Ko ngā pūtake o te mātānawe ki tā te rangatahi

An exploration of self-injury in

rangatahi Māori

Tahlia Erana Te Ao Mihi Kingi

Ngāti Whakaue, Ngāti Rangiwewehi, Te Aitanga-ā-Hauiti,

Ngāti Mākino, Ngāti Rangitihi

A thesis submitted in fulfilment of the

requirements for the degree of

Doctor of Philosophy

Victoria University of Wellington

2018

Tipu ki roto
Tipu ki waho
Tipu ki te whaiao,
ki te ao mārama!

He Whakarāpopoto
Abstract

This thesis explores how *rangatahi* Māori and whānau define and experience self-injury in Aotearoa. The dominance of the current Western knowledge base that contributes to psychology in Aotearoa is questioned, specifically regarding the extent to which current knowledge adequately explains self-injury in *rangatahi* Māori. To do this, I use a mixed-methods approach that is informed by the principles of *kaupapa Māori* (G. H. Smith, 1997), Māori-centred (Cunningham, 2000) and interface research (Durie, 2005).

Our current understanding of self-injury in *rangatahi* Māori is informed predominantly by international research and models grounded in worldviews that differ from the unique cultural context in Aotearoa. These definitions, such as that for "non-suicidal self-injury" (Zetterqvist, 2015), and models, such as the Experiential Avoidance Model (Chapman, Gratz, & Brown, 2006), are then applied to the assessment and treatment of *rangatahi* Māori. In this thesis I highlight why these Western definitions and models become problematic when they are incongruous with the behaviours that *rangatahi* Māori define as 'self-injury' and, as such, fail to consider the unique, complex and diverse experiences of *rangatahi* Māori who self-injure.

The quantitative study involved cross-sectional survey data collected from 343 *rangatahi* who identified as Māori in the Youth Wellbeing Study. This survey data provided initial insight into the prevalence and correlates of self-injury in *rangatahi* Māori. In the second study, sequential focus groups were conducted with 25 *rangatahi* Māori and their whānau. The principles of Interpretative Phenomenological Analysis (J. Smith, 2004) informed the qualitative data analysis.

Definitions of behaviours that *rangatahi* Māori and whānau considered to be self-injury were broad and varied, including harm to *wairua* (essence, spirit) of the *rangatahi* and their whānau. Reasons for self-injuring included experiencing intense emotional pain, for example, that which was caused by peers. The most common functions of self-injury endorsed by *rangatahi* Māori were to express emotional pain, to communicate distress, to maintain a sense of control over their lives, and to manage their suicidal thoughts.

It is my intention to produce research that is directly relevant to *rangatahi* Māori, whānau, the broader community and the clinical profession. In the final chapter of this thesis I answer the question 'how do we support *rangatahi* Māori who self-injure?'. I frame these answers by adapting *whakataukī* (proverb) 'e kore au e ngaro, he kākano i ruia mai i Rangiātea' (I will never be lost, for I am a seed sown in Rangiātea). I argue that, while we as Māori should never feel lost when we know who we are and where we come from, many *rangatahi* feel as though they are lost, and self-injury is one means of coping with this sense of struggle. For *rangatahi* Māori in this research, self-injury is differentiated from suicide by the concept of hope; suicide is a loss of hope whereas self-injury is a means of holding on to hope. By understanding it in this way, self-injury can form a target for early intervention and prevention of suicide.

He tuku aroha

Anei te mihi maioha ki ōku tūpuna kua wheturangitia, ko rātou kua
mene atu ki te pō, e oki oki, e moe, e moe, ā, e moe mai rā e koutou.

Ko Hamilton Manaia Pihopa Kingi tērā.
Ko Russell John Te Aotata Thompson tērā.
Ko Violet Aloha Thompson tērā.
Nei tōku reo ōhākī ki a koutou katoa.

Tae atu rā ki te māreikura e ora tonu ana, ko tōku kuia,
ko Inez Haereata Kingi tērā.
Nei te reo aroha mutunga kore ki a koe.

Te Atua Matakore

Te atua Matakore, ē ī
Ka mōai koa Taupiri, a Te Rewarewa
E tūtei ana rā te kauika taramea
i te mātārae, i waho o Muruika, ē ī.
Kei reira e noho ana Tamarahi-pariri
Tītoko o te rangi, whakawhiti o te rā
Whakaaio whenua, ē ī.
I te ahi kā noa ngā whakatauihu
Ki te mānahanaha o manga-takitahi, ē ī.
Ko te pakū anake nō Riuwhati,
Te waka o Manaia, e rere whakateraki
I te whakawhitianga o Pikopiko-i-whiti, ē ī.
E Awa, hinga noa i mate aitu,
Tē tuku whakarereetia ki te tonga
Mō Tuwharetoa, mō Irohanga, mō Te Riunui,
Te ure o Pukauae, ē ī;
Ngā whakapiako moana ki Rotorua-nui-a-Kahu.
He aha koia te hara, i hohorotia ai,
Ko te kumenga iho, ē ī?
Tāna ka wharau ki te tararau anuanu
Tuai karamea ki te pō, ē ī.
Nā wheatia ai te whiunga o ngā matau
I tukua ai ngā karere ki runga?
Ko tō tupuna kō Tawakeheimoa,
Ko Te Kereru-kaiwai, ē ī.
Hei eketanga mōhou ki Te Rangihakahaka;
Whakawhiti atu ana i Te Raho-o-Te-Rangipiere,
Kia whāngaia koe ki te tauaro kūkū,
Nō Te Ranga-a-whakairihau, e tama ē!

He mihi
Acknowledgements

This thesis is born from the strength, wisdom and courage of the rangatahi and whānau who opened their hearts in support of this kaupapa. It is my absolute privilege to share your kōrero for others to hear, and I thank you all for allowing me to laugh and cry alongside you all as you shared your stories. Nei ngā mihi aroha ki a koutou.

my thesis. To Whaea Lucy Bush, Keri Lawson-Te Aho, Aunty Phyllis Tangitu, Mapihi Raharuhi, Michael Naera and Te Pae Fitzell, Diana Rangihuna, Rozi Pattison, Matene Millar, Chloe Bisley-Wright, John Hickson, Renee Owen, Ihirangi Heke, Simon Bennett, and Clive Banks for all your advice particularly in the initial planning stages of this research. I also acknowledge the guidance of Associate Professor Leonie Pihama, Dr Sarah-Jane Tiakiwai and the kaiwhakahaere of Te Kotahi Research Institute for allowing me to attend the Kaupapa Rangahau Workshop Series which provided unofficial cultural supervision for this research.

To the 'Mai ki Pōneke' crew, in particular Pauline Harris, Mike Ross and the other kaimahi for all of the beautiful *kai* and *kōrero* that was shared. Ki āku ninitia; Vini, Arini and Kimberly, for all of your support; I owe you all thusly. I also acknowledge the past and present Māori psychology students from Victoria.

And to our friends and whānau who have stepped in to support whenever needed, often without being asked. Thank you all for everything you have done for our whānau. To Uncle Hinga for your guidance which has helped to shape this thesis. To Aunty Min and Aunty Denise, both of whom have played a huge role in me deciding to study psychology, pursue a career in clinical psychology and then do this PhD. Thank you both for your support, wisdom and guidance. To Boyd, who planted the seed of becoming a 'Dr' long before I ever considered it. To Mum and Dad, thank you both for all your love and support.

And finally, ki taku tau, e Kererua. Nōku kē te whiwhi! This is as much your work as it is mine; mōu hoki tēnei. Nei ka tūohu ki a koe e te tau, ki ō ringa manaaki, ō ringa raupī, ō ringa poipoiā. E whakamiha ana ki tō manawanui mai ki ahau, oti rā, ki ā tāua tamariki hoki. Nāu tōku wairua, tōku tinana, tōku hinengaro hoki i tauawhiawhi i ēnei o ngā rā taimaha rawa atu kua pahure. Ka kore aku mihi e memeha, tēnā koe. Mei kore i a koe, tē oti nei au.

Table of Contents

Supplementary Material (e.g. consent forms, information sheets, copies of the survey, and debrief information) can be viewed at https://www.dropbox.com/sh/1k4vpd6pk2i8g2x/AADYYIRglTfiBWiHWaheSvRTa?dl=0.

List of Tables

List of Figures

List of Abbreviations

BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Services
CAT Team	Crisis and Assessment Team
DASS-21	Depression Anxiety Stress Scale – Short Version
DSH	Deliberate self-harm
DSHI	Deliberate self-harm inventory
DSHI-s	Deliberate self-harm inventory for adolescents
EA Model	Experiential Avoidance Model
ERCA	Emotion Regulation Checklist for Adolescents
ERICA	Emotion Regulation Index for Children and Adolescents
GP	General Practitioner
HDEC	Health and Disability Ethics Committee
IPA	Interpretative Phenomenological Analysis
IPPA	Inventory of Parent and Peer Attachment
ISAS	Inventory of Statements about Self-Injury
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MMM-ICE	Multidimensional Model of Māori Identity and Cultural Engagement
NSSI	Non-suicidal self-injury
SBQ-R	Suicidal Behaviours Questionnaire – Revised

CHAPTER ONE
Introduction and Overview

This thesis explores how *rangatahi* Māori and whānau define and experience self-injury in Aotearoa today. I begin by describing a Māori worldview and the historical context within which Māori identities have evolved. I present the stories of *rangatahi* Māori in both quantitative and qualitative form through survey data (Study 1) and sequential focus groups (Study 2), and in doing so, relate the experiences of rangatahi Māori to the *whakataukī* (proverb) 'e kore au e ngaro, he kākano i ruia mai i Rangiātea" (I will never be lost, for I am a seed sown in Rangiātea). While this whakataukī asserts that we as Māori should never feel lost when we know who we are and where we come from, I argue that many *rangatahi* feel as though they are lost in different ways, and self-injury is one means of coping with this sense of struggle. From the stories of the rangatahi and whānau presented here I extract themes which provide guidance as to ways rangatahi can be supported to feel less lost, to recognise their potential as 'kākano i ruia mai i Rangiātea' (seeds sown in Rangiātea).

INTRODUCTION TO THE RESEARCH TOPIC

There are many definitions used to describe behaviours when someone has intentionally hurt themselves. Self-injury, self-harm, deliberate self-harm, non-suicidal self-injury, self-mutilation, self-injurious behaviour, parasuicide (to name but a few). Non-suicidal self-injury (NSSI) refers to the deliberate and self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned (Zetterqvist, 2015). Self-injury is the "intentional, self-effected, low-lethality bodily harm of a socially unacceptable nature, performed to reduce

psychological distress" (Walsh, 2006, p. 4). Gratz defines deliberate self-harm (DSH) as "the deliberate, direct destruction or alteration of body tissue, without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur" (2003, p. 192).   Variations in the method, intention and damage caused differentiate these definitions, with some definitions considering socially sanctioned (or culturally acceptable) behaviours to be outside the bounds of what is self-injury.

Indigenous practices that may be analogous to self-injury include *kiri haehae,*[1] *Ma-newa-newa*[2], and sorry cuts. Knowledge of these indigenous cultural practices (from Māori, Hawai'ian and Aboriginal Australians respectively) is passed down through generations (Farrelly & Francis, 2009; Rezentes, 1996; Te Awekotuku, 2009). However, these behaviours are excluded from current definitions of self-injury because they are deemed to be sanctioned, or accepted, by that culture. Indigenous scholars such as Te Awekotuku (2009) and Rezentes (1996) concur that these behaviours are not 'self-injury' in the form that is prevalent in society today. Other cultural researchers assert that self-injury was not a traditional practice for their people, but rather a result of the imposition of Western practices coinciding with the advent of colonisation (Dash, Taylor, Ofanoa, & Taufa, 2017).

There is ample research from around the world that indigenous and minority youth engage in self-injury (Bhui, McKenzie, & Rasul, 2007; Black & Kisely, 2018; Chesin, Moster, & Jeglic, 2013; Croyle, 2007; Cwik et al., 2011; Garisch & Wilson, 2015; Helu, Robinson, Grant, Herd, & Denny, 2009; Wilcox, Caldeira, Vincent,

---

[1] In *te reo Māori kiri* means skin, and *haehae* to lacerate or cut.
[2] See page 64 for a description of Ma-newa-newa, a traditional Hawai'ian practice of self-injury that is an expression of intense grief at the passing of a loved one (Pukui et al., 1983).

Pinchevsky, & O'Grady, 2012). The relationship between these self-injurious behaviours and the traditional cultural practices of these indigenous youth, however, is yet to be explored. To further complicate the story, the aforementioned current definitions of self-injury have been developed within Western cultures (predominantly North America and Europe) and, as such, they lack the intrinsically holistic perspective of wellbeing that is shared by many indigenous cultures.

Research Aims and Objectives

This research emerged from the Youth Wellbeing Study (YWB Study), which aims to understand wellbeing in young New Zealanders, with a specific focus on Non-Suicidal Self-Injury (NSSI). The YWB Study is a longitudinal research project that began in 2012 with funding from the Health Research Council. The research team consists of academic researchers, clinical psychologists, Masters, Doctoral and clinical psychology students (myself included), Māori health researchers, and cultural advisors.

In 2012, the Māori team members of the YWB Study conducted several *wānanga* and informal one-on-one conversations with Māori health professionals who work with *rangatahi*, for example, as youth workers or clinical psychologists. Through these conversations, it became clear that the way that mainstream research defines self-injury fits uneasily into cultural understandings of the behaviour. They highlighted the problematic use of the term "NSSI" and other definitions that exclude behaviours that *rangatahi* Māori engaged in as self-injury. The continued use of such narrow definitions was invalidating some *rangatahi* Māori experiences of self-injury, which subsequently limited their access to support for self-injury. It was concluded

that the use of such definitions also leads to a misrepresentation of the prevalence of self-injury in *rangatahi* Māori.

This research, therefore, set out to understand the self-injuring behaviours of *rangatahi* Māori today, to reconcile their behaviours with current definitions of self-injury, and examine the relevance and potential contributions of traditional practices such as *kiri haehae.* The questions that guided the research process were:

1. How do *rangatahi* Māori define self-injury?

2. Who are the *rangatahi* Māori who self-injure?

3. What are the correlates of self-injury?

4. How can *rangatahi* Māori be supported when they self-injure?

5. What are the experiences of whānau when supporting *rangatahi* who self-injure?

6. Why is it that some *rangatahi* Māori choose not to self-injure? What are their alternative coping strategies?

7. What contributions can traditional knowledge make to how *rangatahi* Māori experience self-injury today?

These research questions are deliberately framed in a way so that they can be answered in a manner which focuses on the strengths and resilience factors of *rangatahi* Māori. L. Smith (2012) asserts that asking deficit-focused questions will only provide deficit-focused solutions, which add to what we already have in Aotearoa; a multitude of disparity statistics which provide few solutions to the problems that these statistics highlight. Therefore, in this doctoral research, I take a holistic and strengths-based approach which focuses on solutions.

HE PAKU WHAKAMĀRAMATANGA[3]

Definitional dilemmas

The present study is part of the YWB Study, which utilises the term 'Non-Suicidal Self-Injury' (NSSI). However, much of the existing research on self-injury in Aotearoa, particularly research with Māori, utilises the term 'Deliberate Self-Harm' (DSH). These two terms differ in the behaviours considered to be self-injury, particularly with regards to suicidal intent (see p. 68). There is a definitional debate as to the extent to which suicidal and non-suicidal thoughts and behaviours are qualitatively, rather than quantitatively, different. The research programme of which this project is a part focuses on NSSI, but also assesses suicidal thoughts and behaviours (Muehlenkamp, 2014). The choice of these terms and the behaviours that they describe has important implications for understanding, research and intervention. In undertaking this research, I needed to begin with a general term to refer to all behaviours that fit under the umbrella of 'harm to self'. I have chosen to utilise the broad term 'Self-Injury' with the goal of clarifying, through this research study, how Māori define self-injury and how this may differ from existing definitions.

Rangatahi Māori

Throughout this thesis, the term '*rangatahi*' will be used interchangeably with 'adolescents' to represent all young people regardless of cultural or ethnic background. When speaking of Māori youth, the term '*rangatahi* Māori' will be specified. I discuss the challenges of defining who is, or is not, *rangatahi* Māori

---

[3] A brief introduction.

where appropriate in each study. In Study 1 I use all *rangatahi* who selected Māori either as a primary ethnicity or as another ethnicity, regardless of ancestry, when completing the YWB Study survey. For Study 2, only the experiences of participants with Māori ancestry were included. Therefore, throughout this thesis, *rangatahi* Māori is used interchangeably to refer to *rangatahi* who either identify as Māori or are of Māori descent.

Cultural concepts

In te reo Māori, the phrase '*He mana tō te kupu'* asserts that words carry power and authority. Throughout this thesis, I use a lot of Māori terms that require translation for those who may not be familiar with te reo Māori. It is conventional practice to provide a translation of non-English terms in parentheses after the first use of that word. However, in the context of te reo Māori, translating these words is not as simple as providing a single English word that captures the essence of that Māori term. Languages reflect the worldviews and values held within a culture and, for Māori, this language is metaphorical and the worldview holistic. In this thesis, when attempting to provide simple translations for Māori terms, I felt as though I was not doing justice to the metaphorical and descriptive nature of te reo Māori, which reflects the way in which we view the world. In this thesis, therefore, I have tried, where possible, to provide simple translations that capture as much of the meaning as possible (see Glossary, p. 321). Where these translations require more than a few words, I either do so in full within the text, or as a footnote.

Another linguistic challenge encountered was in attempting to define and explain concepts such as *mauri*, *wairua*, *whakapapa*, which are inherent in a Māori worldview. Definitions of concepts such as these can vary between individuals,

whānau, *hapū* and *iwi*, and therefore do not lend themselves to generic definitions and have a subsequent loss of meaning. However, I acknowledge that this is a necessary step in the research process when completing a thesis in English on a topic that touches on aspects of *te ao Māori* and Māori customary concepts. I raise these points here to caution against taking the definitions provided as representative of the way by which <u>all</u> Māori view these concepts.

The use of the first-person narrative

To avoid ambiguity, the American Psychological Association (2010) recommends the use of personal pronouns. Writing in the first-person narrative is also a personal preference that feels appropriate given the methodological and analytical approaches I have used in this research. Conducting Māori-centred research that is grounded in *kaupapa Māori* research principles, required the development of relationships with research participants that privilege values such as *manaakitanga* (generosity and hospitality), *whakawhanaungatanga* (establishing relationships and connections) and *kanohi ki te kanohi* (face to face interactions). The way I conducted this research (see Chapter 8) intentionally enabled such relationships to form between research participants, and also between our research team, the *rangatahi* participants and whānau members. Further, the qualitative approach which I use in Study 2 applies Interpretative Phenomenological Analysis to interpret and understand the qualitative data. This approach required full immersion in the data to understand the participants' experiences as they pertain to the subject at hand. To then take this information (or 'data') and present it in a manner that attempts to appear objective and neutral would feel false because, by

the very nature of being immersed in the research, my perspective is no longer objective.

It is also important to reflect on the role that I have as the storyteller in this thesis. The use of the first-person narrative gives me the power, as the author of this thesis, in choosing whose stories are shared and when they are told. While I would love to be able to share the stories of all of the *rangatahi* and whānau participants in full, I do not have the space to do so. The quotes and vignettes throughout this thesis are selected and presented at times when I feel that they highlight the themes that have emerged from this research. While I have attempted to remain faithful to the messages shared by the *rangatahi* and whānau and to privilege their voices, I acknowledge that as the author of this thesis it is ultimately up to me how their stories are shared.

In Chapter 8 (Sequential Focus Groups with *Rangatahi* and Whānau) I present some of the stories shared by *rangatahi* and whānau under the relevant subheadings. These vignettes are presented in formatting consistent with long quotes (according to APA referencing guidelines style). However, because the sessions were not recorded, they are not direct quotes.

THESIS OVERVIEW

Understanding how *rangatahi* Māori define and experience self-injury necessitated a review of some critical areas relevant to this thesis. First, in Chapter 2 I begin by introducing the reader to a Māori worldview, which extends to Māori epistemologies, definitions of wellbeing, and Māori demographic history. It then felt natural to progress from exploring traditional Māori cultural concepts to understanding modern psychology in Aotearoa today, which I cover in Chapter 3. In

this chapter, I include discussions regarding ethnic identity and its relationship with wellbeing, the current state of wellbeing for Māori, and the power of indigenous psychology in decolonising psychological understandings of wellbeing.

Because this thesis investigates how *rangatahi* Māori and whānau define and experience self-injury, it is conventional to explore the current definitions of and literature surrounding self-injury in Aotearoa today. This literature is summarised in Chapter 4, and originates predominantly from Western research settings which provide limited consideration of cultural complexities regarding definition, prevalence, and potential causes. It felt odd to begin by situating the research within a Māori worldview and then to move to define and discuss Western research. However, this was necessary to paint a full picture of the topic and to inform discussions that will be held in successive chapters. In Chapter 4 I also review the little research available on self-injury within ethnic minorities, alongside current prevalence and correlates of self-injury, functions and treatment approaches.

Chapter 5 outlines the Māori methodologies applied in this research. I describe this research as Māori-centred research that is grounded in *kaupapa Māori* research principles, utilising Western research methods, because cross-sectional survey data is overlaid with the stories of *rangatahi* Māori and whānau obtained through sequential focus groups conducted in person. This chapter discusses the complexities of such a research approach and some of the ethical challenges that were encountered and overcome.

Analysis of the qualitative data obtained from the sequential focus groups was informed by the principles of Interpretative Phenomenological Analysis (IPA; J. Smith, 1996). In Chapter 6 I describe this approach and reflect on the advantages and disadvantages of this analytical approach, which was selected because it

allowed rigorous engagement with the data and scope for my reflections to be included.

Chapter 7 presents Study 1, which uses the survey data collected from the YWB Study. In this study, I present the prevalence rates and correlates of self-injury for *rangatahi* Māori. Having identified some preliminary indications of the extent and nature of self-injury for *rangatahi* Māori, in Study 2 (Chapter 8) I then explore how *rangatahi* Māori define and experience self-injury by asking *rangatahi* and whānau to share their knowledge and experiences. The *rangatahi* Māori who participated in these sequential focus groups had a vast and varied knowledge and experience of self-injury; some had little knowledge of self-injury, whereas others had a history of behaviours which they defined as self-injury. Including *rangatahi* who had not self-injured provided an understanding of alternatives to self-injury that *rangatahi* used, with the intention of focusing not only on the so-called maladaptive behaviours but also those that might be considered adaptive. The prediction that *rangatahi* who did not self-injure engaged in adaptive alternatives to self-injury was not as straightforward as anticipated, which I discuss in detail in Chapter 8 (alternatives to self-injury).

In Chapter 9 I conclude this thesis by summarising the research findings according to the specific research questions which guided this research. I present the recommendations from this thesis by answering the question "How should we support *rangatahi* Māori when they self-injure?" I present these recommendations by separating them into the immediate responses to self-injury, and the long-term strategies to reduce or prevent the behaviour. The answers put forth here are my interpretations of the discussions had with *rangatahi* and whānau on what works

and what they want when they or their *rangatahi* self-injure, which is a combination

of *te ao Māori* and *te ao Pākehā*; Māori and Western knowledge.

CHAPTER TWO
Te Aronga Māori: A Māori Worldview

Regardless of culture and country, individuals are all influenced by (and influence) the social and cultural contexts within which we are embedded. As Durie (2002) asserts, "the ways in which people think and feel are often a reflection of the culture within which they have been raised" (p. 19). Likewise, when *rangatahi* Māori self-injure, the functions that the behaviour serves are influenced by the community and context within which that *rangatahi* Māori is located. It is therefore crucial when working with *rangatahi* Māori who self-injure to understand their environment, including the cultural context, as this will help one to understand the functions the behaviour serves for them, and other factors that will assist in understanding their needs.

MĀORI EPISTEMOLOGIES

For Māori, our epistemologies are understood as *mātauranga* Māori (Māori knowledge). Māori hold a unique worldview that stems from *kōrero tuku iho,* also referred to as *pūrākau*[4] (Lee, 2009). *Kōrero tuku iho* are traditional stories that are transmitted over generations. However, *kōrero tuku iho* function as much more than mere stories, myths or legends; they pass on knowledge from *tūpuna* (ancestors) that reflects a Māori worldview (Lee, 2009; Roberts & Wills, 1998). The knowledge

---

[4] The term *kōrero tuku iho* has been deliberately used here rather than *pūrākau* because it was felt that *kōrero tuku iho* better captures the stories passed down within whānau as well as the more widely known myths and legends, whereas *pūrākau* are often referred to as simply myths or legends. Another term to describe the knowledge of tikanga that is transmitted within whānau*, hapū* and *iwi* is *whakapapa kōrero* (Wirihana & Smith 2014).

that is passed on includes Māori *tikanga* and *kawa* (procedures and protocols; L.

Smith, 2008)*.*

Pōhatu (2018) describes *tikanga* as templates that our old people have set

for us to reapply in our own time. *Tikanga* and *kawa* epitomise Māori values which

can guide appropriate behaviour in a way that upholds the *mana* and *tapu* of people.

Kawa include protocols for *marae* ceremonies such as *pōwhiri* (Mead, 2016),

whereas *tikanga* are procedures that, in some situations, can be changed to suit the

particular situation (Simmonds, 2014).

Kaumātua (elders) are regarded by Mead (2016) as the guardians of *tikanga*

Māori. As such, they are held in high esteem in Māoridom because they are

considered to be the storehouses of traditional knowledge (Higgins & Meredith,

2011). This knowledge is passed on over time though numerous media, for example

pūrākau and *kōrero tuku iho.* Other means of traditional knowledge transmission

include *karakia*, *waiata*, *mōteatea*, *oriori*, *whakataukī*, *whakairo*, *tā moko*, and

tukutuku. All of these media can serve as a vehicle for preservation and transmission

of cultural knowledge.

Whakapapa

Within *te ao Māori*, an understanding of the interconnectedness of all things

and people gives the collective impression that what affects one ultimately affects us

all (Durie, 2002). In *te ao Māori*, one's *whakapapa* locates them within their whānau,

hapū (sub-tribe) and *iwi* (tribe). Traditionally, the concept of *whakapapa* meant that

the whānau*, hapū* and *iwi* were collectively responsible for the wellbeing of all

members; physically, spiritually and mentally (McLachlan, Wirihana, & Huriwai,

2017). As such, *whakapapa* is often translated to mean 'genealogy'. However, it is

more metaphorically described by Mikaere (2011) as 'to place layer upon layer'. Pihama (2001) further describes *whakapapa* as both the vehicle for and the expression of *mātauranga Māori*. In Māoridom, the origin of human existence is told in the story Hineahuone, the first woman who was created from red ochre clay. The story of Hineahuone represents the *whakapapa* of all Māori from *atua*.

Through *whakapapa,* Māori collective identities are embedded in the natural environment. In traditional times, Rata describes how, by holding *mana whenua* over their lands, the *mana* of that iwi or *hapū* was upheld, and their collective social identities were strong (Rata, 2012). For Māori, our sense of emotional wellbeing is also intricately tied to the wellbeing of these places with which we identify through *whakapapa*. As Māori, we cannot be well as people if these places with which we identify, these places which contain our *whakapapa*, are being polluted, stolen, abused and degraded (Simmonds, 2018).

Pepeha[5] locate *whakapapa* within time and space (Roberts, 2013). Mead (2016) defines *pepeha* as a way of introducing oneself by identifying the aspects of *te ao tūroa* (the natural world) with which Māori relate in some way. For example, through my *whakapapa* from *Te Arawa*[6] I identify with the *maunga* (mountain) of Ngongotaha. This *maunga* is a prominent feature in the landscape of Rotorua, and my upbringing took place with this *maunga* as the backdrop. Our whānau *urupā* (cemetery) is located at the base of this mountain which is where my Nanny and my Koro are buried. Through identifying and engaging with this maunga I have a strong

---

[5] *Pepeha* is a Māori way of introducing who you are and where you come from.
[6] Te Arawa is one of the many *waka* (canoe) upon which our Māori ancestors first arrived in Aotearoa. The descendants of this Te Arawa waka reside in the area 'mai Maketū ki Tongariro' (between Maketū and Mount Tongariro). This is the *rohe* (region) that I call home.

affinity with this area and, for me, it is a source of strength and connection with my tūpuna.

Kōrero tuku iho and *pūrākau* have been used as methods for understanding psychological experiences (Cherrington, 2009; Cherrington, 2002; Rangihuna & Kopua, 2015) and as research methods (Lee, 2009). As will be discussed later in this chapter, traditional *kōrero* around self-injury can be understood in a similar manner.

Mauri

Mauri is an essence or life force contained in all things. This understanding of *mauri* is depicted in the story of Hineahuone, whose form was crafted from red ochre clay of Kurawaka[7]. To this form *atua* then contributed different traits to her being, including Tāwhirimatea who gifted her with the breath of life.

Because *mauri* is inherent in everything, Marsden, Henare and Marsden (1992) describe its function as to unify diverse elements. The concept of *mauri* is enacted in the process of *pōwhiri*, whereby the voice of the *kaikaranga* calls everyone together and is responded to by the *kaikaranga* of the *manuhiri*. The action of them calling to one another and the words they speak function to bind the respective *mauri* of all who have come together for the *hui. I*n their doing so, they are acknowledging the *whakapapa* of all Māori to Hineahuone as the one who took the first breath.

---

[7] Kurawaka is understood to be "the fertile region of Papatūānuku (Simmonds, 2014, p.232).

In his keynote address at Healing our Spirit Worldwide,[8] Professor Sir Mason Durie described the concept of *mauri* as a reflection of the energy or vitality that encompasses a person's whole self beyond their physical wellbeing. Durie describes Cultural identity as one of eight elements that are essential for a person to reach a state of *mauri ora* (flourishing), whereby:

> *Mauri ora* is mirrored by an enlightened spirit, an alert and inquiring mind, a body that is fit for purpose and free of pain, and engagement with a set of relationships that are positive, nurturing, and mutually beneficial. In contrast, *mauri noho* [languishing] can be manifest by the loss of hope, a mind that is clouded and insular, a tortured body, and engagement in a set of relationships that are disempowering and humiliating. In brief, the *mauri*, whether flourishing or languishing, reflects four dimensions: *wairua* (the spirit), *hinengaro* (the mind), *tinana* (the body), and whānau (relationships). (Durie, 2015, pp. 3–4).

Mana

Mana is regarded as an energy or power that can be held or embodied by an individual or within a whānau (Marsden, 2003; NiaNia, Bush, & Epston, 2017). *Mana* is passed down, through *whakapapa,* and it has the power to act as a social influence, whereby the actions of a person or whānau may cause their *mana* to be enhanced or diminished. Thus, *mana* holds an individual or a whānau accountable, and it also gives them the authority over their own circumstances or situations and actions. In a clinical context, *mana* asserts one's authority over their life without adversely impacting on the *mana* of others. "[Mana] is about being in control of your own

---

[8] Healing our Spirit Worldwide is an international conference that concerns the wellbeing of indigenous peoples. It is held every four to five years, with recent locations including Kirikiriroa (Hamilton, NZ) in 2015, Honolulu, Hawai'i in 2010, and Edmonton, Canada in 2006.

behaviour and not hurting others… [s]o if you are taking care of the *mana* of your family, then you are protecting them from harm, keeping them safe, and showing them respect."(NiaNia et al., 2017, p. 3). *Whakataukī* such as 'Kaua e takahi i te mana o te tangata'[9] demonstrate this importance in *te ao Māori*.

One manner in which *mana* can be enacted and enhanced by an individual, or a group, is through the expression of *manaakitanga* or hospitality (Mead, 2016). *Manaakitanga* is about relationships built on respect, and cultural and social responsibility (Hudson, Milne, Reynolds, Russell, & Smith, 2010). Maynard Gilgen (Gilgen & Stephens, 2016) refers to his use of this process through K, K, K & K – *karakia*, *kaumātua, kōrero* (conversation) and *kai*, where all four of these K's are equally important. Dudley and colleagues (2017) add another 'k', "*kia ora*", whereby merely greeting Māori in te reo Māori is a means of expressing *manaakitanga*. By showing appropriate and adequate levels of *manaakitanga*, the *mana* of the individual or group can be upheld or enhanced.

Utu

The concept of *tauutuutu* (reciprocity) reflects the value Māori place in maintaining balance and harmony, including among individuals and groups. Traditionally *utu* (balance) is linked to *mana* and the maintenance of relationships (Metge, 2015), in that if social relations were disturbed and the *mana* of an individual or group was diminished, *utu* was a means of restoring balance.

---

[9] Do not trample on or diminish the *mana* of the person.

Te Aka provides the following description of *utu*, which has implications that will be discussed in a later section on traditional Māori understanding of suicide and self-injury:

> Any deleterious external influence could weaken the psychological state of the individual or group, but *utu* may reassert control over the influences and restore self-esteem and social standing. Suicide may even reassert control by demonstrating that one had control over one's fate, and was a way of gaining *utu* against a spouse or relative where direct retaliation was not possible. Such indirect *utu* often featured within kin groups.[10]

Tapu and Noa

Extensions of *utu*, or balance, are the concepts of *tapu* and *noa*. *Tapu* means to be restricted, sacred, forbidden, or under the protection of atua. Noa is understood as unimpeded or without restraint. Niania, Bush and Epston (2017) describes the connection of *mauri* with *atua* which inherently affirms *mauri* as *tapu*. By extension, because all things have *mauri*, they have the potential to become *tapu*, however, all things are not inherently *tapu* by having *mauri*.

Mana and *tapu* are regarded by Mead (2016) as interrelated; with high *mana* also comes more *tapu,* and in some instances, the terms *mana* and *tapu* are used interchangeably. Mead (2016) describes two examples that reflect *tapu* in action as justification for some *tikanga*; not stepping over others, and not passing things over their heads. This is because the body and the head (in particular), are *tapu*. When

---

[10] Moorfield, J. (2005). Te Aka: Māori-English, English-Māori dictionary and index. Retrieved 1 August, 2017 from
http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=utu

the *tapu* of something is impinged upon, *noa* functions to correct the balance and restore *tapu*.

Mead asserts that *noa* is not the opposite of *tapu* nor is one defined as the absence of the other. For example, a person can have *tapu* when they are unwell or bleeding, as women are considered to be in a state of tapu when they are menstruating (Simmonds, 2014). *Noa* is about restoring the balance and returning to a state of wellness, but the *tapu* of that person is still present, as it is at all times with all people. The term *whakanoa*, therefore, means to restore the balance or lift the *tapu* and move things into a state of *noa*. In a clinical context, Durie (2002) asserts that *tapu* and *noa* can be used both as an aid to establishing rapport, and as a guide to cultural safety and safe practice.

Walker and colleagues (2006) assert knowledge as *tapu* by way of being highly valued and therefore having restrictions regarding the use of that culturally based knowledge. In Māoridom knowledge is divided into *te kauwae runga* (that may be translated as 'the upper jaw') and *te kauwae raro* ('the lower jaw'). *Te kauwae runga c*orresponds to celestial matters, regarded as *tapu* knowledge, whereas *te kauwae raro* concerns terrestrial knowledge; that knowledge which is of this world (Smith, Whatahoro, Pohuhu, & Matorohanga, 1997). The Mataatua Declaration (First International Conference of the Cultural and Intellectual Property Rights of Indigenous Peoples, 1993) affirms Māori views of knowledge as *tapu* and allows Māori researchers to utilise this *tikanga* in research with whānau, *hapū*, *iwi* and Māori communities. In a research context, by understanding that knowledge is sacred, it protects knowledge from being misappropriated because both the knowledge and those who hold it are treated with respect and held in high esteem (Battiste & Henderson, 2000).

Wairua

In Chapter 1 I described the unease and discomfort I have felt in defining Māori concepts in English because the essence of the concepts cannot be easily captured in any language other than Māori. For me, defining *wairua* epitomises this difficulty. These sentiments are echoed by Valentine, Tassell-Mataamua and Flett (2017) who state that *wairua* holds different meaning to different people.

Valentine and colleagues (2017) also assert that *wairua* is not solely spirituality or religion, which it is often translated to mean when using a single-word definition. Numerous authors, researchers, poets, artists and academics describe *wairua* as relational, special, unprecedented, boundless, relational, fundamental to our existence as Māori, and integral to Māori definitions of wellbeing (for example Durie, 1994; McLachlan et al., 2017; Valentine et al., 2017). Therefore, the purpose of discussing *wairua* here is not to provide a distinct and universally applicable definition but to highlight the complex nature by which *wairua* exists and interacts in our lives as Māori and its inherent value as a pillar of wellbeing. As such, one role that *wairua* can play in facilitating wellbeing is by encouraging individuals to explore what *wairua* means to them and understand the role that it can play in their wellbeing that is unique to that individual (Cherrington, 2009).

Whānau

Whānau form the central social entity for Māori. Whānau were the functional units of traditional Māori social systems, and the concept of whānau expanded beyond the nuclear family unit (Mead, 2016). In their analysis of the characteristics of whānau, (Cunningham, Stevenson, & Tassell, 2005) differentiate between *whakapapa*-based whānau and *kaupapa*-based whānau. *Whakapapa*-based whānau

share common ancestry, and along with this familial connection comes shared responsibilities and obligations to the whānau. *Kaupapa*-based whānau, however, are whānau connected by common bonds that do not necessarily include *whakapapa*; the whānau may be united by a common cause, or geographical location. Ngāpuhi leader Moe Milne[11] describes this as whānau that are constructed to suit their environment. These whānau may still subscribe to whānau values, but the means of engagement and disengagement may be more fluid in a *kaupapa*-based whānau. For example, in this research, some *rangatahi* are part of an Alternative Education School, and they consider their peers to be their *kaupapa*-based whānau when, in the past, their own *whakapapa*-based whānau were not there for them.

An important distinction between *kaupapa*-based and *whakapapa*-based whānau is that there is a mutual obligation inherent in *kaupapa*-based whānau, in that they often aggregate around common values or goals, such as language acquisition (Te Huia, 2013). Therefore, to separate from a *kaupapa*-based whānau may also mean a disregard or rejection of the goal of that *kaupapa*-based whānau.

Whakamā

Whakamā is another Māori cultural concept that lacks a simple and direct translation in the English language. *Whakamā* was described by Durie (2003) as a culturally bound syndrome, and Banks explains *whakamā* as one of or a combination of shame, embarrassment, shyness, modesty, or social withdrawal (1996).

He Pataka Kupu is a monolingual Māori language dictionary published by Te Taura Whiri i Te Reo Māori (The Māori Language Commission). Within this text

---

[11] Retrieved on 12 January, 2018 from https://depression.org.nz/get-better/your-identity/maori/

there are three definitions of *whakamā*. The first definition is defined in by Te Huia as "a sadness or heaviness of disposition due to a personal action or knowledge of another's action that was thought to have been performed incorrectly or inappropriately" (2013, p. 175). Te Huia translates the second definition of *whakamā* as when "[t]he heart [or mind] is ill at ease; the person's spirit is unwell due to a personal action or knowledge of another's action that is thought to have been performed incorrectly or inappropriately" (p.175). In the third definition by Te Taura Whiri I Te Reo Māori (2008, p. 1096), *whakamā* is defined as when "[A person] has become anxious, or vulnerable, and is somewhat fearful in the context of others" (translated by Te Huia, 2013, p. 175). Taken together, these definitions emphasise the role of emotions (such as feeling hurt or inadequate) and the expression of these (Metge, 1986; Natana, 1993).

Metge (1986) groups the common ways in which *whakamā* may be induced for Māori into six factors; the perception of lower status, feelings of uncertainty and confusion, recognition of fault, being 'put down' or insulted, being singled out, and on behalf of others. Banks (1996) associates feelings of *whakamā* with a perception of lowered *mana*.

While often translated to mean shame, *whakamā* differs in that shame is often understood to be an individual experience (Banks, 1996). Earlier in this chapter I have highlighted *whakapapa* as a key cultural concept for Māori; it centralises an individual as part of a broader context of whānau, *hapū* and *iwi*, and is conceptualised as a means of transmitting Māori knowledge (as both the vehicle for, and expression of, *mātauranga Māori*). With the understanding that *whakamā* can be perceived by collectives it also stands that *whakamā* can be transmitted between generations as a result of the ongoing experiences of colonisation that impacted on

our Māori ancestors. The historical trauma literature describes how *whakamā* can be transmitted between generations (Pihama, 2001; Simmonds, 2018; Wirihana & Smith, 2014), and Lawson-Te Aho (2013) asserts that it is common for someone who feels shame induced by trauma to want to distance themselves from those feelings, even in a historical sense. In essence, the power of *whakapapa* can mean that, for Māori today, we feel what our *tūpuna* felt, and this feeling can include that of *whakamā*.

Durie (2001) asserts that *whakamā* manifests as avoidant behaviours whereby an individual may reduce either communication or interaction with others as a result of feeling *whakamā*. By considering *whakamā* in these ways, when one experiences a loss of *mana* the instinct to withdraw and distance oneself would make sense. Examples of the ways that *whakamā* may manifest include physical withdrawal, lack of communication, nervousness, and even aggression, violence and substance abuse (Banks, 1996). Further, the Ministry of Justice report 'He Hinatore ki te Ao Māori' links *whakamā* with suicide in that when an individual transgresses the values of their whānau, *hapū* or *iwi* they feel *whakamā* as "an extremely powerful and emotional force"(The New Zealand Ministry of Justice, 2001, p. 185).

Te Huia has discussed *whakamā* about language learning as something that is experienced not only by early language learners but those more proficient. In her thesis, she conceptualises *whakamā* as part of a process that reflects the development of one's cultural identity. In essence, the emotional responses associated with *whakamā* are "a by-product of becoming aware of cultural inadequacies or limitations" (Te Huia, 2013, p. 197). In this sense, Te Huia posits that when an individual invests themselves in learning te reo Māori, they may feel a sense of *whakamā* due to their shortcomings in the learning of te reo Māori. This

whakamā may either lead them to cease further learning of te reo or, if they feel supported to progress out of this state of *whakamā*, that individual has the potential to achieve and excel in learning te reo Māori. In essence, Te Huia (2013) is conceptualising *whakamā* as a marker of cultural identity transition, as a person is only likely to feel *whakamā* about cultural shortcomings if they are invested in belonging to a community who values Māori culture and language. In her kōrero she highlights the important point that *whakamā* is not consistently a negative emotion, indicating that those who are supported through their inadequacies that precede emotions of *whakamā,* may experience positive outcomes.

Māori epistemologies: A summary

The goal of this chapter thus far has been to situate this research within a Māori worldview by describing *mātauranga* Māori; aspects of *te ao Māori* relevant to this research. *Mātauranga* Māori is transmitted between generations via *pūrākau* and *kōrero tuku iho*, and by engaging in these *kōrero tuku iho,* the *mātauranga* (knowledge) within them can be fully understood. These aspects or cultural concepts are *whakapapa, mauri, mana, utu, tapu* and *noa, whakamā, wairua* and whānau.

HAUORA MĀORI

To further understand a Māori worldview, I now move to discuss Māori notions of wellbeing and the contributions of *mātauranga* Māori. I begin by discussing Māori understandings of wellbeing in a general sense, and then present three prominent models of wellbeing; Te Whare Tapa Whā (Durie, 1994), Te Paiheretia (Durie, 2003) and the Meihana Model (Pitama et al., 2007).

For Māori, a holistic understanding of wellbeing reflects the *mātauranga* passed on from *tūpuna* Māori. In the previous section of this chapter, I demonstrated how concepts such as *wairua, whenua* (land)*,* and *whakamā* contribute to wellbeing. For example, *whakamā* as an emotional force when an individual transgresses the values of their whānau. Māori are not unique in conceptualising wellbeing as holistic; many similarities can be drawn with Pacifica Peoples' beliefs that mind, body, family, spirituality and the environment are all elements that are integral to wellbeing (Crawley, Pulotu-Endemann, & Stanley-Findlay, 1995; Kingi-Ulu'ave, Faleafa, & Brown, 2007). Likewise, the First Nations people depict their views of wellbeing in the form of a medicine wheel that demonstrates the continuity between the physical, emotional, mental and spiritual elements (Dumont, 1989).

Holistic models of wellbeing that have been held by indigenous peoples for generations are also consistent with Western models such as Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1992). This theory conceptualises an individual as embedded within a family and broader social groupings, highlighting the role of the social environment on an individual. Further, holistic models of wellbeing are also now utilised by the World Health Organization which defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (2014).

While the recognition by global organisations of the holistic nature of wellbeing for indigenous peoples is encouraging, Cauce et al. (2002) argue that although the role of context has increasingly been acknowledged as a contributor to wellbeing, culture is not often considered as part of this broader context. Further, McLachlan and colleagues (2017) argue that Western values-based approaches to treatment assume that the underlying values of all cultures are universal and,

therefore, applicable to all regardless of cultural background. Consequently, these cultural stereotypes lead to clients disengaging with treatment (Center for Substance Abuse and Treatment, 2014).

The contribution of Māori models of health that invoke traditional Māori values and belief systems is their ability to translate health into terms of cultural significance. Numerous Māori models of health exist today, for example those mentioned previously; Te Whare Tapa Whā (Durie, 1994), Te Paiheretia (Durie, 2003) and the Meihana Model (Pitama et al., 2007), and others such as Homai te waiora ki ahau (Palmer, 2004) and Te Wheke (Pere, 1997).

The utility of Māori models of wellbeing in clinical practice is that they can direct our attention to where to look and what questions to ask by highlighting elements of a Māori world that reflect a holistic perspective of wellbeing. Māori models of wellbeing such as Te Whare Tapa Whā, Te Paiheretia and the Meihana Model provide a spotlight to highlight areas worthy of investigating when working with Māori clients. For example, *kahupō* is understood as spiritual blindness, whereby *te taha wairua*, *te taha tinana* and *te taha hinengaro* may be disconnected for an individual or a whānau. Lawson-Te Aho and Liu (2010) liken *kahupō* to being in a dissociative state.

Durie (2002) also cautions that there is a need to understand distinctive Māori psychology and that this has implications in clinical practice. For example, the metaphoric style of Māori language may be misinterpreted as tangential thinking or loose associations. Durie (2002) asserts that culturally competent clinicians need to be able to differentiate between 'normal' and 'abnormal' behaviours as they are defined in different cultural contexts. Being culturally competent begins with an understanding of a Māori worldview and how Māori conceptualise wellbeing. Durie

(2002) asserts that it is also necessary that, rather than translating Eurocentric psychometric tools into different languages, they must be developed to measure culturally relevant psychological attributes. I assert that this relates to this research in that to be a culturally competent practitioner we need to understand how *rangatahi* Māori define self-injury, to ensure that we are assessing the correct psychological phenomena.

Te Whare Tapa Whā

Likely the most widely acknowledged Māori model of health is Durie's (1994) *Te Whare Tapa Whā*, which has been used in many sectors including policy, education, public health and justice (Kingi & Durie, 1999). *Te Whare Tapa Whā* is a model of wellbeing that is grounded in traditional Māori values and belief systems. By grounding the model in *te ao Māori*, it allows for a holistic approach, whereby Western medical models of health and wellbeing are balanced with an awareness of the cultural and social factors that also contribute to wellbeing. The four elements of wellbeing that comprise *Te Whare Tapa Whā* are *taha hinengaro* (mental wellbeing), *taha tinana* (physical wellbeing), and *taha wairua* (see page 20 for a description of *wairua*) and *taha* whānau (social wellbeing). In discussing *mana* earlier in this chapter, I presented the kōrero of Professor Sir Mason Durie, who describes the *mauri* of the person as a reflection of their wellbeing. Whether their *mauri* is flourishing or languishing is a reflection of the four dimensions of Te Whare Tapa Whā.

In a collective Māori understanding of health, the wellbeing of individuals is intertwined with the wellbeing of the collective (Lawson-Te Aho & Liu, 2010). Consistent with a holistic and collective sense of wellbeing, Durie (2015) also

describes patterns in thoughts and behaviours that are unique to a Māori view of wellbeing. For example, mental energy is directed outwards, to encompass more than just the individual who is unwell, with a focus on relationships and interactions. Rather than a simple cause and effect view, wellbeing is based on the nature of the relationships between multiple factors, and the meaning of different observations is drawn from context. For example, earthquakes may be rationalised as Rūaumoko, *atua* of earthquakes and the youngest child of Ranginui and Papatūānuku, expressing his anger at the separation of his parents and that his siblings left him to reside within his mother's womb (Rangihuna, D. personal communication, November 2015).

In holistic models of wellbeing, whānau can be a source of strength for Māori in many ways. For example, *whakapapa*-based whānau may have connections to ancestral land and natural resources which can be a source of health promotion (Cunningham et al., 2005). Clark et al. (2011) report that strong whānau connections are a protective factor against suicidal behaviour when *rangatahi* describe their whānau as supportive and caring.

Te Paiheretia

Durie (2003) describes Te Paiheretia as a Māori-centred relational therapy model that reflects the holistic and inter-related nature of Māori models of wellbeing. This approach is a manifestation of Durie's (2005) interface research model, whereby Western and indigenous worldviews are congruent.

Te Paiheretia is grounded in the understanding that an insecure identity and unsatisfactory relationships are a source of ill-health for Māori, but are often excluded from unidimensional understandings of health that discount factors

external to the individual (Durie, 2003). Durie criticises these unidimensional approaches as being too "focused on the acquisition of particular skills (e.g. anger management, positive parenting) or overcoming particular behaviour or emotional problems (e.g. cognitive behaviour therapy)" (2003, p. 48). The aims of Te Paiheretia are threefold. First, the development of secure cultural identity, secondly the establishment of balanced relationships, and, thirdly, the achievement of reciprocity with wider environments.

The Meihana Model

Pitama and colleagues (2014) have operationalised *Te Whare Tapa Whā* by developing the Meihana Model as a tool to guide clinical assessment and intervention for Māori in mental health services. The four elements of the Meihana Model are 1) *Te Waka Hourua*, 2) *Ngā Hau e Whā*, 3) *Ngā Roma Moana*, and 4) *Whakatere*.

The Meihana Model is represented as a double-hulled *waka* (canoe), with the whānau of the *tangata whaiora* (patient) travelling alongside them on their journey in pursuit of wellbeing. Contextual factors (colonisation, migration, racism and marginalisation) and personal factors (*āhua, tikanga,* whānau and *whenua*) influence the direction that the waka travels.

The fourth component, *Whakatere*, represents the navigation of the *waka*. *Whakatere* integrates the above components (*Waka Hourua, Ngā Hau e Whā* and *Ngā Roma Moana*), and in mental health contexts, it represents the selection and implementation of treatments and interventions.

NGĀ KARE-Ā-ROTO: EMOTIONS

Consistent with holistic views of wellbeing, a traditional perspective of

emotions acknowledges that understanding emotions extends beyond individual

feelings and the responses to them (Pihama, 2018). *Ngā kare-ā-roto* (emotions) also

concerns relationships between individuals and collectives and acknowledges

different ways of being. The metaphorical nature of te reo Māori enables language to

demonstrate what these emotions may look like.

There is a commonly-known *waiata* Māori that is often sung in many

contexts. The song is titled 'Purea Nei', and the lyrics and translation are as follows:

> *Purea nei e te hau*
> *Horoia e te ua*
> *Whitiwhitia e te rā*
> *Mahea ake ngā pōraruraru*
> *Makere ana ngā here*
>
> *E rere, wairua e rere*
> *Ki ngā ao o te rangi*
> *Whitiwhitia e te rā*
> *Mahea ake ngā pōraruraru*
> *Makere ana ngā here*
>
> Scattered by the wind
> washed by the rain
> transformed by the sun
> all doubts are swept away
> and all restraints are cast down
>
> Fly, o free spirit, fly
> to the clouds in the heavens
> transformed by the sun
> all doubts are swept away
> and all restraints are cast down

This *waiata* was written by renowned Māori musician Hirini Melbourne for

Kiwi Tuteao. Tuteao was a *tangata kāpō* (blind person) who was experiencing

adversity, and he turned to Hirini for support. It is said that Hirini Melbourne wrote this song to support his troubled friend.

In the lyrics of the song, Melbourne encourages one to let go of the problems holding them down which may be causing anxiety within their life, and it demonstrates the power of connecting with the environment as a means of regulating emotional experiences. What may not be known to many is that this song is a *waiata tangi* or lament; Kiwi Tuteao passed away around the time of composition, and some believe that he took his own life.[12]

The key message about ngā kare-ā-roto is that in *te ao Māori* the expression and acknowledgement of emotions (as opposed to their suppression) can be a means of healing and overcoming trauma and grief.

TRADITIONAL KNOWLEDGE OF SELF-INJURY AND SUICIDE

I now turn to discuss cultural understandings of self-injury and suicide. While these terms will be defined and discussed in later chapters within a Western context, exploring traditional understandings of these behaviours can provide enlightenment about traditional Māori perspectives of wellbeing and emotional expression.

Kiri haehae – self-injury in traditional times

In a later section of this chapter, I will present the current statistics on self-injury for *rangatahi* Māori, and I highlight that most self-injury goes unreported and, therefore, is not captured in official statistics. This may suggest a lack of information

---

[12] That Kiwi Tuteao took his own life was asserted by Hinewirangi Kohu at Ngā Kare-ā-Roto (2018) as part of a discussion of the relationship between Purea Nei and Ngā Kare-ā-Roto.

on self-injury for Māori, but this is not true. In seeking Māori and indigenous

knowledge, we have to look in the right place. This information cannot be obtained

in official government statistics and reports. Within our *kōrero tuku iho*, however,

there is a wealth of knowledge of our traditional practices, including those which

may be considered to be self-injury. The intergenerational transmission of this

knowledge through *kōrero tuku iho* gives this *kōrero whakapapa* or history, which

includes the origins of the Māori names for these practices, the functions of the

behaviours, reasons why they occur, and the responses of the broader community.

In this next section, I present historical *kōrero* regarding self-injury that is contained

within *whakataukī*, *kōrero tuku iho*, academic literature, images, *waiata*, and

mōteatea.

Traditionally, there are reports of *tūpuna* Māori engaging in what may be

considered today to be self-injury; this was often referred to as *kiri haehae*. *Kiri*

haehae is be a practice that warrants exploration as a cultural analogue of self-injury

and is translated to mean to scratch, draw, cut up, lacerate or tear (Moorfield, 2005).

This practice of *haehae* was a culturally sanctioned expression of grief during

tangihanga (death processes) and was a private practice that most Māori would not

disclose.

Haehae is described by Te Awekotuku (2009) as:

> …a more primal form of modifying the body, including the face, in response
> to grief and death… It was inflicted with *tuhua*, or obsidian flakes, sharp
> *mata* or *whaiapu* stone, or razor shells; and you did this to yourself. More
> females than males tended to do it. Unlike ta *moko*, which was an art form
> applied by an expert tohunga using chisels and pigment, haehae was a
> spontaneous expression of intense grief. Many *waiata* tangi, or songs of
> lamentation, allude to this practice as a vivid demonstration of loss. It was
> not seen as mutilation, as self-harm; it was a visceral compulsion. And it still

occurs today – but is usually misread and misunderstood in today's society (p.5).

Te Awekotuku (2009) refers to this scarification process as a mark of honour; a constant reminder of a loved one who has passed on. *Kiri haehae* is also depicted visually in images and paintings (see Fig. 1) from the 1860s that show Māori, often but not solely women, lacerating their arms and chest and letting their blood fall on the tools of war used by their loved ones who were lost in battle (Higgins, 2015).

Image removed for copyright reasons. Copyright holder Alexander Turnbull Library, National Library of New Zealand, Te Puna Mātauranga o Aotearoa

Figure 1. Haehae by Horatio Robley, 1864.

Traditional *waiata* and *mōteatea*, such as 'He Tangi' written by Parewahaika from *Te Arawa*[13] (Ngata & Jones, 1961) also talk of grief and loss. The final lines of this *waiata*, "me ana ripi, hei totohi i ngā toihau" talk of the use of stones as tools for *haehae* (referred to here as *totohi*). This mōteatea was written in the context of mourning for a loved one.

A more commonly known *waiata*, Pūtauaki, from the tribe of Ngāti Awa, contains the line "nāu nei i haehae tō kiri e" (you who lacerated your skin). The well-known story that this song refers to talks of the grief expressed by Tarawera (the river of the Ngāti Awa tribe) when her lover Pūtauaki (the paramount mountain of the Ngāti Awa people) left Tarawera in pursuit of Whakaari (known today as White Island). The lines "hotuhotu ana te whatumanawa e, rere ana te mataku, rū ana te whenua e" speak to the intense emotion felt and the expression of this through the shaking of the earth.

The practice of *kiri haehae* also facilitated powerful connections with *atua*. Roberts (2013) retraces the *whakapapa* of the *pungawerewere* (spider) to *Haumietiketike*, *atua* of uncultivated or wild foods. As the *atua* of things that grow wild, *Haumietiketike* is also considered to be the *atua* of fertility. Dr Ihirangi Heke recalled *kōrero* about grieving mothers who had lacerated their skin in mourning the loss of a child (personal communication, 1 April 2015). This behaviour functioned as expressions of grief and loss and a release of the *mamae* that they were experiencing. Following these acts, they would wrap their wounds in the *whare tukutuku* (spider webs). This behaviour served to stop the blood flow but, on

---

[13] A tribe from the Rotorua region of Aotearoa New Zealand.

a deeper level, it functioned as a connection to *atua*; in particular, to *Haumietiketike* as the *atua* of fertility. By doing this the women were signifying their readiness to move on and the desire to bear children again.

There are also *whakataukī* that speak of *kiri haehae*. For example, 'Wahine tangi haehae he ngaru moana e kore e mātaki', which is translated to mean 'wailing and laceration of women mourning like a wave of the ocean go on unceasingly'. This *whakataukī* likens the wailing tears of grief and the laceration of the body as waves on the ocean. To me, this signals the understanding held by *tūpuna* Māori that emotions are expressed and that there is inherent healing in this.

Our *kōrero tuku iho* also talk of self-injury. In *te ao Māori*, most names have a story as to how they came about. The time of *Matariki* (known as the Māori New Year) occurs around June or July. At this time, the star constellation *Matariki* (also known as the Pleiades) emerges, and it can be seen for most of the year, except for a period of approximately one month around May (Matamua, 2017). The re-emergence of this constellation marks the time of *Matariki*. According to Matamua (2017), the full name for *Matariki* is 'Ngā Mata o Te Ariki Tāwhirimatea' (the eyes of Tāwhirimatea). This name originates from what is regarded by Māori as our creation story; the separation of Ranginui and Papatūānuku.

In the story of *Matariki*, Tāwhirimātea removed his eyes and threw them to the sky in an expression of the pain he felt when his parents were separated by his siblings. Mataamua (2017) describes this as the reason why Māori ancestors would lacerate their skin or cut off their hair when grieving the death of a loved one; the flowing of blood was a symbol of their grief, likened to the way Tāwhirimatea grieved for the separation of his parents.

The examples presented here provide a brief snapshot of a more substantial body of knowledge that describes culturally-sanctioned, traditional Māori practices of emotion regulation, particularly the expression of emotions such as discontent, anger, and the intense grief that comes with the loss of a loved one. These practices occurred in differing contexts over different lifetimes, and have been passed down over generations to preserve the experiences and memories of those gone before. Importantly, these *kōrero tuku iho* demonstrate the metaphorical expression of emotions, and the practice of *haehae* to regulate these.

Whakamate – suicide in traditional times

There are numerous and varied historical interpretations of suicide among Māori that will not be explored in depth here, but to which those interested may turn. For example, Lawson-Te Aho (2013) comprehensively explores traditional understandings of suicide in her doctoral research.

Today there is a strong relationship between suicide and self-injury in both research (Hamza, Stewart, & Willoughby, 2012; Muehlenkamp, Claes, Havertape, & Plener, 2012; Muehlenkamp & Gutierrez, 2007; Whitlock et al., 2013) and popular discourse. The purpose of discussing some of the traditional knowledge regarding suicide here is to understand how suicide was viewed in traditional, precolonial Māori society, and the extent which the two concepts are related in traditional times in comparison to how they are related today.

Whether suicide is a behaviour that existed for Māori in traditional times has been debated by many (see Lawson-Te Aho (2013) for a more detailed account of this debate). Consistent with Māori perspectives of wellbeing, Cameron, Pihama and colleagues (2017) assert that suicide may occur as a result of an imbalance between

wairua and *whakapapa*. Consistent with this, Lawson-Te Aho (2013) posits suicide

as a disconnected cultural identity. Within Māori society suicide was often viewed as

being attributed to breaches of *tapu* that impacted on the wellbeing of the collective,

the death of a partner or a profound experience of *whakamā* (Ministry of Justice,

2001; Lawson-Te Aho, 2013).

Like the story behind the name 'Matariki', names in Māori have *whakapapa*

or history. Relevant to conversations about traditional knowledge of suicide, some

Māori academics (Durie, 2001, Lawson-Te Aho, 2013; Emery, Cookson-Cox and

Raerino, 2015) assert that there is no equivalent word in te reo Māori for 'suicide'.

Within our *whakapapa* Māori (Māori history) there are stories of ancestors taking

their lives, but these were understood differently from the contemporary

understanding of suicide (Lawson-Te Aho, 2013).

Today, *mate whakamomori* is the term that is most commonly used to refer to

suicide. However, a more accurate term would be *whakamate*[14]. While

whakamomori is referred to in *kōrero tuku iho*, it typically refers to the sense of

intense emotional suffering that is felt around the time when someone had taken

their own life. Te Aka (Moorfield, 2005)[15] provides six separate definitions for

whakamomori:

1) "to pine for, mope, fret, grieve for"
2) "to desire desperately, aspire"
3) "to commit a desperate act, act in desperation, commit suicide – in
   traditional Māori society spouses or close relations would express

---

[14] To put to death.
[15] Retrieved from
http://Māoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywor
ds=whakamomori

their grief with women lacerating their breasts and cutting their hair. Sometimes the profound grief would result in the spouse taking her own life. Intense grief over the death of a close relative or friend could also lead someone to attempt suicide"

4) "dangerous, desperate, greatly desired"

5) "suicide, suicide attempt"

6) "desperate desire".

Aside from #5, the majority of these definitions refer to the emotional experiences of grief, desperation, or desire. While definition 3 refers to suicide as a desperate act expressing intense grief, the emphasis is more on the emotional experience, as opposed to the behaviour itself.

Earlier in this chapter, I highlighted a connection between *utu* and suicide in traditional Māori society. The understanding of *utu* as a means of restoring social standing was suggested to be carried out by some through suicide as a demonstration of 'control over one's fate'. In this respect, suicide could be considered to be a deliberate act of restoring the *mana* when direct retaliation to avenge a loved one was not possible. I also believe that this further highlights the power of *mana* and its role in traditional Māori society.

In research on suicide specifically from the perspectives of descendants of Taranaki, descriptions such as *ngākau pōuri* and *hopohopo* are used to describe emotions related to suicide (Cameron et al., 2017). *Ngākau pōuri* translates as heart affliction, which represents the immense grief experienced as *whakamomori*. *Hopohopo* is defined as an intense sensation of fear that is beyond *mataku* or rational fear. With *hopohopo* the fear is in control of the individual, which induces tremendous anxiety that can relate to *whakamomori* (Cameron et al., 2017).

Further assertion that suicide was not accepted in traditional Māori society can be found in the *kōrero tuku iho* of Māui and his sister Hinauri (Lawson-Te Aho,

2013). As the *kōrero tuku iho* goes, during a dispute with Hinauri's husband, Māui turned him into a dog. Upon discovering what her brother Māui had done, so strong was Hinauri's grief for the loss of her husband that she attempted to take her own life by walking into the sea and asking Tangaroa to take her. However, Tangaroa cast Hinauri back on to the shore and she survived. This response from an *atua* Māori is said to be a reflection of traditional Māori beliefs that suicide was not acceptable.

Another *kōrero tuku iho* that is commonly used to refer to suicide is that of Hinetītama, who was the daughter of Tāne and Hineahuone. Hinetītama, without knowing that Tāne was his father, also became his partner. It is said that upon realising that Tāne was her father she felt an intense sense of *whakamomori* and *whakamā*, at which time she fled for Rarohenga, and became Hine-nui-te-Pō, who is now understood to be the *atua* who ushers the dead into the next world.[16]

The traditional *kōrero tuku iho* presented here suggest that in precolonial times suicide was not considered to have a place in *te ao Māori*. However, there are other *kōrero tuku iho* that suggest otherwise. Matua Witi Ashby (personal communication, 2014) told stories of the immense grief and sadness (*whakamomori*) that was experienced by the whānau of loved ones who had died. He explained that sometimes, in traditional times, the whānau of the grieving person accepted that they were in such emotional turmoil that it would be better for them to join their loved one. Upon agreeing as a whānau that this was what would occur, they would support them in this act. This support was shown by giving their

---

[16] Te Rerenga Wairua is a location at the top of the North Island of Aotearoa. In this place, Māori believe the wairua of the dead leave this world following a path known as 'Te Ara Wairua', into the next world (Te Rēinga). (Ashby, W. personal communication, January 2015.).

blessing for the act to be carried out in private, or to surround that person at that time and recite *karakia* and *waiata* to assist that person to leave the present world and be with their loved one. In this respect, the taking of one's life was not an individual or selfish act; it was seen as a means of release to be with their loved one, with the support of the broader whānau.

While it is beyond the scope of the present study to conclude as to whether or not suicide was a traditional act, that stories relating to these behaviours exist within our *whakapapa* Māori (history) highlight the importance of understanding the context within which these behaviours occurred.

MĀORI HISTORY OF COLONISATION

The literature on historical trauma asserts that colonisation has a lot to answer for regarding its impact on Māori mental health, in particular, suicide. Having begun with a description of traditional Māori society and cultural values, it is now pertinent to foray into understanding early settler/colonial interactions between Māori and non-Māori. This will lead into discussing some of the literature regarding the impacts of colonisation on Māori mental health.

Aotearoa (New Zealand) has more than 200 years of colonial history of interactions between Māori as the *tangata whenua* (indigenous people) of the land and European settlers. Whereas pre-colonial descriptions of the health of Māori were as "relatively fit, healthy, and vibrant – though certainly not immune to disease" (Kingi, 2005, p. 4), the signing of The Treaty of Waitangi in 1840 signified a turning of the tide for Māori. Discrepancies in the translations of the texts from English to Māori played a significant role in the miscommunication and misunderstanding which saw Māori chiefs ceding their sovereignty to the British

Crown when they believed that they were maintaining their *tino rangatiratanga* (unqualified authority) over their land.

In 1840, the Māori population in Aotearoa was estimated to be around 85,000 (Davidson, 1987) compared to a European population of about 2000. Māori were the demographic majority in Aotearoa until 1860, when colonisation rendered them a subordinate minority, comprising just 48.6% of the total population (Davidson, 1987). The introduction by the British government of the Native Lands Act of 1862, The New Zealand Settlements Act and the Suppression of Rebellion Act (both of 1863), resulted in the substantial theft of Māori land. This, combined with the drastic multiplication in the numbers of new settlers following the signing of the Treaty of Waitangi, resulted in the colonial dispossession of Māori. So much so that, by 1896, the Māori population had dropped to less than 42,000, only one-twentieth of the total population of Aotearoa at that time (King, 2001). Given the strong ancestral connections that Māori have always held with *whenua*, it is no wonder that the substantial loss of land had significant consequences for the wellbeing of Māori at this time.

The Tohunga Suppression Act

While the primary focus of the Government of Aotearoa at the time was on the acquisition of land for settlement, other legislation was introduced that served to assimilate Māori by targeting the traditional social systems that, at that time, were strong. The Tohunga Suppression Act of 1907 is described by Simmonds as "one of the most aggressive assaults on *wairua* knowledge" (2014, p. 31). It is still regarded as one of the most significant actions of the government at that time to erode Māori social and cultural structures (Rata, 2012). The introduction of this Act and others

contributed to the decline in both the population and the wellbeing of Māori. For example, the Native Health Act of 1909 (which banned traditional Māori family practices) and the Native Schools Act of 1867 (which targeted the exclusion of Māori cultural practices in schools and decreed that English was to be the only language used in the education of Māori children).

The Government of Aotearoa at that time (which included Māori politicians such as Sir Apirana Ngata and Wi Pere[17]) deemed the practices of *tohunga*[18] to be superstitious and, therefore, dangerous because they were not grounded in medicinal science (Dow, 1991). Stephens (2001, p. 469) suggests that the outlawing of traditional practices in favour of Western medicine was introduced because it "offered opportunities for the *Pākehā* dominated legislature to reassert certainty in the face of uncertain medical technologies and millenarianism, and to exert political dominance over growing Māori autonomy".

The impacts of the introduction of this Act had consequences for subsequent generations. The Tohunga Suppression Act classified these *tohunga* as alternative, scientifically unfounded and, therefore, dangerous. This essentially forced *tohunga* to continue to practise their traditional methods but in a covert manner that did not draw the attention of the law (Durie, 1994).

---

[17] Stephens (2000) suggests that Māori politicians agreed to the Act hopes of improving the dire state of health for Māori at the time.

[18] A Tohunga is a "skilled person, chosen expert, priest, healer - a person chosen by the agent of an atua and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation. ... Tohunga were trained in a traditional whare wānanga or by another tohunga." Retrieved on 19 May, 2017 from http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=tohunga

The colonisation of mātauranga Māori

"Colonisation is not a finite process; for Māori, there has been no end to it. It is not simply part of our recent past, nor does it merely inform our present. Colonisation is our present." This quote from Mikaere (1994, p. 142) highlights the widespread, pervasive and multifaceted impact of colonisation on Māori. Colonisation also extended to the imposition of Christian values on Māori (Te Rangi Hiroa, 1949). In Best's (1952) description of what he terms Māori knowledge of the 'afterlife', he describes notions of 'heaven' and 'hell', whereby the righteous dead would ascend to supernatural realms whereas sinners were sent to the underworld. These depictions are inconsistent with the traditional stories of Hinetītama as *atua* of death. In our traditional *kōrero*, there is no talk of heaven or hell. Instead, these depictions by Best (1952) reflect the Christian lens with which he has viewed and described traditional Māori practices.

Professor Linda Tuhiwai Smith (2012) gives an example of how Percy Smith's interpretation of Māori migration to Aotearoa has influenced how generations of indigenous and non-indigenous New Zealanders understood how Māori arrived in Aotearoa. Percy Smith's recount suggests that Māori arrived in Aotearoa through a process of conquest and migration. Professor Linda Tuhiwai Smith asserts that by interpreting and reporting Māori migration in this way, these works of literature "support and give legitimacy to the role of conquest and migration in colonisation" (2012, p. 91).

Colonisation and Christianity also impacted on *tikanga* regarding *tangihanga* (burial processes) and how Māori mourn those who have passed on. Nikora (2016) argues that in traditional Māori society death was regarded as a natural part of life. This is reflected in *tikanga* and *kawa* of *tangihanga* whereby the wider whānau,

hapū and *iwi* are wrapped around the whānau *pani* (the grieving family) to support

them in their grief. This tikanga is still practised today; the duration of *tangihanga* is

typically around four days. "This instructive and comforting institution helps us to

hold each other close during such distressing times" (Nikora, 2016, p. 2). The

suggestions by some Māori[19] that those who take their own lives should not be

accorded the same traditional *tangihanga* protocols is argued by Cameron, Pihama

and colleagues (2017) to be a post-colonial imposition of Christian values regarding

death by suicide.

Colonisation also had a significant and detrimental impact on te reo Māori

through the Native Schools Act. The decline in the use of te reo Māori resulted in the

subsequent erosion of *mātauranga Māori* (Harris & Mercier, 2006). In an earlier

section of this chapter (*Ngā Kare-ā-roto*) I described te reo Māori as a metaphorical

language that reflects our worldviews, and is a language in which emotional

experiences can be verbalised. The decline in the use of te reo Māori as a

consequence of colonisation took away the ability of Māori whānau, *hapū* and *iwi* to

use language as a means of cultural expression and, by extension, the ability for

many Māori to express their emotions in ways that reflect our *mātauranga Māori*

(Simmonds, 2018).

---

[19] In recent years, debate has emerged regarding the way that those who take their own lives are buried, and whether they should be accorded the same tangihanga protocols. This debate was sparked in part by statements by Te Ururoa Flavell, a Māori Party MP at that time. Flavell (2011)[19] stated that: "[p]erhaps we should make a very hard stand with this. If a child commits suicide, let us consider not celebrating their lives on our marae; perhaps bury them at the entrance of the cemetery so their deaths will be condemned by the people. In doing these things, it demonstrates the depth of disgust the people have with this." Flavell's intention with these comments was to spark the debate around suicide, urging *iwi* to hold their own discussions about how to deal with the rising issue of suicide for Māori.

In this section I have highlighted that the ultimate impacts of the process of colonisation have been widespread and include loss of language, the outlawing of the practices of Māori *tohunga*, the reinterpretation and retelling of our migration histories, and the impacts on Māori burial processes. From 1901 the Māori population began to rebound. However, much of the damage to Māori identity and culture had already been done (King, 2001). Traditional Māori social structures had dissipated, the rapid and massive loss of land resulted in the loss of *mana* and ability for Māori to express *rangatiratanga* over land and people (L. T. Smith, 2012).

CHAPTER SUMMARY

In this chapter, I have provided a historical context for this research. I introduced a Māori worldview through the description of key cultural concepts such as *whakapapa*, *mauri* and *whakamā*. The relational and holistic nature of such concepts is reflected in Māori views of wellbeing as holistic and collective. Two prominent Māori models of wellbeing, *Te Whare Tapa Whā* (Durie, 1994)and Te Paiheretia (Durie, 2003) were presented here also provided an overview of the Meihana Model (Pitama et al., 2007), which operationalises *Te Whare Tapa Whā* in a manner that has utility in clinical practice.

Traditional knowledge regarding suicide and self-injury were also explored here. The act of *mate whakamomori* in traditional Māori society was carried out as a consequence of being in a state of *whakamomori* (grief or emotional suffering), but *kōrero tuku iho* and the use of te reo Māori to describe the behaviour suggest that it was not suicide as it is understood today. While the nature in which suicide is carried out today as an individual act may have existed in traditional times, it may not have been widely accepted. *Kōrero tuku iho* regarding *kiri haehae* indicate that it

was also carried out as an expression of grief when mourning the loss of a loved one, often with powerful connections to *atua* (Heke, I. personal communication, 1 April 2015). However, this was not always regarded as self-injury as it is understood today. It is suggested that the advent of colonisation and its subsequent impacts on the identity and wellbeing of Māori have changed the manner in which traditional practices of *mate whakamomori* and *kiri haehae* are interpreted today. In the next chapter, I shall explore this further by expanding on the impacts that colonisation has had on Māori wellbeing and describe the current statistics regarding Māori mental health in Aotearoa today.

CHAPTER THREE
Psychology in Aotearoa

In this chapter, I discuss the relationship between culture, identity and wellbeing, and describe how modern Māori identities are defined and assessed. I also present the current statistics on suicide and self-injury in *rangatahi* Māori. This chapter ends with a discussion of indigenous psychology and Māori psychology as a means of decolonising the academic space of psychology, and its applications in working with Māori in psychological practice.

ETHNIC IDENTITY

Definitions of race and ethnicity are complex. Broadly speaking, identity is composed of the beliefs, attributes and common factors of individuals or groups. Racial identity as Māori would mean someone is biologically Māori (Kukutai, 2004), whereas ethnic identity is more of a cultural marker; for example when someone identifies as Māori for statistical purposes (Cauce et al., 2002; Guerra & Jagers, 1998). Cultural identity as Māori would suggest that an individual feels a cultural affiliation to that ethnic group.

Ethnic identity is one of many means of categorising identity and is the most common identity construct used in psychological literature (Phinney, 1992). In Aotearoa, ethnic identity is measured in the National Census by self-identification. Individuals can choose multiple ethnic identities (Kukutai & Thompson, 2007).

As I have emphasised in Chapter 1, in traditional times, *whakapapa* was an integral component of Māori collective identities. Through *whakapapa*, Māori were connected to their ancestral lands, and by holding *mana whenua* over these lands, their collective social identities were strong, and their *mana* was upheld. Before

colonisation, knowing one's *whakapapa* provided a sense of belongingness, affinity and membership to particular *iwi* (tribes) and *hapū* (sub-tribes) (Mead, 2016).

Identity Confusion

Adolescence is a time when one's identity undergoes significant transformation. This normal phase of development should (and typically does) involve a transition from childhood into young adulthood. However, for many adolescents, this transition is not always smooth, and this can be a confusing time as they seek to gain a newfound identity separate from their childhood (Nicole & Jose, 2017). For many different reasons, identity confusion may result (Erikson, 1968).

Erikson's model of development suggests that when adolescents are between 12 and 18 years, they undergo a process of forming their identity, developing a sense of direction in life and a sense of self. Identity confusion at this time can occur if adolescents are not able to (or are not supported to) understand what their beliefs and desires are, resulting in confusion regarding their future which can extend to confusion about themselves and their identity, hence the term identity confusion.

Modern Māori identities

The YWB Study utilises three questions to determine participants' ethnic identity; by ancestry, by selecting all ethnicities with which they identify, and by prioritising one ethnicity as their primary. Participants are also asked about the importance of their ethnic identity. It could be argued that the notion of descent is most akin to traditional Māori identities based on *whakapapa*, as it explicitly references the notion of *tūpuna* ("Are any of your parents, grandparents or great-grandparents Māori?"). It also can be considered to be more inclusive, because,

while participants may not culturally affiliate with Māori, they could still be considered to be Māori.

Rata (2015) describes how, today, Māori identities have evolved into "multiple ways of being Māori". Individuals' identity as Māori can evolve, shift, and occupy numerous 'positions', as demonstrated in her Māori identity migration model. This model depicts the fluidity of identity, whereby Māori identities move between different spaces, which are represented by the environmental domains of sea, land, river and sky. The four domains are structured in a two-dimensional manner, with the horizontal axis reflecting low to high Māori cultural engagement, and the vertical axis showing high to low mainstream cultural engagement. For example, an individual may reside within the 'Land' domain if they have high Māori cultural engagement and low mainstream cultural engagement. Surrounding the model are contextual factors which represent factors that may influence one's migration between domains. Rata (2015) gives the example of identity affirmation as an influence; the extent to which the environment allows for and supports the expression of Māori identity will determine in which domain an individual will locate themselves. Individuals may move between these domains on a daily basis, or only a few times over a lifetime.

Another model of Māori identity is the Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE, Houkamau & Sibley, 2010). This model and its concurrent measure is the identity measure used in the YWB Study. This model is composed of six dimensions, which reflect the diversity and multifaceted nature of identity as Māori. These dimensions are 1) Group Membership Evaluation, 2) Socio-Political Consciousness, 3) Cultural Efficacy and Active Identity Engagement, 4) Spirituality, 5) Interdependent Self-Concept, and 6)

Authenticity Beliefs. The benefit of both the Māori Identity Migration Model and the

MMM-ICE is that both are structured so that no domain or dimension is assumed

superior to the others, which is affirming to the diverse identities that Māori

possess.

In their analysis of the Youth Connected Project Data, Kukutai and Callister

(2009) found that when youth who identified as both Māori and NZ European were

asked to prioritise one ethnicity over the other, more young people chose NZ

European (n = 114) than Māori (n = 92). This, they assert, has implications when

collecting ethnicity data as it would lead to reduced ethnicity counts. For example, if

applied to the 2006 census data, the number of Māori would reduce from 565,329 to

395,051.

Identity and wellbeing

In Māori models such as Te Paiheretia (Durie, 2003), identity is integral to

wellbeing. For Māori who experience poor mental health, an insecure identity may

play a role in explaining that ill-health. Muriwai, Houkamau and Sibley (2015) report

that cultural efficacy (defined as the importance of connection to one's cultural

values and practices) may act as a protection for Māori who experience

psychological distress. The notion of 'culture as cure' asserts that by enhancing

access to, awareness of and engagement in *te ao Māori* it may serve to protect Māori

who experience psychological distress.

The relationship between identity and wellbeing is also well established in

the Western literature. Phinney and Ong (2007) assert culture as a pivotal

contributor to ethnic identity development. Further, Phinney (1990) and Berry

(1997) assert that having both strong ethnic and national identity is associated with

higher overall wellbeing. When an individual is required to assimilate and choose one identity at the cost of another, this is associated with reduced wellbeing, and feelings of anger and depression (Berry, Poortinga, Breugelmans, Chasiotis, & Sam, 2011). Further evidence has found that when one is raised with a secure ethnic identity (whereby they are part of a secure ethnic community that allows children to form a definite sense of their ethnic group), this allows children to be raised with positive feelings towards their ethnic group which in turn can lead to a source of personal strength and positive self-evaluation (Berry et al., 2011).

Identity and wellbeing as it relates specifically to self-injury will be explored further in Chapter 4 (se p. 61), but in a general sense, Rata (2012) explicitly focused on identity and wellbeing in *rangatahi* Māori. She found that cultural engagement predicted ethnic identity, which in turn predicted psychological wellbeing. Based on this, she developed the Powhiri Identity Negotiation Framework which theorises identity as a dynamic process of negotiating relationships.

Dudley and colleagues (2016) also draw a direct link between acculturation in Aotearoa and psychological wellbeing within the context of performance on neuropsychological tests. They report research by Feigin and Barker-Collo (2007), Ogden and McFarlane-Nathan (1997) and Ogden, Cooper, and Dudley, (2003) who all found that Māori who are more acculturated to the dominant *Pākehā* culture perform better on neuropsychological tests.

Consistent with this, Houkamau and Sibley (2011) found that differences in the manner by which Māori ethnically identify also related to different health outcomes. For example, Māori who identify as both Māori and NZ European have different psychological outcomes from those who identify solely as Māori. Those who identify solely as Māori and were high in their measure of cultural efficacy

(using the MMM-ICE) had better psychological outcomes than mixed Māori-Europeans. Houkamau and Sibley (2015) also found that the greater extent to which an individual self-identified as Māori, the less likely they were to own a home. This suggests that there are also financial and social costs to being Māori.

SELF-INJURY IN RANGATAHI MĀORI TODAY

It is not the goal of this thesis to provide an extensive recount of all of the literature as a means of highlighting how poorly Māori are performing compared to non-Māori on health indicators. This has been done umpteen times over recent decades, and yet the disparities remain and are well established in the literature (See Borell, Gregory, McCreanor, Jensen, & Moewaka-Barnes, 2009; Houkamau & Sibley, 2011; Robson & Reid, 2001; Sibley, Harré, Hoverd, & Houkamau, 2011). In many key areas of mental health, Māori are over-represented in the adverse health indicators. For example, Baxter and colleagues (2006) report that Māori had the highest prevalence of any mental disorder over a 12-month period compared with all other ethnic groups. As Masters et al. (2017) highlight, one key issue is not that the significant inequities between Māori and non-Māori have not been identified, but that the findings of reports are not practical or have not been taken on board enough to make meaningful change.

As mentioned previously, the extent to which self-injury is an issue for *rangatahi* Māori in Aotearoa is not clear. Even in international research, the actual prevalence of self-injury is not apparent. Factors that contribute to this include definitional differences, as well as the use of different measures in each study (Muehlenkamp et al., 2012), both of which contribute to the complexity of interpreting the current information available. To further complicate matters, most

self-injury is not severe enough to warrant hospitalisation, and many who self-injure do not disclose their behaviour. As a result, the majority of self-injury goes unreported and unrecorded in official statistics.

With that in mind, current estimates of prevalence are informed by official government reports in Aotearoa. The most recent statistics on suicide in Aotearoa (Coronial Services of New Zealand, 2017) identifies that while the rates of hospitalisation due to intentional self-harm (broadly defined) are highest for youth, this rate has declined since 1996 (from 46.9% to 27.5%). While non-Māori rates of self-harm hospitalisation have decreased, there is no discernible pattern in the rates of Māori self-harm hospitalisation. The statistics do not, therefore, tell us a lot about the rates of self-injury for *rangatahi* Māori.

The Dunedin Multidisciplinary Health and Development Study (Nada-Raja, Skegg, Langley, Morrison, & Sowerby, 2004) reported that Māori women were the most likely to self-injure. The Youth '12 survey (Crengle et al., 2013) found that 28.7% of *rangatahi* Māori in their sample had self-harmed within the previous year. The Youth '12 survey also found differences in the prevalence rates for males and females, with 36.6% of female *rangatahi* Māori reporting self-harm as opposed to 19.8% of males.

In 2010, Garisch conducted a longitudinal survey of 1162 secondary school students in the Wellington region. Garisch (2010) reported a lifetime prevalence in her sample of almost 50%, using a behavioural measure to assess prevalence. Importantly, and in contrast with both Crengle et al., (2013) and Nada-Raja and colleagues (2004), Garisch found that the 9% of *rangatahi* who identified as Māori in her sample were no more likely than non-Māori students to engage in self-injury.

Currently only one study has specifically investigated self-injury for *rangatahi* Māori that is consistent with *kaupapa Māori* research practices (see Chapter 5). This was conducted by Mendiola (2011) as a qualitative investigation of the functions of Deliberate Self-Harm (DSH) in *rangatahi* Māori. Mendiola (2011) interviewed the whānau and clinicians of ten *rangatahi* Māori clients at a community mental health facility in Auckland. She reported that, according to Māori whānau and those clinicians who worked with them, the functions for DSH in their *rangatahi* Māori included: to communicate distress and seek help; to punish someone else; to get relief from a distressing emotional state; due to the influence of others; as a response to feeling overwhelmed by stressful circumstances; precipitated by social isolation; and due to the cultural influence of *matakite.*[20] The functions of self-harm in *rangatahi* Māori described by Mendiola (2011) overlaps with the existing literature within Aotearoa and internationally.

SUICIDE IN RANGATAHI MĀORI TODAY

In 2017 the Coronial Services of New Zealand released the most recent statistics on the prevalence of suicide in Aotearoa. This data was taken from analysis of all confirmed causes of death for the year 2015, in which 527 people died by suicide in Aotearoa. Of these, 384 were male and 143 were female. The highest rate was amongst youth aged between 15 and 24 years (reported as 16.9 per 100,000 people). Māori continue to have the highest suicide rate of all ethnic groups at 21.7 per 100,000 population (Coronial Services of New Zealand, 2017).

---

[20] *Matakite* (ability to see or hear spirits; clairvoyance; psychic abilities).

Coronial Services of New Zealand (2017) report that rates of suicide among Māori were higher than for non-Māori for both genders; the rate for Māori males was 1.7 times that of non-Māori at 25.3 per 100,000. For Māori females, the rate of suicide in 2015 was 2.4 times that on non-Māori (actual rate per 100,000 is not given). As I have said earlier (p. 53), comparing Māori with non-Māori when discussing health and wellbeing measures has been of little benefit to Māori, and in fact often harmful. I present this data here simply to highlight suicide as a significant issue for Māori today, and in particular for *rangatahi* Māori, who had the highest rates of suicide in 2015.

The available information regarding suicidal thoughts and behaviours in *rangatahi* Māori comes from the Youth '12 survey (Crengle et al., 2013). Just under 19% (18.7%) of *rangatahi* Māori in their sample had seriously thought about killing themselves in the previous 12 months, with 20.3% of males reporting suicidal thoughts and 26% of females. Almost 7% (6.5%) of *rangatahi* Māori had made a suicide attempt in the previous 12 months.

DECOLONISING PSYCHOLOGY

So far in this chapter, I have discussed the relationship between identity and wellbeing for *rangatahi* Māori and presented some of the most recent statistics that provide a snapshot of the current state of wellbeing for *rangatahi* Māori, as measured quantitatively and qualitatively. There are many areas of concern, particularly with regards to the emotional wellbeing of *rangatahi* Māori and the rates of suicidal thoughts and self-injurious behaviours of *rangatahi* Māori today. Also in this chapter, I have asserted that colonisation has impacted on many facets of wellbeing. I now turn to the broader discipline of psychology and argue that

indigenous and Māori psychology have the potential to transform psychological experiences of Māori.

Indigenous psychology

At a time when "an increasingly dominant voice in mental health would have us colonise clients with empirically validated treatments on the grounds that this is 'scientific' and 'best practice'"(Drury, 2007, p. 21), indigenous psychologies offer an approach to understanding the self beyond the dominance of mainstream Western psychological knowledge. Indigenous psychology is an alternative approach to the examination and conceptualisation of the self that counteracts the historical dominance of Western, Eurocentric perspectives.

In Aotearoa, current definitions of many psychological phenomena have been obtained using approaches that are inconsistent with tikanga Māori, which have resulted in definitions that are grounded in individualistic, Western perspectives of wellbeing (Durie, 2002). Definitions of psychological phenomena, such as NSSI and DSH, for example, have been informed using methods of validation and verification that decontextualise the individual, with the intent of creating definitions that can be applied universally to explain psychological experiences. The problem for Māori (and many indigenous people) is that definitions obtained in this manner fail to consider the richness and complexity of Māori definitions of wellbeing, and the culturally specific functions of behaviours, and yet these Western definitions are then used for diagnosis and to inform treatment.

Advocates for indigenous psychology (Durie, 2002; Levy, 2007; Love, 2003; Waitoki, 2012 - to name but a few) argue that applying Western psychology to Māori perpetuates social injustice as further colonisation of Māori. Psychologists are

taught to be impartial and objective, and a client's socio-political history is rarely considered. The separation of Western psychological values, which are entrenched within the discipline, and 'other' cultural values, such as Māori, are clinical/cultural distinctions that resign cultural values as the 'other' or alternatives. The Tohunga Suppression Act sent a clear message to Māori that traditional knowledge and approaches to healing our people were risky and unsafe, and Western approaches to treatment were the only valid means of treating illness. Unsurprisingly, the dominance of Western psychology and the application of Western psychological values with *Māori* clients has resulted in longstanding mistrust by some Māori and other indigenous cultures in Western approaches to psychological diagnoses, because they fail to consider the lived realities of indigenous peoples (Waitoki, 2012). Herbert (2002) suggests that variations in prevalence for some psychological phenomena, as defined using Western values, could be more as a result of the failure to meaningfully incorporate cultural, social, political contexts of the clients than actual differences in rates.

Within Aotearoa Treaty of Waitangi can be operationalised in the practice of psychology to be culturally responsive to Māori. In particular, Article 3 of the Treaty asserts that Māori have the rights of equality and opportunity. In recent years there has been legislation pertinent to the practice of psychology that has made positive steps towards the reclamation of Māori identities in psychology, such as the Health Practitioners Competency Act 2003, Health and Disability Legislation 2000, and the Psychologists Code of Ethics (New Zealand Psychological Society, 2002).

As Waitoki (2012, p. XX) aptly asserts, "I no longer agree that Western-psychology is valid for Māori as long as it has bicultural elements. It can be useful, but only if Māori have picked it apart using their methodologies and taken what is

useful to them." Consistent with this, many Māori and indigenous psychology researchers now acknowledge psychology as it is understood in Western terms to be only one of many forms of psychology that reflect the worldviews of the cultures within which they were developed (Berry, Poortinga, Segall, & Dasen, 2002).

Māori psychology

This year, 2018, is an exciting time to be an (aspiring) Māori clinical psychologist and researcher. In Aotearoa, the focus is no longer on identifying the issues and highlighting the incompetence of Western psychology for understanding Māori psychological experiences (Glover & Hirini, 2005; Masters & Levy, 1995). With these well established, the focus is now on building the critical mass of Māori psychologists (Levy, 2016).

When I began my clinical training in 2011, the advice from Māori clinical psychologists at that time to me as a Māori clinical psychology student was to keep my head down, to 'play the game', and only what was needed to get through the programme. Essentially, this meant being prepared to set aside my cultural values at times, as they would sometimes oppose the protocols endorsed by the clinical programme. For example, the cultural practice of *mihimihi* is enacted by greeting Māori clients with a kiss and hug. This was considered from a Western perspective to be a serious transgression of boundaries between the practitioner and the client.

Once we had graduated, the advice given by those who had gone before was then to "forgive ourselves for our training and practice in ways that were Māori"(Milne, 2014). The ability to do this during our clinical training, has now been strengthened by Māori psychologists who have shared how they do this in practice (NiaNia et al., 2017; Waitoki & Levy, 2016). As a result, we now have a psychology in

which distinctively Māori cultural practices can work independently, or alongside, other clinical practices (such as 'Western' and 'Pacific islander'; Waitoki, 2012). So much so that as clinical psychology students we now feel confident to be able to apply these practices, and often feel supported and encouraged by our clinical programmes to do so.

CHAPTER SUMMARY

The purpose of this chapter was to highlight how Western approaches of psychology act to perpetuate colonisation, and how the movement of indigenous psychology and, specifically in Aotearoa, Māori psychology, can counteract this ongoing colonisation. The impacts are seen in *rangatahi* Māori statistics, in particular regarding suicide and self-injury. This chapter has highlighted suicide and self-injury as issues for *rangatahi* Māori that require solutions that are grounded in *te ao Māori*. Māori psychology has the potential to create Māori psychologists who are grounded in a Māori worldview with the recognition of alternative ways of practising psychology that benefit whānau.

CHAPTER FOUR
Self-Injury – a review of relevant literature

In the previous three chapters, I have reviewed and discussed the need for the continued development of Māori psychology, Māori definitions of wellbeing and Māori approaches to working with *tangata whaiora* that are consistent with Māori worldviews. It now feels conflicting and contradictory to present the existing literature on self-injury in a Western context. Having just espoused developing our indigenous definitions for self-injury obtained using our measures validated by our standards, what relevance do Western knowledge, Western definitions and research that has been obtained using Western-valued and -validated, empirically robust and rigorous research methods have for Māori?

In one sense, the need to present all of the literature about a particular topic is assumed when conducting doctoral research within a mainstream institution. This is a requirement and, in the context of research with indigenous people, a perpetuation of the colonisation practices. It also reflects the lived realities of Māori today and, in particular, of *rangatahi* Māori. While Māori-centred approaches are ideal, the dual ethnicities and mixed identities of *rangatahi* Māori mean that this Western research is still potentially valid and relevant. This was evident in the advisory *hui* that I held at the outset of my research. As a conflict that I had been holding for some time, I presented this to the groups, of *rangatahi* Māori and practitioners, and was reminded that *rangatahi* in Aotearoa today walk in two worlds, at the meeting place. This is why Durie's (2005) interface research paradigm is so relevant for this project; because it acknowledges that both knowledge systems have value to contribute. However, although Māori walk in dual worlds, the research (western) literature does not. Here I present Western knowledge regarding self-

injury, to provide a complete picture of self-injury as it is understood in Aotearoa today. First, I present cross-cultural perspectives on self-injury, including those of other indigenous cultures. I then turn to the much more abundant research speaking to Western definitions, prevalence rate correlates, risk factors, protective factors, functions, models, and treatment approaches, including the existing research in Aotearoa on this subject. Finally, I discuss NSSI and identity, and why identity is relevant for understanding self-injury in *rangatahi* Māori.

CULTURAL PERSPECTIVES ON SELF-INJURY

Indigenous cultures across the world share many similarities regarding cultural values, as demonstrated by the similarities in how they conceptualise wellbeing (see Chapter 2). In addition, the firm connections that *whenua* (land) holds as a place of belonging *(tūrangawaewae)* for Māori is also strong in other cultures. For example, in Hawai'ian culture (Rezentes, 1996), the Western Apache people of Arizona (Basso, 1996) and the Aboriginal communities of Australia (McKay, McLeod, Jones, & Barber, 2001). In all of these cultures, the wellbeing of the land is integral to the health of the indigenous people of that land. Given these similarities in worldview and values, we can and should also look to other indigenous cultures for similarities in traditional knowledge regarding self-injury.

Cross-cultural traditional knowledge

With regards to traditional knowledge of self-injury in other cultures, Favazza (2011) provides one of the most comprehensive accounts of cultural understandings of self-injury knowledge. He describes rituals of indigenous cultures that serve as rites of passage, signs of respect and honour for ancestors, the rebalancing of body and spirit energies, and for the healing of diseased or wounded

body, self, or psyche. Favazza (2011) describes the skin as a border between the internal and external self, which is used by some cultures as a means of communicating beliefs through scarification and tattoo, as well as one's temporary emotional states (McAllister, 2003). This conceptualises self-injury as an expression of internal emotional states, as well as a means of depicting values and beliefs.

Traditional Hawai'ian stories talk of the practice of Ma-newa-newa, which is an expression of Na'au'auwa, or intense grief, at the passing of a loved one (Pukui, Haertig, & Lee, 1983). Examples of such behaviours include scarring the body or knocking out teeth. While the practice of Ma-newa-newa was not culturally mandated or sanctioned as a cultural norm per se, it was in some ways respectfully tolerated during Na'au'auwa (Rezentes, W. personal communication, 29 April 2016).

For Pacific peoples', Dash and colleagues (2017) have proposed a definition of self-injury that incorporates spiritual and mental harm, including disconnect from spiritual faith:

> Deliberate Self-Harm (DSH) is an intentional act of inflicting harm to the physical, mental or spiritual self that serves separate functions from suicidal intent. DSH behaviours can include both direct and immediate self-injury as well as indirect forms of self-harm causing long-term negative consequences. These behaviours include alcohol and drug misuse, gambling, self-starvation and risk-taking behaviours. Additionally, DSH includes intentional harm to the spiritual or the mental self, including deliberate disconnection from spiritual faith and holding negative self, cultural and life perspectives. (p. 119).

In their research on self-harm among indigenous Australian people, Farrelly and Francis (2009) describe self-injurious behaviours, such as cutting wrists and arms, burning themselves, hitting their head, or cutting off their hair. Some tribespeople would engage in initiation rituals such as "teeth extraction, cutting of

arms, chest and abdomen then filling the wounds with ashes to prevent infection

and encourage a raised scar" (p. 186). Farrelly and Francis (2009) also describe

expressions of grief when in mourning in regions throughout Australia that include

grieving rituals. In his example he describes "women striking their heads with

stones, or on the ground or with stones or other hard implements or on the ground,

and cutting, particularly the self-infliction of 'sorry cuts'" (Farrelly & Francis, 2009,

p. 186).

The definitions of self-injury reported by Farrelly and Francis' (2009)

research also included "reckless and self-destructive behaviour such as deliberately

participating in particular activities that are known to have deleterious effects, and

apparently not caring about the consequences" (p.184). For example, substance use.

Participants believed that these behaviours lacked any traditional cultural influence.

When probed, participants believed that, due to the impact of colonisation, most

aboriginal Australians who engaged in these behaviours lacked the traditional

cultural knowledge for these acts to be based in traditional cultural practices

(Farrelly & Francis, 2009). As one participant described "...[I]t's just not acceptable

in the Aboriginal community, you know, it's not common practice, it's not our

culture to hurt ourselves or to self-harm ourselves, you know? It's just not in our

make-up" (Farrelly & Francis, 2009, p. 186).

Participants in Farrelly and Francis' (2009) research also talked of hair-

cutting as a form of self-harm. They spoke of a mother who had cut her hair when

mourning the death of her son by suicide, and also of a Koori woman who was the

victim of domestic abuse. This was described as "a sign and a signal that they've

been bashed, hurt or harmed for anyone that sees them, or that is their way of

showing that you know, they've had it tough, and they don't deserve to look or feel

their best" (p. 187). Similarly, research on NSSI among the North American White Mountain Apache Tribe of America (Cwik et al., 2011) indicated that the young people who engaged in self-injury in their sample also viewed substance use as self-injury, citing similarities in the physical consequences.

Current rates of self-injury in indigenous and minority cultures

The current knowledge of self-injury within indigenous and minority cultures is scarce and paints an unclear picture of the extent of the issue. Some studies report that members of minority groups are just as likely to engage in self-injury as the dominant culture (Croyle, 2007; Whitlock, Eckenrode, & Silverman, 2006; Wilcox et al., 2012). However, others report that minority cultures are less likely to engage in NSSI (Bhui et al., 2007; Gratz, 2003; Gratz & Roemer, 2008). In their research on DSH in Pacific island students, Helu et al. (2009) found that 29% of female students and 17% of male students had hurt themselves in the preceding 12 months.

Chesin, Moster and Jeglic (2013) suggest that the paucity of data does not necessarily mean that these groups do not engage in this behaviour. Instead, it may be that the behaviour is not being captured due to low sample sizes, or perhaps it is because culturally grounded behaviours do not fit the definitions of self-injury that are assessed by current measures (Black & Kisely, 2018; Herbert, 2002).

The importance of cultural understandings of self-injury

Traditional indigenous practices such as Ma-newa-newa and *kiri haehae* have clear antecedents, and demonstrate that there may be behaviours that, from a Western perspective, could be classified as self-injury. This highlights the need to obtain cultural competencies with other cultures to avoid the risk of pathologising

66

culturally meaningful behaviours as self-injury (Black & Kisely, 2018; Langlands, 2012).

The research presented here also highlights that even among those who identify with a Western or dominant culture there are also variations in how self-injury is defined. This, in turn, has consequences for prevalence estimates and understanding of the behaviours involved (Black & Mildred, 2014; Cwik et al., 2011; Straiton, Roen, Dieserud, & Hjelmeland, 2012). That there are differing definitions of self-injury across cultures emphasises the possibilities that, if we were to look at the behaviours of people from different cultures through their unique cultural lenses or worldviews, our understanding of these behaviours and ways of working with these people would differ. This, in turn, could have considerable implications for the manner in which health practitioners engage with people of different ethnicities when they self-injure.

WESTERN DEFINITIONS OF SELF-INJURY

In a research context, definitions of self-injury vary, with distinctions typically based on the types of behaviours and the intent of the behaviours (Lundh, Karim, & Quilisch, 2007). Though historically only found as a symptom of other disorders, Non-Suicidal Self-Injury (NSSI) disorder has been proposed as a new diagnostic entity in section 3 (conditions for further study) of the fifth edition of the Diagnostic and Statistical Manual (American Psychiatric Association, 2013).[21]

---

[21] The debate regarding the merits and consequences of this development sits outside the scope of this thesis. See Plener et al (2015) for more on this.

Non-Suicidal Self-Injury

Non-Suicidal Self-Injury is the intentional, culturally unacceptable, self-performed, immediate and direct destruction of bodily tissue that is of low lethality and absent of overdose, self-poisoning and suicidal intent (Garisch & Wilson, 2015; Klonsky & Muehlenkamp, 2007; Nock, 2010; Wilkinson, 2013). NSSI excludes behaviours, such as excessive alcohol consumption and poisoning, drug overdose, and any risk-taking behaviours, that do not result in tissue damage (for example, engaging in emotionally abusive relationships). For research purposes, the exclusion of suicide attempts from the definition of NSSI allows the investigation of unique risk factors, protective factors and functions that contribute to NSSI (Brausch & Gutierrez, 2010; Wilkinson, 2013). Behaviours considered to be NSSI include cutting, burning, and hitting oneself, among others.

Deliberate Self-Harm

Deliberate Self-Harm typically differs from NSSI concerning suicidal intent. DSH does not exclude the possibility of suicidal behaviour, and some may view suicide as "the ultimate form of deliberate self-harm" (Lundh et al., 2007, p. 33). Aside from Garisch's research (2010), existing Aotearoa-based studies, such as the Youth 2000 study (Adolescent Health Research Group, 2012), have not distinguished NSSI from DSH (see 'Definitional Dilemmas', p. 5).

PREVALENCE OF SELF-INJURY

Accurate prevalence rates of self-injury are challenging to gauge. In Aotearoa, the official prevalence rates of DSH include only hospital admissions for more than two days, which means that youth who report their self-injury to guidance counsellors, General Practitioners (GPs), and *kaupapa*-Māori health services are not

recorded in these statistics. Anecdotal reports from the advisors in this research project assert that it is these locations where *rangatahi* most commonly report to, therefore suggesting that the given prevalence rates may be grossly underestimating the actual numbers of *rangatahi* Māori who self-injure.

The challenge of establishing prevalence is also reported internationally for similar reasons. McAllister (2003) argues that the rates of self-injury are so variable and unreliable because most clients are not seen by health professionals; there is a minority who present to emergency services, and most of these people are not admitted but instead are discharged without a referral. Another challenge faced by researchers in the field of self-injury is due to the lack of one consistent, universal, and consensual definition of self-injury (Muehlenkamp et al., 2012; Nock, 2010).

Variations in the method of measurement or assessment of the behaviour further complicate the issue. In their review of NSSI among adolescents Muehlenkamp and colleagues (2012) reported that the discrepancies in prevalence rates depended on the measurement tool, with checklists of NSSI methods providing higher estimates than single-item questions. Swannell and colleagues (2014) suggest that these differences could, in part, be due to the cognitive processing required in answering a single question versus a checklist which requires the processing of each behaviour in turn. Gratz (2001) asserts that behaviour-based measures can be more sensitive and, therefore, produce higher prevalence rates, because they ask questions regarding specific behaviours, allowing a researcher to define what is and is not self-injury, as opposed to providing a definition and asking the participant to decide whether or not their behaviour fits that definition. Also, the use of single or few item assessments may not capture the full range of methods used by those who self-injure (Garisch & Wilson, 2015).

Internationally, self-reported lifetime history of NSSI among adolescents'

ranges between 7% and 66%, depending on the definition and measure used

(Bjareberg et al., 2014; Marshall, Tilton-Weaver, & Stattin, 2013; Muehlenkamp et

al., 2012; Nada-Raja et al., 2004). In 2014, Swannell and colleagues reported a meta-

analysis of prevalence of NSSI across 119 studies and found that, after adjusting for

methodological factors, 17.2% of adolescents reported a lifetime history of NSSI,

13.4% of young adults and 5.5% of adults. Nock reports the typical age of onset as

between 12 and 14 years old (2009; see also Jacobson & Gould, 2007; Plener,

Schumacher, Munz, & Groschwitz, 2015).

The lifetime prevalence rate within adult community samples has been

reported as between 2% and 6% (Bebbington et al., 2010; Briere & Gil, 1998;

Klonsky, 2011). Within adolescent inpatient populations, however, rates vary

between 35% and 65% (Laurence Claes, Vandereycken, & Vertommen, 2007). This

higher number may be explained by the high comorbidity of self-injury with other

psychological difficulties, for example anxiety (e.g., Wilkinson & Goodyer, 2011) and

depression (Duggan, Heath, & Hu, 2015; Garisch, 2010; Garisch & Wilson, 2015).

Another factor could be the overlap in diagnostic criteria (for example Borderline

Personality Disorder; American Psychiatric Association, 2013).

With regards to gender differences, Whitlock, Powers and Eckenrode (2006)

and Hoff and Muehlenkamp (2008) reported NSSI as being more common in females

than males. Swannell and colleagues (2014) also report that prevalence for females

(19.9%) was significantly higher than males (14.7%). However, Andover, Primack,

Gibb and Pepper (2010; see also Claes, Houben, Vandereycken, Bijttebier, &

Muehlenkamp, 2010) have reported that males were as likely to self-injure as

females.

There are also differences in the forms of self-injury between genders, Gandhi et al. (2017) found that cutting was the most common self-injurious behaviour in females, whereas head-banging was most common for males. In research by both Whitlock, Eckenrode and Silverman (2006) and Andover et al. (2010), females were more likely to cut and males more likely to burn themselves.

In summary, the current international literature on self-injury is variable, as a result of different methods of assessment and different definitions, as well as the information used to obtain the statistics. Mixed reports of prevalence between genders further complicate the issue. The age of onset is between 12 and 14 years and the lifetime prevalence is between 2% and 6%. Self-injury is more common in inpatient samples and is highly comorbid with other psychological difficulties. In the next section, I present the research from within Aotearoa which provides a picture of some of the similarities and differences between international research and research that has used samples from Aotearoa.

Prevalence of self-injury in Aotearoa

Consistent with international research to date, studies of prevalence rates of self-injury for youth in Aotearoa have been highly variable. Garisch and Wilson (2010) reported a 14% prevalence rate in their sample, and the Youth Connectedness project (Jose & Pryor, 2010) reported that one-third of their sample had thought about self-injury in the month preceding participation. Both studies utilising a variation of the same single-item question. Fleming et al. (2014) reported that 24% of their sample had engaged in NSSI in the past 12 months. In a sample of university students, Fitzgerald and Curtis (2017) report a lifetime prevalence rate of 38% (n = 293).

71

While Garisch and Wilson (2010) found no differences in DSH between genders, the Youth '12 survey (Clark et al., 2013) reported that 29% of female youth and 18% of male youth had self-injured in the preceding 12 months (using a single-item measure). Fitzgerald and Curtis (2017) found that 12-month prevalence in their sample was 13%. They report that lifetime prevalence of NSSI for females was 41.7% (229) and, for males, it was 29.4% (n = 64). The average age of onset in their sample was between 11 and 15 years.

Garisch and Wilson (2015) report a two-wave longitudinal study of adolescent NSSI, the first of its kind in Aotearoa (data from the YWB Study). This study utilised the DSHI as a behavioural measure of NSSI. Lifetime prevalence within this sample was 48.7%, with no significant difference between males and females. Twelve percent of those who had self-injured reported having done so in the previous week, 13.5% within the last month, 28.29% in the last year, and 46.4% over one year ago.

Within a sample of university students Fitzgerald and Curtis (2017) report differences in the forms of self-injury between genders, where females were more likely to engage in more 'covert' forms of self-injury that were easily hidden (for example, cutting their wrists, arms or upper thighs). Males were found to engage in what they classified as 'overt' forms of self-injury that included banging or punching themselves or objects with their hands or head. The most endorsed function of self-injury across genders was to regulate emotional experiences and relieve stress in Fitzgerald and Curtis' (2017) sample. They concluded that females were self-injuring to gain control and manage their emotions, whereas, for males, self-injury was more a means of expressing emotions. This conclusion was due in part to the differences in forms of self-injury, in that the overt expression of self-injury for

males (head-banging, for example) combined with their motivations to self-injure for the excitement and energy rush experienced.

COMORBIDITIES

NSSI is listed in the DSM 5 as a 'condition for further study (American Psychiatry Association, 2013). Currently, because it is not a DSM diagnosis, someone who presents with NSSI is often diagnosed with Borderline Personality Disorder (BPD) regardless of whether or not they exhibit any of the other characteristics of BPD, to achieve diagnosis (Crowe & Bunclark, 2000). Advocates for the inclusion of NSSI in DSM 5 believe that this would allow clients who may not meet criteria for BPD but have clinically significant psychopathology of NSSI to be distinguished from those who have lower levels of NSSI (Zetterqvist, 2015). This, in turn, would allow those more severe presentations to access help without needing to be diagnosed with BPD (Zetterqvist, 2015).

While self-injury is more common among those with a psychiatric diagnosis, not all of those who engage in NSSI have a mental health disorder (Chapman et al., 2006; Wilkinson, 2013). Research tells us that the majority of people who engage in self-injury do so only once or twice (Klonsky & Muehlenkamp, 2007). Others, however, adopt NSSI as a coping strategy, whereby the behaviour is reinforced and persists when it produces the desired outcomes (Anderson & Crowther, 2012). One leading model of NSSI is the Experiential Avoidance Model (EA Model: Chapman et al., 2006). Experiential avoidance is defined as the process of avoiding one's emotions, and the thoughts and physical sensations associated with those emotions (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The EA Model posits that comorbidities, such as anxiety and depression, suggest difficulties with managing

emotions and underlying social distress (Wilkinson & Goodyer, 2011). To understand why there are some *rangatahi* Māori who never engage in this behaviour, others who only self-injure once or twice, and others who repeatedly self-injure, knowledge of the risk and maintaining factors, correlates and comorbidities is essential.

RISK FACTORS

Intrapersonal risk factors for self-injury include anxiety (Wilkinson & Goodyer, 2011), depression (Duggan et al., 2015; Garisch, 2010; Garisch & Wilson, 2015), impulsivity, low self-esteem, substance use, alexithymia and emotional dysregulation (Garisch & Wilson, 2015), hopelessness (Wilkinson, 2011) and identity confusion (Gandhi et al., 2017; Nada-Raja, Morrison, & Skegg, 2003; M. K. Nock, 2008). Garisch and Wilson (2015) suggest that the desire for short-term relief in impulsive individuals may cause an individual to use self-injury (and also substance use) as avoidant coping strategies.

Garisch and Wilson (2015) also cite research that suggests that young people who self-injure may experience anxiety related to the scars from their behaviour and fear of discovery by others of their self-injury. This fear of discovery may then lead to a fear of losing control. Because those who chronically self-injure come to rely on NSSI more and more as a coping strategy in response to everyday life stressors, it then becomes habitual; the default coping strategy that the young person turns to when experiencing stress. Garisch and Wilson (2010) found that alexithymia (deficits in understanding and managing one's emotions) may function as a risk factor, as self-harm may be a means of expressing emotions through self-injuring. This argument is also consistent with the EA Model.

74

Interpersonal risk factors include bullying and other related forms of peer victimisation (Brown, 2015; Garisch & Wilson, 2010; Klonsky, 2007; Nock & Prinstein, 2004), as well as weaker attachment to significant others (Heilbron & Prinstein, 2008; Muehlenkamp et al., 2012). Socio-cultural factors include role-modelling of self-harm by others, and social validation of self-injury as an appropriate coping mechanism (M. K. Nock & Prinstein, 2005). Also, inadequate social support systems (Andrews, Martin, Hasking, & Page, 2014; Hankin & Abela, 2011) and environmental risk factors, such as life stressors, have also been found to be related to NSSI (Guerry & Prinstein, 2009; Hankin & Abela, 2011). Research has also found that deficits in communication and problem-solving skills increase the risk of engaging in self-injury, and it is possible that the self-injurious behaviour may function as a form of communication or solution to their interpersonal difficulties (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Nock & Mendes, 2008).

Brocklesby (2017) investigated perfectionism and NSSI. In this research she classified perfectionism into two dimensions; positive perfectionism, which is linked to the pressure one places on themselves to excel, and negative perfectionism, which is considered to be associated with feelings of shame, guilt and worry about making mistakes. Her results showed that for females, negative perfectionism was related to increased self-injury, and that self-punishment was a prominent function.

Nada-Raja and colleagues (2004) found that, for women in Aotearoa, a history of assault victimisation, post-traumatic stress disorder (PTSD) and anxiety were predictors of self-harm. For males, the strongest predictors were anxiety and depression. Plener and colleagues (2015), and also Garisch and Wilson (2015), found that the strongest predictor of future NSSI was a history of NSSI.

In the two-wave precursor to the YWB Study, Garisch and Wilson (2015) found that engaging in NSSI resulted in a diminished capacity to self-regulate, specifically through decreased resilience, lower self-esteem and a sense of self-efficacy, and an increase in impulsivity. Other relevant risk factors include poor distress tolerance, high levels of arousal for stressful events, and the suppression of unwanted thoughts and emotions (Nock & Mendes, 2008). Consistent with the EA Model, these may lead to an individual using self-injury to regulate this negative emotional arousal. As Nock (2010) notes, it is common that the relevant risk factors that may lead to an individual self-injuring are related to the functions that the self-injurious behaviour serves for that individual (see section on functions, p. 80).

The information regarding the risk factors for NSSI in minority cultures is limited. However, Black and Kisely (2017) reported that alcohol use and incarceration were correlated with NSSI in Aboriginal and Torres Strait Islander youth in their sample.

PROTECTIVE FACTORS

There are some factors that research has found to be associated with less self-injury, which might be considered to be protective. For example, self-esteem and resilience (Anderson & Crowther, 2012; Garisch & Wilson, 2015). In addition, having a secure attachment to family and peers has been found to play a protective role. Young people who experience bullying were less likely to self-injure if they had a strong relationship with their parents as key support people in their lives (Claes, Luyckx, Baetens, Van De Ven, & Witteman 2015). Burešová, Bartošová, and Čerňák (2015) reported that adolescents from two-parent homes were less likely to engage in self-injury. They also report that adolescents who experienced weak and

inconsistent parenting styles was highly correlated with self-injury. Fitzgerald and Curtis (2017) found that Māori in their sample were no more likely to self-injure than other New Zealanders. While not a protective factor per se, it is highlighted here to counteract the disparities found in other research areas between Māori and non-Māori which I have alluded to in previous chapters.

SELF-INJURY AND SUICIDE

The difficulty in distinguishing self-injury from suicide is exacerbated by the inclusion of potentially suicidal behaviours in some definitions and measures of self-injury (e.g., Deliberate Self-Harm; Adolescent Health Research Group, 2012), or the lack of explicit exclusion of suicide from a definition. The risk factors, methods (e.g., cutting), and functions (for example, to avoid or ease emotional pain and suffering) of both suicide and self-injury overlap (Lundh et al., 2007).

In many ways the distinction between self-injury and suicide can be ambiguous; Fortune (2006) describes adolescents in her research sample who had no intention to die yet chose a lethal means of self-harming. Stanley et al. (2001) identified that, although self-injurious behaviours were not suicidal behaviours, 10% of their sample eventually died by suicide. With regards to suicidal behaviour, the APA defines three forms; suicidal ideation (thoughts), suicide plan, and suicide attempt. With regards to self-injury, it defines a suicide threat or gesture, thoughts of self-injury and NSSI (American Psychiatry Association, 2013).

Self-injury is known to be a risk factor for suicide (Muehlenkamp et al., 2012; Muehlenkamp & Gutierrez, 2007; Nock et al. 2006 Andover, Morris, Wren, & Bruzzese, 2012; Asarnow et al., 2011; Hamza, Stewart, & Willoughby, 2012; Tang et al., 2011; Whitlock et al., 2013; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer,

2011). NSSI and suicide also share similar risk factors, including depression, impulsivity, and negative self-evaluations (Hamza et al., 2012).

Specifically, NSSI is related to an increased risk of suicidal ideation and attempts (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). A meta-analysis conducted by Franklin et al. (2016) found that NSSI was the most reliable predictor of both future suicide attempts and hopelessness. Similarly, Fox et al. (2015), in their meta-analysis, found that history of suicidal thoughts and behaviours was a risk factor for NSSI, which highlights that all of these factors are interrelated.

According to the Interpersonal Theory of Suicide (Van Orden et al., 2010), an individual acquires the ability to take their own life following repeated exposure to pain and habituation to fear of death. Joiner, Ribeiro and Silva (2012) have elaborated on the Interpersonal Theory of Suicide to identify NSSI as one means to increase acquired capability. Joiner's theory of capability for suicide argues that individuals may become desensitised to pain and fear, and thus acquire the capability to commit suicide.

Klonsky (2016) argues that suicidal ideation and suicide are two distinct phenomena, each with their functions and predictors. In his 'Ideation to Action' model of suicide, Klonsky (2016) argues that while a lot is known about what predicts suicidal ideation, we know relatively little about what predicts suicidal behaviour.

Curtis (2016) builds on Joiner and Klonsky's models to posit a cyclical model, in which NSSI is a means of coping with emotional distress that initially can be an effective means of managing any suicidal ideation. However, Curtis (2016) suggests that, over time, due to reduced efficacy and increased hopelessness, the self-

injurious behaviours may lead to suicide in addition to further patterns of self-injuring.

In their sample of participants of Pacific island descent, Dash and colleagues (2017) report that participants would engage in self-injury as a means of regulating their suicidal thoughts to prevent them from progressing to suicide attempts, which is defined by Suyemoto (1998) as 'anti-suicide'. In this respect, NSSI would not be considered to be an absence of suicidal intent, but that the self-injuring functions to regulate the suicidal thoughts, as opposed to thinking of NSSI as a precursor to suicide (Lang & Sharma-Patel, 2011; Taylor & Ibañez, 2015).

In summary, then, there appear to be clear distinctions between suicidal and non-suicidal self-injury beyond the intent to die (American Psychiatry Association, 2013; Brausch & Gutierrez, 2010; Dougherty et al., 2009; Nock, 2009). Importantly, Suyemoto (1998) differentiates suicide from self-injury concerning the function that it serves for that individual.

Research on suicide-loss survivors

Research on the experiences of suicide through the voices of those bereaved by suicide is scarce. In his recent doctoral thesis, Bowden (2017) explored the experiences of young males in Aotearoa who had lost a close friend (or friends) to suicide. Bowden highlights the increased risk within this population of "suicide-loss survivors"[22] of mental health issues, such as depression, PTSD and suicidal ideation and behaviour, if inadequate postvention support is available.

---

[22] A person who had a personal and close relationship with someone who died by suicide (not a person who has survived a suicide attempt or has been exposed to suicide).

The core focus of Bowden's (2017) research was on understanding how young men experience suicide bereavement and found that silence was a crucial feature in the manner in which the men in his research coped with the loss of a close friend (or friends) to suicide. The experiences of participants in his research included:

- Difficulties expressing their experiences with others

- The deliberate suppression of and control over emotions

- The need to appear stoic

- Deliberately keeping their grief private

- A fear of being judged as weak and vulnerable

- And spending time alone in silence allowed them to process their experiences and the impacts it had had on them.

When they eventually sought help, trust was a critical factor in whom they chose to confide, as well as people who could understand what they were going through and who they felt were there for them. The key message from Bowden's research is the need to understand, recognise and acknowledge silence as a coping behaviour exhibited by men in particular when they have lost someone to suicide.

FUNCTIONS

Self-injury can serve a variety of functions (Klonsky, Glenn, Styer, Olino, & Washburn, 2015), and it has been argued that these functions may fall into two broad 'families' (Klonsky & Glenn, 2008). Intrapersonal functions occur within the individual (for example self-punishment and regulating emotions), whereas interpersonal functions concern one's relationships with others (for example, to communicate distress). Indeed, for adolescents, NSSI serves both intra- and inter-

personal functions (Nock & Prinstein, 2004). Additionally, the behaviour can serve multiple functions at one time, functions are not mutually exclusive, and the reasons for self-injuring may change over time (Nock, 2010).

Intrapersonal functions

Research conducted within Aotearoa (e.g., Langlands, 2012) finds that intrapersonal functions are the predominant functions of self-injury, with interpersonal functions being relatively rare. Within this broad family, the three most common functions identified in this research were to regulate emotions, as self-punishment, and to mark distress. NSSI was a coping strategy for many of the participants in her sample. Langlands (2012) also compared those who had self-injured with those who had never self-injured in the interests of identifying any critical differences in their emotional, cognitive and coping experiences. She found that those with a history of NSSI reported greater, and more frequent, levels of negative emotions and thoughts. Participants with a history of NSSI also used other negative coping strategies, such as substance use and thought suppression, more frequently.

International research tells us that primary intrapersonal functions of self-injury include the regulation of emotional experiences (Klonsky 2007, Nock & Prinstein 2004, Klonsky, 2009; Muehlenkamp, et al 2011; Nock, Prinstein, & Sterba, 2009), self-punishment and expressing hatred towards the self (Lundh et al., 2007), to decrease dissociation and depersonalisation (Nock & Prinstein, 2005), and as an alternative to suicidal behaviour (Klonsky & Muehlenkamp, 2007)

Emotion regulation

The single most common reason for self-injury has been found to be to regulate emotions (Chapman et al., 2006; Fitzgerald & Curtis, 2017; Garisch & Wilson, 2015; Klonsky, 2009; Lewis & Santor, 2008). Emotion regulation refers to the ability to access a range of emotions and to modulate or manage the intensity and duration of an emotion (Barrett, Gross, Christensen, & Benvenuto, 2001). It is also the principal focus of the Experiential Avoidance Model (Chapman et al., 2006).

Individuals who repeatedly engage in self-injury typically report lower self-esteem than those who do not, and cannot regulate emotions and internal distress using strategies like mindfulness, acceptance and non-judgment (Garisch & Wilson, 2015). Friedman and colleagues (2006) suggest that a decrease in self-esteem following self-injury is due to the internalisation of negative stigma, and the shame associated with 'doing it again' (Langlands', 2012). Repeatedly engaging in NSSI may then increase distress, because of the underlying inability to tolerate negative emotions and avoidant coping style (Garisch & Wilson, 2015). Neuro-biological research also corroborates deficits in emotion regulation as an underlying mechanism for NSSI. Research by Groschwitz and Plener (2012) has found that NSSI functions to regulate aversive emotional experiences.

Interpersonal functions

Empirically validated interpersonal functions include communicating distress or influencing others' behaviour (Klonsky & Muehlenkamp, 2007; Nock & Prinstein, 2005), in particular, when other attempts to communicate distress have been unsuccessful (Nock, 2008). Often those who self-injure, particularly adolescents, show deficits in problem-solving and communication. Young people

who self-injure report more difficulties with resolving interpersonal problems than those who do not self-injure (Nock & Mendes, 2008).

In their research with Aboriginal youth in Australia, Farrelly and Francis (2009) reported that some Aboriginal youth self-injured in groups which contributed to a collective sense of identity and being united by the behaviour. There was also an element of masculinity for groups of young men who self-injured together, demonstrated through showing their scars, proudly talking about self-injury in attempts to come across as tough and, for some, showing that they were "real". Engaging in self-injury was sometimes mentioned as a form of initiation into peer-groups, and Farrelly and Francis (2009) speculate that it could also be misguided reconnections with their indigenous culture through such initiation.

CULTURE, IDENTITY AND SELF-INJURY

As discussed in Chapter 3, Māori conceptualisations of identity and wellbeing are intertwined. This also holds true in Western literature, whereby difficulties with identity (e.g., identity confusion) are associated with relationship difficulties and possible changes in mood and behaviour (rebellion, impulsivity: Erikson, 1968). Identity confusion is correlated with many psychiatric disorders (Demir, Dereboy, & Dereboy, 2009), one of these being NSSI (Gandhi et al., 2017). In Chapter 2 I discussed identity confusion. Consistent with this, research (Claes, Luyckx, & Bijttebier, 2014; Gandhi et al., 2017) suggests that the peak in prevalence of NSSI during adolescence may not be coincidental, but rather it may be directly related to changes and challenges in identity formation.

While a strong sense of self can be a protective factor in adolescents, related to high self-esteem and a sense of agency (Schwartz, 2007), Gandhi (2017) found

that a strong ethnic identity did not protect against engaging in NSSI. Research by Breen and colleagues (2013) suggested that self-injury may develop as part of an individual's identity, leading one to then connect with others who also self-injure. Researchers have also found that NSSI was associated with identity confusion that transcended age and gender in both clinical and community samples (Claes et al., 2014; Gandhi, Luyckx, Goossens, Maitra, & Claes, 2016). Luyckx and colleagues (2015) suggest that self-injury can function to regulate the negative emotions associated with identity confusion but this may, in turn, increase one's identity confusion in a cyclic pattern, whereby engaging in NSSI to cope with identity confusion may further exacerbate identity confusion.

Gratz and colleagues (2012) found that feeling detached from one's family is related to self-injury, suggesting that the levels of identity may extend beyond internal identity confusion to one's identity within their own family. Similarly, increased ethnic identity did not decrease the likelihood of NSSI nor did it protect against the risk conferred by anxiety or BPD characteristics (Gratz, 2012). While a strong ethnic identity can protect against psychological difficulties generally (e.g.,Phinney, 1990), only limited research suggests that identification with one's ethnic group may protect against NSSI (Croyle, 2007).

The role of identity in self-injury has multiple implications, particularly with regards to interventions with adolescents who self-injure, and especially for *rangatahi* Māori. Cauce and colleagues (2002) assert that the discrete transitions between childhood and adolescence differ across cultures, citing "age-condensed families and blurred intergenerational boundaries... an accelerated life-course" (p. 45) as some reasons for why inner-city African-American youths are not always

afforded adolescence, but instead place some adolescents in adult-like or developmentally ambiguous roles.

The literature presented here asserts that any possible identity issues may need to be addressed in conjunction with self-injury-specific treatments. Models of practice such as Te Paiheretia (Durie, 2003) already advocate for this.

Another issue to bear in mind when working with *rangatahi* Māori who self-injure is that, if NSSI is part of one's identity, 'removing' this could leave a void that may just get filled with something else. For example, there are other means to avoid emotional experiences than self-injury (e.g., substance use, for example). The literature that has found that those who engage in NSSI also engage in other harmful coping strategies supports this (for example alcohol use; Black & Kisely, 2018).

MODELS OF SELF-INJURY

Two leading multi-function models have been developed to attempt to explain self-injury, specifically non-suicidal self-injury (NSSI). These are the Four Functions Model (FFM; Nock, 2008; Nock & Prinstein, 2005), and the Experiential Avoidance Model (EA Model; Chapman et al., 2006).

The Four Functions Model of NSSI

The FFM categorises NSSI in two dimensions according to the purpose that the behaviour serves; either interpersonal (social) or intrapersonal (automatic), and the nature of the reinforcement (positive and negative). This gives rise to four distinct dimensions; automatic positive reinforcement, automatic negative reinforcement, social positive reinforcement, and social negative reinforcement (Nock, 2008).

The Experiential Avoidance Model of NSSI

One of the most prominent models used to explain and understand NSSI is the Experiential Avoidance Model (EA Model; Chapman et al., 2006), developed as a tool that can be applied "at a general level across various populations" (p. 372). The central premise of the EA Model is that self-injury serves as a coping mechanism used to manage distressing thoughts. Over time, NSSI gradually becomes an automatic response, strengthened through negative reinforcement (the successful avoidance of negative emotion; Chapman et al., 2006).

In 2012, Anderson and Crowther applied the EA Model to understanding three groups; those who had never self-injured, those with a history of self-injury, and those who were currently self-injuring. Those with a history of NSSI reported more intense emotional experiences, had trouble identifying their feelings (alexithymia), had limited access to emotional regulation strategies, and had higher cognitive avoidance. Those who no longer engaged in self-injury, in comparison with those who were currently self-injuring, reported greater acceptance of emotional responses and greater impulse control. Anderson and Crowther go on to explain that people who self-injure often experience increased emotional arousal, and this increases their likelihood to make more rash decisions, i.e. act impulsively, when they experience negative emotional arousal in particular. This can lead them to engage in self-injury in order to decrease this negative emotional arousal. What the authors then conclude is that being able to tolerate emotional responses combined with greater impulse control may be associated with stopping self-injury in those who self-injure. However, what these results don't tell us is what comes first; did the increase in emotional acceptance and impulse control come before, at the same time of after stopping self-injury.

86

CURRENT TREATMENT APPROACHES FOR SELF-INJURY

Very few treatments specifically target NSSI in any population, including adolescents (see Glenn, Franklin, & Nock, 2015; Klonsky, Muehlenkamp, Lewis, & Walsh, 2011 for a review of evidence-based treatments). In their review of evidence-based treatments specifically for youth who self-injure, Glenn, Franklin and Nock (2015) highlight the following components of successful treatment approaches. First, the most efficacious treatment approaches focus on interpersonal functioning and relationships, in particular, familial relationships by including the family in treatment. Secondly, they included skills training components. Thirdly, treatments were intensive and focused on the reduction of behavioural outcomes of self-injury and, finally, they targeted other maladaptive behaviours or risk factors, for example, substance abuse.

Strategies for regulating emotions often utilise mindfulness techniques; mindfulness is grounded in the beliefs of Buddhism, and activities, such as meditation and being fully present in a moment, are standard practices in mindfulness workshops (Brown & Ryan, 2003).

An emerging treatment approach is Emotion Regulation Group Therapy (ERGT), developed by Gratz and Tull (2011) with adult BPD populations. ERGT has been developed based on the EA Model's conceptualisation of NSSI as an emotionally avoidant behaviour. The treatment for NSSI focuses on several components, including mindfulness, emotional awareness, decreasing avoidance, accepting emotions, and a focus on the relationship between emotions and behaviour. The intervention process for ERGT also includes modules that teach participants to identify their values and encourages engagement in valued action. Currently, little information on the effectiveness of ERGT in adolescent populations,

exists although Bjareberg et al. (2014) have piloted emotion regulation therapy as an individualised treatment programme with adolescents in Sweden, with promising results.

In addition to treatment programmes such as ERGT, it is also useful to focus on early intervention and prevention when young people self-injure. This is particularly important given past NSSI is the strongest predictor of future self-injury (Garisch & Wilson, 2015) and suicide (Ribeiro et al., 2016). Plener et al., (2015) suggest a focus on social and family factors in prevention given the social contributors to NSSI.

In their position paper on managing NSSI in schools, Hasking et al. (2016) suggest best practice strategies for responding when a young person reveals that they are self-injuring. Both Walsh (2006) and Hasking et al. (2016) assert that it is essential to validate both the behaviour (without reinforcing it) and the emotions and cognitions that underlie the behaviour. The authors also suggest that rather than focusing on getting a person to stop the behaviour, it is better to focus on the functions that the behaviour serves. Telling them to stop, pressuring them to talk about it, or dismissing the behaviour as attention seeking, are all unhelpful; these responses may exacerbate the negative emotional experiences of the young person, increase their sense of shame, and diminish their self-esteem.

Given the strong correlations between alexithymia and self-injury (Garisch & Wilson, 2010; 2015), patience and persistence, without being forceful, is recommended; provide them with the opportunities to disclose their thoughts and feelings without them feeling pressured or obliged to do so. Also, because the most likely people to first notice a young person is self-injuring are their peers, it is also essential to ensure that those close to the young person are also supported.

The treatment approaches described thus far have centred on supporting the individual. In the interested of understanding how best to support *rangatahi* Māori, I also sought to understand whether any literature endorses the role of whānau in support of adolescents who self-injure. Within Aotearoa, culturally appropriate interventions for mental health, in general, are consistent with a Māori worldview, but there is nothing regarding intervention that is specific to *rangatahi* Māori who self-injure.

Internationally, recent research by Whitlock and colleagues (2018) show that parents of adolescents who self-injure experience 'secondary stress', including self-blame and guilt related to their adolescent's self-injurious behaviours. Parents also experienced significant time and financial pressures when caring for their child. This study also investigated how parental secondary stress can be alleviated. Mindful parenting practices, such as being non-judgmental of oneself and one's child, and practising compassion for oneself and one's child were found to be helpful. In addition, both formal and informal social support networks allowed parents to find comfort in the realisation that they were not alone in their experiences. Whitlock's research also encouraged taking time for themselves and seeking their supports, be it through formal therapy or otherwise (Whitlock et al., 2018).

CHAPTER SUMMARY

In this chapter I have recounted some of the Western literature on self-injury, including prevalence rates, correlates, predictors, and the dominant theories about why people self-injure. I also presented what limited literature there is regarding cultural understandings of self-injury. What this has highlighted is that there are behaviours in other cultures that are analogous to self-injury as it is experienced by

rangatahi Māori today. It also shows that within the traditional stories of other cultures there are stories of behaviours likened to self-injury. The existence of different definitions of self-injury across cultures emphasises the need to understand behaviours through the lenses unique to each culture, as this has considerable implications for the manner in which health practitioners engage with people of different ethnicities when they self-injure.

CHAPTER FIVE
Māori Methodologies

As seen in Chapter 3, Māori have our own indigenous psychology, and research traditions, that are grounded in traditional Māori cultural values and beliefs. Indeed, *kaupapa Māori* research methodologies are not solely ways of answering questions relevant to Māori, but an essential means to counteract the dominance of Western research practices that have been used with Māori communities, and which have in the past resulted in the perpetuation of colonisation and marginalisation of Māori as research participants. Often referred to as research that is 'by Māori, for Māori' (L. T. Smith, 2012), *kaupapa Māori* research represents best (and only) practice for researchers when engaged in research involving Māori in any capacity.

This research is positioned as Māori-centred interface research that is underpinned by *kaupapa Māori* research principles. In this chapter I will define and discuss each of these aspects, describing how they are applied in this research. While *kaupapa Māori* research is what we all aspire to achieve, it may be an ideal out of reach when ultimate control of the research sits within a tertiary institution. This chapter also describes how *tikanga* was applied to the methods used in this research.

MIXED-METHOD RESEARCH DESIGN

This thesis adopted a mixed-methods approach, using both quantitative and qualitative techniques (Tashakkori & Teddlie, 2010). The quantitative section utilised survey data from the YWB Study. While the YWB Study is a longitudinal study, in this thesis I present the data as cross-sectional. I utilise the most recent

survey completed by each person who identifies as Māori, and who completed the survey at least once. For example, a person who completed the first three waves is represented in these data by their third set of survey responses, while a person who completed only in wave two contribute only those responses. For the qualitative data collection, I conducted two series of sequential focus groups (SFGs) with a total of 25 *rangatahi* Māori and their whānau members. I conducted two separate sequential focus groups (SFGs) with a total of 25 *rangatahi* Māori.

Figure 2 provides an overview of the mixed-methods process taken, including participant numbers for each research component.

Study 1: Quantitative - Cross-Sectional Survey Data

Study 1a: Identifying and Describing the Research Sample	Study 1b: Descriptive information on rangatahi who self-injure	Study 1c: The forms and functions of self-injury for rangatahi Māori	Study 1d: Correlates and predictors of self-injury for rangatahi Māori
Part 1: Compare two groups on key variables. Part 2: Merge groups and present descriptive statistics on sample as a whole. $n = 343$	$n = 87$	$n = 87$	Part 1: compare history of self-injury vs. thoughts about it vs. never. $n = 343$. Part 2: Correlate self-injury with key variables $n = 87$. Part 3: What variables predict functions of self-injury $n = 87$

Study 2: Qualitative - Sequential Focus Groups

2 SFG (4 hui) with 25 rangatahi and whānau support

SFG One	SFG Two
18 Rangatahi (5 male, 13 female), 13-18 years old. 7 whānau as supporters	7 Rangatahi (all female), 16 years old. Identified their peers as supporters

Te Roopu Tuatahi History of self-injury 12 rangatahi, 11 female	Te Roopu Tuarua The Supporters 11 in total (3 grandparents, 4 rangatahi, 4 parents/step-parents)	Te Roopu Tuatoru Those who have never self-injured 9 rangatahi in total, 4 male. Whānau members

Figure 2. Research overview.

93

A TAXONOMY OF MĀORI RESEARCH

Cunningham (2000) has described a framework that organises research relevant to Māori into categories along a continuum based on the extent to which Māori are involved in, and in control of, the research. At one end of the spectrum is research that does not appear to involve Māori; Māori knowledge is not sought, a non-Māori organisation or institution controls the research, and non-Māori methods are utilised. At the other end of the continuum lies *kaupapa Māori* research in which Māori control all elements of the research; Māori conduct the research for specific groups of Māori. Between these two extremes lies Māori-centred research.

Kaupapa Māori research

While the term *kaupapa Māori* has been coined in recent decades, Māori have been conducting *kaupapa Māori* research for as long as we have been Māori (Pihama, 2001). In her seminal work 'Decolonising Methodologies; Researching the native in the age of uncertainty' (first written in 1999 and updated in 2012), L. T. Smith describes one of our earliest *pūrākau*, that of Tāne-nui-ā-rangi and his quest to obtain knowledge, as one of our earliest research projects. In this story, Tāne ascended from earth to Te Toi o Ngā Rangi and brought back three baskets of knowledge for the benefit and use of te *iwi* Māori (S. P. Smith et al., 1997). Through this story of Tāne, we learn that knowledge is specialised and connected. Notions of collectivism emerge through Tāne's seeking of that knowledge on behalf of everyone. The voyage of our ancestors across the Pacific to Aotearoa has also been considered an early *kaupapa Māori* research project. Our traditional *pūrākau* talk of our ancestors deliberately setting out across the Pacific to explore new land in a purposeful sense, guided by the stars, migrating birds and sea life.

However, as mentioned previously (see Chapter 2), the impacts of colonisation reached far and wide. Te Awekotuku (1991) describes a history of Māori experiences with research whereby power and control rested with the researcher, arguably to the detriment of Māori. The goal kaupapa Māori research has been to shift this power from the researcher to those who possess the knowledge being sought; the participants and the communities (G. H. Smith, 1997). The assertion that Māori hold the right to self-determination is central to *kaupapa Māori* theory, methodology and practice (Cameron et al., 2017). Distinguished Professor Graham Hingangaroa Smith (1997), a principal founder of *kaupapa Māori* theory and methodology, describes it as a theory and praxis of transformation as a response to colonisation, urbanisation and assimilation.

In this thesis, *kaupapa Māori* is a broad term used to describe a research theory and methodology that serves to validate knowledge obtained in a context that is Māori, that is, it is obtained using Māori *tikanga* to guide the research process (Irwin, 1994). Kaupapa Māori as a theory is bound by our social and cultural history and context; it provides the framework upon which we understand our world. Kaupapa Māori methodology provides a theoretical approach to our method/s. As such, *kaupapa Māori* research is culturally appropriate because it is grounded in a Māori worldview; as a theory and methodology, it begins in *te ao Māori* (Irwin, 1994; L. T. Smith, 2012).

Principles of kaupapa Māori research

Māori people are heterogeneous; there are many wide and varied experiences of being Māori, associated with varying extents to which one identifies as Māori (Houkamau & Sibley, 2010). As such, there is no prescribed method for conducting *kaupapa Māori* research, but rather a set of principles. Graham

Hingangaroa Smith (1997) defined eight aspects that underpin *kaupapa Māori* research, which in turn form the foundations of *kaupapa Māori* theory. These principles are *tino rangatiranganga, taonga tuku iho, ako, 'Kia piki ake i ngā raru o te kainga'*, whānau*, kaupapa, Te Tiriti o Waitangi,* and *Āta*. Consistent with these principles, L. T. Smith (2012) also discussed four core elements that constitute *kaupapa Māori* methodology. These are *whakapapa*, te reo Māori, *tikanga* Māori, and *rangatiratanga*. Regardless of whether or not we are explicitly aware of our whakapapa connections, *whakapapa* remains a powerful force that connects Māori together, and to our ancestors, and our *atua*. Te reo Māori acknowledges the importance of our language as "a cloak which clothes, envelopes, and adorns the myriad of one's thoughts" (Sir James Henare, quoted in L. T. Smith, 2012, p.190). *Tikanga* guide the research process. And the final core element of *rangatiratanga* asserts Māori autonomy.

Guidelines for kaupapa Māori research

These *kaupapa Māori* principles are the underlying values that guide the research process. Linda Tuhiwai Smith (2012) has taken these principles developed by Graham Hingangaroa Smith (1997) and provided a series of seven guidelines or cultural values which operationalise *kaupapa Māori* research.

Aroha ki te tangata

A respect for people is enacted by allowing people to define their own space and meet on their own terms. Consistent with this, I sought to collaborate with my participants at times, and in locations, convenient them. The majority of the time this meant the research team travelling to them, or if participants were in many different locations, meeting at a central location that was convenient for most.

Kanohi ki te kanohi

Māori researchers are accountable to the Māori community, but more specifically, to their respective whānau, *hapū* and *iwi*. The *kaupapa Māori* principle 'kanohi ki te kanohi' emphasises this responsibility. In every engagement of the present study, we, as the Māori research team members, brought our *whakapapa* and the expectations of our *tūpuna*. We were, therefore, ever mindful of how these *tūpuna* would feel about the ways in which we conducted themselves and their *mahi* (work), as researchers. "If you stand tall in this world, your *tūpuna* [ancestors] will stand tall. If you fall down, your *tūpuna* fall down" (Pere, 1991, p. 44). This *whakataukī* served to remind the Māori research team that they aimed not solely to protect and secure their reputations as Māori researchers, but also, through *whakapapa*, the reputations of their *tūpuna*, whānau, *hapū* and *iwi*.

Titiro, whakarongo, kōrero

This directive emphasises the importance of looking or observing and listening to develop understanding and find a place from which to speak – to not make assumptions. In this research several advisory *hui* were held, which informed numerous aspects of the research process. For example, we met with *rangatahi* to gauge their thoughts on the quantitative survey, and with community members and health professionals who worked with *rangatahi* who had self-injured, to do our best to ensure that the research would be as relevant as possible to the communities who would find the research the most useful.

Manaaki ki te tangata

Manaakitanga is about relationships built upon respect, and cultural and social responsibility (Hudson et al., 2010). This reflects the commitment to a process of "giving back", of sharing results, and of bringing closure if that is required for a

project. Giving back might include the provision of meaningful hospitality (e.g., more than tea and biscuits) and more than giving participants a debriefing sheet as they leave the room.

Kia tupato

This principle is about being cautious and culturally safe. The guidance of Matua Witi Ashby ensured that *tikanga* were adhered to and the cultural safety of all was maintained.

Kaua e takahi te mana o te tangata

Essentially, this instructs one to be cautious not to trample on the *mana* or dignity of a person. This is about informing people and guarding against being paternalistic or impatient, about recognising the *mana* inherent in all peoples and upholding it wherever possible.

Kaua e mahaki

This directs us to ways to share knowledge, to be generous with knowledge without arrogance. Sharing knowledge is about empowering process, but the community has to empower itself. In this research the ownership of the knowledge rested with the research participants first and foremost.

Māori-centred research

Māori-centred research sits between *kaupapa Māori* research and research involving Māori (Cunningham, 2000). Māori are involved at all stages of the research process, including the design of the research project, undertaking and participation, dissemination, and the returning of knowledge back to Māori communities. Analysis of the results is undertaken utilising a Māori lens. However, the ultimate control of the overall research project may lie with a non-Māori institution, for example, a

tertiary institution or funding body. Also, ethical consent may need to be sought from governing bodies where, were the research under Māori control, the requirements may have been different. Māori-centred research practices have been applied successfully numerous times within psychology, whereby the requirements of the academic institution have been navigated within a Māori worldview. The doctoral research of Valentine (2009), Rata (2012), Te Huia (2013), are examples of successful research that has been conducted from a Māori-centred approach.

Positioning this research as Māori-centred research

This research sits as Māori-centred because I strongly identify as Māori. It has always been my intention to conduct research that supported the development of Māori knowledge, by applying the Māori cultural values and beliefs that we as Māori share. As a Māori researcher I also feel accountable to my whānau, *hapū* and *iwi*, not only with this research but in all that I do and, therefore, I am held to account by the expectations of my whānau, as well as the research participants, their whānau, and the wider community. However, while I have been encouraged to feel in control of this research process, I am ultimately accountable to the university to fulfil the requirements of a PhD, as well as the Health Research Council, from whom I received a PhD scholarship to conduct this research. Because my research was being conducted with adolescents, who are considered to be an 'at-risk' population according to the Health and Disability Ethics Committee (HDEC), I was also required to obtain ethical approval from HDEC. For this, I was therefore required to fulfil certain requirements to meet their criteria for approval (discussed later in this chapter) and therefore was accountable to them as well. It is for these reasons that I have situated this research as Māori-centred; grounded in the way I was raised as Māori, informed by the *kaupapa Māori* principles I have described above, while also

being accountable ultimately to the tertiary institution and funding bodies that this research sits within.

Interface research

Complementary to the notion of Māori-centred research is research that sits at the interface of Māori and Western worldviews. Durie (2005) describes research at the interface of indigenous knowledge and science as a means of drawing together two independent systems used to create new knowledge, whereby both knowledge systems are valued as valid and legitimate. Similarly, Valentine (2009) describes interface research as "finding common ground without compromising the foundations upon which they are situated". As such, Durie (2005) asserts the outcomes of interface research do not reflect only an indigenous or Western worldview, but a unique and distinct combination of the two. Durie (2005) has elaborated upon the idea of interface research, proposing a set of principles that reflect such an undertaking: mutual respect, shared benefits, human dignity and discovery.

Four principles of interface research

Mutual respect

This principle is about ensuring that the *mana* of each worldview is upheld, whereby no knowledge system is more or less valid. In this research, this is acknowledged in the use of mixed-methods research design which acknowledges that both quantitative methods and qualitative methods, which align with *kaupapa Māori* research principles, are valued.

Shared benefits

According to this principle, the outcomes and benefits of the research are shared between all, consistent with the Māori principle of *tauutuutu*. This includes any commercial benefits and, importantly, that the intellectual property is also shared. Te Huia describes the principle of shared benefit as a shift in "the power dynamics that have historically left indigenous peoples with little benefit and, in some cases, harm" (2013, p. 50). In this research a key priority was to empower rangatahi by sharing their stories, giving them the platform to voice their experiences which counteract some of the negative depictions of *rangatahi* Māori that are currently commonplace in mental health data in Aotearoa.

Human dignity

The essence of this principle is that neither party's worldviews are compromised, and are not to be disregarded if they are incongruous or conflicting. This is particularly important in an ethical context of research, where the ethical requirements of governing bodies may not always align with the cultural values of the researcher.

The principle of human dignity asserts the need for indigenous researchers to hold on to their cultural and spiritual values, beliefs and practices in conducting the research. This has been non-negotiable for me in this research and has resulted in negotiations with both the university and the ethics committee to ensure that my cultural values were not compromised.

Discovery

The generation of new knowledge should be at the heart of all research endeavours. This principle emphasises the importance of new knowledge that can be generated when these two worlds combine, utilising indigenous methodologies

alongside scientific methods. Indigenous knowledge systems can be used to inform the exploration of new knowledge while keeping in mind the uniqueness of Māori knowledge, and letting it assist the interpretation of new findings and their implications in today's modern society (Durie, 2005).

Finally, the principle of discovery encourages the seeking of new knowledge using the combination of indigenous and Western scientific methods that are most appropriate. Qualitative research methods, in this case, sequential focus groups, provided the scope for incorporating *kaupapa Māori* research principles (to be discussed in the sections to follow). The benefit of qualitative data from a sample of *rangatahi* Māori is that it provides stories that provide a richer picture to the numbers in the survey data.

Rata (2012) provides a useful discussion of possible risks associated with interface research. First, those who advocate for indigenous research may consider interface research to be merely 'tacking on' indigenous components to a Western scientific research project. Without grounding in indigenous research, there is the risk of irrelevance to the indigenous communities it seeks to understand. On the flip side, Western-based researchers may view interface research as compromising the scientific principles that enable robust, reliable and valid research that Western science values. Durie's (2005) argument against this notion emphasises the core of interface research, in which the values of one knowledge system should not be used to assess the credibility of the other (Rata, 2012).

Positioning this research as interface research

This research is grounded in *kaupapa Māori* methodologies by applying the guidelines and principles of a *kaupapa Māori* approach, while at the same time also seeking to use non-indigenous analysis tools and processes; a mixed-methods

(quantitative and qualitative) approach. For example, because of a paucity of information regarding the prevalence and correlates of self-injury for *rangatahi* Māori in Aotearoa, I shall report survey data to provide a snapshot of the rates at which *rangatahi* Māori engage in this behaviour. I do this not because surveys are the best way to research collaboratively with Māori, but because there is a lack of alternative information available. As such, I assert that the positioning of this research at the interface is not dissimilar to the reality in which *rangatahi* Māori, the participants of my research find themselves in today; walking in two worlds and navigating the space between.

THE EMIC AND ETIC DICHOTOMY

In this research, it is important to consider my positioning and how it can influence the research. In psychology, these positions are considered through the emic/etic dichotomy (Cheung, van de Vijver, & Leong, 2011). An emic approach is likened to that of an insider's perspective to the research, whereas an etic perspective is from an outsider looking in. The emergence of indigenous psychology in Aotearoa has been in response to the dominance of Western intellectual ethnocentrism (Levy, 2007) and is consistent with an emic approach to research, whereby the knowledge produced comes from within the indigenous culture. This is in contrast to transposing Western knowledge on to other populations or assessing how one construct may be applied in another culture. This would be more representative of an etic approach (Enriquez, 1987).

Consistent with interface research approaches, both emic and etic approaches have merits. An etic approach allows for the incorporation of already established, empirically validated, knowledge in other cultures as a starting point

when studying a phenomenon as it applies to a particular culture. However, constructs across cultures may not be equal, and a construct as it is defined in one culture may be different in another. As Te Huia describes, "[E]tic research does not take into consideration the cultural worldview of the participant. Therefore equivalence cannot be assumed" (Te Huia, 2013, p.52).

Towards an 'etmic' approach

Williams (2010) defines an 'etmic' approach as a means of combining both emic and etic, whereby "the researcher can see both the wood and the trees" (p.108). This etmic approach reflects how I see my position in this research.

From an etic, or outsider, perspective, youth culture might be considered a sub-culture of which I am not a part. Therefore I feel as though I am already coming from an outsider's point of view. Being ten years older than most of these *rangatahi* Māori participants, I cannot assume that I am able to interpret and understand their perspectives within a social and historical context from which they come. Also, the quantitative components of this research apply Western-derived assessment tools to a sample of *rangatahi* Māori, consistent with an etic approach. It is essential to bear in mind that while functional equivalence is a goal of cross-cultural psychology (which takes an etic approach), it is not always possible to 'transfer' constructs across cultures that share different worldviews. An etic approach also involves a commitment to the robust, rigorous and transparent analysis of data, which I aim to achieve. My training as a clinical psychologist has thus far enabled me to develop my skills at being relatable and empathic while at the same time maintaining objectivity.

Kaupapa Māori research in its purest form would be a gold-standard example of emic research, whereby the researcher is embedded within the culture and aware

of the influence that their position plays in the research. Huygens and Nairn (2016) describe *tikanga*-guided psychologists, who "know that when a whānau allows them to enter such a relationship, they become part of the whānau system" (p. 22). Indeed, I believe that I was able to gain the trust of the *rangatahi* Māori and whānau members because they saw me as of the same culture, holding the same cultural values. Through *whakawhanaungatanga*, we were able to develop personal connections based on sharing of personal information. Hence I also occupy the emic position, whereby I am exploring indigenous psychological experiences from within my own culture (Te Huia, 2013).

To conclude, as a researcher holding multiple positions simultaneously, just because I may be an insider in one sense (as Māori) does not preclude being considered an outsider in another sense (as an adult). Therefore, the etmic approach is a pragmatic stance that I took to proceed.

ETHICAL ISSUES

Huygens and Nairn (2016) describe the New Zealand Psychological Code of Ethics as more aspirational than prescriptive and, as such, having the potential to free psychological practice from the constraints of Western orthodoxy. In this research, the constraints that were experienced stemmed from the process of seeking ethical consent.

Young people in Aotearoa are considered to be an 'at-risk' population according to the National Health and Disability Ethics Committee (National Ethics Advisory Committee 2012). All research in Aotearoa that involves human participants requires ethical approval. In this case, the YWB Study obtained ethical approval from the HDEC to proceed. In 2011 the YWB Study received the HDEC's

approval to conduct focus groups and interviews about self-injury with *rangatahi* (of all cultural backgrounds), on the condition that one of the Clinical Psychologists from the YWB Study team was present to manage any concerns regarding risk and safety. However, these Clinical Psychologists were not Māori, and from a Māori research perspective, having non-Māori researchers present in *hui* with *rangatahi* Māori when discussing a *kaupapa* such as self-injury had the potential for *rangatahi* Māori to feel culturally unsafe. The Māori research team, therefore, applied for an amendment, seeking permission for a separate stream of research to be conducted which would complement the broader YWB Study, using *tikanga* to manage both cultural and clinical safety with *rangatahi* Māori.

While the HDEC's ethical requirements may have not overtly inhibited an adherence to *tikanga* Māori, there were points of contention uncovered when the Māori research team members embarked on this research. To navigate these areas of tension, interface research practices (Durie, 2005) allowed the scope for considering our multiple obligations. These were to the Health Research Council (as funders of this research), the university, and the broader YWB Study, while also keeping in mind *tikanga* Māori and the values, beliefs, and worldviews of the researchers, *rangatahi* participants and their whānau. This next section discusses three of the challenges experienced, and how they were overcome. These challenges were obtaining collective consent, and managing distress and contagion.

Collective consent and whānau involvement

In describing ethics as they relate to *kaupapa Māori* research, Hudson (2004) asserts that some ethical issues require the consent of individual participants, whereas others require the consideration of the broader whānau or community.

Hudson (2004) describes how often the early decisions regarding the involvement of the individual in the study involve the collective. Once this consent has been given, the individual is then able to decide whether or not they choose to participate.

In the YWB Study, our Māori research team members wanted to ensure that whānau were well informed that their *rangatahi* were participating in the research and what this participation involved. Ensuring whānau were aware involved more than merely requiring a parent or caregiver to sign a consent form and then drop their *rangatahi* off at the *hui*. Accordingly, whānau were invited to participate in the research with their *rangatahi*, and these whānau members were not restricted to just parents. For example, some *rangatahi* chose an aunty or a whānau friend to bring along as their whānau/support person. However, this posed several challenges.

First, consistent with the tikanga of *tauutuutu*, requiring whānau support and participation in the research process meant that we needed to acknowledge their contribution and involvement with *koha* (gift, donation, offering or contribution), and also by providing them with *kai*. This increased the financial resourcing required. Secondly, by whānau members being actively involved we also needed to meet at a time and place convenient for more than just the *rangatahi*, taking into account that most whānau worked full-time and had other children to consider and, in many cases, bring along to the *hui*.

Another issue with involving whānau was ensuring that having whānau, often parents, attend the *hui* did not influence *rangatahi* participation. We wanted to ensure that *rangatahi* could still speak freely and share their *whakaaro* on the *kaupapa*, without fear that their whānau would know about what they may have been doing. To ensure this, *rangatahi* met in one room, while their whānau met in

another. Everyone came together for *karakia* and *kai* at the beginning of each *hui*, and all jointly finished with a debriefing and *karakia* before departing at the end of the night. While the *hui* with *rangatahi* were occurring, whānau/support people remained in another room with Matua Witi facilitating their conversation. There was considerable feedback regarding the success of this Māori-centred research process, which provided whānau with the opportunity to meet other parents and whānau of *rangatahi* who may have been going through similar experiences, and to talk and share stories in a supportive environment that was culturally understood and validated.

Anticipating and managing distress

Consistent with the understanding that whānau were integral to individual wellbeing, our research team wanted to include whānau as support people who played a role in ensuring that *rangatahi* were safe and supported should they experience distress. Also, we were aware that their distress could occur outside of the *hui* process, for example, when they returned home after the *hui*. Therefore, having whānau involved as support people meant that *rangatahi* could be supported by someone who had been a part of the process, as well as providing an alternative avenue of contact for the research team, so we could check on the *rangatahi* and ensure they were not distressed.

The HDEC advised against encouraging whānau members to attend because they believed that there was a risk that the whānau/support people chosen by the *rangatahi* might be unsafe people for them. However, after some deliberation, the Māori research team chose to pursue this approach regardless, because we felt that it was of greater importance that the *rangatahi* were supported outside of the *hui*.

The Māori research team found that the separation of *rangatahi* and their whānau/support people in the *hui* meant that *rangatahi* were able to speak freely and, in doing so, alleviate any of the committee concerns about 'unsafe' support people being present and influencing any *rangatahi* involvement and contributions to the *hui*. All *rangatahi* provided unsolicited assurances that they felt safe with their whānau/support people.

In Western research contexts, while extensive efforts are often made to ensure physical safety, the importance of cultural safety is not always given equal weighting to sufficient extent that cultural offence does not occur and cultural safety is not compromised (Hudson, 2004). This was a challenge faced in this research; the consideration of cultural versus clinical safety. While the original HDEC application required a clinical psychologist to be present, in this study, in lieu of a clinical psychologist, the skills and experiences of the Māori research team members were drawn on. With the guidance of Matua Witi, our *tikanga* Māori allowed us to ensure that both the clinical and cultural safety of all those present was managed. For example, *kanohi ki te kanohi*, *whakawhanaungatanga*, *whakapapa* – all of which have been discussed in earlier in this chapter.

Managing contagion

In the field of self-injury research, a fear commonly expressed is that talking about self-injury may give *rangatahi* the idea to engage in this behaviour when they may not have otherwise considered it (Walsh, 2006). The HDEC committee reiterated these concerns, resulting in the wider YWB Study deciding not to include

those who had a history of self-injury in focus group discussions.[23] Separate studies by Gould and colleagues (2005) and Reynolds, Lindenboim, Comtois, Murray and Linehan (2006), however, have found that asking about self-injury does not increase the likelihood of engaging in this behaviour.

Anecdotally, the Māori research team was aware that *rangatahi* Māori were talking about self-injury within their peer groups. The team members felt that by not allowing *rangatahi* Māori to come together and speak openly and ask questions of their peers in a safe and supportive manner, that some may interpret this as thinking self-injury was not something that should be talked about. We were particularly mindful that, in excluding those who had a history (current or past) of self-injury, the present study ran the risk of inadvertently sending the message that this behaviour was something to be kept private, hidden, and ashamed of. Accordingly, it was decided not to exclude those *rangatahi* Māori with a history of self-injury from participating. All *rangatahi* who were willing to participate were welcomed, irrespective of their experiences of self-injury. This recognised the understanding that the voices of all *rangatahi*, regardless of experience, are worth being heard, and all their *mātauranga* is significant. In fact, all *rangatahi* and many of the whānau/support people who participated expressed their gratitude for the *hui* providing a safe space for sharing without judgement. It was apparent to us that, over the course of the series of *hui*, new connections and close bonds formed among some of the *rangatahi* to such a degree that they continued to keep in contact after the final *hui* was held.

---

[23] Prospective participants would instead be offered one-on-one interviews.

We were also cognisant of the assertions by Linda Tuhiwai Smith (2012) about asking the right questions. We felt that, by excluding those without a history of self-injury and solely focusing on those who had self-injured, we would not have heard the stories of *rangatahi* Māori supporting their friends when they had not engaged in the behaviour themselves. Nor would we have heard from those who had never considered self-injury and understanding what their alternative ways of managing with the same stressors might be.

The replicability of research

All researchers are encouraged to document their research in a manner that is transparent, whereby another researcher should be able to read the method and replicate the results (Gleitman et al., 2011). However, the idea of an outsider being able to replicate a research process and achieve the same results is inconsistent with *mana* and the perspective put forward by Battiste and Henderson (2000) that the *tapu* nature of some knowledge protects this knowledge from appropriation (see Chapter 2). Conducting 'etmic' *kaupapa Māori* research asserts that relationships between the researcher and participant are important and influence the research process. These relationships are built on a foundation of *whakapapa*. By extension, it is, therefore, unrealistic to expect any other researcher to be able to engage with a group of *rangatahi* Māori in the same manner in which I did and achieve the same results, because our *whakapapa* would be different, therefore the connections we make with others also differ.

Conclusions regarding the ethics process

Research with Māori must be grounded in relationships, and never was this truer than for this present study. Had the Māori research team not taken the time to

111

focus on building relationships with the participating *rangatahi*, as individuals, as a collective, and with their whānau or broader support networks, the knowledge obtained would not have been as vibrant, diverse, or as honest as it was. This research has found that when *rangatahi* Māori are provided with the opportunity to come together in a safe environment, to speak freely with their peers without fear of being judged, stigmatised, or their privacy violated, the outcomes are powerful beyond the new knowledge generated as research findings, and the process is as important as the outcome.

The measures of success in research that are valued by academic institutions fundamentally contradict the values that are at the core of my identity as Māori. Māori culture is grounded in an understanding of relationships and the inter-connectedness of all things (Te Awekotuku, 1991). Māori concepts such as *wairuatanga*, a central component of a Māori belief system and one of the four components of *Te Whare Tapa Whā*, are unable to be conceptualised as falsifiable hypotheses, yet I inherently knew that *wairuatanga* would play a role in the wellbeing of *rangatahi* Māori who self-injured. Through the research process, I have come to understand that there are many different approaches to, and perspectives of, research. In my research, utilising a grounding in *te ao Māori* and applying it in a contemporary, Eurocentric psychological research context allowed the essence of our Māori cultural traditions to be applied functionally. This enabled the bridging of two worlds, *te ao Māori* and *te ao Pākehā*, in the fulfilment of dual notions of accountability (Allwood & Berry, 2006; Cunningham, 2000).

Our experience of obtaining ethics approval highlighted the challenges of undertaking research with Māori and aligning *tikanga* or Māori research ethics with the ethical requirements of funding or governing bodies, from whom permission

must be sought to carry out the research. Hudson (2004) argues that there must be a balance between the goals of the research and the safety (cultural and clinical) of participants. While intended to protect participants of research, often the requirements of ethics committees fail to consider the values that are inherent in Māori culture, as determined in our *tikanga* Māori.

SITUATING THE CURRENT RESEARCH

This research is situated as Māori-centred research (Cunningham, 2000) that incorporates Durie's (Durie, 2005) principles of interface research and is grounded in *kaupapa Māori* research theory (G. H. Smith, 2003). Because the research was funded by the Health Research Council, as part of the YWB Study, it has not been initiated by the community and therefore cannot be called 'pure' *kaupapa Māori* research by Cunningham's (2000) definitions. However, as a Māori researcher who has been working in close contact with the community at every stage of the research, from conception to the dissemination of the findings, I consider this research to be Māori-centred. This is despite being under the control of a mainstream institution and requiring ethical approval by the National Health and Disability Ethics Committee. Irwin (1994, p. 25) refers to the "dual notions of accountability" in Māori research, and in my research this meant the need to fulfil the requirements of the university and funding organisations, while at the same time meeting the expectations of Māori participants and the wider community. While complex and sometimes difficult to navigate, Māori-centred research essentially enables a Māori researcher to have the best of both worlds, drawing on the "robustness" of Western scientific knowledge-seeking as well as the holistic, people-centred *kaupapa Māori* research approaches.

CHAPTER SUMMARY

This thesis applies both qualitative and quantitative research methods to understand the breadth, the depth, and the nature of the issue of self-injury amongst *rangatahi* Māori in Aotearoa. *Kaupapa Māori* theory and principles are applied in a manner consistent with Cunningham's (2000) definition of Māori-centred research, and this also aligns with Durie's (2005) notion of interface research in that it draws on both traditional and Western knowledge bases.

Kaupapa Māori gives us, as Māori, the tools to redefine and re-examine how Western psychology has defined and categorised psychological phenomena, and affirm Māori knowledge of wellbeing and healing. For this research, a critical analysis of Western psychology is applied by questioning the prevailing definitions and models of self-injury used in Aotearoa (and further afield) and their relevance to *rangatahi* Māori. Analysis of SFGs will be guided by the principles of Interpretive Phenomenological Analysis (J. Smith, 1996), adapted to fit with *kaupapa Māori* principles; thereby working from the interface between Māori and Western research practices.

In researching a *kaupapa*, such as self-injury, or, in fact, any area of psychology where *wairuatanga* sits alongside physical and emotional aspects of behaviour, it is possible to conduct research that fulfils mainstream reliability and validity criteria, while simultaneously being meaningful and useful for the communities affected by the behaviour. The processes inherent in this research were not about seeking to falsify hypotheses or obtain certain levels of statistical significance, validity, reliability and objectivity. They were about assisting *rangatahi* Māori and their whānau to find their voice, speak their truth, and maintain power and control over that knowledge.

CHAPTER SIX
An Overview of Relevant Qualitative Methods

This chapter describes the methods used to collect data for Study 2 (Chapter 8). Study 2 utilises the Sequential Focus Group (SFG) method to collect qualitative information from *rangatahi* Māori and whānau on the subject of self-injury. The analysis of this SFG data is analysed using the principles of Interpretative Phenomenological Analysis (IPA). In this chapter, I explain the philosophical underpinnings of both SFGs and IPA and describe how they are applied in Study 2.

SEQUENTIAL FOCUS GROUPS

The Sequential Focus Group (SFG) method was developed by indigenous researchers Boulton and Gifford (Boulton, 2012, see also Boulton & Gifford, 2014). Following their example, I held four *hui* with the same cohort of participants, with each subsequent *hui* building on the preceding one.

The SFG method was developed as an indigenous research method that capitalises upon the multiple benefits of the focus group method. These include collaboration, and obtaining in-depth and detailed data (Krueger & Casey, 2000), enabling relationships to form over time, amongst participants, and between the participants and the researcher/s (Boulton, 2012). This maximises the opportunity for trust to develop and relationships to form, further enhancing the quality of the information obtained. Ongoing data collection with the same cohort of participants is also beneficial because it enables the researchers to clarify and delve deeper into the perspectives and behaviours of the research participants over some sessions. In a *kaupapa Māori* sense, holding a sequential series of focus groups enables the incorporation of *tikanga* Māori into the research process (for example, embodying

principles *of whakawhanaungatanga, manaakitanga* and *kanohi ki te kanohi*
interactions).

INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Through the Sequential Focus Group approach used in Study 2 a substantial

amount of information was collected from the *rangatahi* Māori and whānau

participants. Because the offer to audio-record the *hui* was declined by participants,

this posed a challenge for the analysis of the qualitative data. IPA was the solution,

and in the next section, I explain how IPA was applied to the analysis of the

qualitative SFG data in this research.

The selection of IPA

IPA is an inductive method of analysing qualitative data that was developed

by Jonathan (1996) within the field of psychology. Eatough and Smith (2017)

attribute its gradual rise in popularity to its focus on the first-person subjective

experience of the research phenomena. A core value of IPA is that subjective

knowledge is a means of understanding psychological phenomena.

I chose IPA to analyse my data because I feel that IPA fits well with an

indigenous psychology approach in several ways. IPA suits this research because it

is explorative in that, rather than defining self-injury and then examining how the

experiences of *rangatahi* Māori fit within that, I am seeking their definitions and

experiences, allowing them to define it for themselves. It is also flexible in its

approach, and while there are suggestions for conducting 'good' IPA, it is not

prescriptive, and J Smith (1996) even encourages researchers to develop their

approach to IPA. IPA is also ideal because it allows for a rigorous approach to

understanding the data, which involves engaging with the data and being immersed

in the experiences of the participants. This suits indigenous psychological research

approaches, and in the sections to follow I will explain how this is so, as I define IPA,

its history, and its method.

Philosophical underpinnings of IPA

IPA is described by Eatough and Smith (2017) as the convergence of two

intellectual fields; phenomenological philosophy and hermeneutic theory. The core

components of IPA are defined as idiography, experience, and interpretation. To

understand the application of IPA as an analytic tool that fits with an indigenous

psychology approach, I shall briefly discuss the contributions of phenomenology and

hermeneutics to IPA and its experiential, idiographic and interpretative applications.

Phenomenology

Phenomenology is about how people make sense of their world, and

"assumes some link between what people describe and their inner, subjective

experience" (Alexander & Clare, 2004, p. 73). In essence, it focuses more on how the

phenomenon is experienced by that person than the phenomenon itself. Eatough

and Smith (2017) link IPA with Heidegger's (1962/2004, as cited in Eatough &

Smith, 2017) discussion of 'Dasein'. This is loosely translated to mean 'being in the

world', which emphasises the importance of the social and historical contexts of the

individual, and the relevance of these to the subjective experience.

Hermeneutics

"Without the phenomenology, there would be nothing to interpret; without

the hermeneutics, the phenomenon would not be seen" (J. Smith, Flowers, & Larkin,

2009, p. 37). As such, hermeneutics concerns the interpretation of phenomena. The

field of hermeneutics has an extensive history dating back to biblical times, and in

the context of IPA, hermeneutics is about understanding how our interpretations are a result of the manner in which we understand how we have come to be in this world (Eatough & Smith, 2017). Researchers who utilise an IPA approach work in the knowledge that rather than trying to eliminate bias and assumptions, by engaging with these assumptions and biases we may reach greater levels of understanding (Eatough & Smith, 2017). The understanding of hermeneutics as the "inextricable interweaving of person and world… which is at odds with the idea of transcending the particularities of an individual life" (Eatough & Smith, 2017, p. 195) is consistent with the indigenous understanding of the interrelatedness and interconnectedness of all things.

J. Smith et al. (2009) talk of the 'double hermeneutic'; first, the participant is trying to make sense of their experience, and secondly, the researcher is trying to make sense of the participant making sense of their experience. Eatough & Smith (2017) liken this to a both/and (empathy and suspicion) approach, whereby the researcher attempts to both understand the experiences of the participant while at the same time is "critical of what appears to be the case and probe[s] for meaning in ways which participants might be unwilling or unable to do themselves" (p. 13). The starting point is always the participant.

When researching with focus groups, an additional layer of interpretation exists; that of the group-level interactions. Specifically, a consideration of the relationship between the group as a whole and the individuals (J. Smith et al., 2009). Eatough and Smith (2017) note that when people share information and tell stories there are multiple goals and different levels of interactions, for example in addition to sharing their story they may intend to save face, persuade or rationalise. Consideration of this, then, adds a third hermeneutic and involves analysing the data

multiple times firstly to understand groups dynamics and subsequently for the idiographic accounts (J. Smith, 2004).

Idiography, experience and interpretation

Idiography concerns the experiences of the participants, and essentially this is about treating the participant as the experiential expert in the phenomenon of interest. IPA counteracts the Western concept of generalisability of findings and instead takes a cautious and gradual approach to generalising findings (Eatough & Smith, 2017). IPA is about conducting deep analysis of experiences, with an understanding that their experience is unique to that individual, in that particular context, at that particular time. From this perspective, no two experiences will be alike; it is about what is true for that participant in that particular moment.

IPA project design (method)

When it comes to selecting participants, IPA research advocates for quality over quantity. Therefore, sample sizes are typically small and not necessarily random or representative. J. Smith (2004) recommends the use of broad, open-ended questions that avoid the researcher imparting their perspectives of the research topic on the participants. Eatough and Smith (2017) describe the participant as a story-teller and the researcher as the enabler who evokes the participant's perspectives on the research topic.

IPA with focus groups

There has been much debate about the applicability of IPA to focus groups. In their research on genetic counselling, Macleod and colleagues (2002) recognised that it was common for patients to attend their appointments with several family members in support. Therefore, they conducted their research using IPA methods

with 'family units' ranging from one individual patient to several family members who were attending the consultation in support of that family member. Other researchers have used IPA with focus groups in their research but recognising that it required some flexibility regarding the principles, and in particular the idiographic foundations of true IPA (for example De Visser & Smith, 2007; Dunne & Quayle, 2001; Flowers, Duncan, & Frankis, 2000; Flowers, Knussen, & Duncan, 2001; McParland, Eccleston, Osborn, & Hezseltine, 2011; Palmer, Larkin, de Visser, & Fadden, 2010; Tomkins & Eatough, 2010). J. Smith's (2011) intentions with IPA have been to progress a psychology that focus on the richness of personal experiences, and this, he asserts, could be a way focussing on the individual's personal experiences within an explicit social context.

I will now discuss some of the key challenges identified in the literature; a difficulty in eliciting personal experiences in a group situation, difficulties understanding prevalence, and a more top-down approach that does not hold true to IPA's idiographic roots.

Challenges of IPA with focus groups

Group dynamics

One challenge with IPA in groups is that it can be difficult to understand individual phenomenological accounts within a group setting because of the group dynamics at play (Palmer et al., 2010). Many researchers have found that interviewing participants individually (as opposed to in a group setting) produced different information. J. Smith and colleagues (2009) and Dunne and Quayle (2001) both argue that a critical challenge of conducting IPA with focus groups is that the participants may feel uncomfortable disclosing personal details and discussing them at length. Contrastingly, Flowers and colleagues (Flowers et al., 2000; Flowers,

Duncan, & Knussen, 2003; Flowers et al., 2001) used both focus groups and individual interviews in their research on HIV testing with Scottish gay men and found differences in the information obtained in each setting with the same participants. However, they believed that the focus group setting, with its group dynamics in play, enhanced the conversations and contributions of the participants in a way that would have been missed had the participants been interviewed only individually (Flowers et al., 2001). Dunne and Quayle (2001) argue that the information obtained in their focus group research with Irish women would have been the same as if they had interviewed their participants individually.

Brocki and Wearden (2006), however, portray a more critical perspective, proposing that whether or not IPA conducted with groups produces the same information may depend on the research phenomena being investigated. Neutral topics may be more accessible to discuss in groups but, when discussing personal matters such as sexual health, in a group setting there would be different information revealed.

In the context of focus groups generally (not regarding IPA), Leask, Hawe and Chapman (2001) found that conducting focus group research with pre-existing groups resulted in the pre-established group norms and leadership patterns diminishing the diversity of the responses amongst the group. However, Wilkinson (2003) suggests that under some conditions a focus group setting may encourage more disclosure of information than in an individual interview. Dunne and Quayle (2001) agreed, and argue that establishing a focus group using pre-existing participant groups reduces the interpersonal factors at play. They argue that the processes by which the participant groups were recruited, and focus group sessions

run, mitigate the issues of group dynamics taking precedence over the research topic discussions.

Prevalence and consensus

Another issue relevant to the use of IPA with focus group data concerns prevalence, whereby focusing on what was said in a session as opposed to who said it might give the false impression of consensus. In focus groups, it is difficult to ascertain how many participants agreed or disagreed with a statement or perspective that was put forward in the discussion (Dunne & Quayle, 2001).

Idiographic

A third challenge of conducting IPA with focus groups is that of its ability to remain faithful to the idiographic origins of IPA. Eatough and Smith (2017) are firm in their assertion that IPA must take a bottom-up approach to data interpretation; understanding and immersing oneself in the data and then working to ascertain the meaning/s. However, in a focus group, the first analysis needs to be of the group-level themes, and then the researcher must focus on the individual (J. Smith et al., 2009). Beginning with the group-level data and then establishing themes which are applied to individuals is more top-down and, therefore, not consistent with an idiographic approach. However, J. Smith and colleagues assert that this would be the only way that IPA analysis could be applied to focus groups (J. Smith et al., 2009). They also suggest that if this approach is used, detailed descriptions of the analytic procedures should be provided for the reader to understand how those conclusions were drawn and conversations clustered into themes.

IPA and sequential data collection

Several researchers have applied IPA to data obtained at multiple time points in individual interviews (for example Clare, 2002; Snelgrove, Edwards, & Liossi, 2013). McCoy (2017) asserts that longitudinal research designs align well with IPA's foundations of hermeneutics, phenomenology and idiography. Longitudinal methods focus on how experiences change over time, which enables a deep understanding of an individual's subjective experience and how this evolves (McCoy, 2017). However, I believe that the SFG method differs in this respect from qualitative longitudinal research as we are not so much concerned with how the participants' experiences change over time. In this research the primary function of the sequential manner of SFGs is to allow time for relationships to develop.

Reliability and validity with IPA

In the context of qualitative research within indigenous psychology, the relative importance of reliability and validity is compelling in and of itself. However, I argue that at times may not be congruent with, or appropriate to strive for reliability and validity in some research contexts (for a detailed discussion of this issue, see Kingi, Russell, & Ashby, 2017). Yardley (2000) argues that reliability may be an inappropriate criterion against which to measure qualitative research if the purpose of the research is to offer just one of the multiple possible interpretations. For example, they cite 'inter-rater reliability' as an interpretation of data that is agreed upon by two people, as opposed to an objective assessment of data. For IPA, reliability functions not to ascertain one true depiction from the data, but to ensure the credibility of the final account obtained from the data.

IPA analysis – the process

When developing IPA, J. Smith (2007) did not envision a prescriptive method of analysis to be adhered to. Rather, he described a cycle of iteration and induction. In 2009, J. Smith and colleagues outlined a process for critically engaging with the data in a manner that holds true to IPA's principles when conducting IPA with individuals.

The goal of IPA is to understand the participant's perspective(s), and this involves reading the transcripts numerous times, making a note of any thoughts and comments that may arise. Comments should be grouped into the following categories: descriptive (summarise the data), linguistic (note verbal and non-verbal language use) and conceptual (interpretive). Researchers should then note individual themes that capture the essence of what is said and cluster these themes together at the group level. Researchers should then re-code the data to highlight all instances where a theme is mentioned, noting instances where the perspectives may converge and diverge within a group and, where possible, position themes as opposites on a continuum. J. Smith asserts that one must consider each transcript on its own, and leave no quote on its own.

Palmer and colleagues (2010) have subsequently developed a protocol for conducting IPA research which embodies the principles of IPA and outlines a suggested process for applying them to the analysis of focus group data. The overall process may be viewed as a series of iterative loops, beginning with a top-down, or holistic, view of the data as a group, and each individual's contributions to this data. It is then suggested that the researcher take a bottom-up perspective by considering how each participant's contributions have been reflected in the group-level data summary. This protocol has provided an essential guide for this thesis as it assisted

me in adhering to the principles of IPA as much as possible when researching with focus groups. In the next section, I describe the applications of IPA to my research.

The method of IPA analysis applied in this research

The detailed steps of the analysis will be outlined here to contribute to the discussion that follows about IPA and its fit with sequential focus groups, indigenous psychology, and the notions of emic and etic discussed in the previous chapter.

The sequential focus group process was used for two separate groups of *rangatahi* Māori. For both groups, the possibility of audio-recording was suggested. The participants of SFG Two all had a history of self-injury, and they were happy for the conversations to be audio-recorded. However, the participants from SFG One chose not to have the conversation audio-recorded. Therefore, these *hui* were not transcribed.

Process of data collection

The process of data analysis for SFG Two followed the eight steps from Palmer et al. (2010). Because the process of analysis for SFG One differed because of a lack of transcription, here I describe how the data analysis process was undertaken.

The data collection for SFG One consisted of the following five records. First, detailed field notes were taken by one researcher present in the SFGs with *rangatahi*, whose sole function was to record the conversations in as much detail as possible.

The second record of data came from the field notes, comments and observations from me as the facilitator. My role was to facilitate the discussion and observe the linguistic and paralinguistic features of the interactions. These

comments at the time were not deliberately categorised into the categories of descriptive, linguistic and conceptual but were made post hoc.

The third record of data was obtained by transcription of post hoc audio-recording of my thoughts and reflections following each *hui*. This was also one element of my intense and robust engagement with the data; the night after each *hui* and the following day was a process of constant reflection, recounting, interpreting what was said. Rather than write these thoughts, I preferred to record them as streams of consciousness which I could then transcribe and fit in with the rest of the data.

A fourth source of data record was the quotes from participants written on Post-it® notes and placed on board around the room during the *hui*. These quotes represented viewpoints of participants who did not have a chance to voice them in the group or did not feel confident doing so. These notes had tallies on them; whenever another *rangatahi* participant read this and agreed with what was said they would mark the note.

Finally, at the beginning of each subsequent *hui*, a summary of the key points noted from the preceding *hui* was given back to the group. At this time *rangatahi* were asked to identify by a show of hands who agreed with each critical point. This provided an indication of consensus and prevalence within each group. Any points that did not have consensus were not included in the final results.

Identifying the three participant groups

For SFG One, during the process of *whakawhanaungatanga* in the first session, all participants identified themselves and located themselves in relation to their experience with the research topic. In quantitative research, it is conventional to split samples of participants based on their responses to a question posed initially

by the researcher(s). This may be criticised because what follows may reflect the researcher's understanding at the expense of that of the participants. In my SFG, in the process of introducing themselves, participants spontaneously self-identified into three groups, suggesting that they make sense in the context of the research topic broadly defined. For this reason, I adopted their categorisation in the following analysis.

- Te Roopu Tuatahi: Those who had self-injured, either historically or were still engaging.

- Te Roopu Tuarua: Those who had not self-injured but had experience supporting a friend or family member who had self-injured.

- Te Roopu Tuatoru: Those who had never engaged in self-injury.

The process of IPA analysis of all SFG data

Once all of the data from all of the *hui* were collated, the process of analysis of the sequential focus group data for both groups was informed by the eight steps of Palmer et al.'s protocol (2010). However, in practice, I have divided the process into nine steps, and they vary slightly from the protocol above.

The first step of data analysis involved repeated reading and re-experiencing of the data, over several sessions on several days. While doing this I categorised the comments and contributions of each participant according to their self-allocated group; self-injurer, supporter, or those who had never self-injured. During the sessions, I began to get a feel for, and develop an understanding of, the experiences, concerns and beliefs of each of the three groups as distinct collectives. The post hoc process of separating the comments by group served to strengthen my observations about the perspectives of each group based on the contributions of individual members.

Secondly, I began to identify the emergent themes from each group of participants, noting instances where themes showed divergence, commonalities or other relevant nuances. Through this process, there were several considerations I made:

a. Positionality. This involved separating out my observations, thoughts, and feelings as a researcher. It also involved reflecting on the functions of statements made by the participants and what this may say about their perspective on the subject of the discussion.

b. Consideration of how the participants refer to others and what this may indicate regarding relationships, and what meanings and expectations are attributed to these relationships.

c. Note how the participants refer to organisations and systems, and how this reflects the expectations and experiences of the participants.

d. How stories are shared; note any imagery, tone, and how emotions are portrayed. Also, take note of how these stories were received by the rest of the group.

e. Note the use of language, in particular, the use of metaphor, euphemism, etc.

My third step in the process of IPA was to extrapolate the themes while applying my own psychological and cultural knowledge and understanding of the data. Throughout this process I was cognisant of how the themes fitted within a broader context of theories and models, as well as the reality of life as experienced by the broader population group; in essence, considering how might their experiences reflect those of other *rangatahi* Māori in Aotearoa.

In the fourth step of the data analysis process, I created my framework that illustrated relationships between themes within groups and among groups, while

129

identifying the commonalities and differences in the themes between groups. This took on the form of a series of interconnected mind maps with colour-coded Post-it® notes that covered the four walls and ceiling of my home office. I then organised the data in a spreadsheet to trace the progression of themes from the initial comments in the notes, to the thematic clustering, and then on to the final themes.

Throughout this process, I engaged in on-going reflection, discussion and feedback with the other research team members who were present at the *hui*. Also, all preceding notes and analysis until this point (i.e., the themes as they had been identified at this point) were presented at the beginning of the next *hui* to gain an indication of consensus and feedback which contributed to subsequent iterations of data interpretation.

The analytic process then involved developing a full narrative with detailed commentary on data extracts that takes the reader through the interpretation with a visual guide. Finally, I spent time reflecting on my perceptions, concepts and processes as they related to the topics covered. This was on-going through all phases of data collection, analysis and interpretation.

IPA, emic and etic

I introduced emic and etic approaches in the previous chapter. The approach that I take in this research is described by Williams (2010) as an "etmic" approach or an insider/outsider approach whereby the researcher can see both the wood and the trees. This is appropriate for IPA research because, while an emic approach optimises the ability of a researcher to relate to and understand the lived experiences of the participants, an etic approach also allows the layering of Western psychological knowledge into the analysis.

Challenges of IPA

J. Smith (2011) has published ten guidelines for assessing whether a paper holds true to the principles of IPA and may, therefore, be deemed to be quality IPA – standards that the research presented here may not strictly meet. This is because this research is explicitly grounded in indigenous psychology first and foremost and, as such, it required some negotiating of challenges when the principles of IPA did not fit with an indigenous psychology approach.

Several guidelines relate to the way in which the analysis is presented. I shall describe these here without elaboration, as their measure can be found in Chapter 8 where I present analysis and discussion.

The first of J. Smith's (2011) guidelines states that the research must subscribe to the theoretical principles of IPA: phenomenological, hermeneutic and idiographic. However, focus groups may not exemplify the idiographic because the individual voices may be lost in the group dialogue. J. Smith et al. (2009) propose that a way to overcome this is by recording and transcribing the focus group sessions and then reading the transcripts several times to become immersed in the perspectives of the participants. In the present study, we did not record and transcribe. Instead, we immersed ourselves in the perspectives of the participants by getting to know them over the course of the sequential focus groups. This was assisted by *tikanga*, such as *whakawhanaungatanga*.

A second guideline states that the research must be transparent so that the reader can see what was done. J. Smith (2009) suggests that to increase validity when using IPA with focus groups, an independent audit of the data should be conducted. This involves creating an audit trail, which could include the research proposal with research questions and aims, the interview schedule, any transcripts,

notes, and other data sources with the researcher's comments and thoughts recorded to trace the thought process in establishing the key themes. However, for this research to be consistent with indigenous psychology and the *kaupapa Māori* principle of *tino rangatiratanga*, I will not be sharing the raw data beyond the participants and the researchers present in the room.

Also (and as I have mentioned in Chapter 5 regarding ethical issues), while Western research practices may require validity by documenting the research process in a manner that would enable another researcher to replicate it, this is not how I have conducted this research. Through the process of *whakawhanaungatanga*, relationships are built which lay the foundations for the research process. *Whakapapa* is about making connections with others, and everyone's connections are unique. For example, I introduced myself as a mother with a three-year-old son. This identification as a mother allowed discussions with those present who were also mothers, some with children of the same age. Also, at the time I was paddling for a local *waka ama* crew, and some of the participants were also passionate about the sport, and so we were able to have discussions around this topic.

As I have asserted previously, no other researcher would have engaged with the participants in precisely the same manner to elicit the same results with an equivalent group of *rangatahi* Māori, and it is not guaranteed that the same information would have been elicited from the participants by anyone else. While my method was not transparent and replicable, I have been transparent with my data analysis by writing it up so that it is clear how I went about this and how my themes were drawn, including (where possible) my thought processes. Also, the other researchers were present at each *hui* as collaborators, and following each *hui* we reflected on what was said as another means of checking that the information

was collected correctly. Finally, by adopting the SFG model, I developed something of a relationship with the participants whereby they too became collaborators or, in a sense, co-researchers with whom I was able to check my understanding and interpretation of what was covered at the previous SFG.

The third guideline for gold-standard IPA is that the analysis must be coherent, plausible and interesting. A fourth guideline states that the research must be evidenced. While not audio-recorded, the evidence for this research was obtained from multiple sources (notes from a note-taker, facilitator notes, participant quotes, for example), and the analysis is illustrated using excerpts of those notes to allow the reader to check their understanding against my own.

The fifth guideline for IPA is that the research must have a clear focus that is either determined at the outset or emerges during data analysis. J. Smith (2011) recommends avoiding conducting a broad research focus, but rather focusing on one detailed aspect of a research topic. In this research, because self-injury in *rangatahi* Māori is a relatively new topic I feel as though I am doing more of a broad scoping project. Also, we began these *hui* without a predetermined agenda or set of specific questions. This allowed the *hui* to proceed in a direction and at a rate that the participants were comfortable with, consistent with the *tino rangatiratanga* and the right for participants to have some control over the research.

Another guideline for assessing the quality of IPA research is that it must have robust data; being high-quality data that has been obtained using proper interviewing techniques. Western notions of validity and reliability are secondary to ensuring the process of data collection adhered to *tikanga* and so in a *kaupapa Māori* sense it is of high quality, in that the *mana* of participants was upheld, while simultaneously achieving the research objectives. In my opinion, using 'proper

133

interviewing' techniques but not following *tikanga* would have meant that this data would not be valid. In this context, *tikanga* provides the validity, in that if we consider reliability as representing the idea that another researcher would get the same results if they had followed your process, *tikanga* may also provide a similar framework for achieving this.

J. Smith (2011) also states that the data analysis must be rigorous and give some indication of the prevalence of themes. He specifies that extracts should be selected to give some indication of convergence and divergence, representativeness and variability. For more extensive sample sizes, J. Smith suggests providing illustrations from at least three or four participants per theme, and also to give some indication of how the prevalence of a theme is determined. For my research, the challenge was in figuring out how to show the consensus of the group. This was achieved by providing a summary of the critical points or statements from each session at the beginning the following session, at which time I asked who agreed and disagreed. I noted the ones where all or the majority agreed, or how many disagreed, and in the results section I present the themes endorsed by all or an 80% majority unless specified.

J. Smith (2011) also suggests that proper IPA presents an extended and elaborate account of one of the emergent themes and that all themes should have extensive summaries and many extracts followed by interpretations. In my research, many strong themes emerged, and these are elaborated on in both Chapter 8 and the discussion chapter (Chapter 9).

Consistent with any good analysis, good IPA analysis should also be interpretative and not descriptive. That is to say, the analysis should go beyond the simple provision of description, using the 'data' to achieve something that is more

than a 'script' for the focus groups or interviews. I achieved this by weaving extracts with interpretative commentary. In my research, I have done this throughout my analysis, but I have not included all of the analytic points that are presented in this thesis (only those relevant to the research questions).

Finally, J. Smith (2011) asserts that the hallmark of excellent IPA analysis is that it points to both convergence and divergence of themes within the data. In my research, I have endeavoured to do this most frequently at the group level.

CHAPTER SUMMARY

Careful deliberation and consideration have been given to the methods chosen for data collection and analysis in this research. In the spirit of interface research (Durie, 2005) approaches, I have tried to remain true to the principles of indigenous psychology broadly, and *kaupapa Māori* principles individually, while at the same time utilising the tools of Western-based research methods in a manner that creates robust and rigorous indigenous psychological research.

This research falls short of some of these criteria specified by J. Smith (2011), which I argue has been necessary to remain faithful to the principles of *kaupapa Māori* research. While on the one hand, this might be taken to mean that my research represents poor-quality IPA. However, I have never set out to conduct pure IPA research. As I stated at the beginning of this chapter, my research is informed by the principles of IPA. In accordance with Durie's (2005) interface research, I have endeavoured to 'fit' IPA into a Māori-centred research approach, without compromising the foundations of indigenous psychology and *kaupapa Māori* upon which this research is premised.

To date, there has been little research conducted that uses IPA with focus groups within an indigenous psychology context and at present no projects that did not audio-record and transcribe the sessions. I chose to conduct focus group research using IPA to understand the experiences of the participants at both the individual and group levels, taking into account the interactions and group dynamics simultaneously. My goal was to develop a meaningful analysis of the personal lived experiences of groups articulated initially by the *rangatahi* and whānau themselves; those who have self-injured, those who have supported a *rangatahi* who self-injured, and those who have never self-injured. In this respect, rather than understanding the experience of that individual, each group became the fundamental unit of analysis. This then shifts the focus of the analysis to an understanding of the experience as experienced by that group, in that context, at that time, while taking into account the group dynamics at play.

I believe that this remains true to the core focus of IPA to become immersed in the experiences of the participants and understanding their attempts to make sense of their personal lived experiences (McParland et al., 2011). I have also sought to highlight where prioritising *kaupapa Māori* has led to deviations from the standards expected for IPA but, rather than weakening the process or outcomes, has ensured culturally valid and reliable research.

CHAPTER SEVEN
Study 1: Quantitative

Study 1 uses survey data, collected through the YWB Study (see Chapter 1 for a description of the YWB Study), to ascertain the prevalence rates and correlates of self-injury among *rangatahi* Māori. There are four sub-studies. Study 1A identifies the sample of *rangatahi* Māori that will be used, and Study 1B describes the characteristics of our sample of *rangatahi* Māori who self-injure. Study 1C investigates the forms and functions of self-injury for *rangatahi* Māori in this sample, and Study 1D identifies the correlates and predictors of self-injury. The intention is to clarify anecdotal evidence that *rangatahi* Māori engage in self-injurious behaviours and to identify the psychological variables associated with self-injury for *rangatahi* Māori.

INTRODUCTION TO STUDY 1

Rangatahi Māori are a diverse population (Kukutai, 2004; Rata, 2012). In Chapter 3 I discussed the different extents to which one can identify as Māori, and how these may change as a function of time and place, among other factors. For this research, to understand how *rangatahi* Māori define and experience self-injury, it is first essential to identify the *rangatahi* who identify as Māori in this sample at the time of participation.

The YWB Study utilised three questions to assess ethnic identity. First, participants are asked to indicate any ethnicities that they identify with. Secondly, participants are asked to select their primary ethnicity from those previously indicated and, thirdly, participants are asked if they have any Māori ancestry ("Are any of your parents, grandparents or great-grandparents Māori?").

Depending on how we define and select the *rangatahi* who are Māori, the proportion ranges between 6% and 20%. At the end of 2016, there were 2216 adolescents who had participated in the YWB Study. Of these, 136 participants identified Māori as their primary ethnicity, and 442 indicated that they had Māori ancestry.[24]

In the initial stages of this research, my inclination was to use ancestry as the measure of ethnic identity. I have mentioned previously that I believe that this is most consistent with the traditional concept of *whakapapa* as a measure of identity, whereby *tūpuna* or common ancestors connect Māori with physical locations and play a role in the wellbeing of both the individual and the collective. However, in reviewing the wealth of literature on ethnicity and identity both within Aotearoa and internationally, it became apparent that the simplicity of ancestry was not consistent with the diversity of Māori today.

In an ideal world (and possibly for further research), I would have liked to have been able to investigate whether the *rangatahi* who identified Māori as a primary ethnicity differed from those who identified Māori as another ethnicity on the prevalence, correlates and functions of self-injury. However, statistically speaking, the limited number of *rangatahi* Māori in our sample restricts the types of analyses that can be performed. Therefore, in an attempt to obtain the largest sample of *rangatahi* Māori possible, I hoped to use all *rangatahi* who identified as Māori, either as their primary ethnic identity or as an 'other' ethnic identity. Study 1A assesses the feasibility of using this larger sample, by comparing those who

---

[24] "Are any of your parents, grandparents or great-grandparents Māori?"

identify primarily as Māori with those who selected Māori as one of their many identities but who identify primarily with another, non-Māori, identity. If these two groups differed significantly in their results on the core psychological variables that I intended to use in subsequent analyses (self-injury, suicidal ideation, bullying, anxiety, depression, attachment to parents and attachment to peers), then I would use the sample of *rangatahi* who identified Māori as their primary ethnicity. However, if there were no significant differences between the two groups on the selected variables, then I planned to use the larger sample to maximise statistical power. Once my sample of *rangatahi* Māori was established in Study 1A part 1, the descriptive statistics of the research sample are presented, including key demographics (for example age, gender), and other variables of interest.

Due to a paucity of extant information regarding self-injury specifically in *rangatahi* Māori, Study 1B describes demographic information, for example, the average age of *rangatahi* Māori who self-injure, by gender. I then proceed to investigate the different forms and functions of self-injury for *rangatahi* Māori in Study 1C, and the role of psychological variables (such as emotion regulation) in self-injury among *rangatahi* Māori in Study 1D.

METHOD

The Youth Wellbeing Study (YWB Study) is a longitudinal study, conducted annually since 2012. It focused on understanding wellbeing in the young people of Aotearoa, with a particular interest in NSSI. The project was funded by a grant from the Health Research Council of New Zealand, following successful application in 2010/11 and, therefore, the focal research questions were set before I became involved. The YWB Study researchers were a combination of post-graduate

140

students, research assistants, professors/lecturers, community-based health workers, cultural advisors and clinicians (clinical psychologists). I have been involved in the research as a PhD student since 2011 and had input into developing the methods used, and data collected, that will be described below. The YWB Study investigated an extensive list of psychological variables that were hypothesised to be risk and protective factors for young people who self-injure. For my research, I have selected only those that apply to my research questions. I will expand on these in the sections to follow. While the YWB Study is ongoing, I shall draw from data collected between 2012 and 2016.

Participants

The analyses that follow in this chapter are taken from the sample of participants who identified Māori as either their primary ethnicity or as another ethnicity. Between 2012 and 2016, 2216 individuals participated in the YWB Study, all of whom attended one of 15 schools within the broader Wellington region. Of this sample, 343 high school students identified as Māori in some way (150 male, 188 female, five missing data). The age range was from 13 to 18 years (mean age = 15.26, *SD* = 1.27), and this average age represents the age at which adolescents in Aotearoa are typically in Year 11 of high school, Level 1 for the National Certificate of Educational Achievement (NCEA; New Zealand Qualifications Authority, n.d.). Of this 343 students[25], when asked to select their primary ethnicity, 49.9% identified as being *Pākehā*/New Zealand European, 39.7% as Māori, 1.5% as Samoan, 0.6% as Cook Island Māori, 0.3% as Tongan, and 0.9% as 'Other'. Six-point four percent said

---

[25] All percentages have been rounded to the nearest whole number.

that they were unable to select one ethnicity as their primary ethnicity. Examples of 'other' primary ethnicities in this sample included one who identified primarily as African-American, two Tokelauan and one who identified as Turkish.

Measures

Māori identity

As well as the questions described above (see page 138), identity as Māori was assessed using questions from the Multidimensional Model of Māori Identity and Cultural Engagement (MMM-ICE; Houkamau & Sibley, 2010). This measure was developed in Aotearoa specifically for use with people who identify as Māori. The sample on which the measure was tested consisted of 270 adults who identified as Māori (only participants who identified as Māori were invited to complete these questions). The original measure is composed of six subscales, with eight items for each. For the YWB Study, time did not permit the use of the full questionnaire. Therefore, we chose to use the Group Membership Evaluation and Cultural Efficacy and Active Identity Engagement subscales. These subscales assess the extent to which an individual subjectively identifies as Māori (Group Membership Evaluation) and the extent to which one believes they can engage with other Māori in Māori social and cultural contexts. Group Membership Evaluation subscale sample items include 'I love the fact that I am Māori' and 'I wish I could hide the fact that I am Māori from other people' (reverse-coded), while examples of items from the Cultural Efficacy and Active Identity Engagement subscale include 'I know how to act the right way when I am on a marae' and 'I have a clear sense of my Māori heritage and what it means for me'. All items are scored on a seven-point Likert scale, where 1 = strongly disagree, and 7 = strongly agree. An average score for each subscale is

obtained where a higher score indicates stronger identity as Māori for that particular subscale. Houkamau and Sibley (2010) report that each subscale had good internal reliability, with all α = 0.70 or above.

Importance of ethnicity

The self-reported importance of an individual's ethnicity was assessed using two questions adapted from the work of Luhtanen and Crocker (1992); 'I often think of myself in terms of my ethnic group' and 'My ethnic group is an important part of how I think of myself'. Responses to these two questions were recorded on a five-point Likert scale where 1 = strongly disagree, 5 = strongly agree. The average of the scores on these two questions was calculated to give a measure of the importance of their ethnicity.

NSSI

For the YWB Study, the Deliberate Self-Harm Inventory – Short (DSHI-S; Lundh, Karim, & Quilisch, 2007) was used to measure forms of self-injury, and the Inventory of Statements about Self-Injury (ISAS; Klonsky & Glenn, 2008) was used as a measure of the functions of self-injury. The Deliberate Self-Harm Inventory (DSHI; (Gratz, 2001) is a behavioural measure of self-injurious behaviours, and the DSHI-S (Lundh et al., 2007) is a modified version that was developed for use with adolescents. Both measures define self-injury using the term 'Deliberate Self-Harm', and define this as "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur" (Gratz, 2001). The DSHI-S is composed of 16 items that investigate 14 different types of self-injurious behaviour (as well as an open-ended question regarding nature and frequency of self-injury not covered by preceding items). The DSHI-S asks participants whether they have engaged in each behaviour and then

143

asks them to select one response option for each question. For example, "Have you ever intentionally cut your wrist, arms, or other areas of your body?" Response options for the DSHI-S are "never", "once", "more than once", and "many times". Examples of other behaviours included "Have you ever intentionally burned yourself with a cigarette, lighter or a match?" and "Have you ever intentionally carved words, pictures, designs or other marks into your skin?" These behaviours were selected by Gratz because they are the most common behaviours that are defined as self-injury or self-harm in clinical observations and literature at the time it was developed within the sample population (Gratz, 2001). The DSHI-S has high internal consistency ($\alpha = 0.90$), and has been used previously in Aotearoa (Garisch & Wilson, 2015). In my sample, the DSHI-S was found to have good internal consistency ($\alpha = 0.80$).

First-time participants in the YWB Study are asked to complete the DSHI-S (and related measures) reflecting lifetime engagement in self-injury. For follow-up participants, we (the YWB Study) adapted the format of the questions to specify whether or not they had engaged in the specified behaviours within the previous 12 months. We limited the timeframe for self-injury to the past 12 months because the data was being collected primarily for a longitudinal survey. The analyses below are based on lifetime history of self-injury unless otherwise stated. We also adapted the response options to differentiate between those who had thought about self-injury and those who had engaged in self-injury, consistent with researchers who have found that thinking about self-injury and engaging in self-injury are distinct but related constructs (Martin, Bureau, Cloutier, & Lafontaine, 2011). The response options for each specified behaviour were "I have never thought about doing this", "I

have thought about doing this but have never done it", "I have done this once", "I have done this a few times", and "I have done this many times".

The ISAS (Klonsky & Glenn, 2008) comprehensively measures the functions of self-injury by asking participants to rate how relevant 40 statements about self-injury are to them. Response options are "not relevant", "somewhat relevant" and "very relevant". All items begin with "When I self-injure I am…" and sample items include "…calming myself down" and "…punishing myself". Each of the first 39 statements relates to one of 13 functions that were identified by Klonsky (2007) in his review of the most common functions of self-injury. A final question asks participants to identify any other functions not already assessed. The 13 functions are: affect regulation, interpersonal boundaries, self-punishment, self-care, anti-dissociation, anti-suicide, sensation seeking, peer bonding, interpersonal influence, toughness, marking distress, revenge, and autonomy. Three items assess each of these subscales. Klonsky and Glenn (2008) further defined these 13 scales as falling under two superordinate functions; interpersonal and intrapersonal functions, and Klonsky et al. (2015) reported excellent internal consistency for both the interpersonal factor (α = 0.89) and intrapersonal factor (α = 0.88). Understanding the functions of self-injury for *rangatahi* is significant because research has found that different functions are associated with different risk factors and treatment (Klonsky & Olino, 2008; Nock & Prinstein, 2005). In my sample, the full ISAS was found to have excellent internal consistency (α = 0.94), and the internal consistency for both the interpersonal and intrapersonal subscales was also acceptable (α = 0.91 and α = 0.88 respectively).

The YWB Study survey uses an initial screening question with skip logic to direct participants to answer only the questions on self-injury if they have hurt

themselves on purpose or have thought about it. The survey avoids using the term 'NSSI' but instead describes behaviours and intentions (see Supplementary Material for the full survey):

> Sometimes people have thoughts about hurting themselves on purpose, but do not actually hurt themselves. And sometimes people hurt themselves deliberately (i.e., on purpose) to cause damage to their body but NOT to kill themselves (e.g. cut, burn, scratch, or carve their skin, bang or hit themselves, or prevent wounds from healing)…
>
> Please indicate whether you have had thoughts about hurting yourself on purpose (but not actually done this), whether you have hurt yourself on purpose (e.g. cut, burnt, scratched or carved your skin, etc.), or whether you have never done this
>
> - NO, I have never hurt myself on purpose
> - YES, I have hurt myself on purpose
> - I have thought about hurting myself on purpose
>
> Please only answer these questions if you MEANT to hurt yourself (not if it was an accident), but WITHOUT intending to kill yourself. Do not answer yes if you did something accidentally (e.g., you tripped and banged your head accidentally).

In addition to the two scales used to investigate self-injury, specific questions were asked about the number of times that participants had hurt themselves that required medical treatment or time in hospital, how long since their last episode of self-injury, whether or not others knew that they self-injured, and whether or not they knew anyone else who self-injured (and the nature of any relationship with an acquaintance so identified).

Suicidal ideation and behaviour

International research tells us that self-injury is associated with suicidal behaviours, and this relationship between self-injury and suicide for *rangatahi* Māori is a focus of this thesis. We assessed the history of suicidal ideation and behaviour as a means of identifying adolescents at risk of suicide. We chose to use the Suicidal Behaviours Questionnaire-Revised (SBQ-R; Linehan & Nielsen, 1981) to assess the risk of suicide. The SBQ-R is a shortened version of a 34-item Suicidal Behaviours Questionnaire (M. M. Linehan & Nielsen, 1981). The survey includes four items that assess aspects of suicidality, including past history of suicidal ideation and behaviour (item 1), suicidal ideation and behaviour in the previous 12 months (item 2), whether they have communicated their planned or intended suicidal behaviours (item 3), and their self-reported likelihood of future suicidal behaviour (item 4). The response options varied for each item, but were on either a five- or six-point Likert scale, from 'never' to 'attempted and really wanted to die' (item 1) or 'very often' (item 2), 'more than once and really wanted to die' (item 3) and 'very likely' (item 4). The SBQ-R has been found to have good internal consistency in both clinical and nonclinical samples ($\alpha = 0.76$ and $\alpha = 0.88$ respectively; Osman et al., 2001). In addition to the SBQ-R questions, participants were also asked whether they had seriously thought about killing themselves in the past two weeks and whether they had made a plan or an attempt in the past year. A total score for the SBQ-R is obtained from the four items, with scores ranging from 3 to 18. In non-clinical populations, a score of seven or above is used to identify at-risk individuals (Osman et al., 2001).

As well as the SBQ-R, the additional risk assessment questions were used by one of two team members who were registered clinical psychologists immediately

following completion of the survey to aid in prioritising risk, and the names of at-risk participants were passed on to their school guidance counsellor to follow-up.

Emotion regulation

To assess levels of emotion regulation the Emotion Regulation Index for Children and Adolescents (ERICA) was used (MacDermott, Gullone, Allen, King, & Tonge, 2010). The ERICA was developed as a revised version of the ERCA (Emotion Regulation Checklist for Adolescents; Biesecker & Easterbrooks, 2001), and assesses what has been identified in the literature as critical elements of emotion regulation in samples of children and adolescents. The ERICA has been psychometrically evaluated on a sample of Australian children and adolescents (aged 9–16 years) and found to have both good internal consistency and test-retest reliability ($\alpha = 0.80$; MacDermott, Gullone, Allen, King, & Tonge, 2010).

The ERICA consists of 16 items, examples of which include 'I handle it well when things change or I have to try something new' and 'I have angry outbursts' (reverse coded), and to which participants choose the most appropriate response on a five-point Likert scale ranging from 1 = strongly agree to 5 = strongly disagree. A mean score is obtained, with a higher score indicating a greater ability to regulate emotions.

Depression and anxiety

Depression and anxiety were assessed using the short version of the Depression and Anxiety subscales of the Depression Anxiety Stress Scale-Short version (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 was developed, and psychometric properties were evaluated on a sample of 717 first-year psychology students in Australia (Lovibond & Lovibond, 1995). The suitability of the DASS for adolescents was validated by Szabó (2010) using a sample of 484 high school

students aged 11–15 years. Each subscale consists of seven items, and participants were asked to indicate the extent to which each item was applicable to them over the past week on a four-point Likert scale, where 0 = 'did not apply to me at all', and 3 = 'applied to me very much or most of the time'. A total score is obtained and then multiplied by two, as stipulated by Lovibond and Lovibond (1995) to assess the scores for the full 42-item DASS in normative samples of clinically relevant symptoms.

Bullying

To understand how bullying and self-injury were related, the YWB Study asked questions regarding different aspects of bullying behaviour, regarding both the experiences of being bullied and whether or not participants had bullied others. For my research, I have chosen to use only the questions pertaining to frequency of being bullied, the types of bullying experienced, and a self-report of how bad their experiences of bullying were. These questions were selected because of their perceived relevance to my specific population of *rangatahi* Māori, to assess whether or not they might be related to self-injury for *rangatahi* Māori. The bullying questions used in the YWB Study were adapted from the Youth 2000 survey (Adolescent Health Research Group, 2012), a large cross-sectional survey of adolescents in Aotearoa between 2002 and 2012.

The first bullying-related question asked participants how often they had been bullied in school in the past 12 months, with response options ranging from 'I haven't been bullied' to 'most days'. If participants had been bullied in the past 12 months, they were not required to complete the subsequent bullying questions. Those who had been bullied were also asked 'When it happens, how is it?', with responses on a five-point Likert scale from 'not bad' to 'terrible'.

149

Subjective deprivation

Subjective deprivation was assessed using two 'yes' or 'no' questions; 'Do the people who care for you ever worry about money for food, rent, electricity?' and 'Do you ever worry about not enough money for food, rent, electricity?'. These two questions were then averaged to provide a measure of subjective deprivation.

Attachment to parents and peers

A short version of the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987) was used as an assessment of the levels of attachment to parents and peers. The IPPA was developed for young people aged 12–19 years. The original scale consisted of a subscale that measured attachment to parents (28 items) and one that measured attachment to friends (25 items). For the YWB Study, a shortened version of each scale was used based on Armsden and Greenberg's (1987) factor analysis of the original scale. Twelve items were chosen for each scale based on highest loading items, and respondents indicated on a five-point Likert scale (1= not at all true, 5= very true), how true each statement was for them. Both scales have been previously shown to have good reliability in adolescents (α = 0.88; Armsden & Greenberg, 1987).

The original scale assessed attachment to mothers and fathers separately, and in our shortened version we combined this by asking participants to respond to questions of attachment regarding those who had most influenced them.

Procedure

Ethical approval for the YWB Study was obtained from the National Health and Disability Ethics Committee (NEC/11/12/108). Participants were recruited from 15 secondary schools who had accepted the invitation to participate. With the

150

agreement of the school, parents and whānau members of students were invited to consent for their children to participate in the study, and information regarding the study was provided through pamphlets sent home with all eligible students, as well as promoted through the school's newsletters (see Supplementary Material). Caregivers could indicate consent for their young person to be approached to participate, or indicate that they did not provide this consent, and some schools provided the option of electronic consent (through a URL emailed to the whānau members that connected them with an electronic consent form). As an incentive for students to return their consent forms, regardless of whether or not their parents or whānau members consented to them participating, they received a small chocolate (Freddo Frog or equivalent) for the return of their form. Because the YWB Study is a longitudinal study, participants were recruited from Year 9 in the first wave of the study, Year 10 in the second wave, and so on.

Administration of the survey occurred during school hours, with up to an hour allowed for the completion of the survey. The time of day that the survey was administered varied between schools as we tried to fit in with the school's schedule and what periods of the day students were available to complete the survey. The average completion time was approximately 45 minutes. The process of administration varied slightly for each school as we worked around what was convenient for the school and the students. Most often the students whose parents had consented to participate were asked to report to a classroom or other location (for example, the library, or the I.T. suite if completing electronically) to complete the survey. Participants were first briefed on the survey information and consent to participation. Participation was explicitly indicated to be voluntary, and participants were able to opt out at any time. For those who consented, identifying information

(and signature) was collected on the first page. Students were informed that their responses were confidential and that the front page would, therefore, be separated and stored separately from the rest of the survey after the risk assessment was conducted (see below).

Students were provided with the opportunity to ask any questions and address any concerns that they had before commencing. Students were informed that, though the survey was not a 'test' in the typical school sense, participation should happen under "test conditions" (in silence, without looking at each other's responses). Upon completion, each participant was provided with a debriefing sheet (see Supplementary Material) and received a chocolate bar as a token of appreciation for their participation (including those who opted out at any time).

As a condition of ethics approval, a registered clinical psychologist was present at every data collection, to complete the immediate assessment of risk for each student (based on their SBQ-R responses) and refer any concerns to the school guidance counsellor for follow-up. One week following survey administration the clinical psychologist contacted the school's guidance counsellor to follow up and facilitate further referrals to mental health services if required. The clinical psychologist/s were also on hand should a participant become distressed at any time while participating, although this did not happen at any data collection event.

The final questions in the survey asked students if they would like to be put in contact with specific individuals (e.g. teachers, parents, or other support people), and if this offer was taken up, this contact was facilitated by the research team within one week of participation.

To account for missing data, imputations were used for some scale measures, where those scales were shown to be reliable and participants had completed at

least 75% of the items that were part of that scale. In those cases we replaced the missing variable with the mean responses to the other items. Where participants had missing values (either because they didn't respond at all or didn't complete enough items to allow imputation), those participants were excluded from any analyses for which they had missing data.

STUDY 1A: IDENTIFYING AND DESCRIBING THE RESEARCH SAMPLE
Overview

Part 1 of this study involved determining which variables would be used to identify *rangatahi* Māori by comparing those who selected Māori as their primary ethnicity with those who selected another ethnicity as their primary ethnicity but chose Māori as an 'other' ethnicity.

The variables that these groups were compared on were the core psychological variables that I was interested in for this quantitative section of my mixed-methods research. These variables are self-injury, suicidal thoughts and behaviours, bullying, depression, anxiety, emotion regulation, and attachment to parents and peers. As a point of reference, I also compared the two groups mean scores on the measures of Māori identity (MMM-ICE) and the importance of their ethnicity to their identity.

I anticipated that the two groups would differ on the MMM-ICE scores, whereby those who chose Māori as their primary ethnicity would have a stronger identity as Māori. I did not expect, however, that the two groups would differ significantly on the extent to which their ethnic identity was important to them, because, regardless of one's ethnicity and the number of ethnicities they chose, ethnicity can still be important to them.

I also anticipated that these variables (bullying, self-injury, suicidal thoughts and behaviours, depression, anxiety, emotion regulation and attachment to parents and peers) would be relevant to experiences and challenges that all *rangatahi* experience, regardless of the strength of their identity as Māori. I, therefore, did not expect the groups to differ significantly on these core psychological variables that I was assessing. If my hypothesis was supported and there was no significant difference in the mean scores for these variables between the two groups I would then use the sample as a whole, and could reasonably investigate descriptive statistics about this population.

RESULTS

Study 1A, Part 1

Part 1 investigated the differences between those who selected Māori as their primary ethnicity and those who selected it as another ethnicity, on core psychological variables. The two groups were compared to determine whether or not the differences between the two were substantial enough to warrant analysis of the results as two separate groups, or whether the results for *rangatahi* who selected Māori as a primary ethnicity and those who selected it as another ethnicity could be analysed as one collated cohort.

Descriptive statistics

In this sample, 343 participants selected Māori either as their primary ethnicity (n = 106) or as another ethnicity (n = 174). A one-way between groups multivariate analysis of variance was conducted to compare the mean scores of each group on measures of the importance of ethnicity, bullying, self-injury, suicidal ideation and behaviours, emotion regulation, depression, anxiety, attachment to

154

parents, and attachment to peers. Because of the low response rates for the measure

of Māori identity, mean scores for this variable were assessed using an independent

t-test.

Preliminary assumption testing was conducted to check for normality,

linearity, univariate and multivariate outliers, homogeneity of variance-covariance

matrices, and multicollinearity. Aside from the self-injury scale, all other

psychological scales did not show any evidence of deviations from normality. The

scores for the self-injury scale were distributed consistent with past research

(Garisch and Wilson, 2015), whereby the results were skewed with

disproportionately large numbers of people with low scores. For the MANOVA, there

was a statistically significant difference between the two groups on the combined

dependent variables, $F(9, 269) = 2.60$, p = 0.01; Wilks' Lambda = 0.92; partial eta

squared = 0.07. Univariate tests indicated that the only difference to reach statistical

significance was the importance of ethnicity, $F(1, 277) = 19.14$, p = < 0.01, partial eta

squared = 0.03. An inspection of the mean scores indicated that *rangatahi* who

selected Māori as their primary ethnicity reported a higher importance of ethnicity

to their identity (M = 3.32, SD = 0.10) than those who selected Māori as another

ethnicity (M = 2.77, SD = 0.08).

An independent-samples t-test was conducted to compare the scores for the

MMM-ICE between the two groups. There was a significant difference in scores, with

those who chose Māori as their primary ethnicity (M = 5.24, SD = 0.96) reporting

stronger Māori identity than those who selected Māori as another ethnicity

(M = 4.60, SD = 0.95), t(270) = 5.51, p = < 0.01. These results are also presented in

Table 1.

Table 1.
Means and standard deviations for each group of Māori on core psychological variables.

	Scale reliabilities*	Primary ethnicity Māori M (SD)	Māori as an 'other' ethnicity M (SD)
MMM-ICE score	0.85	5.24 (0.96)a	4.50 (0.95)a
Importance of ethnicity		3.32 (0.10)a	2.77 (0.08)a
Frequency of bullying victimisation		2.00 (1.14)	2.08 (1.11)
NSSI score		0.66 (0.87)	0.64 (0.91)
SBQ score	0.83	4.02 (4.50)	4.35 (4.54)
ERICA average	0.78	3.61 (0.50)	3.60 (0.52)
Depression	0.86	0.77 (0.74)	0.68 (0.69)
Anxiety	0.86	0.59 (0.65)	0.55 (0.64)
Attachment to parents	0.87	3.35 (0.73)	3.46 (0.86)
Attachment to peers	0.84	3.50 (0.71)	3.56 (0.71)

Note: Not all alpha values are reported as some are single items.
a = Primary ethnicity as Māori different from Māori as an 'other' ethnicity.
MMM-ICE: Multi-dimensional Model of Māori Identity and Cultural Engagement;
NSSI: History of self-injury; SBQ: Suicidal Behaviours Questionnaire; ERICA average:
Emotion Regulation Index for Children and Adolescents.

Study 1A, Part 2

The results from Study 1A found that the two groups (those who identified
Māori as their primary ethnicity and those who identified Māori as an 'other'
identity) differed only in the strength of their identity as Māori and the extent to
which their ethnicity was important to them. They did not differ on the other
variables of interest (self-injury, depression, anxiety, bullying, attachment to
parents, attachment to peers, suicidal thoughts and behaviours). Because of this, I
combined the two groups into one sample for subsequent analyses. Importantly, this

initial analysis indicates that among *rangatahi* Māori (broadly defined)

psychological wellbeing appears unrelated to whether one identifies primarily as

Māori or not. The benefit of utilising both groups was that it provided a larger

sample size for subsequent analyses.

The final sample for this quantitative study is 343 participants who identified

as Māori, either as their primary ethnic identity or as an 'other' ethnic identity. Once

the final sample was determined, I next examined the sample as a whole on

descriptive statistics.

The age range was 13–18 years, with a mean age of 15.26 years (SD = 1.27).

In this sample, 44% identified as male, 55% female, and 2% did not specify. When

asked to define their sexuality, 85% of the sample said that they were '100%

heterosexual', 7% said 'mostly heterosexual', 5% identified as 'bisexual', 1% were

'mostly homosexual', 1% were 'homosexual', 2% were 'asexual'. One precent did not

specify their sexuality. Participants were also asked if they worried about their

sexuality (Garisch & Wilson, 2010). Eighty-five percent responded that they did not

worry, 11% said that they 'sometimes' worried about their sexuality, 1% reported

that they 'often' worried about their sexuality, and 3% said that they would rather

not say, with 1% not responding at all.

Of the 343 participants who identified Māori as one of their ethnicities in the

sample, 82% indicated Māori ancestry ('Are any of your parents, grandparents or

great-grandparents Māori?') while 12% did not report Māori ancestry (5% did not

respond). Also, a chi-squared test was conducted to assess whether there was any

significant difference in the likelihood of having, not having, or not knowing if they

had Māori ancestry depending on their identification. No significant difference was

found (χ^2(1, n = 343) = 4.31, p = 0.12). Table 2 presents the percentages of those

who reported Māori ancestry from each group (primary ethnicity as Māori vs 'other' ethnicity as Māori).

Table 2.
Percentages (and *n*) of those who reported Māori ancestry from each group.

	Yes	No	I don't know
Primary ethnicity Māori	80.1 (109)	15.4 (21)	2.9 (4)
Māori as an 'other' ethnicity	83.6 (173)	9.2 (19)	5.8 (12)

Identity as Māori

On our measure of Māori identity using the two MMM-ICE subscales of Group Membership Evaluation and Cultural Efficacy and Active Identity Engagement, *rangatahi* in this sample (n = 272) reported a mean score across all items of 4.92 (*SD* = 1.01) with a range of 1 to 7. For the Group Membership Evaluation subscale, the average score was 5.3 (*SD* = 1.16), the lowest score of 1.88 and highest a maximum possible score of 7.00. Twenty-five of the *rangatahi* in this sample scored the maximum of 7 on this subscale, indicating a very strong identity as Māori on this subscale. For the Cultural Efficacy and Active Identity Engagement subscale, the mean score was 4.54 (*SD* = 1.12), with the lowest score being 1.40 and seven *rangatahi* achieving a maximum mean score of 7.00.

NSSI

All *rangatahi* in the sample were asked to indicate whether or not they had had thoughts of about hurting themselves on purpose (but not actually done this), whether they had hurt themselves on purpose (e.g. cut, burnt, scratched or carved their skin), or whether they had never done this. In this sample, 322 *rangatahi* answered this question, with 66% indicating that they had never hurt themselves on

purpose nor had they thought about doing it. Eight percent indicated that they had thought about it but had never done it, and 27% indicated that they had hurt themselves on purpose.

Suicidal thoughts and behaviours

Scores for the SBQ-R for this sample ranged from 1 to 21, with a mean score of 3.40. When asked if they had ever thought about or attempted to kill themselves, 58% said that they had never done this, and 21% said that it was just a passing thought. Some *rangatahi* said that they had had a plan once but didn't try (7%), whereas 5% said that they had had a plan once and really wanted to die. A further 2% said that they had attempted but didn't want to die, 3% said that they had attempted to kill themselves and really wanted to die (6% did not respond to this question). We also asked participants how often in the past year they had thought about killing themselves, and 195 did not respond to this question because they had responded with 'never' when asked if they had thought about or attempted to kill themselves, or had hurt themselves on purpose in the past year. Of those who did respond to this question, 11% said that they had never thought about killing themselves in the past year, 14% said 'rarely (1 time)', 11% said 'sometimes (2 times)', 5% said 'often (3-4 times)', and 3% said that they had thought about killing themselves in the past year 'very often (5+ times)'.

Bullying

Of the *rangatahi* who identified as Māori, 47% indicated they had never been bullied, 19% had been bullied but not in the past 12 months, 25% had been bullied once or twice, 5% were bullied about once a week, 2% had been bullied several times a week, 2% were bullied most days, and 2% did not respond.

We asked those who had been bullied in the past 12 months how bad it was. Of the whole sample, 13% of those who were bullied responded that it was 'not bad', 16% said that it was 'a little bad', 6% said that it was 'pretty bad', 1% said that it was 'really bad', and 1% said that it was 'terrible'.

Summary of results from Study 1A

Study 1A aimed to identify the sample population of *rangatahi* Māori from the larger YWB Study sample. The two groups (*rangatahi* who identified their primary ethnicity as Māori and *rangatahi* who identified another ethnicity as their primary and Māori as another ethnicity) differed significantly only regarding the importance of their ethnic identity, and identity as Māori. The difference in mean scores for the MMM-ICE was to be expected, as the selection of a primary ethnicity as Māori is thought to be a crude means of measuring the strength of identity as Māori. That the two groups also differed on the importance of their ethnic identity tells us that there are differences in the importance of one's ethnicity between those who identify primarily as Māori and those who identify primarily as another ethnicity.

Once the sample population of *rangatahi* Māori had been determined, my goal was then to obtain a description of the sample as a whole on variables of interest to this research. The results indicate that this sample is diverse in several ways which reflect the diverse experiences of being Māori today. That 12% of those who selected Māori as their ethnicity did not also identify ancestry as Māori is consistent with our experience in conducting the quantitative data collection for this thesis, where *rangatahi* who did not have Māori ancestry wanted to participate in a

research process that was consistent with *tikanga* Māori (see also Chapter 8 for a qualitative analysis of self-injury in *rangatahi* Māori).

A primary goal of this research is to establish initial prevalence rates of NSSI among *rangatahi* Māori. In this sample, 27% had self-injured (which equates to 87 *rangatahi*), with 8% having thought about it (but never engaged in this behaviour). This confirms self-injury as a significant issue that is relevant to *rangatahi* Māori and whānau in Aotearoa. Also, that 58% of *rangatahi* Māori had never considered or attempted suicide, leaves 36% or 166 who had either thought about taking their own life or had attempted (6% did not respond). With regards to bullying, 53% of this sample of *rangatahi* Māori had experienced bullying at some point, with 34% of these *rangatahi* Māori being bullied at least once in the past 12 months. Six of the *rangatahi* Māori in this sample were bullied most days.

In this study, I have been deliberate in not drawing comparisons between the rates of self-injury, suicidal thoughts and behaviours, and bullying reported here, and the current statistics on the general population or other ethnicities in Aotearoa. That 87 *rangatahi* Māori in our sample self-injure, 36% had thought about or attempted suicide, and six *rangatahi* Māori experience bullying almost every day is of concern in its own right, regardless of any comparisons between these rates and other populations. These statistics highlight the need for action in supporting *rangatahi* Māori in Aotearoa, which will be discussed further later in this chapter and the overall thesis conclusions.

STUDY 1B: DESCRIPTIVE INFORMATION ON RANGATAHI WHO SELF-INJURE

Overview

Now that the sample has been established and descriptive data obtained, I now move to focus on the *rangatahi* Māori who have self-injured.

Study 1B aims to describe in more depth the sample of *rangatahi* Māori who reported having engaged in self-injury. Because of the paucity of research that investigates how *rangatahi* Māori define and experience self-injury, obtaining simple descriptive statistics on the sample is useful as a start. Therefore, the research question for study 1B is simply 'Who are the *rangatahi* Māori who self-injure?' The reports of prevalence across gender within Aotearoa, and internationally, is inconsistent. Some research reports that more females than males engage in self-injury (Muehlenkamp et al., 2008; Whitlock et al., 2006; see Chapter 4 for a more detailed discussion). The typical age of onset is reported as between 12 and 14 years (Jacobson & Gould, 2007; Klonsky & Muehlenkamp, 2007; Nock et al., 2006).

I predicted that *rangatahi* Māori who self-injure would also have higher mean scores for the SBQ-R, as well as higher levels depression and anxiety than *rangatahi* Māori with no self-injury history, and this sample would also have lower scores for emotion regulation than the overall sample. I was also interested in any differences by gender for core variables.

Participants

In Study 1A, Part 2, 87 *rangatahi* Māori reported having engaged in self-injury. The results of Study 1B pertain only to these 87 *rangatahi* Māori.

Results

Eighty-seven *rangatahi* Māori reported having engaged in self-injurious behaviours (22 male, 65 female). The overall mean age for this sample was 15.33 years ($SD = 1.23$). The mean age for males was 15.68 ($SD = 0.09$) and for females was 15.22 ($SD = 1.26$). Table 3 presents the frequency of self-injury among this group, and by gender. It shows that a higher proportion of males are more likely than females to engage in self-injury only once, whereas a higher number of females have engaged in self-injury a few times (82% of females as opposed to 60% of males).

Table 3.
Percentages (and *n*) of *rangatahi* Māori who have engaged in NSSI only once, more than once and many times, by gender.

	Never	Once	A few times	Many times
Male	9 (2)	32 (7)	60 (13)	0
Female	5 (3)	14 (9)	82 (53)	0
Total	6 (5)	18 (16)	76 (66)	0

Table 4 presents the data on the total number of *rangatahi* Māori who had self-injured, by gender as a proportion of the total sample. A chi-squared test indicated that the females in this sample of *rangatahi* Māori hurt themselves disproportionately more than chance, compared to the males in this sample, χ^2 (1, n = 343) = 17.32, p < 0.001. Of the total number of females in this sample (189), 35% had self-injured, whereas of the males in this sample (151), 15% had self-injured.

Table 4.

Total numbers of *rangatahi* Māori who had self-injured, by gender.

	Total n	Number who had self-injured
Male	151	22
Female	189	65
Total	343	87

When asked how many times that they had hurt themselves seriously enough to require medical attention or time in the hospital, overall 67.8% said that they had never hurt themselves seriously enough to require medical attention or time in the hospital, with 59% of males and 70% of females. The number of *rangatahi* Māori who had hurt themselves once seriously enough to require treatment was 13.8%; 9.2% said they had done so a few times, and 1.1% said they had seriously hurt themselves many times. The mean age of onset of NSSI was 12.17 years for males (SD = 2.71) and for females it was 13.47 (SD = 1.13). Note that only 21 *rangatahi* Māori completed this question (15 female, six male).

We asked *rangatahi* Māori when their most recent episode of self-injury was, and 17.2% reported having self-injured within the past week, 16.1% within the last month, 13.8% within the last year, and 12.6% more than a year ago. When asked how much they would like to stop self-injuring, all *rangatahi* Māori said that they wanted to stop to some extent (no one reported that they did not want to stop); 9.2% reported that they would very much like to stop, 13.8% said 'somewhat', 37.9% reported that they had stopped.

We were also interested in the networks of *rangatahi* Māori who self-injured, precisely whether or not others knew that they self-injured, and how many others (if any) they knew who self-injured. Understanding the networks of *rangatahi* Māori

164

who self-injured and whether others were aware that they self-injured is essential information with regards to understanding help-seeking. I was curious to understand whether most *rangatahi* Māori keep it to themselves, or whether there were some who had told others, and who these others were.

Of the sample of *rangatahi* Māori who had self-injured, 86% knew someone else who hurt themselves on purpose (86% of females and 86% of males). When asked how many people they knew who hurt themselves, most *rangatahi* Māori knew between five and nine others (30%, with 27% specifying 'a few' or many'). An additional 26% knew between one and four others who self-injured. When asked whether any of their whānau knew that they self-injured, 35.6% of the total sample responded 'not at all' (46% of males, 32.3% of females). Some *rangatahi* Māori (10.3%) reported that their whānau did not know but suspected that they were self-injuring, and 16.1% said yes, their whānau knew that they self-injured. When asked whether or not any of their friends knew that they self-injured, 11.5% said no, none of their friends knew, 3.4% said that they did not know but suspected, and 19.5% said yes, their friends did know that they self-injured.

Summary of results of Study 1B

In this sample, a disproportionately more significant number of females hurt themselves than males, at 35% (as opposed to 15% for males). Most of these *rangatahi* Māori had hurt themselves a few times, with 24.1% having hurt themselves requiring medical attention at least once. The mean age for *rangatahi* Māori in this sample who self-injure is 15 years, corresponding with beginning NCEA, puberty, transitions to adolescence, and emergence into adulthood. Males in

this sample seemed to start almost one year earlier than females (age of onset for males = 12.7 and 13.47 for females).

When asked whether they would like to stop hurting themselves, all these *rangatahi* Māori said that they would like to stop either somewhat (13.8%) or very much so (9.2%). In this sample, 85% of *rangatahi* Māori knew someone else who had self-injured, which has implications for how *rangatahi* Māori begin and maintain their self-injurious behaviour.

STUDY 1C: THE FORMS AND FUNCTIONS OF SELF-INJURY FOR RANGATAHI MĀORI

Overview

In Study 1C the goal was to understand what self-injury looked like for the *rangatahi* Māori in my sample, precisely what are the common forms of self-injurious behaviours that *rangatahi* Māori engage in, by gender. I also wanted to know, empirically, what the common functions of self-injury are for *rangatahi* Māori. It is well established in the literature on self-injury internationally (Najmi et al., 2007; Nock & Mendes, 2008), and within Aotearoa (Brown, 2015; Garisch, 2010; Langlands, 2012), that the regulation of emotional experiences is the primary function that self-injury serves. Consistent with this past literature, it was expected that this would also be the case for *rangatahi* Māori, with cutting anticipated to be the most prevalent form of self-injury. This study used the DSHI-S responses to ascertain overall self-injury scores and a breakdown of the forms of self-injury. The ISAS provided a measure of the functions of self-injury, and these are presented as subscales for each function, as well as a two-factor variable of inter- and intra-personal functions.

166

Results

Table 5 presents the order of self-injurious behaviours by group. Cutting was the most common form of self-injury for both males and females, with scratching the second most common for both genders. The third most common form of self-injury for males was punching or banging oneself to cause bruising, whereas for females it was carving words, pictures or designs into the skin. Some *rangatahi* Māori specified other behaviours that they considered to be self-injury, and these included one male who described not breathing as a form of self-injury, also one male specified overdosing as self-injury. One female described "emotional" self-injury and explained this as "made myself think bad things about myself", and another described how when she was younger she would strangle herself.

167

Table 5.

Prevalence rates and gender differences across types of NSSI behaviour for *rangatahi* Māori.

Type of NSSI	Group	Never thought about it (%)	Thought about it (%)	Done it once (%)	Done a few times (%)	Done many times (%)	Ever engaged in (%)
	Total	5.7	6.9	18.4	37.9	27.6	83.9
Cut	Male	14.3	19.0	23.8	38.1	4.8	66.7
	Female	3.2	3.2	17.5	39.7	36.5	93.7
Burned with a	Total	57.5	12.6	9.2	12.6	0	21.8
cigarette/lighter/	Male	73.7	5.3	5.3	15.8	0	21.1
matches	Female	59	16.4	11.5	13.1	0	24.6
Carved	Total	46.0	8.0	21.8	16.1	2.3	40.2
words/pictures/	Male	60.0	5.0	20.0	15.0	0	35
designs	Female	45.2	9.7	24.2	17.7	3.2	45.1
Scratched skin until	Total	34.5	5.7	19.5	23.0	11.5	54
bled/scarred	Male	50.0	5.0	30.0	15.0	0	45
	Female	32.3	6.5	17.7	27.4	16.1	61.2
Bitten until skin is	Total	70.1	5.7	8.0	9.2	1.1	10.3
broken	Male	80.0	0	10.0	10.0	0	20
	Female	72.6	8.1	8.7	9.7	1.6	20
Rubbed sandpaper	Total	88.5	2.3	2.3	1.1	0	3.4
on the skin	Male	85.0	0	10.0	5.0	0	15
	Female	96.8	3.2	0	0	0	0
Dripped acid on the	Total	89.7	3.4	1.1	0	0	1.1
skin	Male	90.9	0	0	0	0	0
	Female	935.	4.8	1.6	0	0	1.6

Table 5 (continued).

Prevalence rates and gender differences across types of NSSI behaviour for *rangatahi* Māori.

Type of NSSI	Group	Never thought about it (%)	Thought about it (%)	Done it once (%)	Done a few times (%)	Done many times (%)	Ever engaged in (%)
Used bleach/oven cleaner to scrub skin	Total	89.7	2.3	1.1	1.1	0	2.2
	Male	90.0	5.0	0	5.0	0	5
	Female	96.8	1.6	1.6	0	0	1.6
Stuck sharp objects into skin (e.g. needles, pins, staples)	Total	62.1	5.7	8.0	16.1	2.3	26.4
	Male	60.0	0	15.0	25.0	0	40
	Female	67.7	8.1	6.5	14.5	3.2	24.2
Rubbed glass into skin	Total	77.0	4.6	5.7	4.6	2.3	12.6
	Male	85.0	5.0	5.0	5.0	0	10
	Female	80.6	4.8	6.5	4.8	3.2	14.5
Broken bones	Total	82.8	5.7	4.6	0	1.2	4.6
	Male	80.0	5.0	15.0	0	0	15
	Female	90.3	6.5	1.6	0	1.6	3.2
Punched yourself/banged your head to cause bruising	Total	54.0	9.2	13.8	13.8	3.4	31
	Male	50.0	10.0	5.0	25.0	10.0	40
	Female	59.7	9.7	17.7	11.3	1.6	30.6
Prevented wounds healing	Total	62.1	5.7	6.9	11.5	6.9	25.3
	Male	65.0	10.0	15.0	10.0	0	15
	Female	67.2	4.9	4.9	13.1	9.8	27.8

Intra vs Interpersonal Functions
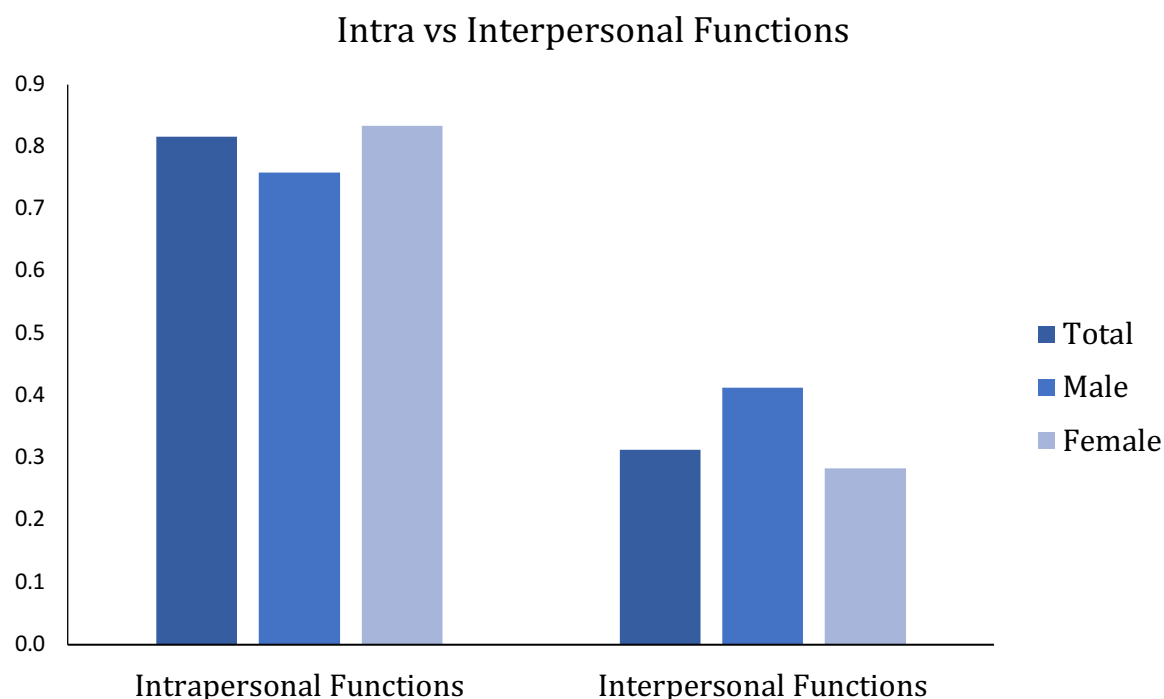
Figure 3. Functions of self-injury categorised as inter- and intra-personal, by gender.

Figure 3 shows the mean scores for functions when aggregated into intrapersonal and interpersonal functions respectively. A repeated measures ANOVA was conducted with interpersonal functions and intrapersonal functions were entered as within-subjects variables, and gender was used as a between-subjects variable. There was an interaction between the type of function (interpersonal vs intrapersonal) and gender, Wilks' Lambda = 0.63, $F(1, 98) = 57.88$, p < 0.001, multivariate partial eta squared = 0.37. It shows that, overall, *rangatahi* Māori participants tend to nominate intrapersonal functions more than interpersonal functions, regardless of gender. There was also no overall difference between males and females, $F(1, 98) = 0.31$, p = 0.29, partial eta squared = 0.01. The interaction, however, indicates that scores on interpersonal vs intrapersonal depend on gender, such that males tend to endorse interpersonal functions more than females, while females tend to endorse intrapersonal

more than males, Wilks' Lambda = 0.95, $F(1, 98) = 5.30$, p < 0.05, partial eta squared = 0.05.
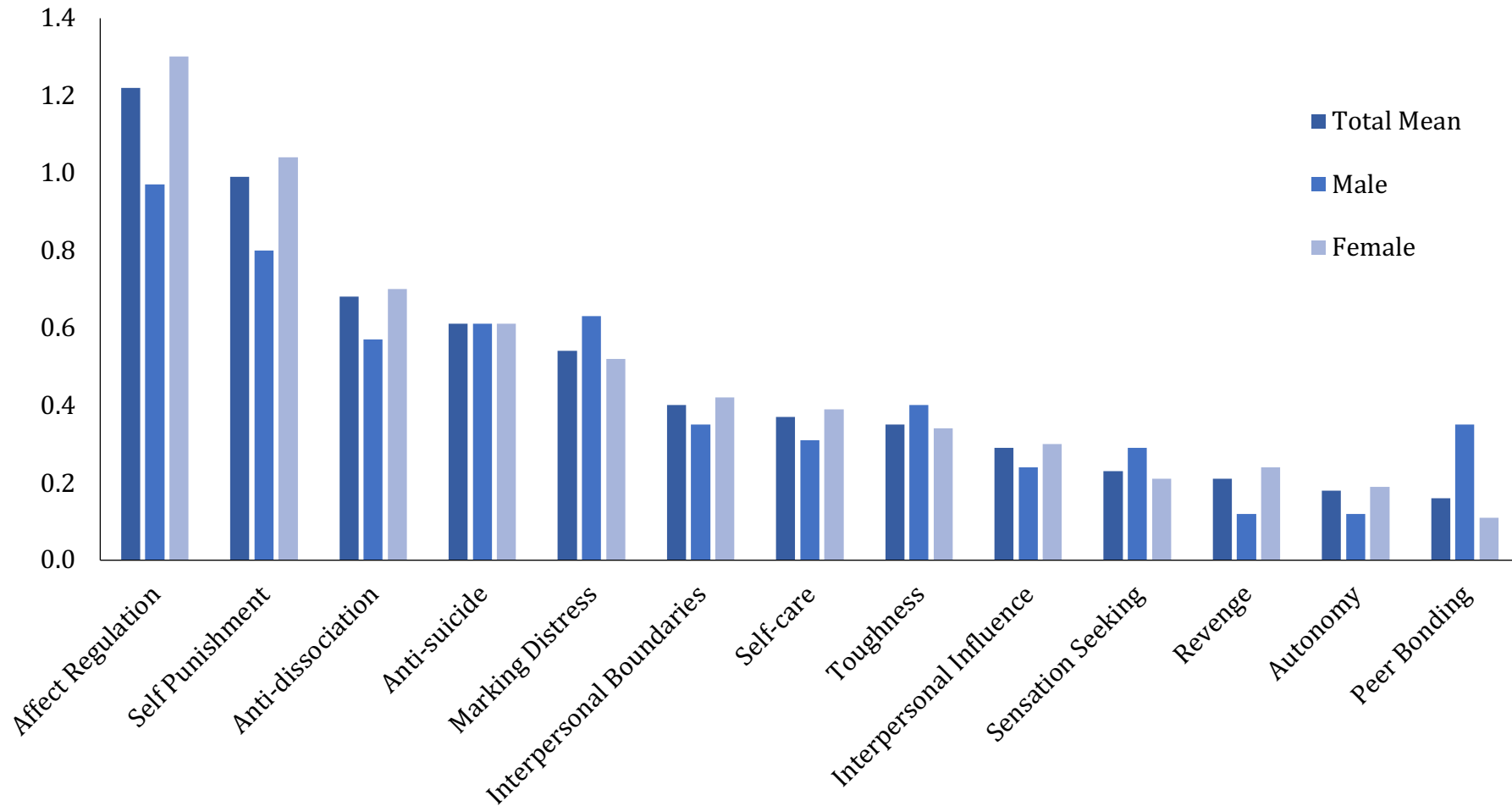
Figure 4. Reasons for (functions of) NSSI for total sample and by gender (ISAS mean score for each function subscale).

Figure 4 presents the mean scores for the functions assessed by the ISAS for the sample of self-injurious *rangatahi* Māori as a whole and broken down by gender. A repeated measures ANOVA was conducted with the individual subscale scores as the within-subjects variable and gender as the between-subjects variable. There was a significant multivariance effect for the subscales, indicating that participants endorsed some subscales more than others, Pillai's Trace = 0.60, $F(12, 81) = 10.16$, p < 0.001. This is consistent with the results presented in figure 3 above, whereby intrapersonal subscales are endorsed more than interpersonal.

Secondly, there was no main effect for gender, regardless of subscale, $F(1, 92) = 2.56$, p = 0.11. There was also no significant interaction between subscale and gender, Wilks' Lambda = 0.40, $F(12, 81) = 1.09$, p= 0.38. This indicates that at the subscale level, while there may be one or two subscales where males and females differ, there is no overall multivariate difference when you consider the number of subscales. The most common function for those who self-injured was affect regulation for both males and females, with self-punishment the second most common for both groups. Table 6 presents the means and standard deviations for the values in figures 3 and 4.

Table 6.

ISAS Function subscale and scale scores by gender for the sample as a whole.

	Female	Male	Total
	M (SD)	*M (SD)*	*M (SD)*
Grouped Intrapersonal Functions	0.83 (0.45)	0.76 (0.58)	0.82 (0.48)
Affect regulation	1.30 (0.56)	0.97 (0.71)	1.22 (0.61)
Interpersonal boundaries	0.42 (0.54)	0.35 (0.50)	0.40 (0.53)
Self-punishment	1.04 (0.69)	0.80 (0.60)	0.99 (0.68)
Self-care	0.39 (0.43)	0.31 (0.45)	0.37 (0.43)
Anti-dissociation	0.70 (0.65)	0.57 (0.65)	0.68 (0.65)
Anti-suicide	0.61 (0.65)	0.61 (0.77)	0.61 (0.68)
Sensation seeking	0.21 (0.39)	0.29 (0.50)	0.23 (0.41)
Grouped Interpersonal Functions	0.29 (0.33)	0.41 (0.57)	0.31 (0.40)
Peer bonding	0.11 (0.32)	0.35 (0.62)	0.16 (0.42)
Interpersonal influence	0.30 (0.49)	0.24(0.33)	0.29 (0.45)
Toughness	0.34 (0.54)	0.40 (0.45)	0.35 (0.52)
Marking distress	0.52 (0.67)	0.63 (0.69)	0.54 (0.67)
Revenge	0.24 (0.50)	0.12 (0.23)	0.21 (0.50)
Autonomy	0.19 (0.44)	0.12 (0.23)	0.18 (0.41)

Summary of results of Study 1C

This study investigated the nature and functions of self-injury in *rangatahi* who identify as Māori, using both the DSHI-S and ISAS measures. Consistent with the literature, the most common form of self-injury for both males and females is cutting, and the most common function of self-injury for both males and females is to regulate

emotions. When the functions are grouped into interpersonal and intrapersonal, both males and females reported greater intrapersonal functions than interpersonal functions.

Now that we have established the forms and functions of self-injury among this sample of *rangatahi* Māori, in Study 1D I will investigate what some of the correlates and predictors of self-injury are for *rangatahi* Māori.

STUDY 1D: CORRELATES OF SELF-INJURY FOR RANGATAHI MĀORI
Overview

Study 1D aims to understand how *rangatahi* Māori who have hurt themselves perform in comparison with those who do not self-injure with regards to emotion regulation, depression, anxiety, suicidal thoughts and behaviours, and bullying experience.

Part D aimed to understand what potentially leads *rangatahi* Māori to self-injure, thinking specifically about the relevance of the EA Model (Chapman et al., 2006). First, I investigated how *rangatahi* Māori who self-injure compare with those who have thought about it and never done it on core psychological variables. If the EA Model is a valid means of understanding self-injury among Māori, I expected that *rangatahi* Māori who self-injure would have the lowest mean scores for emotion regulation, and highest mean scores for depression, anxiety, and suicidal thoughts and behaviours.

For part 2 of study 1D, I correlated self-injury scores (DSHI-S Scores) with core psychological variables. In part 3 of study 1D, I investigated what psychological variables predict different functions by correlating the functions (as assessed using the

subscales of the ISAS) with these core psychological variables. I also correlated these variables with the interpersonal and intrapersonal function groupings.

Results

Study 1D, Part 1

In part 1 I investigated the differences between those who had self-injured, those who had thought about it but not self-injured, and those who had never self-injured on core psychological variables. Of the 343 participants who identified as Māori in some way, 301 completed all measures necessary for this set of analyses. A one-way between groups multivariate analysis of variance was conducted to compare the mean scores of each group on measures of the importance of ethnicity, bullying, suicidal ideation and behaviours, emotion regulation, depression, and anxiety. There was a statistically significant multivariate difference between the three groups, F(10, 590) = 16.74, p = < 0.001; Wilks' Lambda = 0.61; partial eta squared = 0.22). Univariate tests indicate that the group of *rangatahi* Māori who had self-injured differed significantly from either those who had never self-injured or who had only thought about it for all variables. This group (those who had self-injured) reported higher scores for suicidal thoughts and behaviours, the frequency of bullying victimisation, anxiety and depression than either those who had never self-injured or had only thought about it. Those who had self-injured also reported lower levels of attachment to parents and peers and lower scores for emotion regulation. These results are presented in table 7, with the mean scores for each group.

Table 7.
Inspection of mean scores for key psychological variables.

Dependent Variables	Bonferonni adjusted alpha level	F	Partial eta squared	No Never NSSI (n = 197)		Thought About It (n = 23)		NSSI Yes (n = 82)	
				M	SD	M	SD	M	SD
Frequency of bullying victimisation	0.11	19.06	0.11	1.76[abc]	0.08	2.40[ac]	0.23	2.61[b]	0.12
SBQ score	0.34	79.21	0.35	2.22[abc]	0.25	5.30[acd]	0.73	7.97[bd]	0.39
ERICA Average	0.10	17.98	0.11	3.73[a]	0.03	3.61	0.10	3.36[a]	0.05
Depression	0.18	34.39	0.19	0.47[ab]	0.04	0.92[a]	0.13	1.13[b]	0.07
Anxiety	0.18	33.82	0.19	0.35[ac]	0.04	0.62[bd]	0.11	0.94[abcd]	0.06
Attachment to Parents	0.15	26.66	0.15	3.61[a]	0.76	3.45[b]	0.69	2.89[ab]	0.77
Attachment to Peers	0.02	4.65	0.03	3.60[a]	0.71	3.46	0.72	3.32[a]	0.70

Note: Means with a superscript a, b, or c differ significantly from each other. SBQ: Suicidal Behaviours Questionnaire; ERICA average: Emotion Regulation Index for Children and Adolescents.

Study 1D, Part 2

In part 2 I correlated DSHI-S scores with predictor variables depression, anxiety, emotion regulation, bullying and suicidal behaviours to investigate what psychological variables predict self-injury. Table 8 presents the Pearson's correlations (r) for these calculations. This shows the extent to which these variables predict DSHI-S scores both for *rangatahi* Māori who hurt themselves and for all *rangatahi* Māori. Note that all variables are significantly correlated DSHI-S scores for both groups, except for depression, which is only correlated with DSHI-S scores for the whole sample. The SBQ had a moderate correlation for the whole sample but a relatively weak correlation with self-injury for those who had self-injured. In addition, attachment to both parents and peers were both significantly negatively correlated for the whole sample, but were not significantly correlated with self-injury for those who had self-injured.

Table 8.

Correlations of DSHI-S scores with predictor variables.

	DASS Depression	DASS Anxiety	ERICA Average	Bullied ever	SBQ total	Attachment to Parents	Attachment to Peers
History of self-injury[a]	0.17	0.30**	-0.34**	0.34**	0.26*	-0.21	0.04

* $p < 0.05$, ** $p < 0.01$. Note: Superscript a means all Ns were between 83 and 87.

Study 1D, Part 3

In part 3, I investigated how functions scores relate to the key predictor variables of depression, anxiety, emotion regulation, bullying and suicidal thoughts and behaviours to look at what psychological variables predict different NSSI functions. I also correlated these psychological variables with the interpersonal and intrapersonal function groupings. Table 9 presents these findings for the grouped intrapersonal functions, and table 10 presents the findings for the grouped interpersonal functions. Note that the ERICA scale measures positive emotional regulation.

Affect regulation was found to be significantly correlated with anxiety and bullying at the 0.01 significance level, and with depression at the 0.05 level of significance. It was negatively correlated with ERICA at the 0.01 level of significance. Self-punishment was significantly correlated with depression and bullying at the 0.01 level of significance. Anti-dissociation was significantly correlated with depression, anxiety, bullying and the SBQ at the 0.01 level of significance, and it was negatively correlated with the ERICA scores at the 0.01 level. Intrapersonal functions scores were correlated with the scores for five of the psychological variables (except for attachment to parents and peers) at the 0.01 level of significance, with all correlations positive except for the ERICA, which was negatively correlated (as to be expected). Only the ERICA scores were significantly correlated (-0.37) with interpersonal function scores (p < 0.01).

This study also found that self-esteem is correlated not only with self-punishment, but self-esteem is correlated fairly strongly with DSHI score overall. SBQ and bullying are the only two that are correlated with marking distress. Attachment to parents and peers was not significantly correlated with any function or subscale, and

depression was significantly correlated with all intrapersonal subscales but with no

interpersonal items.

Table 9.

Correlations of ISAS intrapersonal function subscales and intrapersonal function groups with key psychological predictor variables.

	Depression	Anxiety	ERICA	Frequency of bullying victimisation	SBQ	Attachment to parents	Attachment to peers
Grouped Intrapersonal functions	0.41**	0.32**	-0.41**	0.50**	0.41**	-0.17	-0.08
Affect regulation	0.27*	0.36**	-0.34**	0.30**	0.12	-0.22	-0.21
Interpersonal boundaries	0.24*	0.20	-0.33**	0.12	0.30*	-0.16	0.02
Self-punishment	0.50**	0.18	-0.18	0.34**	0.13	-0.10	-0.11
Self-care	0.30**	0.17	-0.23*	0.25*	0.31**	-0.01	0.05
Anti-dissociation	0.37**	0.34**	-0.32**	0.30**	0.40**	-0.10	-0.05
Anti-suicide	0.30**	0.30**	-0.40**	0.40**	0.54**	-0.18	0.05

Note: * p < 0.05, ** p < 0.01, all Ns between 78 and 87. NSSI: History of self-injury; SBQ: Suicidal Behaviours Questionnaire; ERICA: Emotion Regulation Index for Children and Adolescents.

Table 10.

Correlations of ISAS interpersonal function subscales and interpersonal function groups with key psychological predictor variables.

	Depression	Anxiety	ERICA	Frequency of bullying victimisation	SBQ	Attachment to parents	Attachment to peers
Grouped Interpersonal functions	0.18	0.08	-0.37**	0.06	0.14	-0.10	-0.02
Sensation seeking	0.13	0.03	-0.21	0.18	0.38**	-0.17	0.03
Peer bonding	0.05	0.05	-0.22	0.01	-0.02	-0.02	-0.04
Interpersonal influence	0.21	-0.03	-0.03	0.22	0.19	-0.13	0.06
Toughness	0.15	0.01	-0.25*	0.18	0.24*	-0.15	-0.11
Marking distress	0.21	0.03	-0.16	0.39**	0.29**	-0.05	0.01
Revenge	0.17	0.06	-0.21	0.13	-0.01	-0.16	-0.19

Note: * p < 0.05, ** p < 0.01, all Ns between 78 and 87. NSSI: History of self-injury; SBQ: Suicidal Behaviours Questionnaire; ERICA: Emotion Regulation Index for Children and Adolescents.

To test the EA Model for *rangatahi* Māori, I also investigated the mean scores for each of the core psychological variables between different experiences of bullying. Table 11 presents these findings. Note that, overall, the mean scores increase as a function of frequency of bullying for all variables except for emotion regulation between having never been bullied, bullied in the last two months, those bullied once or twice in the last two months and about once a week. The decrease in scores for each variable for those who are bullied often reflect the low sample size for that group in that only ten *rangatahi* Māori fall into this category. Table 11 shows that the mean scores for the anxiety and SBQ scales increase with increased frequency of bullying. Further, attachment to parents and peers both decrease with increased frequency of bullying victimisation.

Table 11.

Inspection of mean scores for the different experiences of bullying on core variables.

Dependent Variables	Never bullied (n = 146) M (SD)	Not in last two months (n = 62) M (SD)	Once or twice (n = 82) M (SD)	About once a week (n = 15) M (SD)	Bullied often (several times a week or most days) (n = 10) M (SD)
Depression	0.46 (0.51)[abc]	0.69 (0.64)[d]	0.83 (0.76)[af]	1.17 (0.59)[be]	1.63 (1.20)[cdef]
Anxiety	0.34 (0.38)[abc]	0.53 (0.60)[d]	0.73 (0.71)[a]	0.81 (0.72)[b]	1.16 (0.95)[cd]
SBQ	2.25 (2.49)[abc]	3.57 (0.40)[de]	5.95 (4.66)[adf]	6.20 (4.52)[bg]	11.30 (7.25)[cefg]
NSSI	0.30 (0.70)[ab]	0.64 (0.88)[c]	0.98 (0.94)[a]	1.40 (0.91)[bc]	0.80 (1.03)
ERICA	3.74 (0.49)[ab]	3.60 (0.42)[cd]	3.58 (0.49)	3.22 (0.42)[ac]	3.18 (0.65)[bd]
Attachment to parents	3.55 (0.77)[ab]	3.49 (0.85)[c]	3.23 (0.83)[a]	3.17 (0.60)	2.62 (0.10)[bc]
Attachment to peers	3.64 (0.65)	3.45 (0.66)	3.43 (0.77)	3.34 (0.81)	3.04 (1.08)

Note: Means with superscript a, b, c, d, e, f and g differ significantly from each other.

SBQ: Suicidal Behaviours Questionnaire; NSSI: History of self-injury; ERICA average: Emotion Regulation Index for Children and Adolescents.

Table 12.

Statistical information for Table 11 (Inspection of mean scores for the different experiences of bullying on three key variables).

Dependent Variables	Bonferroni adjusted alpha level	df	F	Partial eta squared
Depression	0.13	5, 300	10.23	0.15
Anxiety	0.11	5, 300	8.42	0.13
SBQ	0.23	5, 300	19.28	0.25
NSSI	0.13	5, 300	9.76	0.14
ERICA	0.07	5, 300	5.58	0.09
Attachment to parents	0.05	5, 300	4.28	0.07
Attachment to peers	0.02	5, 300	2.38	0.04

Note: SBQ: Suicidal Behaviours Questionnaire; NSSI: History of self-injury; ERICA average: Emotion Regulation Index for Children and Adolescents.

Summary of results of Study 1D

On all psychological variables that were analysed, those who had never self-injured differed significantly from those who had self-injured. The results from Study 1D, part 1 found that those who had never self-injured had the lowest mean scores on measures of suicidal thoughts and behaviours, depression, anxiety, and history of being bullied. This group also indicated greater self-reported abilities to regulate their emotions, as well as stronger attachment to both parents and peers. Those who had self-injured had the lowest scores on the ERICA, suggesting potential deficits in emotion regulation. The mean scores for the group who had thought about self-injury but had never done it sat in between the other two groups on all of the measures.

For Part 2 of study 1D, I correlated DSHI-S scores with core variables for both the sample as a whole (n = 343) and solely those who had self-injured (n = 87). Scores for the DSHI-S were correlated with the mean scores for all variables in the sample as a whole but were not significantly correlated with depression and attachment to parents and peers for those who had a history of self-injury. For both the sample as a whole and solely those who had self-injured, their DSHI-S score is likely to be higher when they are more anxious, experience more bullying, have more suicidal thoughts and behaviours, or if they have lower levels of emotion regulation. However, because depression is significantly correlated with DSHI-S scores only for the sample as a whole, with the higher levels of depression someone has, they are also likely to have a higher DSHI-S score, unless they have a history of self-injury.

In part 3 the scores for each of the function subscales of the ISAS and the two-factor inter- and intrapersonal subscales of the ISAS were correlated with the measures of depression, anxiety, suicidal thoughts and behaviours, bullying and the ERICA, as well

as attachment to parents and peers. Affect regulation, self-punishment and anti-dissociation had been previously found to be the three functions most commonly endorsed by *rangatahi* Māori in this sample (Study 1C). In Study 1D part 3 the results between the subscales and the variables assessed are consistent with what is to be expected. For example, depression is significantly correlated with all intrapersonal functions of self-injury. The psychological variables overall were correlated with more intrapersonal than interpersonal functions, adding further weight to the argument that self-injury functions as a predominantly intrapersonal behaviour.

I also compared the frequency of bullying victimisation with the mean scores for key dependent variables. These results were limited by the relatively few participants who had often been bullied (n = 10). However, they still highlight an important relationship between the frequency of bullying and psychological variables between those who never experience bullying and those who are bullied about once a week. Depression, anxiety, self-injury and suicidal thoughts and behaviours all increase the more frequently *rangatahi* Māori experience bullying. Also, the more frequently *rangatahi* Māori are bullied, the lower their ability to regulate their emotions and the lesser their attachment to parents and peers.

DISCUSSION OF STUDY 1

Study 1 was designed to establish the prevalence of NSSI quantitatively and correlates of NSSI in my sample of *rangatahi* Māori using quantitative analysis of survey data from a large group of *rangatahi*. Cross-sectional data from the YWB Study was used to confirm anecdotal evidence that *rangatahi* Māori engaged in self-injurious behaviours. Study 1 confirmed that NSSI is an issue for *rangatahi* Māori and that

rangatahi Māori also experience other significant mental health issues, such as depression, anxiety, and suicidal thoughts and behaviours.

Identity as Māori

Identity and wellbeing are represented as interrelated in models of wellbeing such as Te Paiheretia (Durie, 2003). Muriwai and colleagues (2015) suggest a 'culture as cure' approach whereby culture functions as a protective cure for those who experience psychological distress. In earlier chapters, I also highlighted how historical factors within *te ao Māori*, such as colonisation, could impact on how *rangatahi* Māori may define themselves (Rata, 2012). This is one explanation for the diversity of Māori identities in Aotearoa today. The cultural diversity within my sample of *rangatahi* Māori reflects that of the broader population of Māori in Aotearoa, as provided by official government organisations, such as Statistics New Zealand's 'Te Kupenga' survey (Statistics New Zealand, 2013).

This research has found that while 442 participants reported having Māori parents, grandparents or great-grandparents, only 343 identified as Māori. Further, of this 343, only 106 selected Māori as their primary ethnicity. To further complicate the results, almost one quarter (24.6%) of the 343 who identified as Māori (primary or 'other') did not have Māori ancestry. These diverse results reflect the complexities of ethnic identity that are debated nationally with regards to ethnic identification and highlight the difficulties in using a single measure of ethnic identity. For example, Kukutai (2009) reports in her research on identity within a sample of *rangatahi* that one in five who had Māori ancestry did not identify as Māori.

In discussing ethnic identity in earlier chapters (see p. 48), I posited that ancestry was the measure of ethnicity most consistent with traditional notions of

whakapapa. Selecting all participants who have Māori ancestry could be deemed to be the most inclusive means of capturing the diversity of Māori identities by including those who do not outwardly identify as Māori. However, I chose to use self-identification as Māori, as this is consistent with national census measurements of ethnicity and reflects the post-colonial diversity in ethnicity, whereby multiple ethnic identities are possible.

In honesty, it saddened me to think that some *rangatahi* who were aware that they had Māori *tūpuna* did not feel connected enough to these *tūpuna* to be able to ethnically identify as Māori, not even as a secondary ethnicity. Perhaps it is more comfortable for *rangatahi* who are not firmly connected to their *whakapapa* to say that yes, they do have Māori ancestry, as opposed to self-identifying. In essence, it is possible that ancestry is a more straightforward way of affiliating that does not require them to put their hand up and say explicitly that they are Māori*.*

The *rangatahi* in this sample who selected Māori as their primary ethnicity were found to have both a stronger identity as Māori and they also indicated that their ethnicity was more important to their identity than those who selected Māori as another identity. For *rangatahi* who primarily identify as Māori, not only is being Māori a more critical part of who they are, but ethnicity, in general, is more important. When the two 'identity groups' (primary vs other) were compared, these two variables (Māori identity and the importance of ethnic identity) were the only two variables that differed significantly between the two groups. That the groups did not differ significantly on measures of emotion regulation, depression, anxiety, suicidal thoughts and behaviours, or attachment to parents and peers indicates that psychological wellbeing is not related to whether or not one identifies primarily as Māori in this sample.

In Chapter 3 I reported literature from Durie (2003), Phinney (1992) and others who assert that insecure identities are linked with poorer mental health outcomes. Comparisons between this literature and the present study are difficult to make because the measures of ethnic identity used in this research do not measure the extent to which one feels secure in their ethnic identity. Therefore, it would be unwise to infer that those who identify Māori only as a secondary ethnicity have insecure ethnic identities. This could be an area for further research.

In reviewing the literature on self-injury, I touched on identity confusion during adolescence. Gandhi et al. (2017) suggest that the peak in prevalence of self-injury in this age group may coincide with identity development and subsequent confusion for some. Further, Gandhi reported that ethnic identity was not found to be a protective factor with regards to self-injury. Future research examining whether this was the case for *rangatahi* Māori would be useful, particularly given earlier research on *Māori* which suggests culture as a cure or protective factor in enhancing wellbeing (Muriwai et al., 2015).

I have avoided drawing comparisons between Māori and non-Māori on psychological measures of wellbeing. The purpose of this has been to avoid conducting deficit research that measures Māori against non-Māori, highlighting disparities and perpetuating an attitude of Māori-centred problem ideologies which disregard the intergenerational and pervasive impacts of colonisation. Issues of poorer health outcomes for Māori are often highlighted, particularly in mainstream media and government policies, by presenting non-Māori statistics as a yardstick for which the Māori population are falling short. While useful to highlight the need to increase resources and focused or targeted interventions, regardless of where the blame is placed for these so-called shortcomings, holding non-Māori as the gold standard to

which Māori need to aspire is a perpetuation of the assimilation strategies that have persisted since colonisation.

In this sample, 27% of *rangatahi* Māori have self-injured, 34% have been bullied in the last 12 months, and 3% have often thought about killing themselves in the past year. The 3% who have thought about killing themselves equates to approximately ten *rangatahi* Māori who have wanted to take their own lives. The 34% who were bullied equates to approximately 116 *rangatahi* Māori who have been victimised in some way by someone else. When each of these *rangatahi* Māori are thought of as someone's son, daughter or *mokopuna* as opposed to a number, percentage or statistic, these rates are significant issues regardless of whether or not they are above or below the national rates.

Characteristics of *rangatahi* who self-injure

As I have mentioned previously, there is a dearth of information on *rangatahi* Māori who self-injure. Therefore, any contributions to this field will be of use in understanding who are the *rangatahi* Māori who self-injure and what their experiences are. In this sample, females were found to hurt themselves disproportionately more than males, but the average age of onset for males was over a year younger than for females (12 years and 13 and a half years respectively). In Aotearoa, at 12 years of age one is typically in Year 8 at school and attending either primary or intermediate level schools. At Year 9, typically 13 years of age, adolescents commence their high-school education. Therefore, the difference in mean age of onset for males and females is significant when considering how to intervene early, before self-injury can be used as a coping strategy. All adolescents need to be educated broadly regarding self-injury, coping and emotion regulation, because males may start self-injuring at intermediate

level whereas females more commonly begin at high school, and any gender-specific targeting, if deemed necessary, would need to consider this.

Forms of self-injury

Cutting and scratching were the most common forms of self-injury for both genders. For males, the third most common was punching or banging, and for females, it was carving words, pictures or designs. When participants were asked to specify other forms of self-injury, participants described behaviours, such as punching trees or walls and strangling oneself, which are behaviours that fit within the definitions of NSSI. However, other behaviours specified, such as not breathing, overdosing, and thinking poorly of yourself, are not behaviours considered to be NSSI. That *rangatahi* deemed these to be self-injurious behaviours despite them not fitting with the definition of NSSI that was given in the survey highlights the need to explore in-depth the definitions of self-injury that *rangatahi* Māori hold whether or not they align with 'official' definitions.

Correlates of self-injury for *rangatahi* Māori

Study 1D identified that those who self-injure also experience higher levels of depression, anxiety and bullying. It is also apparent in this sample that those who do not self-injure may have higher capacity to regulate their emotions. These results are consistent with research that shows self-injury is associated with other psychological difficulties (see Nock et al., 2006; Wilkinson, 2013) and provide weight to the argument for deficits in emotion regulation as a critical factor in whether or not *rangatahi* Māori self-injure.

For both genders, affect regulation was the most commonly endorsed function for both male and female *rangatahi* Māori. Self-punishment was also the second most endorsed function for both. For males, marking distress was the third most common

function, and for females this was anti-dissociation. Overall, both genders endorsed more intrapersonal than interpersonal functions; however, male *rangatahi* Māori are reporting more interpersonal functions than the females. Males may be motivated more by the social and interpersonal functions of self-injury, whereas females do so for more personal reasons. This might have significant implications for how we think of self-injury among *rangatahi* Māori, for example, in relation to perfectionism. Brocklesby's research (2017) found that females who engaged in self-injury did so for reasons related to negative perfectionism and self-punishment, in alignment with the intrapersonal reasons reported in my sample.

Taken together, all of these results highlight self-injury as an issue relevant to *rangatahi* Māori today. In particular, the correlations between self-injury and other mental health problems, such as depression, anxiety and suicidal ideation, suggest that these issues are inter-related and that a targeted approach to just one of these issues will not suffice.

Research by Garisch and Wilson (2015) highlights the further significance of correlates of self-injury (particularly depression and emotion regulation (measured in their research as alexithymia, but is similar) for young people who self-injure. They used the longitudinal data from the YWB Study to investigate factors that predicted self-injury (using cross-lagged panel correlations). They found that greater levels of depression and alexithymia, and lower self-esteem, all predicted engaging in self-injurious behaviours five months later. Self-injury predicted lower levels of mindfulness and resilience five months later. They concluded that depression, alexithymia and low self-esteem are risk factors which can lead young people to self-injure as a coping mechanism, in turn resulting in diminished ability to cope adaptively (low ability to use mindfulness and lower resilience). While this research did not focus solely on *rangatahi*

Māori, it has implications broadly speaking in that it highlights and confirms the stressors that lead to self-injury. These can serve as possible early intervention strategies for self-injury, as well as supporting *rangatahi* Māori who do self-injure to increase resilience through strategies, such as mindfulness and meditation.

Functions for *rangatahi* Māori

Emotion regulation

Multiple sub-studies within Study 1 confirmed emotion regulation as a main correlate of self-injury for *rangatahi* Māori that was endorsed by males and females. This is consistent with Brown (2015), who, in her doctoral research (which also used the first two years of data collected from the YWB Study but on participants from all ethnicities) found that emotion regulation and attachment to parents and peers were possible protective factors when young people experience peer victimisation.

Study 1D indicated that affect regulation was correlated with anxiety and bullying, suggesting that those who self-injure to regulate their internal emotional experiences also experience more significant levels of anxiety and peer victimisation. Also, in this sample of *rangatahi* Māori who self-injure, the three most common functions of self-injury (affect regulation, self-punishment and anti-dissociation) were all correlated with bullying. I have reported elsewhere that bullying is one of the most significant issues that face all *rangatahi* today, and in this research, I have found that the number of *rangatahi* Māori who have experienced bullying is of concern particularly for this relatively small sample size. Bullying may induce emotions in victims that they struggle to cope with. Bullying could also induce a negative sense of self-worth that they feel is worthy of being punished or something else that makes them feel the need to punish themselves. Anti-dissociation could also be considered another means of

195

avoiding emotions, which could lend further support to an experiential avoidance model of self-injury.

Anti-suicide was found to be correlated with all psychological variables (negatively correlated for ERICA, positive correlations for all others). Those who self-injure to manage their suicidal thoughts and behaviours also experience more significant levels of anxiety, depression and bullying, and have lower abilities to regulate their emotions in adaptive ways.

Only the scores for the ERICA were significantly correlated with the interpersonal function subscales, whereas intrapersonal functions were significantly correlated with all variables. These *rangatahi* Māori had a lower ability to regulate emotions and they self-injured more to directly influence others around them.

What is the relationship between bullying and self-injury for rangatahi Māori?

In this sample of *rangatahi* Māori, bullying, self-injury and suicidal ideation were all found to be significant challenges experienced by *rangatahi* Māori. Existing research in Aotearoa tells us that young people who are bullied also experience self-injury (Garisch, 2010), and the EA Model suggests a possible mechanism by which bullying can lead to self-injury. According to this model, bullying acts as a stimulus or interpersonal stressor, and elicits unwanted emotional responses that, if overwhelming, leads an individual to self-injure as a means of avoiding these unwanted, negative emotions (Chapman et al., 2006).

In a meta-analysis of research on self-injury and peer victimisation (Brown, 2015), a relatively mild association (r = 0.17) was found between bullying and self-injury and suicidal ideation. However, in the present research, a stronger association (r = 0.34) was found to occur between for *rangatahi* Māori.

Strengths of this study

Given the a dearth of quantitative research that focuses on self-injury specifically in *rangatahi* Māori, any contributions of new knowledge are useful. This research has the largest sample of *rangatahi* Māori to date and has examined specific correlates of self-injury, without drawing comparisons to the general population of young people who also participated in this research. Regardless of whether or not the prevalence rates of self-injury and other psychological difficulties are found to be higher or lower than non-Māori, by avoiding using non-Māori as the benchmark to which *rangatahi* Māori are compared it signals a progression from historical research that has highlighted that Māori are worse-off in comparison to non-Māori. That *rangatahi* Māori self-injure, experience bullying and suicidal ideation is a significant issue in its own right, and the next steps are to figure out how the experiences of *rangatahi* Māori may be unique and how they can best be supported when they self-injure.

Limitations

While this sample of *rangatahi* Māori is the largest upon which data on self-injury has been collected, it is still relatively small and, therefore, I was limited in some of the statistical analyses that I could run. There were many other correlates and mediations in particular that we found to be of interest. However, because of the small sample size the results were questionable. For example, attachment to peers was found to be a full mediator of the relationship between bullying and self-injury. A result such as this would have significant implications on how *rangatahi* Māori are supported when they are bullied to prevent them from self-injuring, therefore analyses such as this warrant further investigation with a larger sample size.

Consistent with the need to increase sample size for future research with *rangatahi* Māori is the need to oversample for male *rangatahi* Māori. This also holds true for Study 2 and will be discussed further in the discussion for that Study.

It is important to note that the data I am using for my research are cross-sectional. However, they have been collected as part of a longitudinal survey. If any participants who identified as Māori had completed the survey more than once, I have taken their most recent survey responses. Using their most recent survey responses has several implications that are significant. First, the spread of ages is broader than had I taken their first time completing the survey. Also, as the sample of adolescents (not just Māori) get older, the lifetime prevalence of self-injury increases, based on the variable that was used to assess the prevalence of self-injury. Further, adolescence is a time of significant change which may, for some, result in identity confusion (Erikson, 1968). This is important to take into account in considering the cross-sectional nature of data collection, in that the responses of *rangatahi* in later surveys may differ with relation to several variables, such as self-injury, but also other variables that may be correlated with self-injury. For example, the identity progression of *rangatahi* Māori may evolve to become more or less focused on their in-group (Māori) experiences, which could in turn impact on their wellbeing, for example, if they were to experience race-related stigma and bullying. Questions related to bullying because of ethnicity were asked in the YWB Study survey, which could be correlated with self-injury and other psychological variables longitudinally to investigate this.

There is also a broader debate regarding the applicability of Western-derived measures of psychological variables for indigenous populations. Of relevance to this research is whether or not *rangatahi* Māori define self-injury in the manner in which it is used here – Non-Suicidal Self-Injury. This definition is used here because that is what

was used at the measure of self-injury in the YWB Study. Both the DSHI-S and the ISAS measures were developed on international sample populations, in America and Sweden respectively, and, therefore, in different cultural environments compared to that in which *rangatahi* Māori in Aotearoa are immersed. The definition of NSSI which was also developed internationally may not necessarily reflect the definitions held by *rangatahi* Māori in Aotearoa. The different definitions could prove problematic if the definitions of self-injury that *rangatahi* Māori hold differ from the term 'NSSI' that is being assessed in this survey. However, I believe that because the YWB Study survey uses a broad description of self-injury without the term NSSI, the wording of the questions has been sufficiently vague to incorporate multiple meanings to the term. The way that *rangatahi* Māori define self-injury will be investigated as part of the qualitative components (Study 2) of this research, and the implications of this will be discussed in detail in the overall discussion chapter of this thesis.

Finally, a process issue that I would like to highlight concerns the support processes employed in the YWB Study. When participants complete the survey, as one of several means of mitigating risk in conducting this research, participants are provided with a list of contacts to whom they can go to if they would like to seek help following participation. These contacts are local services, such as youth centres, guidance counsellors and pastoral support services. In hindsight, a regret that I have is not including culturally relevant support services on these forms, where available. By omission of these services, it could be sending the message to *rangatahi* Māori that cultural forms of support (or in fact, any support not included on the sheet) are invalid or unsafe. This could be seen as a process of othering cultural services and a perpetuation of colonisation and legislation such as 'Te Tiriti o Waitangi' The Treaty of Waitangi, and the Tohunga Suppression Act of 1907.

CONCLUSIONS

Self-injury has been identified internationally as a psychological issue facing many adolescents, with lifetime prevalence rates varying from 20% to 50%. In this study, that rate has been established for *rangatahi* Māori as 27%. Correlates of self-injury for *rangatahi* Māori include depression, anxiety, emotion regulation, and suicidal ideation. These findings and the others in this study highlight self-injury as a significant issue for *rangatahi* Māori, and, by extension, for their whānau and the broader community. With the prevalence and correlates of self-injury now established quantitatively, what is needed are the richer details: the stories of experiences of self-injury, and to hear in their own words how they can be helped; what has helped and not helped in the past. The sequential focus group process allows the space for the application of *tikanga* in a research context. In the next chapter, I explain how this process this has been applied to my sample of *rangatahi* Māori and their whānau members, and the findings of this qualitative research.

CHAPTER EIGHT
Study 2: Sequential Focus Groups with Rangatahi and Whānau

This chapter outlines the sequential focus group (SFG) process undertaken for Study 2. A series of focus groups were conducted with two separate groups of *rangatahi* Māori and their whānau support people. The findings of these SFG *hui* are presented according to three groups of *rangatahi* Māori and whānau. Members of Te Roopu Tuatahi were *rangatahi* Māori who have a history of self-injury. Those in Te Roopu Tuarua were *rangatahi* Māori and whānau members who have experience of supporting *rangatahi* Māori who have self-injured. And Te Roopu Tuatoru consisted of *rangatahi* Māori who had never self-injured nor supported someone who had self-injured.

INTRODUCTION

The objective of Study 1 was to quantitatively establish the prevalence and correlates of self-injury. The survey results highlighted self-injury as a significant and complex issue for *rangatahi* Māori. Specifically, Study 1 found that there were substantial gender differences in the prevalence rates of self-injury, whereby a disproportionately higher number of females than males in this sample had self-injured. There were also gender differences in the age of onset (12 years old for males, 13 and a half years for females). The most common forms of self-injury reported were cutting and scratching for both males and females. With regards to functions of self-injury, emotion regulation and self-punishment were the two most commonly endorsed functions for both males and females.

Study 1 also found that those who self-injured were also more likely to experience bullying, have higher levels of depression and anxiety, experience more suicidal thoughts and behaviours, and had a diminished capacity to regulate their emotions. Given these findings, the aim of Study 2 is now to understand the lived

experiences of *rangatahi* Māori in regards to self-injury. The research questions were 1) How do *rangatahi* Māori define self-injury? 2) What are the experiences of *rangatahi* Māori and their whānau when *rangatahi* Māori self-injure? Moreover, 3) Why do those who have never self-injured abstain from this behaviour?

Objective 1: Understanding definitions of self-injury

As mentioned previously, 'he mana tō te kupu'; *w*ords have meaning, they have power, and, as asserted in this *whakataukī*, words have *mana*. Through language, cultures can express their worldviews. Within the islands of the Pacific, there are strong similarities in language that reflects the worldviews of the many Pacific Island cultures. In "The Coming of the Māori", Te Rangi Hiroa (1949) connects and draws similarities across the Pacific cultures in their depictions of *atua* or gods, for example, in the Marquesas they refer to Ranginui and Papatūānuku as papa-'a'o (papa raro) and Papa-'una (papa-runga) (p. 529).

The Mana Moana project is an indigenous approach to wellbeing that has stemmed from the research of Mila-Schaaf (2010), who investigated 70 source-generative words that were found in at least 15 different languages of the Pacific. The existence of these words in so many different languages all with shared meanings demonstrates the commonalities across Pacific cultures. For example, the word *mana* in te reo Māori is understood to be an energy or power held by an individual or a collective (Māori Marsden, 2003; NiaNia et al., 2017). In the Mana Moana project, the term 'mana' was found to be present in 26 contemporary languages, all with a similar meaning. The commonalities between indigenous cultures also extend to holistic understandings of health and wellbeing that incorporates the relationships between individuals,

communities and the environment within which we live (World Health Organisation, 2014).

There are also similarities across indigenous cultures in their understanding and conceptualisation of self-injury. In Chapter 4 I summarised some of the literature on self-injury within indigenous and ethnic minority populations. Traditional stories within these cultures talk of, for example, causing harm to self in response to the grief felt due to the loss of a loved one. Stories of ancestors engaging in these practices is recounted in the history of the Kanaka Māoli of Hawai'i (Pukui et al., 1983) of the Aboriginal Australian and Torres Strait Island people (Farrelly & Francis, 2009), and in traditional Māori *kōrero tuku iho* where it is often referred to as *kiri haehae*. Current research on self-injury within indigenous and ethnic minorities reports mixed prevalence rates. Some studies report that people from ethnic minorities are no more or less likely to engage in self-injury than the general population (Croyle, 2007; Whitlock et al., 2006). Others suggest that minority ethnic identity may be a protective factor because ethnic minorities are less likely to engage in NSSI (Brausch & Gutierrez, 2010). Chesin and colleagues (2013) suggest that the research on self-injury with ethnic minorities is difficult to capture because the sample size is often too low, whereas Black and Kisely (2017) suggest that it may be due to the culturally grounded behaviours that ethnic minorities engage in as self-injury may not fit with the definitions of self-injury, such as NSSI.

As mentioned in Chapter 5, in seeking to understand how *rangatahi* Māori define self-injury, the prevailing definitions of self-injury currently use terms and distinctions, such as NSSI and DSH. These definitions, indeed the field of research as a whole, have developed with predominantly non-indigenous populations which may not always align with holistic notions of wellbeing. It is encouraging, and essential to note, that there has

been progress in this area in the form of revisions to definitions of wellbeing to incorporate the holistic perspectives of wellbeing held by indigenous populations (World Health Organisation, 2014).

As mentioned previously, indigenous people, specifically Māori, hold holistic views of wellbeing whereby mental, physical, spiritual and collective wellbeing are all interrelated (Durie, 1994). Therefore, in this research, it was anticipated that the lay definitions of psychological concepts such as 'self-injury' would similarly be holistic. While the Western-derived, largely individualistic definitions of wellbeing are used to establish prevalence in all ethnicities in Aotearoa, this research sought to investigate the lived experiences of *rangatahi* Māori and whānau who have self-injured with a particular focus on cultural understandings.

Objective 2: Understand the experiences of *rangatahi* Māori and whānau

The second research objective for Study 2 was to understand the experiences of *rangatahi* Māori and whānau when *rangatahi* self-injured. Researching the lived experiences of *rangatahi* Māori and whānau on such an important but sensitive *kaupapa* such as self-injury necessitated an approach that was culturally appropriate. Māori and indigenous peoples have a history of being researched without being in control of the research process and findings (L. T. Smith, 2012). Research conducted in such a manner is argued by some as an extension of the colonisation and assimilation practices adopted by the first settlers to arrive in Aotearoa after Māori. In Chapter 2 I recalled and described the impact that colonisation has had on Māori. A specific and significant process that caused much subsequent damage to Māori cultural practices and, by extension, our wellbeing was the introduction of the Tohunga Suppression Act. Traditionally, *tohunga* were regarded as experts in matters of culture and healing, with

direct connections to spiritual realms (Valentine et al., 2017). The outlawing of the practices of *tohunga*, who were respected within Māori communities as leaders, classified traditional Māori knowledge and practices, as well as the concept of *wairua*, as inferior or inadequate means of achieving wellness (Valentine et al., 2017). The politicians who were behind the development of this Act argued that the practices were unfounded scientifically and therefore dangerous. It can be argued that this perception of Māori and other indigenous cultural knowledge of wellbeing still persists today. This is suggested within the Clinical Psychology profession, for example, in the manner in which Western psychological knowledge and practice dominates the curriculum, with cultural elements relegated to annual one-day workshops, or overnight *noho marae* (overnight stay at a marae) reserved as the domains in which Māori perspectives on mental health are taught. Inadvertently, Waitoki describes the impact of this in that "the demarcation of healing practices into clinical and cultural perpetuates the belief that one system of practice is valid while the other is not" (2012, p.42).

All of this emphasises the importance of culture-based methods and, for *Māori*, *tikanga*-based methods. *Kaupapa Māori* research principles are grounded in a Māori worldview which is holistic in that it incorporates more than just the individual, and is based on *whakapapa*. In this thesis, I have been determined not to perpetuate these assimilationist strategies used by Western science.

This research sought to understand and explore the experiences of *rangatahi* Māori who self-injure, in particular, how they were supported and how other *rangatahi* in similar situations might be supported. To obtain a broad perspective of the types of support needed, the experiences of *rangatahi* and friends who have supported *rangatahi* who self-injured should also be heard. The research approach for Study 2 uses the Sequential Focus Groups approach used by Boulton (2012). This approach was

developed as an indigenous research method that can be viewed as an interface whereby the SFG process provides the scope for the incorporation of *tikanga* or traditional practices in a research context. Rather than the traditional research one-off focus groups, the SFG method allows the group to come together multiple times to discuss the same broad topic. This has multiple benefits but also some significant challenges (for example, managing the safety of individual participants within a group setting, and presenting the differing points of view within the group;). Benefits include the time for relationships to form as the group continues to meet over time, and increased exposure time to the research participants so more, more in-depth, or broader information may be obtained. In this thesis, two SFGs were conducted with separate groups of *rangatahi* participants. Herein these will be referred to as SFG One and SFG Two, and the participant characteristics for each group will be discussed shortly.

In analysing the SFG data, Interpretative Phenomenological Analysis was used as the analytical tool. This analytical approach values subjective knowledge and suits research that is exploratory, and because it requires robust engagement with the data for the researcher to be immersed in the perspectives and experiences of the participant/s.

Objective 3: Strengths-based perspectives

I saw it valuable to understand alternatives to self-injury for *rangatahi* Māori, and how they cared for their wellbeing. This is consistent with a solution-focused approach and L. T. Smith's (2012) assertions about asking questions in a way that provide solutions. I also sought to hear from *rangatahi* Māori who have never self-injured, to understand their perspectives, including why they had never self-injured.

The purpose of hearing from *rangatahi* Māori who had never self-injured was to understand alternatives to self-injury; where other *rangatahi* Māori go to seek help, and what alternative behaviours they engage in when they experience overwhelming emotions. This was not to assume that the alternative approaches that other *rangatahi* Māori engage in would be better alternatives to self-injury, but by including these participants and asking these questions, it was hoped that solutions might be uncovered that can be applied to, or fostered in, *rangatahi* Māori who otherwise engage in self-injury.

STRUCTURE OF THIS CHAPTER

This chapter begins by outlining the method used in Study 2, detailing the research design procedures for both series of sequential focus groups. Analyses are then presented, divided into the three participant groups. Te Roopu Tuatahi includes those who had self-injured, either historically or currently at the time of participation. Te Roopu Tuarua consisted of those who had not self-injured but had experience supporting a friend or family member who had self-injured. Finally, Te Roopu Tuatoru was made up of those *rangatahi* Māori who were 'naïve' about self-injury, having not hurt themselves or supported someone who had. These groups are composed of participants from both SFG One and Two.

METHOD

In this study, the sequential focus group method was used with two separate groups of *rangatahi* Māori. These will be referred to as SFG One and SFG Two.

Initially, I had planned to conduct one series of sequential focus groups with *rangatahi* Māori and whānau recruited from the local community. However, following the first series of *hui* our research group (the YWB Study) was approached by a group of

students from an alternative education school who wished to participate in the study together as a group. Despite two group members not having Māori ancestry, they explained that they preferred to participate in the research process that had been explicitly designed for *rangatahi* Māori, as opposed to participating in the YWB Study's mainstream interviews and focus group processes.[26] We, therefore, applied for an amendment to the original ethics application of the YWB Study to enable non-Māori to participate in our *hui* for *rangatahi* Māori. The procedure for SFG Two was similar to that for SFG One in that there were four *hui*. However, because the group of students were all known to each other, less time was spent on *whakawhanaungatanga*.

Participant characteristics

Across the two series of SFGs, 25 young people took part. At the initial time of interactions, the age range of the *rangatahi* Māori participants was 13–18 years, 20 were female, and five were male. SFG One was composed of 18 *rangatahi* (five male, 13 female, aged 13–18 years). Whānau/support people also participated in this series of *hui*. Seven *rangatahi* Māori participated in SFG Two, all of whom were female, and all aged 16 years. In both series of SFGs, *rangatahi* Māori were required to identify a support person over the age of 16 who would support the *rangatahi* outside of the research *hui*, and who could be contacted by the research team to check on the safety of each participant. In SFG Two, the participants all listed one of their peers (who were also participating) as their support person. There were no rangatahi who participated in both Study One and Study Two.

---

[26] In the Youth Wellbeing Study, the process followed for the focus groups involved potential participants completing a series of screening questions that determined the participants' history of engaging in self-injury. If a participant reported having self-injured, these participants are invited to participate in a one-on-one interview to minimise the risk of contagion.

In the results and analyses section of this chapter, I present three sets of analyses, reflecting three sets of experiences; those who have self-injured, whose who have supported *rangatahi* Māori who had self-injured and those who have never self-injured. The three groups provide a mechanism for describing how many people were represented in each of those sets of experiences. Figure 5 illustrates how the three groups are composed.
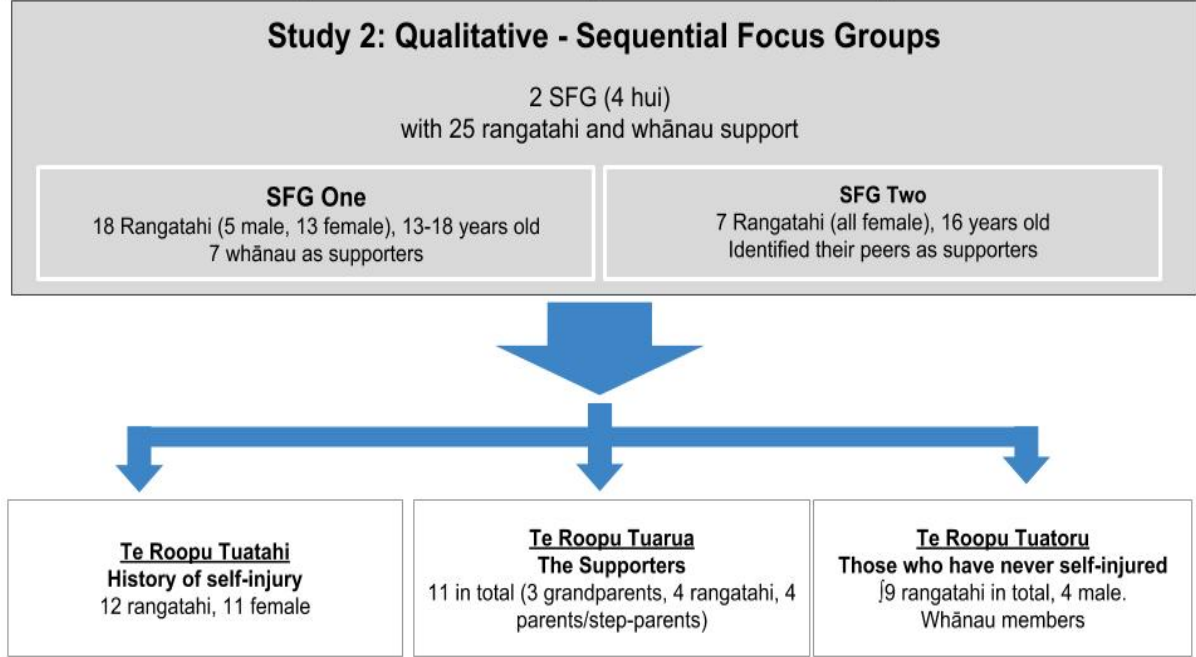
Figure 5. The three participant groups as combinations of participants from SFGs One and Two.

Te Roopu Tuatahi (those who had or were still self-injuring) included 12 *rangatahi* Māori, one of whom was male. Eight of the members of this group were teenage mothers, some with more than one child. Te Roopu Tuarua (those with experience supporting a friend or family member who had self-injured) included 11 participants. This included three *kaumātua* or grandparents who described their experiences supporting a *mokopuna* (grandchild) who had self-injured. Four members of Te Roopu Tuarua were *rangatahi* themselves; two of them spoke of supporting their siblings who were in Te Roopu Tuatahi and were, therefore, also present at the series of

210

hui. Two *rangatahi* had supported friends, one of whom was from also a participant in Te Roopu Tuatahi. None of the *rangatahi* participants in Te Roopu Tuarua had a history of self-injury. Four of the members of Te Roopu Tuarua were parents or step-parents who had supported a child, and one of these parents was male.

Te Roopu Tuatoru consisted of those who participated in the SFG process who had never engaged in self-injury. There were nine participants in this group, four of whom were male.

Participant characteristics across all three groups

History of self-injury

As it was not a requirement for participants to have a history of self-injury, experiences of self-injury varied. Some participants had previously engaged in self-injury, and some identified that they were still currently engaging. Some participants had experience with helping their friends who had self-injured, others knew of friends or family members who had self-injured but were not always the ones who had supported them through this. And then some *rangatahi* Māori had no knowledge or experience with this behaviour. Many participants had filled multiple groups; for example, they had experience and had supported friends who had self-injured.

Ethnic and cultural identity

All participants self-identified as Māori. In SFG Two there were two participants who identified as Pacific Islanders. The contributions of these two non-Māori have not been included in this research. However, it is important to note that their experiences and views were similar to those shared by their Māori peers.

Strength of identity as Māori

Rangatahi varied in the extent of their connection as Māori. Some participants were very strong in their cultural identity; they attended *kura kaupapa* Māori, were

fluent in te reo Māori and often spoke in a mixture of English and Māori to those who could understand it in the *hui*. Whereas other participants were not fluent in te reo but identified strongly and had strong links with their *whakapapa* and their whānau. Others were not strong in their identity as Māori – these *rangatahi* knew their *whakapapa* and their *pepeha*, but did not spend much time in their ancestral *whenua*; did not go back there often and had been living away for some time. There were others in the group who knew little more than that they had *whakapapa Māori* – they did not know their *whakapapa* connections.

Rangatahi from single-parent or blended families

The sense of grief and loss was strong within this sample of *rangatahi* Māori. One *rangatahi* had lost a father to suicide and two siblings had lost their father in a car accident. In the whole cohort of 25, 18 *rangatahi* were either from single-parent families or blended families,[27] and many of these *rangatahi* Māori had little contact with their father. Two of the participants' fathers were in prison for abuse against their mothers.

Research design

The series of research *hui* occurred in three phases. Phase One focused on *whakawhanaungatanga*, specifically recruitment and information sharing, and developing connections and relationships amongst the participants and between the participants and the research team. During this phase, the foundations of the research process were laid, grounded on building connections and laying down the expectations

---

[27]Defined as "a family consisting of a couple, the children they have had together, and their children from previous relationships".

for the research process that followed. Phase Two was the 'data collection' phase, whereby the research questions loosely guided the conversations. Phase Three involved following up with participants, feeding back the research findings, and other forms of reciprocity.

Recruitment

In the case of SFG One, participants were recruited through the research team's networks with the local community. An invitation to participate was distributed as a letter and one-page flyer which was distributed through email networks. For SFG Two, all participants attended an alternative education school that was also participating in the YWB Study.

Research design: Sequential Focus Group One

SFG One, Phase One: Whakawhanaungatanga

For SFG One, three hours were set aside for the first *hui*. This took place at Victoria University's Pipitea Campus, at the Health Services Research Centre. Ideally, for research with Māori communities, Pere and Barnes (2009) argues that it is best to go to the participants' communities rather than expecting them to come to you. This assists the researcher to minimise the power dynamics between the research team and participants and minimises the inconvenience placed on the participants by not requiring transport (Bishop & Glynn, 1999). However, because the participants were located all over Wellington, from Miramar to Lower Hutt and Porirua, it was decided that we would all meet at a central location and at a time that was convenient for most. This was negotiated with the participants and whānau once it was known who the participants would be and where they were all located.

The first *hui* began at 6pm with *karakia* (prayer) and a *mihi whakatau*[28]. This is a process of welcoming visitors by the hosts, in this case, the research team, and of *whakawhanaungatanga*. This process was led by kaumātua Witi Ashby, who filled the role of cultural advisor. The cultural advisor is someone who is steeped in the knowledge of Māori culture, and who can lead and guide the research team on best practice for keeping all the process and all those involved culturally safe. Ensuring the cultural safety of participants is paramount in all research with Māori, but especially in research such as this, which is of a sensitive nature to *rangatahi* Māori and whānau (Cram, 2001). In addition to the cultural guidance of Matua[29] Witi, we were also fortunate to have the support of Whaea Lucy Bush, who, like Matua Witi, had many years' experience working in Māori mental health.

The process of *whakawhanaungatanga* provided the opportunity for all who were present to become familiar not only with the research but with one another, through the sharing of *pepeha* and other forms of introduction. In addition to providing a structure upon which one may introduce themselves, *pepeha* also signal that the Māori cultural values of connections are at the forefront of every *hui* (*Te* Huia, 2013). Following the round of introductions, the food was blessed with a *karakia* and then shared. When people come together the sharing of food serves to *whakanoa,* or to remove the *tapu* or sacredness, of everything under the protection of *atua* Māori (Māori gods), namely all of those present. Importantly, because these *hui* were mostly in the evenings, the *kai* provided was not merely coffee and biscuits, but full meals. We believed that when asking people to give up their lunch or dinner time to be with us, it

[28] A mihi whakatau is a less formal pōwhiri or welcoming/introduction process.
[29] Matua and Whaea are terms used here in respect for our elders and the knowledge that they hold.

was respectful to provide them with adequate food that was healthy and nutritious. The sharing of food also functioned to ease the anxiety levels of all those present, including the research team members. This allowed participants to transition from their formal self to their normal self, which is important for enabling genuine relationships to form, which in turn maximises the validity of the information that is shared and gathered.

While food was shared the research team introduced the research project. Information sheets were disseminated, which had also been sent out prior to the meeting. The research team (Dr Lynne Russell, Witi Ashby and I) introduced ourselves and the history of the research. The research aims and the goals we hoped to achieve through the project were explained, as well as the proposed procedure for the series of *hui*, which was open to any amendments, comments, questions or feedback. The process was flexible and collaborative; we had an initial plan, but this was amenable to change to suit the group's needs. This process of explaining the research to the group in a face-to-face manner was ideal because it provided the participants and whānau with the opportunity to ask any questions and raise any concerns that they had, *kanohi ki te kanohi* (face to face; L. T. Smith, 2008).

The group as a whole was then divided into two; with the *rangatahi* in one room and the whānau members in another. The whānau were accompanied by Matua Witi and Whaea Lucy, who facilitated further the discussion about the research. The *rangatahi* remained with Dr Russell and I, who facilitated further *whakawhanaungatanga* with the group. This was a chance for the *rangatahi* to get to know one another without their whānau members present and to ask questions of the research team and to raise any concerns that they had about the research. Mostly these concerns were centred around confidentiality; many wanted to know whether or not what they said in the *hui* would be shared with their whānau members who were in

215

attendance in the other room. Participants were informed about confidentiality and that, unless the research team had concerns for the safety of any of the *rangatahi*, nothing that they shared would be passed on in any way that made them identifiable to their whānau. Once all questions had been answered and concerns addressed, all participants and whānau members were given consent forms to take home and complete and return the following night, should they choose to return and participate. The *hui* ended with everyone coming together for *karakia*.

The consent process

All *rangatahi* participants under 16 years of age were required to provide their assent to participate in the research, as well as the consent of a whānau member to do so. In addition, all participants, regardless of age, were required to have a support person attend all of the *hui* – a safety requirement decided by our research team that served multiple purposes. First, as a measure of safety, the whānau/support person would provide an alternative contact in case of emergency or if there were any concerns for the safety of that *rangatahi* participant. Each *rangatahi* participant and their support person would be contacted the day following each *hui* to check in as to how the *rangatahi* were feeling following the preceding *hui*. This was a safety measure, but it also provided the opportunity to receive feedback on the research process and for *rangatahi* to share anything that they may not feel comfortable sharing with the rest of the group. Secondly, having whānau involvement was intended to ensure that whānau were actively involved in the research process alongside their *rangatahi* and knew what it was that participation involved and what the *kaupapa* (topic) of the research was.

SFG One, Phase Two: Data collection

Following the initial *whakawhanaungatanga hui* the first 'data collection *hui*' was held the night following the information *hui*. This also began with *karakia* and *kai*, after

which the two groups (*rangatahi* participants and whānau/support people) again met in separate rooms, and finished with *karakia* (consistent with the *tikanga* of a *hui* process). This was important because the research process was unfamiliar to most of the participants. By providing a culturally recognisable structure and consistency to the research process this also functioned to allow participants to become familiar with the process, minimising any anxiety that comes from the uncertainty of not knowing what was coming next.

The *hui* with *rangatahi* began with another reminder of the safety issues, in particular confidentiality, privacy and mutual respect. *Rangatahi* were also provided with the opportunity to identify any additional *tikanga* or rules for the group, some of which included only one person speaking at a time, no laughing at what others have to say, and no cell phones. The *hui* then evolved into a discussion around what it meant to be Māori. There were a series of display boards placed around the room by the research team members, and on these were images, quotes, questions and phrases which aimed to provoke discussion on the subject of being Māori. There were also Post-it® notes and pens available for those who wanted to share their thoughts but not say them aloud.

The second data collection *hui* took place on the night following the first and proceeded in much the same way as the first. This is where self-injury was discussed as the focus of the *hui*. The key benefit of the sequential focus group process was that participants and researchers had the opportunity to go away and reflect on the conversations, and then to return to the following *hui* and clarify statements made in previous *hui*. This was essential for the research team because we decided that we would not audio or video record the series of *hui*, at the request of the *rangatahi* participants. Instead, the researchers took extensive notes as the conversations developed. Allowing the participants as a group to decide whether or not they were

217

happy to be recorded served to diffuse some of the power imbalance in the research process between the researcher and the participants.

At the end of the second *hui,* we held a brief farewell, where everyone had the opportunity to reflect on the *hui* and share their thoughts and feedback. Everyone was given the opportunity to speak, and the overwhelming consensus from the group was that they had enjoyed the *hui* and wanted more. This led to the follow-up phase of the research.

SFG One, Phase Three: Follow-up

At the request of the *rangatahi* participants, following the second data collection *hui,* a private Facebook group was established for all the *rangatahi* participants to keep in contact with one another. This also proved the most effective way for the research team to get in touch with all *rangatahi* as a group to facilitate the discussion regarding meeting again. It was also the forum for the research team to share any news regarding the research, particularly with regards to the dissemination of the research findings in other forums such as workshops, presentations and reports. This ensured that the *rangatahi* were aware of, and maintained power and control of, their knowledge by having a say in when and how and with whom their knowledge was shared.

Four months following the final data collection *hui*, a follow-up *hui* was held in the form of an informal get-together, a chance for the *rangatahi* to catch up with one-another over *kai*. Unfortunately, not all of the *rangatahi* were able to attend – in the end, only seven of the initial 18 participants were in attendance. Although not all attended, it was important for the research team to offer a time and space to share this time as part of the completion of this phase of the project.

Research design: Sequential Focus Group Two

SFG Two, Phase One: Whakawhanaungatanga

The first *hui* with SFG Two was with the school staff – the guidance counsellor, the school principal and two members of the research team. The purpose of this *hui* was to inform them of research aims and proposed process. Immediately following this meeting, the research team also met with the students to inform them of the intended research process. The contact details of those who were interested were then collected by the staff member, and then a second *hui* was arranged between the research team and those students who expressed interest in participating. At this time, it became apparent that a significant number of Māori students were willing to participate, and it was, therefore, decided that a separate process would be carried out for the Māori participants that was consistent with *tikanga* and *kaupapa Māori* research principles (citation). Subsequent discussions with the school staff indicated that the small number of non-Māori students (n = 2) also wished to take part in the same process as the Māori students. We decided that an amendment to our original ethics application would be required which enabled non-Māori to participate in a Māori-centred process. Another *hui* was then held with the participants to inform them of the new process for data collection, which required every participant to identify a support person 16 years of age or over. Each participant selected someone in their peer group as a support person, and all but one of these support people were also participants in the research.

SFG Two, Phase Two: Data collection

For this group, only one data collection *hui* was held because of the additional *whakawhanaungatanga hui* required for recruitment. Also, because the group knew each other well, there was less need for further *whakawhanaungatanga*. However, because they were known to each other and interacted on a daily basis, more emphasis

219

was placed on addressing safety requirements, including confidentiality, as we acknowledged that they needed to feel safe sharing with people they engaged with every day.

The data collection *hui* took place at the school, as this was obviously most convenient for them. Three hours were allocated for the discussion. We began with *karakia* and shared *kai*, and then, because the students knew each other well, we were able to get straight into the conversation after covering the essential safety issues.

SFG Two was structured in a similar manner to SFG One, with little facilitation required by the research team. The participants asked questions of each other and supported each other during the conversations that took place. Again, rather than audio or video recording the discussion, researchers took notes on what was said as the discussion progressed.

SFG Two, Phase Three: Follow-up

A follow-up *hui* was held five months after data collection. The purpose of this *hui* was to reap the benefits of sequential focus group method – namely the ability to clarify information and key messages. This ensured that the power remained with the participants as owners of the knowledge. The conversations were recorded and then transcribed, and similar quotes were grouped using Interpretative Phenomenological Analysis (J. Smith, 1996). Using a method informed by the principles of the Q-sort method of Q-methodology (Stephenson, 1953), the 54 subsequent quotes were then printed on cue cards. This approach was only used with SFG Two because they consented to be audio-recorded as a group. Each participant was given a copy of the set of quotes and was asked to sort the quotes along a five-point continuum, from strongly agree to strongly disagree. Participants were asked to do this individually, and then to mark any quotes that they felt were the key messages that they felt were important to

share with others as part of the dissemination process of this research. This, in turn, facilitated more discussion and debate, which will be elaborated on and discussed further in the analysis section to follow.

Following this *hui*, the research team took their Q-sort arrangements and collated the information into a summary report, a copy of which was provided to all participants. All participants were given the opportunity to read this report and provide feedback. This was important as the report was to be given to the school as an acknowledgement for them participating in the research and making their students available to us. However, because this school was very small (less than 30 students) and the staff were aware of who was participating in the research, it was essential that the participants were comfortable with what information was shared in the report and that no identifying information had been shared that would make any participant feel unsafe. Once a final report had been agreed upon by all participants, this was then passed on to the school in confidence.

RESULTS AND ANALYSIS

The experiences of *rangatahi* Māori who have self-injured: Analysis of Te Roopu Tuatahi

There were 12 *rangatahi* Māori in Te Roopu Tuatahi, which consisted of *rangatahi* who had self-injured, either historically or currently. The results for Te Roopu Tuatahi are presented as follows; first, I present the views of participants from Te Roopu Tuatahi about how they define self-injury. I then move on to summarise the discussions about who self-injures, and then their perceptions of some of the proximal factors that lead to them self-injuring. I then discuss other factors that were not representative of the views of all members of Te Roopu Tuatahi. Following this, I then

221

present the reported functions of self-injury for this cohort of *rangatahi* Māori. I then present the views of participants in Te Roopu Tuatahi regarding whom they turn to for support, how they wish to be supported, and their experiences of alternatives to self-injury and what strategies that these participants use to keep well and avoid self-injuring.

What is self-injury?

When discussing what behaviours they considered to be self-injury, the participants who had a history of self-injury gave examples of a broad range of behaviours. By default, when describing their experiences, they predominantly referred to cutting and burning themselves; behaviours that are consistent with the existing definitions of NSSI (and DSH more broadly). However, in exploring all behaviours that they engaged in that they thought of as self-injury, many of the behaviours given did not fit with a definition of NSSI. These were behaviours such as starving yourself, not sleeping, substance abuse, neglecting yourself on purpose, having unprotected sex, and drinking and driving with the intention of causing harm to yourself. These were all mentioned by participants from Te Roopu Tuatahi as examples of behaviours that they had engaged in themselves as a form self-harm and were also endorsed by the majority of the group as self-harm. In discussing what it was that defined all of these behaviours as self-injury, it came down to the intent behind the behaviour, whereby it served to intentionally inflict pain and cause harm to themselves in some way. One participant described this as "when you know that what you're doing is wrong but you still do it".

There were also some behaviours discussed that were only endorsed by a few members of the group as being self-injury, with the majority of others in Te Roopu Tuatahi disagreeing. For example, the debate regarding whether tattoos and piercings could be self-injury; two participants felt that there was an element of self-harm for

222

them when they had received their tattoos or piercings (see Hine's[30] story, below), but others perceived those behaviours more as statements to others. One female participant described her tattoos and piercings as statements against anti-feminist stereotypes. Others in the group felt that tattoos and piercings were not self-injury because people chose to do it, whereas with self-injury one did not have a choice but to hurt themselves intentionally. Another felt that it would only be self-injury if you let a tattoo or piercing get infected.

One participant who believed that tattoos were a form of self-injury shared her own experience, which is summarised below. This is not presented as a direct quote because the session was not recorded. However, it has been checked with the participant to ensure it represents her experience.

> Hine had been self-injuring (cutting) for about two years prior. She spoke of how she had had a heated argument with her mother, and later that day had gone to town with two of her friends and decided, on a whim, to get a small tattoo. The tattoo artist was not Māori, and the design had the appearance of a Māori tattoo. However, it lacked the cultural meaning behind the design. This is known as a kiri tuhi, as opposed to tā moko which are Māori tattoos that have wider cultural meaning and significance. Hine spoke of the anger and frustration that she had felt towards her mother following their argument. Immediately prior to walking into the tattoo studio, she recalled thinking "Fuck it, I'm going to do it", and she then proceeded to accompany her friend into the tattoo studio, who had planned on getting a new piercing. Upon returning home after receiving the tattoo, Hine had tried to hide it from her whānau, but she described how eventually her mother found out, and she was furious. Hine recalled being confused and surprised at how her mother had reacted; she said that she felt her mother's anger seemed disproportionate to what Hine had

[30] Pseudonyms are employed for all instances of attribution in the analysis section.

done. Hine said that her mother had even called Hine's grandmother, who lived more than 12 hours' drive from them. Her Nan was also upset, and she got in her car and drove to Wellington, and a whānau hui was held. Hine's grandmother spoke of how she felt that she had hurt her whānau by treating her body in this way. And in the manner in which it was done; without any whānau present, and without the correct tikanga or rituals followed (such as karakia). Hine's Nan said that, through hurting her tinana in this way, Hine had also hurt her whānau and her wairua. While Hine did not understand their reactions at that time and did not view the behaviour as self-injury, in hindsight she now understood her whānau and their reactions, and she said that she was ashamed at what she had done and how it had hurt those she loved.

To summarise, through the discussion of what behaviours were or were not self-injury, for Te Roopu Tuatahi it was clear that it came down to the intention and the function of the behaviour more than the behaviour itself. Self-injurious behaviours typically served to physically harm themselves in some way.

Who self-injures?

When asked whether there was a group of people who were more likely to self-injure, participants in Te Roopu Tuatahi felt that self-injury was a behaviour that was predominantly engaged in by teenagers, while the general consensus was that older people turned to drugs and alcohol to cope. Only three participants in the whole cohort knew of adults who self-injured, and the rest of the cohort were somewhat surprised to hear that self-injury was a behaviour that adults engaged in. The cohort as a whole felt that younger *rangatahi* turned to huffing[31] or smoking. However, during these discussions, the younger ones in the cohort (13 and 14 years old, all from Te Roopu

---

[31] Huffing is defined as the act of breathing fumes to get high (Urban Dictionary).

Tuatoru) disagreed. While these younger participants did not explicitly admit that they had 'huffed', they said that they had peers who did it and that it was self-injury; they mainly did it due to peer pressure, in attempts to fit in, to be cool, and because others were doing it.

With regards to what teenagers did it, there was a conversation about whether or not you're more likely to do it if you're Māori, to which they all disagreed. Some participants discussed how one's decision to self-harm depended on the environment that they grew up in.

On distal risk factors, one *rangatahi* said that if someone came from a "good, stable environment", then they wouldn't self-injure, and if they did, it was only for attention. However, others in Te Roopu Tuatahi disagreed with this, some based on their own experiences and from knowing other self-injurers from different walks of life. These participants stated that it did not matter who they were or what their backgrounds were, everyone has their own reasons for self-injuring. This was summarised by one participant in Te Roopu Tuatahi who stated that "everyone's struggles are unique to them. Everyone has different stress and pain." Another participant described how everyone experiences things differently and responds differently. She gave an example of her cat dying which, to her, would be devastating, akin to losing a family member, but that might not affect another person as much.

In discussing whether or not being Māori was a risk factor for self-injury, one *rangatahi* stated that "being Māori doesn't mean you're more or less likely to do it, but you get through it better cos you've got whānau there to help." The importance and power of this notion were evident from the endorsement by the majority of the cohort. Some *rangatahi* went on to describe their frustration that they felt that "Māori were always getting the blame for doing bad things... people think all we do is beat each other

up, steal stuff and end up in prison… and we get really fat." Others contributed to this conversation by saying that that that's where their teachers expect them to end up (in prison) and so felt that a lot of the time they were ignored by their teachers.

The attitudes of these teachers warrant concern. Borrell and colleagues (2009) describe different levels within which racism operates which can have negative effects on health and wellbeing of those who experience any one of these forms of racism (defined as internalised, interpersonal, institutional and societal racism). Dudley (2016) also discusses the concept of stereotype threat whereby assumptions regarding academic performance subsequently influence academic performance, possibly through the internalisation of the stereotypic assumptions. With the *rangatahi* Māori in this sample, however, what was powerful about this conversation was that these participants disagreed with the notion that Māori were violent, criminals and unhealthy and likely to self-injure. Rather, they viewed being Māori as a positive, and that Māori were lucky to have so many whānau around to support them.

Proximal factors that lead to self-injury

The triggers or antecedents that participants talked of preceding self-injury included grief, bullying, depression, relationship problems, substance use, and episodes of abuse (emotional, physical, sexual, domestic). When talking about the first time they ever self-injured (which was almost always cutting their wrists), the stimulus was bullying, a relationship breakup, or the loss of a loved one (e.g. the death of a parent). These proximal triggers are described further below and are discussed in no particular order of prevalence.

Relationships, grief and loss

A significant source of stress in the lives of many of the *rangatahi* Māori who self-injured was grief and loss. This is not to say that only those who have harmed

themselves had experienced grief, but one participant (Mihi) shared her experience of losing her father and the impact that it had on her. She spoke of how her initial shock lasted a few months, and that by the time that the realisation that she had lost her father forever had occurred to her, she felt as though all those around her had moved on. She described how she felt as though her mum had moved on with her grieving and was starting to put her life back together again. She said that felt as though there was a time limit on the offers of support that people had given when her father passed away, and that by the time she wanted to reach out for help, that window of support had closed. "I remember feeling like, if I reached out now they'd be like "Oh what, aren't you over that yet?" And so, she described how she kept it to herself, kept it hidden, and tried to deal with things in her own way. Cutting became a way of expressing the grief and emotional pain that she was feeling after losing her father. This is consistent with the ISAS function of affect regulation (Klonsky & Glenn, 2008). It also echoes what Harms (2010) describes as the fear that adolescents have about standing out, which extends to grief, and they can feel like there is peer pressure to move on from their loss.

Relationship problems were another significant reason why many had self-injured. This included conflict with a parent or family member, an argument with a friend, or a relationship break-up. One participant spoke of how she first started cutting at 13 when she had lost her first love, with many others from Te Roopu Tuatahi agreeing that ending a relationship would lead them to self-injure, particularly "if that person you're breaking up with was the one you were closest to, the one you turned to when it got hard". This is consistent with Walsh's (2006) assertion that self-injury can be precipitated by multiple losses.

Bullying

All of those who had self-injured had been bullied at least once. The *rangatahi* who had self-injured (Te Roopu Tuatahi) all described bullying as a reason why they had self-injured at some point. Several of the *rangatahi* spoke of how not only was bullying the reason why they would cut, but that cutting also became a reason why they were bullied further.

Many were bullied through social media, with stories shared of public humiliation over videos or photos of them being shared, or of so-called friends making their private feelings public knowledge. Participants from the whole cohort talked of how shame and embarrassment are intensified when it happens through social media because of the broader audience, and the speed at which the 'news' travels. Also, most young people have smartphones or some way of accessing social networks 24 hours a day, seven days a week. At the same time, participants were all in agreement that they would not have this any other way; one participant described how losing her phone would be akin to cutting off a limb, and all participants slept with their phones either near or with them, checked them before they went to sleep and some would even wake up and check their phones numerous times during the night (Twenge, 2017). However, participants who had been bullied via social media, or even through text messages and phone calls, described the disadvantage of always having their phone on them because there was no escaping the bullying.

One participant shared what she described as just one of her numerous experiences of peer victimisation directly related to her self-injury.

> Pare had just started at a new school and had struggled to find a group to fit in with. She had come to that school with a lot of "emotional baggage"; unresolved familial conflict, friendship breakups, and breaking up with her boyfriend when she left her old school. She described feeling alone, with no one to turn to, and

228

this was when she first started cutting. Pare said that cutting helped her to deal with what was going on for her at the time. She would cut on her wrists, which in hindsight she described as "stupid and naïve" of her. She said that it would have been smarter to do it where it was easier to hide. Pare said that some of the students at her new school noticed her scars, and this, she said, made her even more of an outcast. In one particular incident, Pare described how she was in the changing rooms before P.E. class when another student noticed her scars. A group of girls then began taunting her, and she quickly left the changing rooms. However, the group of girls then proceeded to chase her outside, hold her down by sitting on her, and they scraped over her cuts while others in the school were looking on.

When Pare shared this story, we were all in tears. Upon reflecting on this story and all of the experiences of bullying that were shared by the participants, it occurred to me how difficult it was for these *rangatahi* to escape the feelings of hatred and negativity that they had received. Today's technology and the fact that most young people have a smartphone have meant that there is no escape from the hurtful words of others. In my experience, prior to this time of ubiquitous social media, there was bullying at school; however, at the end of the day, you were able to go home, to escape. Your home, your bedroom was a safe space. However, for these *rangatahi* this was not the case; the bullying was constant, and there was no escape.

Pare's story, and others' experiences of bullying that were shared, highlighted a cycle of peer victimisation, whereby participants were bullied, and they would cut in an attempt to cope, and then when their peers discovered that they had been cutting, they were bullied further for this, which lead them to need to cut more. And what seemed to exacerbate the issue was that when they were bullied because they had been cutting, this negative experience of others knowing that they self-injured made them afraid to share their self-injurious behaviours with anyone else to seek help. And so, they felt

they had no one to turn to, and so would cut for lack of alternative ways of coping and no one else that they felt they could confide in (see Brown, 2015, for research on the relationship between bullying and self-injury).

Depression

All of those who had self-injured said that they did so when feeling down, low, or depressed; and, as one participant described, "it's not exactly something that you do when you're happy." They also said that self-injuring was almost always done when they were alone; none had heard of *rangatahi* cutting in groups, although two *rangatahi* had heard of their friends doing it together, and another had cut with her boyfriend. Many talked about feeling down or really low, numb, or feeling out of control, or intense emotions prior to cutting.

Other reasons to self-injure

Other triggers of self-injury included perfectionism, substance abuse, and experiencing abuse. These triggers were not endorsed by the majority of participants in Te Roopu Tuatahi, with only four or fewer *rangatahi* endorsing each experience.

Some participants spoke of a pressure to do well in school as a precursor to self-injury and came from their parents and whānau. One *rangatahi* stated that she was expected to excel academically to set an example for her younger siblings. She described how at times this pressure felt so intense that it made her want to cut. For some *rangatahi* the fear of failure was significant, and the anticipation of disappointing those who expected a lot from them. One *rangatahi* was from a small school that her parents and whānau were heavily involved with. She spoke of the increased pressure that she felt was on her because of the frequent reminders from her teachers of the expectations of her whānau, and her mum always knew how she was going in school even before she had told her. She talked about how, if she ever did fail, there was no hiding from it. The

experiences of these *rangatahi* are consistent with the literature on self-injury and perfectionism within Aotearoa adolescents (Brocklesby, 2017), whereby negative perfectionism, in particular, was related to greater self-injury for females. To further complicate the situation, the concept of 'stereotype threat' may be relevant to the *rangatahi* who discussed their experiences of stigmatisation at the hands of their teachers. Stereotype threat occurs when individuals feel that they are at risk of conforming to a stereotype about their social group or culture, which has been found to impact on academic performance for minority groups (Steele & Aronson, 1995), which Dudley (2016) likens to a self-fulfilling prophecy.

Some *rangatahi* spoke of cutting when under the influence of drugs or alcohol, but this was not common. In discussing the definitions of self-injury, some gave examples of 'getting wasted' and doing impulsive things, like driving or jumping from high places with a likelihood of being hurt. In this sense, substance use could be considered both a form of self-injury and a cause.

Some participants spoke of others whom they knew who had self-injured in response to abuse, listing sexual abuse, physical abuse from whānau or a partner, and emotional abuse by a loved one as examples from people that they knew. This is consistent with the international literature, whereby there was found to be a weak but consistent relationship between the history of abuse and self-injury (Klonsky & Moyer, 2008). However, no one elaborated on these and none described a personal experience of abuse that leads to self-injury. Given the group environment in which these conversations occurred, and despite the strong connections that had been built among participants through the *tikanga* of the *hui*, it was not surprising that no experiences of abuse were shared, even if they had occurred within the group.

Functions of self-injury

What functions do self-injurious behaviours serve for *rangatahi* Māori? In general, Te Roopu Tuatahi participants spoke of how one's reasons for self-injuring were very personal; "everyone has their own reasons, different stories for why they cut". One participant described how each cut was deliberate, each cut has a story behind it, but most agreed that these stories would only ever be shared with a select few close friends and whānau in whom they trusted.

The main functions that the self-injurious behaviours served for these *rangatahi* Māori are classified into the following categories: to regulate their emotional experiences, to communicate distress, to maintain a sense of control over their lives, and as an alternative to suicide. These functions were agreed upon by *rangatahi* Māori in all of the groups. Other reasons that were not representative of the group as a whole will also be discussed here: addiction to self-injury and attention seeking.

To regulate their emotional experiences

The *rangatahi* who had self-injured described experiencing intense emotional pain, of "hurting on the inside and needing to let it out". Self-injuring served as a means of releasing and self-medicating. Some described it as an expression; a reflection on the outside of how they were feeling on the inside. But for others, self-injuring served to allow them to keep their emotions to themselves. One *rangatahi* echoed the sentiments of the group when she said that it was about "trying to appear as though you have your shit together and seem calm on the outside". Cutting gave them a release, an outlet, to then be able to keep it together. Some felt that at times when they cut, there was no one who they felt they could turn to, no one they could trust. One participant described the need to "manage on your own, but then you don't know how to do that".

While some talked of each cut being deliberate, some spoke of how they were not always aware of their reasons at the time; "you're in your own world". One described how she would go into a different headspace ("kind of like psychosis") where she was not thinking of anything except what was happening at the present time.

Hine, who deliberately cut, described it in this way:

> For me, it's the burning sensation of the blade on your skin. It kind of makes you feel better afterwards to let it out.... But you don't think of any other thing that's happening at the present time.

In reflecting on this participant's statement, the manner in which it was described made me think of mindfulness practices, and that perhaps self-injury, for some *rangatahi*, may serve as a misguided form of mindfulness, whereby they are attempting to regulate their emotions through an acknowledgement and expression of their internal emotional experiences, in the moment.

To communicate distress

Participants spoke of how they felt that within the community there was a common misconception that those who self-injured were simply seeking attention. All of the participants in Te Roopu Tuatahi had encountered these beliefs at some point; people believed that they were only hurting themselves to get attention. Aroha reflected the views of the group when she described the behaviour in the following way:

> It's a cry for help but that's different to attention-seeking. It's needing someone to notice that something's going on on the inside and being able to tell someone but not actually have to tell them what's going on. Like you want people to notice but you don't know how to tell them.

In this sense, self-injurious behaviours could be considered as a form of communication; a means of reaching out and seeking help or communicating one's internal pain when they don't have other means to do so. The participants in Te Roopu

233

Tuatahi spoke of how, if they wanted to hide it, they would. Many said that it was easy to hide their self-injuring if they wanted to, especially cutting, by doing it in places that were easy to conceal, for example, on their upper arms, upper thighs, and lower stomach region. Participants spoke of how hard it could be to reach out for help or talk to people about what was going on for them for many different reasons (fear of losing control, for example). But they said that if they felt that they wanted to reach out, they would let others know that they were self-injuring, either by inadvertently letting them see their cuts or scars, or revealing them directly, or letting someone see them self-injure. However, they were adamant that this was not about attention-seeking; it was about wanting someone to know that something was going on but not knowing how to put it in words; "you want to share it so that it's not trapped inside" (Hine).

To maintain a sense of control

The need for control was a key function of self-injury, agreed upon by all in Te Roopu Tuatahi. Participants described how at times they felt as though they were losing control over everything else in their life, and so they would turn to self-injury (almost always cutting) to regain a sense of control over something. They talked about wanting to keep it to themselves and not harm anyone else and handle their issues on their own. As one participant described: "You didn't need permission from anyone to do it... it was a secret that was just mine." One participant pointed out the irony in the fact that they would never cause this form of harm to others; that it was never acceptable to cut anyone else, and yet they gave themselves permission to do it to their own bodies, "no one can tell you what you can and can't do to your own body". They also spoke of their need to gain a sense of control over something in their lives when they felt that everything else was spiralling out of control. Aroha shared how cutting helped her to feel like she was in control. She described how she had always suffered from anxiety

and depression and nearly lost her child to social services because she had a "breakdown" when she found out her boyfriend had cheated on her and just couldn't cope. Cutting, for her, was something that she could do for herself that nobody could take away from her. It was the only thing in her life that she felt like she could control at that time, and that helped ease her anxiety and manage her emotions so that she could be there for her child.

As an alternative to suicide

A common misconception by those who do not understand self-injury is that it is an attempt at suicide (Klonsky et al., 2016). One powerful statement from Mihi echoed the sentiments of the group; that self-injury was actually the opposite of suicide; that it was keeping them from attempting to take their own life:

> Self-injury is different to suicide because with suicide there is no hope that things are going to get better. But with self-harm, there's still hope that things are going to get better some day and this is just what's helping you now till you get there. You're still wanting a second chance.

One participant said that at times they had cut "to stop me from wanting to kill myself". This prompted a conversation amongst all *rangatahi* about how they felt that maybe it was not such a bad thing, to self-injure if the alternative was suicide. Mihi spoke of how, when they were in that state of mind of self-injuring, it felt as though to them there were only two options – to cut or to end their life. And so, at that time, to self-injure seemed like the better option. The difference between suicide and self-injury, for them, was that with self-injury there was still hope, whereas with suicide they felt like things never get better. All participants in the cohort agreed that suicide was final, and, to them, that was a waste of life.

The topic of suicide was commonly discussed in the series of *hui*, and all but two

of those in the group had attempted to take their lives in the past, with many making

multiple attempts. They spoke openly and honestly about these experiences, and all of

them were grateful that they had been unsuccessful in their attempts. Many spoke of

how, at the time, it seemed to them like they were alone in their pain. They had since

realised that there are always options, better alternatives, and people who they could

turn to, but they were just unable to see it at the time.

In reflecting on these conversations about suicidal thoughts and behaviours, this

was a key message that came out of the series of *hui*; that *rangatahi* needed to realise

that there was always someone that they could turn to. However, one participant in Te

Roopu Tuatahi believed that this message, to reach out for help, was everywhere in

society. She said that *rangatahi* were always being told to reach out and ask for help.

However, the issue was, in her opinion, that they weren't being listened to. This

sentiment was strongly echoed by the rest of Te Roopu Tuatahi. They all agreed that it

was important to reach out to someone for help. In the past, they had all sought help

from someone, but they were not always listened to, or not in the manner in which they

had needed to be heard. One participant described thinking, "What's the point in

reaching out if no one's going to listen to me?"

Other functions, not representative of the group as a whole

Attention-seeking

Most of those from Te Roopu Tuatahi strongly rejected the notion that all self-

injury is attention-seeking. However, three participants acknowledged that more than

once they had self-injured to gain attention from someone close to them, purely for the

purpose of having the attention. They described how, if they wanted someone to see if

they would do it in obvious parts of their body that were difficult to hide, such as their

wrists. One participant described how at times she had felt their younger siblings received more attention from their parents, and that they had felt that they deserved some attention too. However, the views of these three *rangatahi* were not shared by the remaining members of Te Roopu Tuatahi; most believed that it was never done for attention in this manner (as opposed to wanting attention for something else that's going on). More often than not, participants in Te Roopu Tuatahi would prefer to hide their behaviour.

Addiction

One participant mentioned that they had heard of self-injury being described as an addiction, but that they themselves were never addicted to it, and many other participants were in agreement. However, I found this conversation particularly interesting given that in the preceding conversation participants had been discussing how powerless they had felt to stop. As Kapua noted:

> You can never say that you will never do it again because you never know what's going to happen in the future that might set you off. Something could happen down the track, even in 30 years' time, and you can't handle it, so you turn to what you used to do to get through.

Therefore, these participants were saying that, although they were at times powerless to desist self-injuring, had difficulty resisting the urges to self-injure, and engaged in this behaviour despite being aware of the consequences, they did not perceive it to be an addiction.

Who do they turn to for support?

The next section summarises the conversations regarding who *rangatahi* Māori who self-injure turn to when seeking help. Close friends acted as the initial support people for all of the participants who had self-injured; the participants had either

turned to their friends first for help, or their friends had discovered that they had been self-injuring by some other means, for example, noticing their scars and confronting them about them. Participants' experiences of being supported by whānau (parents, step-parents and grandparents) are then discussed and, finally, I have summarised the participants' experiences of being supported by different services. *Rangatahi* in both SFGs, and across all participant groups, became especially animated when sharing their experiences of guidance counsellors. These results are presented in this section for Te Roopu Tuatahi, despite them covering the views expressed by participants across all three groups (those who had self-injured, those who had supported *rangatahi* who had self-injured, and those who had never self-injured).

Regardless of who they turned to for help when self-injuring, the common factor amongst all participants in Te Roopu Tuatahi about their choice of initial confidant was that it was someone that they could trust completely to listen to them without judgment. It also helped if that person was someone reliable, who was always there for them, and who could let them be emotional.

Close friends

"Close mates understand your pain, and you don't have to tell them your whole story. They're the first people I'd turn to." Participants spoke of how much easier it was to turn to their friends first because they were the ones who had always been there with them, who knew what was going on in their lives and so when they (eventually) sought help they did not have to explain everything from the beginning. For example, Rangimarie explained that her best friend knew that she had been secretly in a relationship with a boy from school. So, when this relationship ended, and she was upset about it, she did not need to explain to her friend everything from the beginning; her friend understood and was there for her without asking any questions. By contrast,

238

she stated that if she were to turn to her mother for support, she would first have to tell her mother that she had been in a relationship, and then tell her that the relationship had ended. She explained that her mother would likely focus on the fact that she had been in a relationship and asked unhelpful questions, such as whether or not she had been having sex and had she used protection. Participants in Te Roopu Tuatahi spoke of how easy it was to turn to their friends because they understood the world in which they lived; they knew what it was like to be a teenager, they were "in the same time as them", and therefore relatable.

However, when I asked *rangatahi* how their friends responded when they found out, some participants shared experiences of how some of their friends had not responded in ways that were helpful. These responses included overreacting, which one participant thought came from a lack of understanding about self-injury and why they were cutting. Some spoke of how their friends had laughed at them or had betrayed their trust and told others. One participant said that she believed this to be a form of bullying; when they had turned to a friend whom they had thought that they could trust, and that friend had told others or had laughed about them, and/or had spoken about them behind their backs. Many *rangatahi* had had experiences similar to this, and one described it as the worst form of bullying because it came when she least expected it and was feeling the most vulnerable.

This, to me, highlighted the need to increase the awareness of all young people about helpful and unhelpful ways of responding to and supporting friends when they seek help. Many had experienced severe bullying from others in their peer groups, but it was these experiences of being hurt by those they were closest to that seemed to hurt them the most and deter them from seeking help elsewhere. I asked participants from Te Roopu Tuatahi how their friends could have reacted and supported them better. The

239

responses are incorporated into the section that follows on how *rangatahi* want to be supported when they self-injure.

Whānau

This section on participants' experiences of being supported by whānau members is divided into support from parents, step-parents and grandparents. Interestingly, when participants were asked who from their whānau they would turn to first, almost all participants from Te Roopu Tuatahi said that they would turn to an older sibling or a cousin. These were people who were of the same generation, but in most cases, slightly older than them. They talked about how often these siblings or cousins were more like best friends. Overall, *rangatahi* talked about how the most important factor in choosing someone to confide in was that it had to be someone who could relate to them. Ultimately, they were seeking a support person who was relatable, trusting, who would listen and support, and not judge.

I asked participants in Te Roopu Tuatahi if they would have been less likely to self-injure had they had an adult in their life who they could trust. Approximately one-third of the Te Roopu Tuatahi agreed with this. However, others said that they believed that they did have an adult who they could confide in. However, they chose not to because it was easier to turn to someone of a similar age.

Parents

A lot of the conversation regarding help-seeking centred on parents specifically. As mentioned above, a key function and significant barrier for *rangatahi* Māori when seeking help for their self-injury was a fear of losing control. This was especially true when it came to confiding in parents; most *rangatahi* were reluctant to turn to their parents for support because of that fear of losing control.

240

One participant in Te Roopu Tuatahi explained that she was close with her mother and, although her mother had never been her first choice as confidant, she had shared most of her life with her mother eventually. She shared with the rest of the group that she believed *rangatahi* should be open and honest with their parents rather than try to hide information from them because they would find out eventually, and if they learned that their child had hidden something from them, it could hurt them. However, many participants across the cohort disagreed with this, some very strongly, stating that there were things that they would never share with their parents. All participants were asked how much of what they did every day – where they were and how they spent their time– that their parents knew about. Most participants settled on about half, as in, their parents only knew about half of what they got up to.

Step-parents

Some of the participants in Te Roopu Tuatahi spoke of how they had great relationships with their step-parents. One described her step-mother as the adult who she would turn to for support. Coincidentally, this step-mother was the participant's whānau support person for this research, who also had a history of self-injury.

It is worth noting that turning to their step-parents was not always an option for many *rangatahi*. Having step-parents in their lives was significant stress for over half of all *rangatahi* in all three groups. For some, having already lost a parent through death or other significant family situation, it was an additional stressor to then have to cope with the changed family dynamics that came with having a step-parent, and often step-siblings also. *Rangatahi* who self-injured discussed the challenges that this entailed. They spoke about how much their lives changed when their step-parents had entered their lives. One talked about how, before her step-mother came along, she had had a close relationship with her father where he trusted her and, as a result, gave her a lot of

241

freedom to come and go from their home as she pleased. However, she spoke of how this had changed when her step-mother moved into their home. Her step-mother had treated her differently from her biological children, for example, by being the only child who was scolded for doing something that the step-mother's children had also been doing. This participant described how this, in turn, caused tension between the step-siblings, which provided even more stress.

Another participant spoke of how difficult it was when her mother found a new partner some years after her father had passed away. This participant described how hurt she had felt at this, and she resented her mother for moving on when she herself was still grieving for her father. She said that she also felt that with her mother having a new partner she now had to compete with the new partner for her mother's love and attention, and this caused her to feel even more alone.

Grandparents

Six of the 12 *rangatahi* in Te Roopu Tuatahi said that they had a close relationship with a grandparent. However, not all of the *rangatahi* in the cohort said that their grandparents were people they would ever confide in. Some participants spoke of how their grandparents had responded in unhelpful ways upon discovering that their *mokopuna* had been self-injuring, often by overreacting or getting angry. But other participants said that if or when they did confide in a grandparent, they had typically responded in ways that helped.

The question was put to the cohort, in what ways did grandparents respond that were helpful? Some participants in Te Roopu Tuatahi described a close bond with a grandparent that was built on trust and mutual respect. Some also believed that their grandparents were able to relate because they had had their own vast range of life experiences from which to draw. There was also an element of loyalty; participants

242

shared stories of how their grandparents had taken the side of their *mokopuna* in an argument with their parents. Others described how their grandparents listened with genuine empathy and made attempts to understand them.

One participant in Te Roopu Tuatahi spoke of how she loved that she could talk to her grandmother about boys. Another participant shared how, when she confided in her grandmother that she had been cutting, her grandmother simply responded by saying "been there, done that". This participant said that she knew that her grandmother was being genuine and appreciated that her grandmother did not overreact. She said that her grandmother listened to her, without trying to fix the problem.

Another participant, Erana, shared this story about confiding in her grandmother. She had been helping her grandmother clear out her garage when Erana found her grandmother's old school stationery. Erana opened the case and found a pencil sharpener with a blade removed, and immediately knew what this meant. Erana then turned to her grandmother, rolled up her sleeves and showed her grandmother her cuts. She immediately knew upon seeing that pencil sharpener without blades that he grandmother used to cut. They sat there in the garage all afternoon and talked, and cried. Her nan cried for her, which meant a lot to Erana because she had always looked up to her nan as strong, knowing that she had been through a lot in her life.

Stories such as this highlight the close connection between a grandparent and *mokopuna*. This relationship has a potential protective factor for *rangatahi* Māori which warrant further exploration as key findings of this research.

Professional support people

In addition to friends and whānau, *rangatahi* also spoke of their experiences of being supported by other health professionals. Guidance counsellors were the primary

243

topic of conversation across all participant groups, and the participants' views and experiences with guidance counsellors form the largest part of the section that follows.

Guidance counsellors

Aside from the three youngest participants in the cohort (who were from Te Roopu Tuatoru), all other participants had seen a school guidance counsellor for help at least once while at secondary school. Unfortunately, the majority of the conversations regarding school guidance counsellors were negative – participants did not feel that many of their guidance counsellors had done an effective job at supporting them. However, some participants spoke of how much they had appreciated the support of their guidance counsellors on numerous occasions. Therefore, while this next section summarises some of the conversations regarding the challenges that *rangatahi* Māori had encountered with their school guidance counsellors, it also highlights what some guidance counsellors had done that was successful, and suggests ways that guidance counsellors could be more effective when working with *rangatahi* Māori.

Twenty of the 25 *rangatahi* asserted that their school guidance counsellor was the last person that they would see voluntarily to talk about their problems. Some of the reasons that participants had seen a guidance counsellor included to seek help for self-injury and other "emotional stuff" they were experiencing. However, some participants acknowledged that they had only been to see their guidance counsellors to get out of going to class. Only two of the *rangatahi* in Te Roopu Tuatahi chose to go and see a guidance counsellor, while the rest of the cohort had been referred to see one, either by friends, by another teacher, or they had been called in at the request of the guidance counsellor.

To summarise the key points regarding guidance counsellors, many of the participants said that often they did not want their guidance counsellors to solve their

problems; they just wanted someone to talk to who would not judge them and who would not tell others. Trust was a big issue; from the participants' perspective guidance counsellors needed to spend time building it, and to not betray it. Many also said that they preferred that there was a mutual sharing of information, and wanted a guidance counsellor who would take their side and be on their side. They also felt that it helped if they were Māori and able to relate to their experiences, having been through similar experiences themselves. Many *rangatahi* in Te Roopu Tuatahi agreed that they did not want to talk to anyone unless they had been through it themselves. By this, they did not necessarily mean only those who had self-injured, but people who had had their own challenges and struggles from which to draw. As one participant described it: "I don't want someone to give me advice based on a book. I want them to tell me based on their own experience."

Other services

Some participants in Te Roopu Tuatahi had first told a health professional, such as a GP, that they had been self-injuring. One participant explained that she preferred talking to her GP because "they did not gossip as counsellors did". However, the rest of the participants who had talked to a GP about their self-injury reported negative experiences. They spoke of how they felt that whenever a GP noticed their scars, they would raise it as an issue of concern and refer them to services, without listening to the participants who had tried to explain to them that the scars were old and not currently an issue for them.

Many of the *rangatahi* also did not like the local Crisis and Assessment Team (CAT Team[32]) becoming involved. However, they did not elaborate as to why, other than to say that they were annoying and ineffective. Some admitted lying to them to avoid having to deal with them, by saying that they were just doing it for attention, which was untrue.

Many of the *rangatahi* in Te Roopu Tuatahi had also been in contact with youth-specific services, such as Evolve and Vibe in Wellington, and Kapiti Youth Support in Kapiti. The participants felt that youth-specific services such as these were essentially a "one-stop shop" for all youth health needs, including finding a midwife, seeing a nurse or GP, and referrals to maternal mental health and Māori mental health. They also appreciated that these services were "culture-friendly"; their workers were from diverse backgrounds – including people who were Māori, Pacific Islander, and LGBTQ. Participants appreciated that these services came across as non-judgmental, and they appreciated the "one-stop shop" nature of the service because it meant that they could go through the one service and have access to so many different services. One participant explained that meant that "you only have to go through them not get up the courage to go see a whole lot of different services and feel like you're doing it on your own."

Four participants from Te Roopu Tuatahi had had experience with helplines, such as Youthline, but no one in Te Roopu Tuatahi had found them helpful. When asked why they were unhelpful, one participant explained how "all you want to do is talk but

---

[32] Crisis and Assessment Team

they ask you a million questions first, and by the time they get through them you feel stupid and just hang up."

Not all of the *rangatahi* in Te Roopu Tuatahi had been through the Māori mental health services, but those who had spoke highly of them. They spoke of how they actually wanted to go to them, as opposed to feeling like they were sometimes forced to see other services. Some talked about how they liked that those working in these services did not force them to talk if they did not want to. They also liked that the Māori mental health services did not just focus on their presenting symptoms, such as being depressed. They took a broader approach at everything that was going on for that person. Participants also spoke of the value that these services placed in being grounded and secure in *te ao Māori* (which will be discussed further in the section on culture). One participant related that "they also told stories about Māori gods that weren't really relevant but were just really cool ways of understanding and reconnecting with our culture."

How rangatahi Māori would like to be supported

Having discussed who *rangatahi* Māori choose to turn to and their experiences of being supported by different groups of people, this knowledge is now used to explore the ways in which *rangatahi* Māori were supported by the groups that have just been discussed; what has helped and not helped when being supported. These results are presented across support groups as different attributes of an ideal supporter regardless of whether it is a friend, parent, grandparent or a health professional.

A key message about how *rangatahi* Māori who have self-injured would like to be helped was that often *rangatahi* do not think that they need to be helped. This is summarised by one participant who said "I don't remember wanting help... you feel like you can do it all by yourself". Another spoke of how she did not appreciate it when those

247

she had confided in were looking for something that they could fix. She explained that "[s]ometimes we don't want to be fixed because we don't see ourselves as broken. We just want to be heard". However, they all agreed that *rangatahi* who were self-injuring or thinking about self-injuring needed to talk to someone, and the key here was to find someone who would listen. "[K]eeping it hidden doesn't help. You have to find someone you can trust…"

That some *rangatahi* who self-injure do not feel they need help highlights the process of help-seeking, which Cauce et al. (2002) break down into three stages: recognising that there is a problem, deciding to seek help, and selecting a help provider. Some of the *rangatahi* from Te Roopu Tuatahi did not believe that they needed help or had not sought help from others; rather they had supported themselves to manage their problems by self-injuring. In their paper on help-seeking behaviours in ethnic minority youth, Cauce and colleagues (2002) highlight the complexity of the help-seeking process, whereby it is not a straightforward linear pathway, and culture and context influence each of the stages. They assert that the decision for an adolescent and their family to progress from problem definition to service selection is influenced by one's culture.

What doesn't help when being supported?

The conversations regarding unhelpful ways that they had been responded to upon disclosing their self-injury centred predominantly on their parents; often parents did not respond in ways that they were helpful. This stemmed from the parents and whānau being caught off guard, and a lack of knowledge regarding what self-injury is, how prevalent it is, and what it means. Unhelpful responses including acting like the *rangatahi* could no longer be trusted, ignoring the behaviour, being influenced by the

media (which in turn can lead them to overreact), being judgmental, expressing shame and embarrassment, calling their bluff or challenging them.

Some participants in Te Roopu Tuatahi shared instances when their parents had found out that they had been cutting and from then on had acted towards them as though they could no longer be trusted, as if they were going to attempt to take their own lives. They described how they felt that whānau members were always watching them, hiding the knives, and spoke of how their parents had gone through their personal belongings looking for blades.

Some parents had responded with anger, which the participants felt came from not knowing how else to respond, and a lack of understanding as to what the behaviour was about and why they were doing it.

Some parents had ignored it and refused to acknowledge it; they had seen their cuts but ignored them because they did not want to believe it, or did not know how to respond or deal with it. Participants agreed that if they believed that their parents would overreact if they did find out, then they felt that it was better if they just never found out because of the risk that they would overreact, which almost always made everything worse.

The *rangatahi* in Te Roopu Tuatahi also talked about how they felt that the media influenced their parents' worrying. Parents would see teenagers overdosing or self-injuring in the news or on social media, and the participant felt that this then put the thoughts in their head that these behaviours were what all teenagers did. They believed that parents then thought that they needed to crack down on these behaviours, regardless of whether or not there was any evidence that their *rangatahi* were doing it.

Other unhelpful responses from parents included coming across as judgmental. Pare provided an example of how she had been lectured about her body being a temple,

249

and that what she was doing was stupid and sinful (she described her whānau as having strong Christian religious beliefs). *Rangatahi* described how, when someone they confide in comes across in this manner (i.e., giving a lecture on self-injury being wrong, or 'anti-self-injury') it caused them to feel even more ashamed, thereby making it even more difficult to reach out for help.

Judgment and feelings of shame can also come from strangers. *Rangatahi* in Te Roopu Tuatahi shared how unhelpful it was when people that they did not know noticed their scars and looked at them with judgment. Some shared stories of complete strangers walking up to them and asking about their scars, or giving them a lecture about how what they were doing was wrong. These strangers were unaware that these *rangatahi* had not self-injured in years; because their scars were still visible they felt like people judged them for having those scars. This was especially hard for the participants from Te Roopu Tuatahi who were young mothers. All those with babies in the group self-injured before they had had their babies, and some had ceased once their babies were born. However, regardless of whether or not they still self-injured, participants spoke of how, when they would drop their children at day-care, or visit their GP, or be at the playground with their children, they felt as though they were being judged because not only had they hurt themselves on purpose but they were also mothers. These participants spoke of how no one asked them about their behaviour; rather, these strangers just made assumptions. As mentioned above, some participants had experienced complete strangers approaching them and asking about their scars. While they described finding this somewhat intrusive, these participants spoke of how they had preferred that people asked rather than simply making assumptions. However, this needed to be conducted with genuine concern (rather than judgementally) or 'anti-

self-injury'. It also helped if people, even complete strangers, focused on them as individuals rather than just the behaviour.

Rangatahi also did not appreciate it when someone who they confided in then challenged them, which had happened on numerous occasions. For example, two of the *rangatahi* in Te Roopu Tuatahi shared experiences of their parents saying to them "why don't you just kill yourself and see if anyone would care". When asked how they would have preferred their parents to respond, one participant wished that her dad had instead said "I do care about you and I wish you wouldn't do it, but if you're going to then can you come and talk to me about stuff".

How can a supporter best support rangatahi Māori when they self-injure?

Some of the ways in which *rangatahi* Māori would like to be supported when they self-injure have been touched on already; for example, by being listened to rather than being fixed. In this next section, all of the attributes of an ideal supporter are presented: common attributes and behaviours of an ideal supporter that are factors agreed on by most of the participants in the group. These attributes include being free to express their emotions safely, someone who is relatable and trustworthy, and are able to connect *rangatahi* with their culture in appropriate ways.

I mentioned to Te Roopu Tuatahi that as part of my research, I had been looking in to traditional Māori understandings of what could be considered as self-injury today. Many of the group said that it was not really relevant, and did not resonate with why they did it today. They said that the traditional behaviour was from a different time. But where they agreed it might be relevant was for their older generations – parents, nannies and koros, aunties and uncles – to maybe help them to understand that it's something that people have been doing for years. As Hine described:

It's helpful to learn about traditional Māori self-injury… like what our *tūpuna* did back in the day and why they did it. Understanding why they did it and even if it isn't relevant to us today it still puts things in to context. And it might help other people to know that it's not something that's new, that what we're doing isn't new it's been around for a long time. Might help people to not overreact when they find out.

It was encouraging to note that for some *rangatahi* this conversation struck a chord, and one participant in particular spoke to me at a follow-up *hui* about how excited she was to go away and learn more about *kiri haehae*, and whether perhaps her ancestors did it. What seemed apparent from the conversations with Te Roopu Tuatahi about the involvement of culture in how they were supported was that culture mattered: "Knowing your culture is important 'cos then you don't have to question who you are. It makes you feel part of something. Makes you feel grounded." The key messages from *rangatahi* regarding the importance of culture were that, first, good support people help *rangatahi* to reconnect with culture, where appropriate. Secondly, they all felt at that time that being *Māori* was a good thing, something positive and to be proud of. And, finally, they appreciated their identity as Māori for enabling them to feel as though they were part of something bigger than themselves, and not so alone.

Attributes of an ideal supporter

1. *They allow them to express their emotions safely.*

The ability to regulate emotions is a key function of self-injury in international literature that was also found to be applicable to a sample of *rangatahi* Māori in Study 1 of this research. The participants from Te Roopu Tuatahi spoke of how they appreciated guidance counsellors who provided them with a safe space that provided respite from the bullying, peer pressure and other stressors. In addition, these people and places provided the avenue for them to let out everything that they were feeling, but in a safe

manner. Some participants talked about supporters who could contain them, could temper their emotions in a way that allowed them to express their emotional experiences while someone was looking out for them and keeping them safe.

2. *They listen.*

"When I talk to someone I want them to just listen to me until I finish and then give me a hug". When participants spoke of what people had done that had helped it was almost always by just listening and supporting. One participant spoke of how she appreciated that her mother let her cry and scream it all out of her while her mother held her. Her mother did not force her to talk or explain herself, and most importantly for this participant, her mum did not try to fix her. Many *rangatahi* echoed this sentiment that when they turned to their parents for help often they did not want to be fixed, they just wanted to be heard. Other *rangatahi* spoke of how they did not appreciate it when their parents would not listen, except to listen for a solution, something that they could action or solve.

3. *They are always there for them.*

Those in SFG One talked about how, following the first *hui*, many of their whānau members had tried to talk to them. Some felt that their whānau had suddenly expressed a keen interest in what was going on for them, but prior to participation in this research they had not showed a lot of concern. Some participants were irritated by this, with one participant wondering "why have they never known, or asked, or cared, until now?" As this discussion evolved, it seemed as though the key issue was that some *rangatahi* wanted to feel as though whānau were there for them all of the time. This was, as Rangimarie put it, so that when the time came when they needed the love and support of their parents, it was natural to confide in them.

But if she's not there for me when I'm just having a crap day, or if someone said something not nice to me when I'm in primary school… but then expects me to tell her everything when I'm a teenager and start cutting? Not gonna happen. It'd be too weird, I would've already found someone else who is my go-to.

Rangimarie went on to explain that this was why she always confided in her close friend first: "'cos they go through all the little things with you and then it's just natural to be able to talk to them about anything… 'cos they've always been there."

What I think what these *rangatahi* are saying is that, unless their parents have always been their support people, suddenly starting to turn to them now would not work. Whānau need to continue to support and always be there. I put this to the participants, and some disagreed and said that they would not turn to their parents regardless of whether or not they were available, others (in particular the females in Te Roopu Tuatahi) said that they would have liked to have a mum who was always there for them.

4. *They focus on 'why' rather than 'what'.*

An ideal supporter does not solely focus on the behaviour. Rather, they focus on what is being communicated through the cutting. This is logical if we consider that self-injury can function to communicate distress. In describing how she had supported a friend who had been cutting, Mihi said:

When I saw that she'd been cutting I was just like "okay so you've cut yourself and that's obviously what you think you needed to do, but let's just wrap this around it and then you can talk to me about what's going on."

All participants spoke of wanting help for the reasons that caused them to hurt themselves, for example, financial difficulties or familial conflict, as opposed to the actual behaviour of cutting. However, many believed that these issues are hard to address and, therefore, supporters were reluctant to deal with them. "When they see

254

your cuts, they're like "oh this is something that we can help you with now". Another *rangatahi* described the response of her GP as "we can get you help for cutting but we can't help you with life because we only have 15 minutes for this appointment."

To the *rangatahi* in Te Roopu Tuatahi, focusing on the problems rather than the behaviour seemed like a no-brainer to them because, if a supporter were to only focus on the cutting, as soon as that person went home or returned to the same circumstances that drove them to cut in the first place, they would start cutting again. It is likely that under the same conditions, within the same environment, a person who has used cutting as a form of coping would revert back to that behaviour. In essence, this approach is about treating the cause rather than the symptoms.

5. *They don't force them to seek help.*

Importantly, an ideal supporter is someone who doesn't force them to go and talk to others. This conversation was especially relevant for guidance counsellors; participants found it difficult when guidance counsellors had asked them to meet with whānau members before they felt ready to do so. *Rangatahi* appreciated supporters who had let them seek support from others in their own time, and who had worked alongside them to help them to build up the courage to open up to others.

Pare shared a story of her experience of supporting a friend she knew had been self-injuring. Pare spoke of not pushing her friend to go and speak to a teacher until her friend was ready and, in the meantime, all Pare had to do was listen to her friend and be there for her. When her friend was ready to seek help from others, Pare went along with her to the guidance counsellor. What was important about this story was that although her friend had insisted on going along to see the guidance counsellor, Pare had gone along as a support person. Pare described how it was lucky that she had been there, because when her friend began talking, she had lost the courage to speak to the

255

guidance counsellor. Pare described how the friend had suddenly felt "silly, like she was making a big deal out of nothing". And so, this friend said to the counsellor that she was fine, to avoid having to talk about why she was really there. That was when Pare interrupted and explained to the guidance counsellor why her friend needed help. Pare stressed that if people were to do this, it needed to be in a way that did not cause their friend to feel betrayed.

In a similar vein, participants from Te Roopu Tuatahi talked about how important it was to tell someone they trusted, no matter what time of day or night. Again, Pare explained why this was important:

> [B]ecause, sometimes you can be feeling really low, really down about everything but then in the morning, even if it's been the longest night of your life and you haven't slept and you've been up all night crying… by the morning you're feeling a bit better about things just because it's morning and you have to get on with your life, you can't be feeling sorry for yourself anymore. Until the next night when it's dark and you're alone and feeling like crap again. So, if you send a text to a mate at that time, or reach out for help in some way, even if it's just to say that you're feeling like shit, but don't want to talk about it right now 'cos it's not an emergency but maybe in the morning we could catch up for coffee or wag class and talk. That way you've let someone know so that in the morning when you're feeling better your mate still gets you to talk about it. You might feel silly like you were being dramatic the night before but you've just gotta tell them.

6. *Connects them with their culture in some way.*

While no participants in this sample had ever been to see a Māori guidance counsellor, some had seen Māori social workers about their self-injuring. Those who had seen a Māori social worker believed that it was easier to talk to a Māori social worker than a non-Māori social worker because they "come from where you come from, they're easier to relate to, and they understand, especially about whānau and respect

256

that sometimes you don't want whānau to know". These participants appreciated how the social workers, counsellors and psychologists at Māori services had opened up in small ways about their own lives, and those who had children talked about them. They appreciated this because it made them seem normal, "like real people who aren't perfect".

As illustrated previously, the *rangatahi* varied in the nature and extent of their identity as Māori, from those who did not know their *whakapapa* connections to those able to speak te reo. What was significant for the *rangatahi* in Te Roopu Tuatahi was that, despite that the extent to which they identified as Māori differed, all participants agreed that being connected to their culture in some way helped them on the pathway to healing.

Those who did not feel strongly connected to their identity as Māori spoke of how they appreciated the services and people who encouraged a connection with their culture. Some talked about how they had never felt confident about "all that Māori stuff" because they never engaged in it with their own whānau. At the same time, they had always wanted to, and one participant spoke of how she was grateful to her social worker who gave her the confidence to join her *kapa haka* group at school.

One guidance counsellor taught her students *karakia* to say at the start and end of each session, as well as a *karakia* for food. Other social workers had helped participants to learn how to say their *pepeha*. One participant, Pīata, spoke of how this ignited her interest in learning more about her *whakapapa*, to the extent that she took a trip home with her son to visit the *maunga* and *awa* from her *pepeha*, which she had never been to before. This process of Pīata reconnecting with her *whakapapa* sparked the rest of her family to do so also and this was good for all of them, to reconnect, and opened the door for them to engage more in their *iwi*, spend more time on their *marae*.

257

An interesting aspect of these conversations within the series of SFGs was that other *rangatahi* in the group who were not yet comfortable in reconnecting with their culture heard how others had done this, and acknowledged that they themselves were starting to think about how they could begin this process for themselves.

To summarise, the features described by *rangatahi* Māori and attributes of an ideal supporter are safe emotional expression, listening, always being there, focusing on why rather than what, not forcing help-seeking, and connecting them with their culture in some way. Other attributes of ideal support people included the ability to distract them from wanting to self-injure when necessary, not overreacting at discovering that someone had been self-injuring, not judging their behaviour, someone trustworthy and relatable. Interestingly, some participants also mentioned the desire for supporters to have their own lives in order and control, so that they are able to solely be there for them in that moment.

Other ways that rangatahi Māori would like to be supported

Other places that *rangatahi* turned to for support included their peers and the internet.

Peer-support networks

One of the most significant outcomes of this research process was the process of the *hui* themselves. The feedback from most of the *rangatahi*, and all of those in Te Roopu Tuatahi, indicated they enjoyed coming together as a group to talk about this subject, and they wished that there were more forums such as our focus groups. They described how they felt the group provided a place where they could all come together and just sit and talk, in a safe space, without being judged. It also helped that their whānau knew about the *hui* and gave their permission for the participants to attend. They appreciated that the focus of the group was only on sitting around, talking and

sharing *kai*; most other forums available for youth typically centred around an activity, such as sport, that was not appropriate for all the *rangatahi* – many liked to simply socialise with their peers.

When asked if similar *hui* would work if run by a guidance counsellor, they all disagreed, explaining that they could not trust that the guidance counsellor would maintain confidentiality (based on past experience). As one participant articulated: "It's easy to talk openly and honestly with people who you don't have like an actual relationship with, who you don't see every day." She explained that these series of *hui* were different from talking with a guidance counsellor because in these *hui* they were simply sharing thoughts and experiences, rather than looking for help. When you see a guidance counsellor, she explained, it's because you need help, so there needs to be that trust and mutual respect.

It also helped that everyone in the group was in some way Māori; that was the one common factor that brought everyone together. They appreciated that there was no pressure to speak or contribute; everyone shared their thoughts and feelings in their own time and way.

Websites

Some participants from Te Roopu Tuatahi had turned to the internet to seek help when self-injuring, but they did not find a lot of useful resources online. There were websites from local organisations in Aotearoa, such as The Lowdown (Health Promotion Agency Website[33]), which contained stories about *rangatahi* who had self-injured. However, the participants raised several issues with the stories on sites such as

---

[33] https://thelowdown.co.nz/

these. They felt that some of the stories seemed fake and not relatable. Often, participants had turned to these websites to hear from others who were going through what they were going through, to validate their feelings and to feel like they were not alone. Their criticism of these stories was that they all ended happily, but they felt that this seemed too unrealistic. Participants talked about needing them to be raw. As one participant described: "When she said "It's been 3 months and now my life is great…" I was like 'but that's not how I feel', which then makes you feel worse because they're feeling better but I'm still feeling shit…"

Other participants agreed with this, explaining that they wanted to be able to relate to what they were going through at that particular moment.

Alternatives to self-injury

In Chapter 5 I discussed the power of *kaupapa Māori* in taking a strengths-based approach to research. This can be manifest in numerous ways, and in the current research, one way in which I have endeavoured to apply this has been in the questions that I have asked. Asking questions that provide solutions and alternatives to mental ill-health are useful. In this research one question that I asked of *rangatahi* across the cohort was what they did as alternatives to self-injury. Participants from Te Roopu Tuatahi spoke of what they did when they felt the urge to self-injure, and what behaviours they had used to replace self-injury but which served the same functions. Their responses were mixed, with some describing positive and adaptive behaviours, such as meditation and connecting with whānau. However, some of the alternative behaviours may be considered maladaptive, as ways of handling their issues when life got too much. This next section begins by expanding on some of these 'maladaptive' behaviours, and then discusses some of the more positive alternatives to self-injuring as a means of regulating their emotional experiences.

Maladaptive coping strategies

As alternative behaviours to self-injuring, some of the behaviours that participants from Te Roopu Tuatahi described could be considered to be maladaptive. These behaviours included catfishing,[34] smoking, drinking, and unprotected sex.

When participants from Te Roopu Tuatahi talked about catfishing, they described it as "being able to hide behind an image that you wish was you" and "a way of being someone you want to be."

Having unprotected sex was described by some participants as an impulsive act when they were either bored or tired of how their life had been. Only two *rangatahi* described this as a behaviour that was an alternative to self-injury, the others in the group felt that they or others did this for different reasons than to cause harm to themselves.

Participants also spoke of drinking and then driving under the influence as an alternative to self-injury. Those who agreed with this as an alternative to self-injury stated that the mindset was the same with both behaviours: "F this shit, F the world."

Adaptive alternatives to self-injury

Alternatives to self-injuring that were more positive or adaptive behaviours, included listening to music, meditation, anonymous blogging, and being around whānau and loved ones.

1.   *Music.*

All *rangatahi* enjoyed listening to music regardless of how they were feeling. When feeling down, many participants asserted that they did not want to listen to

---

[34] "A catfish is someone who pretends to be someone they're not using Facebook or other social media to create false identities, particularly to pursue deceptive online romances." (Urban Dictionary)

necessarily 'cheerful' or happy music; instead they preferred music that validated their mood. Often, when others (usually adults) suggested that they listen to music they were recommended to listen to happy music, which just annoyed most participants. One participant likened it to when someone was feeling heartbroken after a relationship break-up:

> When you break up you're not gonna go listen to lovey songs about women finding the man of their dreams, 'cos this is just gonna make you feel worse 'cos you think you're never gonna find that love and it'd remind you of what you've lost. If you got cheated on, listening to songs by Rihanna or Beyonce where she's singing about being cheated on and getting revenge – that's what you want. To relate and to know that others have gone through that too; other strong, powerful women. Even if it's just a song, you can visualise yourself in that position and what you would do – trash their car and all that.

This story was shared with humour – almost everyone in the room was laughing to the point of tears at her retelling of this. Many later agreed that they could relate to the need to hear music that validates your feelings and can also empower you.

 2. *Mindfulness and meditation*

One participant from Te Roopu Tuatahi, Pare, meditated daily; she said that she had figured out that this was what helped her to "keep herself together". She had also helped others to meditate to calm down when feeling anxious. She spoke of how one friend had called her feeling stressed and unable to sleep, wanting to cut but trying really hard not to cut. And so, Pare guided him through a meditation to calm him down. This centred around focusing on his breath and visualisation techniques, which, in my opinion sounded a lot more like mindfulness practices and relaxation. As Pare was describing this practice, another participant, Erana, realised that this was what she also did to calm down but did not think of it as meditation/mindfulness. She said that her

'Nan' (grandmother) had taught her to visualise being back home at her whānau homestead, where she grew up. She imagined that she was standing with her feet in the river by her house, which was also her ancestral *awa* that she had recited in her *pepeha*. She imagined the wind in her hair and the sun on her face, and her Nan told her that the sound of the wind was her *tūpuna* whispering to her, calling her. Her Nan would also tell her she was safe; that nobody was watching, nobody was judging.

Erana then went on to talk about how going home and physically standing in her *awa*, or climbing her *maunga*, was what she had done once when things got really bad, to the point where she wanted to take her own life. She talked about that reconnection with Papatūānuku, and of how powerful it was to be on her own *whenua*. When she was asked if any *awa* or *maunga* would do she spoke about how it was not just about being in nature but about walking in the footsteps of her *tūpuna* and reminding herself that they were there with her, that she was not alone. In hearing her speak, some of the others in the group spoke of how they wished that they could do that; they wished that they had felt connected enough to where they were from so that it could be a source of healing.

3.   *Tattoos and tā moko*

Participants shared stories of getting tattoos or *tā moko* to cover their scars from cutting, and that this was a part of their process of healing. They described how these tattoos symbolised the reclaiming of their body, a new sense of control, in a healthier way. These tattoos were not necessarily cultural; some had tattooed their daughter's name, or something else symbolic (for example, a butterfly to symbolise freedom and new growth). One had a *tā moko* of their *awa* on their wrist not only to cover their scars, but also because their *awa* symbolised cleansing for them.

4. Whānau

All of the *rangatahi* in Te Roopu Tuatahi spoke of how important whānau were to them. What was interesting was how their definitions of whānau differed. Eight of the 12 participants from Te Roopu Tuatahi were young mothers, and some of these eight mothers described being ostracised from their whānau upon becoming pregnant. For different reasons, they were no longer in contact with their *whakapapa* whānau[35] but talked about how they had built their own whānau, either with other young mums from their school, or with extended *whanāu*. Thus, how they defined whānau was not necessarily by blood, but they all agreed that whānau was an important source of support and strength. This was consistent with the notions of *whakapapa* whānau and *kaupapa*-based whānau (Cunningham et al., 2005)*.*

These young mothers talked about how becoming a mother had changed their lives for the better; some describing the experience as the best thing that had happened to them. While they acknowledged how difficult it had been, in describing why this was such a life-changing experience for them, they shared stories of how becoming a mother "gave [them] a reason to stick around". One participant spoke of a fear that one day she might cut too deep, and this stopped her from cutting. As she explained, "I think having a baby is probably the only thing that has kept me around…. It's the only thing that has kept a lot of girls around".

The young mothers also talked about how becoming a mother made them want to build stronger connections with their culture so that their son or daughter could

---

[35] Defined in Chapter 2 as family related by ancestry or blood.

264

grow up knowing that they were Māori and what that meant. They had "realised the value in knowing who you are and where you come from so that you can stand strong".

Becoming a mother was also a deterrent for self-injuring because of the stigma they experienced as a young mother with scars, and the fear that someone would be concerned and report it to the authorities, and that they might have their children taken from them. One of the mothers from Te Roopu Tuatahi talked about how her son was rough and always play-fighting, and so he always had a bruise or a scratch somewhere on his body just from playing around. But she talked about how she felt that other mothers at her son's day-care looked at her suspiciously because they thought he was being abused, and they judged her for her scars.

A powerful message from these participants who were mothers was that being a parent motivated them to look after themselves, and to do whatever they needed to do to be well, such as seeking help when needing it rather than trying to manage on their own. For one participant, this also included making sure she did not miss a GP visit "because it's not just about me anymore. Like I have to make sure that I take my medication so that I can look after my son... you just do it 'cos you have to."

The voices of rangatahi who self-injure: Analytic summary of Te Roopu Tuatahi

The conversations from participants in Te Roopu Tuatahi have been presented as conversation topics covering how they define and experience self-injury, and their experiences of being helped, and of helping themselves. The next section focuses on the experiences of supporters; of siblings, friends and whānau members who have supported *rangatahi* Māori who had self-injured.

Supporting *rangatahi* who have self-injured: Analysis of Te Roopu Tuarua

Te Roopu Tuarua was composed of both *rangatahi* participants and whānau support people. Four members of Te Roopu Tuarua were *rangatahi*; two had siblings who were in Te Roopu Tuatahi, two *rangatahi* had supported friends, one of whom was in Te Roopu Tuatahi, and the other was not a participant. None of the *rangatahi* in Te Roopu Tuarua had self-injured. Four of the members of Te Roopu Tuarua were parents or step-parents who had supported a child, and three participants were *kaumātua* (grandparents) who described their experiences supporting a *mokopuna* (grandchild) who had self-injured. There were 11 participants in Te Roopu Tuarua.

This next section summarises what friends and whānau define as self-injury, who self-injures and why they think *rangatahi* self-injure. Importantly, this chapter depicts first-hand experiences of those who have supported *rangatahi* who have self-injured. Within these stories are powerful messages about what helps and does not help when supporting *rangatahi*; in particular, the powerful stories from grandparents of supporting their *rangatahi* and the role that their culture played in this process.

What is self-injury?

When asked to define what they considered to be 'self-injury', the *rangatahi* in Te Roopu Tuarua listed behaviours that were consistent with NSSI, for example, cutting and burning. Their definitions were based on the first-hand experiences of those they knew who had self-injured. However, whānau members of *rangatahi* who had self-injured took a broader view. While they agreed that it was predominantly cutting, they viewed their *rangatahi* cutting as causing more than harm solely to themselves. They spoke of their belief that it was also harm to their whānau and harm to the *wairua* of their *rangatahi*, or as one whānau member would call it, "*wairua* pain". Grandparents in particular spoke of how they viewed the self-injurious behaviours that *rangatahi* Māori

engaged in as more than physical injury. One grandparent was more concerned with the damage that their *mokopuna* had caused to their *wairua* than the physical damage and, upon discovering that her *mokopuna* had been cutting, this was what had upset her most. She spoke of it as a physical expression of her mokopuna's *wairua* hurting, and this, she explained, was a lot harder to heal than any physical injuries.

In reflecting on the *kōrero* shared by Te Roopu Tuarua in conjunction with the definitions of self-injury put forward by *rangatahi* from Te Roopu Tuatahi, physical injury seems to be the dominant and default form of injury that comes to mind for them. However, while physical injury may be the most common, other experiences of emotional injury and the impact on whānau are also important. The following figure is an attempt to depict this continuum, whereby a darker fill indicates greater consensus.

Physical Self-injury - Emotional injury - Spiritual injury - Whānau injury
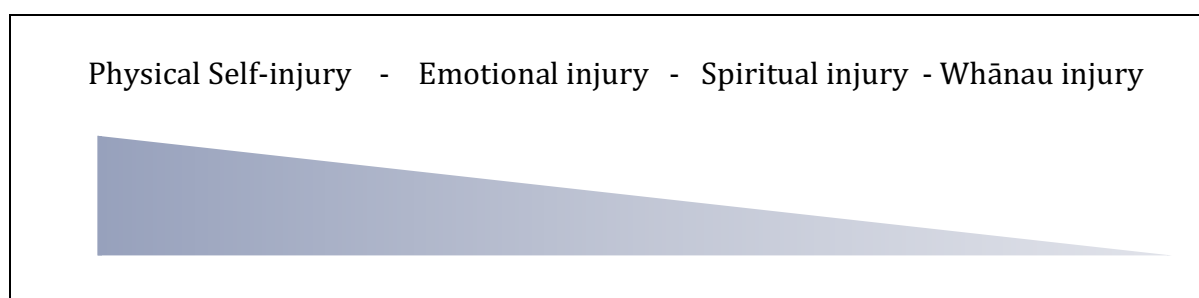
Figure 6. A continuum of self-injurious behaviours (and targets).

Who self-injures?

The *rangatahi* in Te Roopu Tuarua held a view similar to those in Te Roopu Tuatahi that self-injury was something that only young people engaged in. However, one adult step-parent had self-injured when they were a teenager, and so they knew first-hand that it was not a problem unique to *rangatahi*. This participant agreed with the participants from Te Roopu Tuatahi who said that they could never say that they would never do it again, because she had tried and knew how difficult it was to stop.

Why self-injure?

The *rangatahi* participants in Te Roopu Tuarua believed that *rangatahi* engaged in self-injury as a means of coping when things in life became difficult. Their views on the functions of self-injury were the same as for those in Te Roopu Tuatahi, because they had first-hand experience supporting *rangatahi* Māori; they had walked alongside them in their journey and so had a great understanding of why *rangatahi* Māori self-injured.

The whānau members in Te Roopu Tuarua spoke a lot about why they believed their *rangatahi* had self-injured. Many whānau spoke of grief and loss; many of the *rangatahi* had lost loved ones and whānau believed this to be a key reason. Interestingly, a few of the whānau members said that they had always thought that *rangatahi* self-injured to get attention, and that it was not until one of their own had done it that they realised that it was not attention-seeking.

In the previous section I mentioned that one grandmother described it as a physical expression of *wairua* pain. She explained that her *mokopuna* had lost her father, and the grandmother believed that her cutting was a physical expression of the pain, the *mamae* (hurt), and the grief that her *mokopuna* was feeling.

One mother described her daughter as "a very emotional girl", and so she believed that cutting was all about coping with emotions.

What helps when supporting rangatahi Māori?

Supporting as a sibling

The *rangatahi* participants who had supported their siblings described how they had tried to do so. Their most effective strategies were to distract them, or to just be with them. Doing nothing was an effective approach, as was going to see a movie or going shopping; normal activities that they both enjoyed. One spoke of how she did not

push her sister to talk, but would just be with her and make sure that she knew that she was not alone. She mentioned that, when her sister was ready to talk, she would be there, and often they would sit outside on the back doorstep smoking and talking for hours.

One sibling had also gone along to the guidance counsellor with her sister both to provide support, and so that she wouldn't feel alone. She said that she wanted to support her sister to get help, and so asked her to see a guidance counsellor because she did not think that she could support her on her own.

Supporting as a friend

The *rangatahi* who had supported close friends who had self-injured supported their friends in similar ways; by hanging out, listening to music, and just being there with them. The key points that they said were important when supporting a friend were to firstly not ask too many questions but instead to just let them talk. Also, they said that honouring their trust and never telling anyone without their permission was essential. Finally, they believed that hugging their friends and letting them cry it out helped.

One *rangatahi* had learnt that when supporting her friend, it was important to focus on what was going on in their life that had made them want to cut, as opposed to the cutting itself. She said that while it was essential to cover the wound, stop the bleeding, and to make sure they were ok, it was also important not to make a big deal about it. The key message in her story was to focus on why they had done it, rather than what they had done.

Supporting as parents

One mother, Ata, had just recently (within the previous week) discovered that her son had been cutting on his upper thighs. Initially, she had intended to participate in the research *hui* to support her step-daughter, and she was still struggling to come to

terms with the fact that her son was engaging in this behaviour. She shared how

shocked she was to learn that he had been doing this; she described him as the perfect

son, who was doing well in school by achieving excellence in all of his school subjects.

He played rugby and was passionate about *kapa haka* (Māori performing arts or

cultural group) and *manu kōrero* (the national Māori secondary school speech

competitions). Ata apologetically and emotionally explained to the other whānau

members that she had always believed that *rangatahi* who self-injured were troubled;

she never considered that her son would be one of them. But the discovery of her son's

behaviour had taught her that self-injury did not discriminate; she knew of other

teenagers who had been cutting but she felt they were so different from her own son.

Ata described how her first reaction to learning her son had been cutting was

that she thought that he wanted to kill himself, and this caused her to "flip out". But as

more time passed and she began to listen to her son, she began to see what had been

going on for him. She explained that he was feeling a lot of pressure from school and the

numerous other activities he was involved in. He had also lost his father some years ago,

and Ata expressed her guilt because she had not had another partner for a long time

after losing her husband, but had recently remarried. In addition, after his father passed

the two of them moved from the top of the North Island to the bottom to live in

Wellington. In the north, her son spent a lot of time with his grandmother, his father's

mother. Moving away meant that he had moved away from his primary support person;

his grandmother was who he would always turn to first for help. So again, Ata felt guilt

at having taken him away from his main support person. Upon learning what her son

was going through, she called the grandmother who immediately drove down to

Wellington and stayed with her son for the week. Ata admitted that she had no idea

what her son and his grandmother talked about and she knew a lot of what they spoke

about they would never share with her. But Ata explained that this was ok with her, so long as her son had someone he could turn to:

> I know to this day that there's a lot that he's told his Kuia that she hasn't shared with me and that's "kei te pai"; I'm all good with that because for me it was about him needing to talk to someone.

Grandparents

One interpretation of the word '*mokopuna*' is its origins from the word *tā moko*. Matua Witi shared a *pūrākau* with the whānau members the story of how a *kaumātua* looked in to a *puna* (spring) and saw the *moko* on his face, and it was then that he knew that his future was well in hand.

The grandparents in the group shared stories that showed the love that they had for their *mokopuna*; the strong connections between them and their grandchildren was obvious in the way that they spoke of them with unconditional love and affection. One *kuia* talked about how "grandparents hold the secrets of their *mokopuna*", and another described how "as grandparents, all we have to do, and all we do do, is love them".

One grandmother, Riria, was a social worker, and had years of experience supporting people of all ages who had self-injured. She also had two *mokopuna* who had self-injured. One of her *mokopuna* disclosed their self-injury to her, and the other she was told about by their mother (her daughter). In talking of how she supported her *mokopuna*, Riria said that she just talked with them. She mentioned that, at the time, she was fortunate to have been in contact with others who had self-injured, and so she was aware of the behaviour and did not overreact. She believed that for her *mokopuna* it was about not feeling anything that would cause them to cut. Riria said that the biggest challenge as a grandparent was to just sit there and listen, especially when the problems that her *mokopuna* were dealing with involved their parents (her children). She said it

was really hard to resist not jumping in and trying to fix things. In addition to listening, she also spoke of how she would take them home, to their *awa*, (river) to cleanse them. And by taking them home their whānau would also "wrap around them and keep them safe". Her *mokopuna*, she said, were really strong in their culture; they knew all of their *whakapapa*, were "connected to so many different *iwi* it's not funny!" and yet they cut. And so, she believed that it was not about being Māori; it was something all *rangatahi* from all walks of life engaged in.

Riria also spoke of her professional experiences of supporting those who were struggling with cutting but also other "mental health troubles". The most common problem at this time (the early 1990s) was with *rangatahi* Māori sniffing glue. In her line of work, they would take that *rangatahi* to a *tohunga*, and there was a process that they followed with this *tohunga* which would last for three days. This involved bringing the whānau in to all gather around and support that *rangatahi* with *karakia* and *waiata*. Again, Riria spoke of wrapping the whānau around them to "awhi[36] them back down". There was a process that was to be followed, guided by that *tohunga*, which included taking them down to the river at night. Riria spoke of how a lot of how she supported her *mokopuna* today, by taking them to the river, and wrapping the whānau around them, was based on how she was taught to support whānau who weren't well: "It was not about shutting them out or sending them to get help from a stranger, but about wrapping them in a *korowai* (cloak) of love and whānau." She also talked about the spiritual aspects of healing for her *mokopuna*, and how she would talk with them to get a sense of what was going on in all the areas of their life – *wairua*, *tinana*, and whānau.

---

[36] Awhi is to embrace, hug or cherish.

She would work with them to figure out where their *mamae* came from and deal with it together.

Support: What doesn't help?

Supporting as friends and siblings

The *rangatahi* in Te Roopu Tuarua said that the most important thing that you should never do when supporting a friend or sibling was to betray their trust by telling someone else:

> If they trust you enough to confide in you, you're not then going to turn around and betray that by telling someone else, even if you mean well and just want to help. If they want others to know, let them do it.

Supporting as whānau

Speaking from personal experiences, several whānau members acknowledged that overreacting was the worst thing that they could have done upon learning that their *rangatahi* had been self-injuring. One parent talked about how when she first found out she yelled at her daughter "Why are you doing that?", and proceeded to tell her to "stop it" and to "snap out of it". Many others said that they had overreacted because they did not know what self-injury was and automatically assumed that their *rangatahi* were trying to kill themselves. But others' initial responses were that it was just attention-seeking and so the best way to deal with this was to ignore it, to not give them what they wanted.

Whānau had a myriad of responses, many of which they all agreed were not helpful. They spoke of how, once they overcame their initial shock, the best thing that they could do was just to listen to them. They all agreed that understanding why they were doing it really helped. And the only way to understand was to listen.

One mother (who described her daughter as cutting to deal with her emotions) talked about how when she finally listened to her daughter, that all she was wanting by confiding in her was someone she could turn to to keep her safe. And so now the mother knows what to look out for when her daughter starts to go back in to that dark space.

Another parent said that she initially thought that her daughter was just copying her friends who cut. It was not until she truly listened to what her daughter was telling her that she realised that her daughter was doing it for her own reasons.

Challenges of giving support

All of the whānau members had felt guilty, to some extent, when they became aware that their *rangatahi* had been self-injuring. As parents, they felt that they should have known. Even knowing that *rangatahi* often deliberately go out of their way to hide the behaviour unless they wanted someone to know did not help to ease some of the guilt that they had felt. One mother explained that, as a parent, you should just know that something was not right with them. As an observer, I felt that whānau members seemed to be really hard on themselves, and that this illustrated one way that self-injury for *rangatahi* Māori also impacts and harms the whānau, even if this was unintentional by the *rangatahi*.

Another significant challenge for whānau was in knowing where to turn to for help. They said it was hard to know who to trust, as Kahukura describes it:

> A lot of the services you hear bad things about – how unhelpful, how mainstream, how *Pākehā*. They just don't get it, don't get our *rangatahi*, our whānau. So, they're just going to make things worse. And we take our kids to them to try and help them get better and we all end up worse for it. So, we just stop going, and deal with things within our own whānau.

This was a powerful *kōrero* that echoed the sentiments of many of the whānau members. They expressed the frustration of feeling that those who were getting paid to

help their *rangatahi* were not doing their jobs. Or that the ones who were doing their jobs were too hard to get hold of because there were not enough of them. Therefore, it fell to whānau to take care of their *rangatahi*, and a lot of the time they felt that they were just winging it, making it up as they go along.

How do you stay well?

Consistent with strengths-based *kaupapa Māori* research, it was also important to understand how friends and whānau maintained their own levels of wellbeing when supporting *rangatahi* who had self-injured.

How rangatahi Māori stay well

The *rangatahi* in this group did not self-injure, despite knowing people close to them who had. *Rangatahi* in Te Roopu Tuarua found it difficult to answer, when asked, what it was they did instead of self-injuring. I then asked what they spent their time doing that made them feel really good. For one participant, playing different sports took up a lot of their time and energy, and she explained that this meant that she did not have time to be 'emotional'. Rihi was passionate about *kapa haka* and *waka ama*. She described this as her own form of stress relief; she loved being able to take out her anger and frustrations on the water. And she described getting carried away with the intensity that you feel when you're performing *kapa haka*:

> It's a rush, a buzz, and that's what you do it for… to be on that stage, going hard in a *haka* and giving it your all. Feeling my *tupuna* there with me, wearing my nan's earrings and *taonga*,[37] the *heru* (hir comb) my mum gave me. And seeing my whānau proud of me. That's a rush.

---

[37] Treasure or prized posession. In this instance Rihi is speaking of a greenstone pendant that was her grandmothers'

Others strategies that *rangatahi* used to stay well included listening to music and chilling with friends when they were feeling down – consistent with what Te Roopu Tuatahi also described as alternatives to self-injury.

Whānau

As well as whānau describing their guilt, whānau also talked about how important it was that whānau seek support for themselves. They talked about how hard it was as a supporter, how difficult it was to maintain the wellbeing of their own *wairua*. As one grandparent explained, "when you love your *mokopuna* and they're hurting, you're hurting too."

Whānau felt that there needed to be more support available for whānau members, particularly given that when services were inadequate or unavailable (for example, "while they were on a 6-month waiting list for CAMHS[38], or while they waited for their guidance counsellors to figure things out", whānau were the ones to whom responsibility fell to care for their *rangatahi*, to keep them safe.

What they wanted was a support group, such as this series of *hui* had provided them. They desired a safe space to talk with other whānau members who had also been through it. Feedback on the *hui* process was that meeting other whānau members who were all going through similar problems was a highlight for a lot of the whānau support people. They found it invaluable to learn from other whānau members, as well as sharing their own knowledge and experiences. As one mother explained, "the process of the *hui* has helped me to realise that all my kids need is a mum. I don't have to be superwoman, just a mum."

---

[38] Child and Adolescent Mental Health Services

Te Roopu Tuarua: Summary

When discussing the what, who and why of self-injury, the responses of *rangatahi* in Te Roopu Tuarua were similar to those in Te Roopu Tuatahi, which reflected the mutual understanding that came from supporting a close friend who self-injured. Older whānau in general held a broader and more culturally based understanding of self-injury, and this had implications for how they supported their *rangatahi*.

The voices of *rangatahi* who have never self-injured: Analysis of Te Roopu Tuatoru

Te Roopu Tuatoru consisted of nine people who participated in the SFG process who had never engaged in self-injury, and who had no direct experience of others who hurt themselves. While some of their responses and views regarding self-injury may not be 'accurate' in the sense that their perceptions of functions may not reflect the functions that those *rangatahi* Māori endorse (for example, attention-seeking), they are useful because they reflect the perceptions of those without direct contact with and experience of the behaviour.

The primary function of self-injuring, as described by Te Roopu Tuatahi, was to regulate their emotional experience. And while the participants had had their share of intense emotional experiences, they did not use self-injury as a means of coping. Therefore, a key research question for this group was "why have these *rangatahi* Māori never considered self-injury as an option?" The responses of Te Roopu Tuatoru are included and are of value to this research, because, consistent with *kaupapa Māori* research, it is useful and important to explore alternatives to self-injury and to understand the attributes of *rangatahi* Māori who have not self-injured. This is because

within their experiences could lie solutions or features that could be nurtured in all *rangatahi* when Māori aiming to reduce the numbers of *rangatahi* Māori who self-injure.

What is self-injury?

When the question was put to the cohort 'What is self-injury?' the *rangatahi* in Te Roopu Tuatoru who had little to no understanding or exposure to self-injury, defined self-injury as any behaviour that someone did to themselves to cause harm in some way. These participants did not articulate any importance associated with intent behind the behaviours; they described behaviours that they thought were directly harmful to the self. For example, drunk driving, having unprotected sex, prostitution, huffing, as well as cutting, punching a wall, and overdosing. Interestingly, those in Te Roopu Tuatoru who had 'huffed' disagreed that huffing was self-injury, their rationale being that with huffing there was a choice; they chose to do it. Whereas they believed that those who self-injured did not have a 'choice' and did not have control over their behaviour.

Who self-injures and why?

Consistent with *rangatahi* in other groups, when asked who they thought typically self-injured, *rangatahi* in Te Roopu Tuatoru said that only young people did it, and they described these people as 'attention-seekers' or 'drama queens'. They also thought that peer pressure played a role in causing someone to want to self-injure. One participant thought that people did it to get a high, which he likened to sniffing petrol. Another participant described it as just normal teenage behaviour, where teenagers were just being teenagers. This participant was one of the younger participants of SFG One, and my impression when he made this statement was that he was trying to look cool in front of the older participants in the room – an example of the group dynamics.

278

Who do rangatahi in Te Roopu Tuatoru turn to for support?

For those who had never self-injured, when things got hard for them, aunties, uncles, nannies, *koro* (grandfather) and older cousins were typically the first people they would reach out to for help. They said that found their aunties and uncles were easier to talk to. Some talked about how in the past when they had confided in their parents about issues they were facing, they had overreacted, which deterred them from seeking help from their parents. However, one *rangatahi* was really close to her mother and described her as someone who listened and was always there for her.

What keeps them well?

Participants from Te Roopu Tuatoru listed activities such as playing sports, hanging with friends, smoking, and listening to music as things they liked to do when feeling low. Some were really into sport, and were doing well at sport. They did not feel like there was much time for anything else other than sport and school, and everyone else in their peer group were also busy with sports. No one in their social circles self-injured that they knew of, which explained why they did not claim to understand it; it was not a behaviour that was familiar to them.

One participant from Te Roopu Tuatoru talked about going to 'drug parties', where a group of friends would get together and take along whatever drugs they had and they would just share them and take them together.

Summary of Te Roopu Tuatoru

In reviewing the contributions of Te Roopu Tuatoru to the SFG *hui*, it is important to keep in mind that some of the experiences or opinions endorsed by Te Roopu Tuatoru were not unique to this group, and so may be represented in the discussions of either Te Roopu Tuatahi or Te Roopu Tuarua. These have been noted,

where relevant, throughout this chapter. For example, music and sport were important to some *rangatahi* in all groups. This is one reason for why this section is relatively small in comparison to the section for Te Roopu Tuatahi and Te Roopu Tuarua. Another reason for the brevity of information shared within this section is because these *rangatahi* on average were younger than those participants from Te Roopu Tuatahi and Te Roopu Tuarua. Also, following the first *hui*, one *rangatahi* from Te Roopu Tuatoru disclosed how he felt *whakamā* about contributing to the conversations because he felt as though he did not have anything of value to contribute to the discussions on self-injury. I explained to him the value of hearing from all *rangatahi* regardless of experience, and also relayed this numerous times throughout the duration of subsequent *hui*.

In the responses of Te Roopu Tuatoru as a collective there were clear distinctions with regards to their experiences and responses to stress in comparison with Te Roopu Tuatahi and, to a lesser extent, Te Roopu Tuarua. The perspectives of Te Roopu Tuatoru have been useful for reflecting the perspectives of *rangatahi* Māori who lack direct awareness of self-injury. However, not all of the behaviours described as reducing stress were adaptive; some *rangatahi* from Te Roopu Tuatoru used drugs and alcohol as a means of coping.

During the debrief many of the *rangatahi* in Te Roopu Tuatoru shared how helpful they had found the *hui* because it had increased their understanding of what people were going through when they self-injured. They also said that getting together and talking in this manner did not make them want to turn to cutting if things got hard for them, after having heard the perspectives from those who had done it and struggled to never cut again.

DISCUSSION

This next section discusses the findings of Study 2 by theme. The themes are:

1. Definitions of self-injury

2. Identity as Māori

3. Functions of self-injury

4. Triggers

5. Self-injury and suicide

6. Whānau (in particular, grandparents)

7. Being supported

8. Alternatives to self-injury

In this discussion I also reflect on the process of the SFGs.

1. Definitions of self-injury

Much debate exists regarding whether or not it is applicable or appropriate to take definitions developed from Eurocentric worldviews and apply them broadly to all populations for the purpose of clinical assessment, diagnosis and treatment (Waitoki, 2012). Indeed, Herbert (2002) suggest that misdiagnosis in mental health may be more of a reflection of the inadequacy of health professionals to understand cultural diversities in the manifestation of ill-health. The current approach to diagnosis of mental or psychiatric disorders uses the American Psychiatric Association's Diagnostic and Statistical Manual, 5th Edition (American Psychiatry Association, 2013). NSSI is currently listed in the DSM-V as a topic for further study, suggesting that it could be included as a diagnosis in future. And, while diagnoses have some utility in enabling access to treatment and understanding that comes with categorisation, there is also a risk of misdiagnosis should symptoms not be listed on the diagnostic 'checklists'. This

was my concern when it came to defining self-injury for *rangatahi* Māori. My fear was that, should *rangatahi* Māori and whānau define self-injury in a different manner from NSSI, we were risking invalidating and excluding their behaviours and experiences because they did not tick the boxes. This would call into question the statistics regarding prevalence rates not only of self-injury, but of many other, if not all, diagnoses in the DSM-V (American Psychiatry Association, 2013).

In Study 2, I anticipated that the manner in which *rangatahi* Māori and whānau defined self-injury would be different from the current predominantly Western definitions of NSSI and DSH to align with a more holistic, and less individualistic, focus. Cutting has been found to be the prototypical form of self-injury across all genders, ethnicities and ages (Andover et al., 2010; Gandhi et al., 2017; Whitlock et al., 2006). And in this sample of *rangatahi* Māori, when sharing stories of their experiences, cutting was the most prevalent form of self-injury that *rangatahi* Māori referred to. However, lay definitions differed slightly between groups. Participants from Te Roopu Tuatoru, with no first-hand knowledge of self-injury, considered definitions solely based on the behaviour regardless of intent, whereas for *rangatahi* Māori who had self-injured, irrespective of the behaviour it was the intention behind the behaviour that defined it as harm to self. *Rangatahi* provided examples, such as depriving themselves of food or sleep, or abusing substances, as self-harming behaviours.

How whānau defined self-injury varied again but aligned more with the *rangatahi* who had self-injured, in that the focus was more on the intent and impact of the behaviour as opposed to the behaviour itself. Whānau members shared stories of the *mamae*, the pain that was felt by the wider whānau, which highlighted the broader definitions of wellbeing that these whānau held that extended beyond the individual. The story of Hine, who had received a tattoo without the consent and support of her

whānau, showed that her whānau viewed her body as *tapu*, and this story highlighted how the impact of harm to the physical body can extend far beyond the physical, to the spiritual, and the impact on the whānau. While neither Hine nor her whānau believed that the harm was intentional, her whānau still considered it to be self-injury.

NSSI is defined as the "deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned" (Zetterqvist, 2015, p. 1). While the tattoo that Hine received does not fit the definitions of NSSI because the tattoo may be considered to be "socially sanctioned", it is possible to understand from the perspective of her whānau how it could be viewed as self-injury. The tattoo was deliberate, there was immediate tissue damage, and there was no suicidal intent behind the behaviour. While receiving a *tā moko* was socially sanctioned by the wider mainstream society, her whānau did not consent, which to her whānau was what caused a significant amount of pain. This story highlights the importance of considering the impacts of behaviours on wellbeing that are broader than physical definitions of wellbeing, to include the impact on their *wairua*, whānau, and mental state, as well as their physical being.

Durie (2003) also asserts the need to understand cultural nuances that may be relevant in a clinical context. For example, in te reo Māori speaking metaphorically is common. Durie (2003) suggests that some clinicians may consider this to be tangential thinking, for example. However, care must be take about excusing any behaviour that is difficult to understand as culturally sanctioned (as with the example of Hine, above). When clinicians classify any type of behaviour that cannot be understood as 'cultural' it may lead to missed clinical cues and inadequate assessments.

Conclusions regarding self-injury and kiri haehae

In reflecting on definitions, it was apparent to me that there was a need to be mindful of the language that is used with *rangatahi* Māori and whānau. Often psychological definitions, such as self-injury, are useful in practice, but do not resonate with *rangatahi* Māori and whānau. This highlights the need to be somewhat cautious of our use of language, and I think that that could extend to the Māori language that we may use. For example, cultural terms such as *wairua* may hold different meanings for different people who identify with Māori; to some it may mean religion, whereas others may see it more as an understanding of the spiritual nature of all things and the interconnectedness of all things. We cannot assume that *rangatahi* Māori all define Māori and English concepts the same. We may think that we are being supportive of cultural differences by using Māori terms but we may risk *rangatahi* Māori not understanding or, worse, feeling marginalised or judged for not holding a generic Māori view of *wairua*, for example.

The findings of this research then highlight the current definitions of NSSI, DSH and others as inadequate in capturing the experiences, worldviews and functions of self-injury for *rangatahi* Māori and their whānau. Indigenous or cultural explanations of self-injury have more utility for *rangatahi* Māori and whānau than do Western definitions. The utility of culturally grounded definitions is that they can be culturally appropriate and have relevance when working with people of that culture who identify similar experiences. When taken together, the results of the present research suggest that a definition of self-injury for *rangatahi* Māori and whānau needs to include harm to not only the physical self, but also the spiritual self and psychological self, and it is also necessary to consider the impact on the wider whānau, consistent with Māori models of

284

explaining wellbeing such as *Te Whare Tapa Whā*. We need to consider the functions the behaviour serves and therefore this should be included in the definition.

The exclusion of culturally sanctioned behaviours in the definition of NSSI risks behaviours that are not well understood being classified as culturally sanctioned, or deciding that because it is culturally sanctioned does not mean that it is not causing harm (for example, to the wider whānau, which impacts on self in a holistic view of wellbeing). For example, *tā moko* seen as self-harm by whānau because of the manner in which it was done. *Kiri haehae* is also not relevant for *rangatahi* Māori, and this is the view of the *rangatahi* Māori themselves. They do not view the stories of *kiri haehae* as relevant and relatable to all behaviours that they considered to be self-injury. Therefore, we can't force these definitions on them either, but they do have utility in helping whanau to understand that it is not something that is new, that this behaviour has been around in different forms since our *tupuna*, and so not to overreact.

The key messages regarding definitions of self-injury from this research are that, first, to be relevant for *rangatahi* Māori and whānau the definitions of self-injury need to be broader than the current physical definitions. Secondly, while cultural terms, such as *kiri haehae*, are useful for helping older generations understand self-injury (i.e. that it is not a new behaviour unique to this generation), *kiri haehae* as it is spoken of in traditional *korero* is not the same as what these *rangatahi* engage in today. This is why, rather than using the term kiri haehae in the title of this thesis, I use the phrase 'ngā pūtake o te mātānawe ki tā te *rangatahi*', which can be translated to mean 'the origins of the scars as described by (or according to) *rangatahi*'. This emphasises the focus more on the functions of the behaviour than the behaviour itself.

2. Identity as Māori

In Study 1, Part 1 I compared *rangatahi* who primarily identified as Māori with *rangatahi* who identified Māori as another ethnic identity on key wellbeing outcome measures and found that there was no significant difference between the two groups on measures, such as depression and suicidal thoughts and behaviours. In Study 2, all participants identified as Māori and chose to participate in this research specifically because they felt comfortable with research processes that aligned with *tikanga Māori*.

In Chapter 3 I described Rata's (2012) Pōwhiri Identity Negotiation Framework. In applying it to the *rangatahi* participants of Study 2, it would appear that the participants were all at different stages of the model, except for *Te Kore*. I assert that no *rangatahi* participants were in *Te Kore* because, simply, by choosing to participate in this research they have some engagement with, and identification as, Māori. Therefore, the *rangatahi* participants varied from being located in *Te Pō*, through to *Te Ao Mārama*. Importantly, despite the varied extents to which they identified as Māori, they all believed that it was good to be Māori; that being Māori was something to be proud of. This included the *rangatahi* Māori who had experienced the discrimination that they described in school due to their ethnicity (see page 225).

There were varying extents to which *rangatahi* in Te Roopu Tuatahi (those who had self-injured) identified as Māori. Within Te Roopu Tuatahi some *rangatahi* were in the phase of *Te Ao Mārama*, with a secure identity achievement which manifest as confidence in and high engagement with *te ao Māori*. They were fluent in te reo Māori and were strongly connected to their whānau as well as their wider *hapū* and the Māori community. Others were in *Te Pō*, and specifically many could be considered to be in *Waerea*, whereby they had a curiosity and desire to engage in *te ao Māori*. As one mother explained, self-injury does not discriminate; her son was a high-achieving young

286

man who was strong and confident in his identity as Māori, and she expressed her shock that he had been cutting. This was significant when it came to working with *rangatahi* Māori who had self-injured; all *rangatahi* from Te Roopu Tuatahi found that cultural reconnection was effective for them. In the story of the participant who was supported to reconnect with her culture through joining a *kapa haka* group we see that having culture-based support networks of peers can play a powerful role in developing and strengthening their cultural values as Māori. And while definitions of whānau differed among participants, it was clear that, however it was defined, whānau was important, and an integral element of the healing process for *rangatahi* Māori who had self-injured. This brings to mind kōrero from Cherrington (2009, p. 15) who demonstrates the versatility in applying cultural concepts to Māori, regardless of the extent to which they identify or feel familiar with, te ao Māori:

> For many deculturated youth and whānau, it is about reconnecting to their sense of *wairua* and what makes them feel strong spiritually. *Te taha wairua* also refers to beliefs around *tapu* (sacred) and *noa* (safe), *makutu* (Māori curse), *mate Māori* (Māori illness), use of *rongoa* (Māori medicine), *karakia* (incantation), *taonga* (treasure) and *tangihanga* (funeral). These aspects of *te ao Māori* are better left to be assessed by Māori knowledgeable in these areas. However, this does not preclude generic and *kaupapa Māori* practitioners gaining an understanding of what *te taha wairua* may mean for whānau and individuals, without needing to go into an in-depth cultural assessment. Simply finding out what makes a person feel centred and uplifted in some way, such as listening to music, going to the ocean, or laughing with one's children, is an important component of *te taha wairua*.

3. Functions of self-injury

In Study 1, *rangatahi* Māori endorsed intrapersonal functions more than interpersonal functions, and this was consistent for both males and females. This aligns with existing research (Klonsky, 2007; Langlands, 2012).

The substantial proportion of *rangatahi* Māori who had self-injured and also lost a close friend or family member may suggest that grief and loss play a role or are extremely significant stressors that result in self-harming behaviours. In Study 2, *rangatahi* Māori talked of expressing grief at the loss of a loved one and self-injuring was a way of acknowledging their loved ones who have passed. While this may be considered to be an intrapersonal function of self-injury through the regulation of emotions, it may also serve interpersonal functions but in a unique manner. Nock (2008) discusses how interpersonal functions directly influence those physically around the individual. However, the self-injurious behaviours of the *rangatahi* participants in this study are practices that relate to others who are not currently with them physically, but remain with them ā *wairua* (in spirit). While this behaviour may be culturally sanctioned and, therefore, exempt from definition as NSSI, self-injury (in the broader sense of the definition) that occurs within a cultural context may still share similar functions, both inter- and intrapersonal.

The NSSI literature both nationally (Brown, 2015; Fitzgerald & Curtis, 2017; Garisch & Wilson, 2015; Langlands, 2012) and internationally (Chapman et al., 2006; Najmi et al., 2007; Nock & Mendes, 2008) asserts emotion regulation as the primary function endorsed by adolescents who self-injure. For the *rangatahi* Māori participants in Study 2 this was also the most prevalent function. Communicating distress was also important, whereby *rangatahi* Māori described self-injury as a way of wanting attention for other areas of their lives and the self-injurious behaviours functioned to

communicate this to others. This has implications for those who support *rangatahi* Māori who self-injure, whereby it is important to focus more on why they are self-injuring.

Control was another prominent function, and the implications of this are relevant as barriers to help-seeking. Erikson's fifth stage of development describes the stage of adolescence as a time of identity versus role confusion, whereby adolescents are establishing a sense of self. For many of the *rangatahi* Māori who had self-injured, maintaining a sense of control over their lives was important and, in particular, for those participants who were mothers; the sense of being or staying in control was heightened by the fear of losing their child if they were to lose control. The understanding of the need for *rangatahi* Māori to maintain a sense of control is important to bear in mind, in that it can lead to reluctance to seek help for fear of losing control.

4. Triggers

Three prominent triggers that were discussed by Te Roopu Tuatahi relating to what led them to first self-injure were perfectionism, grief and relationships, and being bullied. These factors are not unique to *rangatahi* Māori; Brocklesby (2017) has investigated self-injury and its relationship to perfectionism, and Brown investigated the connections between self-injury and bullying. Both of these researchers used data from the YWB Study and therefore their research is based on a sample of adolescents from Aotearoa.

However, it is possible that the experiences of these *rangatahi* Māori may have unique cultural factors relevant to being Māori that are worth noting. With regards to perfectionism, one *rangatahi* described how at times this pressure to succeed felt so

intense that it made her want to cut, and for some *rangatahi* Māori the fear of failure and the anticipation of disappointing those who expected a lot from them was significant. This is particularly important given the perception that some *rangatahi* Māori report of what they see as the dominant stereotype of Māori, whereby they felt that their teachers did not expect them to excel in school. This could suggest an additional pressure for these *rangatahi* Māori, whereby not only do they feel the weight of their whānau expectations, but they may also fear living up to that negative societal stereotype if they do not excel in school.

Bullying is a reality that many *rangatahi* face today. In Study 1 the prevalence of bullying was found to be correlated with self-injury, and in Study 2 we heard first-hand how some *rangatahi* Māori had experienced bullying, with the most harrowing recollection being that of Pare who experienced significant bullying and physical harm when her scars were noticed in the changing rooms at school. *Rangatahi* shared how, when they were bullied because of their self-injuring, it made it more difficult to seek help for fear others would shame or ridicule them further. This led them to not knowing where they could turn to to seek help, and so cutting became a means of coping on their own without needing to disclose it to others.

Other stories of the inescapability of being bullied over social media highlighted how bullying has intensified and is more public due to the reach of social media; the taunts and abuse of bullies become even more pervasive in the lives of the *rangatahi* when they are loath to be without their smartphones and social media accounts. The implications of this are that escaping school is no longer a means of successfully escaping some bullies.

5. What is the relationship between suicide and self-injury?

The relationship between suicide and self-injury has been explored throughout this thesis. In Chapter 2 I touched on the different perspectives about whether or not suicide existed in precolonial Māori society. The lack of a definition of suicide as it is understood today is one argument for suicide being a post-colonial phenomenon. The use of the term *whakamomori* describes a state of intense grief; *ngākau pōuri* describes a heart affliction, and *hopohopo* an uncontrollable fear that induces anxiety. These terms and the behaviours they describe go far beyond the understanding of suicide as it exists today. The stories passed on about behaviours considered to be suicide highlighted the importance of context; that cultural concepts such as *mana*, *tauutuutu*, and *whakamā* contributed to someone taking their own life. *Kōrero tuku iho* shared by Matua Witi Ashby (personal communication, January 2015) and Te Rangi Hiroa (1949) highlighted that it did occur but was not an isolated or selfish act as it is understood to be today.

In Chapter 3 I presented the current statistics on suicide for *rangatahi* Māori, reporting that in 2015 *rangatahi* Māori as a population had the highest rates of suicide in Aotearoa. In Study 1 I reported that 58% had never thought about or attempted suicide, which left 36% who had suicidal thoughts, with some acting on these thoughts (6% did not respond to this question). In presenting this information I asserted that these statistics regarding the adverse experiences of *rangatahi* Māori (such as suicide and bullying) are of concern in their own right, regardless of whether or not the rates are higher or lower than the rest of the population. In this research 36% of *rangatahi* Māori had thought about or attempted suicide; and when we consider that each one of these *rangatahi* Māori are someone's son or daughter, *mokopuna*, niece, nephew, sibling or friend, these statics are of concern in their own right. Therefore, any information that could contribute solutions to this as an issue warrants investigation.

In Study 1 the results also showed that *rangatahi* Māori who self-injure to regulate their suicidal thoughts were experiencing greater levels of anxiety, depression, were bullied, and had lesser ability to regulate their emotions in adaptive ways. These quantitative findings were endorsed in the experiences *rangatahi* described in Study 2.

The experiences of *rangatahi* Māori who were bullied were particularly heart-breaking, and when they were shared with the focus groups it was difficult for many not to shed a tear. Indeed, many of the whānau members were in tears when speaking of how their *rangatahi* had been victimised by others. The prevalence and severity of peer victimisation within Aotearoa is an issue that needs addressing. It is outside of the scope of this research to suggest how this may be done, only to urge others in positions to do so to address it. The changing world within which *rangatahi* Māori live today is different from previous generations and, with this, the experiences of bullying also differ. Technology enables everyone to be online and accessible 24 hours a day, seven days a week. When *rangatahi* Māori are bullied this often means there is no escaping it, and places that were previously sites of safety and refuge (such as their own homes and bedrooms) are no longer safe. I believe that *whakamā* plays an important role in this experience and its consequences, whereby the sense of *whakamā* experienced as a perception of lower status, or of being 'put down' or insulted, when *rangatahi* are bullied can be intensified when it occurs through public platforms, such as social media. The prevalence of these experiences for *rangatahi* Māori are worrying; in this research 53% of *rangatahi* Māori had experienced some form of bullying.

The relationship between bullying and suicide, in particular, is relevant for *rangatahi* who self-injure. Some of the *rangatahi* Māori who had self-injured as a response to the emotional turmoil they felt when they had been bullied also articulated thoughts of suicide. Self-injury, for them, was a means of regulating these thoughts, and

was summarised by one *rangatahi* (and supported by the rest) as a means of keeping them alive, and maintaining hope. This quote from Mihi (participant from Te Roopu Tuatahi) summarises the perspectives of *rangatahi* Māori regarding self-injury and suicide:

> Self-injury is different to suicide because with suicide there is no hope that things are going to get better. But with self-harm there's still hope that things are going to get better some day and this is just what's helping you now till you get there. You're still wanting a second chance.

Often self-injury is mistaken for suicide, which usually comes from a lack of understanding of what suicide and self-injury are. *Rangatahi* participants viewed this as important, because they believed that if others, particularly whānau members, could understand how different self-injury was from suicide it would help them to not overreact, which was one of the most unhelpful ways that others had responded. This is why it is useful to view self-injury as a means of coping, a means of regulating their emotional responses to stressors in their life to avoid (for some) progressing to suicidal thoughts and behaviours. It is not my intention to advocate for self-injury as an alternative to suicide; I believe that these findings are important because by understanding self-injury as a means of regulating suicidal thoughts, solutions could then lie in finding other ways of coping that are not self-harming. The literature tells us that suicide and self-injury are related, and one manner by which this occurs is where self-injuring may lead to desensitisation to the pain and blood which can lead people to need more to get the same relief. Understanding self-injury as a coping mechanism can direct the treatment focus to other coping mechanisms that have the same effect. For *rangatahi* Māori in this research these alternatives included mindfulness and relaxation. *Rangatahi* Māori also spoke of the power of being reconnected with their culture, or the

incorporation of culture in different ways, when they self-injure. I suggest that future research could be in exploring the role of such culture-based interventions for working with *rangatahi* Māori who self-injure.

6. Whānau (in particular, grandparents)

In *kaupapa Māori* services, the inclusion of whānau is standard practice. The related concept of *whakawhanaungatanga* (making connections) is described by Gilgen (Maynard Gilgen, 1991) as being "one of the, if not the most important tool in a *kaupapa Māori* clinician's toolbox."

The stories shared by both *rangatahi* Māori and whānau of the close relationships between a *mokopuna* and their nanny, Kuia or grandmother spoke of the unique intergenerational relationships built on unconditional love, loyalty and trust. Pohatu (2018) refers to the role of grandparents as to "feed them the food that makes them uniquely what they are". This "food" he referred to was *whakapapa*, passed on through *waiata* and *mōteatea*. In the story from Erana, whose Nan would take her back home to reconnect with her *whenua*, her grandmother is eliciting the *whenua* as a healing space.

Riria, a grandmother in Te Roopu Tuarua spoke of taking *rangatahi* Māori who were self-injuring to *tohunga*, and wrapping the whānau of that *rangatahi* around them to "*awhi* them back down". The role of the *tohunga* in this story was to guide the whānau in the *tikanga* that were to be followed to support their *rangatahi* to be well. This highlights how *tohunga* are still regarded as healers by Māori today, despite historical attempts to outlaw their practices.

Also, in Riria's story, by gathering the whānau around that *rangatahi* to support them, it signals to *rangatahi* that they are important, that they are loved and that they

294

are not alone. This is far more powerful than sending them to see a stranger, or off to a facility that isolates that *rangatahi*; pulling them in close rather than pushing them away. However, this needs to be done with caution; it can be dangerous if the whānau are unable or ill equipped to support that *rangatahi* in the appropriate way, and it could make things worse. But this suggests that potential in exploring how whānau can be strengthened and supported to support their *rangatahi*.

If whānau are able to be strong supporters for their *rangatahi*, they need to have their own support to be strong for their whānau. In a *whare tupuna*, the *pou tokomanawa* is the post in the middle of the *whare* that supports the entire structure. Because of the difficulties that some whānau experience in accessing services for their *rangatahi* in a timely manner, whānau members are often the ones who are left to support their *rangatahi* until professional support is available. While this may be seen as a failure of the health system and the processes involved in obtaining referrals and seeking help, it can also be seen as an opportunity.

The stories shared in Study 2 have highlighted that whānau know their *rangatahi* best. However, we have heard from whānau members who shared their experiences of supporting that factors, such as guilt of not being able to do anything or not having done anything sooner, can cause parental secondary stress (Whitlock et al., 2018). This may arise when caregivers experience caregiver strain leading to caregiver distress, which manifests as negative thoughts and feelings, such as guilt or worry, and the consequences, including emotional consequences, that whānau members may experience.

Durie's Paiheretia model (2003) acknowledges whānau as the primary support when professional support services may not be available. Interventions based on whānau healing are grounded in the understanding of collective responsibility for

individual actions. This is consistent with the perspective of some whānau regarding self-injury being harm not only to the individual but to the wider whānau, as depicted in Māori models of wellbeing such as *Te Whare Tapa Whā*.

The need to support the *pou tokomanawa*/supporters to support *rangatahi* also holds true for friends who are supporters. We need to acknowledge that often friends are the first people who *rangatahi* Māori will reveal their self-injuring to, and so we need to prepare *rangatahi* to support and respond in ways that are helpful. A first step towards this could be to educate *rangatahi* about what self-injury is and how they might be able to support. Through the process of the focus groups it was apparent that knowledge is powerful in this *kaupapa*; those in Te Roopu Tuatoru who had little knowledge of self-injury reported that prior to the series of *hui* they did not know how to respond if someone was self-injuring and believed it was attention-seeking. Through hearing the stories of others in the group who had self-injured, the *rangatahi* in Te Roopu Tuatoru reported at the end that they felt that they had gained understanding and insight, and were better equipped to support any friends who might self-injure.

7. Being supported

All participants from Te Roopu Tuatahi were aware of the need to reach out for help; they had all seen the campaigns and had heard this message at some point. However, the fact that when *rangatahi* Māori do reach out they were not listened to in the manner they desired means that the focus needs to not only be on the *rangatahi* reaching out, but also on those they reach out to to be there for them, to be prepared, and to know what they needed – to listen, not fix, not judge. Table 13 summarises the themes with regards to helpful ways that *rangatahi* Māori can be supported, based on their experiences of what helped and what did not help.

Table 13.
Helpful ways that *rangatahi* Māori can be supported.

How do *rangatahi* Māori want to feel?	• Safe. Allow them to express emotions safely, be that safe place • Like they are not alone, that others do this too, that it's not unique to them • Like they can trust someone, and that they can be trusted too
What do *rangatahi* Māori want a supporter to do?	• Listen rather than focus on finding solutions. "Sometimes you don't want to be fixed, you just want to be heard." • Always be there • Focus on why not what • Support them to get help if they feel they are ready for it. Don't force them to seek help if they are not ready and willing, and it is also unhelpful to tell them to just stop, as if it were that simple. • Connect with their culture in some way • Normal things; talking, shopping, keeping busy, being distracted • Acknowledge the behaviour and talk through it with them. Don't ignore their behaviour and hope it will go away. • Be cautious about being influenced by the media when it comes to *rangatahi*; not all *rangatahi* Māori are alike • Be non-judgmental. Expressing shame or embarrassment at their behaviour is only going to cause them to feel *whakamā*, and may deter them from seeking help.

It can be a tricky balance when supporting *rangatahi* Māori; on the one hand they are saying that they do not want anyone to betray their trust. But then in Te Roopu Tuatahi we heard from two friends, one who revealed to a Guidance Counsellor that her friend was self-injuring, and that friend, while being angry at the time, was grateful that her friend had told someone else. I think it comes down to knowing that *rangatahi* really well and being able to tell when it is appropriate to seek support from others. It also stresses the importance of the supporter having their own support and knowledge of what self-injury is and how best to respond.

One key message that *rangatahi* Māori had for whānau who learn that their *rangatahi* had been self-injuring was not to overreact and instantly assume that it is suicide. From the discussions regarding self-injury and suicide it is clear that for the *rangatahi* in Te Roopu Tuatahi, self-injury was a means of preventing them from wanting to take their own life by allowing them to cope, and so overreacting and assuming that it is suicide does not help. The best strategy is to talk to them and ask them why they are doing it, but in a manner that is non-confronting and makes them feel safe rather than shamed. For most *rangatahi* Māori it is a means of coping with something else that they are struggling with; focus on understanding that, while being aware that you may not be the one that they want to share it with.

8. Alternatives to self-Injury

This research sought to understand alternatives to self-injuring, particularly for those who had never self-injured. Sports, cultural activities, and peer support groups were all popular alternatives. Specifically, for *rangatahi* Māori who had self-injured, music and different forms of meditation and mindfulness were tools they used to regulate their emotional experiences as alternatives to self-injuring. However, it is important to note that not all alternatives to self-injuring were adaptive; for example, smoking, drinking alcohol and attending "drug parties" were some of the alternatives to self-injury that were discussed. It is also important to stress the *kōrero* from Te Roopu Tuatahi regarding self-injury and suicide; self-injury may, for some *rangatahi* Māori, be a means of regulating their emotional responses to stressors in their life to avoid progressing to suicidal thoughts and behaviours.

While it is not my intention to encourage *rangatahi* Māori to self-injure as an alternative to suicide, the important message contained within these *rangatahi*

298

experiences is that self-injury is a means of coping, when there is hope that eventually the storm will pass and things will get better. Focusing on what it is that is causing them significant stress, as well as developing alternative means of coping, are two possible solutions that can support *rangatahi* Māori when they self-injure.

Strengths of Study 2

Feedback from the *rangatahi* Māori and whānau participants in Study 2 indicated that one success for them was the research process itself, particularly for the *rangatahi* who had self-injured, and their whānau. The key features that were successful were that it provided a safe space for *rangatahi* who identified as Māori to share without fear of being judged, and of interacting with peers who understood and could relate. Whānau also valued coming together with other whānau – they participated because of their *rangatahi*, but found benefits for themselves.

This research represents the novel and unique application of the principles of Interpretative Phenomenological Analysis to sequential focus groups with *rangatahi* Māori. While this posed many challenges, in particular, when *rangatahi* elected not to be recorded, the benefits far outweighed any difficulties. For example, that *rangatahi* in SFG One were not recorded enabled *rangatahi* to feel free to share their thoughts and experiences safely, and resulted in great detail being shared because *rangatahi* were more comfortable than had they been recorded. The lack of transcription meant that we had to find novel ways of collecting the information without losing the key conversation points. We found that having the opportunity to share thoughts through different mediums, for example, by writing on Post-it® notes, or through one-on-one conversations with the research team during the follow-up phone calls, was a success, and at some stage in each *hui* all participants had something that they wrote on a Post-

299

it® note and attached to a discussion board. The information shared in these forums was often views, opinions or experiences that they may not have been comfortable sharing with the group, or just had not had the opportunity to speak about at the time.

Another success was that while we, the research team, had key goals and outcomes for the series of *hui*, we did not have any predetermined research questions. Rather than the researchers giving the participants questions to answer, our goal was to facilitate a discussion that was guided by the *rangatahi* participants, where *rangatahi* could take the conversation in whatever direction they wanted to. As I have mentioned earlier, in this respect the participants became co-researchers with whom I was able to reflect on the content. This also served to empower or *whakamana* these *rangatahi* Māori in recognising their knowledge as valued. This proved to be hugely successful, as the conversations steered towards topics that were anticipated as being relevant to the research topic. For example, conversations around the roles of support staff, such as guidance counsellors, where *rangatahi* Māori spoke animatedly about their experiences with guidance counsellors, what they felt they did well and where they thought improvements could be made.

The process of the series of *hui* was a success, with key elements being the sharing of *kai*, the involvement of whānau members to hear their perspectives, and the ability for all *rangatahi* Māori to participate regardless of their history of self-injury. The power in this process has relevance not only in a research setting but also in a clinical context, and is consistent with Pomare's research (2015) which demonstrated that the use of *tikanga* and *mātauranga Māori* had therapeutic value and also enhanced engagement of Māori within clinical settings.

L. T. Smith (2014) writes of multiple truths and partial truths; in essence, she believes that there is no single truth. What research participants speak of may be true

for them at that time, and in that place. The SFG process highlighted this for us, in that on numerous occasions *rangatahi* Māori would contribute their *whakaaro* to a discussion at one *hui*, and then leave to think it over, only to return to the following *hui* and articulate a different stance. On occasion, they wanted to delve deeper and clarify further what they had meant to say. This was a benefit of the SFG in that it added a richer layer of meaning to the research. It also reminded us to be cognisant of the notions of truth that L.T. Smith (2014) refers to.

Limitations of Study 2

The challenge of group-based research with adolescents on sensitive issues is always ensuring a safe environment where *rangatahi* Māori can be free to share without fear of being judged, ostracised or victimised. This seemed particularly relevant for the younger participants who took a longer time to gain confidence to contribute to the discussions. However, as has been mentioned previously, by conducting these *hui* in large groups enabled me, as facilitator, to take a back-seat role and observe while taking notes because the participants facilitated their own discussions.

Another challenge was in obtaining an understanding of consensus and of outliers in what was discussed when the conversations were not recorded. This was made easier by the ability to observe and not facilitate, and by developing a system whereby tallies of agreeance or objections to statements was possible. Also, the ability to re-visit and clarify at subsequent *hui* ensured that the information was a valid reflection of the group, when necessary.

It was also difficult, when presenting these results, to show whether or not the points raised were reflective of the group as a whole or the views of few. This required explicit statements when presenting the quotes, which has been done throughout.

Finally, the smaller number of male participants than female is a possible limitation. In the field of qualitative research on self-injury and suicide the male voice is lacking substantially (Bowden, 2017). The variation in prevalence, forms and functions of self-injury between males and female highlight that there is a difference that needs further exploration.

CONCLUSIONS

The voices of *rangatahi* Māori and whānau needed to be heard to understand their experiences in their own words. The perspectives and experiences from participants in Te Roopu Tuatahi have comprised the bulk of this chapter, simply because it is their voice that is most needed to be heard. *Rangatahi* Māori expressed a desire to be heard, and whānau stressed the need to be supported themselves. The next chapter will incorporate the findings from both Studies 1 and 2 into a discussion and suggestions for future research directions.

CHAPTER NINE
Discussion: How do we support rangatahi Māori when they self-injure?

This research is an exploration of the experiences of *rangatahi* Māori and their whānau, centred around the *kaupapa* of self-injury. In this chapter I summarise the research questions before presenting a framework that answers the question "how should we support *rangatahi* Māori when they self-injure?" I separate this response into two; the immediate responses to self-injury, and the long-term strategies to reduce or prevent the behaviour.

It is my intention to produce research that is directly relevant to *rangatahi* Māori, whānau, the wider community and the clinical profession. The answers put forth here are my interpretations of the discussions had with *rangatahi* Māori and whānau on what works and what they want when they or their *rangatahi* self-injure. The suggested approaches that I put forward here are a fusion between *te ao Māori* and *te ao Pākehā*; Māori and Western knowledge. I use the *whakataukī* 'e kore au e ngaro, he kākano i ruia mai i Rangiātea' to demonstrate the resilience that our *tūpuna* exhibited in navigating their way to Aotearoa, and that within all Māori is the latent potential that is passed down through *whakapapa*. It is important to note that while I am attempting to simplify the best approaches as much as possible, all *rangatahi* Māori are unique, and what works for one *rangatahi* may not necessarily work for another. The suggestions I present are based on what the majority of *rangatahi* Māori reported was helpful. When working with *rangatahi* Māori, the aspiration is to build *rangatahi* Māori who are never lost.

RESEARCH QUESTIONS REVISITED

The purpose of this thesis was to understand self-injury from the perspectives of *rangatahi* Māori and whānau. The specific research questions and summaries of answers to each are presented below.

1. How do *rangatahi* Māori define self-injury?	• Broad range of behaviours, not all that fit with definition of "NSSI". Fits more with a holistic definition of wellbeing, such as *Te Whare Tapa Whā*, including impacts of *rangatahi* self-injuring on *wairua* and on the whānau.
2. Who are the *rangatahi* Māori who self-injure?	• No more or less likely to do it if they are Māori; identity is not a risk factor but does play a role in supporting *rangatahi* Māori.
3. What are the correlates of self-injury?	• Emotion regulation is the most prominent, also self-punishment, marking distress and anti-dissociation. • Bullying and grief are common stressors or proximal triggers.
4. How can *rangatahi* Māori be supported when they self-injure?	• Listen, trust, focus on why not what, peer support groups.
5. What are the experiences of whānau when supporting *rangatahi* Māori who self-injure?	• Supporters need to be supported, and increase education and awareness of the behaviours, functions, correlates.
6. Why is it that some *rangatahi* Māori choose not to self-injure? What are their alternative coping strategies?	• Not all alternatives are adaptive; drug and alcohol use, suicidal thoughts and behaviours. • Adaptive alternatives include sports, *kapa haka* and cultural activities, strong peer support networks.
7. What contributions can traditional knowledge make to how *rangatahi* Māori experience self-injury today?	• The term *kiri haehae* is used to refer to traditional self-injury. In this sample *rangatahi* do not see this as relevant to their experiences of self-injury today, but acknowledged the utility in helping older generations to understand that it is not a new behaviour.

HOW DO WE SUPPORT RANGATAHI MĀORI WHEN THEY SELF-INJURE?

E kore au e ngaro, he kākano i ruia mai i Rangiātea

I will never be lost, for I am a seed sown in Rangiātea

This *whakataukī* is used in many contexts, including education, public policy and mental health, and is a useful way of framing the power of connection and belonging for Māori. In this *whakataukī*, Māori are equated to *kākano* (seeds), filled with latent potential. In Māori and Polynesian history, Rangiātea is understood to be the origin from which Māori ancestors migrated to Aotearoa. This signifies that we are connected with our *tūpuna* and, as a result, we are never lost or alone because our ancestors are always with us. This *whakataukī* also speaks of resilience. To navigate their way from Rangiātea to Aotearoa our *tūpuna* needed to have the knowledge to navigate Te Moana Nui ā-Kiwa, and they needed to be resilient to overcome what was no doubt a difficult and challenging trip.

As it currently stands, I believe that this *whakataukī* may not be relevant for some *rangatahi* Māori today. I suggest that, for these *rangatahi* participants the *whakataukī* could be more accurate written as 'E kore au e ngaro, he kākano i ruia mai i Rangiātea... **engari, kei te māwe au.** (I will never be lost, for I am a seed sown in Rangiatea, and yet, I feel as though I am swirling about or lost). For many *rangatahi* Māori who self-injure they feel lost in many ways; lost in of their knowledge of how to be well, of where to find support, and for some *rangatahi* Māori, lost in knowing who they are and where they are from. The *whakataukī* suggests that if you know where you are from you will never be lost, but in this statement we are assuming that *rangatahi* Māori know where they are from, which is not true for many. This could also be likened to the notion of *kahupō* as spiritual blindness (Lawson-Te Aho & Liu, 2010) and in Te Pō according to Rata's (2012) Pōwhiri Identity Negotiation Framework. In this chapter I

put forward means of assisting these *rangatahi* Māori to connect with Rangiātea, and to in turn realise their latent potential that has been passed on through *whakapapa*.

Table 14.
Overview of strategies for supporting *rangatahi* Māori.

Immediate strategies	Long-term strategies

1. Hangaia te whakaruruhau
2. Whakahono
3. Whakarongo
	4. Hononga
	  a) Positive peers & role models
	  b) Whānau
	5. Mātau
	  a) To be heard
	  b) To be understood
	  c) To understand themselves
	6. Mana
	  a) Choices
	  b) *Whakamā*

When engaging with *rangatahi* Māori who self-injure, there are both immediate and long-term needs to consider. The immediate strategies I conceptualise under three themes: *whakahono* (to connect), *whakaruruhau* (to shelter) and *whakarongo* (to listen). The long-term strategies I present as *hononga* (connections), *mātau* (understanding) and *mana.* These immediate and long-term strategies are summarised in table 14.

Immediate responses to self-injury

1) Hangaia te whakaruruhau

Whakaruruhau means to protect, shield or shelter, and so 'hangaia te *whakaruruhau*' means to build a shelter for these *rangatahi* Māori. This involves ensuring their immediate risks are managed and that *rangatahi* are safe. Depending on the self-injurious behaviour, if immediate medical attention is required then this needs to be taken care of first and foremost. The initial responses of those who support are

crucial. Bear in mind the unhelpful ways of first responding that *rangatahi* Māori recalled, which include overreacting, assuming that it is an attempt at suicide, or disregarding or minimising the behaviour.

2) Whakahono

When engaging with *rangatahi* Māori who self-injure the most important initial step is to '*whakahono*'; to build a connection. As a whānau member there may already be a connection through *whakapapa*, and as a friend there may already be a connection that has developed over time or through shared experiences. If you are a clinician who is meeting *rangatahi* Māori for the first time, the connections will need to be established. Whether these connections are new or existing, *rangatahi* Māori need to feel connected, and these connections must be built on trust.

Part of this connection is the understanding that many *rangatahi* Māori who have been self-injuring may not view their self-injury as an issue for concern. It may be those around them who perceive it as harm, or who feel the hurt or the pain from the action. *Rangatahi* may also not appreciate the significance of the behaviour at the time of self-injuring. This may sometimes be intentional, but often the *rangatahi* is not considering the consequences of the behaviour other than seeking the immediate release or regulation of their emotional experiences.

3) Whakarongo

Once *rangatahi* Māori feel safe and connections are made, built on mutual trust, the next step is to *whakarongo*; to make them feel heard. This has three components; understand their stressors, understand the functions of the behaviour, and explore alternative options for coping.

Understand their stressors

It is important to understand what the behaviour is and why they are doing it.

Keep in mind that not all behaviours that *rangatahi* Māori consider to be self-injury fit

with current definitions, such as NSSI and DSH. The key message here is not to focus on

what they are doing but to seek to understand why they are doing it. What functions

does that behaviour serve for them? Self-injury is commonly a coping strategy;

therefore, it is important to consider what it is that they are trying to cope with.

Common stressors that *rangatahi* Māori shared included the loss of a loved one,

relationship break-ups, and being bullied.

Understand the functions

The next step is to consider what functions the behaviour is serving for them.

The most common functions are to regulate their emotions (i.e., in response to the

stressors mentioned above), to let those around them know that they need help (but not

knowing how to reach out for help other than to harm themselves), and to maintain a

sense of control over their life.

Another important function is to manage suicidal thoughts, and it is important to

note that this is different to suicidal intent (see p.291 for discussion of self-injury and

suicide from the results of this thesis). While often misinterpreted as suicide, for

rangatahi Māori in this sample self-injury is about regulating their emotions to avoid

suicidal intent. The key difference was that *rangatahi* who self-injured still held the

hope that one day things were going to get better, and self-injuring was a means of

coping until that day arrived.

Explore alternative options for coping

If we liken the *rangatahi* Māori who self-injure as being on the journey our

tūpuna took from Rangiātea to Aotearoa, in this step it is about helping *rangatahi* Māori

to navigate their way through the figurative Moana-nui-ā-Kiwa. How could they

navigate their way through the turbulent waters? The answers to this would have to be reached in conversation with *rangatahi* Māori themselves. But once you have an understanding of the functions that the behaviour is serving, the focus can then be on addressing these.

Immediate alternatives to self-injury that some *rangatahi* Māori have found helpful include listening to music and mindfulness, meditation and relaxation practices, and allowing them to express their emotions in safe environments (for example, by letting them cry it out). Also, we heard from rangatahi in Study 2 the power in connecting with their identity as Māori for facilitating healing and wellbeing. In Chapter 2 I described the impact of the loss of mātauranga Māori and te reo Māori on our ability as Māori to express ourselves. Reclaiming this knowledge could then provide an avenue for rangatahi who self-injure to not only connect with their identity as Māori but te reo Māori could also provide alternative means of expressing themselves and their emotions in ways that reflect mātauranga Māori.

Long-term strategies for self-injury

In exploring long-term alternative coping strategies, the manner in which this is done needs to be carefully considered. Inducing feelings of *whakamā*, or *takahī mana*[39] are not going to feel empowered to change their behaviour. From the conversations with *rangatahi* Māori and whanau I propose an approach that is grouped according to three principles: *hononga* (connection), *mātau* (understanding) and *mana*.

---

[39] Do not trample on the *mana* or integrity of the person.

4) Hononga

Hononga is about connections and the need for *rangatahi* Māori to feel connected. For some *rangatahi* Māori this may be about feeling connected through *whakapapa*, for others it may be connection to positive peers and role models or to whānau.

I use the term *hononga* rather than *whakapapa*, because while for some *rangatahi* Māori connections through *whakapapa* might be the key, for others their connections through *whakapapa* may not be strong. *Rangatahi* Māori may also lack the means or the desire to strengthen their connections through *whakapapa*. In Study 1 in particular the number of *rangatahi* who do not select Māori as their primary ethnicity, and those who have Māori ancestry but choose not to identify as Māori, suggest *whakapapa* connections may not be strong for them. While I believe (and hope) that eventually many of these *rangatahi* will one day identify as Māori and attempt to strengthen their identity and connection to *whakapapa*, it cannot be forced on them at a time when they are not ready, or are not supported to do so. Some *rangatahi* Māori participants valued a small connection to *te ao Māori* as a way of healing; speaking of *hononga* as opposed *whakapapa* broadens the sense of connection *rangatahi* Māori need.

At the conclusion of the final *hui* for each group I asked the participants what the key message was that they wanted to share with other *rangatahi* Māori regardless of whether or not they had self-injured. The *rangatahi* from SFG One came to the consensus that even though at times it may seem like they were alone and they had no one to turn to, they realised that there was always someone there; it was just a matter of finding them or reaching out to them. For some *rangatahi* this was a parent, grandparent or sibling. For others it may have been a teacher, guidance counsellor,

311

social worker or a parent's friend. It was always important to reach out for help, to not feel like you had to do it alone.

Connected to positive peers and role models

The *rangatahi* Māori participants asserted that their friends were usually the first people they would turn to when seeking help for self-injury. Therefore, these connections need to be acknowledged. Some whānau members found it challenging to accept that they may not be the ones who their *rangatahi* confided in. This highlights the need for peers to be supported, to ensure that the disclosure of self-injury is dealt with in appropriate ways. These helpful ways of responding are highlighted in the findings from Chapter 8 (for example by focusing on the function and not the behaviour).

Supporters need to be acknowledged and valued, particularly if they are *rangatahi* who have themselves self-injured. The *rangatahi* Māori participants in this research spoke of their experiences in supporting their peers, which were helpful because of their own experiences. Acknowledging the *mana* and valuable contributions that *rangatahi* Māori provide is important; kaua e takahi te mana o te tangata.

Connected to whanau

It is important to keep in mind there are different ways in which whānau can be defined; for example *whakapapa* whānau and *kaupapa* whānau. This research set out to understand not only the experiences of *rangatahi* Māori regarding self-injury, but to hear the stories from the perspectives of the wider whānau when supporting *rangatahi* Māori who self-injure. I was fortunate that the whānau participants were not only parents, but aunties, step-parents and grandparents who had supported one of their *rangatahi* when they had self-injured. When considering the importance of connection to whānau it needs to be in whatever way that whānau is defined by them.

A particular highlight of this research has been to hear from both *mokopuna* and

tūpuna of the special bond that is shared between a Nanny or a Koro and their

mokopuna. These relationships were built not exclusively on a foundation of

whakapapa, but of mutual respect and unconditional love. In Chapter 8 I shared stories

from three generations, all of whom spoke of that close relationship between a

kaumātua and their *mokopuna*. These *tūpuna* were their *pou*, their secure base, without

whom those *rangatahi* felt unsupported and had difficulty coping. Some of the

rangatahi participants spoke of how they felt that their nannies would always be there

for them; some grandparents had supported them when their parents had not, and

others did not feel they could turn to their parents but could their grandparents. The

kaumātua themselves shared powerful stories of how they had supported their

mokopuna in times of distress. Through Riria's story (p. 271) we heard of how she had

initiated for the whole whānau to wrap around that *rangatahi* in times of need, to "*awhi*

them back down". *Kaumātua* themselves would also turn to other *tohunga* for guidance

on the traditional ways of supporting *rangatahi* Māori with specific *mamae* or *mate* or

ailments. This emphasised the role that tohunga still play today in guiding whānau to

achieve wellbeing.

The understanding that connections to whānau are important highlights the

need to support whānau, which is similar to the need to support the peers who support

rangatahi. The stories of the experiences of whānau supporting *rangatahi* Māori

highlighted that being a *pou* is difficult. Whānau spoke of the need to have their own

strong foundations of support to be able to support their *rangatahi*. The support for

whānau may be in the form of education around self-injury, or emotional support, or

even just day-to-day support to have room in their life to support someone else. At the

same time, it is not my intention to place the burden and responsibility of reversing the

rates of suicide and self-injury on whānau. But the fact that whānau are most often left to take care of their *rangatahi* in times of crisis emphasises the need for services to wrap around and support whānau. This may be as effective, if not more effective, than supporting *rangatahi* Māori directly through guidance counsellors who *rangatahi* Māori rarely connect with.

We know that whānau can be a protective factor (Ungar, Clark, Kwong, Makhnach, & Cameron, 2005), 2011) but we need to support them. Durie's (2003) Paiheretia model provides a structure for supporting whānau (whānau healing practice guidelines), which includes identifying leaders within whānau, and supporting whānau to establish their own whānau *kawa*. What is encouraging is the work that is already being done in recent years in this space. Since the initial conversations with *rangatahi* Māori on this *kaupapa*, organisations such as Te Rau Matatini[40] have shown a core focus of their work is on supporting supporters. Resources such as #outintheopen[41] and "See you tomorrow, eh" are encouraging steps in the right direction.

5) Mātau

The term *mātau* is about knowledge and understanding. Under this heading I assert that *rangatahi* Māori need to be understood which, in its simplest form, letting them tell their story. Keep in mind that *rangatahi* Māori do not always want to be fixed; sometimes they just want to be heard.

Widespread awareness and understanding of self-injury needs to increase within the community, including students, teachers, whānau, and those who work with

---

[40] Te Rau Matatini is the National Centre for Māori Health, Māori Workforce Development and Excellence
[41] http://teraumatatini.com/our-team/outintheopen

rangatahi Māori in other capacities (for example, sports coaches). There are better chances that people will respond in ways that are helpful if they are more aware of what self-injury is and, more importantly, what functions the behaviour serves. The third element of understanding is around *rangatahi* Māori who self-injure discovering their identity; how they fit in this world. This could concern their identity as Māori, but does not have to. It is more about the importance of self-awareness.

6) Mana

The concept of *mana* within this framework consists of three factors. Firstly it is about empowering *rangatahi* Māori who self-injure to change their situation by understanding that they have choices. These choices include the opportunity to accept the loss and grief that they have experienced.

Secondly, one of the main functions of self-injury for *rangatahi* Māori is to maintain control. We can view this control as an assertion of the mana *rangatahi* are trying to maintain over their bodies and their lives. By acknowledging the function as an assertion of mana. We need to ensure that the manner in which we respond maintains their mana.

Finally, *mana* is about the right that all *rangatahi* Māori have to feel connected, worthy, loved, or even just to <u>feel</u>. Acknowledging emotions can be difficult for many. We can support *rangatahi* by helping them to understand and tune into their internal emotional states, and to then look at adaptive ways of expressing them.

Whakamā

The concept of *whakamā* warrants further investigation, particularly in how it is understood by *rangatahi* Māori and whānau. As I mentioned in Chapter 2, *whakamā* is related to *mana* in that perception of lowered *mana* can induce feelings of *whakamā.* The emotions induced when one experiences *whakamā* can lead to withdrawal and

social isolation, which may manifest as a lack of communication, but also aggression, violence, or substance abuse. In considering the experiences described by *rangatahi* Māori in the present research, I suggest that self-injury is another expression of *whakamā* for some of the *rangatahi* participants in this research.

In this discussion, I present the cultural concept of *whakamā* as being of relevance to *rangatahi* Māori who self-injure in several ways. First, *whakamā* could be considered an overarching function of self-injury for *rangatahi* Māori. The functions presented in Chapter 8 that could be explained by *whakamā* include the regulation of emotions such as those elicited by experiences of grief and loss, bullying, perfectionism and relationship stresses. These experiences are some of the predominating triggers of self-injury highlighted by *rangatahi* Māori in this research, and can lead to feelings of uncertainty, confusion, hurt, being inadequate, or shame. As defined in Chapter 2 *whakamā* is understood as both internalised feelings and externalised behaviours. As such, these emotions themselves are conceptualised as ways of defining *whakamā* and, thus, for *rangatahi* Māori who self-injure, the difficulties in regulating these emotional experiences can also be linked with *whakamā*.

Another manner in which *whakamā* may be relevant is in a therapeutic context. Maniapoto (2012) suggests that when we recognise and understand an individual's experience of *whakamā*, this can be used as a focus for motivating an individual to progress, make amends and restore wellbeing. *Whakataukī* such as "Kaua e pōuri ina whakamā me tika te take" (there is no shame in being ashamed) may be presented as a means of conceptualising *whakamā* as a strength or resilience factor. The cultural

concept of *muru*[42] can be considered as a pathway out of *whakamā*, whereby one accepts and acknowledges their experience of *whakamā* and its associated emotions, and working with that sense of *whakamā* until the pathway forward is found.

Future research: Māori-centred solutions

> *Hoki atu ki tō maunga, kia purea e koe ngā hau o Tāwhirimatea*
> Return to your mountain so you may be cleansed by the wind of Tāwhirimatea

Solutions need to be provided that are consistent with Māori worldviews to work for Māori. Currently, the best-practice approaches to treatment, such as DBT (Dialectical Behaviour Therapy; Linehan, 2015) and ERGT (Emotion Regulation Group Therapy; Gratz & Tull, 2011), have been developed grounded in Western perspectives of achieving wellbeing. But for solutions to work for *rangatahi* Māori and whānau, they need to come from and be grounded in *te ao Māori*. To conclude this thesis, I now propose possible concepts that could comprise a Māori-centred approach to working with *rangatahi* Māori and whānau when *rangatahi* Māori self-injure. More has to be done to expand these ideas, but I introduce them here as a starting point for future research.

Throughout this thesis I have referenced different *kōrero pūrākau* that relate to aspects of this research, such as the stories of *atua* Māori like Rūaumoko, and in *waiata*, such as 'Pūrea Nei'. The inclusion of these stories and *waiata* to highlight their relevance to this research is inspired by Māori researchers and practitioners who have paved the way: Dr Lisa Cherrington, Dr Diana Rangihuna and Mark Kopua, Dr Waikaremoana Waitoki, Associate Professor Leonie Pihama, and Associate Professor Jenny Lee-Morgan

---

[42] Understood as forgive, absolve, excuse, pardon (Moorfield, 2005).

(to name but a few). *Rangatahi* Māori have also highlighted how they have used traditional practices in the expression and regulation of emotions, for example, by returning to their *marae* when things got tough. Without explicitly being aware of it, some *rangatahi* Māori are already engaging in these practices as forms of healing, for example, by embracing Tāwhirimātea when he is angry and interpreting his behaviours as expressions of emotions.

Essentially it is about engaging in our *mātauranga* rather than locking it into a past that only belonged to our old people; finding ways, finding courage, overcoming fear in the use of our reo and our *mātauranga*. It is the wisdom that sits beyond the *mātauranga* that can only be acquired by working with it and engaging with it in our *kaupapa*. However, as I discussed in Chapter 2, when using *kōrero tuku iho* we must always be cautious and mindful not to *takahī* the *mana* of the whānau and descendants of those original *kōrero tuku iho.*

He Kōrero Whakatūpato

When unlocking the knowledge contained in *kōrero tuku iho*, caution must be taken, particularly if those *kōrero tuku iho* concern specific *tūpuna* or ancestors. While I wholeheartedly support and encourage destigmatising suicide through sharing stories and experiences, the story about the *waiata* 'Purea Nei' (see p.30) highlights the need to understand the story behind the *waiata* and *mōteatea* that we use.

The *mōteatea* 'Te Atua Matakore' was written as a *waiata tangi* (lament) for my *tupuna*, Te Matapihi o Rehua. Recently, the death of Te Matapihi o Rehua has been used as a basis for talking about suicide in traditional times, in the hopes of destigmatising suicide for whānau who had lost loved ones. This *tupuna* is held in very high esteem by our whānau, and my Koro in particular. When this research emerged, my Koro was

318

vehemently against the use of our *tupuna* for the purpose of discussions regarding suicide, because he did not believe that his *tupuna* took his own life in the manner in which others were portraying it. The stories of Te Matapihi o Rehua were passed down through our whānau directly to my Koro. My Koro did not believe that he took his own life, and he refused to let him be remembered in this way. It is possible that the manner in which my Koro opposed the use of his *tupuna's* name in connection with suicide is a reflection of the stigma around suicide and the inherent *whakamā* felt by some whānau who lose a loved on to suicide. However, I share this story to highlight that the knowledge passed down as *kōrero tuku iho,* from a koro to his *mokopuna*, are regarded as truth, irrespective of whatever may be published as recollections of historical events. I saw first-hand the *mamae* that my Koro felt at having what we knew to be true disregarded in favour of the words of others who proclaimed that their knowledge was more accurate. If we are to use the knowledge contained within *kōrero tuku iho*, we must be cautious of where this *kōrero* has come from and how the knowledge will be shared. To not consider this is to risk trampling on the *mana* of that *tupuna* and his direct descendants.

FINAL CONCLUSIONS

The resilience of our *tūpuna Māori* has been passed down from generation to generation to *rangatahi* today. The experience of being *rangatahi* Māori in Aotearoa is different for every generation. All *rangatahi* are unique, and the challenges of each generation differ as technology progresses and the manner by which society communicates and interacts changes. Most adults who have *rangatahi* within their whānau want to help them, to support them, to guide them. This is well intentioned; we all want to help, and often we think that is by fixing their problems and telling them

what to do. In this chapter I have put forward a framework of recommendations for supporting *rangatahi* Māori who self-injure. These recommendations are not about trying to fix *rangatahi* or to *takahi* on their *mana* in any way. Reframing the *whakataukī* to read 'e kore au e ngaro, he kākano i ruia mai i Rangiātea... **engari, kei te māwe au'** highlights the experiences of *rangatahi* Māori and the need for connection and shelter, to be heard, to feel connected, to be understood, and to have a sense of *mana* (authority) over their own lives.

Glossary

āhua	personal factors (Meihana Model)
ako	teaching, learning
aku	crossbeams
aroha	love, compassion
āta	respectful relationships
atua	ancestor with continuing influence, god, deity
awa	river
awhi	embrace, hug or cherish.
hapū	kinship group, sub-tribe
heru	hair comb
hinengaro	mind
hiwi	hull
hononga	connection
hopohopo	intense fear – see p. 38
hui	meeting
iwi	tribe
kahupō	cloak of darkness, see p.26
kai	food
kaikaranga	female performing a karanga
kākano	seed
kapa haka	Māori performing arts or cultural group
kanohi ki te kanohi	face to face (kaupapa Māori principle – see p.97)
karakia	incantation, ritual chant, prayer
karanga	a ceremonial call of welcome to visitors onto a marae
kaumātua	elderly male
kaupapa	subject, topic
kiri haehae	self-injury
koha	gift
kōrero	talk, speech, discussion
kōrero tuku iho	stories passed on through generations (see footnote 4, p.12)
koro	grandfather
korowai	cloak
kuia	grandmother

Kurawaka	the region of Papatūānuku from which Hineahuone, the first woman, was created.
mahi	work
makutu	curse
mamae	ache, pain, injury
mana	authority, control, influence, prestige and power, see p. 16
manaakitanga	hospitality
mana whenua	authority over land or territory
manuhiri	local people of a marae
marae	ceremonial area
matakite	prophecy, prophet, seer, clairvoyant
mātānawe	scar
Matariki	star cluster that signifies the Māori New Year
mataku	rational fear
mātau	knowledge, understanding
mātauranga Māori	Māori knowledge
mate	death
mate whakamomori	intense grief, see p. 37
maunga	mountain
mauri	source of emotions
māwe	to wave about, swirl
mihimihi	to greet, greeting
mihi whakatau	speech of greeting
mokopuna	grandchild
mōteatea	lament, traditional chant
muru	forgive, absolve, excuse, pardon
Ngā kare-ā-roto	emotions, see p. 30
ngākau pōuri	heart affliction, see p. 38
noa	see p. 18
oriori	lullaby
Pākehā	New Zealanders of European descent
pepeha	whakapapa affiliation, see p. 14.
pou	post, support, pole, pillar, sustenance
pōuri	sad
pou tokomanawa	centre pole supporting the ridge pole of a meeting house

pōwhiri	formal welcome
puku	stomach
puna	spring
pungawerewere	spider
pūrākau	story, myth, legend
pūtake	origins
rangatahi	youth
rangatira	leader
rongoa	remedy, medicine
taiao	world, Earth, natural world
tamariki	children
tā moko	Māori tattoo
tangata kāpō	blind person
tangata whaiora	people seeking wellbeing
tangata whenua	people of the land
tangi	to cry, grief ceremony
tangihanga	grief ceremony
taonga	prized possession
tapu	sacred, see p. 18
tauutuutu	see p. 17
te ao Māori	the Māori world
te ao Pākehā	the Pākehā world
te ao tūroa	the natural world
te aronga Māori	the Māori worldview
te kauwae raro	the lower jaw, terrestrial knowledge. See p. 19
te kauwae runga	the upper jaw, tapu knowledge. See p. 19
te taha hinengaro	mental/psychological sphere of wellbeing (Te Whare Tapa Whā)
te taha tinana	physical sphere of wellbeing (Te Whare Tapa Whā)
te taha wairua	spiritual sphere of wellbeing (Te Whare Tapa Whā)
te taha	familial /relational sphere of wellbeing (Te Whare Tapa Whā)
Te Whare Tapa Whā	Māori model of wellbeing
tikanga	protocol
tinana	body

tino rangatiratanga	ultimate self-determination
tohunga	skilled person, chosen expert
totohi	to cut
tūpuna	ancestors
tukutuku	to decorate with lattice-work
tūrangawaewae	a place of belonging
urupā	cemetery
utu	reciprocity
waiata tangi	lament
waiata	song
wairua	
waka	boat, vessel, canoe
waka ama	outrigger canoe
wānanga	learning institution
whakaaro	thought
whakahono	to connect
whakairo	carving, to carve
whakamā	
whakamana	to empower
whakamate	
whakapapa	
whakarongo	to listen
whakaruruhau	to protect, shield, shelter
whakataukī	proverb
whakawhanaungatanga	process of establishing relationships
whānau	family
whānau pani	relations of the deceased
whare	house
whenua	land, placenta

REFERENCES

Adolescent Health Research Group. (2012). *Youth'12 national health and wellbeing survey of New Zealand secondary school students: Questionnaire.* Auckland: The University of Auckland.

Alexander, N., & Clare, L. (2004). You still feel different: the experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community & Applied Social Psychology*, *14*(2), 70–84.

Allwood, C. M., & Berry, J. W. (2006). Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology*, *41*(4), 243–268.

American Psychological Association. (2010). *Publication Manual of the American Psychological Association* (6th ed.). Washington, DC: American Psychological Association.

Anderson, N. L., & Crowther, J. H. (2012). Using the experiential avoidance model of non-suicidal self-injury: understanding who stops and who continues. *Archives of Suicide Research : Official Journal of the International Academy for Suicide Research*, *16*(2), 124–34. http://doi.org/10.1080/13811118.2012.667329

Andover, M. S., Primack, J. M., Gibb, B. E., & Pepper, C. M. (2010). An examination of non-suicidal self-injury in men: Do men differ from women in basic NSSI characteristics? *Archives of Suicide Research*, *14*(1), 79–88. http://doi.org/http://dx.doi.org/10.1080/13811110903479086

Andrews, T., Martin, G., Hasking, P., & Page, A. (2014). Predictors of onset for non-suicidal self-injury within a school-based sample of adolescents. *Prevention Science*, *15*(6), 850–859. http://doi.org/10.1046/j.1440-1614.2003.01133.x .http://dx.doi.org/10.1007/s11121-013-0412-8

Armsden, G. C., & Greenberg, M. T. (1987). The inventory of parent and peer attachment: Individual differences and their relationship to psychological well-being in adolescence. *Journal of Youth and Adolescence*, *16*(5), 427–454.

Association, A. P. (2013). *Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5)* (5th ed.). United States: American Psychiatric Publishing.

Association, A. P. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed..). Arlington, VA: American Psychiatric Association. http://doi.org/http://helicon.vuw.ac.nz/login?url=http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596

Authority, N. Z. Q. (n.d.). New Zealand Qualifiactions Authority - Secondary School and NCEA. Retrieved December 27, 2017, from http://www.nzqa.govt.nz/studying-in-new-zealand/secondary-school-and-ncea/

Banks, C. (1996). *A Comparison Study of Māori and Pakeha Emotional Reactions to Social Situations that involve Whakamaa. A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Psychology.* Massey University.

Barker-Collo, S., Feigin, V. L., & Dudley, M. (2007). Post stroke fatigue-where is the evidence to guide practice? *The New Zealand Medical Journal (Online)*, *120*(1264).

Barrett, L. F., Gross, J., Christensen, T. C., & Benvenuto, M. (2001). Knowing what you're feeling and knowing what to do about it: Mapping the relation between emotion differentiation and emotion regulation. *Cognition & Emotion*, *15*(6), 713–724.

Basso, K. H. (1996). *Wisdom sits in places: Landscape and language among the Western Apache*. UNM Press.

Battiste, M., & Henderson, J. S. Y. (2000). Ethical issues in research. In M. Battiste & J. S. Y. Henderson (Eds.), *Protecting Indigenous Knowledge and Heritage: A Global Challenge*. Canada: UBC Press.

Baxter, J., Kokaua, J., Wells, J. E., Mcgee, M. A., & Browne, M. A. O. (2006). Ethnic comparisons of the 12-month prevalence of mental disorders and treatment contact in Te Rau Hinengaro : the New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*, *40*(10). http://doi.org/10.1080/j.1440-1614.2006.01910.x

Bebbington, P. E., Minot, S., Cooper, C., Dennis, M., Meltzer, H., Jenkins, R., & Brugha, T. (2010). Suicidal ideation, self-harm and attempted suicide: results from the British psychiatric morbidity survey 2000. *European Psychiatry*, *25*(7), 427–431.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology*, *46*(1), 5–34.

Berry, J. W., Poortinga, Y. H., Breugelmans, S. M., Chasiotis, A., & Sam, D. L. (2011). *Cross-Cultural Psychology: Research and Applications*. Cambridge: Cambridge University Press. http://doi.org/10.1017/CBO9780511974274

Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (2002). Acculturation and intercultural relations. *Cross Cultural Psychology*, 345–383.

Best, E. (1952). *The Maori as he was: a brief account of Maori life as it was in pre-European days.* (2nd ed..). Wellington: Govt. Printer.

Bhui, K., McKenzie, K., & Rasul, F. (2007). Rates, risk factors & methods of self harm among minority ethnic groups in the UK: a systematic review. *BMC Public Health*, *7*(1), 336.

Biesecker, G. E., & Easterbrooks, M. A. (2001). Emotion Regulation Checklist for Adolescents. Adapted from Shields, AM & Cicchetti, D (1997). *Unpublished Manuscript, Tufts University*.

Bishop, R., & Glynn, T. (1999). Researching in Maori contexts: An interpretation of participatory consciousness. *Journal of Intercultural Studies*, *20*(2), 167–182.

Bjareberg, J., Sahlin Berg, H., Hedman, E., Jokinan, J., Tull, M., Gratz, K., … Ljotsson, B. (2014). Emotion regulation group therapy for nonsuicidal self-injury: A Swedish nationwide effectiveness study. In *The International Society for the Study of Self-Injury conference, Chicago, United States.*

Black, E. B., & Kisely, S. (2018). A Systematic Review: Non-Suicidal Self-injury in Australia and New Zealand's Indigenous Populations. *Australian Psychologist*, *53*(1), 3–12.

Black, E. B., & Mildred, H. (2014). A cross-sectional examination of non-suicidal self-injury, disordered eating, impulsivity, and compulsivity in a sample of adult women. *Eating Behaviors*, *15*(4), 578–581. http://doi.org/0882-2689/01/1200-

0253/0 C).0191-8869/01/$).http://dx.doi.org/10.1016/j.eatbeh.2014.08.011

Borell, B., Gregory, A., McCreanor, T., Jensen, V., & Moewaka-Barnes, H. (2009). "It's Hard at the Top but It's a Whole Lot Easier than Being at the Bottom:" The Role of Privilege in Understanding Disparities in Aotearoa/New Zealand. *Race/Ethnicity: Multidisciplinary Global Contexts*, *3*(1), 29–50.

Boulton, A. (2012). *Facilitating* whānau *resilience through Māori primary health intervention: Final report to the health research council of New Zealand Partnership Programme.*

Bowden, C. (Christopher J. (2017). *Silence after suicide: A phenomenological study of young men's experience of losing a close male friend. A thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy in Health.* (M. & H. Victoria University of Wellington. Graduate School of Nursing & degree granting institution Victoria University of Wellington, Eds.). Victoria University of Wellington, 2017.

Brausch, A. M., & Gutierrez, P. M. (2010). Differences in non-suicidal self-injury and suicide attempts in adolescents. *Journal of Youth and Adolescence*, *39*(3), 233–42. http://doi.org/10.1007/s10964-009-9482-0

Breen, A. V, Lewis, S. P., & Sutherland, O. (2013). Brief report: Non-suicidal self-injury in the context of self and identity development. *Journal of Adult Development*, *20*(1), 57–62.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry*, *68*(4), 609–620.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, *21*(1), 87–108.

Brocklesby, M. (2017). *A longitudinal investigation of non-suicidal self-injury and perfectionism in a sample of New Zealand adolescents*. Victoria University of Wellington.

Bronfenbrenner, U. (1992). Ecological systems theory. In R. Vasta (Ed.), *Six theories of child development: Revised formulations and current issues* (pp. 187–249). London, England: Jessica Kingsley Publishers.

Brown, E.-J. A. (2015). *Non-Suicidal Self-Injury in New Zealand adolescents ?* Victoria University of Wellington.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, *84*(4), 822.

Burešová, I., Bartošová, K., & Čerňák, M. (2015). Connection between parenting styles and self-harm in adolescence. *Procedia-Social and Behavioral Sciences*, *171*, 1106–1113.

Cameron, N., Pihama, L., Kopu, B., Millard, J., & Cameron, A. (2017). *He Waipuna Koropupū: Taranaki Māori Wellbeing and Suicide Prevention*. Taranaki, Aotearoa: Tū Tama Wahine o Taranaki Inc.

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: a focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*(1), 44.

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: the experiential avoidance model. *Behaviour Research and Therapy*, *44*(3), 371–94. http://doi.org/10.1016/j.brat.2005.03.005

Cherrington, L. (2002). The use of Māori mythology in clinical settings: Training issues and needs. In *Proceedings of the national Māori graduates of Psychology symposium* (pp. 117–120).

Cherrington, L. (2009). Te hohounga mai i te tirohanga Māori: The process of reconciliation towards a Māori view. The delivery of conduct problem services to Māori. *Wellington, New Zealand: Ministry of Social Development*.

Chesin, M. S., Moster, A. N., & Jeglic, E. L. (2013). Non-suicidal self-injury among ethnically and racially diverse emerging adults: do factors unique to the minority experience matter? *Current Psychology*, *32*(4), 318–328.

Cheung, F. M., van de Vijver, F. J. R., & Leong, F. T. L. (2011). Toward a new approach to the study of personality in culture. *American Psychologist*, *66*(7), 593.

Claes, L., Houben, A., Vandereycken, W., Bijttebier, P., & Muehlenkamp, J. (2010). Brief report: The association between non-suicidal self-injury, self-concept and acquaintance with self-injurious peers in a sample of adolescents. *Journal of Adolescence*, *33*(5), 775–778. http://doi.org/http://dx.doi.org/10.1016/j.adolescence.2009.10.012

Claes, L., Luyckx, K., Baetens, I., Van De Ven, M., & Witteman, C. (2015). Bullying and victimization, depressive mood, and non-suicidal self-injury in adolescents: The moderating role of parental support. *Journal of Child and Family Studies*, *24*(11), 3363–3371. http://doi.org/http://dx.doi.org/10.1007/s10826-015-0138-2

Claes, L., Luyckx, K., & Bijttebier, P. (2014). Non-suicidal self-injury in adolescents: Prevalence and associations with identity formation above and beyond depression. *Personality and Individual Differences*, *61*, 101–104.

Claes, L., Vandereycken, W., & Vertommen, H. (2007). Self-injury in female versus male psychiatric patients: A comparison of characteristics, psychopathology and aggression regulation. *Personality and Individual Differences*, *42*(4), 611–621.

Clare, L. (2002). We'll fight it as long as we can: Coping with the onset of Alzheimer's disease. *Aging & Mental Health*, *6*(2), 139–148.

Clark, T., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., … Robinson, E. M. (2013). *Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012*. University of Auckland, Faculty of Medical and Health Sciences.

Clark, T., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S., … Saewyc, E. (2011). Risk and Protective Factors for Suicide Attempt Among Indigenous Maori Youth in New Zealand: The Role of Family Connection. *Journal of Aboriginal Health*, *7*(1), 16–31.

Committee, N. E. A. (2012). *Ethical Guidelines for Observational Studies: Observational*

research, audits and related activities. Revised Edition. Ministry of Health. Wellington.

Cram, F. (2001). Rangahau Māori: Tona tika, tona pono - The validity and integrity of Māori research. In M. Tolich (Ed.), *Research ethics in Aotearoa New Zealand* (pp. 35–52). Auckland, New Zealand: Pearson Education.

Crawley, L., Pulotu-Endemann, F. K., & Stanley-Findlay, R. T. U. (1995). *Strategic directions for the mental health services for Pacific Islands people.* Ministry of Health.

Crengle, S., Clark, T. C., Robinson, E., Bullen, P., Dyson, B., Denny, S., … Sheridan, J., Teevale, T., & T. A. H. R. G. (2013). *The health and wellbeing of Māori New Zealand secondary school students in 2012. Te Ara Whakapiki Taitamariki: Youth'12.*

Crowe, M., & Bunclark, J. (2000). Repeated self-injury and its management. *International Review of Psychiatry*, *12*(1), 48–53. http://doi.org/10.1080/09540260074120

Croyle, K. L. (2007). Self-harm experiences among Hispanic and non-Hispanic White young adults. *Hispanic Journal of Behavioral Sciences*, *29*(2), 242–253.

Cunningham, C. (2000). A framework for addressing Māori knowledge in research, science and technology. *Pacific Health Dialog.* Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11709883

Cunningham, C., Stevenson, G., & Tassell, N. (2005). *Analysis of the Characteristics of* Whānau *in Aotearoa: A report prepared for the Ministry of Education.*

Curtis, C. (2016). Young Women's Experiences of Self-harm. *Young*, *24*(1), 17–35. http://doi.org/10.1177/1103308815613680

Cwik, M. F., Barlow, A., Tingey, L., Larzelere-Hinton, F., Goklish, N., & Walkup, J. T. (2011). Nonsuicidal Self-Injury in an American Indian Reservation Community: Results from the White Mountain Apache Surveillance System, 2007-2008. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(9), 860–869. http://doi.org/10.1016/j.jaac.2011.06.007

Dash, S., Taylor, T., Ofanoa, M., & Taufa, N. (2017). Conceptualisations of deliberate self-harm as it occurs within the context of Pacific populations living in New Zealand. *New Zealand Journal of Psychology*, *46*(3), 115–125. http://doi.org/Retrieved from http://www.psychology.org.nz/wp-content/uploads/NZJP-Vol-46-3-2017.pdf

Davidson, J. M. (1987). *The prehistory of New Zealand* ([New ed.].). Auckland, N.Z.: Longman Paul.

De Visser, R. O., & Smith, J. A. (2007). Alcohol consumption and masculine identity among young men. *Psychology and Health*, *22*(5), 595–614.

Demir, H. K., Dereboy, F., & Dereboy, Ç. (2009). Identity Confusion and Psychopathology in Late Adolescence. *Turkish Journal of Psychiatry*, *20*(3).

Dougherty, D. M., Mathias, C. W., Marsh-Richard, D. M., Prevette, K. N., Dawes, M. A., Hatzis, E. S., … Nouvion, S. O. (2009). Impulsivity and clinical symptoms among adolescents with non-suicidal self-injury with or without attempted suicide. *Psychiatry Research*, *169*(1), 22–27.

Drury, N. (2007). The kaupapa outcome rating scale. *New Zealand Journal of Counselling*, *27*(1), 21–32.

Dudley, M., Faleafa, M., & Yong, E. (2016). Cross-Cultural Neuropsychology in Aotearoa New Zealand. In W. Waitoki, J. Feather, N. Robertson, & J. Rucklidge (Eds.), *Professional practice of psychology in Aotearoa New Zealand* (pp. 247–264). Wellington, New Zealand: New Zealand Psychological Society.

Dudley, M., Scott, K., & Barker-Collo, S. (2017). Is the test of premorbid functioning a valid measure for Maori in New Zealand? *New Zealand Journal of Psychology*, *46*(3), 72.

Duggan, J., Heath, N., & Hu, T. (2015). Non-suicidal self-injury maintenance and cessation among adolescents: A one-year longitudinal investigation of the role of objectified body consciousness, depression and emotion dysregulation. *Child and Adolescent Psychiatry and Mental Health*, *9*. http://doi.org/http://dx.doi.org/10.1186/s13034-015-0052-9

Dumont, J. (1989). *Culture, behaviour, & identity of the Native person*. Sudbury: Laurentian University Press.

Dunne, E. A., & Quayle, E. (2001). The impact of iatrogenically acquired hepatitis C infection on the well-being and relationships of a group of Irish women. *Journal of Health Psychology*, *6*(6), 679–692.

Durie, M. (1994). *Whaiora: Māori Health Development*. Oxford, United Kingdom: Oxford University Press.

Durie, M. (1998). *Whaiora: Maōri health development* (2nd ed..). Auckland, N.Z.: Oxford University Press.

Durie, M. (2001). *Mauri ora : the dynamics of Māori health*. Auckland, N.Z.: Oxford University Press.

Durie, M. (2002). Keynote Address: Is there a distinctive Māori psychology? In *The Proceedings of the National Māori Graduates of Psychology Symposium*. Maori and Psychology Research Unit, University of Waikato.

Durie, M. (2003). *Nga kahui pou: Launching Maori futures*. Huia Publishers.

Durie, M. (2005). Indigenous knowledge within a global knowledge system. *Higher Education Policy*, *18*(3), 301–312.

Durie, M. (2015). Mauri Ora. In *Healing our Spirit Worldwide 7th International Indigenous Peoples Gathering*.

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (2nd ed., pp. 193–211). London: Sage.

Enriquez, V. G. (1987). Decolonizing the Filipino psyche: Impetus for the development of psychology in the Philippines. In G. H. Blowers & A. M. Turtle (Eds.), *Psychology Moving East: The Status of Western Psychology in Asia and Oceania*. Sydney University Press.

Erikson, E. (1968). Youth: Identity and crisis. *New York, NY: WW*.

Farrelly, T., & Francis, K. (2009). Definitions of suicide and self-harm behavior in an Australian aboriginal community. *Suicide and Life-Threatening Behavior*, *39*(2), 182–189.

Favazza, A. R. (2011). *Bodies under siege: Self-mutilation, nonsuicidal self-injury, and body modification in culture and psychiatry*. JHU Press.

Fitzgerald, J., & Curtis, C. (2017). Non-suicidal self-injury in a New Zealand student population: Demographic and self-harm characteristics.(Survey). *New Zealand Journal of Psychology*, *46*(3), 156.

Fleming, T. M., Clark, T., Denny, S., Bullen, P., Crengle, S., Peiris-John, R., ... Lucassen, M. (2014). Stability and change in the mental health of New Zealand secondary school students 2007-2012 : results from the national adolescent health surveys. *Australian and New Zealand Journal of Psychiatry*, *48*(5), 472–480. http://doi.org/10.1177/0004867413514489

Flowers, P., Duncan, B., & Frankis, J. (2000). Community, responsibility and culpability: HIV risk-management amongst Scottish gay men. *Journal of Community & Applied Social Psychology*, *10*(4), 285–300.

Flowers, P., Duncan, B., & Knussen, C. (2003). Re-appraising HIV testing: An exploration of the psychosocial costs and benefits associated with learning one's HIV status in a purposive sample of Scottish gay men. *British Journal of Health Psychology*, *8*(2), 179–194.

Flowers, P., Knussen, C., & Duncan, B. (2001). Re-appraising HIV testing among Scottish gay men: The impact of new HIV treatments. *Journal of Health Psychology*, *6*(6), 665–678.

Fortune, S. A. (2006). An examination of cutting and other methods of DSH among children and adolescents presenting to an outpatient psychiatric clinic in New Zealand. *Clinical Child Psychology and Psychiatry*, *11*(3), 407–416.

Fox, K. R., Franklin, J. C., Ribeiro, J. D., Kleiman, E. M., Bentley, K. H., & Nock, M. K. (2015). Meta-analysis of risk factors for nonsuicidal self-injury. *Clinical Psychology Review*, *42*, 156–167.

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., ... Nock, M. K. (2016). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, *143*(2), 187–232. http://doi.org/http://dx.doi.org/10.1037/bul0000084

Friedman, T., Newton, C., Coggan, C., Hooley, S., Patel, R., Pickard, M., & Mitchell, A. J. (2006). Predictors of A&E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience. *Journal of Psychosomatic Research*, *60*(3), 273–277.

Gandhi, A., Luyckx, K., Goossens, L., Maitra, S., & Claes, L. (2016). Sociotropy, autonomy, and non-suicidal self-injury: The mediating role of identity confusion. *Personality and Individual Differences*, *99*, 272–277.

Gandhi, A., Luyckx, K., Maitra, S., Kiekens, G., Verschueren, M., & Claes, L. (2017). Directionality of effects between non-suicidal self-injury and identity formation: A prospective study in adolescents. *Personality and Individual Differences*, *109*, 124–129.

Garisch, J. A. (2010). *Youth deliberate self-harm: Interpersonal and intrapersonal vulnerability factors, and constructions and attitudes within the social environment*. Victoria University of Wellington.

Garisch, J. A., & Wilson, M. S. (2010). Vulnerabilities to deliberate self-harm among adolescents: The role of alexithymia and victimization. *British Journal of Clinical Psychology*, *49*(2), 151–162.

Garisch, J. A., & Wilson, M. S. (2015). Prevalence, correlates, and prospective predictors of non-suicidal self-injury among New Zealand adolescents: cross-sectional and longitudinal survey data. *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 1–11.

Gilgen, M. (1991, May). *Te Roopu o te* Whānau *Rangimarie o Taamaki Makaurau: A Māori Model for Non-violence'*. Unpublished MA thesis, The University of Auckland.

Gilgen, M., & Stephens, M. (2016). Whanaungatanga: Asking Who You Are; Not, What You Are. In W. Waitoki & M. Levy (Eds.), *Te Manu Kai i te Mātauranga: Indigenous Psychology in Aotearoa/New Zealand* (pp. 71–88). Wellington: The New Zealand Psychological Society.

Gleitman, H., Gross, J., & Reisberg, D. (2011). *Psychology* (8th ed.). London: W. W. Norton & Company.

Glenn, C. R., Franklin, J. C., & Nock, M. K. (2015). Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child & Adolescent Psychology*, *44*(1), 1–29.

Glover, M., & Hirini, P. (2005). Maori Psychology: A long way from imago, He ara roa tonu. *New Zealand Journal of Psychology*, *34*(1), 2.

Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *Journal of the American Medical Association*, *293*(13), 1635–1643.

Gratz, K. L. (2001). Measurement of deliberate self-harm: Preliminary data on the Deliberate Self-Harm Inventory. *Journal of Psychopathology and Behavioral Assessment*, *23*(4), 253–263.

Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, *10*(2), 192–205.

Gratz, K. L., Latzman, R. D., Young, J., Heiden, L. J., Damon, J., Hight, T., & Tull, M. T. (2012). Deliberate self-harm among underserved adolescents: the moderating roles of gender, race, and school-level and association with borderline personality features. *Personality Disorders: Theory, Research, and Treatment*, *3*(1), 39.

Gratz, K. L., & Roemer, L. (2008). The Relationship Between Emotion Dysregulation and Deliberate Self-Harm Among Female Undergraduate Students at an Urban Commuter University. *Cognitive Behaviour Therapy*, *37*(1), 14–25. http://doi.org/10.1080/16506070701819524

Gratz, K. L., & Tull, M. T. (2011). Extending research on the utility of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality pathology. *Personality Disorders: Theory, Research, and Treatment*, *2*(4), 316. http://doi.org/10.1037/a0022144

Groschwitz, R. C., & Plener, P. L. (2012). The neurobiology of non-suicidal self-injury (NSSI): A review. *Suicidology Online*, *3*, 24–32.

Group, A. H. R. (2012). *Youth'12 national health and wellbeing survey of New Zealand secondary school students: Questionnaire.* Auckland: The University of Auckland.

Guerra, N. G., & Jagers, R. (1998). The importance of culture in the assessment of children and youth. In V. McLoyd & L. Stenberg (Eds.), *Studying minority adolescents: conceptual, methodological, and theoretical issues.* London: Psychology Press.

Guerry, J. D., & Prinstein, M. J. (2009). Longitudinal Prediction of Adolescent Nonsuicidal Self-Injury: Examination of a Cognitive Vulnerability-Stress Model. *Journal of Clinical Child & Adolescent Psychology*, *39*(1), 77–89. http://doi.org/10.1080/15374410903401195

Hamza, C., Stewart, S., & Willoughby, T. (2012). Examining the link between nonsuicidal self-injury and suicidal behavior: A review of the literature and an integrated model. *Clinical Psychology Review*, *32*(6), 482–495. http://doi.org/http://dx.doi.org/10.1016/j.cpr.2012.05.003

Hankin, B. L., & Abela, J. R. Z. (2011). Nonsuicidal self-injury in adolescence: Prospective rates and risk factors in a 2 ½ year longitudinal study. *Psychiatry Research*, *186*(1), 65–70. http://doi.org/10.1016/j.psychres.2010.07.056

Harms, L. (2010). *Understanding human development / Louise Harms.* (2nd ed..). South Melbourne, Vic.: South Melbourne, Vic. : Oxford University Press.

Harris, P., & Mercier, O. (2006). Te Ara Pūtaiao. In M. Mulholland (Ed.), *State of the Maori Nation: Twenty First-Century Issues in Aotearoa*. Auckland: Reed.

Hasking, P. A., Heath, N. L., Kaess, M., Lewis, S. P., Plener, P. L., Walsh, B. W., … Wilson, M. S. (2016). Position paper for guiding response to non-suicidal self-injury in schools. *School Psychology International*, *37*(6), 644–663.

Hayes, S. C., Wilson, K. G., Gifford, E. V, Follette, V. M., & Strosahl, K. (1996). Experiential Avoidance and Behavioral Disorders: A Functional Dimensional Approach to Diagnosis and Treatment. *Journal of Consulting and Clinical Psychology*, *64*(6), 1152–1168. http://doi.org/10.1037/0022-006X.64.6.1152

Heilbron, N., & Prinstein, M. J. (2008). Peer influence and adolescent nonsuicidal self-injury: A theoretical review of mechanisms and moderators. *Applied and Preventive Psychology*, *12*(4), 169–177. http://doi.org/10.1016/j.appsy.2008.05.004

Helu, S. L., Robinson, E., Grant, S., Herd, R., & Denny, S. (2009). Youth'07: The health and wellbeing of secondary school students in New Zealand: Results for Pacific young people. *Auckland: University of Auckland*.

Herbert, A. (2002). Bicultural partnerships in clinical training and practice in Aotearoa/New Zealand. *New Zealand Journal of Psychology*, *31*(2), 110–116.

Higgins, R. (2015). Tangihanga – death customs - The tangihanga process. Retrieved from http://www.teara.govt.nz/en/artwork/28786/haehae

Higgins, R., & Meredith, P. (2011). "Kaumātua – Māori elders",.

Hilt, L. M., Nock, M. K., Lloyd-Richardson, E. E., & Prinstein, M. J. (2008). Longitudinal Study of Nonsuicidal Self-Injury Among Young Adolescents: Rates, Correlates, and Preliminary Test of an Interpersonal Model. *The Journal of Early Adolescence*, *28*(3), 455–469. http://doi.org/10.1177/0272431608316604

Houkamau, C. a., & Sibley, C. G. (2010). The Multi-dimensional Model of Māori Identity and Cultural Engagement. *New Zealand Journal of Psychology*, *39*(1), 8–28. http://doi.org/http://dx.doi.org/10.1007/s11205-014-0686-7

Houkamau, C. A., & Sibley, C. G. (2011). Maori Cultural Efficacy and Subjective Wellbeing: A Psychological Model and Research Agenda. *Social Indicators Research*, *103*(3), 379–398. http://doi.org/http://dx.doi.org/10.1007/s11205-010-9705-5

Houkamau, C., & Sibley, C. (2015). Looking Māori Predicts Decreased Rates of Home Ownership: Institutional Racism in Housing Based on Perceived Appearance. *PLoS One*, *10*(3), e0118540. http://doi.org/10.1371/journal.pone.0118540

Hudson, M. (2004). *He Matatika Māori: Māori and Ethical Review in Health*. Auckland University of Technology.

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika Guidelines for Māori research ethics : A framework for researchers and ethics committee members.* Auckland: Health Research Council of New Zealand.

Huygens, I., & Nairn, R. (2016). Ethics and Culture: Foundations of Practice. In W. W. Waitoki, J. S. Feather, N. R. Robertson, & J. J. Rucklidge (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand* (3rd ed., pp. 15–26). Wellington: The New Zealand Psychological Society.

Irwin, K. (1994). Maori research methods and processes: An exploration. *Sites*, *28*, 24–43.

Jacobson, C. M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. *Archives of Suicide Research : Official Journal of the International Academy for Suicide Research*, *11*(2), 129–47. http://doi.org/10.1080/13811110701247602

Joiner, T. E., Ribeiro, J. D., & Silva, C. (2012). Nonsuicidal Self-Injury, Suicidal Behavior, and Their Co-occurrence as Viewed Through the Lens of the Interpersonal Theory of Suicide. *Current Directions in Psychological Science*, *21*(5), 342–347. http://doi.org/10.1177/0963721412454873

Jose, P. E., & Pryor, J. (2010). Does social connectedness lead to a greater sense of well-being in New Zealand adolescents? Findings from the youth connectedness project. *Psychology Aotearoa*, *2*(2), 94–97.

Justice, N. Z. M. of. (2001). *He Hīnātore ki te Ao Māori: A glimpse into the Māori world - Māori perspectives on justice. Hīnātore ki te ao Māori*. Wellington, N.Z.: Ministry of Justice.

King, M. (2001). *Ngā iwi o te motu: 1000 years of Māori history* (Rev. ed..). Auckland: Reed Books.

Kingi-Ulu'ave, D., Faleafa, M., & Brown, T. (2007). A Pasifika perspective of psychology in Aotearoa. *Professional Practice of Psychology in Aotearoa New Zealand*, 67–84.

Kingi, T. (2005). Māori Health and Cultural Responsiveness. In *Hauora Taranaki PHO*. New Plymouth.

Kingi, T., & Durie, M. (1999). *Hua Oranga: A Māori Measure of Mental Health Outcome*. Palmerston North, New Zealand.

Kingi, T., Russell, L., & Ashby, W. (2017). Mā te mātau, ka ora: The use of traditional

Indigenous knowledge to support contemporary rangatahi Māori who self-injure. *New Zealand Journal of Psychology*, *46*(3), 138.

Klonsky, D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*. http://doi.org/10.1016/j.cpr.2006.08.002

Klonsky, D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry Research*, *166*(2), 260–268.

Klonsky, D. (2011). Non-suicidal self-injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological Medicine*, *41*(9), 1981–6. http://doi.org/10.1017/S0033291710002497

Klonsky, D., & Glenn, C. (2008). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment*, *31*(3), 215–219. http://doi.org/http://dx.doi.org/10.1007/s10862-008-9107-z

Klonsky, D., & Muehlenkamp, J. J. (2007). Self-Injury: A Research Review for the Practitioner. *Journal of Clinical Psychology*, *63*(11), 1045–1056. http://doi.org/10.1002/jclp

Klonsky, D., Muehlenkamp, J., Lewis, S., & Walsh, B. (2011). Nonsuicidal self-injury: Advances in psychotherapy evidence-based practice. *Cambridge, MA: Hogrefe*.

Klonsky, E. D., Glenn, C. R., Styer, D. M., Olino, T. M., & Washburn, J. J. (2015). The functions of nonsuicidal self-injury: converging evidence for a two-factor structure. *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 44.

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology*, *12*, 307–330.

Klonsky, E. D., & Moyer, A. (2008). Childhood sexual abuse and non-suicidal self-injury: meta-analysis. *The British Journal of Psychiatry : The Journal of Mental Science*, *192*(3), 166. http://doi.org/10.1192/bjp.bp.106.030650

Klonsky, E. D., & Olino, T. M. (2008). Identifying clinically distinct subgroups of self-injurers among young adults: a latent class analysis. *Journal of Consulting and Clinical Psychology*, *76*(1), 22.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Kukutai, T. (2004). The problem of defining an ethnic group for public policy: Who is Māori and why does it matter? *Social Policy Journal of New Zealand*, *23*(23), 86–108.

Kukutai, T., & Callister, P. (2009). A "main" ethnic group? Ethnic self-prioritisation among New Zealand youth. *Social Policy Journal of New Zealand*, *36*, 16–31.

Kukutai, T., & Thompson, V. (2007). Doing diversity 'down under': New Zealand's ethnic enumeration practices in global perspective. In *Population Association of New Zealand Conference* (pp. 3–4).

Lang, C. M., & Sharma-Patel, K. (2011). The relation between childhood maltreatment and self-injury: A review of the literature on conceptualization and intervention. *Trauma, Violence, & Abuse*, *12*(1), 23–37.

Langlands, R. L. (2012). *Does non-suicidal self-injury function primarily as an experientially avoidant behaviour within Aotearoa New Zealand?* Victoria Univesity of Wellington.

Lawson-Te Aho, K. (2013). *Whāia te mauriora: In pursuit of healing - Theorising connections between soul healing, tribal self-determination and Māori suicide prevention in Aotearoa/New Zealand. Unpublished doctoral dissertation, Victoria University of Wellington, Wellington, New Zealand.* Victoria University of Wellington.

Lawson-Te Aho, K., & Liu, J. (2010). Indigenous Suicide and Colonization: The Legacy of Violence and the Necessity of Self-Determination. *International Journal of Conflict and Violence*, *4*(1), 124–133. http://doi.org/10.4119/UNIBI/ijcv.65

Leask, J., Hawe, P., & Chapman, S. (2001). Focus group composition: a comparison between natural and constructed groups. *Australian and New Zealand Journal of Public Health*, *25*(2), 152–154.

Lee, J. (2009). Decolonising Māori narratives: Pūrākau as a method. *MAI Review*, *2*(3), 79–91.

Levy, M. (2016). Kaupapa Māori psychologies. In W. Waitoki & M. P. Levy (Eds.), *Te manu kai i te mātauranga: indigenous psychology in Aotearoa/New Zealand*. Wellington, New Zealand: The New Zealand Psychological Association.

Levy, M. P. (2007). *Indigenous psychology in Aotearoa: realising Māori aspirations (Doctor of Philosophy)*. University of Waikato, Hamilton.

Lewis, S. P., & Santor, D. A. (2008). Development and Validation of the Self-Harm Reasons Questionnaire. *Suicide and Life-Threatening Behavior*, *38*(1), 104-Threatening Behavior, 2008, Vol.38(1), 104–1. http://doi.org/10.1521/suli.2008.38.1.104

Linehan, M. (2015). *DBT skills training manual. Dialectical behavior therapy skills training manual* (Second edi). New York: The Guilford Press.

Linehan, M. M., & Nielsen, S. L. (1981). Assessment of suicide ideation and parasuicide: Hopelessness and social desirability. *Journal of Consulting and Clinical Psychology*, *49*(5), 773.

Love, C. (2003). Keynote address: Dr. Catherine Love. In L. . Nikora, M. Levy, B. Masters, W. Waitoki, N. Te Awekotuku, & R. J. M. . Etheredge (Eds.), *The Proceedings of the National Māori Graduates of Psychology Symposium 2002: Making a difference. Proceedings of a symposium hosted by the Māori & Psychology Research Unit at the University of Waikato, Hamilton, 29-30 November 2002* (pp. 13–18). Hamilton, New Zealand: Māori and Psychology Research Unit, University of Waikato.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343.

Luhtanen, R., & Crocker, J. (1992). A collective self-esteem scale: Self-evaluation of one's social identity. *Personality and Social Psychology Bulletin*, *18*(3), 302–318.

Lundh, L.-G. L., Karim, J., & Quilisch, E. V. A. (2007). Deliberate self-harm in 15-year-old adolescents: A pilot study with a modified version of the Deliberate Self-Harm Inventory. *Scandinavian Journal of Psychology*, *48*, 33–41.

http://doi.org/10.1111/j.1467-9450.2006.00567.x

Luyckx Amarendra;Bijttebier, Patricia;Claes, Laurence, K. (2015). Non-suicidal self-injury in high school students: Associations with identity processes and statuses. *Journal of Adolescence*, *41*, 76–85. http://doi.org/http://dx.doi.org/10.1016/j.adolescence.2015.03.003

MacDermott, S. T., Gullone, E., Allen, J. S., King, N. J., & Tonge, B. (2010). The emotion regulation index for children and adolescents (ERICA): a psychometric investigation. *Journal of Psychopathology and Behavioral Assessment*, *32*(3), 301–314. http://doi.org/http://dx.doi.org/10.1007/s10862-009-9154-0.

Macleod, R., Craufurd, D., & Booth, K. (2002). Patients' perceptions of what makes genetic counselling effective: An interpretative phenomenological analysis. *Journal of Health Psychology*, *7*(2), 145–156.

Maniapoto, M. (2012). Māori expressions of healing in 'just therapy.' In A. Lock & T. Strong (Eds.), *Discursive Perspectives in Therapeutic Practice*. Oxford University Press. http://doi.org/10.1093/med/9780199592753.003.0012

Māori, T. T. W. i te R. (2008). *He Pātaka Kupu: te kai a te rangatira*. Wellington: Penguin Group.

Marsden, M. (2003). *The woven universe: selected writings of Rev. Māori Marsden*. Estate of Rev. Māori Marsden.

Marsden, M., Henare, T. A., & Marsden, R. M. (1992). *Kaitiakitanga: A Definitive Introduction to the Holistic World View of the Maori*. Ministry for the Environment.

Marshall, S., Tilton-Weaver, L., & Stattin, H. (2013). Non-suicidal self-injury and depressive symptoms during middle adolescence: A longitudinal analysis. *Journal of Youth and Adolescence*, *42*(8), 1234–1242. http://doi.org/http://dx.doi.org/10.1007/s10964-013-9919-3

Martin, J., Bureau, J.-F., Cloutier, P., & Lafontaine, M.-F. (2011). A Comparison of Invalidating Family Environment Characteristics Between University Students Engaging in Self-Injurious Thoughts & Actions and Non-Self-Injuring University Students. *Journal of Youth and Adolescence*, *40*(11), 1477–1488. http://doi.org/10.1007/s10964-011-9643-9

Masters-Awatere, B., Boulton, A., Rata, A., Tangitu-Joseph, M., Brown, R., & Cormack, D. (2017). Behind the label: Complexities of identifying Maori whanau in an away from home hospital transfer. *New Zealand Journal of Psychology*, *46*(3), 20.

Masters, B., & Levy, M. (1995). *An evaluation of Kaupapa Maori within the Psychology Department at the University of Waikato*. Hamilton, NZ.

Matamua, R. (2017). *Matariki: The Star of the Year*. Wellington: Huia Publishers.

McAllister, M. (2003). Multiple meanings of self harm: A critical review. *International Journal of Mental Health Nursing*, *12*(3), 177–185.

McCoy, L. K. (2017). Longitudinal qualitative research and interpretative phenomenological analysis: philosophical connections and practical considerations. *Qualitative Research in Psychology*, (Just accepted). http://doi.org/10.1080/14780887.2017.1340530

McKay, H. F., McLeod, P. E., Jones, F. F., & Barber, J. E. (2001). *Gadi Mirrabooka:*

Australian aboriginal tales from the dreaming. Libraries Unlimited.

McLachlan, A. D., Wirihana, R., & Huriwai, T. (2017). Whai tikanga: The application of a culturally relevant value centred approach. *New Zealand Journal of Psychology*, *46*(3), 46.

McParland, J. L., Eccleston, C., Osborn, M., & Hezseltine, L. (2011). It's not fair: an interpretative phenomenological analysis of discourses of justice and fairness in chronic pain. *Health:*, *15*(5), 459–474.

Mead, H. M. (2016). *Tikanga Māori: living by Māori values (Revised Ed.)*. Wellington: Huia Publishers.

Mendiola, C. (2011). *He Koha Aroha Ki Te* Whānau*: Deliberate Self Harm and Māori* Whānau*. PhD Thesis.* Auckland University.

Metge, J. (1986). *In and out of touch : whakamaa in cross cultural context*. Wellington, New Zealand: Victoria University Press.

Metge, J. (2015). *Tauira : Māori methods of learning and teaching / Joan Metge.* (J. Witehira, Ed.). Auckland, New Zealand : Auckland University Press. http://doi.org/http://site.ebrary.com/lib/vuw/Doc?id=11061509

Mikaere, A. (1994). Māori women: caught in the contradictions of a colonised reality. *Waikato Law Review*, *2*, 125–149.

Mikaere, A. (2011). *Colonising myths, Māori realities: He Rukuruku Whakaaro*. Wellington, N.Z.: Huia Publishers.

Mila-Schaaf, K. (2010). Polycultural capital and the Pasifika second generation: negotiating identities in diasporic spaces: a thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Sociology at Massey University, Albany, New Zealand.

Milne, M. (2014). Māori and Indigenous Suicide Prevention Symposium, Wellington, NZ.

Moorfield, J. C. (2005). *Te Aka: Māori-English, English-Māori Dictionary and Index*. Longman.

Muehlenkamp, J., Claes, L., Havertape, L., & Plener, P. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, *6*. http://doi.org/10.1007/s10802-011-9597-0.;http://dx.doi.org/10.1186/1753-2000-6-10

Muehlenkamp, J., Claes, L., Smits, D., Peat, C., & Vandereycken, W. (2011). Non-suicidal self-injury in eating disordered patients: A test of a conceptual model. *Psychiatry Research*, *188*(1), 102–108. http://doi.org/10.1521/suli.2009.39.1.58;http://dx.doi.org/10.1016/j.psychres.2010.12.023

Muehlenkamp, J., Hoff, E., Licht, J.-G., Azure, J., & Hasenzahl, S. (2008). Rates of non-suicidal self-injury: A cross-sectional analysis of exposure. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues*, *27*(4), 234–241. http://doi.org/http://dx.doi.org/10.1007/s12144-008-9036-8

Muehlenkamp, J. J. (2014). Distinguishing between suicidal and nonsuicidal self-injury. *The Oxford Handbook of Suicide and Self-Injury*, 23–46.

Muehlenkamp, J. J., & Gutierrez, P. M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archives of Suicide Research*, *11*(1), 69–82. http://doi.org/http://dx.doi.org/10.1080/13811110600992902

Muriwai, E. M., Houkamau, C. A., & Sibley, C. G. (2015). Culture as cure? The protective function of Māori cultural efficacy on psychological distress. *New Zealand Journal of Psychology*, *44*(2), 14–24.

Nada-Raja, S., Morrison, D., & Skegg, K. (2003). A population-based study of help-seeking for self-harm in young adults. *Australian and New Zealand Journal of Psychiatry*, *37*(5), 600–605. Retrieved from http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=3&sid=7551bfff-1e33-4abb-babf-9fb0a3bee4ab%2540sessionmgr115&hid=121

Nada-Raja, S., Skegg, K., Langley, J., Morrison, D., & Sowerby, P. (2004). Self-harmful behaviors in a population-based sample of young adults. *Suicide & Life-Threatening Behavior*, *34*(2), 177–86. http://doi.org/10.1521/suli.34.2.177.32781

Najmi, S., Wegner, D. M., & Nock, M. K. (2007). Thought suppression and self-injurious thoughts and behaviors. *Behaviour Research and Therapy*, *45*(8), 1957–1965. http://doi.org/10.1016/j.brat.2006.09.014

Natana, I. (1993). Why be a whakamaa! In V. Miller, S. Robertson, M. Teesson, & B. Garvey (Eds.), *On the Street Where You Live: The 3rd Annual Mental Health Services Conference* (pp. 19–26). NSW Australia: Fast Books.

Ngata, A. T., & Jones, P. T. H. (1961). Nga Moteatea Vol. 2. *Wellington, The Polynesian Society*.

NiaNia, W., Bush, A., & Epston, D. (2017). *Collaborative and Indigenous Mental Health Therapy. Tātaihono - Stories of Māori Healing and Psychiatry*. New York: Routledge.

Nicole, M. J., & Jose, P. E. (2017). "I can't Take Hold of Some Kind of a Life": The Role of Social Connectedness and Confidence in Engaging "Lost" Adolescents with Their Lives. *Journal of Youth and Adolescence*, *46*(9), 2028–2046.

Nikora, L. (2016). Tangi and Final Responsibilities: Keynote paper presented at the World Indigenous Suicide Prevention Conference. Rotorua, NZ.

Nock, M., Joiner, T., Gordon, K., Lloyd-Richardson, E., & Prinstein, M. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research*, *144*(1), 65–72. http://doi.org/10.1177/0272431608316604;http://dx.doi.org/10.1016/j.psychres.2006.05.010

Nock, M. K. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviors. *Applied & Preventive Psychology : Journal of the American Association of Applied and Preventive Psychology*, *12*(4), 159–168. http://doi.org/10.1016/j.appsy.2008.05.002

Nock, M. K. (2009). Why do People Hurt Themselves? New Insights Into the Nature and Functions of Self-Injury. *Current Directions in Psychological Science*, *18*(2), 78–83. http://doi.org/10.1111/j.1467-8721.2009.01613.x

Nock, M. K. (2010). Self-injury. *Annual Review of Clinical Psychology*, *6*, 339–363. http://doi.org/10.1146/annurev.clinpsy.121208.131258

Nock, M. K., & Mendes, W. B. (2008). Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers. *Journal of Consulting and Clinical Psychology*, *76*(1), 28.

Nock, M. K., & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology*, *72*(5), 885–90. http://doi.org/10.1037/0022-006X.72.5.885

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology*, *114*(1), 140–6. http://doi.org/10.1037/0021-843X.114.1.140

Nock, M. K., Prinstein, M. J., & Sterba, S. K. (2009). Revealing the form and function of self-injurious thoughts and behaviors: A real-time ecological assessment study among adolescents and young adults. *Journal of Abnormal Psychology*, *118*(4), 816–27. http://doi.org/10.1037/a0016948

Ogden, J. A., & McFarlane-Nathan, G. (1997). Cultural bias in the neuropsychological assessment of young Maori men. *New Zealand Journal of Psychology*, *26*, 2–12.

Ogden, J., Cooper, E., & Dudley, M. (2003). *Adapting Neuropsychological Assessments for Minority Groups: A Study Comparing White and Maori New Zealanders*. *Brain Impairment* (Vol. 4). http://doi.org/10.1375/brim.4.2.122.27026

Organisation, W. H. (2014). Mental health: a state of wellbeing. Retrieved January 12, 2016, from http://www.who.int/features/factfiles/mental_health/en/

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. *Assessment*, *8*(4), 443–454.

Palmer, M., Larkin, M., de Visser, R., & Fadden, G. (2010). Developing an Interpretative Phenomenological Approach to Focus Group Data. *Qualitative Research in Psychology*, *7*(2), 99–121. http://doi.org/10.1080/14780880802513194

Palmer, S. (2004). Hōmai te Waiora ki Ahau: A tool for the measurement of wellbeing among Māori - the evidence of construct validity. *New Zealand Journal of Psychology*, *33*(2), 50–58.

Peoples, F. I. C. of the C. and I. P. R. of I. (1993). *The Mataatua Declaration on Cultural and Intellectual Property Rights of Indigenous Peoples. Geneva, Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities*. Geneva.

Pere, J. (1991). Hītori Māori. In C. Davis & P. Lineham (Eds.), *The Future of the Past: Themes in New Zealand History*. Palmerston North: Department of History, Massey University.

Pere, L., & Barnes, A. (2009). New Learnings from Old Understandings: Conducting Qualitative Research with Maori. *Qualitative Social Work*, *8*(4), 449–467. http://doi.org/10.1177/1473325009345796

Pere, R. (1997). *Te wheke: A celebration of infinite wisdom* (2nd ed..). Gisborne, N.Z.: Ao Ako Global Learning New Zealand.

Phinney, J. S. (1990). Ethnic Identity in Adolescents and Adults: Review of Research. *Psychological Bulletin*, *108*(3), 499–514. http://doi.org/10.1037/0033-

2909.108.3.499

Phinney, J. S. (1992). The Multigroup Ethnic Identity Measure: A New Scale for Use with Diverse Groups. *Journal of Adolescent Research*, *7*(2), 156–176. http://doi.org/10.1177/074355489272003

Phinney, J. S., & Ong, A. D. (2007). Conceptualization and Measurement of Ethnic Identity: Current Status and Future Directions. *Journal of Counseling Psychology*, *54*(3), 271–281. http://doi.org/10.1037/0022-0167.54.3.271

Pihama, L. (2018). Kare-ā-Roto: Decolonising emotions. In *Ngā Kare-ā-Roto: Decolonising emotions symposium & thought space wānanga*. Waikato.

Pihama, L. E. (2001). Tīhei mauri ora: honouring our voices: mana wahine as a kaupapa Māori: theoretical framework. ResearchSpace@ Auckland.

Pitama, S., Huria, T., & Lacey, C. (2014). Improving Maori health through clinical assessment: Waikare o te Waka o Meihana. *The New Zealand Medical Journal (Online)*, *127*(1393).

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana Model: A Clinical Assessment Framework. *New Zealand Journal of Psychology*, *36*(3), 118–125.

Plener, P. L., Schumacher, T. S., Munz, L. M., & Groschwitz, R. C. (2015). The longitudinal course of non-suicidal self-injury and deliberate self-harm: a systematic review of the literature. *Borderline Personality Disorder and Emotion Dysregulation*, *2*(1), 2.

Pohatu, T. (2018). Ka noho au i konei ka whakaaro noa - Tracing potential in Tīpuna experiences. In *Ngā Kare-ā-Roto: Decolonising emotions symposium & thought space wānanga*. Waikato.

Pomare, P. (2015). He Kākano ahau i ruia mai i Rangiātea e kore ahau e ngaro: Engaging Māori in culturally responsive Child and Adolescent Mental Health Services. ResearchSpace@ Auckland.

Pukui, M. K., Haertig, E. W., & Lee, C. (1983). *Nana i Ke Kumu (look to the source) volume 1*. Hui Hanai.

Rangihuna, D., & Kopua, M. (2015). Mahi a Atua - An Indigenous Approach to Building a Critical Mass. In *Healing our Spirit Worldwide 7th International Indigenous Peoples Gathering*.

Rata, A. (2012). *Te Pītau o te Tuakiri: Affirming Māori identities and Promoting Wellbeing in State Secondary Schools*. Victoria University of Wellington.

Rata, A. (2015). The Māori identity migration model: Identity threats and opportunities for Māori youth. *MAI Journal*, *4*(1), 3–14.

Reynolds, S. K., Lindenboim, N., Comtois, K. A., Murray, A., & Linehan, M. M. (2006). Risky assessments: participant suicidality and distress associated with research assessments in a treatment study of suicidal behavior. *Suicide and Life-Threatening Behavior*, *36*(1), 19–34.

Rezentes, W. C. (1996). *Ka Lama Kukui--Hawaiian Psychology: An Introduction*. 'A'ali'i Books.

Ribeiro, J. D., Franklin, J. C., Fox, K. R., Bentley, K. H., Kleiman, E. M., Chang, B. P., & Nock,

M. K. (2016). Self-injurious thoughts and behaviors as risk factors for future suicide ideation, attempts, and death: a meta-analysis of longitudinal studies. *Psychological Medicine*, *46*(2), 225–236.

Roberts, R. M. (2013). Ways of Seeing: Whakapapa. *Sites: A Journal of Social Anthropology and Cultural Studies*, *10*(1), 93–120.

Roberts, R. M., & Wills, P. R. (1998). Understanding Maori Epistemology - A Scientific Perspective. In H. Wautischer (Ed.), *Tribal Epistemologies: Essays in the Philosophy of Anthropology* (pp. 43–77). Hants, England: Ashgate Publishing Ltd.

Robson, B., & Reid, P. (2001). *Ethnicity Matters: Maori Perspectives*. Wellington.

Schwartz, S. J. (2007). The structure of identity consolidation: Multiple correlated constructs or one superordinate construct? *Identity: An International Journal of Theory and Research*, *7*(1), 27–49.

Services, N. Z. C. (2017). Suicide Statistics: Provisional figures - August 2017. Retrieved January 12, 2018, from https://coronialservices.justice.govt.nz/assets/Documents/Publications/2016-17-annual-provisional-suicide-figures-20170828.pdf

Sibley, C., Harré, N., Hoverd, W., & Houkamau, C. (2011). The Gap in the Subjective Wellbeing of Māori and New Zealand Europeans Widened Between 2005 and 2009. *An International and Interdisciplinary Journal for Quality-of-Life Measurement*, *104*(1), 103–115. http://doi.org/10.1007/s11205-010-9729-x

Simmonds, N. (2018). Called home: Whenua, whare, wai and emotional wellbeing. In *Ngā Kare-ā-Roto: Decolonising emotions symposium & thought space wānanga*. Waikato.

Simmonds, N. B. (2014). *Tū te turuturu nō Hine-te-iwaiwa: Mana wahine geographies of birth in Aotearoa New Zealand*. University of Waikato.

Smith, G. H. (1997). *The development of Kaupapa Maori: Theory and praxis*. The University of Auckland. Retrieved from https://researchspace.auckland.ac.nz/handle/2292/623

Smith, G. H. (2003). Kaupapa Maori Theory: Theorizing Indigenous Transformation of Education & Schooling. *Presentation to the "Kaupapa Māori Symposium" NZARE AARE Joint Conference*, (December), 17.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, *11*(2), 261–271. http://doi.org/10.1080/08870449608400256

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*(1), 39–54.

Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(1), 3–11.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9–27. http://doi.org/10.1080/17437199.2010.510659

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Smith, L. (2008). *On tricky ground: Researching the native in the age of uncertainty*. (N. K. Denzin, Ed.)*Handbook of critical and indigenous methodologies*. Sage.

Smith, L. T. (2012). *Decolonizing methodologies: Research and indigenous peoples* (2nd ed.). Dunedin: Zed Books Ltd.

Smith, L. T. (2014). Kaupapa Māori Methodology. In *Kaupapa Rangahau Workshop Series, Ngaruawāhia*.

Smith, S. P., Whatahoro, H. T., Pohuhu, N., & Matorohanga, T. (1997). *The Lore of the Whare-Wānanga: Or Teachings of the Maori College on Religion, Cosmogony, and History. Written down by H.T. Whatahoro from the teachings of Te Matorohanga and Nepia Pohuhu, priests of the Whare-wānanga of the East Coast, New Zealand. Trans* (Vol. 3). Hamilton: University of Waikato Library.

Snelgrove, S., Edwards, S., & Liossi, C. (2013). A longitudinal study of patients' experiences of chronic low back pain using interpretative phenomenological analysis: changes and consistencies. *Psychology & Health*, *28*(2), 121–138.

Society, N. Z. P. (2002). *The code of ethics for psychologists working in Aotearoa/New Zealand*. Wellington, New Zealand: New Zealand Psychological Society.

Stanley, B., Gameroff, M. J., Michalsen, V., & Mann, J. J. (2001). Are suicide attempters who self-mutilate a unique population? *American Journal of Psychiatry*, *158*(3), 427–432.

Statistics New Zealand. (2013). Te Kupenga. Retrieved from http://archive.stats.govt.nz/browse_for_stats/people_and_communities/maori/Te Kupenga_HOTP13.aspx

Steele, C. M., & Aronson, J. (1995). Stereotype Threat and the Intellectual Test Performance of African Americans. *Journal of Personality and Social Psychology*, *69*(5), 797–811. http://doi.org/10.1037/0022-3514.69.5.797

Stephens, M. (2001). A Return to the Tohunga Suppression Act 1907. *Victoria University of Wellington Law Review*, *32*, 437–462.

Stephenson, W. (1953). The study of behavior; Q-technique and its methodology.

Straiton, M., Roen, K., Dieserud, G., & Hjelmeland, H. (2012). Pushing the Boundaries: Understanding Self-Harm in a Non-Clinical Population. *Archives of Psychiatric Nursing*, *27*(2). http://doi.org/10.1016/j.apnu.2012.10.008

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review*, *18*(5), 531–554. http://doi.org/10.1016/S0272-7358(97)00105-0

Swannell, S. V, Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of Nonsuicidal Self-Injury in Nonclinical Samples: Systematic Review, Meta-Analysis and Meta-Regression. *Suicide & Life-Threatening Behavior*, 1–31. http://doi.org/10.1111/sltb.12070

Szabo, M. (2010). The Short Version of the Depression Anxiety Stress Scales (DASS-21): Factor Structure in a Young Adolescent Sample. *Journal of Adolescence*, *33*(1), 1–8. http://doi.org/10.1016/j.adolescence.2009.05.014

Tashakkori, A., & Teddlie, C. (2010). *Sage handbook of mixed methods in social & behavioral research*. Sage.

Taylor, J. D., & Ibañez, L. M. (2015). Sociological Approaches to Self-injury. *Sociology Compass*, *9*(12), 1005–1014. http://doi.org/10.1111/soc4.12327

Te Awekotuku, N. (1991). *He tikanga whakaaro: research ethics in the Maori community: a discussion paper*. Ministry of Maori Affairs.

Te Awekotuku, N. (2009). *Memento Mori: Memento Māori – Moko and memory*. Hamilton.

Te Huia, A. (2013). *Whaia Te Iti Kahurangi, ki te tuohu koe me he maunga teitei: Establishing psychological foundations for higher levels of Māori language proficiency*. Victoria University of Wellington.

Te Rangi Hiroa. (1949). *The coming of the Maori*. Wellington, NZ: Māori Purposes Fund Board.

Tomkins, L., & Eatough, V. (2010). Reflecting on the use of IPA with focus groups: Pitfalls and potentials. *Qualitative Research in Psychology*, *7*(3), 244–262.

Treatment, C. for S. A. (2014). *Improving cultural competence*. Rockville, MD: Substance abuse and mental health services administration.

Twenge, J. M. (2017). *IGen : why today's super-connected kids are growing up less rebellious, more tolerant, less happy-- and completely unprepared for adulthood (and what this means for the rest of us) / Jean M. Twenge, Ph. D.* (First Atri). New York, NY : Atria Books.

Ungar, M., Clark, S. E., Kwong, W.-M., Makhnach, A., & Cameron, C. A. (2005). Studying Resilience across Cultures. *Journal of Ethnic & Cultural Diversity in Social Work*, *14*(3–4), 1–19. http://doi.org/10.1037//0002-9432.72.4.596http://dx.doi.org/10.1300/J051v14n03_01

Valentine, H. (2009). *Kia Ngäwari ki te Awatea: The relationship between Wairua and Mäori well-being: A psychological perspective* . Massey University.

Valentine, H., Tassell-Mataamua, N., & Flett, R. (2017). Whakairia ki runga: The many dimensions of wairua. *New Zealand Journal of Psychology*, *46*(3), 64.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & T, J. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, *117*(2), 575–600. http://doi.org/10.1037/a0018697

Waitoki, W. (2012). The development and evaluation of a cultural competency training programme for psychologists working with Māori: A training needs analysis. University of Waikato.

Waitoki, W., & Levy, M. (Eds.). (2016). *Te Manu Kai i te Mātauranga: Indigenous Psychology in Aotearoa/New Zealand*. Wellington: The New Zealand Psychological Society.

Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Maori research, its principles, processes and applications. *International Journal of Social Research Methodology*, *9*(4), 331–344. http://doi.org/10.1080/13645570600916049

Walsh, B. W. (2006). *Treating self-injury: A practical guide*. New York: Guilford Press.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics*, *117*(6), 1939–48. http://doi.org/10.1542/peds.2005-2543

Whitlock, J. L., Powers, J. L., & Eckenrode, J. (2006). The virtual cutting edge: the internet and adolescent self-injury. *Developmental Psychology*, *42*(3), 407–17. http://doi.org/10.1037/0012-1649.42.3.407

Whitlock, J., Lloyd-Richardson, E., Fisseha, F., & Bates, T. (2018). Parental Secondary Stress: The Often Hidden Consequences of Nonsuicidal Self-Injury in Youth. *Journal of Clinical Psychology*, *74*(1), 178–196.

Whitlock, J., Muehlenkamp, J., Eckenrode, J., Purington, A., Abrams, G., Barreira, P., & Kress, V. (2013). Nonsuicidal self-injury as a gateway to suicide in young adults. *Journal of Adolescent Health*, *52*(4), 486–492. http://doi.org/http://dx.doi.org/10.1016/j.jadohealth.2012.09.010

Wilcox, A., Caldeira, K., Vincent, K., Pinchevsky, G., & O'Grady, K. (2012). Longitudinal predictors of past-year non-suicidal self-injury and motives among college students. *Psychological Medicine*, *42*(4), 717–726. http://doi.org/http://dx.doi.org/10.1017/S0033291711001814

Wilkinson, P. (2013). Non-suicidal self-injury. *European Child & Adolescent Psychiatry*, *22 Suppl 1*(Suppl 1), S75-9. http://doi.org/10.1007/s00787-012-0365-7

Wilkinson, P., & Goodyer, I. (2011). Non-suicidal self-injury. *European Child & Adolescent Psychiatry*, *20*(2), 103–8. http://doi.org/10.1007/s00787-010-0156-y

Wilkinson, P. O. (2011). Nonsuicidal Self-Injury: A Clear Marker for Suicide Risk. *Journal of the American Academy of Child & Adolescent Psychiatry*. http://doi.org/10.1016/j.jaac.2011.04.008

Wilkinson, S. (2003). Focus Groups. In J. Smith (Ed.), *Qualitative psychology: a practical guide to methods.* London: Sage.

Williams, J. (2010). Towards a model for Indigenous research. In B. Hokowhitu, N. Kermoal, C. Anderson, A. Petersen, I. Reilly, I. Altamirano-Jimenez, & P. Rewi (Eds.), *Indigenous identity and resistance: Researching the diversity of knowledge*. Dunedin: Otago University Press.

Wirihana, R., & Smith, C. (2014). Historical trauma, healing and well-being in Maori communities. *Mai Journal*, *3*(3), 197–210.

Yardley, L. (2000). *Dilemmas in qualitative research. Psychology & Health - PSYCHOL HEALTH* (Vol. 15). http://doi.org/10.1080/08870440008400302

Zetterqvist, M. (2015). The DSM-5 diagnosis of nonsuicidal self-injury disorder: A review of the empirical literature. *Child and Adolescent Psychiatry and Mental Health*, *9*. http://doi.org/10.1155/2013/159208.