on my feet, kept me busy and helped me set goals for myself.*

Since the break up with her boyfriend, Pologa's positive outlook on life is a result of prioritising her spiritual life. She feels indebted to God and as a consequence has chosen life - "I have chosen to live cos God gave me another chance to live." It is this spiritual revival which gives her direction - "My faith has helped me get back on my feet, kept me busy and helped me set goals" and supports the work of Pardini and colleagues (2000) (see Chapter Two) who maintain that higher spirituality increases optimistic life orientation.

Similarly, Satia had also drawn upon her union with God which she maintains helped her through her ordeal. Moreover, in her response, God is likened to a friend and seen as someone with whom she can confide in.

Lately God plays a big part in my life, I always pray. I know that one thing's for sure, God is always there and if ever I'm down He'll always be there to turn to. Sometimes if I'm driving I'd just talk to Him like I would a friend and I think that's what's helped me get through what happened during Christmas [suicide attempt]. Last year was when things just went a bit funny and it's good I guess cos now it has given me time to refresh my faith and a reason to keep alive.

For both Pologa and Satia, it is apparent that a higher force had been identified as an alternative to turn to in a time of distress. This supports claims that suggest that spiritual interconnectedness is a significant coping mechanism for young people in general (Early & Akers, 1995; Holder *et al.*, 2000; Hovey, 1999; Kim & Seidlitz, 2002). It is also interesting to note that both Pologa and Satia deem their suicidal acts as opportunities to renew their faith. Both these young women believe that as a consequence, God's influence in their lives has given them a reason to live.

Joe also considers God as someone who he could turn to and acknowledges that, although God is not a tangible presence, He is his “foundation” and provides him the reassurance that he is “always there”.

It's one of the good things in my life, the bonus I have. When I've got family problems the first one I turn to is God. I still have this foundation that's always there and it's God. Even though he's not physical at least he's always there. Praying gets me through the rough spots in life. God gives me hope and let's me know it'll be okay, to value life and to hold onto the fact that life is worth living.

It appears that when a situation in his *aiga* is problematic, Joe's first point of contact is God. Once again, as with other participants' comments presented in this section, God has provided this participant with hope and a reason to live. Joe believes that prayer is a stress release and has helped him cope.

Nofoa, in this next extract, shares a similar view to Joe's. Her coping strategy is to draw upon her spiritual connectedness with God.

I've made God number one in my life, He's given me a way out. I think it's made me wiser especially in decision making and it's just a comforting thought knowing that if I ever get angry I know that there is always someone there. You can't really see Him but you know that He's there and He's always very close to you. God has made me handle things. Getting in touch with my spiritual side is helping me cope heaps better.

She too considers that although God is an intangible presence, His company is always felt. God helps her with decision making, negative emotions - “if I ever get angry”, coping - “God has made me handle” and has given her direction - “He's given me a way out”.

These statements suggest that spiritual experiences continue to play a vital role in the lives of Samoan young people brought up in Aotearoa/New Zealand. What is notable for these young people is that God is a being with whom they could connect after they had attempted to take their lives. God seemed to be compensating for everything that had failed them or been missing at the time -

he was there, was someone to talk to, provided them with hope, and had given them a reason to live. It therefore seems appropriate that, in the planning and development of suicide prevention strategies, spiritual or religious components must be included for there to be any meaningful effect for Samoan youth.

Service Delivery Considerations

Kim, when asked to describe why she thinks Samoan young people are taking their lives, responded by raising three concerns. In addition to discussing the most common themes to emerge from the findings like having “no one to turn to”, being subjected to “too much pressure from family “ and having “too many expectations”, she also alludes to the inappropriateness of service delivery:

They have no one to turn to, or maybe they've tried but the response from the people they try to get help from isn't what they wanted, like counselling. Maybe it's too much pressure from family and too many expectations and they're not fulfilling them. It's like the best answer to solve their problems is to - just go.

A reoccurring theme throughout this thesis is that Samoan young people are pleading for someone to listen. Saeni's narrative highlights the relationship between suicidal behaviours and having no one to turn to. She states:

You need someone to try and support you and get you through the hard times because, the way I see it, Samoan youth who try to commit suicide basically want someone to sit there and listen to them. I think that would give someone a reason to live. You know letting it all out and sharing it instead of keeping it in.

Saeni believes that suicidal behaviours amongst Samoan youth are more a 'cry for help', thus conveying the message that what youth desire is someone to listen to them and offer them support. It appears that talking through problems or issues is an incentive for young people to have a reason to live - "letting it all out and sharing it instead of keeping it in". This once again raises the concern addressed in Chapter Six, that in most cases, Samoan young people are expected to restrain from venting emotional negativity in the presence of their

elders. This is an important consideration as it restricts young people from “letting it all out and sharing it”. In addition, there is the issue of relevancy or appropriateness of support services for Samoan young people. For example Sala recalls:

She [her counsellor] asks me what I wanna do but like, I don't know how to get rid of the anger. So I can't tell her how I want to get rid of it because it's still there. She told me to write it out in a letter, but you know, still that doesn't help.

Sala expresses the frustrations with counselling sessions which, she later discloses during this interview, was with a mainstream mental health service. Sala admits her counsellor tried to rectify the situation yet it was considered to be unaccommodating - “She told me to write it out in a letter, but you know, still that doesn't help”. This raises the issue of inappropriate service delivery for Samoan young people as well as the implications for the involvement of some Samoan young people in mainstream services. It is worth mentioning that Sala's reference to the ineffectiveness of expressing her anger “in a letter” is contradicted by Talia's earlier comment (p. 168) thus suggesting that letter writing may be only useful for some. Of particular concern is Sala's inability to deal with her anger and the frustrations of overcoming it - “I don't know how to get rid of the anger”.

It appears from the narratives so far that mainstream services are not catering to, or are perceived to be inappropriate, for some NZ-born Samoan young people. The following are suggestions that young people consider would help towards Samoan youth suicide prevention.

Loleta: *I reckon there should be more hamo [sl. Samoan] counsellors in schools, but at the same time it's sort of shameful if there were. You know how every Samoan's related? You're scared that it will get back to people and every Samoan family would know your private life. Maybe if there were NZ-born counsellors, you know people we could relate to. I guess then it would also be easier for us get the help we need.*

Loleta agrees that within schools there is a lack of Samoan counsellors. However she acknowledges that this is problematic as most Samoan people

are connected in some way and, as a result, her private life may potentially become public gossip. She believes NZ-born counsellors would be helpful. This raises the dilemma, however, that Island-born and NZ-born people's experiences may be incompatible and once again draws attention to intergenerational misunderstandings. So whilst mainstream services may be seen as problematic for some, Loleta also thinks that services which employ staff with a similar ethnic background but have limited insight into the specific needs of NZ-born Samoan youth might remain a challenge.

In this next narrative, Satia's perception appears to contradict Saeni's in terms of staffing and having the appropriate people in place. She states:

There should be more Samoan or Pacific younger people working in schools like counsellors and that, because there's not enough. Sometimes they have more understanding of where the younger generation is coming from. Also in schools we should get the Samoan people talking about our Samoan problems.

Satia addresses three concerns; she first supports the idea that age does, in fact, influence the decision by some Samoan young people to refrain from talking about their problems. Secondly, she reinforces the concept addressed in Chapter Two, whereby suicide prevention and interventions are most likely to be successful if they are staffed by individuals with a similar background to the young person. This is also consistent with Coggan and colleagues' (1999) findings in Chapter One. These authors find that Pacific students feel a Pacific youth health worker is desirable for the promotion of positive mental health. Thirdly, Satia suggests that - "we should get the Samoan people talking about our Samoan problems" which reaffirms the view that suicide prevention should enable full ownership and be conducted at a community level, on the initiative of the members of that community (Clarke *et al.*, 1997).

Satia's view is also supported in the following narrative. It is also suggested that if NZ-born Samoan young people could not talk to their *aiga*, they need to be aware of existing alternatives. For example Zarnia states:

There are heaps of Youthline counsellors. I wasn't really into that and I didn't want to go to counselling it was a hassle for me with transport. You could talk to a neighbour. We should have more of those groups that could go to the house and visit them and Samoan people doing so. I mean on TV like with that suicide programme that came on, I didn't even see a brown person on there. I mean this kind of topic like suicide doesn't only involve white people; you know brown people are involved in it too. They should have more brown faces, Pacific Island kids such as myself. Then we can see that Island people go through this as well.

Zarnia suggests that home visits are considered an appropriate method for some NZ-born Samoan young people. In addition, she maintains that in order to raise the profile of suicide prevention in both the Samoan and Pacific communities, there must be people on the frontline with whom Samoan and Pacific youth can relate to and identify with. This is consistent with Rosenberg and Mercy's (2001) third principle in the public health approach, which argues that suicide prevention be inclusive in scope.

Otila, in the following extract, describes her experiences in the ED following her suicide attempt, in relation to how she was treated by hospital staff and the lack of subsequent follow-up care.

When I was in hospital I noticed that the doctors weren't that helpful, I think it's because I came in for a 'bad' reason they probably saw me as some sort of case that's come off the street and doesn't value life. The doctor was a bit mean and he talked kinda nasty to me. Anyway they only checked on me once and that's it! Before I went home a psychiatrist lady came and saw me. She asked if I was all right and stuff that was good, she figured I wasn't mental or anything [laugh] but she didn't really refer me to any other help. I think she probably thought I didn't need any - but deep down inside I needed someone to talk to.

Otila's narrative is indicative of the marginalisation experienced by some who present to an ED following an episode of deliberate self-harm (Bennett, 2002; Niruni & Chenoweth, 1999). She further recounts that in her case there was a lack of appropriate follow-up care, which she feels was needed. The implications of appropriate follow-up care is discussed further in Chapter Eight.

Solomona's narrative suggests that the best approach to address suicidal tendencies is to identify someone who can be trusted and to talk through the issues:

Suicide should not be the only way out. There are some other good ways, without involving physical harm. There are better ways of coping or trying to get outta the shit. A biggie would be speaking to someone you can trust and being able to offload to them.

Solomona agrees that talking through problems with someone trustworthy is a coping mechanism and helps to alleviate stress. This is consistent with the recommendations made in a survey of secondary school students in Australia who believe that talking through problems would help prevent youth suicide (Victorian Task Force, 1997). With regards to what may be needed for effective suicide prevention, one key informant in the Australian survey argues that:

Prevention is far more effective than intervention. We need to build on and not dismantle our social support structures. Self-esteem, stress management, managing emotions and practical communication skills should be part of preparation-for-life skills, not just available in crisis counselling situations (Victorian Task Force, 1997:55).

Earlier chapters reveal that there is a breakdown in communication - particularly between young people and their elders - which has, in turn, impacted upon their suicidal behaviours. For instance, some Samoan young people tend to refrain from sharing problems with members of their *aiga*, particularly regarding things of a sensitive or private nature. The dilemma for Samoan young people - as findings have indicated thus far - is that they may not be able to identify anyone who they can turn to at a time of a suicidal crisis. Consequently, this has been an added frustration and stumbling block for these young people. As depicted in the above quotation, what needs to happen for Samoan youth suicide prevention is to develop the personal skills and capabilities necessary to cope with negative effects, to deal with the demands of day-to-day living and to realise their aspirations.

Initiatives such as FLEP highlight how the arts are an effective means of delivering health promotion messages as they are something that Samoan and

Pacific young peoples can relate to and identify with. Some participants identify alternative ways of coping as well as or instead of drawing upon spiritual connectedness with God. For example, the following three narratives illustrate some of the self-initiated mechanisms used to help cope in times of distress.

Talia: *I think it was the letter, that stopped me, that's why I didn't do it the last time, because um, you know my tears would be flowing and I would just write in anger. I was writing and after I'd read through it I suddenly realised that what I was doing was quite silly.*

Loleta: *Now when I get stressed out and can't cope, I read, or if not that I just go and sit under a tree and just try and let the wind blow away everything negative and that clears my head.*

Fatu: *I usually relieve my stress through my music, I love music, I always listen to music. When I go to sleep I always put it on and just listen. There aren't many support groups or counselling groups. A lot of them are mainly for Europeans and they don't understand where we're coming from. So listening to music was, and is, my way of coping.*

Talia finds solace in writing out her frustrations. She recounts that once she had read over what had been written, it had woken her up - "I suddenly realised that what I was doing was quite silly". In the same way, Loleta finds that her stress relief is to read. She also engages in 'time-out' periods which provide her with the opportunity to draw mental pictures and allow her to "let the wind blow away everything negative". Lastly, Fatu claims that in order to cope and manage stress, he listens to music. He makes the comment about the limitations of resources and services available to him and feels that they cater more for "Europeans". Furthermore, he believes that often mainstream services often misunderstand the experiences of NZ-born Samoan young people.

These three narratives illustrate that there are easily accessible alternatives for Samoan young people. These beliefs also confirm that artistic modes - such as those FLEP employ - as discussed in Chapter Two, are effective ways to manage day-to-day stressors. These examples describe young people's constructions of coping mechanisms they best understand, and are relative and

appropriate to their specific needs. They are also mechanisms which are absent from public health suicidality literature. It appears that these participants engage in coping strategies that make sense to them, where comfort is found in things they can identify with. Whether it is turning to God, engaging in artistic activities, or reading and writing, these help-seeking behaviours and coping strategies have been central to their lives. It is these alternatives that are in need of further investigation and must be recognised and promoted if the planning of suicide prevention strategies are to be constructive for NZ-born Samoan young people.

Participants were asked how, if given the opportunity, best would they promote the message of 'life' amongst their Samoan peers. Michael responds:

It's sort of hard because I reckon it needs to start within their homes with the family situation. If that's where the problem is for the kids, then that's where you need to start solving it. You can go to the schools and promote 'choose life' but it always goes back to the home. Like if I was a student and some group came in and they promoted 'choose life' I would be real happy but then when I got back home, I'd face all those pressures and expectations again then I might start to fall back into that suicidal phase.

This statement seems contrary to the literature addressed in Chapter Two which assumes that the school environment is a strong setting for positive mental health promotion for most young people (Bennett & Coggan, 1999; Klingman & Hochdorf, 1993). Yet for these NZ-born Samoan youth, there is the strong argument that the home environment is a more relevant and appropriate site for change and mental health promotion. For instance, in the following narrative, Fatu emphasises that the home environment should be the first step toward culturally appropriate suicide prevention:

I'd have to say that with Samoan youth and giving them some kind of reason to live, you have to start in the home and with parents. Not to say that parents are bad but, times have changed and I guess parents are just scared their children will forget about them. That's what I found with my parents - 'If you do it your way, you'll forget who your parents are, if you do it our way, you'll remember who we are'. Well I remember who they are and I reckon it starts within the home.

Fatu claims that focusing upon the *aiga* provides young people with an incentive to live. He addresses the significance placed on remembering where one comes from and to whom one belongs - a concept which strengthens the belief that for some young NZ-born Samoans, their lives are undoubtedly connected to that of their *aiga*. This implies that the Samoan proverbial expression *e leai se aoga e tele ai au mea, ae leai ni ou aiga*, (it is of no use for one to possess the riches, fame or success of the world and have no family) is still very much relevant today.

It therefore seems fitting that the *aiga* be the foundation for any strategy to work effectively as it is both a contributing factor to NZ-born Samoan suicidal behaviours as well as equally having a buffering affect against such behaviours. Moreover, as discussed in Chapter Five, within some *aiga* intergenerational misunderstandings are most often the cause of a breakdown in communication between its members - particularly between parents and their children, affecting young people's options of who they can turn to in times of distress. Fatu was asked to elaborate on a point that he raised earlier in his interview about what was considered a contributing factor toward Samoan youth suicidal behaviours. He responds:

I think how kids can't communicate with their parents, it's a cultural thing. I don't know how it was in Samoa, like they weren't allowed to talk to their parents and stuff like that, and so that's sort of come down to us. I think it might help us maybe if our parents actually recognised the problem you know and maybe start it within our culture, we need to break out of that for future generations so it won't be so hard for the kids to communicate with parents.

Fatu feels that a lack of communication is a key factor for suicidal behaviours amongst Samoan young people and implies that this lack of communication is typical of Samoan culture - "kids can't communicate with their parents, it's a cultural thing". It is possible that in this statement, parents are deemed to be unapproachable because of the stringent observance by some Samoans of the hierarchical nature of their society. The situation arises where there is a difference between NZ-born young people, who adopt the values of the host culture, and their Island-born parents and elders who wish to see them adhere

more to the values of their own culture. It is argued that this, in itself, can place the family support structure itself at risk (Bathgate & Pulotu-Endemann, 1997).

CONCLUDING COMMENTS

This chapter has illustrated that there is no one solution for suicide prevention. Whilst the role of the *aiga* has been considered a source of conflict for some, in most cases it is imperative to include the *aiga* in suicide prevention planning and development. Findings reveal that spirituality is a common trait in the lives of these Samoan young people and suggests that spiritual connectedness to God may be important to include in suicide prevention initiatives. In addition, others drew upon coping alternatives such as writing, reading or music and these may be deemed just as important to include. Most participants stress the need to have someone to talk to who will listen - particularly someone from a similar background to whom they can relate. This highlights the need for more Samoan people to be trained to communicate with youth and raise awareness amongst *aiga* and the community.

CHAPTER EIGHT: CONCLUDING COMMENTS, RECOMMENDATIONS AND IMPLICATIONS FOR POLICY

INTRODUCTION

Both nationally and internationally, public health perspectives of youth suicide (as well as the focus on risk factors for suicidal behaviours amongst young people) are predominantly informed by epidemiological analyses of routinely collected statistical data (Coggan, 1997; Gunnell, 2000; Kosky, 2000; Shaffer, 1993). A growing body of literature has also recently emerged in relation to young people's suicidal behaviours with a focus on resiliency and protective factors (Bennett *et al.*, 2002; Borowsky *et al.*, 1999; Forman & Kalafat, 1998; Resnick, 2000). Yet the supremacy of risk factor-based epidemiology has maintained the subordination of certain suicidal populations. For instance, there has been little research exploring suicidal behaviours and suicide prevention not just for the Samoan community, but for the Pacific peoples of Aotearoa/New Zealand generally (Tiatia *et al.*, 2002).

The research about NZ-born Samoan youth suicidal behaviours and reasons to live detailed in this thesis seeks to contribute to the relatively little public health knowledge currently available. Furthermore, given the abundance of epidemiological research in the area of youth suicidal behaviours on a global and national scale, the current research is unique in that it takes a sociocultural approach within public health, which has traditionally been dominated by the mental illness approach to describe the aetiology in youth suicidal behaviours. It is also unique in that within the context of Aotearoa/New Zealand there has previously only been a public health focus on youth suicidal behaviours amongst Pakeha and Maori populations. This research is unique in that it is an attempt to facilitate incremental shifts in public health understandings of Samoan young people's experiences of suicidal behaviours. This current research therefore provides information which has not previously been available within the arena of public health.

The research comprises two parts: part one being a quantitative descriptive analysis via a medical record review, and part two involving analysis of in-depth face-to-face interviews with Samoan young people who had attempted suicide. The aim of this research, as outlined in Chapter One, is to explore the perceptions of Aotearoa/New Zealand Samoan young people (16-25 years) who had attempted suicide, as well as their reasons to live. In so doing, this research investigates: firstly, the characteristics of all Samoan young people who presented to EDs as a result of a suicide attempt by reviewing their medical records (see Chapter Four); secondly, issues young Samoan people who had attempted suicide believe contributed to their suicide attempts using in-depth interviews (see Chapters Five and Six); and lastly, the views of young Samoan people who had attempted suicide regarding their reasons to live, thus providing information that will contribute towards overall future wellbeing, be it physical, mental, spiritual, or emotional (see Chapter Seven).

THE RESEARCH PROCESS

How appropriate was the research process for this current study in the exploration of NZ-born Samoan young people's suicidal behaviours? By unravelling the intricacies of conducting Samoan focused research in relation to youth suicidal behaviours, an alternative cultural perspective and 'reality' is shaped within the field of public health.

The inclusion of a multi-method approach provides more meaningful results as a means to delve deeper into and analyse the inner-workings of the statistical evidence, thus providing a holistic consciousness of reality (Samiee & Anthanassiou, 1998). Furthermore, the research methodology for this current study supports Range and Leach's (1998) criticisms of a scientific approach outlined in Chapter Three. The research approach in this current study also strengthens the claim made by Tamasese, Peteru and Waldergrave (1997) in Chapter Three, that if research is to be faithful to the context of its participants' involvement, then it must include a process which facilitates a paradigm that truthfully reflects the cultural values and meanings of its research community. A scientific, experimental, laboratory-based approach does not allow for cultural

values and meanings to take precedence.

In relation to the qualitative component in phase two of this current study, Range and Leach (1998) maintain that in any investigation of suicidal behaviours, the population must drive the questions, the format of questions should be open-ended, the process must allow an opportunity for people to share their experiences, and the relationship between the researcher and participants should be fairly open and flexible. In this current study, it was important to provide question zones (reviewed by the adult and youth cultural mentor groups and supervisors) which enabled participants to manoeuvre the direction of the interview (with subtle prompting by the interviewer when the discussion became far removed from the scope of the research). It is also important to mention that the vital component of spirituality was incorporated into the format in order to be consistent with the holistic Pacific and Samoan perceptions of health. The question zones format offered participants an opportunity to 'voice' their experiences and insights around their self-destructive behaviours. This participant input and a degree of involvement during the interviewing process allowed for a comfortable and flexible rapport to develop between the researcher and the participant.

Given the sensitive nature of this research, as outlined in Chapter Three, there were many concerns raised by the cultural mentor groups about the safety and ethical issues regarding the interviewing process. Participants were asked, before the close of the interview, to comment on how they felt about the interviewing process and their perceptions of the overall objectives of the research. The following narratives are telling:

Talia: *It's been great, I was looking forward to it. You've made me come out with things, like my feelings that I would never be open about. It's been kinda liberating. I also think that if it's something that's gonna make a difference and make people more aware of what's going on, then I'll do it. Also I can get away with words [laugh]. You've made me feel comfortable.*

Pologa: *I've really enjoyed this talk, you know you don't have anyone here that is looking at you differently and going 'oh here we go again'. You've been non-judgemental and that's really good. It's made it easier for me to share my experiences, like*

the deep stuff, you know stuff you don't really talk about. It's been a relief.

All participant responses are positive and most considered the interviews to be therapeutic as well as allowing for wider dissemination of suicidal issues and information to the Samoan community. Talia and Pologa acknowledge that the interviewing process enabled them both to openly express their “feelings” and enable them to delve into the “deep stuff” - concerns they consider have never really been publicly discussed. Nevertheless, both found the interviewing process to be “liberating” and a “relief” - possibly implying that the process may have had therapeutic benefits. In addition, the way in which the interviews were conducted appears to provide a non-threatening, “comfortable” and “non-judgemental” atmosphere for the participants. This confirms that a one-off interview with participants (as opposed to the three meetings proposed by the adult cultural mentor group as mentioned in Chapter Three) was an appropriate method for rapport to be established - particularly for such a sensitive topic.

The inclusion of cultural mentor groups adds great value to this research. The groups provide the necessary cultural guidance and, with their various backgrounds in academia, community work, social work, parenting, teaching, injury, medicine, secondary and tertiary schooling, and pastoral care, enabled an array of occupational, gendered, age-related and Pacific and Samoan perspectives to emerge.

In terms of suicide prevention, Timo and Aniva share the view that the dissemination of Samoan youth ‘voices’ would be a positive step towards increasing awareness for suicide prevention within both the Samoan and Pacific communities. For instance they state:

Timo: *I think it's good, all this research about us young Pacific kids. Especially with my situation, because I think we just need support and need people to talk to about what has happened and then researchers get to write about it and get it out to other Pacific Islanders. I think this research is a really good idea especially for us Pacific Islanders.*

Aniva: I commend you and what you're doing, I think it's good because I mean the problem's there, the suicidal thing, but it's hidden within our culture. And it's good that the work you guys are doing will get it out there.

Both affirm that talking about suicidal behaviours is “good” - particularly in terms of enabling wider dissemination of the issue within the Samoan and Pacific communities. Aniva suggests that the research is to be commended as it brings to the fore an issue she regards as too often “hidden within our culture”. Moreover, in Timo’s view, the study is valuable for “us Pacific Islanders”, as there is a “need” for it.

Overall, the interviewing process gives participants an opportunity to be heard and to have someone to speak to about their experiences. Whilst it is thought (and there is much debate) that talking about suicidal behaviours may in fact increase a young person’s risk (Ministry of Health, 1998; The New Zealand Youth Suicide Prevention Strategy, 1999), participants in the current research suggest otherwise. Generally all participants welcome the opportunity to share their stories and find the research process to be appropriate and most useful.

The inclusion of debriefing sessions with a mental health professional for participants immediately after an interview was a crucial element to include in the investigation of Samoan youth suicidal behaviours. Regardless of the small number of participants who agreed to these debriefing sessions, it ensured a safeguard for them and was ethically appropriate.

Challenges

During the recruitment period for interviewing, one major concern arose. There were no Samoan or Pacific Psychiatric Liaison staff in any of the participating hospitals. It is beyond the scope of this study to consider whether response rates might have been affected by this. Would follow-up care for the young person have been any different? For instance, would a NZ-born Samoan young person be more compelled to attend post-discharge treatment had a Psychiatric Liaison staff member been someone from a similar ethnic background to the

potential participant? This is an area in need of further investigation. The implication for NZ-born Samoan youth is that, if the ED setting is considered an appropriate site for suicide intervention (Hurry, 2000; Bennett *et al.*, 2002; Kruesi *et al.*, 1999; McManus *et al.*, 1997; Silburn & Zubrick, 1995), how effective can it be for NZ-born Samoan young people if the 'appropriate' people are not in place?

REVIEW OF MEDICAL RECORDS

This chapter presents the medical record review findings for phase one of the research. This first phase involved a 12-month medical record review of all Samoan young people (16-25 years) who presented to public hospital EDs in the Auckland region. This chapter is a stand alone chapter, as the information is limited to an investigation of what is included in the medical records. This chapter provides previously unknown information in the area of public health related to Samoan young people (16-25 years) who presented to EDs at any of the three Auckland public hospitals following a suicide attempt, and the trends and patterns of these presentations.

As stated earlier, recent international evidence suggests that suicide attempts by young people are a familiar presentation in most EDs world-wide (Kapur *et al.*, 1999; McManus *et al.*, 1997; Taylor & Cameron, 1998). Furthermore, it is suggested that non-fatal suicidal behaviours are likely to result in significant use of emergency services (Robicsek, Ribbeck & Walker, 1993). The exploration of ED presentations following a suicide attempt seemed relevant for the current research.

Findings suggest that there are a number of consistencies with national and international evidence. For instance, the majority of ED presentations are by young females, the majority lived with family at the time of the attempt, most suicide attempts took place at home, most participants were accompanied to the ED by a family member or partner, the majority of suicide attempts occurred on a weekday, were outside office hours and were seen within an hour of presenting to the ED.

In this study, the occupational status of Samoan young people who attempted suicide appears contradictory to Western research which suggests that the unemployed have a higher risk of engaging in suicidal behaviours compared to those who are employed (Jones *et al.*, 1991; Lester, 1991; Morgan *et al.*, 1975; Morrell *et al.*, 1998). It is apparent in this study that those NZ-born Samoan young people who are employed may, in fact, have an increased risk of suicidal behaviours. This is consistent with the Pacific youth ED medical record review of suicide attempters in Aotearoa/New Zealand (Tiatia & Coggan, 2001). It is possible that this could be attributed to the frequent and often substantial financial contribution towards *aiga*, church and cultural obligations some young Samoan people feel obliged to commit to. This has, for those in paid employment, placed them under considerable strain (Tau'le'ale'ausumai, 1994; Tiatia, 1998). Findings in the medical record review also indicate that interpersonal conflicts with family members and partners are a leading contribution to Samoan young people's suicidal behaviours. It seems apparent that assisting Samoan young people in solving their interpersonal conflicts may be an effective method of reducing the number of suicide attempts. It also appears NZ-born Samoan young people need to be aware of mechanisms which would help them cope when in conflicting situations with a significant other. These mechanisms should not only include the education of young people in positive relationship building, but equally to incorporate strategies NZ-born Samoan young people can employ to manage their emotions after a dispute. Assisting NZ-born Samoan young people in solving their interpersonal conflicts may be an effective method of reducing the number of suicide attempts. These findings also emerged from the narratives (phase two of this study), particularly in relation to the stress associated with young people's financial contributions towards *aiga* and cultural obligations as well as their emotions and positive relationship building. Whilst this particular phase of the study provides some indication of the characteristics of the sample population and the circumstances surrounding the events, the young people's narratives in phase two provide more in-depth analyses.

These findings confirm the need for diverse suicide prevention and mental health promotion strategies for youth at the public health level. The majority of

attempted suicide presentations to EDs are young people who have no recorded history of previous suicide attempts, and who could benefit from mental health promotion care regimes, including conflict and stress management skills.

Useful follow-up care is likely to be that which can be offered in a way which acknowledges how life stressors may vary, depending on the stage of life. It is probable that such skills will be of use to young people in the general population (i.e., those who have not attempted suicide) as a means of potentially enhancing protective factors against suicidal behaviours and all other forms of self-destructive behaviours. Programmes or interventions incorporating such factors could be offered within environments that have previously been identified as being amenable to mental health promotion programmes (Coggan *et al.*, 2002).

Finally, it is beyond the scope of part one of the research to investigate the uptake of, and Samoan young people's satisfaction with, follow-up care opportunities offered following a suicide related ED presentation. This is an area in need of further investigation. These issues, however, emerged from interview data in Part Two of the research.

INTERVIEWS WITH SAMOAN YOUNG PEOPLE

The objective of part two of this study is to explore contributing factors in suicidal behaviours and reasons to live amongst Samoan young people in Aotearoa/New Zealand (See Chapters Five and Six). This is achieved using in-depth face-to-face interviews. In particular, the role of the *aiga* (family) and emotions are discussed in relation to their impact upon Samoan young people's suicidal behaviours. In addition, an exploration of young people's reasons to live as a means of identifying factors which may help to buffer future suicidal behaviours is also considered.

It seems narrative analysis is an appropriate tool for exploring suicidal behaviours among NZ-born Samoan young people. This approach allowed for an exploration into the intricacies and interweaving of cultural and human

experience. It also is fitting in that as Mishler (1995) argues, enables a critical reflection of participants' social and cultural contexts and in this thesis is coherent with the sociocultural take on Samoan young people's worldviews in relation to their suicide attempts. The current study's narrative approach also supports the work of Anae and co-investigators (2000) who contend that this approach is a suitable method to address 'sensitive' issues within the Samoan community.

Aiga

The analyses presented in Chapter Five suggest that the *aiga* plays a significant role in the overall health and wellbeing of Samoan young people. This chapter addresses some of the intricacies within the *aiga* which are seen to contribute to young Samoan's suicidal behaviours. For instance, young Samoans are always to be mindful of their position within the *aiga*. This is illustrated in Mageo's (1998) statement:

Within the aiga the younger members respect and serve those who are older ... there is one dictum that is so fundamental a guide for conduct that it can be made even to someone older, 'stand at your post' (tu i lou tulaga). 'Stand at your post' is a special metaphor for performing a role in the group that accord with one's status and rank, which to Samoans is tantamount to behaving respectfully (p. 4).

The chapter explores participants' positions and the frustrations associated with allegiance to *aiga* and the "pressures" of obligation in relation to suicidal behaviours. It also addresses the obligatory role of the eldest sibling. For instance, it is argued that the eldest is required to take on additional roles and responsibilities (Ritchie & Ritchie, 1979). Hence, Chapter Five investigates the extent to which these additional roles, responsibilities and expectations within the *aiga* have impacted upon suicidal behaviours. A lack of communication is identified as a major factor contributing to Samoan youth suicidal behaviours. This chapter also addresses the lack of parent-child communication and raises issues in relation to: unspoken hurts and frustrations; being a "cultural thing"; the embarrassment and shame of discussing private matters; the dilemma of physical discipline as a communicative style; and intergenerational

misunderstandings. It is evident that traditional views regarding the *aiga* still hold amongst most participants. Furthermore, there are also those who considered that the traditional structure of the *aiga* is transforming. For instance, Thomas perceived his gang affiliation was his extended family. Yet as the eldest in his immediate *aiga* there were still the expectations to carry out certain duties and responsibilities. Participants' experiences reflect how the *aiga*, although important as a support system, may have equally contributed to their suicidal behaviours. For instance, all participants acknowledge that *aiga* is fundamental, yet the complexity of obligation, the reluctance of dishonouring the *fa'asamoa* and family name, as well as being made to feel accountable had they not met these demands, diminishes the ability to identify methods of coping effectively with familial pressures. Yet in saying this, in Chapter Seven most participants deem the *aiga* or home environment as the most effective in terms of the initial basis for suicide prevention. The question may be - How do we engage the *aiga*? It may not necessarily mean physically entering the homes but rather promoting suicide prevention messages within the Samoan community. The emphasis may focus upon what NZ-born Samoan young people feel is appropriate. It is encouraging that the young people in this current study value their *aiga*. It appears that these young people do not want to sever all ties with their *aiga* but somewhat suggest that the *aiga* be the initial starting point for action. Such action includes strengthening and rebuilding relationships within an environment that is relevant and will positively contribute to the mental and overall health and wellbeing of these young people and their families. For instance a starting point for suicide prevention within the homes may be the relationship between brothers and sisters which findings have highlighted is a significant support structure for some. It therefore seems apparent that in terms of strengthening relationships and communication the *feagaiga* in particular encourages some young NZ-born people to talk through their problems. This however is not to say that it may not be relevant for those families who have single-sexed siblings within their households. The crucial point is that if this is the reality for some NZ-born Samoan youth, then should we not identify the sibling relationship as a first point of contact for young people in a time of suicidal crisis? It was beyond the scope of this study to investigate the views of the young NZ-born people's *aiga* or significant other(s). However, it is

acknowledged that this would be an important contribution and is in need of further research.

Emotions

The analyses presented in Chapter Six explore Samoan young people's emotional states immediately prior to their suicide attempts and raises a number of issues. In particular, the cultural expectation of emotional reservation seems to impact upon young NZ-born Samoan's suicidal behaviours. A common theme to emerge is that most NZ-born Samoan young people are expected to restrain from venting emotional negativity in the presence of their elders so as to remain faithful to the cultural code of respect or *fa'aaloalo*. This chapter argues that interpersonal conflicts - particularly with *aiga* or a partner - trigger anger which leads to suicidal behaviours. The analyses presented in this chapter imply that NZ-born Samoan young people who have attempted suicide have few or no coping mechanisms in order to deal with negative emotions. It is suggested that helping young people at risk of suicidal behaviours to practice effective coping skills may enhance suicide prevention (Apter, Gothelf, Offer *et al.*, 1997). So, if anger is shown to play a role in suicidal behaviours, there needs to be anger-related management strategies relevant for the Samoan community. Suicide prevention should therefore also focus on developing the ability for NZ-born Samoan young people to express their emotions and needs, and to learn to use alternative behaviours to communicate and convey feelings. It is identifying these alternative behaviours that are relevant for NZ-born Samoan youth that is an area in need of further investigation. It is also vital to consider that due to the cultural expectation of no overt emotional expression towards one's elders, services looking to cater to NZ-born Samoan youth needs will have to consider hierarchical constructs as an influential factor. This current study reaffirms that lack of overt expression and control of emotions are central to the lives of some NZ-born Samoan youth and therefore should be considered in the investigation of suicidal behaviours in this population.

Shame and masking in this chapter are also discussed in relation to the interweaving of *aiga*, of saving face, of remaining within cultural boundaries and

their association to suicidal behaviours. With regard to shame, recorded suicides in Samoa for all age groups are generally the result of discovery of offences against sexual morality, lost pre-nuptial virginity, adultery in prominent *aiga*, incest, elopement of a *taupou* (village maiden), inappropriate marriage contracted without consent, termination of love affairs and crimes (Macpherson & Macpherson, 1985). According to current research findings, shame and suicidal behaviours amongst NZ-born Samoan young people are associated more to feeling like a 'failure', the lowering of the family name and the pressures associated with high familial expectations (Tupuola, 1998; Bathgate & Pulotu-Endemann, 1997; Taule'ale'ausumai, 1997). The dilemma exists for some NZ-born Samoan youth that they may have to either live with the shame of their offence or resolve it by making an attempt on their life, which ultimately brings more shame upon the *aiga*. It seems that in relation to masking, given the scenarios presented by participants, the dilemma is that masking type behaviour may impede opportunities for some NZ-born Samoan young people to seek help.

The term depression is not only used to define a mental disorder, but also to describe a frequent human emotion (National Health & Medical Research Council, 1997). Findings in this chapter and those from the medical record review in Chapter Four, illustrate that a small number of participants identify as being depressed at the time of their attempted suicide. However, the majority of participants report that the social context of their lives was more important to their decision to take their own lives than their individual mental health status. This challenges a large body of research which, in the investigation of the aetiology of youth suicidal behaviours, tends to use psychological autopsy studies, controlled studies, case-control and longitudinal studies. These studies argue that those young people who engage in suicidal behaviours suffer primarily from a psychiatric disorder (Beautrais *et al.*, 1998a; Beautrais, 2000b; Brent *et al.*, 1993b; Fergusson & Lynskey, 1995a; Houston *et al.*, 2001; Shaffer *et al.*, 1988; Shafii *et al.*, 1985). It is suggested from these studies that the central role for suicide prevention is to increase the recognition and treatment of mental disorders. However, much of these conclusions are based on studies in Western societies and are based more on the individual which is not necessarily

the case for other societies - particularly the Samoan community. For instance, in the current study it appears that the common finding amongst participants is heightened stress due to social and interpersonal problems. This view supports the argument that risk factors for youth suicidal behaviours have no universal authority (De Leo, 2002), and so suicide-prevention strategies need to be tailored to the local culture (De Leo, 2002).

However, for the small number who identify as being depressed, there is the concern that they are unable to cope with their depressive states. The implication is - how can Samoan young people and their families best address this 'depression' and what culturally appropriate help and accessible coping mechanisms are at their disposal?

Reasons to Live

This chapter contributes to the field of suicide prevention within public health with a focus upon the Samoan community. Much of the literature discussed in both this chapter and Chapter Two, in relation to protective factors and suicidal behaviours amongst young peoples have relied upon Western and non-western theories. This is primarily a consequence of the lack of public health literature addressing suicidal behaviours and protective factors amongst NZ-born Samoan young people.

It has been suggested that a better understanding of factors which protect against suicidal behaviours amongst young people is needed to identify adaptable factors and develop culturally appropriate suicide prevention and intervention strategies (Borowsky *et al.*, 2001). It is argued that for those who are working with ethnic minorities, it will be important to understand the unique ways culture may interact with individual and familial forces to contribute to, or buffer against, suicidality (Range *et al.*, 1999).

As mentioned earlier in this chapter and further discussed in Chapter Two, traditionally suicidal behaviours are associated with mental illness, thus suicide prevention was primarily oriented towards those people who suffer mental illnesses, such as depression, schizophrenia and anxiety disorders, which

consequently lead to their suicidal behaviours (Rosenberg & Mercy, 2000). In addition, it is also claimed that most research has focused on risk factors associated with suicidal behaviours rather than potentially protective factors like resiliency (Royal New Zealand College of General Practitioners, 1999; Willis *et al.*, 2002).

Findings from the current research highlight the strengths of the *aiga* which may be considered a starting point for effective and appropriate suicide prevention strategies specifically targeting Samoan young people. Thus the strong argument is that the home environment is a relevant and appropriate site for change and mental health promotion for Samoan young people. It is emphasised that the home environment should be the first step toward culturally appropriate suicide prevention and seems fitting that the *aiga* be the foundation for any strategy to work effectively. In addition, and in line with findings in Chapter Five, and as mentioned earlier in this chapter, the *feagaiga* (brother-sister covenant) may be considered an effective starting point for promoting dialogue within the *aiga*. The development of the *feagaiga* as a potential strategy for suicide prevention within the Samoan community is a novel finding specifically in relation to Samoan youth suicidal behaviours and suggests that this relationship may be considered a social support structure. Not only will it reassure the young person that they have someone to turn to in the *aiga* in a time of distress, but also encourage young people to talk through their problems.

It is maintained that to be culturally sensitive, suicide prevention initiatives should not only facilitate pride in heritage and incorporate community outreach efforts but also package resources unique to the specific cultural group such as family and spirituality and/or religion (Range *et al.*, 1999).

However, spirituality is often ignored in a public health approach to suicide prevention despite the recognition that the spiritual world is considered a positive feature and should not be ignored as a potential suicide prevention resource (Kim & Seidlitz, 2002; Range *et al.*, 1999). After all, the core beliefs and behaviours associated with spirituality have been recognised as being related to positive mental health outcomes (Pardini *et al.*, 2000). In relation to

the NZ-born Samoan youth experience, the current study suggests that spirituality is of great importance in the lives of most Samoan young people and appears to be an appropriate consideration for suicide prevention.

Spirituality is believed to sustain an individuals' optimism, social support and resilience to stress (Pardini *et al.*, 2000) and has been the case for NZ-born Samoan young people in this research. It is therefore most important that healthcare professionals address spiritual concerns of Samoan young people in relation to their suicidal behaviours. It may be that as part of the planning towards suicide prevention, a standard approach to dealing with young suicidal Samoans is that priority be given to elicit information about their spiritual lives. In addition, it may be useful that help or follow-up care for the suicidal Samoan young person should include pastoral care, where services should work closely with, or are aware of, appropriate pastoral services for referral. However, approaching spiritual issues requires considerable sensitivity, cultural acceptance and the ability to be non-dogmatic (Hassed, 2000).

Chapter Seven also highlights alternatives for Samoan young people which they identify as being easily accessible. For instance artistic modes such as music, as well as expression through reading and writing, seem an effective way to manage day-to-day stressors. Analyses illustrate that the uses of alternative media are constructions of coping mechanisms these young people understand best, and are relevant to their specific needs. Participants locate themselves within worlds that make sense to them, where their comfort is found in activities they can relate to and they are most passionate. It is alternatives such as these that are in need of further investigation and development and must therefore be recognised and promoted if the planning of suicide prevention strategies is to have any impact for Samoan young people. In addition, most participants agree that initially, suicide prevention needs to start within the home environment.

It is also vital to consider that the development of health services needs to be appropriately geared towards the experiences of young people (Bennett, 2002). In some cases it appears that suicidal behaviours amongst Samoan young people are more a 'cry for help', thus conveying the message that what young people desire is for someone to listen to them and offer support. Analyses

suggest that talking through problems or issues is an incentive for Samoan young people to have a reason to live as it gives them the opportunity of, as one participant states, “letting it all out and sharing it instead of keeping it in”. This again reiterates the concerns addressed in Chapter Six - that in most cases, Samoan young people are expected to restrain from venting emotional negativity in the presence of their elders. This is an important consideration as it restricts young people from talking openly about issues or seeking help.

It appears that Samoan young people are not seeking help beyond those they know. Subsequently when that ‘fails,’ they feel they have no one else. Could this then suggest that Samoan young people are not comfortable with those outside their *aiga* or circle of friends? Or is it that they are uninformed of services available to them? This raises the issue, that if this is the case, then who could Samoan youth share with, if not with those familiar to them? What services are able to cater to this need? And what is most effective means for Samoan young people (in terms of future help-seeking) to enhance their reasons to live? In response, a common perception in the findings is that young people should seek help and talk to someone they can trust. This reinforces the claim that trust is a vital ingredient for young people and seems to be a buffer against suicidal behaviours (Coggan, Patterson *et al.*, 1999; Zechetmayr & Swabey, 1998). Yet, the question still remains, where will young people find this ‘trustworthy someone?’

Reasons to live also suggest that appropriate staff at clinical care services need to be in place if suicide prevention is to have any success. As suggested by one participant - “we should get the Samoan people talking about our Samoan problems” reaffirming the notion that suicide prevention should enable full ownership, be conducted at a community level, on the initiative of the members of that community (Clarke *et al.*, 1997).

Chapter Seven also identifies gaps in follow-up care. This is consistent with a study conducted by Coggan, Patterson and Fill (1997) that finds that young people are highly critical of ED practice in Aotearoa/New Zealand with regard to acute management and follow-up care of youth suicide attempters. This view also emerges from the current research where it is identified that there is a lack

of appropriate follow-up care upon ED departure. The implication is that although a member of the Psychiatric Liaison team may have contact with the young person in the ED, the lack of an established post-discharge treatment plan for some may be detrimental. Furthermore, it is plausible that providing follow-up care which is not specifically focused within a treatment paradigm for mental (ill)health, or provided from services solely oriented toward mental (ill)health may address some of the barriers to compliance for youth and their families.

It is agreed that all young people who have attempted suicide need a comprehensive outpatient treatment plan before discharge from an ED as well as suitable follow-up care (American Academy of Pediatrics, 2000). It appears that ED procedures need to be revisited to focus upon the requirements of young people, as well as to allocate resources to ensure that appropriate clinical support is provided (Coggan, Disley & Patterson, 1997). This would allow for better follow-up care of high-risk young people and may stimulate the implementation of early intervention initiatives (Birkhead *et al.*, 1993). To improve non-compliance with follow-up care for Samoan young people, if not all young people, it may be useful to employ someone post ED assessment to maintain contact with suicidal young people even after referrals have been made.

A predominant recommendation from the current study is that NZ-born Samoan young people need someone with whom they can relate and talk through problems with. Furthermore, a consistent and central finding of the current study is the continual and continuing importance of the *aiga* in the lives of some young NZ-born Samoan people.

In closing, it seems fitting to end this thesis with the voices of the participants themselves. In essence, these narratives encapsulate the research and describe the realities of NZ-born Samoan young people who may have taken a wrong turn only to discover that there is “renewed hope”.

Satia: *We need to be able to talk about suicide in our community. I believe homes are where its at – that means families have to pull together. Young people need to feel they are supported and can turn to someone – why not in their own*

aiga? If you ask me, the youth need to know that the struggle is only for awhile.

Joe: *I'm glad I got through it. After I went for it on myself, the next day I felt that it wasn't the answer. It was out of it I had a renewed hope. I've got a new lease on life now and that's where I wanna be. I wouldn't change it for the world. I just wanna live cos I know there's so much more I would like to achieve and so much more I'm capable of. God came through for me I admit, but the thing that stuck out for me is the family. If we want to prevent suicides, we have to first start talking about it and having services, programmes and stuff like that, that are relevant to us as Samoan youth in New Zealand.*

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