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**A Hermeneutic Phenomenological Analysis of Clinical
Psychologists' Understandings of Youth Suicide.**

A thesis presented in partial fulfilment of the requirements
for the degree of

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Psychology

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Hannah Brown
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Dedications

*This thesis has been inspired by the extraordinary people in my
life who chose to take their own lives.*

May they finally have the peace they were searching for.

Abstract

New Zealand has one of the highest youth suicide rates in the developed world. There are many ambiguities around the risk factors and life events preceding a suicide attempt or completion, despite the vast amount of research done in this area. Clinical psychologists have the ability to add a wealth of knowledge on this topic, and surprisingly there has been little research done with this group. I wanted to find out directly from clinical psychologists about their experiences of working with youth who have attempted or completed suicide. I also wanted the opportunity to explore, from a clinical psychologists' perspective, the questions surrounding prevention and treatment programme efficacy. These topics and ideas are considered to be complex and controversial.

Interpretive phenomenological analysis was used to investigate detailed reports of youth suicide from eight participants. Three master themes emerged from the analysis, those being "Client Actions", "Social and Cultural World" and "Psychological Person", as the central features of the phenomenology of suicide. Suicide is often explained in statistical terms, and an extensive amount of research has found many risk factors pertaining to youth suicide. However, the present study found that statistics cannot fully grasp the phenomenon of suicide, and participants were unable to meaningfully relate to suicide in this way.

Findings in this study also suggest that one of the biggest gaps in the research is around the psychosocial aspects of youth suicide, particularly the socio-cultural specificities of New Zealand youth. More training and research around these areas is recommended, along with inclusion of family in the treatment of youth suicide and mental illness.

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1. INTRODUCTION

There is a significant amount of research illustrating how the New Zealand youth (15-24 years old) suicide rate has been rising since the 1970's. This is causing considerable concern across health sectors (Beautrais, 2000a; Beautrais, 2002; Fergusson, Woodward & Horwood, 2000; Drummond, 1997). In this section youth suicide statistics and historical information about New Zealand are introduced to contextualise the problem of youth suicide. Risk factors for suicide among young people are discussed.

The most recent statistics available for New Zealand youth (15-24 years old) suicides is the provisional 2001 data provided by New Zealand Health Information Service (NZHIS, 2004). This data is considered provisional because there are a small number of deaths the coroner has not yet assigned to a cause of death. More recent statistics are unavailable due to the lengthy process involved in determining suicide as a cause of death. An inquest needs to be completed before the coroner can officially deem a death a suicide, which can take over a year currently. This is especially the case if the circumstances surrounding the death need to be investigated (NZHIS, 2004).

1.1 New Zealand Youth Suicide Statistics

According to NZHIS (2004), the total number of suicides in New Zealand for 2001 was 499; an increase from 2000 where there were 458 completed suicides. 458 deaths by suicide was the lowest recorded number since 1990. Of the total number of suicides for 2001, 107 were youth suicides (at a rate of 20 deaths per 100,000 of population). In 2000 there were 96 youth who died by suicide, and 120 in 1999. Of the 107 deaths in 2001, 84 were male suicides and 23 were female suicides (NZHIS, 2004).

When comparing the 2000 and 2001 NZHIS youth suicide data, the total number of suicides increased for both males and females. For males the number of suicides rose from 375 to 382; and for females it rose from 83 to 117. This is a rate of 31.1 deaths per 100,000 population for male youth in 2001

compared to 29.9 per 100,000 population in 2000. The female rate of youth suicide for 2001 was 8.7 deaths per 100,000 population, and 5.8 per 100,000 population in 2000.

Compared to other Western countries, New Zealand has the highest male youth suicide rate, and the second highest female suicide rate. The youth suicide rate for Māori is higher than that for non-Māori. In 2001 the Māori youth suicide rate was 28 deaths per 100,000 population; the rate for non-Māori was 18.1 per 100,000 population (NZHIS, 2004). Both of these rates have increased since 2000, with the rates for Māori in 2000 recorded at 25.7 per 100,000 population, and the rates for non-Māori in 2000 being 16.2 per 100,000 population.

In 2001 the youth suicide rate for Māori males was 38.9 deaths per 100,000 population, and the non-Māori male youth suicide rate was 29.2 per 100,000 population. In 2001, the youth suicide rate for Māori females was 17.2 deaths per 100,000 population, in comparison to the non-Māori female rate of 6.6 deaths per 100,000 population. These statistics equate to 29 Māori youth deaths from suicide in 2001 (20 males and 9 females). There were 28 in 2000 and 33 in 1999.

NZHIS (2004) statistics have shown a decrease overall, in the youth suicide rate for five consecutive years, up until 2001. In 2000 the rate dropped to 18.1 deaths per 100,000 population, which was the lowest rate since 1986 (NZHIS, 2004). Provisional 2001 statistics show an increase to 20.0 deaths per 100,000 population. Rates have increased for both non-Māori males and females between 2000 and 2001. The Māori male rate however has decreased between 2000 and 2001.

Historically, the youth suicide statistics were considerably stable between 1948 and 1968. Prevalence increased noticeably from then until they peaked in 1995 (28.7 deaths per 100,000 population). Since then the youth suicide rate has shown a decrease overall.

1.2 Hospitalisation Data

In New Zealand, youth have the highest hospitalisation rates for intentional self-harm (NZHIS, 2004). The most recent hospitalisation data available is for the year 2002. There were 931 hospitalisations in 2002 (186.5 per 100,000 population) for youth. Of those 688 were females (277 per 100,000 population), and 243 were males (97.2 per 100,000 per population). The whole population in New Zealand had a hospitalisation rate of 85.5 cases per 100,000 population in 2002. These rates indicate that intentional self-harm is more prevalent than suicide for our youth.

Māori had a lower rate per population of hospitalisation due to intentional self-harm than non-Māori, in 2002. The rate for Māori was 179.0 cases per 100,000 population and 188.2 per 100,000 population was the rate for non-Māori (NZHIS, 2004). The hospitalisation rate for Māori females in 2002 was 238.6 cases per 100,000 population. This is lower than non-Māori females with 285.8 per 100,000 population. Māori males had a higher hospitalisation rate (117.2 per 100,000 population) compared to non-Māori males (93.1 per 100,000 population) in 2002 (NZHIS, 2004).

However, we need to be cautious when talking about hospitalisation rates, as these are only the records for people who are hospitalised as inpatients or day patients (West-Blair & Mellsop, 2001; NZHIS, 2004). Therefore the rates are not necessarily accurate. People who do not seek medical treatment, or who are seen by a General Practitioner or an Accident and Emergency facility only, will not be included in the statistics. Those youth who self-harm without the intention of suicide and death will inevitably be included in these statistics. Youth who self-harm have different intentions from suicide attempters. The argument here is that self-harmers do not wish to die, while suicide attempters do wish to die, although this argument remains controversial (McAllister, 2003).

Hospitalisation data will include every instance of attempted suicide and intentional self-harm. The rates also include repeated admissions and people

who die from their injuries or complete suicide (Blair-West et al 2001; NZHIS, 2004). Treatment practices that may change from year to year can also have an effect on the statistics. For example, overdose patients can now be treated as out patients, consequently not included in the overall hospitalisation data (NZHIS, 2004). Between 1999 and 2000 New Zealand started using the ICD-10-AM (International Classification of Diseases for Morbidity and Mortality Statistics). This new system has changed the inclusion criteria for the diagnosis of intentional self-harm and this may account for some of the changes in prevalence rates. Admissions have also been altered including a new definition of admissions enabling previously banned cases to be accounted for (NZHIS, 2004). It is important to take note of these changes and the subsequent inclusions and exclusions when reporting on and discussing statistics (Blair-West et al, 2001).

1.3 International Comparisons

It is very hard to accurately compare youth suicide rates between countries, as classification methods are diverse (NZHIS, 2004). Suicide is also defined differently through a range of criteria across countries. However, according to OECD criteria New Zealand had the second highest youth suicide rate compared to other Western countries for both males and females in 2001 (NZHIS, 2004).

So why does New Zealand have such a high youth suicide rate compared to other countries? What is it about New Zealand's society that causes our youth to take their lives at such an alarming rate? What might be specific to New Zealand's socio-cultural history that could help to explain the phenomenon?

In the 1800's the British arrived, and Western colonisation began in New Zealand (Langford, Ritchie & Ritchie, 1998). This had a dramatic effect on New Zealand's economy changing it from depending on primary production to industrial employment and services as a society. We moved very quickly from rural to urban ways of living after World War II. This urbanisation of New

Zealand showed changes in the roles for Māori and women, in particular, shifting from a traditional rural lifestyle, to an urbanised one with more employment opportunities (Langford et al, 1998). After World War II, what is known as the welfare state came to be in New Zealand. New Zealand's primary produce created never seen before prosperity. This meant cradle (family benefits) to the grave (superannuation schemes) economic support for New Zealanders. There was no (recognised) hardship, and education and medical services for all New Zealanders at all levels was free. There was a period of high employment and housing was more accessible for more New Zealanders at very low cost (Langford et al, 1998).

The 1970's endured two international oil crises that showed how vulnerable and unsustainable New Zealand's economy really was (Langford et al 1998). As a result the economy began a process of restructuring. In 1984, and with no warning, the Labour Government cut public sector employment, privatised public services, eroded trade and economic protections and controls, and sold state assets (Langford et al, 1998; Drummond, 1997). This was all done to reduce government debt, but inevitably lead to high levels of unemployment and poverty. This all occurred in a very small space of time and what followed were considerable social changes for New Zealand communities, including stress on resources.

This basic history of how New Zealand's culture developed and has changed enables us to understand a psychosocial context for our high suicide rates. Statistics show that there is in fact a considerable increase in youth suicide statistics after 1984 (NZHIS, 2004).

The rapid rise in unemployment producing economic hardship may be a contributor to death by suicide by our male youth population (Langford et al, 1998). Males are expected to be materially successful, and this appears to be getting harder to achieve as even obtaining a University degree does not guarantee a well paying job. It has also been suggested that if the quality of

one's life is 'good' (i.e. having all the 'toys' such as cell-phones, label clothes and so on), people have fewer external sources to blame for their unhappiness. As a result, the gap in resources could lead to depression and subsequent suicidal tendencies, with youth blaming any kind of failure on their personal inadequacies (Lester, 1998). Lester also suggests that the media supports the notion of access to material wealth as necessary to success, increasing stressors for young people to achieve. However, such economic change has similar effects in other Western countries. So can these economic developments explain New Zealand's high rate of suicide?

1.4 Suicide and Māori

In the 19th Century Māori experienced the effects of colonisation differently to their pākehā counterparts. Processes of acculturation have had devastating effects. Māori experienced land loss through warfare and legislative theft (Langford et al, 1998). The move from rural to urban settings during the 20th Century has led to cultural loss and insecurity, alienation and oppression (Langford et al, 1998; Skegg, Cox & Broughton, 1995).

Māori males have the highest suicide rate in New Zealand (NZHIS, 2004; Langford et al, 1998). Māori also have higher rates of psychological disorders; leaving school earlier, and are over represented in school exclusions; and have higher levels of unemployment compared to Pakeha in New Zealand (Langford et al, 1998; Skegg et al, 1995). With the ongoing erosion of a welfare state Māori have become overrepresented in lower socioeconomic groups (Langford et al, 1998). Māori often experience racism and negative attitudes, which impact on identity.

Māori mortality data after 1996 cannot be compared with data collected before 1995. This is because of the change in how people could define their ethnicity on the census. Prior to 1996, Māori descent was measured biologically. This was quantified as 50% 'blood' enabling Māori to claim their cultural identity. After 1996 the census allowed for people to self-identify as Māori, through

whakapapa, and more than one ethnic classification was possible. Deaths for Māori prior to 1996 will, as a result of these classification changes, be largely underreported (Coupe, 2000a; Coupe, 2000b; Skegg et al, 1995; Durie, 2001).

Suicide for Māori was historically culturally bound. It was often present with grieving widows, extreme shame or disgrace of someone in the community. Through processes of colonisation it is reported that alienation from Māori culture itself might account for the alarmingly high suicide rate in our Māori population (Skegg et al, 1995; Durie, 2001). Evidence shows that a secure cultural identity is a protective factor for Māori against suicide. Identifying and embracing their culture and cultural roles may have an effect reducing the suicide rate for Māori (Skegg et al, 1995; Durie, 2001).

Other indigenous populations around the world have experienced an unbalanced number of suicides when compared to the whole population. For example indigenous Americans, Alaskans, Pacific Peoples, Hawaiians, Canadians and Australians have all experienced higher suicide rates when compared to the whole population of their country (Durie, 2001; Kirmayer, Simpson & Cargo, 2003; Hunter & Harvey, 2002). These statistics help support the argument that cultural alienation and colonisation do have a negative effect on indigenous peoples (Durie, 2001).

Suicides that occur within a prison setting are also higher among indigenous groups, including Māori (Durie, 2001; Simpson, Brinded, Fairley, Laidlaw, & Malcolm, 2003). Some of the cultural reasons may be to do with the person being psychologically/emotionally affected with shame (whakamaa) and humiliation (whakamomori). Māori have higher rates of suicide in prison due to disproportionate rates of imprisonment and increasing rates of mental illness in Māori (Durie, 2001; Simpson et al, 2003). Prisons were found to be unable to meet the needs of Māori inmates for treatment. This has led to the introduction of Māori service providers and the use of more suitable protocols when dealing with Māori inmates.

1.5 Risk Factors

There is no 'typical' person who dies by suicide. However, from the research we do know some of the risk factors that may contribute to a person towards ending their life by suicide (Smyth & MacLachlan, 2004; Beautrais, 2000a; Beautrais, 2002; Vajda & Steinbeck, 2000; Fergusson, Beautrais, & Horwood, 2003; Fergusson et al, 2000; Blair-West et al, 2001; Drummond, 1997).

Mental Health Factors

Mental health factors, especially depression, have been reported to be the strongest risk factor for completed suicide and attempted suicide (NZHIS, 2004; Beautrais, 2000a; Blair-West et al, 2001; Parker & Roy, 2001; Fergusson et al, 2003; Fergusson et al, 2000; Carter, Issakidis & Clover, 2003 ; Vajda et al, 2000). There has been research showing that the rates of depressed people experiencing suicidal behaviour are as high as 15% (Blair-West et al, 2001). However there is controversy over these rates of comorbidity. Blair-West and Mellsop (2001) disagree with the well-known rate that 15% of major depressive people will commit suicide. They believe it is a mathematical impossibility to have a lifetime rate this high. Suicide is a rare phenomenon and Blair-West and Mellsop (2001) claim that if 17% of the population will at some stage experience depression and 15% of them will commit suicide, suicide should therefore be a relatively common event. They believe the actual rate of suicide in depressed people to be around 3.4%, with the lifetime suicide risk for men to be around 7% and 1% for women.

There are other mental disorders that are associated with suicide. These include substance use disorders (Wilkinson & Gunnell, 2000; Fergusson et al, 2000; Carter et al, 2003; Vajda et al, 2000; Burns & Patton, 2000; Toumbourou, & Gregg, 2002; Morrison & L'Heureux, 2001; Stewart, Manion, & Davidson, 2002; Beautrais, 2000; Blair-West et al, 2001; NZHIS, 2004), antisocial behaviours, including conduct disorders, ODD, and antisocial personality disorder (Beautrais, 2000; Fergusson et al, 2000; Carter et al, 2003; Burns et al, 2000; Stewart et al, 2002), anxiety disorders (Fergusson et al, 2000;

Toumbourou et al, 2002), psychosis (Stewart et al, 2002; Power, Bell, Mills, Herrman-Doig, Davern, Henry, Yuen, Khademy-Delijo & McGorry, 2003), and eating disorders (Manley & Leichner, 2003).

Research has shown that suicide is comorbid with each of these disorders; people with the above disorders may be at a higher risk of suicidal ideation, completed suicide and suicide attempts. Multiple disorders and diagnoses are often reported in youth who commit suicide, with the possibility that having more than one mental disorder can increase risks of suicide (Beautrais, 2000a).

Life Circumstances

There has been considerable research completed on the life circumstances surrounding people who have made suicide attempts or completed suicide. New Zealand and overseas research has found some common circumstances for youth who attempt suicide (Fergusson et al, 2003; Fergusson et al, 2000; Beautrais, 2000a; NZHIS, 2004). As mentioned above an obvious loss or adjustment difficulty; a mental disorder; a stressful life event around a supportive or emotional relationship are all common factors before a suicide attempt (Smyth et al, 2004; Beautrais, 2000a).

Those who commit or attempt suicide may come from unhappy and/or disturbed family and childhood backgrounds. These may include parental divorce or separation (Beautrais, 2000a; Fergusson et al, 2000; Carter et al, 2003); marital problems in general (Smyth et al, 2004; Beautrais, 2000a; Fergusson et al, 2000; Carter et al, 2003); a history of childhood physical and/or sexual abuse (Beautrais, 2000a, Fergusson et al, 2003; Fergusson et al, 2000; Carter et al, 2003); and impaired or poor child-parent relationships (Beautrais, 2000a; Fergusson et al, 2000; Carter et al, 2003; Burns et al, 2000; Toumbourou et al, 2002). All of these can vary to the extent they have an effect on suicide due to their intensity and frequency.

Socially disadvantaged backgrounds are also implicated in the research. These can include low socio-economic status (Beautrais, 2000a; Fergusson et al, 2000); little educational achievement (for example dropping out of school young) (Denny, Clark & Watson, 2003; Vajda et al, 2000; Carter et al, 2003; Beautrais, 2000a); low income and poverty (Beautrais, 2000); and unemployment (Mitchell, Betts, & Epling, 2002; Vajda et al, 2000; Beautrais, 2000a; Wilkinson et al, 2000).

Other risk factors seem to include parental psychopathology (Beautrais, 2000a; Vajda et al, 2000; Burns et al, 2000; Toumbourou et al, 2002; Stewart et al, 2002); a family history of suicidal behaviour (Beautrais, 2000a; Vajda et al, 2000; Burns et al, 2000; Fergusson et al, 2003; Morrison et al, 2001); victimisation at school (Cleary, 2000); genetic factors (Beautrais, 2000a), and personality factors including neuroticism, novelty seeking behaviours and low self-esteem (Fergusson et al, 2003; Fergusson et al, 2000; Beautrais, 2000a). Smyth et al (2004) found that loss of any kind can also contribute to suicidal behaviour.

Previous Suicide Attempts

Prior suicide attempts seem to be an indicator of future suicidal behaviour (Toumbourou et al, 2002; Vajda et al, 2000; Kirmayer et al, 2003; Aoun, 1999). While there is no causal relationship between suicidal attempts and completed suicide the two appear to be on a continuum of behaviour, ranging from suicidal ideation through to suicide attempts and completed suicide (Stewart et al, 2002; Aoun, 1999; Morrison et al, 2001).

There is however some debate over whether or not risk factors for attempted suicide are the same for completed suicide (Stewart et al, 2002; Morrison et al, 2001; Aoun, 1999). It is possible that attempted suicide is associated with self-harm behaviour (McAllister, 2003). There are arguments that self-harm is different from suicidal behaviour in as much as it is understood as a 'cry for help' rather than a wish to die. While wrist cutting and other intentional damage to one's body may look the same as suicidal behaviour, it is the intent

that defines it. Self-harming behaviour comes not from a place of wanting to die, but wanting to survive and connect (McAllister, 2003).

Sexual Identity

Sexual orientation is considered by some as yet another potential risk factor for suicidal behaviour (Morrison et al, 2001; Beautrais, 2000a). It is not that gay, lesbian or bisexual identity is inherently a suicide risk, but more that the societal attitudes surrounding being gay, lesbian or bisexual are stressful. The social processes, attitudes and stigma around being homosexual can leave these youth feeling lonely, isolated and hopeless (Morrison et al, 2001; Beautrais, 2000a). While not fitting into the 'norm' as an adolescent can be hard enough, it seems to affect gay, lesbian, and bisexual youth such that suicidal behaviour in this population group is increasing (Morrison et al, 2001). A shift in how society, including school systems views and treats homosexuality is in need of further understanding.

Method

There has been considerable research discussing methods of suicide (Beautrais, 2000b; Carter et al, 2003; Burns et al, 2000; Morrison et al, 2001; Beautrais, 2001; Beautrais, 2000a; Wilkinson et al, 2000). There have been some concerns that the Internet has enabled greater access to certain methods of suicide. Some research claims that restricting access to specific methods of suicide can reduce the suicide rate however limiting access to information can not be interpreted as a means of suicide prevention (Beautrais, 2000a; Beautrais, 2000b; Page & Fragar, 2002). Once legislation against methods of suicide are enforced, method substitution can occur (Wilkinson et al, 2000; Beautrais, 2000b). For example, Wilkinson and Cunnell (2000) found that restricting gun licenses limited access to firearms and resulted in a reduction in suicide through gun shot and an increase in suicide through hanging. This research supports the notion that restricting access to specific methods of suicide does not reduce suicide rates overall.

There are other potential ways of reducing access to methods or making methods less lethal. For example, it is possible to detoxify vehicle exhaust emissions, and clinical drugs (Beautrais, 2000b). These arguments do not address the most common means of suicide for youth (15-24 years old) for the year 2000 in New Zealand – hanging, strangulation, and suffocation (Beautrais, 2001). While restricting access of particular methods may be a short-term solution for impulsive suicidal acts, and those who are at high risk of suicide completion, it does not change a young person's desire to complete the act.

Gender Differences

Research has also found gender differences in the method chosen to complete or attempt suicide (Blair-West et al, 2001; Beautrais, 2002). In New Zealand, males generally use more lethal and permanent means than females (Beautrais, 2002). Males tend to use hanging, carbon monoxide poisoning and firearms to die by suicide. Females tend to use self-poisoning as a method. While this method has the potential to be highly toxic, it has low lethality as it has a slow rate of action, and high potential to be reversed (Beautrais, 2002).

This research may help to explain why more females are thought to attempt suicide than complete suicide. Females have a higher rate of suicidal ideation and suicide attempts than males, while males have a higher completed suicide rate (NZHIS, 2004; Beautrais, 2002). These results have been interpreted to suggest that females intentionally use less fatal methods of suicide as a cry for help rather than to die (Beautrais, 2002). Support for this interpretation is evidenced by the fact that barbiturates and hypnotics have been replaced with less lethal drugs. This interpretation raises questions about how knowledgeable young women are about the effects of the self-poisoning.

An Australian study found that male youth suicide was related to how they perceived themselves in comparison with those around them (Barber, 2001). When young males believed others around them were better off, the risk of suicide increased. Barber (2001) also found that young females were more

influenced by their absolute level of unhappiness. These results suggest that young males are more influenced by external factors and females by internal factors. Males possibly react more to society's pressures than young females (Barber, 2001).

Furthermore, an analysis of gender differences may take into account the idea that men are 'allowed' to act in more violent ways than females. Gender differences in the rates of internalising and externalising disorders may also help to explain suicide attempted and completed suicide rates (Beautrais, 2002; Cleary, 2000). Females are twice as likely to experience internalising disorders compared to males, and males are more likely to experience externalising disorders compared to females (Beautrais, 2002). It is possible to see methods of suicide as 'acting out' (externalising), and 'acting in' (internalising). For example, hanging could be seen as acting out for males, and self-poisoning could be seen as acting in for females. Therefore, it might be necessary to be gender specific when conducting research on youth suicide in New Zealand.

Rural and Remote Areas

Systematic research in Australia has found that rural and remote areas have a higher completed suicide rate than urban areas (Beautrais, 2000; Wilkinson et al, 2000; Slaven & Kisely, 2002; Malcolm, 2002; Page et al, 2002; Aoun, 1999; McLaren & Hopes, 2002). One of the main concerns seems to be that the suicide rate for young males in rural areas is rising (Beautrais, 2000a; Wilkinson et al, 2000). Some of the suggested reasons for this difference between rural and urban areas could be due to the lack of government and private services available in rural areas (McLaren et al, 2002). This includes medical, psychological, and educational services available to rural residents, which are far less resourced than their urban counterparts. There is also an increase in rural unemployment and poverty due to the collapse of the rural economy in many places (McLaren et al, 2002).

One of the main findings was that accessible local mental health services positively impacts on rates of suicide. Research has shown that having an accessible mental health service in town enables residents the opportunity to seek help for suicidal ideation, and attempted suicide (among other concerns), thus reducing the overall suicide rate (Slaven et al, 2002; Aoun, 1999; Malcolm, 2002).

Media Influences

Another controversial issue reported in the literature is the influence of the media on rates of suicide. Some research claims that media publicity and media portrayals of suicide encourage further suicidal behaviour (Beautrais, 2000a; Burns et al, 2000; Toumbourou et al, 2002; Morrison et al, 2001; Miller, Segal & Coolidge, 2001; Slaven et al, 2002). It has been noted that youth suicides gain more media attention than suicide within other age groups, as they seem to have more public appeal (Miller et al, 2001).

Particular music (rock/metal) and the large amount of suicide information, stories and discussion groups on the Internet has also been reported as increasing suicidal behaviour, but there is no empirical support linking media stories and acts of suicide (Beautrais, 2000a). It could be that media representations of suicide tend to sensationalise suicide and often the information is inaccurate (Beautrais, 2000a). Beautrais also states that media portrayals of suicide may have an unexpected effect on vulnerable individuals.

It is also possible that media representations of suicide can normalise and reduce the taboos around suicide (Beautrais, 2000a). Beautrais, Horwood & Fergusson (2004), found that the media was the main source of information regarding suicide for youth. The implications of the media being both inaccurate and a major source of information suggest that the media needs to provide responsible and informed coverage of such information. The study also found that youth seriously overestimate the number of deaths caused by suicide in New Zealand. This may be due to the way the media has made explicit the fact that New Zealand has one of the highest suicide rates in the world. This

can be linked to the idea that suicide is becoming 'normalised' for the youth of New Zealand, and therefore presenting the possibility of suicide as more accessible.

1.6 Protective Factors Against Suicide

The research previously discussed documents many risk factors that may make an individual vulnerable to suicidal behaviour. Little research has been done to determine factors that may protect against suicide (Beautrais, 2000a; Fergusson et al, 2003).

Some of these protective factors found in New Zealand research include; good coping skills, problem solving skills, good social skills, positive and life affirming beliefs and values, resilience, high self-esteem and a sense of belonging, secure cultural identity, school and family ties, good support networks, parenthood and marriage, and moral values against suicide. According to research all these can help protect an individual from suicide (Fergusson et al, 2003, Beautrais, 2000a; Alperstein & Raman, 2003).

School Based Programmes

Early evaluation research indicates school based programmes can work in reducing suicide. In Australia, Toumbourou and Gregg (2002) found that empowering and educating parents and students could enhance protective factors and therefore reduce rates of youth suicide. It even had a positive effect on those in the community not directly involved in the programme.

Schools educate and shape our youth through a significant part of their lives, not to mention through a very turbulent time in their lives - adolescence. Schools therefore have the potential to help reduce the youth suicide rate in New Zealand. They can help to teach our youth important life skills and educate them on being healthy, both physically and emotionally. While suicide is rare with school students (estimated at about 3%), it is regarded as important

to still take suicide seriously and acknowledge its existence through the medium of schools (Ministry of Youth Affairs, 2003).

The Ministries of Education, Health and Youth Affairs have all produced resources for schools to use as guidance in preventing youth suicide in New Zealand. School based programmes are intended to enhance protective factors in our youth. There are however debates over the best way to deal with addressing suicide in schools and these debates also resonate with arguments around responsible reporting by the media.

One of the recommendations for schools is to establish connections with professional mental health organisations in the community. It is important to have trained professionals the schools can call on and work with in a partnership, as well as having community and family links (Ministry of Youth Affairs, 2003). By educating students and encouraging understandings about mental health, schools can help reduce the misconceptions around mental health and enable students to talk about any negative thoughts they may be experiencing (Ministry of Youth Affairs, 2003).

The Ministry of Education offers professional development opportunities for teachers, managers and board of trustee members. It provides training for the development of systems to prevent suicide and promote mental health, including links with the Ministry and the community. The 'Evidence for Student Focused School-based Suicide Prevention Programmes' raised concerns with student focused awareness and education programmes. This report argues that focusing on suicide specifically, rather than general mental health can have negative effects on some individuals (Ministry of Youth Affairs, 2003). The report also states that open conversations around suicide without teaching knowledge and skills on how to deal with these feelings and emotions effectively, could have a negative effect on youth suicide rates.

The report 'Evidence for Student Focused School-based Suicide Prevention Programmes' (University of Auckland: Injury Prevention Research Centre, 2003) found that schools are a perfect setting for encouraging mental health and overall well being in students. Because schools deal with youth on a regular basis they have the potential to teach our youth useful skills, such as problem solving skills, to deal with stressful life events. Schools can also teach youth how to recognise symptoms of mental illness in themselves and others and how to seek help (Ministry of Youth Affairs, 2003).

Generally there is support and evidence to promote school-based youth suicide prevention programmes. However, schools need to be aware of the safety issues and negative consequences poorly carried out programmes may have on vulnerable individuals. Research on how effective school-based programmes are for enhancing protection from suicide needs to be ongoing.

1.7 Aims and Objectives of the Current Study

New Zealand has an alarmingly high youth suicide rate. There is considerable research in the area of youth suicide, yet surprisingly research that makes use of the experiences of clinical psychologists is lacking. Much of the previous research has looked at identifying risk factors that may preclude a suicide or suicide attempt.

Health care professionals and services have a responsibility to their clients to provide the best service available. Clinical psychologists play a vital role in assessment and treatment processes; their interpretations of suicidal clients can be of value to the profession, and may help us understand the issues relevant to this specific client group.

The aim of the present study is to review the research we have on youth suicide specific to New Zealand culture and how it is understood in practice. I will therefore examine practitioner's understandings of youth suicide and identify the strengths and gaps in the knowledge we have about precursors of youth

suicide. It is intended that this research will enable an exploration of the possibilities of improving assessment, treatment and training techniques pertaining to youth suicide in New Zealand.

An interpretive phenomenological analysis was conducted to explore the consistencies and contradictions in psychologists' understandings regarding *their* experiences of youth suicide - by focusing in great detail on a small number of participant reports; to enquire into the phenomenon of suicide on account of the reports given; and to explore the implications of these findings with previous research on youth suicide. The chosen methodology for this study endeavours to disregard predetermined beliefs and assumptions, therefore there was no hypotheses regarding the phenomenon itself or of any possible implications the study may reveal.

2. METHOD

2.1 Methodological Rational

The aim of this study is to explore clinical psychologists' understandings of youth suicide in New Zealand. I will also be looking at how their understandings of youth suicide might inform treatment and prevention strategies for youth suicide. New Zealand has one of the highest suicide rates in the developed world (NZHIS, 2004). There is much controversy around risk factors, prevention strategies and treatment programmes; as well as questions about the effectiveness of interventions.

I believe clinical psychologists have a wealth of knowledge to share in these areas of concern, and very surprisingly there has been little research done with this group. I want to find out directly from clinical psychologists about their experiences of dealing with clients who have attempted or completed suicide. I also want the opportunity to explore, from a clinical psychologists' perspective, the question of prevention and treatment programme efficacy. All of these topics and ideas are complex and controversial.

It is for these reasons that I chose to use a qualitative methodology. Qualitative research works particularly well with topics that are complex, controversial and little understood topics (Smith, 2003). Other studies in this area tend to focus on risk factors and other objective factors, not on psychologists' reactions, attitudes and perspectives on suicide. There are not very many studies that scrutinise psychologist's experiences. To me, this is very surprising given that they hold first hand knowledge of dealing with suicide, and they participate in case formulations.

In the present study I use Interpretive Phenomenological Analysis (IPA) as a methodology. IPA interprets participants' experiences and world-views. It is concerned with how a participant is making sense of their personal and social life-world. It is very much interested in subjective meanings and interpretations

of particular phenomenon, rather than abstracting objective quantitative information on the topic (Smith, 2003).

IPA acknowledges the fact that the researcher is going to have some influence on the data collection, (the interview process in this study). The process involves participants interpreting their experiences, along with the researcher making sense of the participants interpreting their world (Smith, 2003). The researcher is interpreting as they are interviewing, inevitably adding their own experiences to the study.

IPA is therefore connected to hermeneutics, as it assumes we cannot observe without interpretation. All interpretation takes place within a context, and there are no context free elements in the world (Packer, 1985). Hermeneutics is largely concerned with understanding and interpreting human life and the meanings we attach to actions and experiences. It assumes that as human beings we engage in meaningful action that is explicit and ambiguous. Hermeneutics is useful to address current concerns, not to discover a singular truth. It does not assume there is only one meaning of an action (Packer, 1985). This is particularly important in looking at suicide. How can there ever be one single reason why people take their own life, everyone is unique and experiences life differently. There are various ways that suicide can be interpreted. Clinical psychologists bring their expertise to their interpretations. Understanding how psychologists interpret suicide could contribute first hand clinical expertise to our knowledge of suicide and treatment efficacy.

Theoretically phenomenology and symbolic interactionism have helped shape IPA (Smith, 2003). Edmund Husserl founded phenomenology in the early 20th century. One of the main concepts to come out of Husserl's work was to 'return to the things themselves' (Smith, p.12, 2003). It is primarily concerned with the actual experience or phenomenon itself, rather than to determine general abstract statements about the world. By psychologically analysing meanings and experiences of people we can reveal a lot of information, as we are not

always conscious of the underlying meanings associated with our actions and conversations (Smith, 2003).

The key to phenomenology is to look at how people interpreted their lived experiences, from a non-positivistic perspective. It takes information from participants exactly as it is presented (for example interview transcripts), and the researcher will then interpret the raw data. The idea here is to look at first hand experiences as they actually took place- that is within the context they occurred (Smith, 2003). Phenomenology aims to understand their life world and experiences, from a first-person perspective. Phenomenology is only interested in what actually happened, not in theory testing or hypothesis proving (Smith, 2003).

Symbolic interactionism, which was developed by G. H Mead in the 1930's, has had an influence on IPA. The idea that meanings are constructed by individuals made a particular impact (Smith, 2003). Central to symbolic interactionism is the assumption that individuals construct their realities, both in their personal and social worlds. Interpretation and meanings only occur through social interaction, and these meanings are essential to understanding human action (Smith, 2003).

IPA captures key themes from phenomenology and symbolic interactionism to gain some insight into a participant's worldview. It encapsulates an "insiders' perspective", with the aim of understanding any one phenomenon from the unique point of view of the participant. It acknowledges that the relationship between researcher and participant is an active one, where each influences the outcome (Smith, 2003).

This methodology will allow me to develop an insiders' perspective on understanding youth suicide from clinical psychologists. With IPA participants are seen as the expert of their experiences and their world. This will allow me to see how a professional psychologist constructs suicide, and more specifically

how suicide is constructed in psychology through language used in psychology. Such a qualitative method will help to explore what suicide means for psychologists, and how a client's attempted or completed suicide affects them in their work and personal life. What can we learn from them to enhance prevention of youth suicide in New Zealand?

2.2 Steps in Interpretive Phenomenological Analysis

IPA's methodology involves three steps in the data collection process; they are developing a semi-structured interview, recruitment of participants and data collection. There are four main steps in the data analysis; writing the initial notes, establishing themes, connecting the themes and the creation of a summary table. The 'writing up' of IPA can involve the results and analysis in one section, as in the present study. Each master theme is presented with links to the literature and direct quotes from the participants' transcripts to support the arguments. It is important to differentiate between the participants' responses and the researchers interpretations.

2.2.1 Development of a Semi-structured Interview Schedule

I designed my interview questions together with specific prompts to give me my semi-structured interview schedule (see Appendix A). This is designed to guide the interview rather than direct it. The questions are not rigid and fixed but are there to invite participants to explore the topics the researcher suggests. All the while, the interviewer still allows the interview to be adaptable, pursuing any interesting ideas or topics that arise (Smith, 2003). Therefore, while each interview will follow the same basic framework, each one may vary in which order the questions are asked and the detail given.

The questions were arranged in their order so that more general questions were asked first. This was to allow the participants to discuss the broad topics around the phenomenon and then move on to more personal experiences of the phenomenon, once they were more comfortable. The questions were designed

to be 'open and neutral', with specific prompts in place to guide the participants if needed for additional elaboration (Smith, 2003).

The interview schedule was revised a number of times. The first version was too constrained by the researchers' expectations of what participants would say. Once revised, it contained a more clinical perspective and the questions were more open and less leading. These changes helped to phrase the interview questions in a language the participants would know and feel comfortable using.

2.2.2 Recruitment of Participants

Participant requirements were that they needed to be registered clinical psychologists, who have in the past or who currently work with suicidal New Zealand youth (15-24 year olds). Participants included seven women and one man. Purposive sampling was used and participants were chosen in relation to the specific requirements of the present study. Participants were recruited with the help of a supervisor, through distribution of Information Sheets (see Appendix B). Potential participants were selected based on where they worked (with high risk youth), and given Information Sheets. These registered psychologists were invited to contact the researcher if they were interested in participating in the study. Consent forms (see Appendix C) were given to participants to be signed once they agreed to take part in the study. The participants chose their own pseudonym and were reassured their identity would be kept confidential at all times.

2.2.3 Data Collection

The process for the data collection, storage and use was approved by the Massey University Human Ethics Committee, Protocol 04/77. The interview occurred at a time and place chosen by the participant. Each interview was audio taped, with the option of the tape being turned off at anytime. Interviews lasted between 28 and 50 minutes. The researcher then transcribed each interview, with a total of 85 pages of text forming the data for analysis. Whilst transcribing, all features of speech were preserved, such as pauses, laughing,

and repetitions. However, where quotes were used in the results and analysis, these features of the speech (“um”, repetitions and so on) were omitted when they did not add to the meaning of the text. If indicated by the participant on the consent form, copies of the transcript were sent to participants to be amended or commented upon. One participant corrected all grammatical errors in their transcript, and several other participants corrected words the researcher had misheard during the transcribing process.

2.2.4 Data Analysis

It is important to note that with IPA and other phenomenological methodologies, reflexivity can be an issue. IPA analysis is iterative in nature, and the researcher needs to be mindful of their influence in the analysis process (Smith, 2003). Previous studies have researched the literature *after* they have collected the data to ensure the data collection is as unbiased as possible. The current study however did not do this, as the interviewer was already informed through graduate training. IPA acknowledges that the researcher is will affect the data collection and interpretation of the data. It is impossible to be completely objective when conducting the research process. Knowing this, the researcher has to be reflexive in their work. This allows the researcher to be aware of their personal opinions and views towards the phenomenon in the study. It is understood that previous experiences in the researchers’ life would have lead them to the topic and phenomenon in question, which means they have been exposed to some information already on the phenomenon (Willig, 2001).

IPA is idiographic in method, where individual cases are looked at first, gradually working towards generalisations. For the purpose of analysis, one interview was studied in detail, before continuing onto the other interviews one by one.

There are four interpretive processes during the analysis done by the researcher:

1. Initial Notes

Each individual transcript was transcribed by the researcher and was read in detail numerous times, with early responses to the material recorded in the left hand margin. The initial notes included any associations and connections; preliminary interpretations, remarks on the use of language, contradictions, and questions used by the participant. This is the most basic outline of the text showing any concerns and questions that arose, based upon the researcher's first experience of each transcript.

2. Establishing Themes

Emerging theme titles, keywords and phrases were recorded in the right hand margin. At this stage the intention is to portray the essential quality of the text, whilst using as much of the participants' original language and meaning as possible. The titles and keywords were conceptual and descriptive in nature. They were then listed on a sheet of paper with participant and page number recorded to identify them. Some examples of themes titles that emerged were, 'completers', 'family and community', 'risk factors', 'media influences', and so on. There were 15 sub-ordinate themes in total (see Summary of Results for all final master and sub-ordinate themes below).

3. Connecting the Themes

Emerging relationships between the theme titles and key words were identified, allowing for master themes and sub-ordinate themes to emerge. Once sub-ordinate themes clustered together, a title to encompass them was given. This process was repeated across all transcripts ensuring each one matched with all transcripts.

At first 17 sub-ordinate themes were identified. They were then analysed again, prioritised and studied in detail to see if any changes were necessary. This led

to 'Myths' being excluded as a sub-ordinate theme, as it did not seem to fit with the other data, and the data under that heading was best fitted to other categories. 'Method' was also left out as a sub-ordinate theme as this was discussed in detail under 'Gender Differences'. As a result, 15 sub-ordinate themes remained.

Each cluster of sub-ordinate themes was analysed, constantly checking back with the transcripts to make sure the participants' original wording was being used. Similarities and differences were frequently looked for among the transcripts. Any patterns that emerged were noted, as well as any major discrepancies. Unique material given by one participant was not left out, but used to show a different perspective on the phenomenon. Once the list of theme titles was completed for each transcript, each individual transcript was analysed for master themes.

Eventually four master themes emerged to cover all the clusters of sub-ordinate themes, and the majority of all the participants' transcripts. These however became three master themes when it was apparent two of the themes were closely inter-connected. 'Client' and 'Act' became 'Client Actions', since the participants viewed their clients through their actions.

4. Creation of a Summary Table

The final stage was to create a summary table that showed the general structure to the analysis. This identified master themes and subordinate themes across all participants. Earlier studies using IPA have included keywords and page and paragraph numbers for identification of the text in the table. These has been left out of the table in the present study, and instead included in the Results and Analysis section in greater detail.

2.3 Summary of Results

Summary Table

1. Client Actions

Attempters

Completers

Self-Harm

Statistics

2. Social and Cultural World

Gender Differences

Media Influences

Community and Family

New Zealand's Cultural Diversity

3. Psychological Person

Developmental Stages of Youth

Clinical Psychology Training

Dealing with Suicide

Supports for Psychologists

Programmes and Services

Risk Assessment

Risk Factors

3. RESULTS & ANALYSIS

3.1 The Three Master Themes

In analysing the individual texts, key themes emerged that organised large amounts of the material. Once key themes were identified, they were compared with all of the material and were found to be common across all transcripts. The three master themes were 'Client Actions', 'Social and Cultural World' and 'Psychological Person'.

These master themes show some of the question groupings from the interview schedule. This reflects how IPA works in helping the researcher include all the material they want to cover, yet is flexible enough to go where the participants want to go as well.

Quotes taken directly from the transcripts that are used to illustrate interpretations are referenced with three numbers. These numbers indicate the participant (1-8), the page number of the transcript and the number of the paragraph containing the quoted text. When the word 'Participant' is used it is referring to the people who took part in the study, and 'Client' refers to people seen by the participants in a psychological setting.

3.2 Client Actions

This master theme organised descriptions of how the participants perceived clients actions: how the psychologists view their clients and talk about their clients' acts.

I originally had this theme as two master themes "Client" and "Act". But they seemed to merge, thus one master theme of "Client Actions" transpired. Psychologists appeared to interpret their clients through the actions they took, so the relationship between the two was interconnected.

This master theme has four sub-ordinate themes, 'attempters', 'completers', 'self-harm' and 'statistics'. These are four different kinds of client acts, with 'statistics' showing the act of suicide in a statistical context.

Attempters

Participants discussed clients who had attempted suicide as separate from self-harm behaviour and completed suicides. This is in agreement with the current literature. McAllister (2003) discusses how suicide comes from a place of wanting to die, whilst self-harm behaviour is coming from a place of the need to connect and feel.

Some participants viewed attempted suicide and self-harm behaviour on a continuum, with self-harm behaviour at one-end and suicide attempts, and completed suicide at the other. Others stated they are two completely different acts. Participant two discussed how attempted suicide and self-harm behaviour were on a continuum. They discuss how some clients can actually want to die while others do not.

"...there's probably grades of it. When the kids are attempting suicide there are some kids who attempt impulsively and then they're found or caught or they panic, and they ring and get help...And then they're pleased that they haven't. That's probably the large proportion of people that I have seen that are suicidal. There's a small proportion of people who I've seen who have attempted suicide and been found accidentally and rescued, and have not been pleased with that, and have really wanted to die. That's a much smaller percentage of the kids that I've seen. I couldn't give you definite figures but I would probably be talking 90%: 10%..." (2, 4, 15).

Participant three talks about attempted suicide as a means of stopping what they are feeling at the time; to not be feeling so awful. This indicates that participant three views the two acts as separate. Participant seven makes the differentiation explicit.

"...in my experience a person can want to die, no I'll back track on that a bit, a person can say they want to die but what they

want is to not to be feeling like they do and they just don't see any other way to stop feeling like they do other than to die..." (3, 5, 29).

"...but they are two different acts..." (7, 7, 36).

This sub-ordinate theme suggests that there are contradictions in the way that psychologists interpret these acts. The implication of this contradiction is that psychologists might make different decisions with different clients, depending on how they view the relationship between self-harm and suicide. If the psychologist views self-harm behaviour as a separate act from suicide, the client might not get the same treatment as if they were seen by a psychologist who views the two acts on a continuum.

Participant two did not think the research we have is completely consistent. This shows how there are disagreements around the argument that suicide attempts and self-harm behaviour are separate. The participant views this as problematic because each case is subjective. Clients may be telling you what you want to hear, or not telling you the full story, as shown in the next quote.

"...and I think too there's a danger in assuming that the information we've got from people who don't complete is in itself complete and accurate and reliable, because it may not be. They're telling you sometimes something that maybe they think that you want to hear or they're telling themselves something that they might believe but it's not actually what's necessarily happening. So the information that we have can only be as good as the people who inform us about that..." (2, 11, 52).

Several things emerged in the interviews about suicide attempts. Participants described from their experiences that they understood their clients were not 100% positive that they want to die. Accordingly, some people who attempt suicide want help. Participants three and seven discuss the ambiguity of a suicide attempt. If a client is speaking with a psychologist about a suicide attempts it does show that they are concerned about their act. It shows how they are resilient and receptive, just with the act of seeking help. These are seen as protective factors against suicide (Alperstein et al, 2003).

"...but there has to be a certain amount of ambivalence there of they wouldn't be sitting there talking about it...And they wouldn't be seeking help and that's just so heartening that there's that little bit there um, I don't suppose that I've ever talked to anyone who was 100% convinced that they wanted to die or they wouldn't have been talking to me..." (3, 5, 29).

"...but I think mostly by the time they've come to ask if they've agreed to come to see you then most of the time they're they can be receptive..." (7, 4, 20).

The research clearly shows that suicide attempts or intentional self-harm is statistically more common than completed suicides. There were 931 hospitalisations in 2002 for youth alone. Of those 688 were females and 243 were males. This compares to 107 deaths by suicide in 2001, 84 were male suicides and 23 were female suicides (NZHIS, 2004). The text supports this argument. But it also goes further, suggesting that the attempted suicide statistics are much higher. There are unknown people who attempt suicide who do not come and seek help. This shows how the research is incomplete if there is a whole group of people who never seek help about their suicidality. This is discussed in the current literature. Research suggests that hospitalisation rates may be largely inaccurate as it only includes those who were hospitalised as inpatients or day patients. This data also includes people who self-harm, not just people who attempt suicide (NZHIS, 2004).

"...one of the things that I know is that there's a whole hidden enormous number of kids who try who never get any where near an organisation because their attempts are may not be known to their parents or carers if they are known to their carers or parents they are dealt with in that family situation..."(7, 5, 29).

There are inconsistencies in the arguments and research available regarding people who attempt suicide. If attempted suicide is so ambiguous and its relationship to self-harming behaviour is so unclear, then possibly every case needs to take into account the context of the clients' life circumstances.

Completers

None of the participants I interviewed had experience with a client who had completed suicide. But all knew it was a highly possible outcome (Kapoor, 2002). In this subordinate theme 'completers', I found contradictions in the text from the generally recognised risk factors for youth suicide. Participants discussed the risk factors associated with a client completing suicide (discussed further in Risk Factor section). But then they would also go on to say how we do not know about the highest risk group of individuals – those who complete suicide without first seeking help.

This text suggests that the current research we have does not describe all youth who die by suicide. There is a gap in the research and knowledge we have on the precursors of youth suicide. Several of the participants did not think we had sufficient information on the group of youth who complete suicide.

"...and the highest risk clients we know nothing about because they've already died..." (1, 14, 78).

"...and I guess the problem is we sometimes don't know much at all about the people who complete..." (2, 4, 14).

"...I'm not sure we know an awful lot about the group who complete, who haven't sought any help, because we're doing a hindsight view on what was going on for them. And while they might be impulsive, if they had that ideation for a long time and they were planning and they were actually intending to, they probably wouldn't tell you...Cause they don't want to be stopped..." (2, 5, 16).

"...they won't come in the door at all. And that certainly seems to be the anecdotal evidence, I think from some experts in the research as well, that completers have not always sought help. So it's not that they've seen help and thought this is no use but they just never go there. It's like 'this is what I intend to do, this is a choice'..." (2, 9, 41).

"...and the information we've got is hugely incomplete because we've got this group of people who complete suicide and we haven't got any information from them..." (2, 10, 52).

"...but I have experienced a situation where a person has given no indication that they were going to do anything to harm themselves and has gone ahead and done that, and that was really scary because there really in reflecting back there wasn't any indication that I could have picked up on..." (3, 5, 30).

This text indicates the highest risk clients are not accessing resources. Or if they are accessing help and are in the health care services, they might not be showing up as 'highest risk' clients. Is our risk assessment working if this is the case? How can we claim we have accurate risk assessment tools, and then go on to say we are not identifying a whole group of people?

It is possible that people who attempt suicide and those who complete suicide are two separate groups of people performing two different, but not separate acts. However, the interpretations of participants suggest they are ambiguous and overlap so much that it may be hard to distinguish them. Participants suggest that we are in urgent need of information about completers, but this information is virtually impossible to get. Continually refining the possible distinctions between self-harm, attempted and completed suicides may only be useful for the group of clients who are seeking help, while the group most at risk is still not well understood.

Self-harm

In this subordinate theme, self-harm behaviour is described as a separate phenomenon to attempted suicide. Many of the participants described the two as separate behaviours, with separate intentions with each act. From their experiences, participants discussed clients' clarity that self-harm behaviour is not suicidal.

"...Oh I do think they are different...the teenagers that I see who self-harm are usually very clear that this is not a suicidal gesture in any way. Or if they say that it is, they also are usually very clear that 'what I wanted was someone for to take some notice of me'..." (2, 2, 10).

"...it's a way of expressing distress, but usually when people are self-harming they don't actually intend it to be a suicidal gesture...So there is a big difference between that, and they are usually very clear about whether 'I meant to kill myself' or whether 'I actually just meant to cut' or whatever it is that they are doing as far as self-harming goes..." (2, 3, 10).

"...are actually using that as a strategy to numb psychic pain and not as a way of trying to kill themselves so I think most of them do not have the intention of killing themselves..." (4, 8, 48).

"...my understanding is that people who are who tend to self-harm are more likely to have chronic suicidality rather than acute suicidality so they are more likely...to not want to die but...to not really want to live..." (6, 7, 29).

"...I mean psychologically they're really different sorts of thing self-harm's usually something people do to relieve their distress and to sooth themselves to some point and even dissociate and distract themselves from emotional pain...and suicide, and perhaps some of those people go to far I don't think...I think those people who end up suiciding probably made a mistake I think they are very different...true suicide is completely different psychologically...self-harm is soothing suicide is escaping..." (8, 5, 25).

Participants generally discussed how clients wanted to gain some kind of relief and feel better by self-harming. However, there were contradictions in the text, with participant six talking about how clients sometimes do not wish to live or to die either (above). This dilemma shows how there are times when psychologists' interpretations of the acts are more ambiguous.

Several participants drew on some of the ethical dilemmas associated with self-harm behaviour. Participants two and three discussed how it is difficult to know how to manage self-harm behaviour. If it provides enough relief to avoid suicide attempts, should you try to stop them from cutting? This presents as an ethical dilemma for psychologists as they are bound by their code of ethics to protect their clients from self-harm. Both participants two and three discussed their concerns over this ethical dilemma.

"...they're about trying to manage distress and it's not uncommon to have teenage clients who have been cutting and actually say 'this helps me to not suicide because actually I feel better at the end of it'...so for some kids it's almost not...well it's almost protective, and then you get into that awful therapeutic bind about how much do you address the self-cutting when it's actually stopping the suicidality. You still need to address the cutting but you need to do it very cautiously if what if what they're saying is 'this helps me to not feel suicidal'..." (2, 3, 10).

"...self-harm's often a, protective factor against suicide, and it's quite it's difficult in working with someone for example to try and stop them cutting or doing other things that are kind of tension relief if that's going to increase...more lethal means that they may use yeah, but still and all you've go to do it, like it's a horrible thing to have to condone someone cutting because they feel that's the only thing that protects them on the

day from killing themselves I find that really difficult, but, it's still the lesser of two evils..." (3, 5, 27 & 28).

Participant four talked about a dilemma around wanting to examine the 'injury', to see if it was life threatening.

"...if somebody for example...is doing lots of shallow cutting with a razor blade across their thighs, which is common place they'll do it cause it doesn't show...that's extremely unlikely to be lethal, if they're fiddling around with their wrists I'd actually, there's some controversy around this as well, I always ask to see I want to have a look...because I wanna have a look to see whether they need medical attention do they need stitching is there any infection or anything like that so I want to see it from that point of view so I want to be able to make a judgement about if this is actually a behaviour that is risky enough that they could whether they mean to or not cut an artery..." (4, 9, 49).

From the participants' interpretations, we can see that youth who self-harm are at risk of dying. While this may not be explicitly planned, it is a real possibility and still needs to be taken into account. Again this shows how attempted suicide and self-harm behaviour are not so easily distinguished. If we interpret self-harm behaviour as attention seeking then clients may not receive the interventions they need to protect them from dying as a result of their behaviour.

Statistics

The youth suicide rate in New Zealand is one of the highest in the Western World (NZHIS, 2004). NZHIS (2004) has recorded the total number of suicides in New Zealand for 2001 as 499. From this total number of suicides for 2001, 107 were youth suicides (a rate of 20 deaths per 100,000). Of these 107 deaths 84 were male suicides and 23 were female suicides (NZHIS, 2004).

Several participants discussed the fact that although New Zealand has one of the highest suicide rates in the world, it is a small number of people who commit suicide. These statements made by participants show how using rates to describe a phenomenon such as suicide make it difficult to comprehend.

"...but you've got to remember that statistics are hard because actually, (sigh) although it's too high, it's a relatively small number of people who do commit suicide statistically..." (1,3,18).

"...yeah it's gonna to be almost impossible to measure because we're talking about, such a relatively small number of people acting in this way, that statistics, just it's not going to be powerful enough to study it..." (1,4,24).

"...I guess we do we do talk a lot about how the statistics are higher in New Zealand but it's such a low base rate thing suicide..." (3,1,3).

The text corresponded with the research (NZHIS, 2004); one participant described why we might have deviations and increases in our statistics. Participant one appears to be questioning the magnitude of changes in suicide rates through reference to New Zealand's population.

"...we're not a country like the States where, you know you're talking about tens of thousands and changes are small, I mean you only need, you only need a few people to have a response to somebody else's suicide and kill themselves and you're going to get a blip..." (1, 3, 18).

One of the main findings under this sub-ordinate theme was that, overall, participants were uncertain why New Zealand in particular had one of the highest suicide rates in the world. Participants clearly find New Zealand's suicide rate puzzling and confusing, so they problematise it.

"...I don't see why it's so much higher than Australia or countries that are reasonably similarly close culturally and all those kinds of issues. No, I don't. I don't think I know why New Zealand specifically..." (2, 1, 3).

"...I find it really puzzling that that it's so high in New Zealand and I haven't really got an easy answer for it..." (4, 1, 3).

"...it kind of seems surprising that a country like this would have such high stats..." (5, 1, 1).

"...Yeah it's really alarming I know that there's been quite a lot of increased research...in sort of, the New Zealand's guidelines group do some put out some publications on it, but I don't know if there's anything done that's specifically had an impact on reducing the rate or any effects on the rate..." (6, 1, 2).

Other sub-ordinate themes within this master theme suggest that psychologists interpret suicide and other acts of self-harm as complex and ambiguous. Suicide statistics do not seem to add to psychologists' knowledge of the phenomenon in New Zealand. The participants were not able to convey their passion and desire to help their clients in the discussion of statistics.

3.3 Social and Cultural World

This master theme came together with the sub-ordinate themes that pertained to the social and cultural aspects of youth suicide. How society, and the sub-cultures of New Zealand in which we live, shape our understandings and beliefs about suicide.

Gender Differences

Some of the participants discussed gender differences in youth suicide. Participant one commented on how the method of choice for young men and women can be different. They talked about how young women want to 'look good' and hold onto their vanity right up to the end, including in death.

"...I've heard the argument that young women don't know how to use firearms I think that's complete bollocks in New Zealand I and also I think most young women would be smart enough to figure out how to put a round in a gun, I think young women don't want to mess them selves up...they don't want to be found with a bullet through their head, you know if they cut themselves, I know of one client actually tried to make sure they didn't get too much blood on them selves when they cut themselves..." (1, 5, 32).

"... so there's that kinda idea of being found glamorous and wane and dead, and that's not necessarily saying that they had no less wish to die or they don't understand the consequences it's just simply the idea that women hold on to that vanity till the last thing,...I wonder, we often describe young women as impulsive, but I actually wonder how impulsive these young men are..." (1, 5, 33).

This participant also discusses how the difference in the public and private spheres might account for differences in access to resources. This might explain the differences in method of choice between men and women.

"...It's kinda like you know how women are good at doing house work but men are good at putting up a garden fence (laughs) I think there is a sex difference (laughs), I think the underlying stress is the same, you know I think we are very very lucky that women are quite bad at killing themselves..." (1, 5, 31).

Young women and men often choose different methods to attempt and commit suicide (Blair-West et al, 2001; Beautrais, 2002). Both the literature and the participants' interpretations mention that young men are typically found to use more 'lethal' methods, such as firearms and hanging. Young women are typically found to use less 'lethal' methods, such as an overdose and cutting. They are said to be less lethal as intervention is more likely to succeed in saving their life if the person is found or changes their mind. What can this tell us? Young women have a higher rate of suicide attempts and young men have a higher rate of completed suicides. But is it possible that young women are caught before they die, or change their minds before they die? Young men do not have that choice. Once they pull the trigger or jump with a rope around their neck it is too late. Method of choice may be related to societal constructions of how men and women are *expected* to act (Beautrais, 2002; Cleary, 2000). For example men are generally found to be more external and 'act out' in their behaviours, and women are more internal and 'act in' (Beautrais, 2002). Could this be one of the reasons why young men and women choose different methods of suicide? And ultimately have different rates of suicide attempts and completions? This does not imply that young women are vain, but could possibly explain gender differences in how men and women internalise life events.

Several participants described how young men are less likely to be seeking out the help they need, when compared to young women. The current literature supports the argument that men are less likely to seek help (Beautrais, 2002). Participants two discusses how New Zealander's, in particular young men, have trouble asking for help. This participant interprets help seeking as slowly changing, but it is still an issue for young men. Participant six discusses how

young men are more likely to report suicidal tendencies to a friend rather than a professional treatment provider.

"...I think that New Zealand has quite a culture, or it has had and I think it's slowly changing, that you don't ask for help - that that's seen as a sign of weakness and I think that's still very prevalent more for males than for females and always has been and that females are changing; males are changing more but maybe a little bit slower. It's still not ok for teenage boys to come and ask for help and come to counselling, it's still a weakness..." (2, 1, 6).

"Well males are less likely to report things in general including suicidal feelings and thought...for males I think peer networks...I think peer networks are important because often if they don't tell a treatment provider they'll tell a friend or they'll give some indication to their mate that maybe things aren't...it won't be the same as often the way a female would, but there is some you know, some things that that could be done in schools, or you know that kind of thing where peers are encouraged to look out for particular signs and encourage their friend to seek help or go along with them or whatever..." (6, 6, 26).

What does this say about the resources available to our youth? Why are young men less likely to seek help when they need it? It is possible men and women communicate suicidality differently? Men tend to display external symptoms and women internal symptoms, so maybe young men and women present differently when it comes to suicidality (Beautrais, 2002). This suggests that intervention strategies need to take gender roles and differences into account in their formulation. Further gender specific research might enable us to better understand these experiences.

Media Influences

The media came up in the text in several competing ways. This is consistent with the literature on the effects of media on rates of suicide (Beautrais, 2000A; Burns et al, 2000; Toumbourou et al, 2002; Morrison et al, 2001; Miller, Segal & Coolidge, 2001; Slaven et al, 2002).

Several participants talked about how the media has a negative effect on youth suicide rates in New Zealand. Participant one discussed how the media's

openness might influence others to try suicide as an option. But there is no research that shows conclusively that talking about suicide in the media increases prevalence. It is also argued by participants that the media keeps suicide in the forefront which is again an argument reported in the literature (Beautrais, 2000A; Burns et al, 2000; Toumbourou et al, 2002; Morrison et al, 2001; Miller, Segal & Coolidge, 2001; Slaven et al, 2002). Suicide has been present in New Zealand communities for decades whether it was discussed openly or not. New Zealand statistics on suicide have been kept systematically since 1948, with records dating back as far as 1901 (NZHIS, 2004).

"...I had a really interesting discussion with another senior psychologist the other day about some of the medias comments that...the openness about suicide might be influencing more young people to try..." (1, 3, 16).

"...Oh because they [song lyrics] keep issues more to the fore..." (7, 2, 8).

"Yes, I think the media has a role. I think Internet has quite a big role and the Internet is probably one of the things that is a bit overlooked. I mean people hone in on what's happening on TV, what's happening in the movies - and they are certainly getting more explicit, they are getting more graphic. It's becoming more common to see suicides homicides, you know that that kind of high level of violence...But the Internet has opened a whole world for these teenagers and they get on and they look up how to suicide...There are step-by-step instructions...And the kids sit there and for hours at a time they read about how every body's going to kill themselves, and what do you do, and what's successful and what's not successful, and it's really worrying when you've got a very depressed impulsive suicidal teenager who is a client who is sitting there reading that stuff, so I think that that's that's got a really big influence..." (2, 2, 7&8).

"...and the kind of things that are out there that are so unhelpful for young people like web sites that actually give people more information about how to commit suicide..." (5, 3, 15).

The media was also judged to sensationalise suicide, in the sense that it is a 'significant' incident that has occurred in the community and needs lots of attention. Participants talked about how the attention the media can give youth suicide is not beneficial to youth. However, they showed some contradictions, as the other option is not talking about suicide. As psychologists, it is expected that talking is beneficial. This creates a dilemma if media is regarded as a way

that a community speaks about suicide. The argument that talking about suicide in the media, whether it is in song lyrics, on the Internet, or in movies is causing suicide is not supported in the research literature.

"...I think it does in the sense that it rarkes up feelings about youth suicide and misrepresents in many cases the facts around youth suicide, and reports things quite sensationally as well, because I mean it's a shocking event when any person kills themselves but when it's a youth it does tend to be quite quite high profile..." (3, 2, 11).

"...after a young person had killed themselves, and I don't know whether the media was partially a contributing factor or not, but it isn't helpful to be kind of publicising a lot of sensational stuff, without that being integrated into something helpful to like help people to understand it and to comes to terms with it..." (3, 3, 14).

"...I know that there's criticism at times of the media for sensationalising ah suicide...but I've kind of got mixed feelings about that because I sort of think what do we do do we just not talk about it, is that better?..." (4, 2, 10).

"...I think there are there have been some situations with the media where like say a school has been blasted and seen as responsible and there's been some sensationalist stories that maybe there's been bullying and those might have been ill conceived and caused more harm than good..." (4, 2, 12).

Participants however, also talked about how the media has had a positive influence, and increased the awareness of youth suicide in a constructive way. This also shows that there are contradictions in the interpretations of the media's negative effects on rates of suicide. The following material illustrates how participants have seen the positive effects of the media. For example, the Like Minds, Like Mine media campaign, television and movie programmes have positively brought about awareness of some of the issues associated with suicide, mental illness and violence. Participants have had clients discuss these positive changes with them directly. There is evidence in the literature that illustrates that it is *how* we discuss suicide that can make the difference. The Ministry of Youth Affairs (2003) has reported that if suicide is discussed in a mental health context the effects can be very educational and rewarding. However if suicide is just talked about without the appropriate context in place, it can have negative outcomes for some individuals.

"...I think they have the ability to be an incredibly positive influence...there's a newsletter I've got that's an international newsletter, that was praising New Zealand's, like minds...like me or whatever it's called campaign. I've had, probably five or six clients comment on it when they've been given a diagnosis...they'll say things like 'oh I'm like that person on TV'..." (1, 3, 20 & 21).

"...I think that New Zealanders are probably becoming more aware of abuse and that's through some of the media stuff that's happened - the highlighting of the cases in the last decade, through the culture and the arts, you know things like Once Were Warriors are just raising our awareness of those kinds of issues..." (2, 1, 4).

"...But I also think there's been some quite good programmes on television that've shown the heart ache and heart break that ah families are left with when they loose a child to suicide..." (4, 2, 13).

According to these accounts the media has the ability to have a profound effect on the youth suicide rates in New Zealand, if done appropriately. The media has the potential to reduce the taboo and stigma surrounding mental health and suicide. Participants' commented on the positive effects of programmes such as the 'Like Minds, Like Mine' campaign when it is contextualised. The participants also discussed how making suicide more explicit has raised awareness of the issue. Through educating the public the media can then have a positive effect on our youth seeking help when they are feeling suicidal, giving them the space to speak out.

Community and Family

This sub-ordinate theme produced information in relation to how families and the wider community react and respond to youth suicide.

One of the main ideas that came out of this sub-ordinate theme was that youth are largely detached from their family, friends and communities. Some of the participants thought that youth at risk of suicide did not feel they belonged. This emphasised the importance of being connected to community and family, as a lack of social supports and not belonging can negatively influence someone. The breakdown of family life and other significant relationships can seriously impact on suicidality. These arguments are also discussed as risk factors for

suicide in the current literature (Beautrais, 2000A; Fergusson et al, 2000; Carter et al, 2003).

Participant one demonstrated in a psychosocial context how youth might be emotionally disconnected from their communities, families and peers.

"...they tend to be often at least emotionally disengaged from their communities, and their families, not to the extent...where they are not seeing their families, but where they feel disengaged, they feel not part of it. Worse case scenario they also feel not part of their peer group..." (1, 1, 1).

These next quotes show how participants have concerns about relationship and community breakdowns. Participants also show how our youth feel very alone and the individuation may not be very helpful or productive for them.

"...it's nice to have these official you know, counsellors and things like that, but really it's not the same as being able to go to your grandma and sit down and she knows you and she's known you your whole life and understands your family values and things like that...and that's missing, and also what's missing is the more casual connections with older people..." (1, 2, 9).

"...and that's either relationship problems with parents, relationship problems with peers, relationship problems with boyfriends/girlfriends, intimate relationships. Any or all of those...often there's some kind of relationship breakdown that triggers those episodes, so that would be a big one for kids. A sense of not belonging. A real sense of isolation, particularly from peers but also from the families...a sense of hopelessness and a sense of worthlessness, like they've internalised that sense that 'I can't do anything right and so I might as well give up now and I might as well not try'..." (2, 3, 11).

"...lack of integration into even their own peer group, pressure to be and or look a certain way, and disconnection from the previous generation like just even for kids that are still at home..." (3, 3, 15).

Several participants described youth suicide as an issue the community and society as a whole needs to address, rather than it being an individual problem. This seems to be different from the research pertaining to risk factors for suicidality, which is more focused on identifying *individual* risk factors and

reasons for the suicidality. Western Psychology has the individual as the subject, as Western Society privileges the individual over the collective.

The participants argue in the text that suicide is not something one person can deal with, or even one family. We need to look at it in terms of a community as a whole, and we are all part of that community called New Zealand.

"...but I think the issue, is, and it's probably being avoided cause it's, it's going to require people who aren't suicidal to change and I think society like's the idea of 'why don't we just fix these people who are suicidal', rather than this idea that, all of us might have to change our beliefs and behaviours..." (1, 4, 26).

"...and I think every single person in New Zealand needs to take a look at why young people kill themselves...I think that other than yellow ribbon...the best thing New Zealanders could do is say hi to a neighbour every morning and smile at people in the street and just get those connections back because we're loosing them..." (1, 8, 43).

"...I don't think parents can ever know how to manage suicidality it's like your child getting cancer it is not manageable and it not something people can cope with and I say that to parents a lot they say I don't know if I can cope and I say you're not supposed to cope with this no one can cope with this this is too much for anybody to cope with..." (1, 11, 58).

"...you know people may have a sense of like shame you know because it's different to when you have say a child that dies in a car accident or something like that...But the general public don't under, you know not being experienced in it are more inclined to think that's a terrible tragedy, but to be really avoidant about actually engaging with the people..." (3, 8, 51).

"...so perhaps it's not so much about problems psychologists specifically need to deal with in individual sort of cases, maybe it's more of a you know school issue or community issue..." (8, 5, 28).

These interpretations suggest that we need to start viewing suicide as a social responsibility. It is not the individual or individual family's problem it is a problem for all New Zealanders. People in society pass suicide off as other people's responsibilities. Once we all start taking responsibility for suicide, we might then have the chance to make a positive change.

However, I found contradictions in the text. There were some interpretations that still placed responsibility on family or individual factors. These quotes below are inconsistent with the arguments just made. They discuss how one suicide opens up the possibility for another suicide. This is illustrated as one of the topics raised in the text by several participants, was the suggestion that youth suicide is more of an option these days for our youth, for various reasons. Having a suicide in the family was raised as being a major risk factor for youth suicide.

"...I retain the impression that the people I've meet are still at higher risk, of suicide simply because that there was that suicide in their family and also the other factors associated with it but...you know basically just seeing that that as an option..." (3, 9, 53).

Participant seven talked about whether or not suicide was more of an option in the context of a prescriptive and proscriptive society. But other Western societies are similarly prescriptive and proscriptive. This is not specific to New Zealand as research from other Western cultures shows that having a suicide in the family or having a close friend commit suicide will influence at risk individuals (Fergusson et al, 2003; Beautrais, 2001; Beautrais, 2000).

"...my personal opinion is, some wonderings really rather than an opinion, about whether it's become more of a choice, now life is less, our society our community is less prescriptive proscriptive or prescriptive either way so people have it more as a choice..." (7, 5, 29).

But, as mentioned earlier, New Zealand has been recording suicide statistics since 1948 and the number of people to die by suicide has been rising (NZHIS, 2004). So is it more of an option for our youth these days than say 10, 20 or 30 years ago? Or are deaths by suicide being recorded differently and more accurately now than in the 1940's? There is research that suggests this is possible (Blair-West et al, 2001; NZHIS, 2004). It argues that since suicide is regarded as taboo, coroners have tended to rule suicides as 'accidental' deaths wherever possible, especially with youth deaths. More recently however, the way suicides have been recorded has changed, including more of the

'accidental' deaths as suicides. This may account for the change in suicide statistics over time.

New Zealand's Cultural Diversity

This sub-ordinate theme is concerned with New Zealand's own particular culture. Culture may be understood in several different ways, for example, youth culture, drug culture, culture of violence and Māori culture. There are many sub-cultures in New Zealand; it is not just Māori and Pakeha and it is not just based in ethnicity.

One of the findings with 'culture' was that there are many different definitions of culture, and there were many forms culture can take. The participants referred to various types of cultures specific to New Zealand. These include a culture of not seeking help, a youth culture, cultures of violence and cultures of drugs.

"...I think that New Zealand has quite a culture, or it has had and I think it's slowly changing, that you don't ask for help - that that's seen as a sign of weakness..." (2, 1, 6).

"...I mean we've got a bit of a, a kind of a gung-ho culture if you like too, I think there's still quite a bit of that it's not cool to seek help or to say that you're not doing well or that you're feeling depressed..." (3, 1, 6).

"...Cultural - there are all sorts of definitions of culture. Such as cultures of violence that are perpetuated through cycles and through generations, and that has a really big impact on parenting..." (2, 10, 44).

"...I think the other thing is you know drugs, so unfortunately a lot of our young people are starting to use maybe cannabis in the beginning, and from what I've seen from teenagers and this is based on you know when my kids were teenagers and friends and things, there is a cannabis culture as well and it's kind of an anti-authority kind of anti-straight people culture and that might feed into it a bit..." (4, 2, 9).

Participant one discussed the possibility that dislocation and breakdown from tradition contribute to youth feeling that they do not belong. Pakeha defined this as a lack of access to their culture of tradition. This shows how culture, or rather the disconnectedness from it, can be problematic in New Zealand.

These ideas can be linked back to the Community and Family section above, where individualisation is privileged over the community and family values.

"...but I think our culture especially Pakeha culture is extremely young, and we don't have the traditions, and the support networks that used to exist and that exist today in more established countries..." (1, 1, 6).

"...my dream would be that we actually have our culture start to recognise young people, and value them and that one of the ways...we need to do that is start to change our culture purposefully, to have (sigh) to to basically set up some traditions that recognise our young people, we are a new culture and we don't have those, we've abandoned most of them especially the Pakeha part of our society..." (1, 9, 50).

I found several participants interpreted Māori as vulnerable to particular issues, which can have an effect on the Māori youth suicide statistics. Current literature is in support of this view. Research illustrates how Māori have been negatively affected through the processes of alienation (particularly from their culture), and processes of colonisation (Durie, 2001).

"...I don't think that any particular culture as far as I know is more suicidal than other cultures but rates are higher in some specific cultures. Acculturation difficulties would be expected to add to any sense of disconnectedness. Taking people out of their culture and not paying attention to that I think that just increases their sense of isolation...however, this still doesn't explain why rates are higher in New Zealand. Acculturation and colonisation have occurred in other countries also, such as Australia..." (2, 10, 48).

"...I have just always thought that one of the problems was for New Zealand is how disenfranchised Māori are in general..." (3, 1, 1).

"...I guess in terms of Māori populations and higher statistics amongst Māori youth and cultural factors and identity...that seems like identity and that sort of feeling of belonging and sort of relatedness to culture are really important protective factors, so I suppose from a Māori understanding then that would make some sense that there might be higher...stats amongst Māori..." (5, 1, 3).

"...there's a high rate for Māori and Pacific Island people and, I'm not sure why that would be but some ideas would probably be things around...cultural identity and maybe things linked with urbanisation and the impact of that on culture...the difficulties in terms of socio-economic problems and jobs and

mental health conditions that are undiagnosed or been untreated..." (6, 1, 4).

But the research still does not explain why New Zealand has higher youth suicide rates than other countries. Māori research has however, done research specific to Māori, by Māori, for Māori (Durie, 2001; Coupe, 2000a). This research has identified many risk factors unique to the Māori population. What would happen if we ask Pakeha the same questions? Would we be able to identify unique risk factors that pertain to New Zealand culture specifically? Why does a general risk assessment leave out spiritual components, but include them for Māori?

Some participants talked in the text about issues that New Zealand's culture has specifically produced. Participant seven discussed the nature of the settlers who colonised New Zealand and the possibility of their genetic predisposition to depression. Participant eight is concerned with how, from their own observations, New Zealander's are not comfortable with being unique, standing out or excelling to their best abilities. This interpretation is not mentioned in the literature.

"...my experience is that there is a lot of depression in New Zealand, and a Psychiatrist friend of mine has a theory that that was because of the nature of the people who colonized the country...and that they might have been trying to use, a couple of hundred years ago or whatever, a geographical cure for the depression they had in their own country...but those kinds of miseries they were trying to solve by coming here, in fact brought a genetic pre-disposition..." (7, 1, 5).

"...from my knowledge of New Zealand culture...there are some issues around people sort of standing out as individuals, and I think that young adolescents are particularly prone to kind of needing self validation and needing to explore themselves as individuals and that's not really encouraged..." (8, 3, 16).

"...it is this sort of quote tall poppy syndrome or lack of kind of making your self all you can be or special or whatever it is that might be particularly negative for adolescents..." (8, 3, 17).

"...it's one thing that I notice particular to the Kiwi culture that's quite different, kind of a discomfort standing out and almost a discomfort with self..." (8, 4, 20).

New Zealand has its own unique circumstances that make up its specific and complex cultures. These interpretations suggest that we might need to ask specific questions for New Zealand's cultural context in our research. Rather than comparing our context to that of other countries, we need New Zealand specific research so that we can target our prevention programmes directly at the high-risk youth.

3.4 Psychological Person

This master theme is about aspects that relate to the psychological characteristics of both the participants, and their clients.

Developmental Stages of Youth

This sub-ordinate theme concerns how developmental stages in an adolescent's life can have an impact on the youth suicide rates.

Several participants observed how youth are coming to terms with the idea that they will one day cease to be, and with time and life experience, people develop further perspectives around death and the impact of suicide on others.

"...I think probably that's...one of the concerns with suicidality and youth, is that I think it's a developmental stage to actually recognise that...you know one day you'll cease to exist whatever your beliefs in the after life are, and I think with suicide perhaps it's actually that realisation that, you can cease to live and that you...could actually take control of that...maybe one of the reasons it's such a risky time is that recognition of mortality, that recognition, that control over it, but not having had the time...and I'm oh I hate that word maturity-that's not the right word but not having had the time to work through your beliefs and feelings around that..." (1, 6, 35).

"...And you know when you add in the fact that young people have less idea about the impact of perhaps their own death on others, and just the impact...it reverberates right down the generations of the family really...It has a, huge, huge impact, but they don't have the perspective perhaps to realise that because they're still in that kind of developmental stage, especially teenagers where everything's either black or white..." (3, 9, 57).

One of the participants commented on how our developing cognitive systems might have an impact on how youth perceive the world around them.

Participant one argues that adolescents' are experiencing adult emotions for the first time. They are learning how to deal with these and lead a full productive life at the same time, with large expectations put on them to achieve well.

"...there's actually neurological changes going on during teenage people which is when your limbic system and your actual cognitive systems link up properly...and your experience of emotions as teenagers is brand new, and children can't actually experience those emotions, so teenagers experience the same emotions as adults for the very very first time...and then we ask them to go to school full time, work, establish peer relationships, discover about the world, do three hours of homework a night and for god sake don't you fail or let anyone down!..." (1, 12, 66 & 67).

This argument shows how much pressure we put on our youth. We expect them to go to school, work part-time, be active and have a social life - all without failing. Along with these expectations they are also dealing with all the new experiences their bodies are going through. This raises questions about the link between youth suicidality and the pressure and expectations that young people experience.

Clinical Psychology Training

This sub-ordinate theme includes the participants' beliefs about how their clinical training has prepared them for dealing and working with suicidal youth.

Many participants thought their clinical training prepared them well for working with and assessing suicidal youth. This training included case formulation, risk assessment and treatment.

"...yes I think probably a clinical psychologist would be the best trained to deal with it...mainly because of the type of training we're given, the idea of the individual formulation. There are no rules...there'll never be a form or guideline that'll say this is how you assess suicidality this is how you prevent it there just won't be...because everyone's so different..." (1, 7, 37).

"...I think the clinical training did a good job because it was certainly something that we've learnt about. We read the research about suicide, we were trained in how to assess and how to treat it. And having said that I would see my work as part of my training as well..." (2, 5, 17).

"...I think that your training prepares you well for having done everything that you can, so that if it does happen you've reduced that potential for it having been due to something that should have been done and wasn't..." (3, 4, 23).

"...I think that we do get well trained in assessing for potential suicide and safety issues, and that's certainly well instilled in us that that's something that you always check for and keep an eye on, and that we talk with the what the risk factors are..." (4, 4, 26).

"...Definitely! Absolutely...even though it's upsetting to me when I ask cause I don't like seeing my clients in distress, I find that the training that I've had means that...if I'm concerned I'll just ask it, and I'll be really up front about it and I won't you use words like top your self or do away with your self. I'll be really specific and ask the question..." (6, 3, 14).

"...yip definitely...yeah the training was very good right from the very first suicidal client I had..." (7, 3, 15).

Participants also commented on aspects of the clinical training that they thought could be improved, added to, or that they thought didn't work so well. These comments show that among the participants there was still some discomfort about the adequacy of training for youth suicide. Participant one discusses how they do not feel there are many clinicians who can deal with suicide effectively in the country. Participant two points out the need to have current information that is specific to suicide in New Zealand.

"...I think we've got really good at identifying it, but I think there's only a few clinicians in the country who are capable-who feel confident to deal with it and are trained properly to deal with it..." (1, 9, 48).

"...I think it might have been nice if we'd had more, or perhaps even like a good work shop by somebody who worked currently in that area (Child & adolescent severe mental health and risk assessment work). We had lecturers who had previously worked in that area but weren't currently working in that area - well not specifically, not exclusively...Just looking back I can't remember that we actually had a lecture in that area, so that would be a good topic for a workshop really...we've the highest one of the highest youth suicide rates in the world so we should be definitely knowing about that..." (2, 6, 21 & 22).

These interpretations of the adequacy of training suggest that it might be necessary to have on-going training and supports for clinicians to build their confidence working in the area. From the text it appears that there is a gap in the training when it comes to effectively working with suicidal youth.

Two participants commented on how they did not think there is any amount of training that will help you to prepare for coping with suicidality. This was from their personal experiences, and is also discussed below in the section on dealing with suicide.

"...I don't know if anything ever prepares you for dealing with it..." (3, 4, 22).

Participants made reference to the importance of the therapeutic relationship as an implicit part of being an effective clinical psychologist.

"...The therapeutic relationship is the most important thing. I've seen remarkable changes because of the impact of a positive therapeutic relationship..." (2, 8, 36).

"...I suppose part of prevention is being able to build a good therapeutic alliance with the young person, and hopefully within that they're able to share things that they have found difficult to talk with other people about..." (4, 4, 27).

"...as part of that beginning to form a good therapeutic relationship and work with that person...a good relationship I think that's really important part of, maybe prevention and treatment..." (5, 6, 28 & 29).

"...sometimes I guess it comes back also to the therapeutic relationship, the relationship as we know the alliance is really important and if you don't actually get there with a particular client then it's much more difficult..." (7, 4, 19).

While every attempt is made to teach clinicians how to establish and maintain effective therapeutic relationships, training alone cannot always ensure that these relationships are possible. The participants and the research (Collins et al, 2003), suggest that the therapeutic relationship between the client and clinician is absolutely essential.

Dealing with Suicide

This sub-ordinate theme includes how the clinical psychologists interviewed dealt with suicide, both in their personal and professional lives. It is about what they do to deal with suicide.

Some of the participants openly discussed how working with suicidal clients is extremely worrying, and takes a lot of energy.

"...And that it's a highly nerve racking...it's very difficult working with high risk clients..." (3, 4, 22).

"...Yeah well it's scary...it can definitely be scary and draining...you're giving them everything you've got really (laughs)...you do worry, it does take a toll...you're giving them all you've got so it takes a lot of energy..." (4, 11, 62).

Throughout the transcripts participants' mentioned how they did not think anything could prepare you for dealing with suicide. Participants drew from their own experiences of dealing with suicidal clients here.

"...you cannot prepare your self for working with suicidal clients and if you're not ok you have to say so...and you won't be ok..." (1, 14, 76 & 77).

"...I don't know if anything ever prepares you for dealing with it (laughs)..." (3, 4, 22).

Participants discussed how managing their caseloads and knowing their limits, when working with suicidal clients is essential.

"...it's partly about limiting your case load so that you don't have lots of high risk clients, so that you know...to have like a mix if you like..." (3, 6, 35).

"...it's more probably more about accepting what you can and can't do...we want to be clinical psychologists because we want to help people...but you can't, you're not helpful if you take on so much that you get burnt out or you can't manage it..." (3, 6, 34).

"...so all of us hope that we haven't got you know even more than one at a time (laughs)...and that's the problem that people in the mental health system have...are dealing with more than

one at time they're dealing with a whole raft of people who might be at quite high risk, and it must really take a lot out of them..." (4, 11, 63).

These comments show contradictions from the section discussing the clinical training. Participants were positive about their training and stated it prepared them properly for working with young people who are suicidal. However, in this section they indicate that they do not think anything can really prepare them for dealing with suicide. This indicates that while their training provides adequate preparation for the content of their work, the processes of dealing with the emotional demands of working with suicidal youth cannot be taught or anticipated in the same way.

Supports for Psychologists

This sub-ordinate theme is concerning the professional supports that are available for clinical psychologists while they are working with high risk and suicidal clients.

All participants explicitly discussed supervision as the main support available to them. Each participant agreed that supervision was a vital aspect of being a capable and professional clinical psychologist. The literature supports this interpretation of the value of supervision (Howard, 2000).

"...there's supervision and I have access to my supervisor by phone if I need to, and I have after hours access to my supervisor if I need to if it's urgent..." (2, 6, 23).

"...my professional supervision is fantastic and whatever I whatever I needed to talk about I would be able to talk about..." (3, 5, 32).

"...the main thing that I use is supervision...it might be ah a lot of supervision (laughs)..." (4, 5, 34).

"...well I'd certainly need supervision with regard to youth suicide..." (8, 2, 12).

Participants were in agreement that supervision works well, however many believed they needed personal as well as professional supervision. The text showed that there was great benefit from discussing caseloads and clients with peers and colleagues, in addition to their main supervisor.

"...we had two lots of supervision so we would have internal supervision within the service and we would have external supervision, so we had two supervisors there available..." (2, 6, 23).

"...There was always peer support; there was always somebody else in the building and we could go and knock on the door and say 'I need to talk this over with you'..." (2, 6, 24).

"...you have to have a few people that you can ring or call on. You've got to have people who understand what this is like as well, so peer groups are just crucial..." (2, 7, 27).

"...it's not just formal supervision but there are other clinical psychologists and senior clinical psychologists that I could utilise for supervision in the absence of my supervisors, personally it's actually really difficult because you can't come home and talk about the specifics of your clients or even really in that much detail, and I was always a person that like came home and talked about everything..." (3, 5, 32).

"...I wouldn't want to be in that situation without that support network because it would be really dangerous for me and the client..." (6, 4, 18).

Participants showed that they unquestionably required more than one form of support available to them. It needs to be accessible at all hours of the day and night. In addition, participants found peer and colleague consultation to be invaluable. Psychologists need good strong support networks if they are to be effective with their clients.

Programmes and Services

This sub-ordinate theme was related to the programmes and services in New Zealand that focus on youth suicide. I wanted to find out first hand what the people working in the area of youth suicide thought of the prevention programmes, in regards to their effectiveness.

Several of the participants commented that they did not think the current programmes and services in New Zealand were working well. Participant one argued that programmes cannot be expected to manage youth suicide. It needs to be more of a community effort. Participant two mentioned that they did not think our programmes were particularly successful. Participants four and five argued that it is the way we deliver the programmes that is ineffective.

"...I think the idea of programmes managing youth suicide is a cop out and I think every single person in New Zealand needs to take a look at why young people kill themselves..." (1, 8, 43).

"...My understanding of the research is that they are not actually overly effective, and I think with the Yellow Ribbon scheme there's been some research that indicated that it might actually make things worse rather than better. So, no, I don't think we've got it right yet. I think we've got a long way to go and I'm not sure that you can get group education for what is a very specific problem. So maybe we're going in the wrong direction..." (2, 7, 28).

"...it seems that if they focus purely on suicide it's actually thought to be unhelpful in some school based interventions..." (5, 8, 41).

"...there is some follow up from community mental health but it's...not very good or thorough and basically if that person doesn't turn up for their appointment or says they're not interested that's the end of it..." (4, 6, 37).

Whilst some participants did not think some of the programmes and services were working well, some did think that there were questions around whether what was being done was indeed helpful. Participants three and four discussed how the programmes and services we have are not necessarily ineffective, but they aren't ideal either.

"...in terms of old older younger people if you like cause in the schools there's the yellow ribbon programme and the little cards that they have, and I think that's a good thing..." (3, 7, 42).

"...I certainly think they're helpful I don't see them as unhelpful, and what I hear from my clients...is that over time that is actually starting to reduce the kind of prejudice people have about mental health issues, and so people who felt deeply ashamed of having something like depression or anxiety seem to be able to be more open about that than they used to be. So yeah I do I think it's helpful, and especially

when we've got really good role models like John Kirwin who are willing to stand up and say I've suffered from depression and it was really awful but I'm out the other end now and I'm ok...I think that's stunning...Those are the kinds of people that do make a difference because the young people that have hero worship and will listen to that..." (4, 8, 46).

"...it seemed like some programmes could be really useful if they're...focusing maybe more broadly on kind of strength based and identity and self esteem interventions..." (5, 4, 22).

This material suggests that further evaluation research on the effectiveness of such programmes could be useful to practitioners.

In the text several participants discussed how they were concerned with low risk clients becoming high-risk clients, because the Mental Health systems are under-staffed and under-resourced.

"...If you've got a lot of high risk clients that's a very stressful thing to manage. And what happens is that you can you pour all your attention to your high risk clients because you have to, and your lower risk clients you might have to not see for a while because you've only got so much time and then your lower risk clients become higher risk clients..." (2, 7, 31).

"...that means while all these people who aren't getting any help are deteriorating, and they won't be seen until they're at high risk which can't be good..." (4, 8, 45).

Participants were explicit about what they thought needs to be done to help prevent youth suicide. These needs were based on the participants' own experiences, rather than the current literature. Some of the ideas participants discussed involved improving connections and social and community supports for youth. Participants thought that many of our youth were disconnected from others in their life. Money was another issue participants discussed. They were concerned with the lack of funds available for services to be able to run efficiently and effectively. The possibility of specialist teams of people working specifically with suicidal youth was also raised, as was working more closely with General Practitioners in identifying clients to refer. Participants also called for more specific research in New Zealand.

"...I think that other than yellow ribbon that the best thing New Zealanders could do is say hi to a neighbour every morning and smile at people in the street and just get those connections back because we're losing them..." (1, 8, 43).

"...I think a massive public campaign to get people to reach out to each other, ask how you're doing and refuse to take OK as an answer, to talk to your neighbours...my dream would be that we actually have our culture start to recognise young people, and value them...and that one of the ways we need to do that is start to change our culture purposefully. To...basically set up some traditions that recognise our young people we are a new culture, and we don't have those we've abandoned most of them especially the Pakeha part of our society..." (1, 8, 43).

"...There needs to be a lot more money put into it. But the money actually needs to translate to more people on the ground to do the work. One of the frustrating things...is that you read in the budget that there's this much money earmarked for youth mental health because of the high suicide rates and it sounds great...and you see absolutely no changes with the number of clinicians. Absolutely no changes for reducing the work load. You see absolutely no change for reducing the pressure on the people working in the front line, and then you just think where's the money going?..." (2, 7, 29 & 30).

"...It comes down to money and people, and there's not enough of either...another thing that could be done is to provide young people with education regarding emotions and how to manage mood difficulties. This would need to be a preventative scheme, and could be incorporated as part of the health syllabus in early high school. New Zealand youth (particularly males) are often not good at knowing how to discuss emotions. And even less good at being able to manage difficult emotions and emotional situations in a positive and effective manner..." (2, 8, 33).

"...any work towards reducing people's self-harming behaviours like communicative kind of suicidal gestures that are really saying you know this is how desperate I feel and I need some help..." (3, 7, 47).

"...I guess what I would like to see is...maybe a dedicated team of people who work with that particular group, so the adolescent age group who are at risk, and who work with them quite intensively and follow up properly..." (4, 8, 43).

"...maybe some involvement with GP's because they are often the first people that hear about they are...primary treatment providers so they they're often the first in line to be exposed to that kind of thing from their clients. If they're not already involved with mental health services or somebody else I wonder about...how comfortable they feel sometimes about asking because they're so pressured and they've got huge case loads..." (6, 6, 25).

“...I think more research needs to happen...in my mind the research happens first and then assessment and intervention tools are developed from that, so first thing I'd say it just needs to be understood better...I think even the experts in the field are not altogether certain why it's the case youth in New Zealand...have a higher suicide rate...So then I think the first order of business is to deal with the research...” (8, 3, 14).

This material shows the participants are actively looking for ways we can improve our services for our suicidal youth. Whether or not the voices of these clinicians are heard by those who could initiate such improvements remains open to question. It does seem possible that practitioners could be key informants in the development of suicide intervention policy.

Risk Assessment

This sub-ordinate theme is connected with how New Zealand's clinical psychologists assess suicide risk, and whether the participants think these assessment processes are effective.

Several participants mentioned that their clinical training included assessing suicide risk. Participants discussed how they would fail if they did not assess for suicide in a particular case.

“...I think knowing that you failed the final exam if you didn't assess risk made you always aware of the need to assess risk ...you know one of the things in the training was we all knew 'if you don't assess suicidality, if you don't do a good safety screen, it's all an automatic fail'...” (2, 5, 19).

“...in my experience the things that...bear out are what I had read about on how to assess for suicidality and how to construct a good safety plan...” (3, 10, 59).

“...when your actually learning how to assess properly in actual face to face terms, because while you can have lots of text book reading and things behind you it's a completely different situation when you're sitting in front of somebody...it's the actual practice of it and experience of doing it that really solidifies that knowledge and that training...” (6, 4, 16).

Participant five discussed in the text how they thought there was some subjectivity in risk assessment from client to client. This participant mentioned how it is impossible to actually predict suicide.

"...I was just thinking really it'd be interesting to know what people's bottom lines are in terms of referring to crisis and how many people you know...cause...you can have it's sort of a thorough assessment but there is some subjectivity isn't there..." (5, 6, 32).

"...and he was talking about suicide prevention and it stuck in my mind from him that it's actually impossible to predict on an individual basis who will who won't commit suicide..." (5, 11, 61).

Participant seven mentioned in their interview how determined some people can be to complete suicide. No amount of risk assessment may be able to stop them.

"...ultimately if somebody wants to kill themselves you are not going to be able to stop them...and so you have to do everything you can cause that's a legal and a personal requirement and ethical requirement, but if it does happen then get good supervision and things and know that if somebody's really determined to do it they're going to find a way...of course you really can't watch them 24/7 they only need 15 minutes..." (7, 7, 39).

Participants have argued in this section that risk assessment training is thorough and critically important. Even so, there is always room for the clinician's subjective judgement, and there will always be people who are so determined to complete suicide that risk assessment will not necessarily prevent them.

Risk Factors

This sub-ordinate theme was concerned with how well the participants were able to distinguish the risk factors pertaining to youth suicide.

All participants were able to recognise and describe various risk factors associated with youth suicide. The literature suggests depression as a strong risk factor, and the participants also included depression in their interpretations (Beautrais, 2000A; Parker & Roy, 2001; Carter, Issakidis & Clover, 2003). Overall, the participants seemed to list all of the common risk factors found in the research, which suggests that they were well informed about current literature in this area.

The following quote discusses how youth suicide is linked to mental illness and psychological pain. This reiterates the link of depression with suicide.

"...in my opinion, most young people who commit suicide...are suffering from a mental illness, I wouldn't say all...the issues for them really I think are the same issues as other people go through in their lives, they tend to be a lot about...feeling like they are not worth while...a lot of these young people are in incredible amounts of psychological pain and they feel like it's intolerable..." (1, 4, 25).

Here participant two talks about how previous attempts, rather than depression itself, is the highest indicator of another suicide attempt or completion.

Hopelessness, no sense of the future, and alcohol and drug use are also said to be high indicators by this participant.

"...I think the indicators that they've come up with in the research are pretty valid. You know, like the highest indicators are previous attempts...things like hopelessness - hopelessness is a really big one...and no sense of future...and alcohol and drug use. I mean all the indicators certainly bear out..." (2, 2, 9).

Another risk factor commonly discussed by participants was the break down of relationships. Not feeling like they [the clients] belonged within a group or family was a topic discussed by the participants as a key issue for our youth.

"...relationship problems with parents, relationship problems with peers, relationship problems with boyfriends/girlfriends, intimate relationships. Any or all of those...often there's some kind of relationship breakdown that triggers those episodes, so that would be a big one for kids. A sense of not belonging. A real sense of isolation, particularly from peers but also from the families..." (2, 3, 11).

The impact of cultural and societal influences on suicide rates was talked about by participants in detail. This next quote illustrates this by focusing on how the break down of the nuclear family is having an influence on youth suicide.

"...I'm sure there are lots of things about culture and lots of things about society that impact. I previously worked with one person whose suicidality was very culturally based...and

certainly about society. When you talked before about what society did, I think that the issues of separation, divorce, and blended families are impacting..." (2, 10, 43).

Participant three discussed how youth drinking levels in New Zealand and depression may be linked. It interprets drinking as self-medication in youth who are depressed. This can have negative impacts on our youths' at-risk behaviour, including suicide attempts and completion.

"...certainly things like the drinking levels that we have in New Zealand for a start because there's an association between excessive drinking and depression for younger people...a lot of people who are self medicating depression and anxiety problems..." (3, 2, 8).

Unemployment is seen below to be a risk factor for youth suicide. This participant discusses sociological variables that can influence youth suicide, not only psychological disorders.

"...Unemployment, lack of integration into even their own peer group, pressure to be and or look a certain way, and disconnection from the previous generation even for kids that are still at home..." (3, 3, 15).

Developmental stages were talked about as influencing youth. Participant four also discussed social isolation and not belonging as risk factors for youth suicide.

"...also we know that adolescents is a very difficult phase of life for people, and so if you've got a young person who is socially isolated who doesn't have good support from home who doesn't have a good friendship network, then I guess bullying could start to have an impact on them and they might start to wonder whether life is worth living..." (4, 3, 15).

Individual problems were also mentioned as impacting on youth and their choices in life. This participant suggested that poor problem solving skills can lead to negative solutions to young people's problems.

"...their problem solving skills aren't great so that's what they come up with as a solution..." (4, 3, 17).

Pressures on our youth to obtain tertiary education were mentioned in the text. This suggests that our youth are under pressures to succeed beyond their abilities.

"...I think it's tougher cause I think there are more pressures to get a good education, and I think that the consequence of that and...the demise of the apprenticeship systems that we used to have, is that we've got people struggling to try and get university degrees that would have been much better off getting apprenticeships..." (4, 3, 18).

Psychological factors were mentioned to increase suicide risk, in comparison with mental disorders such as depression. This interpretation suggests that research findings on depression as one of the main risk factors for suicide may be excluding other relevant psychological considerations.

"...I think sometimes impulsivity and anger can increase risk because there are people who kill themselves out of anger rather than depression..." (4, 9, 52).

Gender differences have been associated with suicide risk, with young men being at higher risk of suicide than young women.

"...males have a higher risk than females and as we know in that younger group..." (4, 10, 53).

Issues associated with sexual identity were mentioned as impacting on youth suicide. Young people with sexual identity issues are considered a minority group, facing feelings that they don't belong.

"...there's growing evidence about sexual identity gender identity as well..." (5, 2, 8).

Unemployment and financial problems were mentioned as negative factors for youth.

"...employment I would imagine is a big huge one and associated with that is financial issues..." (6, 1, 5).

Negative peer associates were said to be linked with drug use and other delinquent behaviours. This can then increase suicide risk as substance use increases.

"...I think there are a lot of things around drug use now that are a big contributor, in that youth are associated with peers who are delinquent and getting into delinquent behaviour and drug and substance use which increases their risk..." (6, 1, 6).

Social factors such as being in prison were discussed by participant seven to be associated with increased suicide risk. This is related to feelings of isolation and hopelessness.

"...being in prison..." (7, 1, 4).

Biological causes were also discussed to help explain why we have such a high suicide rate in New Zealand.

"...genetic pre-dispositions...so there's a serotonin imbalance I think...not just a few individuals but a hereditary thing..." (7, 1, 6).

Participant eight discussed economic and cultural factors that have an impact on our youth's morals. This participant explored ideas around New Zealand's youth not having many options available to them, and having a sense of isolation. These were associated with an increased suicide risk.

"...there is a combination of economic and cultural factors that influence a young persons' moral and perhaps...I think probably one of the things that influences them more than anything is not really having an idea of what else they could do, perhaps a sense of isolation in New Zealand relates to young people feeling a lack of options, and that in turn might drive them to suicide..." (8, 1, 1).

This participant discussed the influences of substance use and depression of parents as having a negative impact on youth.

"...perhaps parenting practices you know would result in higher a suicide rate...perhaps parental alcoholism I know depression can be a real problem in New Zealand among adults perhaps parental depression maybe parental discord is related to it..." (8, 1, 3).

From the text we can see there are many variables that practitioners associate with youth suicide. However, differing from the research and previous comments, I found several participants describing clients, or personal friends or

family members who had unpredictably committed suicide. They also mentioned how little we know about why people choose to kill themselves.

Our current risk assessment tools were questioned here. While psychologists were able to identify key risk factors associated with youth suicide, they also experienced problems with assessment procedures.

Participant one discussed concerns over the fact that the clients who are at the highest risk of suicide are not currently seen by health care services. These are the individuals who complete suicide on their first attempt.

"...we don't know about the clients, the young people who kill them selves that we don't see, and with the highest risk groups as young men who complete at their first attempt..." (1, 1, 1).

"...I mean this is the highest risk group the guys who just do it...actually one of my, a family friend, yeah I didn't know him very well, he actually died recently and it was, no one has any idea why it happened..." (1, 6, 33).

"...we know very very little about suicidal clients and identifying the risk...and the highest risk clients we know nothing about because they've already died..." (1, 14, 78).

Participant two discussed the fact that because someone scored low on an assessment tool, does not necessarily mean they are at low risk of committing or attempting suicide.

"...just because somebody comes out low on some rating scale that they've done according to usual risk factors, doesn't mean that they are actually low risk. As much as we might like to feel as clinicians that it gives us the sense of comfort in some ways that 'oh yes we've done all this and the clients is low risk' our judgements are only as good as the information we've got. And the information we've got is hugely incomplete because we've got this group of people who complete suicide and we haven't got any information from them..." (2, 11, 51).

Participant three also expressed concern over our assessment tools, as they had experience of working with a client who had given no indication of suicidality and then attempted suicide.

"...I have experienced a situation where a person has given no indication that they were going to do anything to harm themselves and has gone ahead and done that, and that was really scary because...in reflecting back there wasn't any indication that I could have picked up on, but that's even scarier when you're a fairly new practitioner cause you're always thinking then you know is there something that I should have seen and I missed..." (3, 5, 30).

This next participant voiced concerns regarding the main indicators of suicide. They discussed how people do not always have to have a psychological disorder to attempt or complete suicide.

"...and to be mindful that it's not always the case that people who are suicidal are depressed or having a psychological problem, sometimes people just do it with no...young kids in my personal life who are...just like family friends or family members of friends, who had no risk factors really just suddenly attempted suicide...almost you know strangely surprisingly..." (8, 5, 26).

Participants displayed concerns over the fact that there is a group of youth out there who are acutely suicidal, and yet they will not even see them in their service. This material shows that participants have reservations about our current risk assessment criteria and raises questions about the implications of this for psychological practice.

Participants seemed to be very well trained in recognising and detecting the risk factors associated to youth suicide. The research we have available on suicide risk factors is excellent. But from the text, we can see that there is also a lot we do not know about the precursors of a suicide attempt or completion. The text suggests that every person is individual and unique, and each situation of suicide is subjective to its own context and life events.

4. CONCLUSION

This study sought to enquire into practicing psychologists' understandings of the phenomenon of youth suicide. The purpose was to explore the possibilities for improving safety assessment, treatment and training for practitioners.

The first theme concerned client actions. In subordinate themes, the participants distinguished between completed and attempted suicide. This distinction was ambiguous, however, and participants claimed that there were difficulties obtaining crucial information about completed suicides. Participants also distinguished between suicide and self-harm. Some participants interpreted self-harm as a strategy of relief. They were concerned, though, that self-harming acts that were life threatening were hard to distinguish from attempted suicide. The distinctions through which the participants understood client acts were unclear, suggesting that further training and research that enables psychologists to take account of the context of clients' lives would be helpful.

Another subordinate theme of client actions concerned psychologists' understandings of suicide statistics in New Zealand. New Zealand has one of the highest rates of youth suicide in the Western world. The participants in the current study had difficulties relating to statistics in a meaningful way. They found the use of statistics to explain suicide puzzling and confusing, and from this questioned New Zealand prevalence rates. While statistics are helpful in the way that they allow us to compare the rates between countries, they did not allow the psychologists in the study to explain of the phenomenon of suicide.

The second master theme concerned the social and cultural world. The subordinate theme of gender involved participants' understandings of the methods of suicide chosen by young women and men. Young women were said to use less lethal methods than young men, but in explaining this difference, the relationship between masculinity and violence was not considered. The less lethal methods chosen by young women were explicitly

connected to derogatory feminine characteristics like vanity. Gender roles and expectations need to be taken into account when researching or planning interventions. These aspects of gender may be helpful to understanding the social context of suicide and making sense of client acts.

In the second subordinate theme participants discussed the potential positive and negative influences of the media. Media attempts to reduce stigma were regarded as positive, while sensationalized reporting of suicide was regarded as negative. Participants expressed concern that the media was not always socially responsible in reporting the phenomenon. Despite contention around whether or not the media influences suicide rates, research on how the media represents suicide could assist prevention strategies at the community education level.

The subordinate theme of community and family drew attention to the difference between participants' concern with community responsibility for suicide, and an emphasis on individual risk factors in research. Participants discussed several ways in which communities and families influence suicide, such as emotional dislocation. This suggests that the phenomenon of suicide is embedded in social context. However, responsibility for suicide continued to be attributed to individuals.

In the final subordinate theme, participants talked about multiple meanings of culture, including youth culture. Youth were understood as alienated from cultures of tradition and family values. Māori youth were specified as particularly vulnerable. This view is supported by the literature. Māori research on mental health has developed specific models of Māori wellbeing. One of these is the Whare Tapa Wha Model (Durie, 2001). This model of mental health is a four-sided concept, based on the four walls of a house. They are Te Taha Hinengaro or mental/emotional and Psychological health; Te Taha Wairua or spiritual health; Te Taha Tinana or physical health and Te Taha Whanau or family health. This model is holistic rather than individualistic like Western

Psychology. Wairua/spirituality is considered the most fundamental component of health from a Māori perspective. Yet Western Psychology does not usually include it. Both participants and Māori researchers have identified connectedness with people, their environment and their traditions as important for Māori, and for all young people. Participants understanding of the phenomenon suggest that the Western emphasis on the individual may need to be revised

The final master theme concerned psychological aspects of suicide for both participants and their clients. The subordinate theme of development stages incorporated participants' concerns that young people were under considerable pressure and faced failure in living up to the expectations placed on them. In discussing their training for suicide intervention, the participants considered their own psychological preparedness for dealing with the phenomena. While they expressed satisfaction in their training, they also recognized that the realities of dealing with suicide are difficult to anticipate. Participants suggested improvements in training so that their New Zealand context was taken into account more specifically, and training needed to be on going. The participants also suggested that personal supervision, as well as professional supervision, would assist them to feel well supported in dealing with the phenomenon of suicide.

Participants were not convinced that suicide prevention programmes were working because they did not address social context well and were not well funded. They suggested further evaluation of the programmes.

While participants affirmed the importance of risk assessment, they also argued that the subjective judgment of clinicians is vitally important. They understood that sometimes clients' determination to suicide could not be readily assessed. Ambiguity between completed and attempted suicides as well as self-harm problematises risk assessment and means that suicide cannot be accurately predicted.

In discussing risk factors, participants were able to clearly identify individual risk factors such as depression or previous suicide attempts. They also identified a number of psycho-social factors such as unemployment, use of alcohol and other drugs, social pressure, gender expectations and increasing social isolation. They expressed concerns that acutely suicidal youth did not seek health care interventions. The participants understanding of the phenomenon suggested a need to take specific and complex social factors into account.

4.1 Future Research for Youth Suicide in New Zealand

Although there is a considerable amount of research on youth suicide, this study suggests that psychologists would benefit from specific research pertaining to New Zealand. This would increase the ecological validity of research, allowing researchers to generalize their findings to the New Zealand population instead of relying on international norms.

New Zealand would benefit from further evaluation of programmes that aim to reduce the taboo and stigma around suicide in general. Participants suggest the current Like Minds, Like Mine media campaign is having a positive effect in the community. Such programmes may encourage social responsibility for psychological wellbeing.

One of the findings from this study was the understanding that young people are feeling a lack of connectedness and belonging. Including family and extended family in the risk assessment procedure and participating in treatment, may increase subjective connectedness and sense of belonging.

Little attention has been paid to actual individual accounts of attempted suicide. Maybe we could learn from these individual experiences. It could provide an insider's perspective into suicidality, something the research has lacked. One of the clearest gaps in research and training are the psychosocial aspects of suicide, and in particular knowledge of the diverse socio-cultural and

gendered specificities of particular communities in New Zealand. More and more knowledge is being produced here, and this may enable psychologists to better understand this phenomenon.

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Appendix A

Semi-structured Interview Schedule

1. Based on your experience as a psychologist, how do you explain youth suicide rates in NZ?
 - discussion based on NZ statistics
2. What kind of social influences affect youth suicide in NZ?
 - Education
 - Co-morbidity
 - Violence
 - Media
 - Bullying in schools

 - **SADPERSONS**
sex age depression previous attempts ethanol abuse
rational thinking loss social supports lacking organised
plan no spouse sickness
3. Based on your own experience, what do you think is going on for our young people?
 - What issues are raised by clients?
4. How well do you think your training prepared you for addressing prevention and treatment of youth suicide?
 - What works?
 - What doesn't?
5. What supports are in place to deal with the effects of youth suicide in your own life – both professionally and personally?
 - Is supervision enough?
6. How effectively is youth suicide managed in NZ?
 - Are current programmes effective?
 - What else needs to be done? Who should do it?
 - What works? What doesn't?
7. Is there anything from your own experience that you would like to pass on to new psychologists undergoing training?



Appendix B

A Hermeneutic Phenomenological Analysis of Clinical Psychologists' Understandings of Youth Suicide.

INFORMATION SHEET

My name is Hannah Brown and I am currently a Masters student with the School of Psychology at Massey University. My supervisor is Dr Leigh Coombes. My thesis is a hermeneutic phenomenological study on how clinical psychologists' understand youth suicide, particularly through their training and own experiences as a psychologist. I will also be looking at how these understandings inform treatment and prevention strategies for youth suicide.

What is this study about?

New Zealand has one of the highest suicide rates in the developed world. There is considerable controversy around risk factors, prevention strategies and treatment programmes concerning youth suicide. I believe clinical psychologists have a wealth of knowledge to share in these areas, and surprisingly there has been little research done with this population group. Therefore I am currently looking for clinical psychologists to participate in this research project.

What would I have to do?

If you agree to participate you would need to be available for an interview with the researcher to talk about your understanding of youth suicide. The interview will be audio taped and transcribed by the researcher. No identifying information will appear on the transcript, as pseudonyms will be used. Audio tapes will be erased or returned to you after transcription as you so choose.

How much time will be involved

Each interview will take approximately one hour. Interviews will take place at a location and time that is convenient for you as participant. You will also be asked to comment on the transcript of the interview and make any changes you require.

What can I expect?

If you choose to take part in the research, you have the right to:

- refuse to answer any questions
- turn off the audio tape at any time during the interview
- withdraw from the study at any time

- ask any further questions about the study that occur to you during your participation
- provide information on the understanding that it is completely confidential to the researcher. All records will be identifiable only by pseudonym, and will be seen only by the researcher and her supervisor. Though excerpts from your transcript may be included in the thesis it will not be possible to identify you in any reports that ensue from this study.
- have access to your transcripts and be able to comment on or make changes to them.
- be given a summary of the findings from the final report.

If you have any questions, please don't hesitate to ask. I can answer any further questions you might have at the interview, should you decide to participate.

Researcher:

Hannah Brown
School of Psychology
Massey University
Private Bag 11-222
Palmerston North
hannahbrown@paradise.net.nz

Supervisor:

Dr. Leigh Coombes
School of Psychology
Massey University
Private Bag 11-222
Palmerston North
(06) 350 5799 ext. 2058
L.Coombes@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 04/77. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz.



Appendix C

A Hermeneutic Phenomenological Analysis of Clinical Psychologists' Understandings of Youth Suicide.

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me.

My questions about the research have been answered to my satisfaction and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time and to refuse to answer any particular questions.

I agree to provide information to the researcher on the understanding that it is completely confidential and will not be used for any purpose other than this research.

I agree to the researcher audio taping the interview and I know that I have the right to ask for the tape to be turned off at any time during the interview.

I wish the audio tape to be destroyed/returned (delete one) to me after the transcription is complete.

I do/do not (delete one) request a copy of my transcript for alterations and/or comments. I understand that my responses will be analysed during the study. To illustrate research findings, excerpts of some of my responses may be included in the study as direct quotations. I wish the following pseudonym to be used when reporting my responses _____.

I wish to participate in this study under the conditions set out on the information sheet.

Signed:

Name:

Date:

Researcher:

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 04/77. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz.