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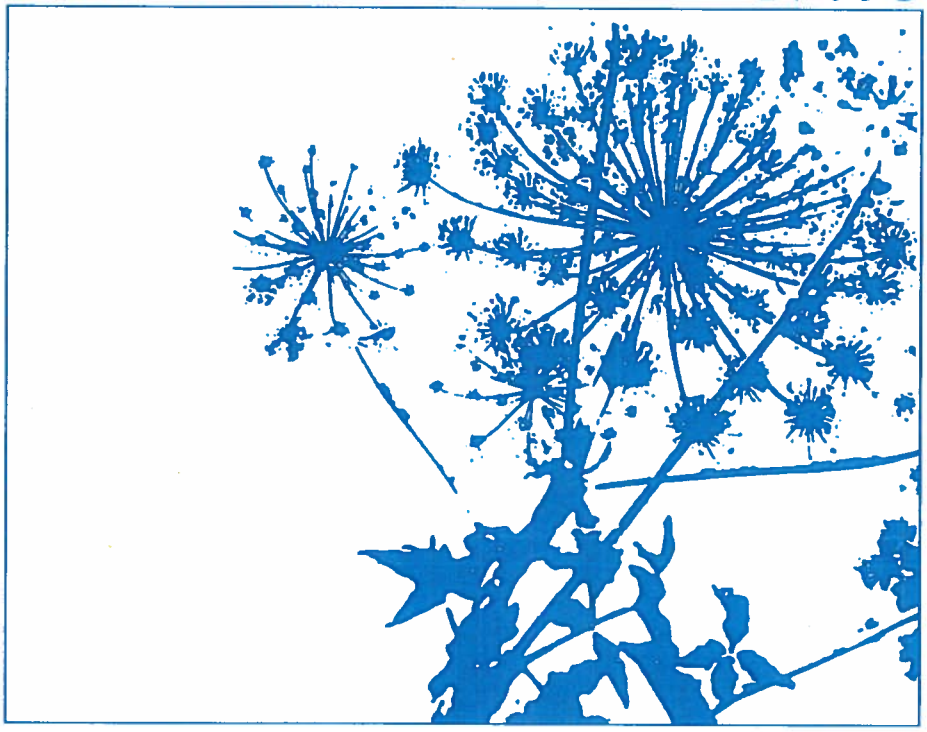

SUICIDAL BEHAVIOR AMONG INDIGENOUS SAMI IN ARCTIC NORWAY

A special focus on adolescents and young adults

Anne C. Silviken

Tromsø 2007

Centre for Sami Health Research
Institute of Community Medicine
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ISBN 82-90263-07-04

2007

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1. ACKNOWLEDGEMENT

This project owe thanks to many people. Above all, I want to thank Siv Kvernmo my supervisor, co-author and leader of the project "The North Norwegian Youth Study". I am really impressed of your constructive supervision and positive attitude, always lifting the most miserable drafts or ideas to an enhanced level. Next, I want to thank my co-supervisor Tormod Brenn for his valuable and interesting reflections. Thanks, also to co-author Tor Haldorsen, Finn Gjertsen for constructive comments on Paper I, Marita Melhus for statistical support, Mona Ingebrigtsen for controlling the projects' financiers in an optimistic and appropriate way, and the adolescents and teachers participating in "The North Norwegian Youth Study". Furthermore I want to thank all my good colleagues at the Centre for Sami Health Research and the Sami National Centre for Mental Health. Among these, I particularly want to mention Anna Rita Spein, Ragnhild Vassvik Kalstad and Gunn Heatta. These unique women have become an important part of my life, "say no more".

I greatly appreciate the financial support which I have received from the aid of EXTRA funds from the Norwegian Foundation for Health and Rehabilitation and Centre for Sami Health Research and Institute of Community Medicine, Faculty of Medicine, University of Tromsø. Furthermore, I want to thank Centre for suicide prevention in Northern Norway, UNN (now RVTS-Nord) and the Sami National Centre for Mental Health who financed my part time postgraduate study in suicide prevention at The Suicide Research and Prevention Unit, Department of Medicine, University of Oslo (2004/2005). This study guided me into the field of suicidology in a very inspiring way.

During my years in Karasjok there have been incidents of pleasure and friendship. First of all I am deeply grateful to Livchristin, Per, Biret Irja and Elle Máijá Klefstad Bær, Hilde Skancke Pedersen and Anna Anita Hætta Guttorm. Thank you all for your warm and including practice of the extended family from the very first beginning. Centre for Sami Health Research constitutes a small department in Karasjok, making our "colleagues" in Asplan Viak a stimulating input, especially at our annual happening "julebordet". Finally, I want to thank my beloved ones, my parents Inez and Edvard for your care and long lasting financial support, Per-Olav and Claudia for giving me two beautiful nieces, and Line for all your support and inspiring creativity.

Karasjok, July 2007
Anne C. Silviken

2. LIST OF PAPERS

I: Silviken, A., Haldorsen, T. and Kvernmo, S. (2006). Suicide among indigenous Sami in Arctic Norway, 1970-1998. *European Journal of Epidemiology* 21: 707-713

II: Silviken, A. and Kvernmo, S. (2007). Suicide attempts among indigenous Sami adolescents and majority peers in Arctic Norway: prevalence and associated risk factors. *Journal of Adolescence* 30: 613-626

III: Silviken, A. and Kvernmo, S. (*manuscript*). Risk factors associated with different types of suicide attempters: A longitudinal study among ethnic diverse adolescents in Arctic Norway.

3. ABBREVIATIONS

CI	Confidence interval
OR	Odds ratio
PY	Person years
SD	Standard deviation
SMR	Standard Mortality Ratio
SPSS	Statistical Package for the Social Science
YSR	Youth Self-Report
YASR	Young Adult Self-Report

4. INTRODUCTION

4.1 Background

Since the 1950's the global suicide rates have continued to increase, and today suicide has become an important public-health problem worldwide (World Health Organization (WHO), 2002). According to WHO there are approximately one million deaths from suicide each year worldwide, and about 20 times this number of people attempt suicide (2002). There are substantial variations in the national suicide rates (Lester, 1997), and in addition great variation in rates within the same country and between different ethnic groups (Roberts, Chen & Roberts, 1997). During the last decades suicide rates have increased alarmingly among indigenous people, and especially among indigenous residing in the Arctic, such as the Inuit in Greenland (Leineweber et al., 2001) and in Canada (Sigurdson et al., 1994), and among Alaskan Natives in the US (Borowsky et al., 1999). The increase in suicide rates among indigenous people in the Arctic have been so alarmingly high that it has been described as an epidemic level (Bjerregaard & Lynge, 2006; Leenaars, 2006) and it has been declared that certain indigenous people have the highest suicide risk of any identifiable cultural (or ethnic) group (Leenaars, 2006; Kirmayer, 1994). Unfortunately, suicide has become the leading cause of death for young indigenous people, especially among males, and is a significant contributor to potential years of life lost. Although there is carried out research on the prevalence of suicidal behavior among several indigenous people, e.g. in Canada, Alaska, Greenland, Sweden, Australia, New Zealand, our understanding of suicidal behavior among indigenous people is still limited (Cutcliffe, 2005; Leenaars, 2006; Stewart, 2005).

There is no registration of ethnicity in the national population register in Norway, for that reason there are neither official statistics of health and living conditions nor suicide rates for indigenous Sami (hereafter called Sami). There have so far been conducted limited research on health and living conditions among Sami in Norway, and suicidal behavior has not previously been studied in a systematically way. Although some Sami communities have experienced high rates of suicides, there is in general lack of specific prevention strategies. Epidemiological knowledge about suicidal behavior among Sami is important for implementation of appropriate prevention strategies in Sami communities, and in addition useful to public health practitioners and policy makers in addressing this problem.

4.1.1 Definitions of suicidal behavior

Suicidal behavior can be considered as a continuum ranging from merely thinking about ending one's life through attempting suicide and finally completed suicide. Suicidal behavior,

as it is used in this project, is a broad concept including suicidal ideation, suicide attempts and completed suicide. "There has been much disagreement about the most suitable terminology to describe suicidal behavior" (WHO 2002: 185) and in the field of suicidology "there are at present no standard, widely accepted definitions or criteria for suicidal behaviors, particularly non-lethal behavior" (Wagner, Wong & Jobes, 2002: 284). However, in this thesis suicide and suicide attempts are used in accordance with these definitions: "Suicide is deliberated self-harm which lead to death" (Retterstøl, Ekeberg, Mehlum, 2002: 13) and "Attempted suicide is an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dose, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences" (Bille-Brahe et al., 1995: 74). Although the intent to die is a central aspect in suicide, intent to die is not always obvious in suicidal behavior. For many suicidal people the most pronounced intent is to escape an intense pain or an unbearable situation. Suicidal ideation, on the other hand, refers to thought of killing oneself, being tired of life or a belief that life is not worth living (Wagner et al., 2002).

4.2 Suicidal behavior among indigenous peoples

Although suicide among indigenous is characterized as a modern phenomenon, suicide also existed among indigenous in the distant past. However, suicide in the old times has rather been described as a "voluntary death", which occurred rarely and mainly took place among elderly and those suffering from physical illnesses (Young, 1994; Lester, 2006). For example, among older Chuckhee in Siberia, death by suicide was thought to be preferable to death from disease or old age. Subsequently, they have a particular term for voluntary death in their language, "single fight" (Bogoras, 1975). To my knowledge there is no documented information of suicide in the traditional Sami culture in Norway, but is it likely to presume that this kind of suicide also took place among Sami in the distant past. However, the suicide found in traditional indigenous culture can be characterized as social or institutionalized suicide, in contrast to the personal or individual suicide found in modern time. Today the picture has changed remarkably as suicidal behavior is an individual act and primarily a problem among young indigenous people.

To get a better understanding of suicidal behavior among indigenous people, culture and living conditions are important and inevitable explanatory factors. Culture is a concept with many definitions, however, in this thesis culture is understood as: "the deeply embedded

patterns of meaning which we share with groups we belong to and which guide us in interpreting and relating to our environment" (Skogen, 1997: 4). Although suicide occurs all over the world in different kind of cultures, there has been limited focus on the significance of culture in suicidology. The emphasis has so far mainly been upon commonalities in suicidal behavior. However, the relevance of culture is of current interest in the field. According to Mishara (2006: 2), the president of the International Association of Suicide Prevention, "An important challenge for future research is to explore and understand the frontier between universal aspects of suicide and it cultural specificity". Although indigenous people all over the world are different in many respects, culturally, socially and historically, they share some common characteristics concerning suicidal behavior.

4.2.1 Characteristics of suicidal behavior among indigenous people

Several common characteristics concerning suicide among indigenous people have been identified (Hunter & Harvey, 2002; Clarke, Frankish & Green, 1997). First, there is great variation in the prevalence of suicide within the indigenous groups. Second, there has been a general and more rapidly increase in prevalence of suicide among indigenous people during the last three decades. Third, suicide among indigenous people seems to be more frequent among adolescents and young adult. Fourth, indigenous males seem to be most vulnerable to suicidal behavior. Fifth, suicides among indigenous often occur in clusters in time and space. And finally, suicides among indigenous involves a higher proportion of violent methods.

4.2.1.1 *Variation in suicide rates*

The distribution of suicide between indigenous groups is not uniform, and besides, great variations in prevalence of suicide within indigenous groups regarding different communities and geographical areas have been documented (Kirmayer, 1994; Cutcliffe, 2005: Bjerregaard & Lynge, 2006; Hunter & Milroy, 2006; Young, 1994). The geographical variation found in suicide rates among indigenous in the state of Queensland, Australia, made the authors propose there had been an overlapping "wave" of suicides, implicating a condition of community risk varying by location and time (Hunter, Reser & Baird, 2001 in Hunter & Milroy, 2006). A similar pattern in geographical variation was found in Greenland. Initially the suicide rate peaked among youth in the capital Nuuk in 1980-1984. Then five years later the trend among young people in the rest of West Greenland reached a plateau, while the rate was very high and still increasing among the young in East Greenland during the 1990's (Bjerregaard & Lynge, 2006). Moreover, among indigenous in Australia suicide was initially

located largely in areas of rapid change and inter-cultural pressure, but has now become more common in certain remote and "traditional" populations (Davidson, 2003).

4.2.1.2 *Rapid increase in suicide rates*

During relatively few decades the suicide rates among several indigenous people have increased rapidly from being a relatively rare phenomenon to reach an epidemics character. What can be said about the remarkable change in rates is that it has followed the process of colonization and modernization (Boothroyd et al., 2001; Hunter & Harvey, 2002; Kirmayer, 1994). In Greenland the rapid socio-cultural changes during the last 50-years has been paralleled by an increasing number of suicides among Inuit (Bjerregard and Lynge, 2006). Furthermore, the regional variations in suicide rates found in Greenland, corresponded well with the regional process of modernization. According to WHO, one of the underlying causes for the increased suicide rates among indigenous people are "the enormous social and cultural turmoil created by the policies of colonialism and the difficulties faced ever since by indigenous peoples in adjusting and integrating into the modern-day societies" (WHO, 2002: 190). The rapid increase in indigenous suicide rates are most pronounced among the 15-24 year age group (Clarke et al., 1997; Sigurdson et al., 1994; Bjerregaard & Lynge, 2006).

4.2.1.3 *High suicide rates among young indigenous*

Today suicidal behavior among indigenous people is primarily a problem among young people. Globally, suicide rates tend to increase with age for the general population (Diekstra, 1993). In contrast to this pattern, in indigenous populations suicide rates peak at age 15-24 and then decrease with age (Bjerregaard et al., 2004). This disproportional pattern of age distribution in suicide exists in almost all identifiable indigenous people, e.g. in the Arctic, America and Australia (Leenaars, 2006; Chandler and Proulx, 2006; Clarke et al., 1997). For example, in Greenland the suicide rates are in general high (100 per 100,000), however, the rates among young males aged 15-24 years are even higher (450-500 per 100,000 person-years) (Bjerregaard & Lynge, 2006). The alarming increase in suicide rates have been most pronounced among young indigenous males. Among American Indian and Alaska Natives, males aged 15-34 made up 64 % of all suicides in the time period 1979-1992 (Wallace et al., 1996).

4.2.1.4 *Young indigenous males' most vulnerable to suicidal behavior*

Gender is one of the most important demographic markers of suicide risk. Worldwide suicide is more prevalent among males, while suicide attempts in general are more prevalent among females than males. A phenomenon often described as the "gender paradox" in suicidology (Canetto & Sakinofsky, 1998). Although these gender patterns of suicidal behavior are common, they are not universal, suggesting cultural influences (Canetto, 1997). Exceptions to this gender paradox have been reported in the general population (e.g. in China and Finland) (Cheng & Lee, 2002; Kerkhof, 2002) and also among indigenous. In two studies from Inuits in Nunavik, Kirmayer and colleges (1996; 1998) reported that young males were not only much more likely to complete suicide but also more often attempted suicide. A similar pattern is reported in two studies from Greenland based on patients admitted to hospital, men and women had equally often exhibited suicidal behavior (Grove & Lynge,1979; Thorslund, 1992).

Although the suicide rates are especially high among young indigenous males, the rates found among young indigenous females are high as well compared to their majority counterparts. In a study in Manitoba, Canada, suicide was about 23 times more frequent among First Nation females 15 to 19 years of age than among non-indigenous counterparts (Malchy et al., 1997). Also the prevalence of suicide attempts among indigenous females have been reported to be high, e.g. 22 % among American Indian-Alaska Native females (Blum et al., 1992) and 33 % among Inuit females in Greenland (Curtis et al., 2006).

4.2.1.5 *Clustering of suicides*

Clustering of suicides is one of the common characteristic concerning suicide among indigenous people, and has been reported in several indigenous communities in both the US, Canada, Greenland and in Australia (Bechtold, 1988, 1994; Kirmayer, 1994; Thorslund, 1991; Hunter and Harvey, 2002). In epidemiology cluster is defined as: "A disease cluster is a mini-epidemic or outbreak of a rare event; that is, occurrence of disease clearly in excess of that expected" (Bhopal, 2002: 59). According to Gould and colleges (1990a), a suicide cluster is characterized by an unusually high numbers of suicides occurring in a small area during a brief time period.

In the general population clusters of suicide are occurring to a greater extent among adolescents and young adults (Gould et al., 1990a, 1990b). Due to the generally high proportion of young people in the indigenous populations, clustering of suicide has been proposed to occur to a greater extent among indigenous people (Wissow et al., 2001). A study

from Greenland reported that 60 % of all suicides in the young population took place within four months following another suicide in the same district (Thorslund, 1990).

4.2.1.6 *Violent suicide methods*

Violent method such as firearms and hanging, are frequently used among indigenous people (Hunter & Harvey, 2002; Stevenson et al., 1998; Kosky & Dundas, 2000; Bjerregaard & Lynge, 2006). Firearms are reported to be responsible for over 50 % of all suicides among Native Americans (Stevenson et al., 1998), and in Greenland, firearms and hanging accounted for 91 % of cases among males and 70 % among females (Bjerregaard & Lynge, 2006). One factor that possibly influences the extensive use of firearms among indigenous, in general, is the widespread ownership of firearms due to traditional and modern hunting/labor and leisure time activities. However, widespread ownership of firearms does not necessarily imply that firearms are the preferred suicide method. Although firearms are widespread among Inuit people in Northern Canada, firearms are much less frequently used in suicide than hanging (Boothroyd et al., 2001).

In conclusion, focus on suicidal behavior among indigenous people is of special concern for several reasons. First, they have among the highest suicide rates in the world, a tragedy which according to WHO "call for action" (Leenaars, 2006). Second, although research on indigenous groups continues to demonstrate the negative impact of colonization and modernization on their mental health, several indigenous people does not access mental health services at a level that is commensurate with this need. Third, several indigenous societies have implemented prevention strategies by utility of a dual strategy of both reducing risk and also improving protective factors, focusing on resilience and traditional culture. It is important to transfer this kind of knowledge between indigenous groups. And finally, in spite of the fact that suicidal behavior is a serious problem among indigenous, the majority of young indigenous are not suicidal. Therefore, it is about time to question the stereotypic myth about the "suicidal indigenous", to obtain information about prevalence of suicidal behavior and a broader understanding of the underlying mechanisms.

4.3 Risk and protective factors associated with suicidal behavior

4.3.1 Risk factors

Suicide is a complex phenomenon described as a "multidimensional malaise" (Leenaaars, 1996), influenced by biological, psychological and socio cultural factors. There has been an increasing research interest in the risk factors and life processes that encourage people to

engage in suicidal behavior. In the general literature several articles are summarizing risk factors for suicidal behavior among adolescents (e.g. Brent, 1995; Lewinshon, Rohde & Seeley, 1996; Beautrais, 2000). Nevertheless, cohesive models are relatively scarce in suicidology, which can be related to the large number of potential variables that can account for variance in the outcomes of interest (Gutierrez et al., 2005). However, according to Beautrais "... examination of the literature yields a generally consistent and coherent account of the risk factors and life process that lead to suicidal behaviours" (2000: 429). Beautrais has proposed a conceptual model to summarize current knowledge about risk factors for suicide and suicide attempts among young people (2000) (Figure 1.) According to this model there are series of correlated sets of factors, such as social background, family factors, psychiatric and personality factors, which act as broad determinants of an individual's vulnerability to suicidal behavior. The model implicates that these vulnerability factors influence both an individual's susceptibility to mental illness and his or her level of life event exposure. Beautrais propose further, that these sets of risk factors in combination make both direct and indirect contributions to an individual's risk of suicide or suicide attempt (2000). However, the most important suicide risk predictors in adolescence are affective disorders, disruptive disorders, previous suicide attempts and substance abuse (Brent, 1995).

At the individual level the risk factors identified among indigenous are in many respects identical to those found in general populations (e.g. Borowsky et al., 1999; Grossman, Milligan & Deyo, 1991; Howard-Pitney et al., 1992; Grove & Lynge, 1979). For example risk factors for suicide attempts identified among Navajo Indian adolescents include female gender, prior mental health problems, suicide attempts among friends and family, alcohol consumption, and physical and sexual abuse (Grossman et al., 1991). On the other hand, among young Inuit's in Nunavik risk factors for suicide attempts were male gender, a history of substance abuse (especially solvents or inhalants), a history of a psychiatric problem, a parental history of substance use or a psychiatric problem, feelings of alienation from the community, and a history of physical abuse (Kirmayer, Brass & Tait, 2000). In a study among American Indian and Alaska Native youth the strongest association with a history of attempted suicide was having a friend attempt or complete suicide, and in addition somatic symptoms, a history of sexual or physically abuse, having a family member attempt or complete suicide, having health concerns, frequent alcohol or marijuana use, or ever using any other drugs (Borowsky et al., 1999). In a study from Greenland, suicide attempters had compared to a control group, more often a disharmonious childhood with alcohol problems in the home and more often alcohol problems themselves, a loose connection in the labor

marked and problems in relation to their family and relatives (Grove & Lynge, 1979). Another study among Greenlandic Inuit's showed that alcohol problems in the home and being the victim of sexual violence as a child increased the frequency of suicidal thoughts (Bjerregaard & Curtis, 2002). Research among Canadian Inuit has identified several risk factors for suicide, such as poverty, childhood separation and loss, accessibility to firearms, alcohol abuse and dependence, a history of personal or familial health problems, and past sexual or physical abuse (WHO, 2002).

An essential discussion in suicidology is whether risk factors contribute independently to suicidal behavior or whether some risk factors are mediated with more basic individual differences. Although, majority of completed suicides occur in the context of psychiatric disorder, primarily depression, a minority of depressed persons is suicidal. Subsequently, mediating and moderating risk factors, such as hopelessness, impulsivity and problem-solving strategies, become important research topics in suicidology. Furthermore, the influence of risk factors, may according to Beautrais, be modified or changed by social, cultural and contextual factors that may act to encourage or discourage the development of suicidal behaviors in young people (2000).

4.3.2 Protective factors

Protective factors and resilience are important contributors to the understanding of suicidal behavior. General protective factors against the development of suicidal behavior among young people have been summarized by Beautrais (2000), such as, the role of various social support (e.g. family cohesion or belonging to social peer group), good social skills, marriage and parenthood, good coping skills and problems-solving behaviors, positive and life-affirming beliefs and values, high self-esteem and holding attitudes and moral values against suicide. Although suicidal behavior is a serious problem among many indigenous people, the majority of young indigenous are not suicidal. This indicates that knowledge about protective factors and resilience among indigenous is important. Unfortunately, research among indigenous are primarily focus on risk factors, similar to the general trend in suicidology. However, some studies among indigenous groups have been reporting protective factors against suicidal behavior. For example, good school performance and regular attendance at church has been reported to be protective against suicide attempts among young Inuit's in Nunavik (Kirmayer et al. 2000). In the study by Borowsky and colleges several factors significantly reduced the odds of attempting suicide, such as discussing problems with friends or family members, having a good emotional health, and having a sense of connectedness

with family (1999). An interesting finding in their study was that increasing the number of protective factors was more effective in reducing the probability of a suicide attempt than were decreasing of risk factors (1999). Furthermore, integration of traditional culture in several Native American tribes and degree of self-government among Native Canadian bands have been reported as protective factors against suicide (Lester, 1999; Chandler & Lalonde, 1998).

In conclusion, several risk factors and protective factors have been identified to influence the risk of suicidal behavior. However, it is important to emphasize that suicidality can be understood as a state of mind (Schneidman, 1997), and that several factors contribute in the suicidal process as illustrated in Figure 2.

4.4 Suicidal behavior in Norway

Norway has together with, Finland, Ireland, the Netherlands, Scotland, Spain and Sweden, experienced a significant increase in suicides during the 20th century, while England and Wales (combined data), Italy, New Zealand and Switzerland have experienced a significant decrease (WHO, 2002). Previously Norway had relatively low suicide rates compared to the neighboring countries Denmark, Sweden and Finland, but from the end of 1960's to 1988 there has been a general increase in the suicide rates in Norway (Retterstøl et al., 2002). In 1988 was the highest ever documented suicide rate in Norway, 16.8 per 100 000, and since then the rates have steadily decreased (11.5 per 100 000 in 2004) (Statistics Norway). Norway had, similar to other European countries, a remarkably increase in suicide among young males aged 15-24 years from the 1970s to the beginning of 1990s (Mehlum, Hytten & Gjertsen, 1999). However, since 1990's there has been a decline in youth suicide, especially among young males.

The general suicide rate in Northern Norway is slightly higher than the average national rate (12.8 vs. 12.1 per 100 000, 1998-2004) (Gjertsen, 2006). However, the suicide rate in Finnmark county is high (17.3 per 100 000) compared to the national rate and the rates in Troms and Nordland counties (9.6 and 11.4) (Gjertsen, 2006). Furthermore, suicide rates among adolescents and young adults aged 15-24 years in Northern Norway are high compared to their national counterparts (e.g. in 1994, males 37/100 000 and females 6/100 000 vs. national rates 21 and 5 per 100 000, respectively) (Gjertsen, 2002a).

In Norway, like several other countries, there is no official reliable data on suicide attempts. One important reason for this is that the majority of suicide attempters never contact mental health services (e.g. Grøholt et al., 1997). However, several studies have explored the

lifetime prevalence of self-reported suicide attempts among Norwegian adolescents such as the Young in Norway studies from 1992 and 2002 (Wichstrøm, 1992; Wichstrøm, 2007). In this representative national sample (aged 12-20 years) 8.2 % had ever attempted suicide, and females were almost twice as likely as boys to report suicide attempts (10.4 % vs. 6.0 %) (Wichstrøm & Rossow, 2002). In 2002 the prevalence of self-reported suicide attempts had increased to 13.6 % among females, whereas the rates among males were stable (6.2 %) (Wichstrøm, 2007). Furthermore, findings from the WHO/EURO Multicentre Study on Parasuicide indicated that rates for hospitalized suicide attempt from Norway (Sør-Trøndelag) were 191 per 100 000 (mean 1989-1992, aged 15 and over) for females and 147 for males (Kerkhof, 2002). According to Hjelmeland (2001) the general rates in Sør-Trøndelag decreased in the time period 1989-1999, whereas the rates among females 15-19 years old increased remarkably from the middle of the 90ties (315 per 100 000 in 1999).

In conclusion, although the national suicide rates can be considered as moderate, suicidal behavior is a public health concern also in Norway. At present approximately 500 persons die in suicide annually in Norway and suicide attempts among adolescents are an increasing problem, especially among females. During the last three decades research in the field of suicidology has increased significantly in Norway. In 1994 the Norwegian Plan for Suicide Prevention (1994-1999) was launched, and one of the main goals in this plan was to increase the national research activities. Unfortunately, there has so far been limited research in suicidology in the north Norwegian context.

5. AIMS OF THE STUDIES

Suicidal behavior among Sami in Norway has previously not been studied in a systematically way. The aims of this study were: 1) primarily to acquire epidemiological knowledge about prevalence of suicidal behavior among Sami in Arctic Norway, in particular among adolescents and young adults. 2) To explore sociodemographic factors, such as gender, age and cultural context, associated with suicide, and to 3) examine risk factors associated with self-reported suicide attempts, both cross-sectional and prospective among adolescents and young adults. Since this work is of an exploratory character no hypotheses are explicit presented in the papers. However, in an indigenous perspective our main working hypotheses were that Sami would have a significant increased risk of suicide and a higher prevalence of suicide attempts compared to their majority counterparts.

The following research aims were investigated:

- To examine the risk of suicide mortality among Sami during the last three decades, 1970-1998 (Paper I).
- To explore suicide mortality stratified by age, gender, cultural context, and traditional Sami core management (Paper I).
- To examine the prevalence of suicide attempts among Sami adolescents and their non-Sami peers (Paper II).
- To explore for ethnic differences in patterns of risk factors associated with previous suicide attempts among Sami adolescents and their non-Sami peers (Paper II).
- To explore for differences between subgroups of attempters according to development of emotional/behavioral problems and substance use in a longitudinal perspective (Paper III).

6. METHODS AND SUBJECTS

6.1 Study design

This thesis is based on two studies: Study I is a register-based follow-up study with focus on suicide mortality among Sami in Northern Norway in the time period 1970-1998 (Paper I). Study II, The North Norwegian Youth Study, is a longitudinal epidemiological study of high-school students in the three northernmost counties of Norway: Finnmark, Troms and Nordland (Papers II and III). The first wave was in 1994-1995, and the second in 1997-1998. Data used for this thesis are based on both waves. The students completed an extensive questionnaire covering demographic, socioeconomic, emotional, behavioural and social characteristics.

6.2 Procedure

6.2.1 Study I

As there is no ethnicity information in the national population register of Norway, the national census from 1970 represents an exception and was used to define the Sami cohort. In connection with the national census in 1970, a survey of Sami ancestry was performed in preselected census tracts in the three northernmost counties of Norway: Nordland, Troms and Finnmark (see Appendix). The census was carried out by Statistics Norway in cooperation with Sami organizations (Aubert, 1978). Table 1 shows the census tracts included in the census by ethnic context. Established knowledge and pilot studies on Sami inhabitation were used to identify these areas. The selected census tracts covered 6.1 % (n=14,760) of the

population in Nordland (N=241,967), 22.9 % (n=31,160) in Troms (N=136,070) and 89.7 % (n=67,954) in Finnmark (N=75,757). The total population participating in the selected census tracts was 113, 874 persons. Unfortunately, it has not been possible to obtain information about the exact response rate for the census in 1970.

On behalf of Institute of Population-based Cancer Research, Cancer Registry of Norway, Statistics Norway conducted the record linkage through the participants' birth number. Information on vital status and cause of death of the subjects identified as Sami in the census where obtained through record linkage with the Norwegian Causes of Death Register and were compared to the expected number of deaths in a control population residing in rural Arctic Norway. Information about emigration was obtained through the Central Population Register. Institute of Population-based Cancer Research, Cancer Registry of Norway received an anonymous data file from Statistics Norway.

6.2.2 Study II

The North Norwegian Youth Study was part of the Young in Norway study (Wichstrøm, 1992), but in a revised version, and was first conducted in 1994 in the county of Finnmark. Later in 1995, it was also carried out in the southern and northern parts of Troms and Nordland counties. Communites with a Sami population were chosen to achieve a representative sample of Sami. Twenty-one high schools in the three counties were selected for the study. All high schools in Finnmark except one and all high schools in the southern and northern parts of Troms and Nordland were included. The excluded school in Finnmark was known to have mainly adult students and did not represent the target group for the study. None of the schools was located in urban areas; they were all in rural areas. The schools were selected to represent geographical areas that were inhabited by adolescents from three ethnic groups: the Sami, Kvens and Norwegians. Teachers specially trained for this purpose carried out the study at the schools. The questionnaire was completed during two sessions of 45 minutes each and covered a broad range of topics central to the adolescents' stage. No students were excluded from participation. To avoid students influencing each other's responses, all eligible students at each school completed the questionnaire at the same time. Students who had consented to participate but were not present in class during these two sessions completed the questionnaire together at a later date. In Finnmark where most of the Sami-speaking population live, the questionnaires and information letters were available in both Sami and Norwegian at baseline/T1. The North Norwegian Youth Study has been

described in several publications (Kvernmo & Heyerdahl, 2003; Spein, Kvernmo & Sexton, 2002; Spein, Sexton & Kvernmo, 2004).

6.3 Study populations

6.3.1 Study I

The cohort included 19,801 persons with Sami ethnic ancestry, 10,573 (53.4 %) men and 9,228 (46.6 %) women. The cohort included 890 (4.5 %) people from Nordland, 4,847 (24.5 %) from Troms and 14,064 (71 %) people from Finnmark. Information about date of birth, sex, residence, and occupation was supplied by the regular census. In the census 1,604 people were registered as belonging to reindeer herding household (1,498 associated by ownership and 106 as herders). People living in the same household were identified and parents were allowed to answer on behalf of their children (<15 years). The follow up of suicide incidence took place from the beginning of November, 1970 (date of census) until the end of 1998. The follow-up included 471 028 p.y., 245 408 for men and 225 620 for women, respectively. Altogether, 5,955 deaths (of these were 500 violent deaths and 5455 deaths were caused by various diseases) and 172 emigrations were observed in the cohort.

6.3.2 Study II

A total number of 4,019 students aged between 15 and 21 years were invited to participate in the North Norwegian Youth Study in the first wave (T1). The response rate was 85 % (*N*=3,417). There were 286 adolescents who refused to participate, 260 did not adequately complete the form for a variety of reasons and 56 students withdrew form the study. Students from other ethnic groups (n=33), who had incomplete identification numbers (n=25), part-time students or students not reporting their grad level (n= 47) and participants who were younger than 16 years or older than 18 years (n=621) were also excluded. The cross-sectional sample analysed in paper II (1994/1995/T1) included 2,691 students (1,402 females, 52 % and 1,289 males, 48 %) aged 16-18 years (mean age 16.9, SD 0.8 years) with no differences in the mean age between the genders or between the ethnic groups. The sample consisted of 591 (22 %) Sami (323 females and 268 males; 55 % and 45 %, respectively) and 2,100 (78 %) non-Sami subjects (1,079 females and 1,021 males; 51 % and 49 %, respectively).

At follow-up 2,947 of the students from T1 were invited to participate. Those who were older than 22 years at T2 were not invited to participate (n=344). Furthermore, one school did not participate at T2 because it had lost the participant list prior the follow-up survey (n=126). The follow-up sample from the North Norwegian Youth Study consisted of

1,678 students (T2) with a response rate of 57 % and mean age 19.6 (SD 1.0) years. At follow-up, only 31 % (440) attended state school, a fact that may have contributed to the low response rate, as the majority received a mailed questionnaire. Those adolescents who were lost to follow-up were at T1 significantly more likely to report male gender, non-parental living arrangements (e.g. relatives, foster parents or boarding school), attend vocational studies, report being current smokers and use cannabis during last 12 months, report lower mean scores on Somatic complaints, Anxious/depressed Problems, Hopelessness and loneliness, and report higher mean scores on Social Problems and Delinquent Behavior. The follow-up sample analysed in paper III (1997/1998/T2) included 1528 students (926 females, 61 %, and 602 males, 39 %) aged 18-22 years (mean age 19.8, SD 1.1). The sample consisted of 363 (24 %) Sami (225 females and 138 males; 62 % and 38 %, respectively) and 1165 (76 %) non-Sami subjects (701 females and 464 males; 60 % and 40 %, respectively). Figure 3 shows a flow chart of the subjects included in Study II at T1 (Paper II) and T2 (Paper III).

6.4 MEASURES

Several measures are used in the presented papers. In this section only some essential measures will be presented (ethnicity, ethnic context, suicidal behavior, emotional and behavioral problems, and substance use). The other variables such as sociodemographic characteristics (reindeer herding (Paper I), SES (Paper II and III), family structure (Paper II) and living arrangements (Paper III), type of education (Paper II and III)), eating behavior problems (Paper II), loneliness and hopelessness (Paper III), perceived pubertal timing (Paper III), sexual debut and involvement in romantic relationships (Paper II), and parent-child relationship (Paper II and III) are described in the respective papers.

6.4.1 Ethnicity

In Study I ethnicity was categorized according to four questions about Sami ancestry which were supplemented in the 1970-census forms in the selected areas (see Appendix): 1) Was Sami the first language spoken by the person? (Yes/no). 2) Was Sami the first language spoken by one of the person's parents? (Yes/no/don't know). 3) Was Sami the first language spoken by one of the person's grandparents? (Yes/no/don't know?). 4) Does the person consider himself or herself a Sami? (Yes/no/uncertain/don't want to answer). If the subject answered positively on one of the four questions he/she was categorized as Sami. The first three questions were considered to be of an objective character and the last question to be

more subjective. Tables 2a-d show the distribution of the answers to questions about Sami affiliation by county.

In Study II a broad set of measures was used to tap various aspects of ethnicity. However, in Papers II and III ethnicity was defined according to a set of objective measures. Maternal and paternal language and languages for each of the four grandparents were reported separately with alternatives "Norwegian", "Sami", "Kven", "Finnish", or "other" (write in). Similarly, the ethnicity of the parents (separately) was assessed with the same five answering options as for language. For all questions more than one language/ethnicity were allowed. Using the method described by Kvernmo & Heyerdahl (2003; 2004) these items were combined into one Ethnicity variable. Consequently, in Paper II and III adolescent were classified as Sami if one of the parents' ethnicity was reported as Sami or if one of the grandparents' or parents' languages was Sami (Kvernmo & Heyerdahl, 2003; 2004).

6.4.2 Ethnic context

In Study I (Paper I) the Sami population was divided into three groups regarding ethnic context. Ethnic contexts were classified according to the density of Sami within the municipality of residence (Aubert, 1978) and grouped into three categories: (1) Southern area, low density (< 25 %), (2) Coastal area, medium density (25 – 60 %) and (3) Sami core area, high density (> 60 %) of Sami. Table 1 show the communities included in the different ethnic contexts.

6.4.3 Suicidal behavior

The outcome variable in Study I (Paper I) was suicide registered by the Norwegian Causes of Death Register. Cases of suicide were identified by the International Classification of Diseases (ICD-10, codes X60-X84, Y87.0). Recoding from ICD-8 and ICD-9 was done accordingly.

In Paper II and III (Study II) the outcome variable was lifetime prevalence of suicide attempt which was measured with the question "Have you ever tried to commit suicide?". At T1 the response categories were "Yes" and "No", while at T2 the response categories were "No, never", "Yes, one time", and "Yes, several times". In Paper III this question was categorized as "Yes" and "No" in the analyses. Furthermore, in Paper III were those adolescents reporting suicide attempts at T1, and not at T2, categorized as "Early suicide attempters", whereas adolescents' reporting attempts both at T1 and during the study period (at T2) were categorized as "Repeating suicide attempters". Those adolescents who reported

their fist suicide attempt during the study period were categorized as "Late suicide attempters".

The question "If you answered "yes" on C, how long is it since you last time attempted suicide? ..... year ..... months", was used to make a distinction between attempts during the study period vs. attempts before T1.

Suicidal ideation (during the last six months) was measured by item 91 in Youth Self Report (YSR) (Achenbach, 1991) (described below) in Paper II and in Paper III at T1. At follow-up in Paper III suicidal ideation was measured by item 91 in Young Adult Self-Report (YASR) (Achenbach, 1997). The phrasing of item 91 in both studies was "I am thinking of ending my life". In the analyses the item was categorized as "Yes" and "No".

6.4.4 Emotional and behavioral problems

Assessment of emotional and behavioral problems was measured by YSR (Paper II and in Paper III at T1) and YASR (Paper III at T2). YSR is a self-report questionnaire for ages 11-18 years, consisting of 112 items describing a broad range of problems and recording problem behavior during the six months previous to assessment (Achenbach, 1991). The YASR has 130 problem items plus competence and socially desirable items that are scored on three-step scales like those of the YSR. Additional YASR items obtain data about work, school, marital and other relationships, and substance use (Achenbach, 1997). The informants are instructed to circle "0" if the item is *not true*, 1 if the item is *somewhat or sometimes true* and 2 if the item is *very often true*. Norwegian and Sami language versions of the YSR were applied at T1. Professional bilingual (Sami/Norwegian) translators had translated the YSR into Sami with an independent back translation. In Paper II only the syndrome scales Anxious/Depressed Problems, Delinquent Behavior and Social Problems were used, while the syndrome scales Withdrawn, Somatic complaints, Anxious/depressed problems, Social problems, Thought problems, Delinquent behavior and Aggressive behavior were used in Paper III. In both studies the items "I deliberately try to hurt or kill my self" (18) and "I am thinking of ending my life" (91) were removed from the Anxious/depressed YRS and YASR scales.

6.4.5 Substance use

In Paper II and III several different risk-taking behaviors were measured using single items from different scales such as Olweus' scale of antisocial behavior (Olweus, 1989) and National Longitudinal Study of Youth (Windle, 1990). The items used to measure cigarette

smoking, alcohol intoxication (T1 only) and cannabis use at T1 and T2 were identical to those used by The National Institute for Alcohol and Drug Research (SIRUS) and in "The Young in Norway" surveys (Wichstrøm, 1992). In addition, the item used to measure alcohol consumption at T2 was from YASR (Ashenbach, 1997).

Current smoking was measured by the question "Do you smoke?" with five possible response categories "I have never smoked", "I have never been a regular smokers and I don't smoke now", "I used to be a regular smoker, but I have quit", "Smoke, but not daily" and "I smoke, about.....cigarettes per day". In the analyses the question was categorized as "Yes" (daily smokers and occasional smokers) and "No"(never, experimenters and former smokers) (Spein et al., 2004) in both Paper II and III (T1/T2). Alcohol intoxication was measured by one question concerning the preceding 6 months; "Have you had so much to drink that you felt drunk?" in Paper II and Paper III (T1). The question was recorded on a 6-point scale ranging from "never" to "more than 50 times". In the analyses in Paper II the question was categorized into "Yes"(≥ 1 times/12 months) and "No", while in Paper III (T1) adolescents reporting that they had been intoxicated more than 10 times were categorized as "Frequent alcohol intoxication" in the analyses, as "Occasional" (1-10) and as "Never". In Paper III (T2) alcohol consumption at follow-up was measured by one question from YASR concerning the preceding six months; "In the past 6 months, about how often have you been drinking alcohol?". The question was recorded on a 6-point scale ranging from "never" to "more than 21 units/glass per week". Cannabis use was measured in Paper III at T1 by one question concerning the preceding 12 months; "Used hashish or marihuana?". The question was recorded on a six-point scale ranging from "never" to "more than 50 times". In the analyses the variable was categorized as "No" and "Yes". On the other hand, at follow-up (Paper III), the question "Have you ever used hashish or marihuana?" (yes/no) was used.

6.5 Ethical aspects

Study I was conducted in cooperation with senior researcher Tor Haldorsen, Institute of Population-based Cancer Research, Cancer Registry of Norway. Dispensation from the professional secrecy was initially given to the Cancer Registry of Norway by Norwegian Board of Health Supervision and renewed by The Directorate for Health and Social Affairs in 2002. In 2000 The Data Inspectorate gave their dispensation and renewed this in 2003. Common deadline for deletion given from the three institutions was 31.12.2006. Because register studies previously didn't require approval form ethical committee's in Norway, Study I was initially not approved by the Regional Medical Ethical Committee. However, since the

topic is of sensitive character, suicide is a rare phenomena and a study on suicide regarding to gender, age and cultural context may increase the risk of loosing anonymity on an individual level, Study I was presented for Regional Medical Ethical Committee of Health Region North (REK-Nord) in 2006. REK-Nord responded that this register study did not fall into their directive, but they appreciated being informed about the study.

Study II has been approved by REK-Nord and was permitted by the Norwegian Data Inspectorate, the Ministry of Research and Education, and the schools authorities of the counties and the municipalities, and of each school board. Written consent based on both oral and written information was obtained from every student.

6.6 Statistics

In Paper I the mortality of suicide in the Sami cohort was compared with that of the rural population within the same three counties in Northern Norway, weighted according to the number of Sami in each. Gender, five-year calendar periods and five-year age groups were used for computing reference rates. Expected values were computed by multiplying the person years in the cohort by the reference rates. Standardized Mortality Ratios (SMRs) were computed by taking the ratio of observed to expected cases of suicide, and if this ratio exceeded one, the Sami were said to have increased suicide mortality. For these estimates, 95% confidence intervals (95% CI) were computed, based on the assumption that observed cases follow the Poisson distribution.

In Papers II and III suicide attempters were compared to non-suicide attempters on all independent variables for Sami and majority adolescents separately (Paper II) and for different types of attempters separately (Paper III). In both papers two sample t-tests were used for the continuous measures and Pearson Chi-square tests for the categorical ones. Fisher's Exact Test was performed when the expected count was less than five in at least one cell. All variables that were significantly associated with suicide attempts in the univariate analyses were included in multiple logistic regression analyses for Sami and majority suicide attempters separately (Paper II) and for different types of attempters separately (Paper III). In the logistic regression analyses the outcome variable (suicide attempt) was coded as a dummy variable comparing subjects by the presence (0) or absence (1) of the characteristics (suicide attempt), yielding odds ratios (OR) and 95 % confidence intervals with values including 1.0 indicating no significant association. In Paper II the interaction of gender was first controlled for in the univariate analyses and then all the significant interactions effects were included in multivariate analyses. In Paper III the interaction of gender, age and ethnicity were controlled

for similarly. Finally, the significant main and interaction effects were included in the multivariate analyses, using "conditional forward" approach. Data analyses were performed with the current version of SPSS (13.0 in Paper II and 14.0 Paper III). Due to the stratification by ethnicity (Paper II) and suicide attempters (Paper III) (e.g. smaller sample sizes), the significance level was set to 5 % in all statistical tests.

7. RESULTS:

7.1 Paper I: "*Suicide among indigenous Sami in Arctic Norway, 1970-1998*"

In Paper I, suicide mortality between 1970-1998 was examined in a cohort of 19, 801 persons categorized as Sami in Arctic Norway. One of the purposes was to investigate suicide mortality stratified by age, gender, cultural context, and traditional Sami core management. The results indicated that there was a significant moderate increased risk for suicide among indigenous Sami (SMR=1.27, 95 % Confidence interval (CI):1.02-1.56) compared to the reference population. In the study period, 89 suicides occurred in the cohort (70 men and 19 women) with increased suicide mortality both for indigenous Sami males (SMR=1.27; 95% CI: 0.99-1.61) and females (SMR=1.27; 95% CI: 0.77-1.99). The results showed a significant increased suicide mortality among young Sami aged 15-24 for both males (SMR=1.82; 95% CI: 1.13-2.78) and females (SMR=3.17; 95% CI: 1.17-6.91). In addition, significant increased suicide mortality was found for indigenous Sami males residing in Finnmark county (SMR=1.50; 95% CI: 1.14-1.94), Sami core area (SMR= 1.54; 95% CI: 1.04-2.20) and for indigenous Sami males not belonging to semi-nomadic reindeer herding (SMR=1.30; 95% CI: 1.00-1.65). On the other hand, across gender, Sami belonging to semi-nomadic reindeer herding household did not have significant increased suicide mortality. Although no significant changes in male and female rates were observed over time periods during the study period, a higher relative risk of suicide was observed from 1981 to 1990 across gender compared to the reference population.

In conclusion, although the finding, of a moderate significant increased risk of suicide among Sami, is consistent with the general findings among indigenous, the suicide rates found among Sami is moderate compared to several others indigenous people. Consistent with findings among other indigenous young Sami males and females in the age group 15-24 years had significant increased risk of suicide. Furthermore, the significant increased risk of suicide found among Sami males in Sami core area may be explained by suicide cluster at the end of the 1980's.

7.2 Paper II: *"Suicide attempts among indigenous Sami adolescents and majority peers in Arctic Norway: prevalence and associated risk factors"*

The aim of Paper II was to examine the prevalence of suicide attempts and associated risk factors such as sociodemographic conditions, emotional/behavioral problems and parent-child relationships among 591 indigenous Sami and 2100 majority adolescents in Arctic Norway. There were no significant ethnic differences in prevalence of suicide attempts between indigenous Sami adolescents (10.5%) and their non-Sami peers (9.2%). On the other hand, it was significant gender differences in both ethnic groups. The gender differences were more pronounced among Sami adolescents, with females twice as likely to report a suicide attempt than males (14 % vs. 7 %). There were some common risk factors associated with suicide attempts across ethnic group, such as suicidal ideation, anxious/depressed problems and eating behavior problems. However, cross-cultural differences in risk factors associated with suicide attempts existed. For Sami adolescents, factors diverging from the traditional cultural norms were associated with suicide attempts, such as alcohol intoxication, single-parent home and paternal overprotection. Vocational studies, not living together with parents, current smoking and experienced sexual intercourse were ethnic specific risk factors associated with suicide attempts among majority peers.

It can be concluded that among adolescents in Northern Norway there are no ethnic differences in prevalence of suicide attempts. This finding is inconsistent with research from several indigenous peoples. In both ethnic groups there were significant gender differences and most pronounced among Sami adolescents. Sami females reported relative high prevalence of suicide attempts compared to their majority female counterpart and to a representative national sample. Ethnic specific risk factors associated with suicide attempts among Sami adolescents, can be characterized as diverging from the traditional cultural norms.

7.3 Paper III: *Risk factors associated with different types of suicide attempters: A longitudinal study among ethnic diverse adolescents in Arctic Norway*

The objectives of paper III were to examine variation in risk factors associated with different types of suicide attempters among ethnic diverse adolescents in a longitudinal perspective. The results showed that 10.4 % (n=155) of the adolescents in the follow-up sample had reported a previous suicide attempt at T1. Among these attempters at T1, 81.3 % (n=126) did not report a re-attempt during the study period (Early suicide attempters), whereas 18.7 % (n=29) reported a re-attempt at T2 (Repeated suicide attempters). On the other hand, 1.7 %

(n=24) reported a first attempt during the study period (T2) (Late suicide attempters). The results indicated that there were significant ethnic differences in the prevalence of previous suicide attempts at T1, with a higher prevalence of attempts among Sami adolescents than among their majority peers (14 % vs. 9.3 %). However, the significant ethnic difference was only found among females and may be due to sample characteristics at follow-up. An important finding in this paper was the diverse patterns of associated risk factors and prognosis that were found between the attempters. Repeating attempters constituted a high risk group compared to early and late attempters. There were also ethnic-specific associations with suicide attempts such as Anxious/depressed Problems, Sami ethnicity and female gender found at T1, and having become a parent with Sami ethnicity and female gender found at follow-up.

In conclusion, this longitudinal study revealed diverse patterns of associated risk factors and prognoses for suicide attempters, especially with respect to level of emotional/behavioral problems and substance use. Although an important finding from this study was that repeaters had long-term emotional and behavioral problems, all types of suicide attempters should be taken seriously and given appropriate treatment.

8. DISCUSSION

In this discussion section the main focus will be given to selected topics not discussed entirely in the presented papers.

8.1 Discussion of design and methods

8.1.1 Strengths:

Since there is no registration of ethnicity in the national population register in Norway, register based study, like Study I, is an appropriate alternative method for obtaining information, such as for suicide among Sami. According to Gjertsen (2002b), the National death register in Norway is a reliable source of gaining information about cause of death. Furthermore, since the incidence of suicide in general is rare, the long study period, 1970-1998 and the sample size, approximately 20 000 persons in the cohort, enhanced the reliability of the findings. However, because the Sami population becomes small when divided into gender, age and ethnic context, even a single suicide can have dramatic effect upon the calculated rates. Consequently, although the long study period and a relatively huge sample size may have decreased the risk of statistical artificial results, the results must be interpreted with caution.

Anonymous self-report has been found to be a good method for collecting information of such a sensitive nature as suicidal behavior (Hawton, Rodham & Evans, 2006). In a review article of the international literature on studies of suicidal and deliberate self-harm phenomena in adolescents the authors concluded that reported prevalence figures for these phenomena are higher in studies employing anonymous questionnaires compared with interview-based studies (Evans et al., 2005). This finding supports the notion that the higher the perceived anonymity of responses, the fewer tendencies there is towards socially desirable responding (e.g. Embree & Whitehead, 1993). Consequently, a questionnaire may reduce the obsequiousness bias (Clever Hans bias). The tendency that subjects systematically alter their responses in the direction they perceive to be desired by the investigator or interviewer (Gertsman, 1998). Moreover anonymity is of a special significance in adolescence and anonymous questionnaires have been found to be particularly suited to collecting information of a sensitive nature from adolescents (Hawton et al., 2006). A literature review of adolescents self-reported suicide attempts found that lifetime prevalence of attempted suicide is reported about two to three times more often under conditions of anonymity (3-4 % using structured interviews in epidemiological studies vs. 7-10 % using anonymous questionnaires) (Safer, 1997). Although The Norwegian Youth Study not is an anonymous study per se, there are several advantages with the confidentiality in the study, compared to an interview situation, which makes it suitable to collect sensitive data such as suicidal behavior.

As mentioned in the introduction section, there is no official data on suicide attempts in Norway. One important reason for this is that the majority of suicide attempters never contact mental health services (e.g. Grøholt et al., 1997), and consequently, the hospitalized attempters only represent the tip of the iceberg (Diekstra & Garnefski, 1995). For this reason studies conducted on a community level will give a more accurate representation of the prevalence of suicide attempts compared to studies based on hospital admissions. Since the North Norwegian Youth Study was a community–based individually questionnaire study and reached a large sample of adolescents, the findings in Papers II and III may give a representative picture of the prevalence of suicide attempts in adolescence during the 1990's.

Another advantage with Study II is the longitudinal perspective (Paper III). The majority of research on risk factors for suicidal behavior in suicidology is based on cross-sectional studies. A longitudinal study like the North Norwegian Youth Study has a major advantage, e.g. to examine the risk factors and life pathways associated with the development of suicidal behavior and other mental health outcomes in adolescence and young adulthood.

8.1.2 Limitations:

Conducting research on a rare phenomena such as suicidal behavior in a population estimated to be approximately 40 000 - 70 000, has several methodological considerations. First of all, small samples affect all three papers, such as Sami sub-samples in Papers I and II and different types of suicide attempters in Paper III. For example in Paper I the number in each cell becomes extremely small when exploring for within group differences among Sami stratified by gender and age. Furthermore, the associations between risk factors and suicide attempters (Papers II and III) could be accidental because of the small number (*n*) and too many independent variables. An examination of a large number of risk factors implicates an increased danger of Type I error (false positive results). On the other hand, the problem with small sample size can minimize the true effects or Type II error (false negative results). However, small sample size is a well-known challenge in research among minority groups. Furthermore, an important limitation with Paper III is the lack of longitudinal analyses. Multilevel analyses could have been a better approach to utilize the potential in the data.

An important consideration in this thesis is the classification of Sami ethnicity. Although ethnicity, ethnic group or ethnic self-labelling are basic sociodemographic variables used in epidemiological research (Senior & Bhopal, 1994), both measurement and definition of ethnicity is a demanding aspect in research among culturally diverse populations. According to Bhopal (2002: 283) "the concept of ethnicity is that human beings identify themselves as belonging to a group because they differ culturally in fundamental ways including language, food, religion, lifestyle and, geographical origins". This illustrates that ethnicity is a complex and dynamic phenomenon, with many potential components. In addition definitions of ethnicity is influenced by time and place/context.

There is no official registration of ethnicity in the population register of Norway. After Second World War there was a general norm that ethnicity and race should not be registered in official statistics in Norway (Pettersen, 2006). Furthermore, as a consequence of the assimilation process in Norway Sami ethnicity became a stigma that led many Sami to suppress their affiliation (Bjørklund, 1986). Through history several different inclusions criteria for Sami ethnicity have been used in the census' in Norway (Pettersen, 2006), and, unfortunately, a superior interdisciplinary discussion seems to be lacking. At present there are no official criteria for how to define Sami ethnicity or identity in Norway.

In Paper I a combination of objective (ethnic ancestry and language competence) and subjective criteria (ethnic self-identification) were used. These criteria are in accordance with the Sami electoral register (Agenda, 2002). On the other hand, in Paper II and III objective

criteria without ethnic self-identification were used. However, in the present papers a rather broad set of criteria was used to define Sami ethnicity. Consequently, a subject could actually be categorized as Sami on the basis of only one objective criteria, e.g. if one of the grandparents spoke Sami. There are several arguments for choosing this kind of categorization. As a consequence of assimilation and discrimination, many Sami avoid reporting their Sami background. Therefore, classification based on self-reported ethnicity is shown to be misleadingly low. However, reporting language competence is not considered to be as stigmatizing as ethnic background (Høgmo, 1986). In the census from 1970 this phenomenon can be illustrated in Tables 2a and 2d that show the distribution of the answers to questions about Sami affiliation by county. A higher prevalence of persons in Troms (4.6 %) and Finnmark (12.6 %) reported that Sami was their mother tongue (Table 2a), but not all of these reported a subjective Sami affiliation (3.2 % and 11 %, Table 2d). There are very few non-Sami who speak Sami, therefore language competence and parents' ethnicity together are considered to be the most reliable measure of Sami ethnicity (Aubert, 1978; Høgmo, 1986; Kvernmo & Heyerdahl, 1996). Furthermore, about half of the participants (53 %) in Nordland County did not answer the questions about Sami background (Tables 2a-d). This may indicate that Sami affiliation was a sensitive topic in Nordland County at that time. Or, others may not have answered all the questions because of lack of knowledge about their ethnic ancestry. As can be seen from Table 2c about 6 % of the total study population (N=113,874) in the selected census tracts did not know if Sami was the first language spoken by at least one of the grandparents. This could also affect Study II, since the question regarding ethnic affiliation and language competence among parents and grandparents were only assessed from the adolescents.

However, most importantly in this regard is that the type of categorization used in this thesis can be considered to be broad and unspecific. Consequently, a broad definition will result in a sample of "Sami" which vary from mono-ethnic Sami to almost Norwegian. This may have serious implications for our results. For example, a broad definition may result in misclassification and subsequently reduce the differences between the groups making them almost identical. In The SAMINOR study, a population based study of health and living conditions in areas with mixed Sami and Norwegian population conducted in 2003-2004 (Lund et al., 2007) a graded definition of Sami ethnicity was used: I) Sami language spoken by all grandparents, parents and respondents (3 generations), II) at least two Sami-speaking grandparents, and III) at least one Sami identity mark (language, self-perceived ethnicity or family background). According to Lund and colleagues (2007) the stringent definition of

category I produced clearer differences between Sami and Norwegians, hence reducing the risk of misclassification. However, conditions such as small sample size and research on low prevalent phenomena (e.g. suicidal behavior) make it inappropriate to use a stringent definition such as category I. In conclusion, at present there are several possible ways to categorize Sami ethnicity and criteria for ethnicity categorization will be influenced by research topic and methodological considerations.

In Papers II and III the outcome variable was lifetime prevalence of suicide attempt, measured by the question "Have you ever tried to attempt suicide?" ("Har du noen gang forsøkt å ta ditt eget liv"). Since the response categories only were "Yes" and "No" (at T2 "No, never", Yes, one time" and, "Yes, several times"), we have no concrete information of the reported attempts. This is a serious limitation influencing the internal validity (information bias) of our outcome variable in papers II and III. Furthermore, although the term used in papers II and III "...tried to end your own life" ("*...forsøkt å ta ditt eget liv*") implies that death (e.g. suicide) was the intended outcome, a serious limitation is the lack of information concerning attempters actual intent (e.g. to die, seek attention, reduce pain etc.) and also the lethality of the attempt. Our reliance on self-report limited our ability to assess the seriousness of reported suicide attempts and even more important to differentiate between suicide attempts and deliberate self-harm. Self-report questionnaire responses have been found to fail to reveal any overlap between deliberate self-harm and suicide attempts (Safer, 1997). Consequently, Papers II and III would have increased their methodological quality if the specificity of the outcome variable had been increased. To overcome this kind of problems Hawton and van Heeringen have proposed that "A standardization of criteria for identification of deliberate self-harm, including subcategories of types of acts, would be another important step that could lead to improve data for such use in epidemiological and other research approaches" (2002: 716). The Child and Adolescent Self-harm in Europe (CASE) Study is one good example of how it is possible to increase the internal validity (Hawton et al., 2006). In the CASE Study adolescents were asked to describe in their own word what they had done to themselves (for a description see Hawton et al., 2006). Subsequently the researchers could determine whether what the adolescents considered to be self-harm actually met the predetermined criteria for deliberate self-harm.

Papers II and III were based on data from questionnaires. Self-reported questionnaire is in general vulnerable for recall bias, and sensitive information may be even more exposed for this bias. Recall bias is the form of bias that appears when self-reported, historical information is inaccurate (Gertsman, 1998). This bias may influence Papers II and III in many

respects. However, most important in this regard is the self-report of suicide attempts. As reported in Paper III a high percentage of suicide attempters at T1 (72 %) did not report their previous suicide attempt at T2. There may be several possible explanations for this underreporting of retrospective self-report data, such as reinterpretation, shame, lack of honesty and the severity of the suicide attempt itself. Due to long the follow-up period in our study (average 36 months), adolescents may not remember or may minimize the significance of the previous attempt. Suicide attempts may also be perceived as a sign of weakness and as a feminine act, something which could make males more vulnerable to underreporting suicide attempts (Canetto & Sakinofsky, 1998). However, underreporting among males is considered to be a minor problem in anonymous questionnaires (Wichstrøm & Rossow, 2002).

Neither the YSR nor the YASR have been standardized with either Sami or Norwegian populations. The use of assessment instruments that are translated and/or adapted from an original language and culture to a new one can entail problems, primarily with respect to equivalence (translation, conceptual and metric) (Brislin, 1993; Okazaki & Sue, 1995). Due to respondent feedback slight linguistic revisions were made to the Sami version. YSR have been used previously in studies among Sami and Norwegian adolescents (Heyerdahl, Kvernmo & Wichstrøm, 2004; Kvernmo & Heyerdahl, 1998). Reliabilities for the instruments for both Sami and majority groups were satisfactory in this survey both for YSR (Cronbach's $\alpha \geq .65$) (Heyerdahl, Kvernmo & Wichstrøm, 2004; 1998) and YASR (Cronbach's $\alpha \geq .75$). However, the findings from YSR and YASR must be interpreted with caution.

Cross-sectional design can never document a causal relationship e.g. between risk factors and suicide attempts. Hence, the use of the term risk factor in Paper II and III may be misleading. A *risk factor* can simply be explained as a factor that is thought to cause the disease in question (Gertsman, 1998). In epidemiology, a causal factor is any event, condition, or characteristic that increases the likelihood of a disease, all other things being equal. The term risk factor could have been replaced with the more proper term *risk indicator*, a factor that is statistically associated with a disease but has not yet been proved to be causal (Gertsman, 1998). However, all the associated risk factors found in our study are all well documented risk factors for suicide attempts, indicating that they after all are significant risk factors somehow. On the other hand, not knowing whether or not risk factors were temporally antecedent to the onset of suicidal behavior, they could be either *consequences* (variables present *after* but not before the attempt), *triggers* (variables present *before* but not after the attempt), or *markers* (variables present before and after the attempt) for suicide attempts.

Initially Study II focused on three ethnic groups in Finnmark; Sami, Kvens (descendants of Finnish-speaking immigrants from northern Finland and Sweden who settled in northern Norway in the 1700s and 1800s) and Norwegians. Since this investigation had a special focus on indigenous Sami, Kvens and Norwegians adolescents were taken together in one group and categorized as majority (Paper II) or non-Sami (Paper III). There is found a strong similarity between the Kven and Norwegian group, according to cultural and behavioral problems (Kvernmo & Heyerdahl, 2003, 2004). However, the term "majority" used in Paper II is misleading and could have been replaced by non-Sami.

Another serious limitation with this investigation is the lack of focus on the influence of acculturation and cultural factors on suicidal behaviour among Sami in Paper II and III. The North Norwegian Youth Study included comprehensive ethnic and cultural measures, such as The Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992) and a measure of acculturation strategies (Berry et al., 1995). However, the main reason for not examine the influence of acculturation and cultural factors in Paper II and III was because of the small numbers within the Sami group, that made it impossible to run reliable analyses concerning the association between cultural factors and suicide attempts within the Sami group.

Unfortunately, there were no questions regarding a history of sexual and/or physical abuse in the Study II questionnaire. Several studies have found a strong association between a history of physical and/or sexual abuse during childhood and suicide attempts (see Beautrais, 2000). Furthermore, physical and sexual abuse have been found to be independently associated with repeated suicide attempts when controlling for the effects of other childhood adverse factors (Ystgaard et al., 2004). Hence, inclusion of central topics such as physical and sexual abuse would have given an important contribution to the understanding of risk factors associated with suicidal behavior among adolescents in Northern Norway.

Finally, another limitation with this study is the lack of focus upon protective factors or resilience. In general, research in suicidology is dominated by discussions of risk factors, and much less focus has been given to protective factors and potentially moderating co-variables (De Leo, 2002). However, concerning suicidal behavior among Sami, it is of special interest to documented possible protective factors. Much of the focus given to indigenous has been of an overwhelming negative character, which may contribute to increase negative stigmatization of indigenous group. Furthermore, to prevent suicidal behavior among Sami it is also important to focus on factors that protect against the development of suicidal thinking and translation of such thoughts into suicidal acts.

In conclusion, these considerations and limitations implicate that the results may be unreliable and that results in presented papers have to be replicated to confirm their reliability.

8.2 Sample representativity

The Sami cohort in Study I did not include all people of Sami ancestry in North Norway, and even some Sami who were living in the census wards did not participate. In the areas covered by the study, some Sami, for example, may have disapproved of the questions about ethnic background because they perceived them to be controversial or sensitive. For example in Nordland County about half of the participants (53 %) did not answer the questions about Sami background (Tables 2a-d). Furthermore, others may not have answered all the questions because of lack of knowledge about their ethnic ancestry. As can be seen from Table 2c about 6 % of the total population (N=113,874) in the selected census tracts did not know if Sami was the first language spoken by at least one of the grandparents. In addition, in some areas the counters did not distribute questions regarding Sami affiliation because they considered the topic to be sensitive (Aubert, 1978). Underreporting of Sami origin is therefore possible (Aubert, 1978).

It is also important to have in mind that dramatically changes have taken place in several Sami areas since the census was conducted, in 1970 (Aubert, 1978). Since the revitalization process started among Sami in Norway, the ethno political debate and revitalization have taken different forms at different times all over Sampi. The process started in Sami core area three decades ago and today there is an ongoing revitalization process in several Sami areas all over Norway. Furthermore, in computing the local reference rates, we were not able to exclude the Sami people, so our estimates of the relative risks for Sami people could well be slightly biased towards unity. However, we presume that those categorized as Sami in this study, in one or another way, have an affiliation to Sami culture, in contrast to those who did not report any Sami affiliation.

Approximately 10 % of the Sami population in Norway is occupied in reindeer herding (2, 900) with slightly more men than women (Jernsletten, 1986). In contrast to the situation in Finland, the right to breed reindeers in Norway and Sweden is restricted by law to Sami (Reindeer husbandry act, 1978). Among persons categorized as belonging to reindeer herding household in the cohort, about every body had Sami language as their mother tongue (99.5%) (Aubert, 1978). In the census 1,604 people were registered as belonging Reindeer herding household (Aubert, 1978). The majority of these came from Finnmark county: Kautokeino (n=858), Karasjok (n=455), Porsanger (n=80), Tana (n=40), Nesseby (n=28). In

addition all the reindeer herders south of Bodø were not included in the census. Thus the population belonging to reindeer herding household in Study I is primarily representative for Finnmark County.

The census covered about 90 % of the total population in Finnmark, 23 % in Troms and 6 % of the population in Nordland. According to Aubert was the census tracts selected on the basis of available information on where one might expect to find persons with Sami language or ancestry (1978). The investigated cohort cannot be considered representative for all Sami in Northern Norway. Only 4.5 % (n=890) of the analysed cohort were from Nordland and 24.5 % (n=4847) from Troms. Furthermore, Sami who live in Southern Norway or urban areas in Troms and Nordland fell outside the scope of the census. In conclusion, these considerations are implicating that the findings from Paper I are merely representative for Sami in Finnmark (71 %, n=14,064 of the cohort). However, at presence the census is the best available data source to explore suicide in a larger Sami population.

In Study II (papers II and III) suicide attempts were studied among ethnic diverse adolescents in the age group 16 to 22 years. These adolescents in Study II were recruited from high schools from rural areas in Northern Norway. All high schools in Finnmark were included except for one, whereas for Troms and Nordland every high school in the southern and northern areas of the counties was included. The selected areas in Troms and Nordland were chosen to obtain representative samples of the ethnic groups in northern Norway. The sample in Finnmark is representative of the total population of high-school students in the county, whereas for Troms and Nordland the sample is representative of high-school students from the ethnic groups living in multiethnic areas. The sample of Study II cannot be considered representative of all Sami adolescents because south Sami adolescents living outside Northern Norway were not included. Adolescents who had not attended high school or had dropped out were not included in the sample of Study II, and may represent a risk group for maladjustment. However, in Norway, 96 % of the total adolescent population is proposed to attend high school, and even higher rates are assumed after Reform-94 (Wichstrøm, Skogen & Øia, 1996). Study II was conducted in Nordland and Troms after the Reform-94 was introduced. With its high response rate, this sample in Study II can be considered representative of the adolescent population in semirural areas in northern Norway. As no urban schools are included in the study, and only a few individuals coming from urban areas are included, the sample cannot be claimed to be representative of the urban youth population in Northern Norway.

Those adolescents who were lost to follow-up (Paper III) were at T1 significantly more likely to report male gender, non-parental living arrangements (e.g. relatives, foster parents or boarding school), attend vocational studies, report being current smokers and use cannabis during the last 12 months, report less somatic complaints, emotional problems, hopelessness and loneliness, and report more social problems and delinquent behavior. There were no significant differences between follow-up respondents and non-respondents regarding lifetime prevalence of suicide attempts at T1. However, since non-respondents (T2) tend to be characterized with several risk indicators at T1, including non-parental living arrangements (e.g. relatives, foster parents or boarding school), attending vocational studies, being current smokers, ever using cannabis, and having higher mean scores on Social Problems and Delinquent Behavior, the absence of these adolescents in the study may have resulted in an underestimation of the number of suicide attempts during the study period. On the other hand, the non-respondents at T2 had less Anxious/depressed Problems which are a well-known risk factor for suicide attempt. This group may therefore not represent a high risk group for suicidal behavior. In conclusion, the response rate was good in Study II and this probably results from the fact that parental consent was not necessary, from the high motivation for the study among the teachers conducting it and because the topics covered in the study dealt with broad aspects of adolescents' lives and were not exclusively problem oriented.

8.3 Discussion of some selected findings

- The significance of living conditions and cultural context in indigenous suicide
- Why are young indigenous males especially vulnerable to suicidal behavior?
- Suicide cluster in Sami core area

8.3.1 The significance of living conditions and cultural context in indigenous suicide

In the context of indigenous suicidal behavior socio-cultural factors and socioeconomic conditions are important risk indicators. The high prevalence of accidental and violent deaths (including suicide, homicide, and family violence) found among indigenous can be attributed to both social and economic factors, and can according to Young (1994) reflect the wide gap between indigenous and non-indigenous in socioeconomic indicators such as income, housing, social assistance, and child care. These assumptions are consistent with general findings in suicidology that report increased risk of suicidal behavior among individuals from socially disadvantaged backgrounds characterized by such features as low socioeconomic status and income, limited educational achievement, and poverty (e.g. Beautrais, 2000). In

view of indigenous suicide it is necessary to have an understanding of the historical and cultural context in which the problems are located (Hunter & Milroy, 2006).

During relatively few decades the suicide rates among several indigenous people have increased rapidly from being a relatively rare phenomenon to be of an epidemic character. One of the proposed underlying causes for the increased suicide rates among indigenous people are "the enormous social and cultural turmoil created by the policies of colonialism and the difficulties faced ever since by indigenous peoples in adjusting and integrating into the modern-day societies" (WHO, 2002: 190). No indigenous settings are unaffected by the process of rapid social changes due to colonization and modernization (Hunter & Milroy, 2006). In this process of change many indigenous people lost their roots, their beliefs, and their value systems very quickly, and this led to a loss of self-worth, to diseases of self-neglect, and to suicide (Ferry, 2000). The situation found among indigenous is in accordance with Durkheim's classic theory, proposing that anomic suicide increases during periods of social change (Davenport & Davenport, 1987). According to Durkheim's theory anomie refers to situations where changes take place too fast, leading to rejection of existing norms before new norms are generally accepted and internalized (Bille-Brahe, 2002).

On the community and family life level the rapid social changes can lead to instability, which have severe consequences such as dysfunctional homes e.g. due to increased alcohol consumption and domestic violence, high rates of crime, delinquency and imprisonment (Hunter & Milroy, 2006; Young, 1994). Another factor contributing to poor parental care among some indigenous people is the extended use of boarding school, one of many strategies used in the forced assimilation process of all indigenous peoples in western countries. According to Hunter and Milroy the most vulnerable within the changing social and family structures among indigenous were the children (2006). Those dying by suicide among indigenous in Kimberley, Australia, since the mid- 1980s have been teenagers, the child of parents who experienced the rapid social transformations of deregulation as young adults (and new parents) (Hunter, 1999). The characteristic of these young indigenous is that they belonged to the first generation that had been raised in communities and families affected by normative instability.

Historical and structural factors have important implications for the present socioeconomic status and living conditions among indigenous people. Accordingly, these circumstances will generate diverse health conditions and socio pathologies among indigenous, which subsequently will influence their respective suicide rates. In this respect, suicide can be considered as an indicator of distress in indigenous populations (Kirmayer et

al., 2000). Among some indigenous groups the cumulative effect of the colonization and assimilation policies is so terrible that it has been described as cultural genocide (Kirmayer et al., 2000; Leenaars, 2006). Although the assimilation policy towards Sami in Norway also was strong, the process can not be considered as genocide. Today the socioeconomic status and living conditions among Sami in Norway is considerable different from the situation found among several other indigenous groups. Although, the socio-economic status in most Sami areas is at the lowest national level with regard to income, educational level and employment (Statistics Norway, 2006), the gap in living conditions between Sami and their majority population residing in Northern Norway has decreased after the Second World War. During the last three-four decades, a process of integration and increased cultural revival has gradually replaced a history of forced assimilation and colonization among Sami in Norway (Kvernmo, 2006). Although, the outcome of the acculturation and the ethnic revitalization processes has varied in different regions inhabited by Sami, generally speaking, Sami have, to a greater extent, achieved cultural equality and are less socially disadvantaged when compared to other indigenous people. According to the relatively few studies on the health situation in the Sami population, there is so far no evidence of a more disadvantaged health status. Compared to the majority population studies have shown less alcohol use among Sami adults and adolescents (Larsen, 1993; Kvernmo et al., 2003; Spein, Sexton & Kvernmo, 2006), similar rates of mental health problems, smoking and sexual risk taking behavior for adolescents (Kvernmo et al., 2003; Heyerdahl et al., 2004; Spein et al., 2002), equal or lower rates for infectious and cardiovascular diseases (Njølstad, Arnesen & Lund-Larsen, 1998; Tverdal, 1997; Utsi & Bønaa , 1998; Thelle & Førde, 1979). This picture differs with that for several other indigenous populations worldwide.

On a general level the moderate rates of suicidal behavior found among Sami (Paper I) are consistent with the hypothesis about cultural continuity proposed by Chandler and colleagues (1998; 2003). In their studies among First Nations peoples in British Columbia, the influence of social and cultural change on the individual's continuity of a sense of self was found to explain the variability in suicide rates. Cultural self-continuity, "...the ways in which these young persons undertake to construct and defend a sense of identity that allows them to survive as continuous or numerical identical persons despite often dramatic individual and cultural change", was found to be associated with low rates of youth suicide (Chandler & Lanlonde, 1998: 213). In their study markers of cultural continuity and degree of local social and political control, were measured along different dimensions, such as land claims, self-government, education services, health services, cultural facilities and police and fire services.

They found an additive effect of these cultural factors, indicating that when the indicators presence in the community increased, the suicide rates decreased. Generally, Sami in Norway have had the opportunity to experience cultural continuity and have now also received relatively high degree of local social and political control, compared to other indigenous that are living on reservations or in worst case still experiencing genocide. According to Chandler and colleague's hypothesis, it could be expected that Sami had relatively low suicide rates, which is consistent with the findings in Paper I (suicide rates for men and women in the study period, 28.5 and 8.4 per 100 000 p.y.).

Ethnic differences in suicide rates may stem from variations in the exposure to risk factors between the groups under study, or in the availability of protective factors, or the pattern of responses to either (Taylor Gibbs, 2005). The increased risk of suicidal behavior among indigenous people can to some extent be explained by the high prevalence of general risk factors, such as substance use, mental health problems, sexual abuse and family violence. It appears that the high rates of suicidal behavior among indigenous people may be an expression of the accumulation of risk factors across a variety of domains, rather than a single all-important determining factor. Kaslow and colleges (2000) applied a cumulative risk model among female African American suicide attempters and found that four or five risk factors increased the likelihood of making an attempt threefold and six or more risk factors increase the risk tenfold. Hence, the cumulative model seems to be an appropriate explanation for the high rates of suicidal behaivor among indigenous people.

In conclusion, in several indigenous groups the socioeconomic status and living conditions are different from the majority population, making it easier to reveal ethnic differences. Consequently, high suicide rates among indigenous can be explained by factors such adverse socioeconomic status and living conditions, rather than ethnicity per se. Conversely, the moderate prevalence of suicide attempts and suicide mortality found among Sami in Norway may to some extent be explained by cultural continuity and socioeconomic circumstances, and subsequently lower prevalence of general risk factors.

8.3.2 Why are young indigenous males especially vulnerable to suicidal behavior?

Suicidal behavior among indigenous is mainly a problem among young people, and especially among young males. Several hypotheses have been proposed to explain the alarming suicide rates among young indigenous males following the colonization and modernization process, such as disruption in gender role and upbringing (Wexler, 2006; Kirmayer et al., 2000). According to Kirmayer and colleagues, high prevalence of suicide among indigenous males,

fit with the perception that there has been greater disruption of traditional roles for indigenous males, resulting in profound problems of identity and self-esteem, and increased vulnerability for self-destructive behavior (1998, 2000). Similar to other indigenous groups Sami culture had previously a traditional gender role pattern. Generally speaking indigenous males had responsibility for hunting and fishing subsistence activities, whereas females did primarily childcare and household. Although the transition from a traditional way of living to modern Westernized way of life has influenced both genders, the changes have affected the male gender role more radically (Wexler, 2006). In several indigenous societies there have been radical changes in the traditional core management such as fishing, hunting and reindeer herding. A quotation of an elder Inupiat in Northwest Alaska may illustrate this dilemma "What is left for those (young males) to feel like a man? They were traditionally the caretakers of the family, now things are really changing. They no longer feel they are caring for their families. Subsistence is really important for men to feel like they are contributing. It gives them a place" (Wexler, 2006: 2943). In contrast, indigenous females have had more continuity in their gender role, with respect to giving birth to children, responsibility for child-rearing and household. These changes in gender roles or lack of social roles may make males more vulnerable to frustration and meaninglessness, and subsequently increased risk for substance abuse, depression, hopelessness and cultural alienation. All well-documented risk factors for suicidal behavior.

Several studies have documented the significant influence of parent-child relationships and suicidal behavior (see Beautrais, 2000). Traditional Sami child-raring values are in many respects similar to that found among other indigenous that encourages independence, autonomy, hardiness and closness/love (Javo et al., 2003). An interesting matter in this regard is hardiness, the ability to be psychologically strong and be able to endure stress and frustrations in order to survive in a tough outside world. "Nárrideapmi" (teasing) is a child-rearing technique used to reinforce independence training and make the child hardy by teaching it self-control (Javo et al., 2003). Through "nárrideapmi" the child develop its verbal ability which helps them to control their anger, temper outbursts, vulnerability, aggression and shame (Balto, 1997). Simplified this technique is implicit fostering the expectation and cultural norm that you should control your emotions, not let anybody knock you off your perch and to cope with difficulties. This upbringing technique is also an effective method to maintain traditional gender roles (Balto, 1997). In general, the cultural norm is expecting that Sami males don't express emotions or behave "feminine", and that females should not be naughty. Furthermore, in traditional Sami child-rearing independence implicates the ability to

think for oneself and to manage on one's own, with minimal need for help from others (Javo et al., 2003). The characteristics of male gender role described among Sami are consistent with tendencies found among other indigenous groups. For example, among Inuit in Nunavik, Canada, a cultural pattern of emotional restraint and reluctance to disclose distress were found among males, and in addition the tendencies for males to express distress through conduct problems and substance use (Kirmayer et al., 1998).

Although the living conditions have changed radically, the ideal to be "garra almmái" (a tough/hard man), who survive in a wild and harsh environment/climate, is still present in Sami culture (Balto, 1997). There is no doubt that independence is a required or adaptive ability in a harsh and tough climate. However, in a culture undergoing radical changes a traditional male gender role may constitute a static and less "functional" role today (similar to the majority male gender role). An interesting question in this regard is under which circumstances is it accepted for males to seek help or express their vulnerability without being characterized as feminine or "weak". Borowsky and colleges have proposed that American Indian and Alaska Native cultures emphasis on male strength and control may provide strong disincentives for male youths to disclose problems and obtain needed help (1999). A cultural norm telling young indigenous males to manage on their own without help from others, may give the impression that suicidal behavior, substance abuse and drop-out of school are personal tragedies or problems, that the individual should be able to cope with. Rather these social pathologies should have been considered as public health problems and not isolated private matters. Wexler has called attention to the importance of an collective consciousness among indigenous regarding "an understanding of how colonization began and continues today puts the villages' problems into a historical context and provides youth with concepts to better understand and respond to their experiences" (2006: 2946). Social support is expected to have a direct impact on adolescent development and well-being, and, in addition, family and peer relationships may also constitute important buffers against the impact of stressful life events (Aro, Hanninen & Paronen, 1989; Ystgaard, Tambs & Dalgard, 1999). However, if the cultural norm is telling young indigenous males not to communicate their problems, which negative implications will this have for their help-seeking behavior and subsequently degree of social support received?

In conclusion, high suicide rates among indigenous males can both be interpreted as a communication of a collective despair of hopelessness and/or powerlessness, and as an individual way of coping with overwhelming social pathologies. The high rates of suicide found among young Sami males is consistent with pattern found among other indigenous

people. This may be explained by the fact that indigenous male gender role have been more vulnerable in the process of rapid social changes and modernization compared to their female counterparts. However, irrespective of gender, suicidal behavior among young indigenous should be a public health concern and not merely considered as a private problem.

8.3.3 Suicide cluster in Sami core area

During summer 1987 five young males died by suicide in a small community (2666 inhabitants) in the Sami core area (Dagbladet, 1987). They all lived in the same village and some of them were even close friends. The same year, all together eight males in the study cohort from Sami core area committed suicide, and they accounted for about 27 % of all suicides among males in Sami core area during the study period 1970 – 1998 (Paper I). The suicides were a great trauma and loss for the bereaved and the whole community. The tragedy was given much attention at the local level, and subsequently health services and prevention strategies were established. Unfortunately, the cluster of suicide was exposed in local and national media. As a result the village became a well-known place all over Norway, and a common opinion about this being a "suicide-village" and a stereotypic myth about the "suicidal Sami" was established.

The suicide cluster referred to in Paper I has not been analyzed statistically to distinguish significant elevations from random fluctuations within a larger study period. However, there should be no doubt that those five suicides during summer 1987, or eight suicides throughout the whole year, occurring in a small population of 2666 inhabitants, constituted a suicide cluster. Another condition confirming the hypothesis of a suicide cluster is the diverse suicide rates in Sami core area. Although there are some diversity in historical and cultural context within Sami core area, we could expect to find comparable suicide rates between the different villages. While one village had extremely high suicide rates at the end of 1980's, and totally over 30 suicides during the last three decades (Eikeland, 2003), there are almost no registered suicides in a neighbour village during the same time period. Furthermore, recently another village (3000 inhabitants) experienced three suicides during eight weeks during summer 2005. This pattern is consistent with findings from indigenous in Australia, "there appearing to be overlapping "waves" of suicides, suggesting a condition of community risk that varies by location and time" (Hunter & Harvey, 2002: 19). In the following discussion some general factors that may have influenced the clustering that took place will be explored.

First, clustering of suicides is more common among adolescents and young adults (Gould et al., 1990a). In a study based on analysis of US national data for 1979-1984 by Gould and colleges, found that clusters of suicide were rather rare and that it occured primarily among teenagers and young adults (15-19 and 20-24 year olds) (1990a). The relative risk of suicide for those exposed to an index suicide has been shown to be 2-4 times higher in 15-19-years-old that in older age groups (Gould, Wallenstein & Davidson, 1989). As mentioned in the introduction section, clustering of suicides is one of the common characteristics concerning suicide among indigenous people. Since clustering is more common among adolescents and young adults, it has been proposed to occur to a greater extent among indigenous people due to their generally higher proportion of young people (15 to 24 years) compared to majority populations (Wissow et al., 2001; Clarke et al., 1997). In the US this age group comprises 18 % among the indigenous and 14 % among the non-Indigenous, for Australia 21 % of indigenous and 15 % among non-indigenous (Stevenson et al., 1998). A similar distribution is found among Sami in Norway (Nystad, 2003; Aubert, 1978). For example, in 1974 61 % of the population in Kautokeino was under 30 years compared to the average national level of approximately 47 %. In 1999 it had decreased to 48 % vs. 39 %, in Kautokeino and average national level, respectively (Nystad, 2003).

Contagion is a factor that has been proposed to explain the appearance of suicide clusters among adolescents and young adults (Johansson, Lindqvist & Eriksson, 2006). Initially, the term contagion is somewhat misleading. Suicide is not a contagion disease in a medical manner, but a suicide can have fatal influence on other vulnerable persons in risk of suicidal behaviour (Gould, Jamieson & Romer, 2003). Although time-space clustering found among young people is consistent with a mechanism of contagion, it does not necessarily identify it as the underlying mechanism (Gould et al., 1990a). Gould and colleagues are underlining that in some cases "it is not possible to ascertain whether clusters were precipitated by an initial suicide, acting as a model, or whether the presumed model merely happened to be the first person who committed suicide in response to conditions that then led others to suicide" (1990a, p. 76). According to Gould and colleagues, if contagion is an underlying mechanism it would assume either direct or indirect awareness of the prior suicide. They propose that various suicide contagion pathways may exist, such as direct contact or friendship with a victim, word-of-mouth knowledge, and indirect transmission through media (1990a; 2003). According to the cluster of suicide in Sami core area, several of these conditions were present. Those who died in suicide during summer 1987 were close friends,

part of a respected group/gang and the cluster was also exposed to local and national media (Eikeland, 2003).

Imitation and model learning are also relevant factors in suicide clusters. A factor common among indigenous that may be significant in this respect is the tight social relation between group members. Traditionally the band/tribe/clan and family have been the basis of the social structure among indigenous people. Besides, indigenous communities are often small and organized in physical proximity. If one person in the village dies by suicide the possibility that every body will be affected in one or another way is significant. Subsequently, any suicide might serve as a model for solving problems. Furthermore, high rates of risk behavior, such as suicide, in indigenous societies may function as a form of "cultural scripting" (Hunter & Harvey, 2002). In a study by Borowsky and colleagues the high number of suicidal American Indian and Alaska Native youth who indicated that they had a friend who had attempted suicide, illustrates the significance of being exposed for suicide (1999). In this study actually the most powerful risk factor for a past suicide attempt among male and female youth was having a friend who attempted or completed suicide (Borowsky et al., 1999). Consistent with this finding, a significant predictor of moving from thought to action across gender was knowing a friend (but not a family member) who had attempted suicide (Bearman & Moody, 2004). Hence, contagion, imitation and model learning seem all to be significant underlying mechanisms explaining the occurrence of suicide clusters.

It is important to underscore that subsequent suicide in a cluster are characterised by a priori history of difficulties and/or mental disorder (Gould et al., 1990a). This implies that only vulnerable persons are actually committing suicide in a cluster. Exposure to the suicide of a friend or acquaintance has been associated with a markedly increased incidence of new-onset major depression (Brent et al., 1993a). Depression may occur as a complication of bereavement and is more likely to develop in youths who had a close relationship with the victim, spoke to the victim on the day of suicide, viewed the scene of death, or have personal or family history of depression (Brent et al., 1993b).

In conclusion, clustering of suicidal behavior, together with regional influence, was the specific factor that may have contributed to increased rates of suicide among an American Indian tribe residing in a reservation in the southwest (Wissow et al., 2001). This may also be a probable reason for the increased suicide mortality found among Sami males in Sami core area (Paper I). It is important to take clustering of suicides with respect to time, group and locality into consideration, if not, aggregation of suicide statistics among indigenous people may lead to misleading interpretations (Hunter & Harvey, 2002). Although suicide cluster is

proposed as one important factor explaining the high suicide rates in Sami core area, other factors may as well have significance.

8.4 Prevention implications

Suicidal behavior is an important public-health problem. Because of its complex etiology suicidal behavior demands a multi-faceted prevention approach. Unfortunately, there is generally limited evidence based knowledge in suicide prevention (Hawton & Heeringen, 2002). It is difficult to evaluate prevention strategies when the out-come variable is a rare phenomenon such as suicidal behavior. Although the findings from this investigation revealed that the situation among Sami in Norway is different from several other indigenous with respect to their moderate prevalence of suicidal behavior, Sami societies also need strategies to prevent suicidal behavior in a systematically way. This thesis have revealed that suicidal behavior among Sami differ from the majority population in some respect. Suicide among Sami is primarily a rural phenomenon with an increased risk of cluster suicide. The suicide risk is most pronounced among adolescents and young adults. Lethal methods are often used across gender. And finally, disruption in traditional male gender role together with expectations of autonomy may make Sami males more vulnerable to suicide. These findings implicate that it is necessary to implement culturally appropriate interventions tailored to specific local settings at all three levels of prevention (primary, secondary and tertiary). To full fill an effective prevention of suicidal behavior among Sami a special strategy for suicide prevention is recommended. Some indigenous people have by now developed their own prevention strategies. In 2004 PAARISA (Greenland Home Rule) published a proposal for a national strategy for suicide prevention in Greenland (www.peqqik.gl/Sundhed/Selvmordsforebyggelse.aspx accessed 23.03.06). This proposal is presenting different specific recommendations to ensure the desired reduction in the number of suicides in Greenland. Although Norway published their first national suicide prevention plan in 1995, this plan does not have any special focus on the Sami. It is my opinion that it is necessary to develop a culture sensitive and specific suicide prevention plan be able to organize and conduct appropriate strategies in Sami societies. Sami National Center for Mental Health (SANKS) could be the proper institution to invent such a prevention strategy for the Sami in Norway. In the following some suggestions are proposed aimed at reducing suicidal behavior among Sami.

This investigation has confirmed previous studies regarding the significant association between suicide attempts and suicidal ideation (Paper II and III). An important aspect in

suicide prevention is to improve the awareness of warning signs of suicidality and to develop appropriate ways of responding to people in risk of suicide. Unfortunately, an important general barrier to treatment of suicidality in e.g. adolescence may be failure of parents and teachers, the traditional gatekeepers to child and adolescent mental health care, to recognize adolescent suicidality (Thompson et al., 2006). One of the suicide prevention strategies SANKS already have started to implement in Sami communities is the distribution of the course "Applied suicide intervention skills training" (ASIST, Living Works Education, www.livingworks.net) a national education program (http://www.unn.no/vivat). The aims of ASIST workshop are to aid gatekeepers to become more comfortable, confident and competent in their contact with suicidal people to prevent the immediate risk of suicide. A suicide prevention plan for the Sami population should have as goal to distribute ASIST in all Sami areas in Norway.

Suicidal behavior is affecting all Sami societies in one or another way and Sami core area have experienced especially high suicide rates (Paper I). It is well documented that a family history of suicidal behavior increased the risk of suicide and suicide attempts in young people (see Beautrais, 2000). On the other hand bereaved by suicide has an increased risk of post-traumatic reactions and complicated mourning (Dyregrov, Nordanger & Dyregrov, 2003). For this reason support and treatment of bereaved should have a special focus in the suicide prevention plan among Sami.

Suicide cluster is a common characteristic among indigenous in Arctic area. Unfortunately, each new suicide in Sami societies could possibly elicit a subsequent suicide. Since the occurrence of a suicide within a community appears to increase the risk of a subsequent suicide, the community should be defined as a high risk population (Gould et al., 1990a). According to Gould and colleagues it is necessary to think worst case, and prevention should therefore always have in mind that one suicide may influence other vulnerable inhabitants (1990a). The prevention of suicide clusters and intervention during a cluster have to be an important aspects of suicide prevention plans in Sami communities. For example, development of a high risk profile over vulnerable persons in the community is one possible strategy (Bechtold, 1988). Actually, predicting a subsequent cluster suicide within a community may be easier than predicting the initial single suicide (Gould et al., 1990a).

There is generally a widespread ownership of firearms in Norway, and especially in the rural areas, where most of the inhabitants in Northern Norway actually are situated. In the National Suicide Prevention Plan for Norway, legislation of firearms and appropriate home storage has been one target prevention strategy. However, no such interventions have been

adjusted for implementation into Sami societies, e.g. information on the safe use and storage of firearms in Sami language. A recent study exploring whether the declines in household firearm prevalence in the United Sates were associated with changes in rates of suicide, concluded that reducing availability to firearms in the home may save lives, especially among youth (Miller et al., 2006).

Help-seeking behavior among adolescents and young adults is another important suicide prevention target. Studies have shown that the majority of suicidal adolescents never contact mental health services (e.g. Grøholt et al., 1997), and that adolescents appear to rely upon informal help-seeking, such as support from family and friends, rather than professional services (Rickwood & Braithwaite, 1994; Grøholt et al., 1997). There are many relevant aspects of help-seeking among adolescents and young adults in general which could be target in prevention of suicidal behavior, such as information about local help services and campaigns to change attitudes towards mental help services and mental health. There has been implemented several school programs in Norway intended to change attitudes and inform about mental health problems, and inform about local help services (e.g. Mental health in school/Psykisk helse i skolen, www.phis.no). However, only one of these programs, "Zippy's friends" an international program that teaches coping skills to six and seven year old children, is evidence based. None of these programs are translated into Sami language. However, SANKS should adjust and implement at least one of these programs in Sami societies.

Inconsistent with findings among other indigenous, there is generally similar smoking rates and use of illicit drugs, and lower (T1) and similar (T2) use of cannabis and lower drinking rates among young Sami when compared to majority peers (Spein et al., 2002; 2004; 2006; Kvernmo et al., 2003). However, the findings from Papers II and III indicating that substance use was significantly associated with suicide attempters both cross-sectional and longitudinal must be taken seriously. According to Wichstrøm (2007) one of the factors explaining the increase in prevalence of depression and suicide attempts found among adolescents in Norway between 1992 and 2002 is the increase in alcohol consumption. Subsequently, general prevention strategies to reduce substance use among adolescents are necessary, and in addition specific culture sensitive strategies are required in Sami areas.

8.5 Clinical implication

The general impression from Paper II and III is that suicide attempters have higher mean scores on both internalizing and externalizing problems, and additionally higher mean scores on substance use. This is consistent with the opinon that the strongest risk factors for youth

suicide are mental disorders (in particular, affective disorders, substance use disorders and antisocial behaviors) (Beautrais, 2000). This implicate that priorities for intervention to reduce youth suicidal behaviour should focus on improved assessment and treatment of young people with mental disorders.

Today mental health services delivery to adolescents and young adults requires some rethinking of traditional models into a more "user-friendly" approach (Hazell, 2002). Subsequently, mental health services have a special responsibility to make their services more accessible and attractive to young people, both females and males. In addition, mental health services in Sami areas must adjust their clinical practice to the context they are embedded in, Sami culture. Clinicians should either have indigenous heredity or native Sami language competence themselves, and/or formal education in Sami culture competence. Furthermore, it is important that adolescents and young adults have easy access to the treatment facilities and that they are able to admit themselves for treatment. Treatment should also be delivered in their local communities and in their own arenas such as in school. Since adolescents and young adults often make use of treatment only when they have problems, the clinicians must give a flexible service depending on adolescents' varying motivation. This is a very important aspect in clinical work with adolescents in general and specially with suicidal adolescents due to their fluctuating suicidal impulses. Increased use of modern communication services, such as short message services (SMS) to arrange appointments and as part of clinical intervention, and internet based therapeutic interventions, could also be part of a "user-friendly" service approach.

8.6 Research implications

Initially, this is the first investigation to study suicidal behavior among Sami in a systematically way, and the findings must be considered as preliminary. Future research is necessary to confirm the reliability of these findings. As suicidal behavior is a multidimensional phenomenon a combination of epidemiological, clinical and qualitative research methods is recommended. However, the findings in this thesis may suggest several perspectives for future research.

The prevalence of suicidality among Sami has in this thesis been compared to the non-Sami (majority) population. A comparative perspective is in many respects a necessary approach in a brand new field of suicidology among Sami. However, in the future it will also be important to examine within-group differences among Sami. The Sami people in Norway consist of diverse subpopulations with several common characteristics but also great variation

with regard to their unique historical experiences of assimilation and revitalization, local culture and living conditions. It is important to understand suicidal behavior in specific social and cultural contexts in order to better understand culturally specific suicide pathways or trajectories (Cutcliffe, 2005). Furthermore, within group variation in factors, such as acculturative stress and lack of ethnic support, as well as socio-economic factors, such as economic disadvantages and unemployment, are interesting topics for future research. More research into these matters would increase our understanding of the mechanisms underlying suicidal behavior and the variation in rates within the Sami population in Norway.

Furthermore, the high suicide rates found across gender among Sami youth (Paper I) and high prevalence of suicide attempts among Sami females (Paper II) warrant further studies to identify both risk and protective factors and culturally appropriate interventions that can successfully nurture resilience in high risk groups. Gender differences in risk and protective factors associated with suicidal behavior and the influence of gender role are also topics which should be explored in future research.

As several Sami areas have many bereaved after suicide a specific research project should focus on this risk group. Although the study by Dyregrov and colleagues (2003) was a nationwide cohort study, it is unknown whether there were any Sami participating. At present there is no documentation of the situation among Sami bereaved. To implement appropriate provisions and organization of intervention strategies in local communities inhabited by Sami, future research on consequences and needs among bereaved Sami is necessary.

Help-seeking and problem-solving behavior among Sami adolescents and young adults are interesting topics for future research. It could be interesting to explore how an autonomous child-rearing practice influence on help-seeking behavior and what kind of problem-solving strategies are preferred by Sami adolescents. Furthermore, knowledge about pathways to services for young people, and the barriers they encounter when trying to reach them, is essential for prevention strategies conducted to increase help-seeking behavior. Gender differences are a highly relevant perspective in this regard. Another research field of interest is adjustment of mental health services for young Sami males. It is necessary to explore what kind of mental help services this target group actually need and would like be served by.

Research on indigenous people has mainly been focusing on negative behavior and risk factors. Unfortunately, the results in thesis are in line with this trend. Future research should focus on resilience and/or identify protective factors that prevent young people from attempting suicide, which also is an important aspect in the prevention of suicidal behaivior.

Furthermore, factors associated with suicide risk are well known but have very high false positive rate (Hawton, 1987), and future research should increase the understanding of the key psychological processes involved in suicidal behavior. These mediating factors are likely to be of great value in informing interventions and helping to target at risk assessments (MacLeod et al., 2005).

9. SUMMARY OF FINDINGS AND CONCLUSIONS

This thesis has examined suicidal behavior among indigenous Sami residing in rural areas in Arctic Norway, especially among adolescents and young adults. The finding in Paper I, of a moderate significant increased risk of suicide among Sami, is consistent with the general findings among indigenous. However, the suicide rates found among Sami is moderate and may be explained by better living conditions and subsequently lower prevalence of general risk factors. Furthermore, several common features concerning indigenous suicide have been identified among the Sami, such as within group variation, age distribution, gender differences, cluster of suicides and frequent use of violent methods. On the other hand, from Paper II it can be concluded that there are no ethnic differences in prevalence of self-reported suicide attempts between Sami and non-Sami adolescents in Northern Norway in the mid 1990's. This finding is inconsistent with research from several indigenous peoples. Ethnic specific risk factors associated with suicide attempts among Sami adolescents were found, and these can be characterized as diverging from the traditional cultural norms. The main findings in Paper III indicated diverse patterns of associated risk factors and prognoses for the different types of suicide attempters, especially with respect to level of emotional/behavioral problems and substance use. Repeating attempters generally reported higher scores on emotional/behavioral problems and lower use of substances such as alcohol and cannabis compared to other attempters.

Suicidal behavior is a complex phenomenon hence making it difficult to entirely explore its causes, intent and meaning. This investigation is of epidemiological character, primarily focusing on prevalence of suicidal behavior and associated risk factors, which mean, that the results only reveal a slight part of the suicidal phenomenon among Sami in Arctic Norway. The fact that Sami is a minority and an indigenous group makes the picture even more complex. The findings in the presented thesis should be viewed as exploratory until confirmed in other samples. Central topics in future research could be to explore for the significance of socio economic conditions, social integration, cultural change, acculturation and ethnic identity. In addition, future research should utilize a risk and resilience framework

in which the potential protective role of culturally-related processes would be of especially importance.

Indigenous suicides share several common characteristics, however, prevention of indigenous suicide necessarily demands an understanding of the specific historical and cultural context in which the suicides are situated. Even though research may generate many possible useful implications for prevention and clinical practice, the most important after all is to "facilitate a communal response by eliciting a shared conviction that something can, in fact, be done" (Wexler, 2006: 2941).

10. CORRECTIONS

Some mistakes have unfortunately been printed in the papers.

First, the description of sample characteristics in Paper II (page 3) is incorrect. The correct number of excluded participants who were younger than 16 years or older than 18 years should have been n=621.

Secondly, the description of sample characteristics in Paper II (page 3) is also incomplete. Part-time students or students not reporting their grad level (n= 47) were also excluded from the analyzed sample.

Thirdly, the description of Ethnicity in Paper II (page 4) is incorrect. Adolescents' self-reported ethnicity was not used as a criteria for Sami ethnicity.

Fourthly, after publishing we got aware that the EAT-12 scale used in Paper II was based on the 3-Likert's score and not the more commonly used 4-Likert's score.

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12. FIGURES AND TABLES

Figure 1. Conceptual model of domains of risk factors for suicide and suicide attempts (Beautrais, 2000).

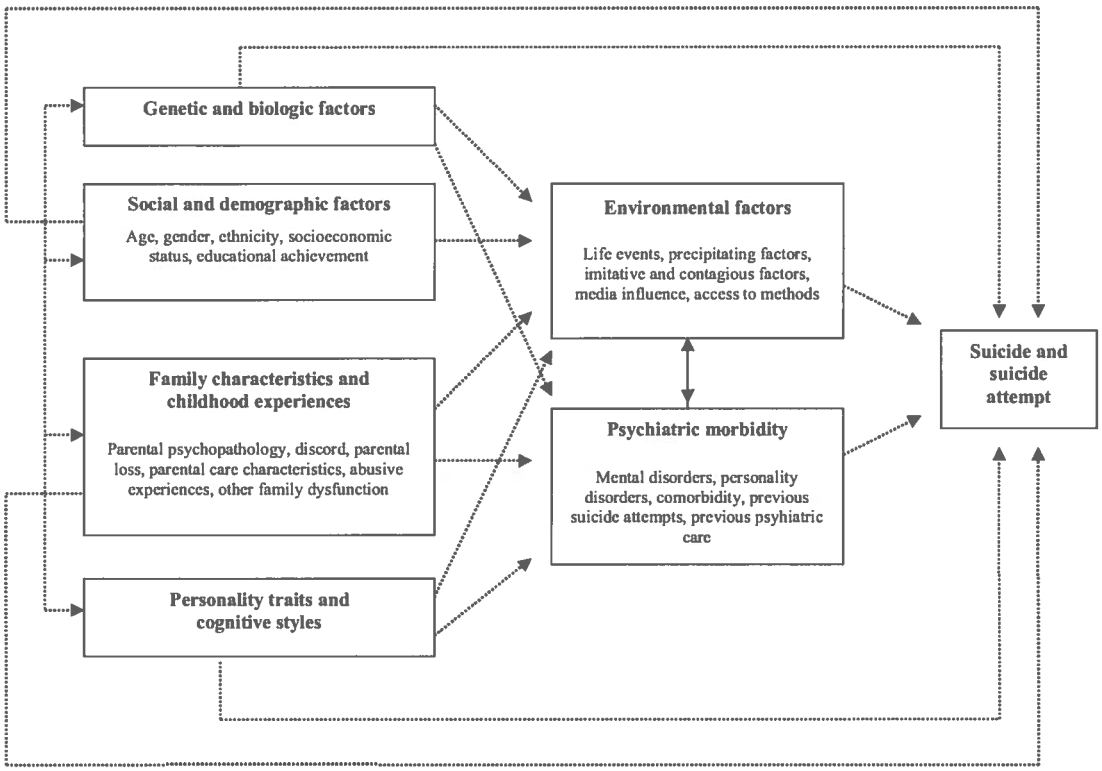
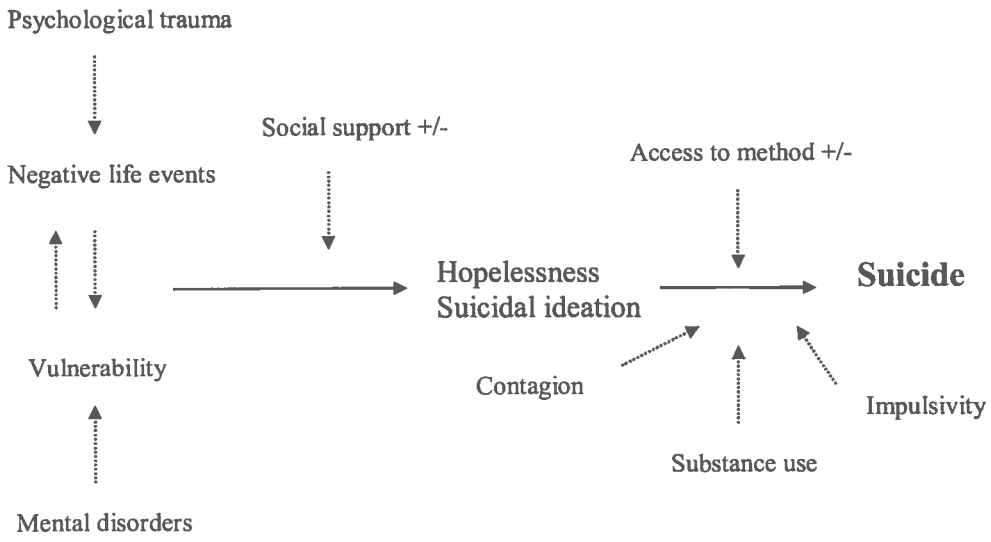
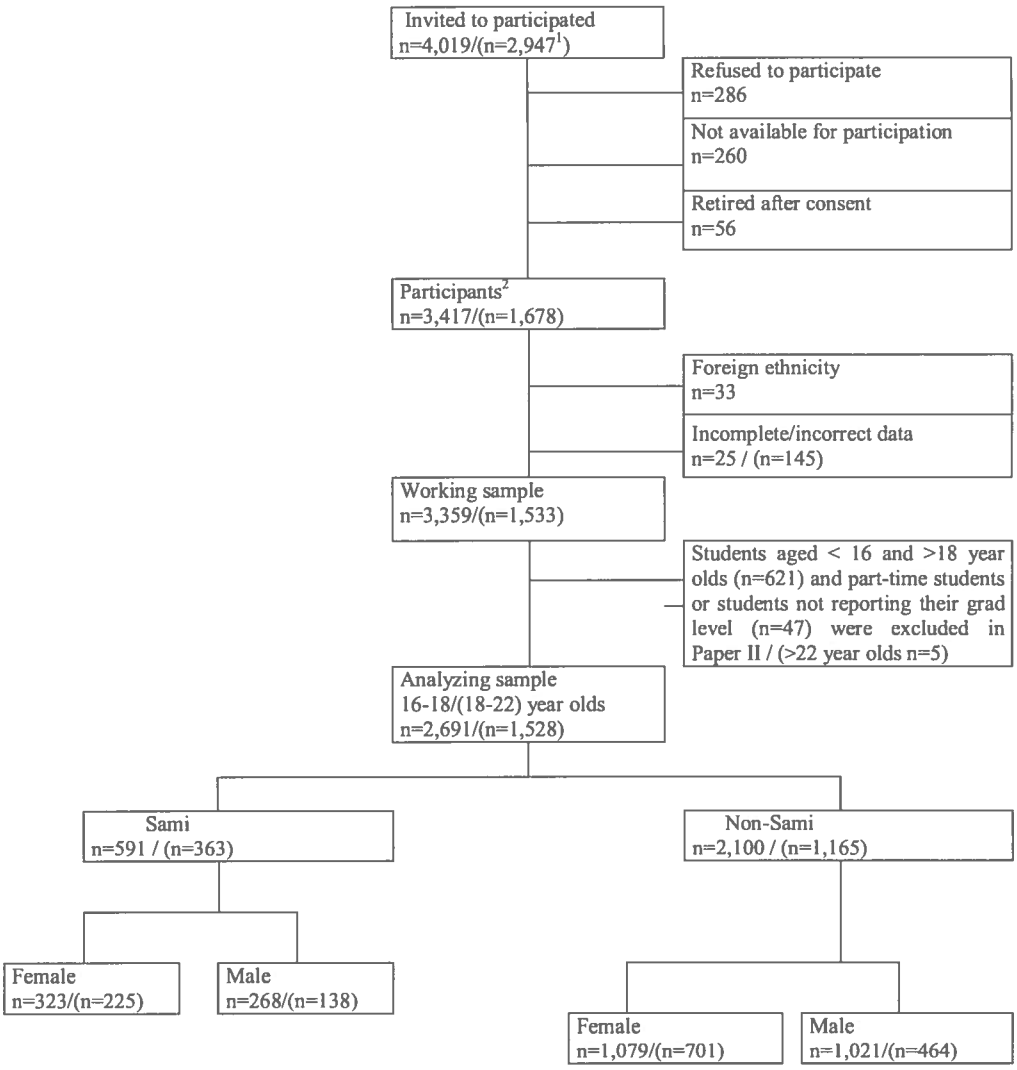


Figure 2. The suicidal process (Mehlum, 2007)*



* Presented at the 5th National conference for suicide prevention in Lillehammer. The model has been translated into English.

Figure 3. Flow chart for T1 (1994-95) and T2 (1997-98) samples



[1] Participants from T1 who were older than 22 years at T2 were not invited at follow-up (n=344). In addition, one school lost its participant list prior the follow-up survey, thus excluding 126 participants at T2.

[2] The response rates were 85% and 57% at T1 and T2, respectively.

Table 1. The census tracts included in the 1970 census by ethnic context.

Sami core area:	**Coastal area:**	**Southern area:**
2011 Kautokeino	2001 Hammerfest	1913 Skånland
2021 Karasjok	2003 Vadsø	1919 Gratangen
2025 Tana	1911 Kvæfjord	1921 Salangen
2027 Nesseby	2012 Alta	1931 Lenvik
	2014 Loppa	1841 Fauske
	2015 Hasvik	1845 Sørfold
	2016 Sørøysund	1849 Hamarøy
	2017 Kvalsund	1850 Tysfjord
	2018 Måsøy	1853 Evenes
	2019 Nordkapp	1854 Ballangen
	2020 Porsanger	1855 Ankenes
	2022 Lebesby	
	2023 Gamvik	
	2024 Berlevåg	
	2030 Sør-Varanger	
	1939 Storfjord	
	1902 Tromsø	
	1925 Sørreisa	
	1926 Dyrøy	
	1927 Tranøy	
	1929 Berg	
	1933 Balsfjord	
	1936 Karlsøy	
	1938 Lyngen	
	1940 Kåfjord	
	1941 Skjervøy	
	1942 Nordreisa	
	1943 Kvænangen	

Tables 2a-d. Distribution of answers to the questions regarding Sami language competence and ethnic self-identification by county (Aubert, 1978).

Table 2a. Persons in preselected census tracts in Nordland, Troms and Finnmark, by answer to the question if Sami was the first language spoken by the person him/herself

County	Total population in the tracts[1]	Sami first language	Sami not first language	Not reported
Nordland	14 760	507	6 391	7 862
Troms	31 160	1 446	24 359	5 355
Finnmark	67 954	8 582	55 749	3 623
NN[2], total	113 874	10 535	86 499	16 840

Table 2b. Persons in preselected census tracts in Nordland, Troms and Finnmark, by answer to the question if Sami was the first language spoken by at least one of the parents.

County	Total population in the tracts[1]	Sami first language	Sami not first language	Do not know	Not reported
Nordland	14 760	777	6 022	97	7 864
Troms	31 160	3 473	21 541	797	5 349
Finnmark	67 954	12 558	50 365	1 433	3 598
NN[2], total	113 874	16 808	77 928	2 327	16 811

Table 2c. Persons in preselected census tracts in Nordland, Troms and Finnmark, by answer to the question if Sami was the first language spoken by at least one of the grandparents.

County	Total population in the tracts[1]	Sami first language	Sami not first language	Do not know	Not reported
Nordland	14 760	860	5 834	198	7 868
Troms	31 160	4 807	18 429	2 575	5 349
Finnmark	67 954	13 968	45 877	4 496	3 613
NN[2], total	113 874	19 635	70 140	7 269	16 830

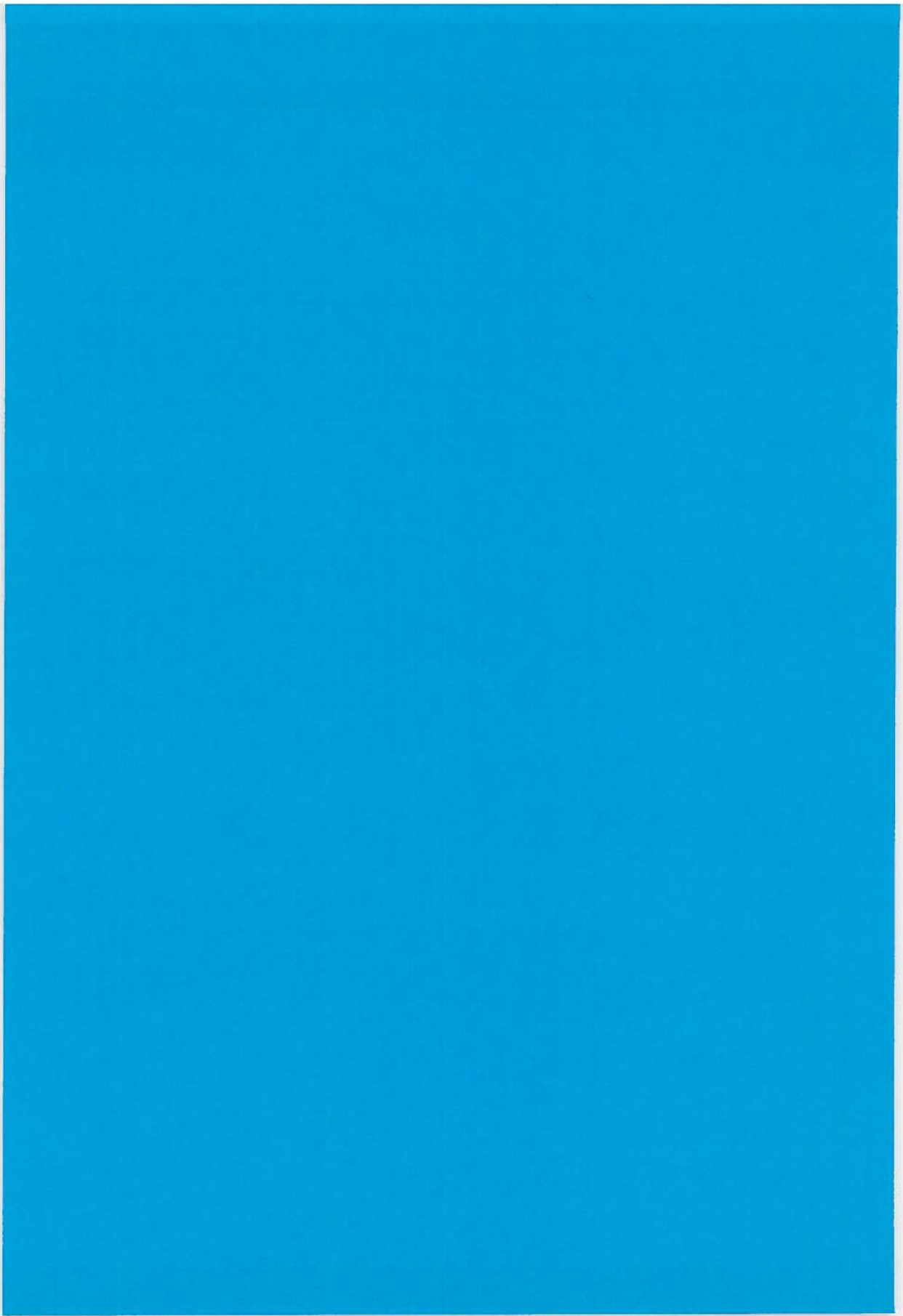
Table 2d. Persons in preselected census tracts in Nordland, Troms and Finnmark, by answer to the question if the person considers him/herself to be Sami.

County	Total pop. in the tracts[1]	Considers him/herself to be Sami	Considers him/herself not to be Sami	Uncertain	Does not wish to answer	Not reported
Nordland	14 760	668	6 015	111	159	7 807
Troms	31 160	994	23 817	746	333	5 320
Finnmark	67 954	7 563	53 842	1 775	1 321	3 453
NN[2], total	113 874	9 175	83 674	2 632	1 813	16 580

[1]Population in the preselcted tracts from which one has received at least one additional questionnaire with answer to at least one of the four questions.

[2] Northern Norway

Paper I



European Journal of Epidemiology (2006) 21:707–713
DOI 10.1007/s10654-006-9052-7

PSYCHIATRIC EPIDEMIOLOGY

Suicide among Indigenous Sami in Arctic Norway, 1970–1998

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Accepted in revised form 23 August 2006

Abstract. Suicide mortality was examined between 1970 and 1998 in a cohort of 19,801 persons categorized as indigenous Sami in Arctic Norway. Standardized mortality ratios (SMR) were calculated using the suicide rates of the rural population of Arctic Norway as reference. There was a significant moderate increased risk for suicide among indigenous Sami (SMR = 1.27, 95% Confidence interval (CI): 1.02–1.56). In the study period, 89 suicides occurred in the cohort (70 men and 19 women) with increased suicide mortality both for indigenous Sami males (SMR = 1.27; 95% CI: 0.99–1.61) and females (SMR = 1.27; 95% CI: 0.77–1.99). Significant increased suicide mortality was found for young Sami aged 15–24 for both males (SMR = 1.82; 95% CI: 1.13–2.78) and females (SMR = 3.17; 95% CI: 1.17–6.91). Significant increased suicide mortality was found for indigenous Sami males residing in Sami core area (SMR = 1.54; 95% CI: 1.04–2.20) and for indigenous Sami males not belonging to semi-nomadic reindeer herding (SMR = 1.30; 95% CI: 1.00–1.65). Clusters of suicides in Sami core area may explain the increased suicide mortality found in subgroups among indigenous Sami.

Key words: Cause of death, Cluster, Indigenous Sami, Suicide

Abbreviations CI = Confidence interval; SMR = Standardized mortality ratio

Introduction

Suicide has become a serious problem among several indigenous people in the Arctic (for example, the Inuits in Greenland [1]) and the Arctic parts of Canada [2], as well as among Alaskan natives in the US [3]. In Greenland, the suicide rates were as high as 100 per 100,000 in 1990–95, and the rates among young males aged 15–24 were even higher [4]. Suicidal behavior among indigenous people is most commonly explained by the importance of cultural factors [5] such as the undermining and breakdown of traditional cultural structures and acculturation as a consequence of colonization and modernization. For many indigenous people, a forced acculturation process has caused acculturative stress and psychopathology such as depression, suicide and alcohol abuse [6]. In contrast, suicide rates have been found to be negatively associated with integration of traditional culture in several Native American tribes [7] and degree of self-government among Native Canadian bands [8].

The Sami people is an indigenous group residing in the arctic part of Scandinavia. In Norway, the indigenous Sami (hereafter called Sami) are an ethnic minority mainly residing in northern Norway which, like other arctic areas, is sparsely populated. The Sami population is estimated to be about 100,000 individuals living in northern Fenno Scandinavia, including the Russian Kola Peninsula. The majority (70%) of Sami live in Norway, where they are formally considered an indigenous people with their own culture and native language. During the last three decades, a process of integration and increased ethnic revival has gradually replaced a history of forced assimilation and colonization. The outcome of the acculturation and the ethnic revitalization processes has varied in different regions inhabited by Sami, such as the highland of the northernmost county Finnmark which is considered as the Sami core area, and the coast. The assimilation process had the greatest impact on the coastal communities where the Sami became a minority, and many Sami lost their Sami identity and their language [9]. In this area, prejudice and ethnic conflicts about for instance land rights and teaching in the Sami language are still present, as well as little structural and practical support for the Sami culture. In the highland communities, however, the majority of the population is Sami and Sami speaking, several Sami institutions are resided here such as the Sami parliament, Sami research centres and broad casting, and education in the indigenous language is possible from compulsory school to

college level. There is a well-organized indigenous oriented health and social service of high professional level run by Sami medical doctors, social workers, nurses, etc. The strengthening of the Sami culture in this area has taken place particularly during the last three decades.

In general, the socio-economic status in most Sami areas is at the lowest national level with regard to income, educational level and employment. Generally, there are more use of social well-fare and disability benefits, more single-parent families, and a higher rate of people belonging to the primary industries like fishing and reindeer herding than elsewhere. However, the status within the Sami communities varies considerably with municipalities in the Sami core area showing the most advantaged situation. In this area the proportion of college and university graduated females aged 25–40 years is on the highest national level.

The Sami areas are characterized by a younger population with approximately 60% of the population being younger than 39 years of age [10]. According to the relatively few studies on the health situation in the Sami population, there is no evidence of a more disadvantaged health status. Compared to the majority population studies have shown less alcohol use among Sami adults and adolescents [11, 12], similar rates of mental health problems, smoking and sexual risk taking behavior for adolescents [12, 13], equal or lower rates for infectious and cardiovascular diseases [14–17]. This picture differs with that for several other indigenous groups worldwide.

Semi-nomadic reindeer herding is one of the traditional Sami core occupations. Although reindeer herding has undergone radical changes during the last decades due, in part, to increased motorization and socio-economic pressure, reindeer herding is still an important way of living and a significant symbol of Sami culture.

In the 1980s, the suicide rate among young males was particularly high in some areas in Arctic Norway where the majority of the population was Sami. The suicides were assumed to reflect mental health problems in Sami areas arising from identity problems and cultural change [18]. However, studies among Sami adolescents on mental health and suicidal behavior showed only weak or no associations to ethnocultural factors [Kvernmo and Rosenvinge, submitted; 19]. There are few epidemiological studies of the Sami people in Norway, and the suicide mortality among Sami in Arctic Norway has never before been explored in a systematic way.

The purpose of this study was to examine the suicide mortality among Sami in Arctic Norway during the last three decades, 1970–1998. Another purpose was to investigate the suicide mortality between subgroups according to age, gender, cultural context, and traditional Sami core management.

Materials and method

Study cohort

In connection with the national census in 1970, a survey of Sami ancestry was performed in preselected census tracts in the three northernmost counties of Norway: Nordland, Troms and Finnmark. The study was carried out by Statistics Norway in cooperation with Sami organizations [9]. Established knowledge and pilot studies on Sami inhabitation were used to identify the areas. The selected census tracts covered 6.1% of the population in Nordland, 22.9% in Troms and 89.7% in Finnmark.

Our cohort included 19,801 persons with Sami ethnic ancestry, 10,573 men and 9228 women. The cohort included 890 people from Nordland, 4847 from Troms and 14,064 people from Finnmark. Information about date of birth, sex, residence and occupation was supplied by the regular census. People living in the same household were identified. Parents were allowed to answer on behalf of their children.

Procedure

Since there is no registration of ethnicity in the national population register in Norway, we used the national census from 1970 to define the Sami cohort. Information on vital status and cause of death of the subjects identified as Sami in the census where obtained through record linkage with the Norwegian Causes of Death Register and were compared to the expected number of deaths in a control population residing in rural Arctic Norway. The follow up of suicide incidence took place from the beginning of November, 1970 (date of census) until the end of 1998. The follow-up included 471,028 person years, 245,408 for men and 225,620 for women. Altogether, 5955 deaths and 172 emigrations were observed in the cohort. The study obtained consent from the Regional Medical Ethical Committee and The Norwegian Data Inspectorate.

Measures

Ethnicity

In selected areas, the census forms were supplemented with four questions about Sami ancestry: (1) Was Sami (Lappish) the first language spoken by the person? (Yes/no). (2) Was Sami (Lappish) the first language spoken by one of the person's parents? (Yes/no/don't know). (3) Was Sami (Lappish) the first language spoken by one of the person's grandparents? (Yes/no/don't know?). (4) Does the person consider himself or herself a Sami (Lapp)? (Yes/no/uncertain/don't want to answer).

Sami ethnic ancestry was categorized on the basis of these four inclusion questions. If the person

answered positively on one of the four questions he/she was categorized as Sami. The first three questions were considered to be of an objective character and the last question to be more subjective.

Ethnic context

The Sami population was divided into three groups regarding ethnic context. Ethnic contexts were classified according to the density of Sami within the municipality of residence [9] and grouped into three categories: (1) Southern area, low density (< 25%), (2) Coastal area, medium density (25–60%) and (3) Sami core area, high density (> 60%) of Sami.

Reindeer herding

If at least one person in the household participated in semi-nomadic reindeer herding, all the persons in the household were categorized as belonging to reindeer herding household.

Suicide registration

Cause of death of the subjects identified as Sami in the census where obtained through record linkage with the Norwegian Causes of Death Register. Cases of suicide were identified by the International Classification of Diseases (ICD-10) code (X60-X84, Y87.0). Recoding from ICD-8 and ICD-9 was done accordingly.

Statistics

The mortality of suicide in the cohort was compared with that of the rural population within the same three counties in Arctic Norway, weighted according to the number of Sami in each. Gender, 5-year calendar periods and 5-year age groups were used for computing reference rates. Expected values were computed by multiplying the person years in the cohort by the reference rates. Standardized Mortality Ratios (SMRs) were computed by taking the ratio of observed to expected cases of suicide. For these estimates, the 95% confidence intervals (95% CI) were computed, based on the assumption that observed suicides/cases follow the Poisson distribution.

Results

In the study period 1970–1998, a total of 89 suicides occurred in the Sami cohort. There was a moderate significant increased risk for suicide among Sami (SMR = 1.27, 95% CI = 1.02–1.56), showing

Table 1. Distribution of suicide mortality for 19,801 people of Sami ancestry, 1970–1998

Variables	Men				Women			
	O	E	SMR	95% CI	O	E	SMR	95% CI
Suicide	70	55.1	1.27	0.99–1.61	19	14.9	1.27	0.77–1.99
County								
Finnmark	59	39.2	1.50	1.14–1.94	17	11.0	1.55	0.90–2.48
Troms	10	13.5	0.74	0.36–1.37	0	3.3	0.00	0.00–1.11
Nordland	1	2.4	0.42	0.01–2.35	2	0.6	3.17	0.38–11.46
Cultural context								
Sami core area	30	19.5	1.54	1.04–2.20	7	5.3	1.31	0.53–2.70
Coastal area	38	30.7	1.24	0.88–1.70	10	8.3	1.21	0.58–2.23
Southern area	2	4.9	0.41	0.05–1.48	2	1.3	1.51	0.18–5.46
Reindeer herding								
No	64	49.4	1.30	1.00–1.65	18	13.4	1.34	0.80–2.12
Yes	6	5.7	1.06	0.39–2.30	1	1.5	0.66	0.02–3.68
Age								
0–14	0	0.2	0.00	0.00–20.14	0	0.0	0.00	
15–24	21	11.6	1.82	1.13–2.78	6	1.9	3.17	1.17–6.91
25–34	17	12.6	1.35	0.79–2.17	5	2.7	1.83	0.59–4.27
35–44	12	8.6	1.40	0.72–2.44	3	2.7	1.13	0.23–3.30
45–54	13	9.0	1.45	0.77–2.48	2	2.8	0.72	0.09–2.61
55–64	5	6.2	0.81	0.26–1.89	3	2.2	1.36	0.28–3.99
65–	2	7.0	0.29	0.03–1.03	0	2.7	0.00	0.00–1.39
Time period								
1970–80	16	13.7	1.17	0.67–1.90	4	3.5	1.14	0.31–2.92
1981–90	36	26.4	1.36	0.95–1.89	10	5.2	1.92	0.92–3.54
1991–98	18	15.0	1.20	0.71–1.90	5	6.2	0.81	0.26–1.88

Notes: Observed number of suicides (O), expected number of suicides according to a regional reference population (E), standardized mortality ratios (SMR) and 95% confidence interval (CI).

increased suicide mortality for both genders (Table 1). The mortality rate between 1970 and 1998 for Sami men and women was 28.5 and 8.4 suicides per 100,000 person years, respectively.

Significant increased suicide mortality was found for Sami males and females aged 15–24 years (SMR = 1.82, 95% CI = 1.13–2.78 and SMR = 3.17, 95% CI = 1.17–6.91, respectively). About 30% of the suicides in the study cohort occurred in the 15–24 years age group with a male/female ratio of 3.5:1. The suicide rates in 15–24 years olds were 53.2 per 100,000 person years for males and 16.0 for females (Figure 1). As can be seen from Figure 1, suicide rates among Sami males showed two striking peaks, at age 15–24 and at age 45–54. Among Sami females the suicide rates were highest at age 15–24 and at age 55–64. For both genders, there was a marked fall in the oldest age groups.

Sami males residing in Finnmark County had a significantly increased mortality by suicide (SMR = 1.50, 95% CI = 1.14–1.94). With respect to cultural context, there was a significant increase in suicide mortality among Sami males residing in Sami core area (SMR = 1.54, 95% CI = 1.04–2.20). Across gender, Sami belonging to semi-nomadic reindeer herding household did not have significant increased suicide mortality compared to the reference population. Sami males not belonging to semi-nomadic reindeer herding household had a significantly increased mortality of suicide. A corresponding significant result was not found among Sami women.

No significant changes in male and female rates were observed over time periods during the study period. For both males and females, a higher relative risk of suicide was observed from 1981 to 1990 compared to the reference population. The estimated suicide rates for the time periods 1970–80, 1981–90, 1991 and 1998 were 15.9, 42,0 and 30.4 per 100,000 person years for Sami males and 4.8, 12.6 and 8.8 per 100,000 person years for Sami females, respectively (Figure 2).

Firearm (41%) and hanging (37%) were the two most common methods of suicide used by Sami males (Table 2). Among Sami females, hanging accounted for the highest proportion of deaths by suicide (53%), followed by intoxication (26%) and drowning (21%) (Table 2).

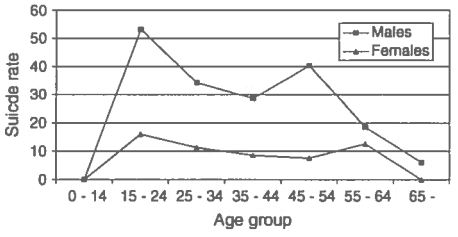

Figure 1. Suicide rates per 100,000 person years in Sami by age group and gender, 1970–98.

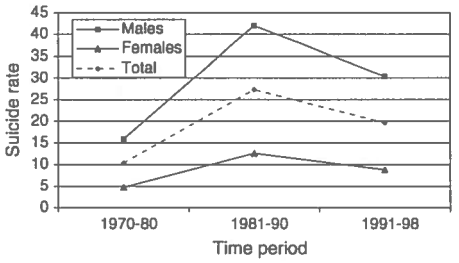

Figure 2. Suicide rates per 100,000 person years in Sami by time periods and gender.

Discussion

The main finding in this study is that of a significant moderate increased suicide risk among indigenous Sami in Arctic Norway compared to the reference population. Although great variation in prevalence of suicidal behavior is found between and within different indigenous groups [5], our finding corresponds with other research that generally reports higher suicide rates among indigenous groups than among majority populations [1–4]. On the other hand, our finding is inconsistent with results from a study among Sami adolescents and their non-Sami peers in Arctic Norway, which reports no ethnic differences in prevalence of self-reported suicide attempts [Silviken and Kvernmo, submitted]. Although there was found no ethnic differences in this study, suicidal behavior among indigenous Sami adolescents seemed to be related to cultural factors. Among Sami adolescents' risk factors diverging from traditional Sami cultural norms were associated with suicide attempts, such as alcohol intoxication, single-parent home and paternal overprotection.

The significant increase in suicide mortality among Sami males aged 15–24 years old, is consistent with findings among other indigenous groups [3, 5, 20] and

Table 2. Distribution of methods of suicide used by 89 persons of Sami ancestry, 1970–1998

	Men	Women	Total
Method	*n*, (%)	*n*, (%)	*n*, (%)
Intoxication	9 (13%)	5 (26%)	14 (16%)
Hanging/strangulation	26 (37%)	10 (53%)	36 (40%)
Drowning	2 (3%)	4 (21%)	6 (7%)
Firearm	29 (41%)	0	29 (33%)
Cutting	2 (3%)	0	2 (2%)
Jumping	1 (1%)	0	1 (1%)
Other, not reg.	1 (1%)	0	1 (1%)
Total	70 (100%)	19 (100%)	89 (100%)

with the trend seen among young males in Norway during the study period [21]. Although the finding that indigenous Sami females aged 15–24 years also had a significant increase in suicide mortality is consistent with findings among other indigenous adolescents [22], the finding was surprising due to the lack of attention paid to female suicides in the Sami society. However, the finding is in accordance with results from the study among Sami adolescents in Arctic Norway [Silviken and Kvernmo, submitted], that report a higher lifetime prevalence of suicide attempts among Sami females compared to their majority counterparts. Although the suicide rates among adolescents and young adults aged 15–24 years in Arctic Norway are, in general, high (in 1994, males 37/100,000 and females 6/100,000 [23], respectively), the rates found among young Sami in the study period are even higher. In contrast to the national population's suicide rates, which indicate minor differences between age groups among adults [24], the age specific rates among Sami indicate a more variable pattern, especially among males. This pattern is more consistent with findings among other indigenous populations where suicide rates peak at age 15–24 and then decrease with age [25].

The finding that Sami males residing in Sami core area had a significant increase in suicide mortality indicates within group variation with respect to cultural context and gender. This finding is unexpected, due to the fact that structural and practical support for the Sami culture and degree of self-government are high in the Sami core area when compared to the other two cultural contexts. Based on the documented negative consequences of cultural assimilation [26] and low degree of self-government [8], we expected to find significant increased suicide mortality in the low and medium density cultural contexts. According to The North Norwegian Youth Study from the mid nineties, Sami adolescents in the Sami core area reported the strongest ethnic identity, separation attitudes, but at the same time also favored integration more than peers in the other areas [27]. The study also revealed that ethnocultural factors did not have any impact on mental health in young Sami males in this context at this time [19]. The suicides in young males in this area mainly took place a decade before The North Norwegian Youth Study and at the beginning of a strong cultural revival period and in an older cohort who possibly did not benefit from the positive socio cultural development in their area. Crossing and mismatching expectations from both the indigenous Sami and the dominant Norwegian societies may possibly have created stress and psychological maladjustment for vulnerable young indigenous males without the necessary bicultural competence and coping strategies. These cultural factors can have accumulated other risk factors well-known for suicidal behavior, such as alcohol misuse, depression, loss of significant others etc.

The Sami core area has generally had a high rate of suicide during the last three decades, especially at the end of the 1980s. During a 12-month period, eight persons committed suicide in the study cohort. This outbreak of suicides took place mainly in two neighboring villages in the Sami core area having a total population of approximately 6000 inhabitants. This outbreak was probably triggered by mechanisms other than ethnicity per se; for example, by imitation and contagion. Due to the small numbers of inhabitants in the Sami communities and the interconnectedness of the population, any suicide might serve as a role model for others and may, through contagion, influence already vulnerable inhabitants. A study from Japan found that after controlling for structural conditions, proximity to high suicide rates increases the risk of suicide [28]. Clustering of suicides is one of the common features concerning suicide among indigenous people, and has been reported in several Native American communities in both the US and Canada [29, 30] and among indigenous in Australia [5]. Generally, clustering of suicides is more common among adolescents and young adults [31]. Clustering has, therefore, been proposed to occur to a greater extent among indigenous people due to their generally high proportion of young people in the populations [20]. Since there is a higher proportion of young people in the Sami population [9], this may be a plausible factor explaining the outbreaks of suicide among Sami in Sami core area. Accordingly, these outbreaks of suicide may have contributed to the increased suicide mortality found among Sami males in Sami core area and across gender among young Sami aged 15–24 years old.

There was almost no increased suicide mortality among Sami males and a lower risk among Sami females belonging to reindeer herding household. This finding is consistent with a study from Sweden [32], which showed no significant increased risk of suicide among reindeer herding Sami males. Our finding may indicate that a traditional way of living with a strong ethnic group membership such as reindeer herding, acts as a protective factor against suicide among Sami in Norway. This finding may be due to the significance of reindeer herding as a traditional, culturally significant occupation among the Sami in Norway. Today, Sami in Norway who are involved in reindeer herding have high status within the Sami culture. They occupy a unique cultural position and have a strong ethnic identity [33].

Suicide mortality among Sami in Arctic Norway has followed the same time patterns as in the non-Sami reference population in the study period. In the time period 1981–90, there was an increase in suicide mortality among Sami males and females. This peak corresponds with the clusters of suicide in Sami core area and also with the general suicide rates in Norway which increased in the period 1970–1989 [34]. In 1988, the suicide mortality rate was at the highest

level ever in Norway with a rate of 16.8/100,000, compared to 12.4/100,000 in the year 1998 [24].

The finding that Sami males relatively often use violent methods such as firearms is consistent with findings among other indigenous males [20], and is a common feature concerning suicide among indigenous peoples [5]. Firearms are reported to be responsible for over 50% of all suicides among Native Americans [20]. However, compared to the national rates among Norwegian males (33%, 1976–98) [24], the use of firearms among Sami males is not exceptionally high. One factor that possibly influences the extensive use of firearms among Sami in Arctic Norway, and in Norway, in general, is the widespread ownership of firearms due to traditional and modern hunting/labor and leisure time activities. The finding that about half of the Sami females used a violent method (hanging) is inconsistent with the general opinion that women tend to use less violent methods [35], however consistent with findings among other indigenous females [22]. Although hanging has increased among young females (10–24 years) in Norway during the period 1973–1994 [21], the high frequency found among Sami females exceeds the general national frequency for females (27%, 1976–98) [24]. Due to the small number of suicides among Sami females in this study, further research will be required to determine whether this pattern is representative for Sami females in Arctic Norway. One of the worrying aspects of the high frequency of suicide by hanging is that, in contrast to suicide by firearms, little can be done to reduce the frequency by limiting access to the implements used [36].

Our cohort did not include all people of Sami origin in North Norway, and even some Sami who were living in the census wards did not participate. In the areas covered by the study, some Sami, for example, may have disapproved of the questions about ethnic background because they perceived them to be controversial. Others may not have answered all the questions because of lack of knowledge about their ethnic ancestry. Underreporting of Sami origin is therefore possible [9]. In computing the local reference rates, we were not able to exclude the Sami people, so our estimates of the relative risks for Sami people could well be slightly biased towards unity. We presume that those categorized as Sami in this study, in one or another way, have an affiliation to Sami culture, in contrast to those who did not report Sami affiliation.

In Norway, there has been an official register for suicides since 1826 [34], and the official suicide statistics in Norway are considered to have sufficient reliability and validity on a national level [37]. However, the significance given to the outbreaks of suicide in this article must be viewed with caution. The suicide outbreaks referred to have not been analyzed statistically to distinguish significant elevations from random fluctuations within a larger study period. Assumptions about suicide outbreaks are based on data from the Norwegian Causes of Death Register and simple statistical comparisons. However, several factors indicate that a cluster of suicides, in fact, took place in Sami core area during the 1980s. During a period of 12 months, eight males in the study cohort from Sami core area committed suicide. The victims were living in physical proximity to one another, they had knowledge of one another, and some of them were even close friends. The cluster accounted for about 27% of the completed suicides among males in Sami core area during the study period 1970–1998. Aggregation of suicide statistics among indigenous people may lead to misleading interpretations if clustering of suicides with respect to time, group and locality is not taken into consideration [5].

Conclusion

There was a significant moderate increased suicide risk among indigenous Sami in Arctic Norway compared to the reference population during the study period 1970–1998. Several common features concerning suicide among indigenous people have been identified. The outbreaks of suicide in Sami core area is one factor that may have contributed to the increased suicide mortality found in subgroups among indigenous Sami. Future studies are necessary to explore the relationship between suicide and ethno cultural factors, such as ethnic identity, acculturation and cultural change, but also the pattern of general risk and protective factors. Suicide prevention among indigenous Sami in Arctic Norway requires data derived from specific target communities, so that local trends and population characteristics can be identified, and appropriate strategies devised from both the Norwegian and the Sami society.

Acknowledgements

This project has been financed with the aid of EXTRA funds from the Norwegian Foundation for Health and Rehabilitation. The authors want to thank Bjarte Aagnes, Cancer Registry of Norway, for his computational assistance.

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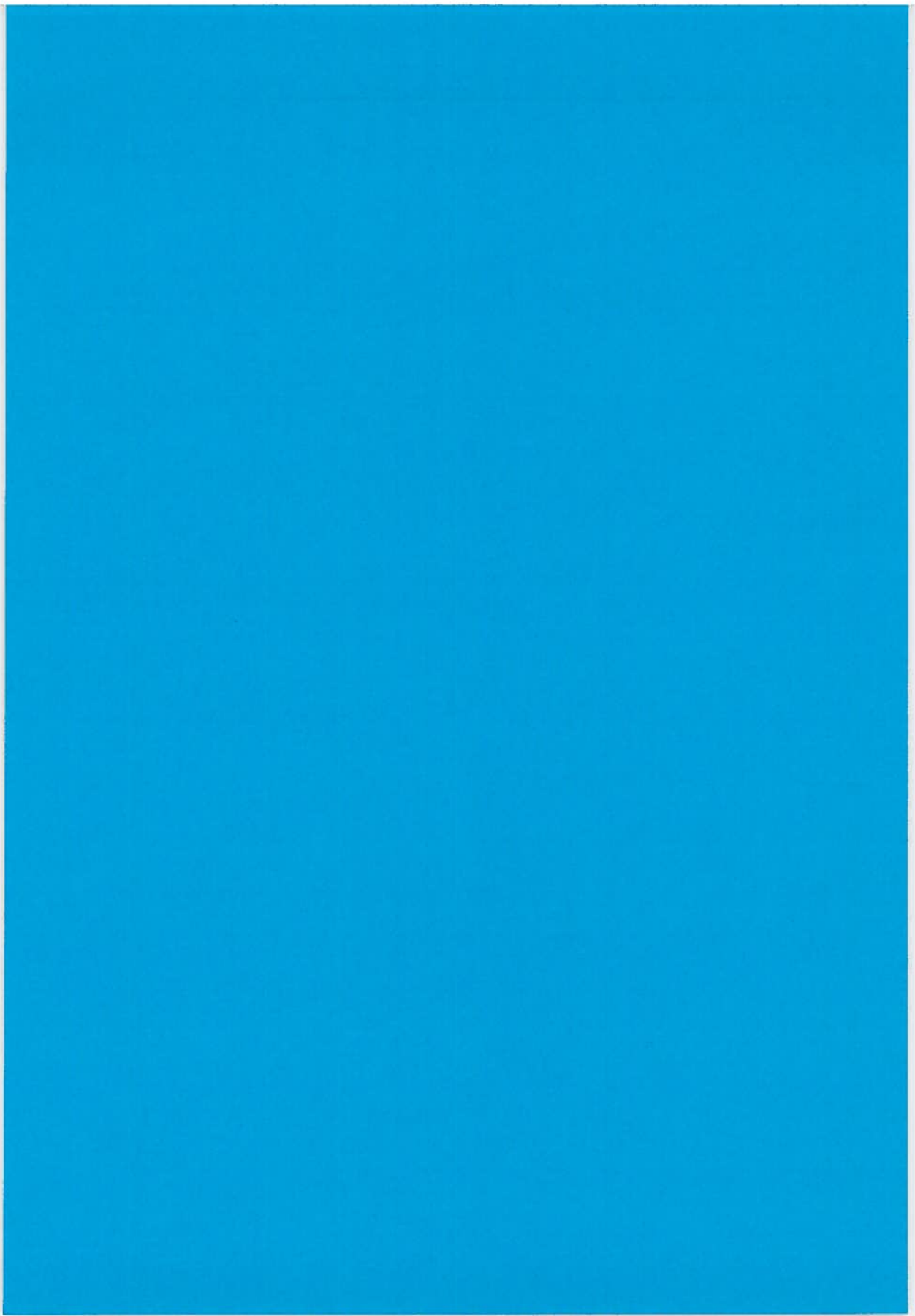
Paper II



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Journal of Adolescence 30 (2007) 613–626
Journal of Adolescence
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Suicide attempts among indigenous Sami adolescents and majority peers in Arctic Norway: Prevalence and associated risk factors

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Abstract

The prevalence of suicide attempts and associated risk factors such as sociodemographic conditions, emotional/behavioural problems and parent–child relationships were examined among 591 indigenous Sami and 2100 majority adolescents in Arctic Norway. There were no significant ethnic differences in prevalence of suicide attempts. In both ethnic groups, suicidal ideation, anxious/depressed problems and eating behaviour problems were associated with suicide attempts. Cross-cultural differences in risk factors associated with suicide attempts existed. For Sami adolescents, factors diverging from the traditional cultural norms were associated with suicide attempts, such as alcohol intoxication, single-parent home and paternal overprotection ($p \leqslant .05$). Vocational studies, not living together with parents, current smoking and experienced sexual intercourse were ethnic specific risk factors associated with suicide attempts among majority peers ($p \leqslant .05$). Clinicians should take into account that risk factors can differ between ethnic groups and should be sensitive to culturally divergent behaviour.

Keywords: Suicide attempts; Risk factors; Adolescents; Ethnicity; Indigenous Sami

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0140-1971/$30.00
doi:10.1016/j.adolescence.2006.06.004

Introduction

During the last three decades, the rates of suicidal behaviour among several indigenous people have increased alarmingly (Hunter & Harvey, 2002), and especially among adolescents and young adults (Kirmayer, Brass, & Tait, 2000; Leineweber, Bjerregaard, Baerveldt & Voestermans, 2001). High suicide rates are seen among several indigenous people in the Arctic such as the Inuits in Greenland (Leineweber et al., 2001) and the Arctic parts of Canada (Sigurdson, Staley, Matas, Hildahl, & Squair, 1994) and among Alaskan natives in the US (Borowsky, Resnick, Ireland & Blum, 1999). The suicide rates in Greenland are estimated to be 100 per 100 000, and the rates among young males aged 15–24 are even higher (Leineweber et al., 2001). Today, suicides are among the most significant reasons for lost years of life among indigenous people/groups in the Arctic. A history of prior attempts is a leading risk factor for youth suicide (Grøholt, Ekeberg, Wichstrøm, & Haldorsen, 1997). This study examines the prevalence of self-reported suicide attempts in indigenous Sami and majority adolescents in Arctic Norway, and explores for possible ethnic differences in patterns of associated risk factors.

Epidemiological studies indicate that the lifetime prevalence of suicide attempts among high school students ranges from 3% to 15% (Lewinsohn, Rohde, Seeley, & Baldwin, 2001), with the rates being even higher among indigenous adolescents (up to 30%) (Howard-Pitney, LaFromboise, Basil, September, & Johnson, 1992; Kirmayer et al., 2000; Langford, Ritchie, & Ritchie, 1998). Affective, disruptive, psychotic and substance abuse disorders are well-known risk predictors related to suicidal behaviour in adolescence (Brent, 1995), and female gender is one of the strongest predictors of suicide ideation and attempts (Canetto & Sakinofsky, 1998). Several explanations for the female predominance in nonfatal suicidal behaviour exist and include validity problems, lethality of methods, differential risk factors and differential socialization (Canetto & Sakinofsky, 1998). Among these, the differential risk factor explanation seems to be a valid potential explanation for the gender difference (Wichstrøm & Rossow, 2002). Adolescents engaging in risk behaviour, such as drinking, smoking and/or sexual activity, are in increased odds for depression, suicidal ideation, and suicide attempts (Hallfors, Waller, Fond, Halperm, Brodish, & Iritani, 2004). Risk factors for suicide attempts identified among Navajo Indian adolescents were, e. g. female gender, prior mental health problems, suicide attempts among friends and family, alcohol consumption, and physical and sexual abuse (Grossman, Milligan, & Deyo, 1991).

The Sami people is an indigenous group residing in the arctic part of Scandinavia. In Norway, the Sami are an ethnic minority mainly residing in northern Norway which, like other arctic areas, is sparsely populated. The Sami population is estimated to be about 100,000 individuals living in northern Fenno Scandinavia including the Russian Kola Peninsula. The majority (70%) of Sami live in Norway, where they are formally considered an indigenous people with their own culture and native language. During the last three decades, a process of integration and increased ethnic revival has gradually replaced a history of forced assimilation and colonization by the Norwegian government. In the 1980s the rate of suicides was particularly high in some areas in Arctic Norway where the majority of the population was Sami. The suicides were assumed to reflect mental problems in Sami areas due to identity issues and cultural change (Hildal, 1997). The estimated suicide rates for the time period 1981–1990 among Sami in Arctic Norway were 42 per 100 000 person years for males and 13 per 100 000 person years for females (Silviken, Kvernmo, & Haldorsen, submitted).

The aims of this study were (1) to examine the prevalence of self-reported suicide attempts among indigenous Sami adolescents and their majority peers residing in Arctic Norway, and (2) to explore for ethnic differences in patterns of risk factors associated with previous suicide attempts.

Method

Procedure

The data are from The North Norwegian Youth Study, a longitudinal epidemiological anonymous questionnaire survey based on adolescent self-reports. The study was conducted in areas inhabited by Sami, Kvens and Norwegians in Arctic Norway. The first wave was conducted in 1994/1995 and the second in 1997/1998. Twenty-one state high schools (10–12th grade students) in the three counties Finnmark, Troms and Nordland, were selected for the study. All high schools in Finnmark, except one, and all high schools in the northern and southern parts of Troms and Nordland were included. The twenty-one high schools were located in semi-rural and rural areas and represented a variety of ethnic contexts. These ethnic contexts encompass different Sami subgroups, with different proportions of Sami inhabitants in the communities and differences in assimilation-related experiences. The students filled out the questionnaires at the schools. Every student gave his/her written consent based on oral and written information about the project. The questionnaires were completed during two regular school hours. All eligible students at each school completed the questionnaire at the same time, and refusers were in the same class room as participants. Students who were not present at school during the testing period, completed a questionnaire at a later session. The North Norwegian Youth Study obtained prior approval and consent from the Regional Medical Ethical Committee, The Norwegian Data Inspectorate, the Ministry of Research and Education, the school authorities of the respective counties, as well as from each school board. Details about the sample and procedure have been described elsewhere (Kvernmo & Heyerdahl, 2003, 2004).

Sample characteristics

All high school students (15–21 years) in the study schools were invited to participate in the survey ($N = 4019$). The overall response rate was 85% ($N = 3417$). There were 286 (7%) who refused to participate, 260 (6%) did not adequately complete the form for a variety of reasons, and 56 students (1%) withdrew from the study. Students from other ethnic groups ($N = 33$), those who had incomplete identification numbers ($N = 25$) and students who were younger than 16 years or older than 18 years ($N = 306$) were also excluded. Thus, the sample analyzed (1994/1995) included 2691 students (1402 females, 52% and 1289 males, 48%) aged 16–18 years (mean age 16.9, SD 0.8 years) with no differences in the mean age between the genders or between the ethnic groups. The sample consisted of 591 (22%) indigenous Sami (323 females and 268 males; 55% and 45%, respectively) and 2100 (78%) majority subjects (1079 females and 1021 males; 51% and 49%, respectively).

Measures

Sociodemographic variables

Family structure: Family structure was classified as (1) Two-parent home (biological parents), (2) Single parent home (living in a mother or father headed household), (3) Parent/step-parent home (one biological parents and one step-parent), and (4) Others (e.g. relatives, foster parents or boarding school).

Type of education: Type of education was classified as vocational and general (theoretical) studies.

Socio-economic status: Socio-economic status was classified according to International Standard for Classification of Occupation, ISCO-88 (International Labour Office, 1990), based on the profession of the parent with the highest occupation. Occupations were recorded on a 5-point scale: ranging from upper class/higher administration (I) to primary industry (V).

Ethnicity: Ethnicity was classified as Sami or majority. Adolescents were classified as Sami if one of the parent's ethnicity was reported as Sami, if one of the grandparents' or parents' languages was Sami or if adolescents' self-reported ethnicity was Sami (Kvernmo & Heyerdahl, 2003). Because of discrimination, many Sami avoid reporting their Sami background. However, reporting language competence is not considered to be as stigmatizing as ethnic background. Therefore, classification based on self-reported ethnicity is shown to be misleadingly low. Inasmuch as very non-Sami speak Sami, language competence and parents' ethnicity together are considered to be the most reliable measure of Sami ethnicity (Kvernmo & Heyerdahl, 1996).

Emotional/behavioural problems and risk-taking behaviour

Suicidal behaviour: The question "Have you ever tried to commit suicide?" (yes/no) was used to measure prevalence of suicide attempts. Suicidal ideation during the last 6 months was measured by item 91 in Youth Self Report (YSR) (Achenbach, 1991), "I am thinking of ending my life". In the analyses the item was categorized as "Yes" and "No".

Emotional/behavioural problems: Sami and Norwegian versions of YSR were applied. The instruments have been used previously in studies among Sami and Norwegian adolescents (Heyerdahl, Kvernmo, & Wichstrøm, 2004; Kvernmo & Heyerdahl, 1998), and reliabilities for the instrument for both Sami and majority groups were satisfactory (Cronbach's $\alpha \geqslant .65$) in this survey (Heyerdahl et al., 2004). Only the syndrome scales Anxious/Depressed Problems, Delinquent Behaviour and Social Problems are used here.

Eating behaviour problems: A short version of the Eating Attitudes Test (EAT-12) (Garner, Olmsted, Bohr, & Garfinkle, 1982) developed by Lavik, Clause, and Pedersen (1991) was used to measure eating problems (in Wichstrøm, 1995). EAT-12 consists of 12 items recorded on a four-point scale from "never/seldom" to "always". As the scores were both kurtotic and skewed, they were log transformed prior to the analyses to normalize their distribution. The reliability (Cronbach's α) was tested for both ethnic groups and was satisfactory in both ethnic groups (0.70).

Current smoking: Current smokers were categorized as "Yes" (daily smokers and occasional smokers) and "No"(never, experimenters and former smokers) (Spein, Sexton, & Kvernmo, 2004).

Alcohol intoxication: Alcohol use was measured by one question concerning the preceding 12 months; "Have you had so much to drink that you felt drunk?". The question was recorded on a

six-point scale ranging from "never" to "more than 50 times". In the analyses the question was categorized into "Yes"(≥1 times/12 months) and "No".

Sexual behaviour: One question measured debut of sexual intercourse; "Have you ever experienced sexual intercourse?" (yes/no).

Involvement in romantic relationships: The question "Do you have a boy/girlfriend?" measured involvement in romantic relationships, with response categories "Yes, presently", "Yes, previously" and "No, never". In the analyses the item was dichotomized into "Yes" and "No".

Parent–child relationship

Parental bonding: Parental bonding was measured by means of the Parental Bonding Instrument, a measure assessing the adolescents' perception of the care and protection provided by both parents (Parker, Tupling, & Brown, 1979). The internal consistency (Cronbach's α) of PBI was satisfactory for both ethnic groups. For the Sami, the values were 0.69, 0.74, 0.77 and 0.72 for maternal care, maternal overprotection, paternal care and paternal overprotection, respectively, and for majority peers; 0.74, 0.75, 0.78 and 0.71 for maternal care, maternal overprotection, paternal care and paternal overprotection, respectively.

Statistical analysis

Suicide attempters were compared to non-suicide attempters on all independent risk factors for Sami and majority adolescents separately. Student *t*-tests were performed for the continuous risk factors and χ^2 tests performed for the categorical ones, respectively. Fisher's Exact Test was performed when the expected count was less than five.

All significant risk factors in the univariate analyses were then included in a binominal logistic regression analysis using forward conditional approach for Sami and majority suicide attempters separately. The interaction of gender was controlled for the following variables; in both ethnic groups: experienced sexual intercourse, girl/boyfriend, anxious/depressed problems, eating behaviour problems and paternal care; among Sami adolescents: current smoking; and among majority adolescents: type of education, family structure, socioeconomic status, suicide ideation, delinquent behaviour, maternal care and paternal overprotection. Data analyses were performed with the SPSS 13.0 software.

Results

Table 1 shows the distribution of sample characteristics in the overall sample by ethnicity and gender. There were significant ethnic differences in the distribution of socioeconomic status, alcohol intoxication, social problems and paternal care. More Sami adolescents reported primary industry background, had never been intoxicated and had higher scores on social problems while more majority adolescents reported having higher scores on paternal care.

In both ethnic groups there were a significant difference between the gender in the distribution of suicide attempts, girl/boyfriend, experienced intercourse, anxious/depressed, eating behaviour problems and paternal care. Among majority adolescents ethnic-specific gender differences such as, family structure, socioeconomic status, suicide ideation, maternal care and paternal

Table 1
Distribution of sample characteristics in the total sample and by ethnicity and gender

	Total sample						Indigenous Sami					Majority				
	Female ($n = 1402$)		Male ($n = 1289$)		Effect of gender (χ^2)	Effect of ethnicity (χ^2)	Female ($n = 323$)		Male ($n = 268$)		Effect of gender (χ^2)	Female ($n = 1079$)		Male ($n = 1021$)		Effect of gender (χ^2)
	n	%	*n*	%			*n*	%	*n*	%		*n*	%	*n*	%	
Type of education					75.97***	3.71					19.31***					56.11***
General studies	901	64	612	48			219	68	134	50		682	63	478	47	
Vocational studies	497	36	670	52			103	32	133	50		394	37	537	53	
Family structure					16.56***	2.45					1.86					16.79***
Two-parent	948	68	930	72			213	66	189	71		735	69	741	73	
Single parent	212	15	210	16			56	17	43	16		156	15	167	16	
Parent/Step-parent	160	12	104	8			32	10	25	9		128	12	79	8	
Others	74	5	42	3			20	6	11	4		54	5	31	3	
Socioeconomic status					11.94*	30.70***[a]					4.20					14.41**
Higher adm. professionals	68	5	74	6			17	6	10	4		51	5	64	7	
Upper middle class	340	26	355	30			72	24	54	22		268	26	301	31	
Lower middle class	210	16	165	14			45	15	30	12		165	16	135	14	
Working class	520	39	479	40			103	35	104	43		417	41	375	39	
Primary industry	184	14	128	11			59	20	44	18		125	12	84	9	
Suicide attempts					17.33***	1.17					7.83**					10.11***
No	1192	88	1156	93			261	86	239	93		931	89	917	93	
Yes	165	12	91	7			44	14	18	7		121	12	73	7	
Suicide ideation					10.80***	1.06					2.38					8.23**
No	1130	82	1080	87			255	81	218	86		875	83	862	87	
Yes	243	18	162	13			60	19	36	14		183	17	126	13	

Current smoking					8.05**	2.55					11.81***					2.18
No	779	58	776	63			175	57	178	71		604	58	598	61	
Yes	573	42	454	37			133	43	73	29		440	42	381	39	
Alcohol intoxication					1.88	14.67***[b]					1.03					1.26
No	285	20	290	23			82	25	78	29		203	19	212	21	
Yes	1117	80	999	78			241	75	190	71		876	81	809	79	
Girl/boyfriend					47.95***	3.24					19.58***					30.63***
No	268	20	391	31			63	21	95	37		205	19	296	30	
Yes	1098	80	854	69			244	80	159	63		854	81	695	70	
Experienced intercourse					73.83***	1.07					23.07***					52.03***
No	455	34	617	50			201	66	115	46		697	67	494	51	
Yes	898	66	609	50			105	34	138	55		350	33	479	49	
	Mean	SD	Mean	SD		*t*	Mean	SD	Mean	SD	*t*	Mean	SD	Mean	SD	*t*
Age 16–18	16.9	0.8	17.0	0.8	−0.35	−0.29	17.0	0.8	16.9	0.8	1.65	16.9	0.8	17.0	0.8	−1.26
Anxious/depressed	7.4	5.0	5.0	4.0	13.56***	−0.96	7.5	5.0	5.1	4.3	6.11***	7.4	5.0	5.0	3.9	12.06***
Delinquent behaviour	4.6	2.7	5.3	3.0	−5.45***	−1.04	4.9	2.6	5.2	3.3	−1.16	4.6	2.7	5.3	2.9	−5.63***
Social problems	2.5	1.8	2.5	1.9	−1.03	−3.74***[c]	2.7	1.9	2.8	2.0	0.88	2.4	1.8	2.5	1.9	−0.83
Eating behaviour problems	0.5	0.3	0.3	0.3	19.36***	−0.45	0.4	0.3	0.3	0.3	6.15***	0.5	0.3	0.2	0.3	18.66***
Maternal care	3.2	0.6	3.1	0.6	3.38***	1.0	3.2	0.6	3.1	0.5	0.79	3.2	0.6	3.1	0.6	3.43***
Maternal overprotection	2.0	0.6	2.1	0.6	−1.51	−0.24	2.1	0.6	2.1	0.6	−0.21	2.0	0.6	2.1	0.6	−1.60
Paternal care	2.8	0.7	2.9	0.6	−4.03***	3.23***[d]	2.7	0.7	2.9	0.6	−3.32***	2.9	0.7	2.9	0.6	−2.71**
Paternal overprotection	2.0	0.6	1.9	0.5	3.66***	−0.15	2.0	0.6	1.9	0.5	0.84	2.0	0.6	1.9	0.5	3.69***

Notes: * $p \leqslant .05$; ** $p \leqslant .01$; *** $p \leqslant .001$ SD: Standard deviation.

[a]Primary industry: Sami > majority.

[b]Never intoxicated: Sami > majority.

[c]Sami > majority.

[d]Sami < majority.

overprotection were found. Among Sami adolescents the only ethnic-specific differences between the genders was in the distribution of current smoking.

No ethnic differences were found in prevalence of suicide attempts between indigenous Sami adolescents (10.5%, $n = 62$) and their majority peers (9.2%, $n = 194$). In the overall sample, 9.5% ($n = 256$) reported suicide attempts.

There was a significant gender difference in both ethnic groups, with females being more likely to attempt suicide than males. The gender differences were more pronounced among Sami adolescents, with females twice as likely to report a suicide attempt than males (Table 1).

Sociodemographic characteristics

Across ethnic groups, family structure was significantly associated with previous suicide attempts. Sami adolescents living in single parent homes were more likely to report suicide attempts as were majority adolescents living with others (e.g. relatives, foster parents or boarding school). Among majority adolescents, ethnic specific characteristics for suicide attempts such as attending vocational studies and reporting primary industry background (Table 2) were found. Across ethnic groups, age was not significantly associated with suicide attempts.

Emotional/behavioural problems, risk-taking behaviour and parent–child relationship

Across ethnic groups, suicidal ideation was significantly associated with suicide attempts, with approximately one third of the suicidal adolescents reporting suicidal ideation during the last 6 months. All applied YSR subscales, Anxious/Depressed Problems, Delinquent Behaviour and Social Problems, were in both ethnic groups significantly associated with suicide attempts. The strongest association was found for Anxious/Depressed Problems for both ethnic groups. Significant relationships also occurred between suicide attempts and eating behaviour problems (Table 3).

Across ethnic groups, smoking, alcohol intoxication, involvement in romantic relationships and experienced intercourse were significantly associated with suicide attempts (Table 3).

Paternal lack of care and paternal overprotection were significantly associated with suicide attempts in both ethnic groups (Table 3). Among Sami adolescents, maternal overprotection was associated with suicide attempts. Among majority adolescents, maternal lack of care was associated with suicide attempts.

Risk factors associated with suicide attempts

In the logistic regression analyses, suicidal ideation, Anxious/Depressed Problems and having higher mean scores on eating behaviour problems were common risk factors associated with suicide attempts in both ethnic groups (Table 4). For indigenous Sami adolescents, being alcohol intoxicated, living in single parent home and reporting paternal overprotection were all associated with an increase in reporting suicide attempts (Table 4). Majority adolescents who reported being current smokers, attending vocational studies, living with others (e.g. relatives, foster parents and boarding school), and experiencing intercourse had an increased risk for reporting suicide

Table 2
Sociodemographic characteristics for suicide attempters by ethnicity

	Suicide attempters					
	Indigenous Sami ($n = 62$)			Majority ($n = 194$)		
	%	(n)	χ^2	%	(n)	χ^2
Age			1.18			0.04
16	9.3	(18)		9.5	(70)	
17	12.7	(26)		9.6	(68)	
18	11.0	(18)		9.3	(56)	
Gender			7.83**			10.11**
Female	14.4	(44)		11.5	(121)	
Male	7.0	(18)		7.4	(73)	
Type of education			0.01			18.01***
General studies	11.4	(38)		7.0	(80)	
Vocational studies	10.6	(24)		12.6	(113)	
Family structure			11.50**			27.21***
Two-parents	7.8	(30)		7.3	(105)	
Single parent	18.3	(17)		14.0	(44)	
Parent/Step-parent	18.2	(10)		11.7	(23)	
Others	13.8	(4)		27.3	(21)	
Socioeconomic status			0.79[a]			16.67**
Higher adm. professionals	7.4	(2)		8.3	(9)	
Upper middle class	9.9	(12)		5.7	(32)	
Lower middle class	10.6	(8)		8.9	(26)	
Working class	12.6	(25)		10.6	(82)	
Primary industry	11.3	(11)		14.5	(29)	

Notes: $^{*}p \leqslant .05$; $^{**}p \leqslant .01$; $^{***}p \leqslant .001$.
[a]Fisher's Exact Test.

attempts (Table 4). Across ethnic groups gender did not have a main effect, but female gender had an interaction effect with Anxious/Depressed Problems among Sami.

Discussion

The main finding in this study was that there were no ethnic differences in prevalence of suicide attempts between indigenous Sami adolescents and their majority peers. An important finding in our study is the cross-cultural differences in patterns of risk factors associated with suicide attempts. The ethnic specific associations found among Sami adolescents, single parent home, alcohol intoxication and paternal overprotection, can be characterized as diverging from traditional cultural norms.

Although great variation in prevalence of suicidal behaviour is found between and within different indigenous groups (Hunter and Harvey, 2002), our main finding contrasts with other

Table 3
Factors associated with suicide attempts by ethnicity

Variables	Indigenous Sami ($n = 62$)			Majority ($n = 194$)		
	%	(*n*)	χ^2	%	(*n*)	χ^2
Suicidal ideation			72.36***			227.01***
No	6.1	(28)		5.4	(93)	
Yes	36.6	(34)		33.1	(100)	
Current smoking			15.40***			38.38***
No	7.2	(25)		6.1	(73)	
Yes	18.0	(37)		14.3	(117)	
Alcohol intoxication			13.29***			19.50***
No	3.2	(5)		3.7	(15)	
Yes	14.0	(57)		10.9	(179)	
Girl/boyfriend			7.97**			15.99***
No	5.2	(8)		4.9	(24)	
Yes	13.6	(54)		11.0	(168)	
Experienced intercourse			12.39***			38.12***
No	5.9	(14)		4.8	(39)	
Yes	15.4	(48)		13.1	(153)	
	Mean	SD	*t*	Mean	SD	*t*
Anxious/depressed			−5.9***			−8.4***
Non-attempters	5.9	4.4		5.9	4.5	
Attempters	10.7	6.2		9.3	5.5	
Delinquent behaviour			−3.4**			−6.8***
Non-attempters	4.9	2.9		4.7	2.7	
Attempters	6.2	3.0		6.3	3.1	
Social problems			−2.0*			−4.2***
Non-attempters	2.7	1.9		2.3	1.8	
Attempters	3.2	2.1		3.0	2.0	
Eating behaviour problems			−4.5***			−5.4***
Non-attempters	0.3	0.3		0.3	0.3	
Attempters	0.5	0.3		0.5	0.3	
Maternal care			1.8			2.6**
Non-attempters	3.2	0.6		3.2	0.6	
Attempters	3.0	0.6		3.0	0.7	
Maternal overprotection			−2.2*			−1.6
Non-attempters	2.0	0.6		2.0	0.6	
Attempters	2.2	0.6		2.1	0.7	
Paternal care			3.2**			4.0***
Non-attempters	2.8	(0.7)		2.9	0.6	
Attempters	2.5	(0.7)		2.7	0.7	
Paternal overprotection			−3.2**			−2.8**
Non-attempters	1.9	(0.6)		1.9	0.5	
Attempters	2.2	(0.7)		2.1	0.6	

Notes: $^{*}p \leqslant .05$; $^{**}p \leqslant .01$; $^{***}p \leqslant .001$.

Table 4
Risk factors associated with suicide attempts by ethnicity

Variables	OR	95% CI	*p*-value
Indigenous Sami adolescents ($n = 487$)			
Suicidal ideation (no vs yes)	6.6	3.3–13.0	.000
Anxious/depressed problems by female gender	1.1	1.0–1.2	.002
Family status, single parent	3.2	1.4–7.4	.006
Alcohol intoxication (no vs yes)	3.6	1.2–10.9	.021
Eating behaviour problems	3.5	1.1–10.3	.030
Paternal overprotection	1.7	1.0–2.9	0.044
Majority adolescents ($n = 1,687$)			
Suicidal ideation (no vs yes)	5.7	3.7–8.8	.000
Family status, others	3.9	1.9–7.8	.000
Vocational studies	2.0	1.4–2.9	.000
Exp. intercourse (no vs yes)	2.4	1.5–3.8	.000
Current smokers (no vs yes)	2.0	1.4–3.0	.001
Anxious/depressed problems	1.0	1.0–1.1	.046
Eating behaviour problems	1.9	1.0–3.4	.050

Notes: OR: Odds ratio, CI: Confidence interval.

research that generally indicates a higher prevalence of suicide attempts among indigenous adolescents than among their majority peers (Kirmayer et al., 2000; Langford et al., 1998). During the last three decades Sami in Norway have been in an ongoing cultural revitalization process. Today, the Sami have, to a great extent, achieved cultural equality and are less socially disadvantaged when compared to other indigenous people. The lack of ethnic differences in prevalence of suicide attempts found in our study may be explained by these cultural and socioeconomic circumstances.

This study indicates that the prevalence of suicide attempts among indigenous Sami adolescents is relatively low compared to other indigenous peers. Moreover, the prevalence of suicide attempts among ethnic diverse adolescents in Arctic Norway corresponds well with results from a representative national Norwegian sample (8.2%) (Wichstrøm, 2000). The percentage found among Sami females is moderate compared to, for example, American Indian-Alaska native females (22%) (Blum, Harmon, Harris, Bergeisen, & Remick, 1992). However, compared to a representative national Norwegian sample for females (10.4%), Sami females' percentage can be considered high. There was an interaction effect of female gender with Anxious/Depressed Problems among Sami suicide attempters. In a study by Kvernmo and Heyerdahl (1998) parents reported more internalizing problems among Sami adolescents, while Sami adolescents themselves reported more externalizing problems. However, there is substantial evidence that females dealing with acculturation may be more at risk for problems than males (Beiser & Edwards, 1994). This may also be true for Sami females.

The ethnic-specific association found in our study between alcohol intoxication and suicide attempts may be explained by the strong influence of Laestadianism, "the Sami Christianity".

Since the 1840s, Laestadianism has had a historically strong influence in Sami areas of northern Scandinavia. This pietistic movement has strong anti-alcohol norms (Larsen, 1993), hence making alcohol intoxication a more culturally divergent behaviour among Sami adolescents than among their majority peers. Correspondingly, lower intoxication rates have been found among Sami adolescents when compared to their majority peers (Spein et al., 2004).

Cultural differences between Sami and Norwegian cultures exist regarding family structure and the significance of relatives (Javo, Rønning, & Heyerdahl, 2004). Traditionally, Sami families consist of an extended family that often includes parents, children and other close relatives such as grandparents. In a Sami cultural context, single-parent homes are culturally divergent. As a result, single-parent homes may therefore represent a stronger risk factor among Sami adolescents than they do in the Norwegian culture where nuclear family structure and single-parent homes are more common.

Although parental overprotection seems to play a less important role in adolescent psychopathology than parental care (Burbach, Kashani, & Rosenberg, 1989), it may be of importance in the present study. Central features in Sami child rearing are the strong emphasis on individual autonomy and a parenting style characterized by high permissiveness, low control and high warmth (Javo et al., 2004). According to Javo et al. (2004), paternal overprotection contrasts with the common child rearing norms in Sami culture, and may therefore increase the risk for conflicts, especially during adolescence. Conflict with parents is one of the primary precipitating events for suicidal behaviour in adolescence (Beautrais, Joyce, & Mulder, 1997).

The risk factors diverging from traditional Sami culture may represent a stronger risk among Sami adolescents due to the ethnic-specific meaning of these risk factors. However, it is important emphasize that individual risk factors do not exert their effect in isolation. Risk of developing suicidal behaviour depends on accumulative exposure to series of social, family, personality and mental health factors (Fergusson, Woodward, & Hornwood, 2000).

In this study, suicide attempt was based on self-reports, and no validation was used. However, the survey method (self-administration questionnaire), the setting (at school) and the degree of anonymity are factors that may have increased the validity of self-reported suicide attempts. A serious limitation with the present study is that the survey did not investigate suicidal method used, seriousness of injury or whether there was intent to die. The wide confidence interval found for several variables in this study, are most likely due to small groups and great individual variance within the groups.

Further investigations are necessary in order to study and enhance knowledge of how both general living conditions and indigenous-specific processes such as acculturation, ethnic identity development and culture transference, among others, act as protection against or influence risk for suicidal behaviour among indigenous adolescents from different groups and cultural contexts. In the future, it will be of interest to explore for common factors as well as factors differentiating the risk for suicidal behaviour in adolescence and young adulthood between indigenous groups. Longitudinal studies with multiple informants will be needed for this purpose.

Proper treatment and prevention of suicidal behaviour among indigenous adolescents necessitate both knowledge of general risk and protective factors but also knowledge about indigenous cultures in order to identify risk factors diverging from traditional culture.

Acknowledgements

This research has been financed by EXTRA funds from the Norwegian Foundation for Health and Rehabilitation through the Norwegian Council for Mental Health. The authors want to thank statistician Tormod Brenn, University of Tromsø, for his advice and assistance on statistical procedures.

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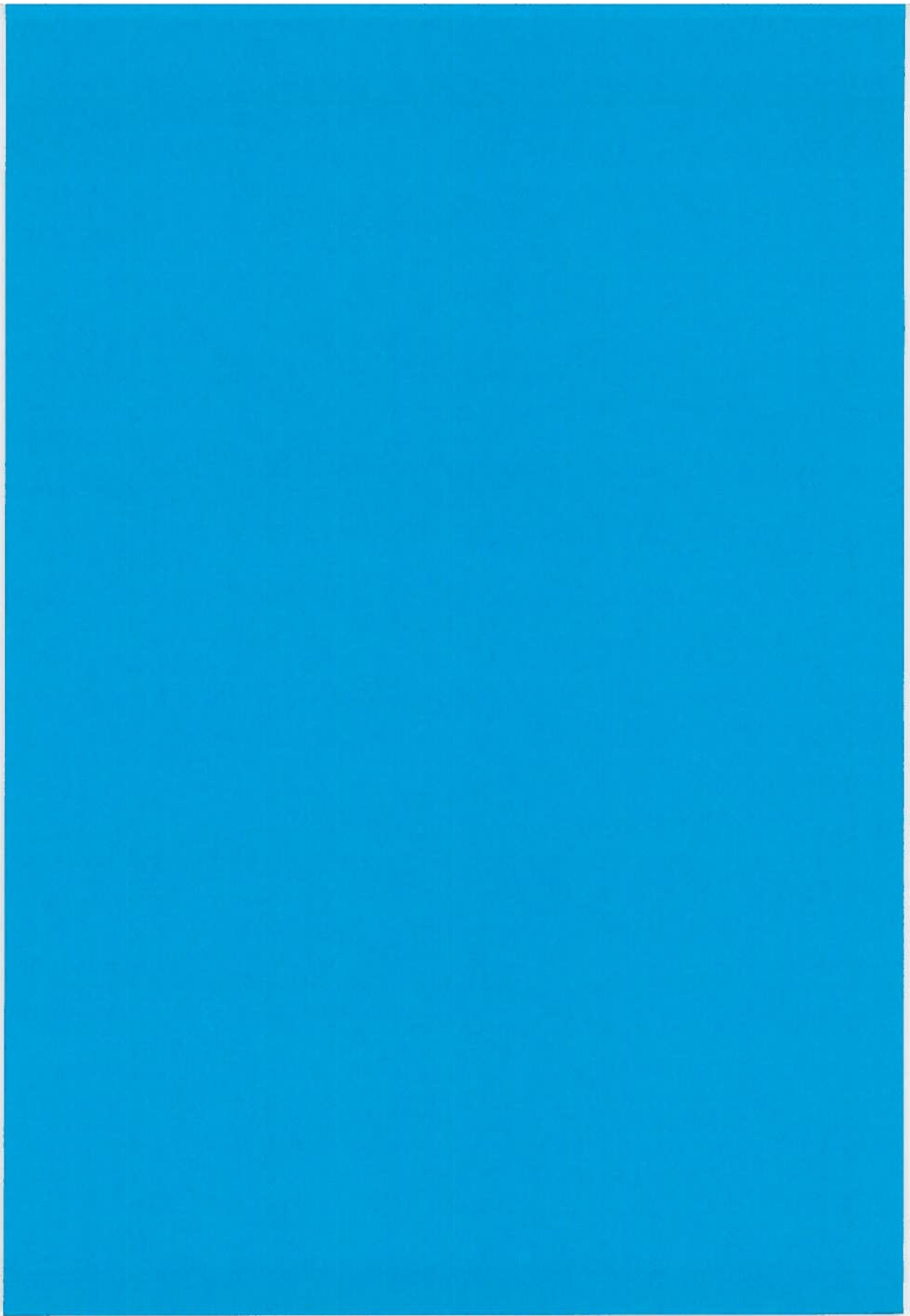
Paper III



Risk factors associated with different types of suicide attempters: A longitudinal study among ethnic diverse adolescents in Arctic Norway

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Abbreviated title: Risk factors associated with diverse suicide attempters

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Abstract

Objectives: To examine variation in risk factors associated with different types of suicide attempters among ethnic diverse adolescents in a longitudinal perspective. **Design:** A longitudinal epidemiological anonymous questionnaire survey based on adolescent self-reports. The first study wave was in 1994-95 (T1; school-based; full-time 10th – 12th graders; response rate (RR): 85%, N=85% (N=3,417)) and the second in 1997-98 (T2; combined school-based and postal questionnaire study; RR: 57% (N=1,678)). The present follow-up sample, for which both T1 and T2 data were available, included 1,528 adolescents aged 18 to 22 years. The sample consisted of 24 % (n=363) indigenous Sami and 76 % (n=1165) majority subjects. **Results:** In the overall sample, 10.4 % (n=155) of the adolescents reported a previous suicide attempt at T1. Among these attempters at T1, 81.3 % (n=126) did not report a re-attempt during the study period (Early suicide attempters), whereas 18.7 % (n=29) reported a re-attempt at T2 (Repeated suicide attempters). On the other hand, 1.7 % (n=24) reported a first attempt during the study period (T2) (Late suicide attempters). Diverse patterns of associated risk factors and prognosis were found between the attempters, with repeating attempters constituting a higher risk group compared to early and late attempters. Ethnic-specific associations with suicide attempts such as Anxious/depressed Problems, Sami ethnicity and female gender were found at T1, and being a parent with Sami ethnicity and female gender were found at follow-up. **Conclusions:** Suicide attempters comprise a heterogeneous group regarding level of emotional/behavioral problems and substance use. Clinical and prevention implications are discussed.

Keywords: Suicide attempts, risk factors, adolescents, indigenous Sami

Introduction

Adolescence is a transitory period characterized by physiological and psychological changes, acting-out and risk-taking behavior. Although risk-taking behaviors in many respects have become normative among westernized adolescents, high-risk behavior tends to cluster in the same individual (Petridou *et al* 1997). Adolescent life-style has long-term consequences for physical and mental health and, for some, may even have fatal consequences. Suicidal adolescents constitute a group at risk not only for negative psychosocial development but, unfortunately, also for mortality (Laurent *et al* 1998). The aim of this study is to examine risk factors associated with suicide attempters among ethnic diverse adolescents in Arctic Norway from a longitudinal perspective.

Suicidal behavior has an underlining multi-factorial nature, and there has been increasing research interest in the risk factors and life processes that encourage adolescents to engage in suicidal behavior (e.g. Brent, 1995; Lewinsohn *et al*, 1996; Beautrais 2000; Fergusson *et al* 2000; Grøholt *et al* 2000a; Wichstrøm 2000). Nevertheless, cohesive models are relatively scarce. This can be related to the large number of potential variables that can account for variance in the outcomes of interest (Gutierrez *et al* 2005). Risk factors for suicidal behavior have been found in different domains, such as (i) social and family factors; (ii) individual and personality factors; (iii) mental health factors; (iv) precipitating circumstances and stressful life events; and (v) environmental and contextual factors (Beautrais 2000). Affective disorders, disruptive disorders, previous suicide attempts and substance abuse are well established as suicide risk predictors in adolescence (Marttunen *et al* 1992; Brent 1995; Grøholt *et al* 1997). Studies of suicide attempters may add important knowledge to the understanding of the much less frequent occurrence of actual suicide (Lewinsohn *et al* 1996).

Suicide attempters constitute a heterogeneous group, and multiple attempters constitute a qualitatively different and potentially higher risk group compared to single attempters. A study by Rudd and colleagues (1996) showed that multiple attempters presented a more extreme clinical picture (e.g., depressive and anxiety symptoms, suicidal ideation, hopelessness and negative problem solving), and accordingly, an elevated suicide risk when compared with single attempters and ideators. Negative problem solving has also been associated with multiple suicide attempters (Jeglic *et al* 2005). A past history of suicide attempt represents the strongest known risk factor for future suicide attempts and completions (e.g. Marttunen *et al* 1992). A recent follow-up study by Grøholt and colleagues evaluated predictors for repetition of suicide attempts among adolescents hospitalized in medical wards after a suicide attempt (2006). In their study four factors had an independent predictive effect on repeating suicide attempt during the follow-up period: comorbid disorders, hopelessness, having ever received treatment for mental or behavior problems, and having a father exerting control without affection (2006). The identification of subtypes of adolescent suicide attempters may have important implications for the choice of treatment prevention strategies (Kienhorst *et al* 1993).

Suicidal behavior varies to some extent by ethnocultural background of the adolescents (Roberts *et al* 1997). Especially high rates of suicidal behavior are found among several indigenous people all around the world, e.g., among Australian Aboriginal people (Hunter & Harvey 2002), the Maori of Aotearoa/New Zealand (Langford *et al* 1998), the Canadian Inuit (Sigurdson *et al* 1994), the Alaskan natives in the US (Borowsky *et al* 1999) and among the Inuit in Greenland (Leineweber *et al* 2001). Arctic Norway is a region with a multiethnic population, inhabited with a majority population (Norwegian), indigenous Sami (hereafter called Sami) and the national minority Kvens (descendents of Finnish-speaking immigrants from northern Finland and Sweden). The Sami are the indigenous people of

Scandinavia residing in the arctic parts of Norway which, like other arctic areas, is sparsely populated. The Sami population is estimated to be about 100,000 individuals living in northern Fenno Scandinavia including the Russian Kola Peninsula. The majority (70%) of Sami live in Norway, where they are formally considered an indigenous people with their own culture and native language. During the last three decades, a process of integration and increased ethnic revival has gradually replaced a history of forced assimilation and colonization by the Norwegian government.

According to the relatively few studies on the health situation in the Sami population, there is no evidence of a more disadvantaged health status. Compared to the majority population, studies have shown less alcohol use among Sami adults and adolescents (Larsen 1993; Kvernmo *et al* 2003a), and similar rates of mental health problems, smoking and sexual risk taking behavior for adolescents (Kvernmo *et al* 2003a; Heyerdahl *et al* 2004). This picture differs with that for several other indigenous groups worldwide. In spite of this similarity in prevalence of mental health problems, significant intragroup variation is found in emotional and behavioral problems in Sami adolescents. In particular, ethnocultural issues influenced mental health status significantly in young Sami males (living in Norwegian dominated areas with low density of same ethnic peers and little support for their native culture, and favoring assimilation were strongly associated with emotional problems).

In the 1980s, the suicide rate was particularly high in some areas of Arctic Norway where the majority of the population is Sami. The suicides were assumed to reflect mental health problems in Sami areas due to ethnic identity issues and cultural change (Hildal 1997). In a recent study, a significant moderate increased risk for suicide was found among Sami in Arctic Norway (Silviken *et al* 2006). On the other hand, another study from the North Norwegian Youth Study found no ethnic differences in prevalence of suicide attempts between Sami adolescents and their non-Sami peers in Arctic Norway (Silviken & Kvernmo

in press). Although no ethnic differences were found in this study, suicidal behavior among Sami adolescents seemed to be related to cultural factors. Among Sami adolescents, risk factors diverging from traditional Sami cultural norms were associated with suicide attempts, such as alcohol intoxication, single-parent home and paternal overprotection.

The aims of this study were (1) to differentiate risk factors associated with three groups of suicide attempters (early, late and repeated attempts) among ethnic diverse adolescents in Arctic Norway, (2) to examine developmental outcome in emotional/behavior problems and substance use among suicide attempters during the study period, and finally (3) to explore for ethnic differences in prevalence of suicide attempts and associated risk factors between Sami adolescents and their non-Sami peers.

Methods

Procedure

The data are from The North Norwegian Youth Study, a longitudinal epidemiological anonymous questionnaire survey based on adolescent self-reports. The study was conducted in areas inhabited by Sami, Kvens and Norwegians in Arctic Norway. The first study wave was in 1994-95 (T1; school-based; N=3,186; full-time 10th – 12th graders; response rate (RR): 85%) and the second in 1997-98 (T2; combined school-based and postal questionnaire study; N=1,670; RR: 57%). Twenty-one state high schools (10-12th grade students) in the three counties of Finnmark, Troms and Nordland, were selected for the study. During the study period, one school had lost its participating list prior to follow-up (excluding N=125 subjects). The twenty-one high schools were located in semi-rural and rural areas and represented a variety of ethnic contexts. These ethnic contexts encompass different Sami subgroups, with different proportions of Sami inhabitants in the communities and differences in assimilation-related experiences. At T1, the students filled out the questionnaires at the

schools. Every student gave his/her written consent based on oral and written information about the project. The questionnaires were completed during two regular school hours. All eligible students at each school completed the questionnaire at the same time, and refusers remained in the same class room as participants. Students who were not present at school during the testing period completed a questionnaire at a later session. The 3-year follow-up interval reflects the usual duration of high school education in Norway. At T2, only 31% (N=440) still attended high school. The remaining 69% received mailed questionnaires, thus explaining the lower response rate at follow-up. A Sami version of the questionnaire was available in the main Sami dialect. The North Norwegian Youth Study obtained prior approval and consent from the Regional Medical Ethical Committee, the Norwegian Data Inspectorate, the Ministry of Research and Education, the school authorities of the respective counties, as well as from each school board. Details about the sample and procedure have been described elsewhere (Kvernmo & Heyerdahl 2003b; 2004; Spein *et al* 2002; 2004).

Sample Characteristics

At T1, all high school students (15-21 years) in the study schools were invited to participate in the survey (N=4,019). The overall response rate was 85% (N=3,417). There were 286 (7%) who refused to participate, 260 (6%) who did not adequately complete the form for a variety of reasons, and 56 students (1%) who withdrew from the study. Students from other ethnic groups (N=33) and those who had incomplete identification numbers (N=25) were also excluded.

At follow-up 2,947 of the students from T1 were invited to participate. Those who were older than 22 years at T2 were not invited to participate (n=344). Furthermore, one school did not participate at T2 because it had lost the participant list prior the follow-up survey (n=126). The follow-up sample from the North Norwegian Youth Study consisted of

1,678 students (T2) with a response rate of 57 % and mean age 19.6 (SD 1.0) years. At follow-up, only 31 % (440) attended state school, a fact that may have contributed to the low response rate, as the majority received a mailed questionnaire. The present follow-up sample, for which both T1 and T2 data were available, included 1,528 adolescents aged 18 to 22 years (mean age at T2 (T1) was 19.8 (17.1)). Females comprised about 61 % (N= 926) of the follow-up sample, and there were no differences in the mean age between the genders or between the ethnic groups. The sample consisted of 363 (24 %) indigenous Sami (225 females and 138 males; 62 % and 38 %, respectively) and 1,165 (76 %) majority subjects (701 females and 464 males; 60 % and 40 %, respectively). Those adolescents who were lost to follow-up were at T1 significantly more likely to report non-parental living arrangements (e.g. relatives, foster parents or boarding school), attend vocational studies, report being current smokers and use cannabis during last 12 months, report lower mean scores on Somatic complaints, Anxious/depressed Problems, Hopelessness and loneliness, and report higher mean scores on Social Problems and Delinquent Behavior.

Table 1 shows the distribution of the overall sample and the variables under investigation at T1 by gender and ethnicity. This table serves only descriptive purposes. At T1, more girls reported general studies, suicidal ideation, previous suicide attempt, current smoking, occasional alcohol intoxication and higher mean scores on Withdrawn, Somatic Complaints, Anxious/depressed Problems, Thought Problems, Aggressive Behavior, hopelessness, loneliness, maternal care and paternal overprotection. On the other hand, more boys reported higher socioeconomic status and higher mean scores on perceived pubertal timing, Delinquent Behavior and paternal care. More Sami adolescents reported general studies, not having used cannabis during last 12 months and higher mean scores on age, perceived pubertal timing, Withdrawn, Social Problems and loneliness, while more majority

adolescents reported frequent intoxication by alcohol and having higher mean scores on paternal care.

Table 1 about here

Table 2 shows the distribution of sample characteristics in the overall sample at T2 by gender and ethnicity. More girls reported suicidal ideation and higher mean score on Withdrawn, Somatic Complaints, Anxious/depressed Problems, Social Problems and hopelessness, while more boys reported living together with mother and/or father, unemployment, cannabis use and higher mean score on Alcohol Consumption. More Sami adolescents reported unemployment, being a parent and higher mean score on age, Withdrawn and Delinquent Behavior, while majority adolescents reported higher mean score on Alcohol Consumption.

Table 2 about here

Measures

Sociodemographic variables

Living arrangements At T1,living arrangements were classified as (1) Two-parent home (biological parents), (2) Single parent home (living in a mother or father headed household),

(3) Parent/step-parent home (one biological parents and one step-parent), and (4) Non-parental arrangements (e.g. relatives, foster parents or boarding school). At T2, living arrangements were classified as (1) Living together with mother and/or father, (2) Living alone or in communal living, (3) Living together with spouse/partner/boy- or girlfriend, (4) Other arrangements (e.g. own children, military/initial service, extended family or relatives).

Type of education Type of education was classified as vocational and general (theoretical) studies.

Socio-economic status Socio-economic status (SES) was classified according to International Standard Classification of Occupation, ISCO-88 (International Labour Office 1990), based on the profession of the parent with the highest occupation. Occupations were recorded on a 5-point scale, ranging from upper class / higher administration (I) to primary industry (V). In the analyses, SES was dichotomized into "High" (1-2) vs "Low" (3-5).

Unemployment Unemployment at T2 was measured with one question: "Have you ever been unemployed?" (Yes/No).

Being a parent At T2, the following statement was used to measure whether or not the adolescents had children: "Yes, I have .....(number of) children" or "No". In the analyses this variable was dichotomized into "Yes" vs "No".

Ethnicity Ethnicity was classified as Sami or non-Sami/majority. Adolescents were classified as Sami if one of the parent's ethnicity was reported as Sami, if one of the grandparents's or if one of the parent's languages was Sami (Kvernmo and Heyerdahl, 2003b; 2004). Because of fear of discrimination, many Sami avoid reporting their Sami background. However, reporting language competence is not considered to be as stigmatizing as reporting ethnic background. Therefore, classification based on self-reported ethnicity is shown to be misleadingly low. As very few non-Sami speak Sami, language competence and parents'

ethnicity together are considered to be the most reliable measure of Sami ethnicity (Kvernmo & Heyerdahl 1996).

Perceived pubertal timing

Perceived pubertal timing Pubertal timing was measured with one item (Alsaker 1992): "When you look at yourself now, do you think that you are more or less physically mature compared to others at your own age?". The item was recorded on a 7 point scale ranging from "much later" to "much earlier".

Suicide attempts

Suicide attempts The question, "Have you ever tried to commit suicide?" was used to measure prevalence of suicide attempts at T1 and T2. At T1 the response categories were "Yes" and "No", while at T2 the response categories were "No, never", "Yes, one time", and "Yes, several times". In the analyses the answers were categorized as "Yes" and "No". Those adolescents reporting suicide attempts at T1, and not at T2, were categorized as "Early suicide attempters", whereas adolescents' reporting attempts both at T1 and during the study period (at T2) were categorized as "Repeating suicide attempters". Those adolescents who reported their fist suicide attempt during the study period were categorized as "Late suicide attempters". The question "If you answered "yes" on C, how long is it since you last time attempted suicide? ..... year ..... months", was used to make a distinction between attempts during the study period vs. attempts before T1.

Emotional/behavioral problems

Suicide ideation Suicidal ideation during the last six months was measured at T1 by item 91 on the Youth Self Report (YSR) (Achenbach 1991) and at T2 by item 91 on the Young Adult

Self Report (YASR) (Achenbach 1990; 1997) by the statement, "I am thinking of ending my life". In the analyses, the item was categorized as "Yes" and "No".

Emotional/behavioral problems The syndrome scales Withdrawn, Somatic Complaints, Anxious/depressed Problems, Thought Problems, Delinquent Behavior and Aggressive Behavior from the YSR and YASR were used in the analyses. The items, "I deliberately try to hurt or kill myself" (18) and "I am thinking of ending my life" (91) were removed from the Anxious/depressed YRS and YASR scales.

Loneliness Loneliness was measured at T1 by the question, "I feel lonely", from the UCLA Loneliness Scale, with scores ranging on a 4 point scale from "Never" to "Often". *Loneliness was not measured at T2.*

Hopelessness Hopelessness was measured at T1 and T2 with one item from Hopkins Symptom Checklist: "Felt hopelessness thinking of the future". The item was recorded on a 4 point scale ranging from "Not bothered at all" to "Bothered a lot".

Substance use variables

Current smoking Current smokers were categorized as "Yes" (daily smokers and occasional smokers) and "No"(never, experimenters and former smokers) (Spein *et al* 2004) at T1 and T2.

Alcohol intoxication/consumption Alcohol intoxication was measured at T1 by one question concerning the preceding 12 months: "Have you had so much to drink that you felt drunk?". The question was recorded on a six-point scale ranging from "never" to "more than 50 times". Adolescents reporting that they had been intoxicated more than 10 times were categorized in the analyses as "Frequent alcohol intoxication", "Occasional" (1-10) and "No". At T2, Alcohol Consumption during the preceding six months was measured by one question from the YASR: "In the past 6 months, about how often have you been drinking alcohol?".

The question was recorded on a six-point scale ranging from "never" to "more than 21 units/glass per week".

Cannabis use Cannabis use was measured at T1 by one question concerning the preceding 12 months; "Used hashish or marihuana?". The question was recorded on a six-point scale ranging from "never" to "more than 50 times". In the analyses the variable was categorized as "No" and "Yes". At T2 the question, "Have you ever used hashish or marihuana?" (Yes/No), was used.

Parent-child relationship

Parental bonding Parental bonding was measured by means of the Parental Bonding Instrument, a measure assessing the adolescents' perception of the care and protection provided by both parents (Parker *et al* 1979).

Statistical Analysis

Suicide attempters were compared to non-suicide attempters on all independent risk factors for each group separately (early, late and repeated suicide attempters). Student t-tests were performed for the continuous risk factors, and chi-square tests were performed for the categorical risk factors. Fisher's Exact Test was performed when the expected count was less than five.

All significant risk factors in the univariate analyses were then included in a binominal logistic regression analysis using forward conditional approach separately for early, late and repeated suicide attempts. The interaction of age, gender and ethnicity were controlled for separately in each suicide attempt group, and the following interactions were examined among early attempters: SES x age, Anxious/depressed Problems x gender x ethnicity and loneliness x ethnicity x gender at T1, and being a parent x ethnicity x gender, Withdrawn x

gender and Delinquent Behavior x gender at T2. Among late attempters, loneliness x age and maternal protection x age at were examined at T1 and Alcohol Consumption x age, Somatic Complaints x gender and Anxious/depressed Problems x age at T2. Among repeating attempters: suicide ideation x age, Withdrawn x age, paternal overprotection and age and paternal care x gender at were examined at T1, and Alcohol Consumption x age at T2. Data analyses were performed with the SPSS 14.0 software.

Results

In the overall sample, 10.4 % (n=155) of the adolescents reported previous suicide attempts at T1. Among these attempters at T1, 81.3 % (n=126) did not report a re-attempt during the study period (Early suicide attempters), whereas 18.7 % (n=29) reported a re-attempt during the study period (Repeated suicide attempters). On the other hand, 1.7 % (n=24) reported a first attempt during the study period (T2) (Late suicide attempters). The prevalence of suicide attempts was in general higher for girls than for boys. However, significant gender differences were found only among Early suicide attempters at T1 (Table 1 and Table 2). There were significant ethnic differences in the prevalence of previous suicide attempts at T1, with a higher prevalence of attempts among Sami adolescents than among their majority peers (14 % vs 9.3 %). However, the significant ethnic difference was found only among females, resulting in 18.7 % for Sami and 10.7% for majority Norwegians (χ^2=9.14, p. ≤ .01). Among the males, the differences were only minor (Sami 6.7 %, and for majority Norwegians 7.2 %) (results not shown). Nevertheless, across all three suicide attempt groups, early, late and repeaters, no ethnic differences were found in prevalence of suicide attempts between indigenous Sami adolescents (10.5%, n=38; 1.7%, n=6; 2.8%, n=10) and their majority peers (7.6%, n=88; 1.5%, n=18; 1.6%, n=19).

Early suicide attempters

Sociodemographic characteristics at T1/T2 and parent-child relationship at T1

Type of education and living arrangements were significantly associated with early attempters. Early attempters were more likely to pursue vocational studies than general studies (11.1 %, n=69 vs 6.6 %, n=56) (χ^2=9.61, p. ≤ .01) and to live in non-parental arrangements (e.g. relatives, foster parents or boarding school) at T1 (29.5 %, n=13) (χ^2=31.98, p. ≤ .001). Conversely, fewer early attempters than expected were living alone or in communal living arrangements at T2 (5.5 %, n=24) (χ^2=13.72, p. ≤ .01). On the other hand, unemployment at T2 was significantly associated with early suicide attempts (42.6 %, n=52) (χ^2=6.74, p. ≤ .01), and those with early suicide attempts were also more likely to have low socieconomic status (9.4 %, n=86) (χ^2=3.93, p. ≤ .05). At follow-up, early attempters were more likely to have become parents during the study period than were non-attempters (12.7 %, n=16 vs 4.5 %, n=60) (χ^2=15.84, p. ≤ .001). At T1, early attempters also had significantly lower mean scores on maternal and paternal care and higher mean scores on paternal overprotection compared to non-attempters (Table 3).

Table 3 about here

Emotional/behavioral problems and substance use at T1 and at T2

Although suicidal ideation was significantly associated with early suicide attempts at both T1 and T2, there was a remarkable decrease of 47% and 16%, respectively, in the prevalence of suicide ideation during the study period, (Table 3 and 4). Current smoking, Alcohol

intoxication/Consumption and cannabis use were all significantly associated with early suicide attempts at T1 and T2 (Table 3 and 4). However, the results indicated only a slight increase in the frequency of current smoking among early attempters during the study period. Concerning Alcohol intoxication/Consumption, fewer early attempters (6.3 %, n=8) than expected had never been intoxicated during the last 12 months at T1, and at T2, they had higher mean score on consumption. Cannabis use was significant associated with early attempters both at T1 (last 12 months) and T2 (lifetime prevalence). Although cannabis use among non-attempters increased during the study period, from approximately 6 % to 15 %, the increase among early attempters of approximately 17 % at T1 and 33 % at T2, was much higher. At T1, perceived pubertal timing was significantly associated with early suicide attempts, with suicide attempters reporting earlier pubertal timing compared to non-attempters.

All applied YSR subscales, Withdrawn, Somatic Complaints, Anxious/Depressed Problems, Social Problems, Thought Problems, Delinquent Behavior and Aggressive Behavior, were significantly associated with early suicide attempts at T1, as were hopelessness and loneliness (Table 3). At T2, only five YSR subscales, Withdrawn, Somatic Complaints, Thought Problems, Delinquent Behavior and Aggressive Behavior, were significantly associated with early suicide attempts (Table 4). Furthermore, during the study period, early attempters decreased their mean scores on almost all continuous variables/subscales, with the exception of Social Problems. The most striking decreases among early attempters were seen on subscales Anxious/depressed Problems and Delinquent Behavior.

Table 4 about here

Risk factors associated with early suicide attempts at T1 and T2

In the logistic regression analyses, suicidal ideation, vocational studies, non-parental living arrangements (e.g. relatives, foster parents or boarding school), current smoking, being frequent intoxicated by alcohol, perceived pubertal timing and Anxious/Depressed Problems by Sami ethnicity by female gender were all significant risk factors associated cross-sectionally with early suicide attempts at T1. In addition, paternal care was a significant protective factor associated with early attempters (Table 5). On the other hand, current smokers, Alcohol Consumption, cannabis use, living together with spouse or partner, Withdrawn by female gender and being a parent by Sami ethnicity by female gender were significant risk factors associated cross-sectionally with early attempters at T2 (Table 5). About 40 % of the Sami females who were parents at T2 reported a previous suicide attempt at T1 (results not shown).

Table 5 about here

Late suicide attempters

Sociodemographic characteristics at T1/T2 and parent-child relationship at T1

Age was the only sociodemographic variable significantly associated with late suicide attempts, with late attempters having lower average age than non-attempters both at T1 (16.6, SD=0.8 vs 17.1, SD=1.0, t=2.9, p. ≤ .05) and at T2 (19.3, SD=1.0 vs 19.8, SD=1.1, t=2.1, p. ≤

.05). At T1, late attempters had significantly higher mean scores on maternal and paternal overprotection compared to non-attempters. (Table 3).

Emotional/behavioral problems and substance use at T1 and at T2

Suicidal ideation was significantly associated with late suicide attempts at T2. During the study period, suicide ideation increased from 17 % to approximately 60 % among late attempters. Cannabis use was the only substance use which was significantly associated with late suicide attempts at T1 and T2 (Table 3 and 4). Approximately one third of late attempters reported cannabis use at T1 (last 12 months) compared to about 7 % among non-attempters. Remarkably, at T2, cannabis use (lifetime prevalence) among late attempters had increased to approximately 60 %. There was a trend toward higher prevalence of current smoking at T1 among late attempters than among non-attempters (57 % vs 37 %, p. 0.053). However, corresponding with the trend found among early attempters, current smoking increased slightly during the study period among late attempters.

At T1, only one YSR subscale, Aggressive Behavior, was significantly associated with late attempters at T1, whereas at T2 several subscales were significantly associated with late attempters; specifically, Withdrawn, Somatic Complaints, Anxious/depressed and Aggressive Behavior, and hopelessness (Table 4). During the study period, late attempters increased their mean scores on almost all these variables, with the most striking increases occurring for Anxious/depressed Problems and hopelessness.

Risk factors associated with late suicide attempts at T1 and T2

For late attempters, cannabis use during the last 12 months and maternal overprotection were the only significant risk predictors for suicide attempts during the study period (Table 5). On the other hand, at follow up/T2, suicide ideation, lifetime prevalence of cannabis use and

hopelessness were significantly associated cross-sectionally with late suicide attempts (Table 5).

Repeated suicide attempted

Sociodemographic characteristics at T1/T2 and parent-child relationship at T1

Unemployment was the only sociodemographic variable significantly associated with repeating suicide attempts at follow-up, with repeating attempters being more likely to have been unemployd than non-attempters (62.1 %, n=18 vs 31.1 %, n=397) (χ^2=12.50, p. ≤ .001). At T1, repeating attempters had a significantly lower mean score on maternal care compared to non-attempters (Table 3).

Emotional/behavioral problems and substance use at T1 and at T2

Suicide ideation was significantly associated with repeated suicide attempts at both T1 and T2 (Table 3 and 4). The highest prevalence of suicide ideation was found among repeaters at T1, with approximately 80 % reporting suicide ideation during the last six months. Although the prevalence decreased to 52 % during the study period, it can still be considered high when compared to the percentage for non-attempters at T2 (9 %). Current smoking at T2 was the only substance use which was significantly associated with repeating attempters (Table 4). The frequency of smoking increased remarkably among repeaters during the study period, from 48 % to 72 % (Table 3 and 4). Although the repeaters were more likely to have used cannabis during the last 12 months than non-attempters at T1, the increase in lifetime prevalence of cannabis use during the study period among repeaters was minor compared to early and late attempters. Moreover, at T2, repeating attempters had a lower mean score on Alcohol Consumption than non-attempters.

All applied YSR subscales, with the exception of the Delinquent Behavior subscale, were significantly associated with repeated suicide attempts at T1 (Table 3), while at T2 all subscales, except from Thought Problems, were significantly associated with repeated suicide attempts (Table 4). Hopelessness was significantly associated with repeaters both at T1 and T2 (Table 3 and 4). Although repeaters' mean scores on several variables/subscales decreased during the study period, the scores for hopelessness and Aggressive Behavior were stable.

Risk factors associated with repeated suicide attempts at T1 and T2

Suicidal ideation by age (rising age increased the risk for suicide attempts) and Somatic Complaints at T1 were significant risk predictors for repeated suicide attempts during follow-up (Table 5). On the other hand, at T2, suicide ideation, unemployment and Delinquent Behavior were significantly associated cross-sectionally with repeated attempts (Table 5). In addition, there was a borderline association between hopelessness and repeated suicide attempts at T2 (OR 1.5; 95 % CI 0.99, 2.4).

Discussion

This longitudinal study examined variation between different types of suicide attempters among ethnic diverse adolescents in Artic Norway. The finding that about 10 % of the adolescents in the total follow-up sample reported a previous suicide attempt at T1 is consistent with results from a representative national Norwegian sample (8.2%) (Wichstrøm 2000), and from international studies which estimate that the lifetime prevalence of suicide attempts in high-school-aged adolescents is between 3 % and 15 % (Lewinsohn *et al* 2001). Consistent with other studies (Canetto & Sakinofsky 1998; Wichstrøm & Rossow 2002), there were significant gender differences in lifetime prevalence of suicide attempts in the total sub-sample at T1, with females more frequently reporting previous suicide attempts. At

follow-up, 1.7 % of the total sample reported their first attempt (late attempters) during the study period. The finding that about 19 % of the suicide attempters at T1 made a re-attempt during the study period is consistent with other research, indicating that approximately 20 % repeat their suicide attempts (Retterstøl *et al* 2002). However, the recent study by Grøholt and colleagues reported that almost half of the adolescents (43 %) repeated a suicide attempt during the follow-up (2006). Compared to our finding the much higher prevalence of repetition found in this study may be explained by a long follow-up period (8-10 year) and that the study included adolescents hospitalized in medical wards after a suicide attempts.

The significant ethnic differences found in this sample of a higher prevalence of suicide attempts among Sami adolescents than their majority peers at T1, is inconsistent with recent cross-sectional results from The North Norwegian Youth Study (Silviken & Kvernmo *in press*). However, the ethnic differences found in this follow-up sample are due to the high prevalence of suicide attempts among Sami females. Although the prevalence found among Sami girls was high in the initial total sample (14 %) (Silviken & Kvernmo *in press*), the prevalence in this follow-up sample was remarkably higher than among their female counterpart (about 19 % vs. 11 %, results not shown). One possible explanation for this finding is that significantly more Sami adolescents reporting suicide attempts at T1 participated at follow-up (results not shown). However, the higher lifetime prevalence of suicide attempts found among Sami females is consistent with another study among Sami in Arctic Norway where a significant increase in suicide mortality was found for 15-24 years old Sami females (Silviken *et al* 2006). Although the lifetime prevalence of suicide attempts among Sami adolescents in general is relatively low (10.5 %) (Silviken & Kvernmo, *in press*) compared to other indigenous peers (up to about 30 %) (Blum *et al* 1992; Kirmayer *et al* 1996), the prevalence found among Sami females can be considered to be moderate when compared to, for example, Greenlandic females (33 %) (Curtis *et al* 2006). On the other hand,

compared to a representative national Norwegian sample for females (10.4%), the percentage for Sami females can be considered to be high. However, after controlling for other risk factors in the multiple logistic analyses, this ethnic difference disappeared.

Suicide ideation

A main finding in our study was that suicidal ideation was one of the strongest risk factors associated with suicide attempts across attempt groups. Among repeating attempters, long-term suicidal ideation was revealed during the study period, whereas suicidal ideation was only associated with early attempters at T1 and among late attempters at follow-up. The interaction effect of suicidal ideation and age at T1 among the repeaters indicated that rising age at T1 increased the risk for re-attempt during the study period. Moreover, the descriptive data indicated that for both early and repeating attempters, suicide ideation decreased during the study period (though the most pronounced decrease was among early attempters), while suicide ideation increased remarkably among late attempters. Our findings emphasize the important influence suicidal ideation has on suicide attempts. Suicidal ideation has been found to convey uniquely important information for predicting future suicide attempts, even after controlling for depression (Lewinsohn *et al* 1996). According to Lewinsohn and colleagues (1996) suicidal ideation acts as a potentiator for suicidal behavior in a way that depression, by itself, does not. Interestingly, the descriptive data in our study shows the same pattern for Anxious/depressed Problems as for suicidal ideation; e.g., for early attempters, the mean scores on Anxious/depressed Problems decreased during the study period, while they increased among late attempters. Adolescents can be extremely depressed, but it seems that if they do not exhibit suicidal ideation, then they are unlikely to make a suicide attempt (Lewinsohn *et al* 1996).

Substance use

Another main finding in our study was the diverse patterns of substance use among the attempters. While a comprehensive pattern of substance use were associated with early attempters, especially at T2 (current smoking, Alcohol Consumption and cannabis use), cannabis use was the only substance associated with late attempters, both prospectively at T1 and cross-sectionally at T2. In contrast to early and late suicide attempters, current smoking was the only substance use associated with repeating attempters in the multivariate analysis at follow-up. Our findings are consistent with studies that demonstrate that suicide attempts are more likely to occur among adolescents who drink frequently or heavily (Shaffer & Pfeffer 2001) and among adolescents who use illicit drugs (Gould *et al* 1998, Beautrais *et al* 1999).

An interesting finding in our study was the prospective influence of cannabis use on late attempters during the study period. Although cannabis use has increased in Norway during the 1990's (Skretting 1996) and, at least experimental use, has become a normative life-event for many westernized adolescents (von Sydow *et al* 2002), the prevalence of cannabis use among adolescents in Artic Norway is moderate (about 10 % 1994/95) (Kvernmo *et al* 2003a). Therefore, cannabis use in Artic Norway can still be considered as deviant behavior, suggesting that adolescents using cannabis may represent a marginalized group. Cannabis use has been found to be more prevalent among individuals characterized by sociodemographic disadvantage and disadvantageous childhood family circumstances (Beautrais *et al* 1999). Pedersen and colleagues (2001) found a strong linkage between early conduct problems and subsequent cannabis use. According to social-interactional theory, early antisocial and delinquent behaviors may lead to involvement with deviant peers who model and reinforce various deviant behaviors, including substance use (e.g. Dishion *et al* 1997). Moreover, cannabis is most frequently used by adolescents as the first illicit use/"gateway drug"

(Kingery *et al* 1999), indicating that early and late attempters are more vulnerable for developing severe substance abuse in the future.

Although substance dependence is a well-documented risk factor for both attempted and completed suicides among adolescents (Gould *et al* 1998; Beautrais 2000; Fergusson *et al* 2000), even high alcohol consumption (binge drinking) without dependence can increase risk for suicidal behavior (Grøholt *et al* 1997). Heavy alcohol consumption and suicidal behavior may both serve as an immediate way of escaping an intolerant situation (Rossow *et al* 1999). Substance use has been found to have an effect on unplanned suicide attempts, but not a significant effect on planned attempts (Borges *et al* 2000). Since impulsiveness is one of the main characteristics of adolescent suicide attempts (Williams & Pollock 2002), substance use is a highly potent risk factor for suicidal behavior in adolescence. On the other hand, the finding that repeating attempters had lower mean scores on Alcohol Consumption than non-attempters at T2 is consistent with the pattern that low consumption of alcohol or substance use may, for some subgroups of attempters, represent a risk indicator. Both Alcohol Consumption and cannabis use were less prevalent among repeaters than among the other suicide attempters at follow-up. Adolescents who are abstainers or drink less than their peer counterparts have been associated with psychological maladjustment (Pape & Hammer 1996) and characterized by poor sociability, feelings of insecurity, lack of popularity in school, fewer friends and never having intimate conversations with friends (Leifman *et al* 1995). In a study by Grøholt and colleagues, suicide attempters who drank less than the average adolescent were clinically more depressed, and tended to isolate themselves (2000b). Our findings may confirm the paradox, that both extremes, high and low prevalence of Alcohol Consumption may represent a risk factor associated with diverse suicide attempters.

The finding that current smoking was significantly associated with early suicide attempts both at T1, at follow-up, and among repeaters at follow-up, corresponds with findings from

other studies (Tanskanen *et al* 2000; Mäkikyrö *et al* 2004). Smoking behavior and regular smoking, in particular among adolescents in Arctic Norway, are associated with risk-taking or health compromising behaviors such as substance use, delinquency, and sexual behavior (Spein *et al* 2004). Although the prevalence of current smoking was higher among all three groups of attempters when compared to non-attempters, the prevalence increased noticeably among the repeaters, with almost 70 % of the repeaters being current smokers at follow-up. Studies have documented a positive relationship between smoking and suicidality and between smoking and depression among adolescents (Haarasilta et al 2004) in non-clinical (Tanskanen *et al* 2000) and clinical samples (Mäkikyrö *et al* 2004). It is hypothesized that smoking may function as "self-medication" to obtain relief from feelings of depression, despair, impulsivity, and suicidality (Mäkikyrö *et al* 2004). On the other hand, this "self-medication" can lead to further substance abuse, which can thus increase the risk for depression (Lerman *et al* 1998). However, at present, there is no evidence to confirm a causal relationship between smoking and suicidal behavior. Thus, the relationship could mediate the presence of other risk factors that may, in turn, increase the risk of suicidality (Mäkikyrö *et al* 2004).

Emotional and behavioral risk factors associated with suicide attempters.

A central finding in our study was the variation in patterns of internalizing problems associated with the diverse suicide attempters. The only risk factor of internalized character found among early attempters at T1, except for suicidal ideation, was the interaction of Anxious/depressed Problems with Sami ethnicity and female gender (discussed below). However, at T2 we found a cross-sectional interaction effect among early attempters between Withdrawn and female gender in multivariate analyses. This finding is consistent with the general impression in suicidological research showing that social isolation is a risk factor for

suicidal behavior. On the other hand, our finding is inconsistent with a community based study from Sweden among younger adolescents (7-9 grades) (Ivarsson *et al* 2002). In the Swedish study, high score on YSR subscale Withdrawn was negatively associated with suicide attempts, indicating that withdrawal was a protective factor. However, this finding does not necessarily imply that withdrawal is a protective factor in late adolescence and among young adults. A related finding was reported in a community-based study among American adolescents, where socially isolated females were more likely to have suicidal thoughts than their male counterparts, but where the social network variables that shaped suicidal ideation failed to predict suicide attempts (Bearman & Moody 2004).

The finding that suicide ideation and hopelessness were associated with late and repeating attempters at follow-up (a trend was suggested for hopelessness among repeaters), may indicate that both groups are characterized by depressive symptoms. The most striking increases among late attempters during the study period were, in fact, seen on Anxious/depressed Problems and hopelessness, while repeaters reported high and stable scores during the study period. Our findings are consistent with the notion that depression and hopelessness affect adolescents with suicidal ideations more frequently than non-suicidal peers (de Man & Leduc 1995; Kumar & Steer 1995). Although depression is a major risk factor for suicidal behavior, hopelessness is a key psychological variable mediating between depression and suicidal behavior (Dieserud *et al* 2001) that has been found to be a core issue in the suicidal adolescent's wish to die (Grøholt *et al* 2000b).

In contrast to the early and late attempters, prospective risk factors associated with repeaters at T1 indicated problems primarily of an internalized nature, specifically, suicide ideation by age and Somatic Complaints. Somatic complaints, without medical origin, are considered to be a physical expression of an emotional disturbance (Chapman 2005), and youth with frequent somatic complaints have higher rates of depressive symptoms (Dopheide

2006). According to Terre and colleagues (2003), is it unclear whether somatic complaints represent a component of depression or whether somatic complaints independently increase the risk of developing depressive symptoms in the future. However, somatic complaints have been found to predict subsequent symptoms of depression, but only in women (Terre *et al* 2003). Consistent with this finding, Egger and colleagues (1999) found that somatic complaints in adolescence were associated with depression and anxiety disorders in females and disruptive behavior disorders in males. Although females are more likely to report somatic symptoms than their male counterpart during adolescence (Aarø *et al* 2001), we didn't find any interaction effect between Somatic Complaints and gender in our study. Furthermore, the impression from the descriptive data is that suicide attempters in general had higher mean scores on Somatic Complaints. It could be that attempters have more somatic symptoms than non-attempter. However, another hypothesis could be that somatization is a way of experiencing and communicating distress, provided that attempters are less able to verbalize their emotional problems. Descriptive data in our study showed that repeaters had high mean scores both on Anxious/depressed Problems and also on Social Problems, confirming the impression that repeaters lack social competence or have problems regarding interpersonal relationships.

Since depression is one of the most important risk factor associated with suicidal behavior among adolescents, is it interesting that Anxious/depressed Problems did not appeared as a significant risk factor, with the exception of in the interaction effect between Sami ethnicity and female gender among early attempters at T1. This finding could be explained by the fact that this scale measures both anxiety and depressed problems, making it harder to find an association between depression and suicide attempts. However, we don't find this argument plausible. First, several studies have showed that anxiety disorder and depressive disorder in general co-occur in children and adolescents (Verhulst *et al* 1997;

Costello *et al* 2003). A Dutch study, using the YSR in a general population sample of young adolescents, found that only very small numbers of individuals had mainly anxiety or mainly depression, and most (99 %) had comorbid symptoms (van Lang *et al* 2006). Next, the role of depression as related to suicide risk may not be as direct and simple as it seems (Tomori & Zalar 2000). Woods and colleagues (1997) have hypothesized that suicide attempts among adolescents may be more closely associated with risk and problem behaviors, than with depression and psychiatric indicators. In their study, smoking, substance use and sexual behavior were associated with suicide attempts. The results from our study support these findings regarding the significance of smoking and substance use. On the other hand, several studies suggest that externalizing behavior problems and internalizing symptoms often coexist in adolescence (e.g. Lewinsohn *et al* 1995; Ivarsson *et al* 2002). Our descriptive data showed a similar pattern, with attempters having significantly higher mean scores on several internalizing and externalizing subscales both at T1 and T2 as compared to non-attempters. In addition, delinquent behavior was associated cross-sectionally with repeaters at T2, with the attempters comprising most internalizing association at T1.

Development of emotional/behavior problems and substance use during the study period. An interesting finding in our study was the different developmental trajectory of risk factors found among suicide attempters. Early attempters reported high mean scores at T1 on several risk factors; however, with the exception of Social Problems, they were characterized by a decrease in mean scores on almost all YSR scales and hopelessness at follow-up. The most striking decreases among early attempters were seen on subscales Anxious/depressed Problems and Delinquent Behavior. However, the decrease in emotional/behavior problems among early attempters at follow-up didn't reached the level of non-attempters. Although the results from T2 can give an impression of an enhanced psychological well-being among early

attempters, past suicide attempt is not an isolated problem (Lewinsohn *et al* 1996). Adolescents who have made a previous suicide attempt show problematic functioning even though the attempts may have occurred several years earlier. The finding that a comprehensive pattern of substance use was associated with early suicide attempters at follow-up, may indicate that this group is at risk for developing future substance abuse and/or emotional/behavior problems. Additionally, non-parental livings arrangements at both T1 (e.g., relatives, foster parents or boarding school) and at T2 (living with spouse/partner) were associated with early suicide attempts. The finding that non-parental living arrangements increased the risk of suicide attempts is in accordance with other studies among adolescents from non-intact homes (Beautrais 2000; Grøholt *et al* 2000a; Garnefski & Diekstra 1997). On the other hand, the finding that paternal care was a protective factor among early suicide attempters at T1, confirms the significance of adequate parental care during adolescence.

The descriptive data indicated that late attempters primarily had high scores on substance use and externalizing behavior at T1, and that internalizing problems first started to increase during the study period, reaching the level found among early attempters at T1. The cross-sectional association with suicidal ideation and hopelessness at T2 confirmed this pattern of increased depressive symptoms/internalizing problems. The finding that maternal overprotection was a significant predictor for late suicide attempts at T1, may indicate that late attempters' substance use and externalizing behavior increased parental worries and overprotection. On the other hand, maternal overprotection may be an indicator of an authoritarian parenting style, that is characteristic of demanding and controlling parents who are neither responsive nor warm (Adalbjarnardottir & Hafsteinsson 2001). Studies from Iceland and Norway, found that an authoritarian parenting style was associated with adolescent substance use (Adalbjarnardottir & Hafsteinsson 2001; Clausen 1996). In our study, descriptive data at T1 indicated that late attempters in general reported that their

perceived pubertal timing was "just like others", but compared to the other attempters, late attempters had the lowest mean score (indicating a later perceived pubertal timing). The finding that early pubertal timing was significantly associated with early suicide attempters at T1, may confirm the hypothesis that adolescents reporting their first attempt at T2 were "late starters" due to lower mean age and later pubertal timing at T1. Hence, this may suggest that late attempters were protected against suicide attempts at T1 and that the risk first started to increase during the study period. The timing of pubertal maturation has, in general, a strong influence on mental health and has been found to affect females and males differently, with early-maturing females and late-maturing males having more psychological problems and disorders (Graber *et al* 1997). In a study by Wichstrøm, a linear effect of perceived early pubertal timing was found among girls, whereas both late- and early-developed boys were at risk for suicide attempts (2000). However, in our study there was no significant interaction effect between gender and pubertal timing.

Although repeaters' mean scores on several variables decreased slightly during the study period, the general impression from the descriptive data was that repeaters had a stable pattern of high scores at T1 which sustained during the follow-up period. The finding that unemployment was associated cross-sectionally with repeated attempters at follow-up, may confirm a negative trajectory with problematic functioning and poor adjustment. According to findings from a study by Beautrais and colleagues, the association between unemployment and suicide attempts is non-causal and appears to arise from the correlation that exists between unemployment and psychiatric disorder (1998). With these findings in mind, the results found for repeaters in our study may reflect that repeaters had an increased risk of impaired mental health and socio-economic disadvantage as compared to other attempters. A possible explanation is that repeaters may already have developed chronic psychiatric morbidity and psychological dysfunction. Even more distressing, a past history of suicide

attempts represents the strongest known risk factor for future suicide attempts and completions (e.g. Marttunen *et al* 1992).

Ethnic specific associations

The interaction effect between Anxious/depressed Problems, Sami ethnicity and female gender found among early suicide attempters at T1, is in accordance with cross-sectional results from the initial total sample (Silviken & Kvernmo *in press*). On the other hand, this finding is inconsistent with results showing that there are no significant ethnic differences in Anxious/depressed Problems between Sami adolescents and their majority peers (Heyerdahl *et al* 2004). However, adolescent females in Arctic-Norway have, in general, higher scores than males on YSR Total Problems, the Internalizing syndrome scales and Attention Problems, and Sami females have even higher scores (Heyerdahl *et al* 2004). Beiser and Edwards (1994) claimed that girls dealing with acculturation were at a higher risk for problems than boys. However, this was not supported in the study by Kvernmo and colleagues (2003a), as acculturation attitudes and ethnic identity predicted fewer problems in females than in males. The interaction effect of Anxious/depressed Problems, Sami ethnicity and female gender may be explained by within group variation among Sami females. Sami females residing in the southern area (areas with low density of Sami) have the highest rate of problem behavior when compared to Sami adolescents residing in medium and high density areas (Kvernmo *et al* 2003a). Moreover, Sami adolescents residing in the southern area have the highest lifetime prevalence of suicide attempts (Kvernmo *et al* 2003a), and the rate was especially high among Sami females (19 % at T1 in the total sample, 30 % in the follow-up sample, result not shown).

The other ethnic-specific association found in this study was the interaction effect between being a parent with Sami ethnicity and female gender associated with early

attempters at follow-up. There are, in general, many factors associated with adolescent pregnancy, including early sexual intercourse debut (Scott-Jones & Turner 1998), sexual abuse (Saewcy *et al* 2004) and other high-risk behaviors such as substance use (Rome *et al* 1998). Although teenage pregnancy is in general considered to be obstetrically and socially undesirable, there exist considerably regional, social and ethnic differences (van Enk *et al* 2000). The finding that more Sami adolescents in the total sample were parents at follow-up is consistent with other findings showing that adolescent pregnancy is more common among indigenous people and minority groups than among majority groups (Quinlivan & Evans 2002; Rome *et al* 1998). The underlying causes of adolescent pregnancy may be different in different countries and cultures, and there is little knowledge of the factors specific to Sami culture for adolescent pregnancy.

Limitations

There are several limitations in this study. First, suicide attempt was based on self-reports, and no validation was used. However, the survey method (self-administration questionnaire), the setting (at school and post-enquete) and the degree of anonymity are factors that may have increased the validity of self-reported suicide attempts. A serious limitation with the present study is that the survey did not investigate the method used, seriousness of injury or whether there was intent to die. Furthermore, a high percentage of suicide attempters at T1 (72 %) did not report their previous suicide attempt at T2. There may be several possible explanations for this underreporting of retrospective self-report data, such as reinterpretation, shame, lack of frankness and the severity of the suicide attempt itself. Due to long the follow-up period in our study, adolescents may not remember or may minimize the significance of the previous attempt. Self-report questionnaires are, in general, subject to recall bias, and sensitive information may be even more vulnerable to this type of bias. Furthermore, adolescents in our study may have re-defined their previous suicide attempt as a stupid/foolish or non-serious act

as they get older. Suicide attempts may also be perceived as a sign of weakness and as a feminine act, something which could make males more vulnerable to underreporting suicide attempts (Canetto and Sakinofsky 1998). However, underreporting among males is considered to be a minor problem in anonymous questionnaires (Wichstrøm and Rossow 2002).

The wide confidence intervals found for several variables in this study, are most likely due to small groups, especially among late and repeating attempters, and great individual variance within the groups. Furthermore, the small number of subjects in our study evokes limited statistical power to detect weak but important associations. Several of our measures were quite brief (e.g., hopelessness and loneliness) and were assessed through single items which were extracted from larger scales. Therefore, little is known about the reliability of these single items. Additionally, since cannabis use was dichotomized, it was not possible to look at the prevalence of cannabis use, nor to look at whether use was experimental or on-going. However, even experimental use of cannabis at this age may be an important indicator of maladjustment. Another limitation with our study is that the study is based on univariate and bivariate methods of analyses, overlooking the effect of combined influence of several separate risk factors. However, univariate relations may provide valuable information regarding the role of specific variables, albeit in isolation (Lewinsohn *et al* 1996).

There were no significant differences between follow-up respondents and non-respondents regarding lifetime prevalence of suicide attempts at T1. However, since non-respondents (T2) tend to be characterized with several risk indicators at T1, including non-parental living arrangements (e.g. relatives, foster parents or boarding school), attending vocational studies, being current smokers, ever using cannabis, and having higher mean scores on Social Problems and Delinquent Behavior, the absence of these adolescents in the

study may have resulted in an underestimation of the number of suicide attempts during the study period.

Clinical and prevention implication

Assessment of previous and current suicidal behavior (ideation and attempts) should be an important component of the intake procedure in clinical practice. In addition, health care providers should have a special focus on key psychological variables mediating between depression and suicidal behavior, such as suicidal ideation and hopelessness. Since both substance use and suicidal behavior may serve as inadequate problem solving strategies, an important objective is to explore negative cognitions concerning attempter's ability to solve future problems (Jeglic *et al* 2005). Furthermore, in suicide risk assessments, clinicians should be responsive to the critical function substance use has for suicidal adolescents.

Increased awareness of warning signs of suicidality and the development of appropriate ways of responding to adolescents in distress are two important aspects of suicide prevention. Unfortunately, an important barrier to treatment of suicidality in adolescence may be the failure of the traditional gatekeepers to child and adolescent mental health care, parents and teachers, to recognize adolescent suicidality (Thompson *et al* 2006). Increased competence among gatekeepers in recognizing suicidality is necessary in order to overcome this barrier (e.g., Applied suicide intervention skills training, Living Works Education. www.livingworks.net). Help-seeking behavior among adolescents is another important prevention target. Studies have shown that the majority of suicidal adolescents never contact mental health services (e.g. Grøholt *et al* 1997), and that adolescents appear to rely upon informal help-seeking, such as support from family and friends, rather than professional services (Rickwood & Braithwaite, 1994). Consequently, mental health services have a special responsibility to make their services more accessible and attractive to young people;

for example, adolescents should have easy access to the treatment facilities, they should be able to admit themselves for treatment, and they should be able to receive treatment in their local communities. Furthermore, health providers working with indigenous and/or other cultural minorities should emphasize a culturally sensitivity approach. Ideally, professionals would have either indigenous/minority background or native language competence, or would have formal education in culture competence, including knowledge about the past- and present-day history of the culture and life.

Conclusions

This longitudinal study revealed diverse patterns of associated risk factors and prognoses for suicide attempters. Although an important finding from this study was that repeaters had long-term emotional and behavioral problems, all types of suicide attempters should be taken seriously. Appropriate treatment is necessary both to increase psychological well-being and to prevent future suicidal behavior among attempters. Much attention has been given to the high suicide rates among young indigenous males, however, clinicians working in Sami areas should also be aware of the high prevalence of suicidal behavior among young Sami females. Further research is necessary to examine within group differences in prevalence of suicidal behavior and associated risk factors among Sami adolescents.

Acknowledgements

This research has been financed by EXTRA funds from the Norwegian Foundation for Health and Rehabilitation through the Norwegian Council for Mental Health and Department of Community Medicine, Faculty of Medicine, University of Tromsø. The authors want to thank statistician Marita Melhus, University of Tromsø, for her advice and assistance on statistical procedures.

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Table 1

Distribution of sample characteristics by gender at T1

	Total sample (*n*=1,528)		Females (*n*=926)		Males (*n*=602)		Effect of	
							Gender	Ethnicity
Variables at T1	*N*	%	*n*	%	*n*	%	χ^2	
Ethnicity							0.4	
Sami	363	24	225	24	138	23		
Non-Sami	1165	76	701	76	464	77		
Type of education							31.4***	5.2*a
General studies	880	58	587	64	293	49		
Vocational studies	642	42	337	37	305	51		
Living arrangements							7.0	4.5
Two-parent	1084	71	638	69	446	75		
Single parent	227	15	141	15	86	14		
Parent with partner	164	11	109	12	55	9		
Non-parental arrangements	45	3	33	4	12	2		
Socioeconomic status							5.1*	1.8
High	498	35	284	32	214	38		
Low	943	65	595	68	348	62		
Suicidal ideation							8.7**	0.4
No	1267	84	748	82	519	88		
Yes	240	16	166	18	74	13		
Previous suicide attempts (T1)							11.5***	6.1*
No	1335	90	785	87	550	93		
Yes	155	10	113	13	42	7		
Early suicide attempts (T1)							7.8**	3.1
No	1402	92	835	90	567	94		
Yes	126	8	91	10	35	6		
Current smoking							7.7**	3.0
No	942	63	544	60	398	67		
Yes	552	37	359	40	193	33		

Alcohol intoxication							6.8*	20.1***b
No	310	20	181	20	129	21		
Occasional	687	45	441	48	246	41		
Frequent	531	35	304	33	227	38		
Cannabis							0.2	9.1**c
No	1417	93	862	93	555	93		
Yes	109	7	64	7	45	8		
	Mean	SD	Mean	SD	Mean	SD	t	
Age	17.05	1.0	17.1	1.0	17.0	1.0	0.6	2.3*d
Pubertal timing	1.8	0.7	1.7	0.7	1.9	0.8	-3.6***	2.0* d
Withdrawn	4.3	2.2	4.6	2.2	3.8	2.2	6.5***	4.6***d
Somatic Complaints	3.3	3.0	3.9	3.1	2.2	2.4	12.4***	0.2
Anxious/depressed Problems	6.5	4.7	7.5	5.0	4.9	3.9	11.5***	0.7
Social Problems	2.4	1.8	2.4	1.8	2.4	1.8	0.4	3.9*** d
Thought Problems	2.2	2.3	2.4	2.3	2.0	2.2	3.9***	-0.4
Delinquent Behavior	4.8	2.8	4.7	2.7	5.0	2.8	-2.4*	1.7
Aggressive Behavior	9.0	4.8	9.2	4.4	8.6	5.2	2.0*	1.4
Hopelessness	1.8	0.9	1.9	0.9	1.6	0.8	8.0***	-0.5
Loneliness	2.0	0.9	2.2	0.9	1.8	0.9	9.1***	3.2**d
Maternal care	3.2	0.6	3.2	0.6	3.1	0.5	2.1*	-1.2
Maternal overprotection	2.0	0.6	2.0	0.6	2.0	0.6	-0.1	0.1
Paternal care	2.9	0.6	2.8	0.7	3.0	0.6	-4.1***	-2.0*e
Paternal overprotection	1.9	0.6	2.0	0.6	1.9	0.5	3.3***	0.1

Notes: * p. ≤ .05;** p. ≤ .01;*** p ≤ .001 SD: Standard deviation. [a] General studies: Sami > majority. [b] Frequent intoxication: Sami < majority. [c] Never used cannabis: Sami > majority. [d] Higher mean score Sami > majority. [e] Higher mean score Sami < majority.

Table 2

Distribution of sample characteristics by gender at T2

	Total sample (n=1,528)		Females (n=926)		Males (n=602)		Effect of	
							Gender	Ethnicity
Variables at T2	*N*	%	*n*	%	*n*	%	χ^2	
Living arrangements							75.3***	3.8
Mother and/or father	520	34	250	27	270	45		
Living alone/communal living	452	30	293	32	159	27		
Spouse/partner	339	22	260	28	79	13		
Other arrangements	204	14	117	13	87	15		
Being parent (T2)							8.1**	7.8**
No	1437	95	860	93	577	97		
Yes	82	5	62	7	20	3		
Unemployment							14.87***	18.45***a
No	972	67	619	71	353	61		
Yes	478	33	254	29	224	39		
Suicidal ideation							4.56*	0.16
No	1359	90	814	89	545	92		
Yes	148	10	102	11	46	8		
Late suicide attempts (T2)							1.1	0.2
No	1504	98	909	98	595	99		
Yes	24	2	17	2	7	1		
Repeated suicide attempts (T1/T2)							2.9	1.9
No	1499	98	904	98	595	99		
Yes	29	2	22	2	7	1		
Current smoking							1.22	2.38
No	890	59	531	58	359	61		
Yes	621	41	388	42	233	39		
Cannabis							6.26*	3.30
No	1246	83	776	85	470	80		
Yes	263	17	142	16	121	21		

	Mean	SD	Mean	SD	Mean	SD	t	
Age	19.8	1.1	19.8	1.1	19.8	1.1	0.3	4.7***[b]
Alcohol Consumption	2.8	1.1	2.6	1.0	3.1	1.3	-8.9***	-2.7***[c]
Withdrawn	3.7	2.3	3.9	2.3	3.3	2.2	5.2***	3.7***[b]
Somatic Complaints	3.1	2.8	3.9	3.0	2.0	2.1	14.5***	0.5
Anxious/depressed Problems	5.2	4.5	6.0	4.8	4.0	3.8	9.0***	-0.3
Social Problems	2.5	1.8	2.6	1.9	2.3	1.8	3.0**	1.4
Thought Problems	1.8	1.9	1.9	1.9	1.8	1.9	1.2	-1.1
Delinquent Behavior	2.4	1.7	2.3	1.6	2.5	1.8	-1.8	2.4*[b]
Aggressive Behavior	7.5	4.5	7.7	4.4	7.2	4.8	1.7	1.1
Hopelessness	1.7	0.9	1.8	0.9	1.5	0.7	7.5***	-07

Notes: * p. ≤ .05;** p. ≤ .01;*** p ≤ .001 SD: Standard deviation. [a] Unemployment: Sami > majority [b] Higher mean score: Sami > majority. [c] Higher mean score: Sami < majority.

Table 3

Cross-sectional and prospective influence of risk factors at T1 on suicide attempters

	Early attempters (T1) *n*=126			Late attempters (T2) *n*=24			Repeating attempters (T1/T2) *n*=29			Non-attempters (T1/T2) *n*=1349	
Variables at T1	%	(*n*)	χ^2	%	(*n*)	χ^2	%	(*n*)	χ^2	%	(*n*)
Suicidal ideation			114.4***			0.8			114.9***		
Yes	47	(59)		17	(4)		79	(23)		12	(154)
Current smoking			35.1***			4.9*			2.5		
Yes	61	(76)		57	(12)		48	(14)		34	(450)
Alcohol intoxication			21.5***			4.5			2.4		
Never	6	(8)		4	(1)		10	(3)		22	(298)
Occasional	45	(57)		54	(13)		48	(14)		45	(603)
Frequent	48	(61)		42	(10)		41	(12)		33	(448)
Cannabis			22.3***			22.6***			3.3		
Yes	17	(21)		29	(7)		14	(4)		6	(77)
	Mean	SD	t	Mean	SD	t	Mean	SD	t	Mean	SD
Pubertal timing			-3.3***			-0.3			-1.6		
	4.7	1.3		4.4	1.1		4.8	1.4		4.3	1.2
Withdrawn			-5.0***			0.3			-4.7***		
	5.3	2.6		4.0	1.7		6.2	2.4		4.1	2.1
Somatic Complaints			-5.4***			0.1			-4.5***		
	4.8	3.6		3.0	2.9		6.1	3.7		3.0	2.8
Anxious/depressed			-6.6***			-0.7			-5.5***		
	9.4	5.6		6.7	3.9		11.4	5.2		6.1	4.5
Social Problems			-3.6***			2.1*			-2.6*		
	3.0	1.9		1.9	1.3		3.3	1.9		2.4	1.8
Thought Problems			-3.7***			0.9			-2.2*		
	3.0	2.5		1.7	2.2		3.3	2.7		2.2	2.2
Delinquent Behavior			-6.5***			-2.3*			-2.2*		
	6.4	3.0		6.2	3.3		5.9	3.0		4.6	2.7
Aggressive Behavior			-4.8***			-2.6*			-2.3*		
	11.0	5.0		10.9	3.9		11.0	5.4		8.7	4.7

Hopelessness			-4.7***			0.2			-3.4**			
	2.1	1.0		1.7	1.0		2.4	1.1		1.7	0.9	
Loneliness			-4.4***			-0.1			-5.5***			
	2.4	1.0		2.0	0.9		2.9	0.9		2.0	0.9	
Maternal care			2.4*			0.1			2.5*			
	3.0	0.7		3.2	0.6		2.8	0.9		3.2	0.6	
Maternal overprotect			-1.8			-2.7*			-1.8			
	2.1	0.6		2.4	0.6		2.3	0.8		2.0	0.6	
Paternal care			4.3***			0.7			2.0			
	2.6	0.7		2.8	0.7		2.5	0.9		2.9	0.6	
Paternal overprotect.			-3.1**			-2.1*			-1.5			
	2.1	0.6		2.2	0.7		2.1	0.7		1.9	0.5	

Notes: * p. ≤ .05; ** p. ≤ .01; *** p ≤ .001

Table 4

Cross-sectional influences of risk factors at T2 on suicide attempters

	Early attempters (T1) *n*=126			Late attempters (T2) *n*=24			Repeating attempters (T1/T2) *n*=29			Non-attempters (T1/T2) *n*=1349	
Variables at T2	%	(*n*)	χ^2	%	(*n*)	χ^2	%	(*n*)	χ^2	%	(*n*)
Suicidal ideation			9.9***			79.2***			71.8***		
Yes	16	(19)		58	(14)		52	(15)		8	(100)
Current smoking			30.1***			4.1*			14.1***		
Yes	63	(78)		58	(14)		72	(21)		38	(508)
Cannabis			25.9***			33.0***			2.1		
Yes	33	(41)		58	(14)		25	(7)		15	(201)
	Mean	SD	t	Mean	SD	t	Mean	SD	t	Mean	SD
Alcohol Consumption			-2.5*			-0.6			0.8		
	3.1	1.4		2.9	1.2		2.6	1.2		2.8	1.1
Withdrawn			-2.7**			-4.2***			-2.7*		
	4.2	2.5		5.2	1.8		4.7	2.2		3.6	2.3
Somatic Complaints			-3.3**			-3.0**			-3.1**		
	4.1	3.5		4.7	2.8		4.8	3.0		3.0	2.7
Anxious/depressed			-1.9			-4.6***			-4.5***		
	6.5	5.2		10.8	5.5		10.0	5.2		5.5	4.7
Social Problems			-1.7			-1.6			-2.2*		
	2.8	2.1		3.0	1.9		3.1	1.7		2.4	1.8
Thought Problems			-2.9**			-4.4***			-1.9		
	2.3	2.0		3.6	2.1		2.5	2.0		1.7	1.8
Delinquent Behavior			-3.1**			-0.8			-3.8***		
	2.9	1.9		2.6	2.0		3.6	1.9		2.3	1.6
Aggressive Behavior			-3.5***			-3.3**			-3.2**		
	8.9	5.0		10.5	4.9		10.7	5.8		7.2	4.4
Hopelessness			-1.9			-4.9***			-3.8***		
	1.8	1.0		2.7	1.1		2.5	1.2		1.6	0.8

* p. ≤ .05; ** p. ≤ .01; *** p ≤ .001

Table 5

Risk factors associated cross-sectional and prospective with suicide attempters at T1 and T2[a]

Early suicidal attempters (T1)[b]					
Variables at T1	OR	95% CI	Variables at T2	OR	95% CI
Suicidal ideation	4.7	2.9, 7.8***	Cannabis	2.1	1.3, 3.4**
Anxious/depressed Problems by Sami ethnicity by female gender	1.2	1.1, 1.2***	Children by Sami ethnicity by female gender	9.1	3.2, 25.7***
Current smokers	1.7	1.0, 2.8*	Current smokers	1.8	1.2, 2.9**
Frequent alcohol intoxication	4.2	1.5, 11.7**	Alcohol consumption	1.3	1.0, 1.5*
Living arr., Non-parental arr.	4.9	1.8, 13.2**	Living arr., Spouse/partner	1.7	1.0, 2.9*
Vocational studies	1.7	1.0, 2.7*	Withdrawn by female gender	1.1	1.0, 1.2*
Paternal care	0.7	0.4, 0.9*			
Perceived pubertal timing	1.2	1.0, 1.5*			
Late suicidal attempters (T2)[c]					
Cannabis	7.1	2.6, 19.8***	Suicidal ideation	8.0	3.0, 21.6***
Maternal overprotection	2.4	1.2, 4.9*	Cannabis	4.4	1.8, 10.7***
			Hopelessness	1.9	1.2, 3.0**
Repeated suicidal attempters (T1-T2)[d]					
Suicidal ideation by age	1.2	1.1, 1.3***	Suicidal ideation	6.2	2.5, 15.6***
Somatic Complaints	1.2	1.1, 1.4***	Current smokers	2.9	1.1, 7.5*
			Unemployment	2.8	1.2, 6.3*
			Delinquent Behavior	1.3	1.1, 1.7*

Notes: OR: Odds ratio. CI: Confidence interval. * p. ≤ .05;** p. ≤ .01;*** p ≤ .001

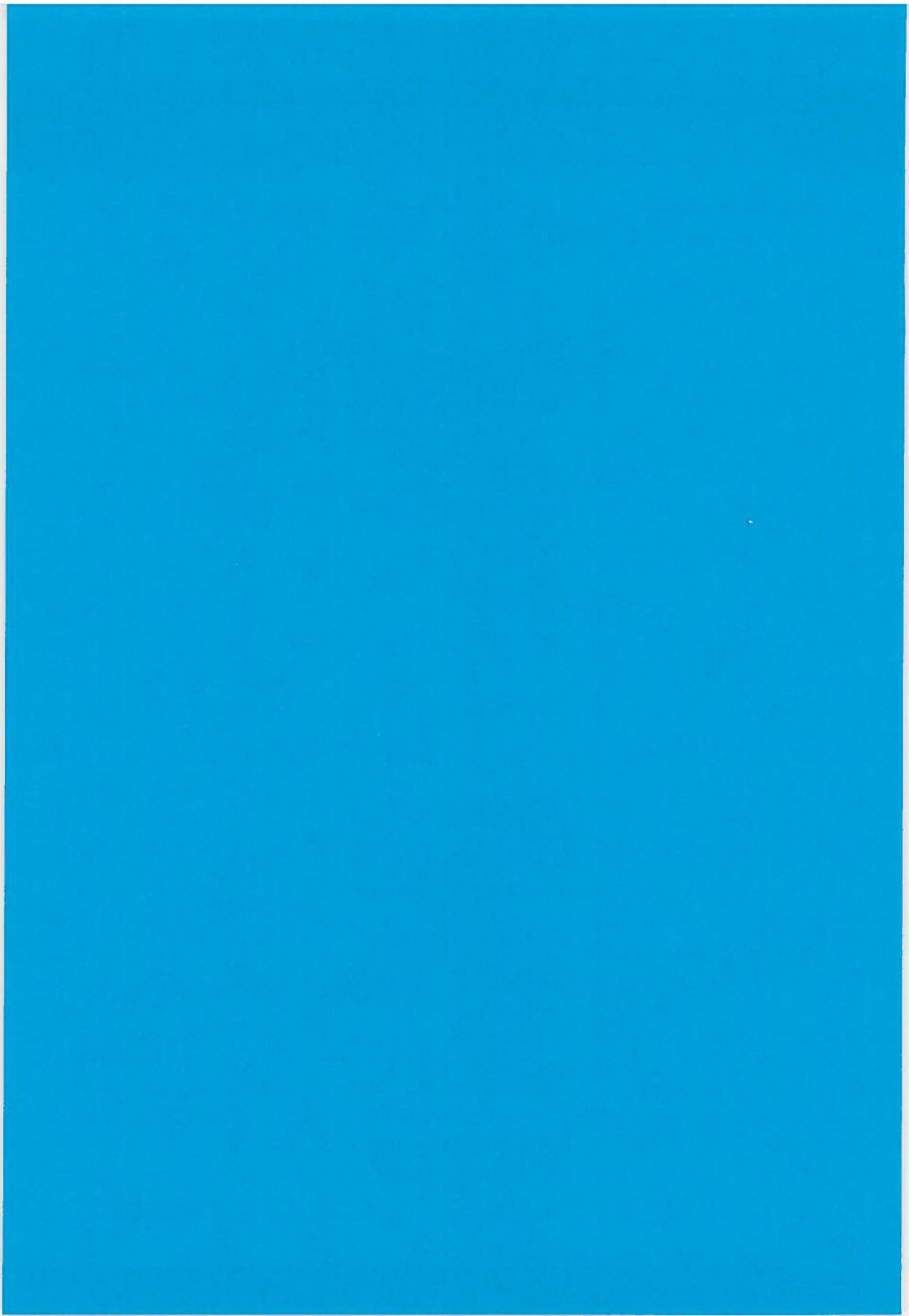
[a] All variables and interaction effects significant in the univariate analyses were included in the logistic regression analyses.

[b] Totally, *n*=1,226 cases were included in the logistic regression analysis at T1 and *n*=1,286 cases at T2.

[c] Totally, *n*=1,301 cases were included in the logistic regression analysis at T1 and *n*=1,274 cases at T2.

[d] Totally, *n*=1,243 cases were included in the logistic regression analysis at T1 and *n*=1,219 cases at T2.

Appendices



The Population and Housing Census 1970

Questions about Sami ancestry

Šamá sámegiel-teavstain nubbe bæl'de
(Skjema med samisk tekst på neste side)

Vedlegg 3
Appendix 3

Statistisk Sentralbyrå
Oslo-Dep.

Tilleggsskjema
Konfidensialt

Folke- og boligtelling 1. november 1970

Finansdepartementets bestemmelse av 12. februar 1970 gitt med hjemmel i: 1) lov nr. 2 av 25. april 1907 § 5, jfr. Stortingets vedtak av 14. november 1900 og 2) lov nr. 1 av 16. januar 1970 § 5, jfr. kgl. res. av samme dato.

Hovedpersonen i leiligheten (eller hovedpersonens stedfortreder) må sørge for nå dette skjemaet blir fylt ut for hver person i tillegg til personskjemaet.
Skjemaet må være klart for avlevering sammen med de andre skjemaene mandag 2. november.

Opplysning vil bli behandlet strengt konfidensialt
Telleren har taushetsplikt.
De som ønsker det, kan levere utfylt skjema i lukket konvolutt.

Etternavn, fornavn, mellomnavn	Fødselsdato og -år	Skriv ikke her Personnr.
Gate/vei, nr. eller bostedets navn		Kretsnr.
Poststed / Kommune		Leilighetsnr.

1. Var samisk det første språk som personen selv snakket? (Sett kryss i ruten foran riktig svar)
   For barn som ennå ikke har lært å snakke, skal det settes kryss for Ja dersom samisk antas å bli det første talespråket. I motsatt fall settes kryss for Nei.
   1 ☐ Ja
   2 ☐ Nei

2. Var samisk det første språk som minst én av personens foreldre snakket? (Sett kryss)
   1 ☐ Ja
   2 ☐ Nei
   3 ☐ Vet ikke

3. Var samisk det første språk som minst én av personens besteforeldre snakket? (Sett kryss)
   1 ☐ Ja
   2 ☐ Nei
   3 ☐ Vet ikke

4. Regner personen seg selv som same? (Sett kryss)
   Foreldre eller andre foresatte avgjør om barn under 15 år skal regnes som same.
   1 ☐ Ja
   2 ☐ Nei
   3 ☐ Usikker
   4 ☐ Ønsker ikke å svare

Merk: Bare én av sidene skal fylles ut.

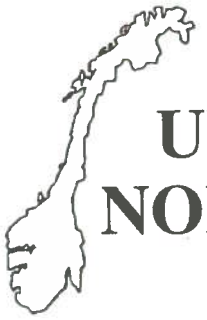
Grøndahl & Søn, Oslo.

The North Norwegian Youth Study:

Questionnaire in Norwegian 1994-95

Norges forskningsråd

UNIVERSITETET I TROMSØ



UNG I NORGE

Spørreskjema til ungdom i Norge

Dette spørreskjemaet går ut til 10.000 ungdommer i hele Norge. Hensikten med undersøkelsen er å få bedre kunnskap om hvordan det er å vokse opp og være ung i Norge i dag. Vi ønsker å vite mer om unges behov, ønsker og livssituasjon. Det er også en målsetting å få fram kunnskap som kan bidra til å styrke ungdomspolitikken i Norge.

Bak undersøkelsen står Program for ungdomsforskning (UNGforsk) og Universitetet i Tromsø. UNGforsk er opprettet av Norges forskningsråd i samarbeid med Ungdomsseksjonen i Barne- og familiedepartementet.

Vi håper at du vil fylle ut dette skjemaet. Hvis det er noen spørsmål du synes er for personlige, eller som du ikke vil svare på, så kan du hoppe over dem. Men vi vil helst at du svarer på alle spørsmålene.

Dette er en frivillig undersøkelse. Det betyr at du ikke behøver å være med. Dersom du ønsker å trekke deg fra undersøkelsen senere, så gi beskjed til skolen. Skolen vil så gi oss ditt kodenummer slik at svarene dine kan bli slettet.

Alle svarene vil være konfidensielle. Det betyr at ***ingen*** *vil få vite hva akkurat* ***du*** *har svart.*

De fleste stedene setter du et kryss i den ruta som passer for deg. Noen steder står det bare prikker. Da må du skrive ut svaret selv.

Når du har fylt ut skjemaet, legger du det i den konvolutten du har fått utlevert og limer den igjen selv.

I neste time får du et skjema til. Det skal fylles ut på samme måten, og skal også legges inn i en konvolutt i slutten av timen.

Takk for hjelpen!

Vennlig hilsen

Lars Wichstrøm *Siv Kvernmo*

UNGFORSK
Program for Ungdomsforskning
Gaustadalléen 21, 0371 Oslo 3
Tlf.: 22 95 84 01 - Fax: 22 60 44 27

ABUP
Avd. for barne- og undgomspsykiatri
Fagområdet medisin
UiTø
Tlf.: 77 64 59 30 - Fax: 77 64 59 40

Program for Utdanningsforskning
Gaustadalléen 21, 0371 Oslo 3
Tlf.: 22 95 84 11 - Fax: 22 60 44 27

Er du jente eller gutt?

☐ Jente
☐ Gutt

Hvor gammel er du?

Jeg er ..... år

Er du på skole eller i jobb

☐ Jobb ☐ Skole ☐ Annet, hva .....

Dersom du går på skole, hvilket klassetrinn går du på?

☐ Grunnkurs
☐ Videregående kurs I
☐ Videregående kurs II
☐ Delkurselev

Hvilken studieretning går du på?

☐ Allmenne fag
☐ Handels- og kontorfag
☐ Håndverks- og industrifag
☐ Husflids- og estetiske fag, duoddji
☐ Husholdningsfag
☐ Idrettsfag
☐ Helse- og miljøfag
☐ Fiskerifag
☐ Sjøfartsfag
☐ Landbruksfag og naturbruk, reindrift
☐ Tekniske fag
☐ Annet (skriv hva): .....

Hvilken språkklasse gikk du i på ungdomskolen?

☐ Norsk
☐ Samisk
☐ Annen, hvilken, ...

Hva er 1. språk på skole nå?

☐ Norsk
☐ Samisk
☐ Annet, hvilket, ...

Er du født i Norge?

☐ Ja
☐ Nei

Hvor lenge har du bodd i Troms/Nordland?
(stryk det som ikke passer)

☐ Hele livet

..... år

Hvor kommer foreldrene dine fra?

Mor
☐ Norge
☐ Annet land, nemlig .....

Far
☐ Norge
☐ Annet land, nemlig .....

Er du adoptert fra et annet land?

☐ Ja
☐ Nei

Hvem bor du sammen med hjemme?

- ☐ Mor og far
- ☐ Mor
- ☐ Far
- ☐ Mor/far og hennes/hans nye samboer eller ektefelle
- ☐ Omtrent like mye hos mor og far
- ☐ Fosterforeldre
- ☐ Besteforeldre, andre slektninger
- ☐ Annet (skriv hva): .....

Hvor bor du under skolegang eller arbeide?

- ☐ Hjemme
- ☐ Besteforeldre, andre slektninger
- ☐ Bor på hybel, internat e.l.
- ☐ Annet (skriv hva): .....

Hva er din hjemkommune? ..... kommune

Hvilken ungdomskole gikk du på? ..... skole

Hvor mange søsken har du? Jeg har ..... (antall) søsken

Hvilke yrker har foreldrene dine?
Skriv tittelen på yrket, kort hva de driver med, og om de er i arbeid for tiden, om de jobber heltid eller deltid. Er far eller mor hjemmeværende eller trygdet, så skriv det også. Er noen av foreldrene dine døde, vil vi gjerne at du nevner det også.

Er far i arbeid nå?

- ☐ Ja, heltid
- ☐ Ja, deltid
- ☐ Arbeidsløs
- ☐ Hjemmeværende
- ☐ Trygdet
- ☐ Går på skole, kurs, e.l.
- ☐ Far er død

Yrket til far: .....

Skriv kort hva han gjør på jobben: .....

.....

Er mor i arbeid nå?

- ☐ Ja, heltid
- ☐ Ja, deltid
- ☐ Arbeidsløs
- ☐ Hjemmeværende
- ☐ Trygdet
- ☐ Går på skole, kurs, e.l.
- ☐ Mor er død

Yrket til mor: .....

Skriv kort hva hun gjør på jobben: .....

.....

Hvis du bor eller har bodd sammen med bare en av foreldrene dine, hvor mange år har dette vart tilsammen?

Antall år .....

Hva slags utdanning har faren og moren din? Sett så mange kryss som passer:

	Far	Mor
7-årig grunnskole (eller kortere)	☐	☐
Ungdomsskole/realskole	☐	☐
Videregående almenfaglig (gymnas)	☐	☐
Videregående yrkesfaglig (yrkeskole)	☐	☐
Fagopplæring innen håndverk, industri, landbruk e.l.	☐	☐
3-årig høyskole (lærer, sykepleier, distriktshøgskole, e.l.)	☐	☐
Universitet eller annen langvarig utdanning	☐	☐
Annen utdanning	☐	☐
Usikker/vet ikke	☐	☐

Hvor høy tror du at du er? ..... cm

Hvor mye tror du at du veier? ..... kg

Hvis du tenker tilbake på den siste uka — de siste 7 dagene — hvor mye har du vært sammen med **andre voksne enn foreldrene dine?** Med «voksne» mener vi folk over 25 år. Ikke regn med lærere som du er sammen med i skoletida. Regn heller ikke med voksne som du bor sammen med, selv om de ikke er foreldrene dine. Prøv å huske **omtrent** hvor mange timer du har vært sammen med voksne den siste uka.

	Ingenting	Under 1 time	1—2 timer	2—3 timer	4—6 timer	Mer enn 6 timer
Idrettsledere, trenere	☐	☐	☐	☐	☐	☐
Fritidsklubbledere, utekontakt	☐	☐	☐	☐	☐	☐
Naboer	☐	☐	☐	☐	☐	☐
Voksne som leder fritidsaktiviteter (utenom fritidsklubb og ikke lærere)	☐	☐	☐	☐	☐	☐
Lærere utenom skoletid	☐	☐	☐	☐	☐	☐
Slektninger	☐	☐	☐	☐	☐	☐
Andre voksne	☐	☐	☐	☐	☐	☐

Hvor ofte pleier du å dra ut av lokalmiljøet i fritida for å treffe andre ungdommer, eller gjøre ting på egen hånd?

- ☐ 4 ganger pr. uke eller oftere
- ☐ 2—3 ganger pr. uke
- ☐ Ca. en gang pr. uke
- ☐ Ca. en gang hver 14. dag
- ☐ Ca. en gang pr. måned eller sjeldnere

Nedenfor er endel spørsmål omkring hvor fornøyd du er med kroppen din og utseendet ditt.

Hvor fornøyd eller misfornøyd er du med:

	Svært mis-fornøyd	Ganske mis-fornøyd	Ikke helt fornøyd	Fornøyd	Svært fornøyd
Ansikt	☐	☐	☐	☐	☐
Hoftene og baken	☐	☐	☐	☐	☐
Magen	☐	☐	☐	☐	☐
Bryst	☐	☐	☐	☐	☐
Musklene	☐	☐	☐	☐	☐
Vekten	☐	☐	☐	☐	☐
Høyden	☐	☐	☐	☐	☐

Hvor pen eller kjekk tror du klassekameratene synes du er?

- ☐ Svært pen/kjekk
- ☐ Ganske pen/kjekk
- ☐ Vanlig
- ☐ Litt lite pen/kjekk
- ☐ Svært lite pen/kjekk

Vil du si om deg selv at du er:

- ☐ Svært tykk
- ☐ Ganske tykk
- ☐ Omtrent som andre
- ☐ Ganske tynn
- ☐ Svært tynn

Nedenfor er en del utsagn om mat og spisevaner. Kryss av for hva som passer deg.

	Alltid	Ofte	Sjelden	Aldri
Jeg er opptatt av å bli tynnere	☐	☐	☐	☐
Jeg prøver å holde diett	☐	☐	☐	☐
Jeg føler ubehag etter at jeg har spist søtsaker	☐	☐	☐	☐
Jeg trimmer for å gå ned i vekt	☐	☐	☐	☐
Jeg kaster opp etter at jeg har spist	☐	☐	☐	☐
Når jeg først har begynt å spise, kan det være vanskelig å stoppe	☐	☐	☐	☐
Jeg bruker for mye tid til å tenke på mat	☐	☐	☐	☐
Jeg føler at maten kontrollerer livet mitt	☐	☐	☐	☐
Når jeg spiser, skjærer jeg maten opp i små biter	☐	☐	☐	☐
Jeg bruker lengre tid enn andre på et måltid	☐	☐	☐	☐
Andre mennesker synes at jeg er for tynn	☐	☐	☐	☐
Jeg føler at andre presser meg til å spise	☐	☐	☐	☐

Har du planer om å gå på skole eller studere etter at du er ferdig med videregående skole?

- ☐ Vet ikke om jeg vil gå videre
- ☐ Nei, jeg vil ikke gå videre
- ☐ Ja, men jeg vet ikke på hvilken skole
- ☐ Ja, jeg har planer om å gå på

..... (hva slags skole)

Hvor mange timer bruker du gjennomsnittlig pr. dag på lekser?

- ☐ Gjør ikke eller nesten aldri lekser
- ☐ Mindre enn ½ time
- ☐ 1 time
- ☐ 1—2 timer
- ☐ 2—3 timer
- ☐ 3—4 timer
- ☐ Mer enn 4 timer

Hvis du hadde fått deg en jobb nå, ville du heller jobbe enn å gå på skolen?

- ☐ Ja
- ☐ Nei

Hvilke to jobber eller yrker tror du det er **mest sannsynlig** at du har når du er 40 år? Selv om du slett ikke er sikker, så skriv det du **tror** eller gjetter på.

Første plass: .....

Annen plass: .....

Hvor sikker er du på det du har satt opp på første plass?

- ☐ Svært sikker
- ☐ Ganske sikker
- ☐ Ikke sikker

Her er det beskrevet en del handlinger som har å gjøre med brudd på regler i skole og samfunn. Andre spørsmål gjelder ting som er ulovlig eller på grensen til det ulovlige, men som mange allikevel gjør.

Har du vært med på/gjort noe av dette det siste året — **de siste 12 månedene?**

	Aldri	1 gang	2—5 ganger	6—10 ganger	10—50 ganger	Mer enn 50 ganger
Hatt en voldsom krangel med en lærer?	☐	☐	☐	☐	☐	☐
Blitt sendt ut av klasserommet?	☐	☐	☐	☐	☐	☐
Stjålet penger eller ting fra noen i familien din?	☐	☐	☐	☐	☐	☐
Tatt saker til en verdi av mindre enn 500 kr. fra butikk eller kiosk uten å betale?	☐	☐	☐	☐	☐	☐
Bannet til en lærer?	☐	☐	☐	☐	☐	☐
Med vilje ødelagt eller knust vindusruter, bussruter, telefonkiosker, postkasser eller lignende?	☐	☐	☐	☐	☐	☐
Blitt innkalt til rektor for noe galt du har gjort?	☐	☐	☐	☐	☐	☐
Lurt deg fra å betale på kino, buss, tog eller lignende?	☐	☐	☐	☐	☐	☐
Skulket skolen?	☐	☐	☐	☐	☐	☐

Vært borte en hel dag uten at foreldrene dine visste hvor du var, eller hvor du sa at du var et annet sted enn du var i virkeligheten?	☐	☐	☐	☐	☐	☐
Kjørt bil eller motorsykkel uten førerkort?	☐	☐	☐	☐	☐	☐
Stjålet bil eller motorsykkel?	☐	☐	☐	☐	☐	☐
Stjålet noe til en verdi av mer enn tusen kroner?	☐	☐	☐	☐	☐	☐
Gjort hærverk eller skade for mer enn tusen kroner?	☐	☐	☐	☐	☐	☐
Brutt deg inn for å stjele noe?	☐	☐	☐	☐	☐	☐
Vært i slåsskamp hvor du har brukt våpen (f.eks. kniv)?	☐	☐	☐	☐	☐	☐
Slått eller truet med å slå noen?	☐	☐	☐	☐	☐	☐
Vært i kontakt med politiet på grunn av noe ulovlig du har gjort?	☐	☐	☐	☐	☐	☐
Drukket så mye at du har følt deg tydelig beruset?	☐	☐	☐	☐	☐	☐
Brukt hasj eller marihuana?	☐	☐	☐	☐	☐	☐
Sniffet?	☐	☐	☐	☐	☐	☐
Brukt andre narkotiske stoffer som kokain, LSD, morfin, amfetamin, heroin eller noe annet?	☐	☐	☐	☐	☐	☐

Hvis du svarte ja, hvilke stoffer var det? .....

Hvis du skulker skolen noen gang, hva er den vanligste grunnen til at du gjør det? Sett bare **ett kryss** for den viktigste grunnen.

- ☐ Jeg skulker aldri
- ☐ Lærerne behandler meg urettferdig
- ☐ Jeg blir mobbet av andre elever
- ☐ Det er bortkastet tid å være på skolen
- ☐ Jeg greier ikke å henge med i timene
- ☐ Av og til har jeg mer lyst til å gjøre noe annet enn å gå på skolen
- ☐ Jeg forbereder meg til prøver eller gjør annet skolearbeide
- ☐ Andre grunner, nemlig .....

Sist du skulket skolen, hvordan tilbrakte du tida? Sett kryss for det som passer best.

- ☐ Har aldri skulket
- ☐ Alene
- ☐ Sammen med andre som også skulket
- ☐ Sammen med andre ungdommer som ikke går på skolen
- ☐ Annet, skriv hva: .....

Nedenfor kommer en del utsagn om hvordan en kan forholde seg til sin egen og andres kultur. I hvilken grad er du enig med de følgende utsagn?

(Sett ring rundt det tallet som passer best)	Helt enig				Helt uenig
Jeg foretrekker bare å ha norske venner	1	2	3	4	5
Jeg foretrekker bare vestlig (norsk, engelsk, amerikansk) musikk	1	2	3	4	5
Jeg bryr meg ikke om hvilken mat jeg spiser	1	2	3	4	5
Jeg foretrekker ikke å ha venner	1	2	3	4	5
Jeg foretrekker å ha både samiske/kvenske/finske *(strek under alternativet som passer deg)* og norske venner	1	2	3	4	5
Jeg ønsker å tilhøre både norske og samiske/ kvenske/finske lag og foreninger	1	2	3	4	5
Jeg vil helst spise norsk mat	1	2	3	4	5
Jeg ønsker bare å tilhøre norske lag og foreninger	1	2	3	4	5
Jeg vil helst spise både norsk og samisk/finsk/ kvensk mat	1	2	3	4	5
Jeg foretrekker både vestlig og samisk/finsk/ kvensk musikk	1	2	3	4	5
Etter min mening bør vi lære både norsk-/ verdenshistorie og samisk/kvensk/finsk historie på skolen	1	2	3	4	5
Jeg foretrekker bare samisk/kvensk/finsk musikk	1	2	3	4	5
Jeg foretrekker å ha bare samiske/kvenske/finske venner	1	2	3	4	5
Jeg foretrekker ikke noen form for musikk	1	2	3	4	5
Jeg ønsker ikke å tilhøre noen forening eller lag i det hele tatt	1	2	3	4	5
Etter min mening bør vi lære bare norsk-/ verdenshistorie på skolen	1	2	3	4	5
Selv om jeg lever i Norge, synes jeg at jeg bør leve som same/finlender/kven	1	2	3	4	5
Etter min mening bør vi ikke lære hverken norsk-/ verdenshistorie eller samisk/finsk/ kvensk historie på skolen	1	2	3	4	5
Siden jeg bor i Norge, er det best jeg lever som norsk	1	2	3	4	5
Jeg ønsker å tilhøre bare samiske/kvenske/finske lag og foreninger	1	2	3	4	5
Jeg setter like stor pris på å leve som norsk og same/kven/finlender	1	2	3	4	5
Jeg har vanskeligheter med å bestemme meg for om jeg vil leve som same/finlender/kven eller som norsk	1	2	3	4	5
Etter min mening bør vi lære bare samisk/ kvensk/finsk historie på skolen	1	2	3	4	5

Hvor ofte gjør du følgende?

	Nesten aldri				Nesten alltid
Jeg spiser i hovedsak vestlig mat	1	2	3	4	5
Jeg lytter helst til vestlig musikk	1	2	3	4	5
Det spiller ingen rolle hvilken musikk jeg lytter til	1	2	3	4	5
Jeg vil si at jeg for det meste lever som norsk	1	2	3	4	5
Det spiller ingen rolle for meg hvilken mat jeg spiser	1	2	3	4	5
Jeg vil si at jeg for det meste lever både som norsk og same/finlender/kven	1	2	3	4	5
Jeg lytter både til vestlig og til samisk/kvensk/ finsk musikk	1	2	3	4	5
Jeg vil si at jeg for det meste lever som same/ finlender/kven	1	2	3	4	5
Mesteparten av tiden vet jeg ikke hvordan jeg lever (eller hva jeg lever som)	1	2	3	4	5
Jeg spiser i hovedsak samisk/finsk/kvensk mat	1	2	3	4	5
Jeg lytter helst til samisk/finsk/kvensk musikk	1	2	3	4	5
Jeg spiser både norsk og samisk/kvensk/finsk mat	1	2	3	4	5

Nedenfor kommer en del spørsmål om språk og kulturell tilhørighet. Kryss av det som passer for deg så godt du kan.

	Stemmer svært godt	Stemmer ganske godt	Ikke sikker	Stemmer ganske dårlig	Stemmer svært dårlig
Jeg oppfatter meg som:					
Norsk	☐	☐	☐	☐	☐
Samisk	☐	☐	☐	☐	☐
Kvensk	☐	☐	☐	☐	☐
Finsk	☐	☐	☐	☐	☐
Annet, beskriv hva	☐	☐	☐	☐	☐
Jeg tror andre (venner, naboer e.l) oppfatter meg som:					
Norsk	☐	☐	☐	☐	☐
Samisk	☐	☐	☐	☐	☐
Kvensk	☐	☐	☐	☐	☐
Finsk	☐	☐	☐	☐	☐
Annet, beskriv hva	☐	☐	☐	☐	☐
Hvilket språk snakkes **mest** hjemme?	☐	☐	☐	☐	☐
Norsk	☐	☐	☐	☐	☐
Samisk	☐	☐	☐	☐	☐
Kvensk	☐	☐	☐	☐	☐
Finsk	☐	☐	☐	☐	☐
Annet, beskriv hva	☐	☐	☐	☐	☐

Med vennene mine vil jeg helst snakke:

Norsk	☐	☐	☐	☐	☐
Samisk	☐	☐	☐	☐	☐
Kvensk	☐	☐	☐	☐	☐
Finsk	☐	☐	☐	☐	☐
Annet, beskriv hva	☐	☐	☐	☐	☐

Kryss av for ett eller flere alternativ etter som det passer.

Besteforeldrene mine på farsiden snakker:

Bestemor	Bestefar
☐ Norsk	☐ Norsk
☐ Samisk	☐ Samisk
☐ Kvensk	☐ Kvensk
☐ Finsk	☐ Finsk
☐ Annet, hva	☐ Annet, hva

Besteforeldrene mine på morsiden snakker:

Bestemor	Bestefar
☐ Norsk	☐ Norsk
☐ Samisk	☐ Samisk
☐ Kvensk	☐ Kvensk
☐ Finsk	☐ Finsk
☐ Annet, hva	☐ Annet, hva

Mor snakker:

- ☐ Norsk
- ☐ Samisk
- ☐ Kvensk
- ☐ Finsk
- ☐ Annet, beskriv hva

Far snakker:

- ☐ Norsk
- ☐ Samisk
- ☐ Kvensk
- ☐ Finsk
- ☐ Annet, beskriv hva

Hjemme har jeg lært følgende språk:

- ☐ Norsk
- ☐ Samisk
- ☐ Kvensk
- ☐ Finsk
- ☐ Annet, beskriv hva

På skolen har jeg lært:

- ☐ Norsk
- ☐ Samisk
- ☐ Kvensk
- ☐ Finsk
- ☐ Annet, beskriv hva

Hvor viktig mener du de nedenfornevnte momentene vil være for deg for å oppfylle ditt eget idealbilde?

	Svært viktig	Viktig	Noe viktig	Lite viktig	Ikke viktig
Fysisk styrke	☐	☐	☐	☐	☐
Ro i kritiske situasjoner	☐	☐	☐	☐	☐
Spenst/hurtighet	☐	☐	☐	☐	☐
Være et positivt forbilde for andre	☐	☐	☐	☐	☐
Fysisk utholdenhet	☐	☐	☐	☐	☐
Klare seg selv/være uavhengig	☐	☐	☐	☐	☐
Orienteringssans, finne fram (f.eks. ute i naturen)	☐	☐	☐	☐	☐
Være «stjerne»	☐	☐	☐	☐	☐
Ha egenskaper som andre ønsker seg	☐	☐	☐	☐	☐

Nedenfor er en del beskrivelser som ungdommer har gitt av seg selv. Les hvert utsagn, og angi i hvor stor grad det passer på dine egne tanker og følelser. Dersom et utsagn har flere ledd, angi din reaksjon på utsagnet **som helhet.** Skriv den bokstaven som best beskriver deg i ruten til venstre for spørsmålet.

A = Helt enig **B** = Ganske enig **C** = Enig **D** = Litt enig **E** = Ganske uenig **F** = Helt uenig

..... Det finnes mange slags mennesker. Jeg utforsker fremdeles alle muligheter for å finne de vennene jeg ønsker å ha.

..... Av og til deltar jeg i fritidsaktiviteter når jeg blir spurt, men det er sjelden jeg prøver noe på egen hånd.

..... Jeg føler meg ikke helt sikker på politikk fordi alt forandrer seg så fort. Men jeg mener det er viktig å ta stilling i politiske saker.

..... Jeg prøver fremdeles å finne ut hva jeg duger til som menneske, og hvilke yrker som passer for meg.

..... Det kan være så mange grunner til at man blir venner, men jeg velger mine venner på grunnlag av bestemte verdier og likheter som jeg mener er viktig.

..... Det finnes ikke en bestemt fritidsaktivitet jeg foretrekker — jeg prøver forskjellige for å finne en jeg virkelig kan like.

..... Jeg tenker ikke mye på politikk. Synes ikke det er særlig interessant.

..... Jeg har nok tenkt på mange forskjellige yrker, men jeg har aldri egentlig vært i tvil etter at foreldrene mine sa hva de ønsket.

..... Mine foreldre vet hva som er best for meg når det gjelder hvem jeg bør ha som venner.

..... Jeg har bestemt meg for en eller for flere fritidsaktiviteter etter å ha vurdert flere, og jeg er godt fornøyd med dem.

..... Jeg er ikke så veldig opptatt av å finne det rette yrket — en hvilken som helst jobb er OK. Jeg flyter liksom med strømmen.

..... Jeg har ikke noen virkelig nære venner, og er heller ikke på jakt etter noen akkurat nå.

..... Av og til deltar jeg i fritidsaktiviteter, men føler ikke behov for noe å holde på med regelmessig.

..... Det finnes så mange forskjellige politiske partier og meninger. Det er vanskelig å slutte seg til noe før jeg har tenkt grundig igjennom sakene.

..... Jeg har tenkt fram og tilbake, og nå vet jeg hva slags jobb jeg vil satse på.

..... Jeg velger bare venner som mine foreldre ville kunne godta.

..... Jeg har alltid forettrukket de samme fritidsaktiviteter som mine foreldre og har egentlig aldri vurdert noe annet.

..... Jeg har gransket mine politiske holdninger og funnet ut at jeg er enig med mine foreldre på enkelte punkter og uenig på andre.

..... Mine foreldre bestemte for lenge siden hvilket yrke som passer best for meg, og jeg retter meg etter det.

..... Jeg har hatt en god del forskjellige venner, og nå vet jeg hva jeg ønsker å legge vekt på hos mine venner.

..... Jeg har prøvd mange forskjellige fritidsaktiviteter, og har funnet en eller flere jeg virkelig liker å holde på med.

..... Jeg er ikke helt sikker på hvor jeg står politisk, men jeg forsøker å finne en plattform som passer for meg.

..... Det tok tid å finne ut av det, men nå vet jeg hvilket yrke jeg ønsker å satse på.

..... Jeg har ingen nære venner. Foretrekker å gli inn i mengden.

..... Jeg har forsøkt meg på forskjellige fritidsaktiviteter og håper på den måten å finne en eller flere jeg vil fortsette med.

..... Jeg har aldri hatt et sterkt nok politisk engasjement til å ta ordentlig stilling.

..... Jeg synes det er vanskelig å bestemme seg for et yrke. Det finnes så mange spennende muligheter.

..... Jeg vet ikke hva slags venner jeg foretrekker. Jeg prøver å gjøre meg opp en mening om hva vennskap betyr for meg.

..... Jeg har fått de fleste fritidsinteressene fra mine foreldre, og har vel egentlig ikke forsøkt meg på noe annet.

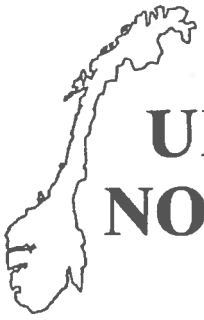
..... Jeg har ikke funnet ut hvilket yrke jeg vil ha i fremtiden, og jeg bare tar det som tilbys inntil jeg finner noe bedre.

..... Mine foreldre har alltid hatt sine politiske og moralske holdninger om abort, barmhjertighetsdrap og slike saker, og jeg har bestandig vært enig.

Hvor mange poeng hadde du da du gikk ut av ungdomsskolen? Antall poeng: .....

Del 2

Norges forskningsråd



UNG I NORGE

Spørreskjema til ungdom i Norge

Dette er annen del av spørreskjemaet,
og den skal fylles ut på samme måten som den du fylte ut i forrige time.

Takk for hjelpen!

□ □ □ □ □ □

UNGFORSK
Program for Ungdomsforskning
Gaustadalléen 21, 0371 Oslo 3
Tlf.: 22 95 84 01 - Fax: 22 60 44 27

PUF
Program for Utdanningsforskning
Gaustadalléen 21, 0371 Oslo 3
Tlf.: 22 95 84 11 - Fax: 22 60 44 27

Nå kommer en del spørsmål om deg og foreldrene dine. Hvis du bare eller nesten bare er sammen med den ene av dem, så ta bare hensyn til den av foreldrene du er sammen med. Noen av dere vil også bo sammen med en voksen som ikke er en av foreldrene. Du kan da avgjøe selv om du vil regne han eller henne som en av foreldrene.

Nedenfor er endel utsagn ungdommer kan gi om seg selv og sine foreldre (voksne de bor sammen med.) Vi vil be deg om å krysse av i den ruten som passer best på situasjonen hjemme hos deg.

	Stemmer helt	Stemmer godt	Stemmer ganske godt	Stemmer omtrent	Stemmer ikke særlig godt	Stemmer ikke i det hele tatt
Foreldrene mine pleier å vite hvor jeg er og hva jeg gjør i helgene	☐	☐	☐	☐	☐	☐
Foreldrene mine vet ganske godt hvem jeg er sammen med i fritida	☐	☐	☐	☐	☐	☐
Foreldrene mine kjenner de fleste av de vennene/ venninnene jeg er sammen med i fritida	☐	☐	☐	☐	☐	☐
Foreldrene mine pleier å vite hvor jeg er og hva jeg gjør på hverdagene	☐	☐	☐	☐	☐	☐
Foreldrene mine liker de fleste av de vennene/ venninnene jeg er sammen med i fritida	☐	☐	☐	☐	☐	☐
Det er viktig for foreldrene mine å vite hvor jeg er og hva jeg gjør i fritida	☐	☐	☐	☐	☐	☐

Nedenfor er det beskrevet forskjellige måter ungdommer kan ha opplevd sine foreldre på i oppveksten. Kryss av for hva som stemmer for deg.

	Stemmer svært godt	Stemmer ganske godt	Stemmer ganske dårlig	Stemmer svært dårlig
Far har likt at jeg har tatt mine egne beslutninger	☐	☐	☐	☐
Far har latt meg bestemme ting selv	☐	☐	☐	☐
Far har forsøkt å kontrollere alt jeg har gjort	☐	☐	☐	☐
Far har behandlet meg som om jeg var yngre enn jeg er	☐	☐	☐	☐
Far har vært overbeskyttende	☐	☐	☐	☐
Far har ikke snakket noe særlig med meg	☐	☐	☐	☐
Far har vært kjærlig mot meg	☐	☐	☐	☐
Far har forstått mine problemer og bekymringer	☐	☐	☐	☐
Far har ikke hjulpet meg så mye som jeg har trengt	☐	☐	☐	☐
Far har ikke forstått mine behov og ønsker	☐	☐	☐	☐
Mor har likt at jeg har tatt mine egne beslutninger	☐	☐	☐	☐
Mor har latt meg bestemme ting selv	☐	☐	☐	☐
Mor har forsøkt å kontrollere alt jeg har gjort	☐	☐	☐	☐

Mor har behandlet meg som om jeg var yngre enn jeg er	☐	☐	☐	☐
Mor har vært overbeskyttende	☐	☐	☐	☐
Mor har ikke snakket noe særlig med meg	☐	☐	☐	☐
Mor har vært kjærlig mot meg	☐	☐	☐	☐
Mor har forstått mine problemer og bekymringer	☐	☐	☐	☐
Mor har ikke hjulpet meg så mye som jeg har trengt	☐	☐	☐	☐
Mor har ikke forstått mine behov og ønsker	☐	☐	☐	☐

Har du en fast kjæreste?

☐ Ja, jeg har en kjæreste nå
☐ Nei, men jeg har hatt kjæreste tidligere
☐ Nei, jeg har aldri hatt fast kjæreste

Har du noen gang hatt samleie? ☐ Ja ☐ Nei

Hvis du svarte ja, hvor gammel var du da du hadde samleie første gang? Jeg var ..... år

Hvor mange har du hatt samleie med til sammen (antall partnere)? .....

1. Omtrent hvor mange nære venner har du?
☐ Ingen ☐ 1 ☐ 2 eller 3 ☐ 4 eller flere

2. Omtrent hvor mange ganger i uken er du sammen med dem?
☐ Mindre enn 1 ☐ 1 eller 2 ☐ 3 eller mer

Sammenliknet med jevnaldrende, hvor bra synes du at du:

	Dårligere	Omtrent likt	Bedre
a. Kommer overens med dine søsken?	☐	☐	☐
b. Kommer overens med andre barn/unge?	☐	☐	☐
c. Kommer overens med foreldrene dine?	☐	☐	☐
d. Gjør ting på egen hånd?	☐	☐	☐

Aktuelle skoleprestasjoner

☐ Jeg går ikke på skolen

	Langt under gj.snittet/ si stryk	Under gjennom-snittet	Gjennom-snittlig	Over gjennom-snittet
a. Norsk	☐	☐	☐	☐
b. Matematikk	☐	☐	☐	☐
c. Engelsk	☐	☐	☐	☐
d. Samisk	☐	☐	☐	☐
Andre fag (f.eks. samfunnsfag, kjemi, fysikk, fransk, tysk) e.	☐	☐	☐	☐
f.	☐	☐	☐	☐
g.	☐	☐	☐	☐

Her er en liste over egenskaper som barn og ungdom kan ha i større eller mindre grad. For hver egenskap som passer på deg **nå eller siste 6 måneder,** ber vi deg sette en ring rundt 2 hvis beskrivelsen **passer bra eller ofte.** Sett en ring rundt 1 hvis beskrivelsen **passer til en viss grad eller iblant.** Hvis beskrivelsen **ikke passer på deg,** sett en ring rundt 0. Vennligst svar så godt du kan på alle spørsmålene selv om noen ikke passer på deg.

0 = Passer ikke 1 = Passer til en viss grad eller iblant 2 = Passer bra eller ofte

0 1 2 1. Jeg oppfører meg som yngre enn det jeg er
0 1 2 2. Jeg er allergisk (notér mot hva og hvordan det arter seg):.....
.....
.....
0 1 2 3. Jeg krangler mye
0 1 2 4. Jeg har astma
0 1 2 5. Jeg oppfører meg som det motsatte kjønn
0 1 2 6. Jeg liker dyr
0 1 2 7. Jeg skryter
0 1 2 8. Jeg har vanskelig for å konsentrere meg eller være oppmerksom
0 1 2 9. Jeg har tvangstanker, fikse idéer (beskriv):
.....
.....
.....
0 1 2 10. Jeg har vanskelig for å sitte stille
0 1 2 11. Jeg er for avhengig av voksne
0 1 2 12. Jeg føler meg ensom
0 1 2 13. Jeg føler meg forvirret, eller som i en tåke
0 1 2 14. Jeg gråter mye
0 1 2 15. Jeg er ganske ærlig
0 1 2 16. Jeg er slem mot andre
0 1 2 17. Jeg dagdrømmer mye
0 1 2 18. Jeg prøver å skade meg selv med vilje eller har forsøkt å begå selvmord
0 1 2 19. Jeg prøver å få mye oppmerksomhet
0 1 2 20. Jeg ødelegger mine egne ting
0 1 2 21. Jeg ødelegger ting som tilhører andre
0 1 2 22. Jeg er ulydig overfor foreldrene mine
0 1 2 23. Jeg er ulydig på skolen
0 1 2 24. Jeg spiser ikke så godt som jeg burde
0 1 2 25. Jeg kommer ikke overens med andre unge
0 1 2 26. Jeg har ikke skyldfølelse etter å ha gjort noe jeg ikke burde
0 1 2 27. Jeg blir lett sjalu og misunnelig på andre
0 1 2 28. Jeg er villig til å hjelpe andre når de trenger hjelp
0 1 2 29. Jeg er redd for visse dyr, situasjoner eller steder utenom skolen (beskriv): .....
.....
.....
0 1 2 30. Jeg er redd for å gå på skolen
0 1 2 31. Jeg er redd for å tenke eller gjøre noe galt
0 1 2 32. Jeg føler jeg må være perfekt
0 1 2 33. Jeg føler at ingen er glade i meg
0 1 2 34. Jeg føler at andre er ute etter meg
0 1 2 35. Jeg kjenner meg mindreverdig eller underlegen
0 1 2 36. Jeg slår meg mye, ulykkesfugl
0 1 2 37. Jeg kommer ofte i slagsmål
0 1 2 38. Jeg blir ofte ertet
0 1 2 39. Jeg henger sammen med kamerater som kommer opp i bråk
0 1 2 40. Jeg hører ting som ingen andre er i stand til å høre (beskriv): .....
.....
.....
0 1 2 41. Jeg handler uten å tenke
0 1 2 42. Jeg liker å være alene
0 1 2 43. Jeg lyver eller jukser
0 1 2 44. Jeg biter negler
0 1 2 45. Jeg er nervøs eller anspent
0 1 2 46. Jeg har nervøse bevegelser eller rykninger (beskriv): .....
.....
.....
0 1 2 47. Jeg har mareritt om natten
0 1 2 48. Jeg blir ikke likt av andre unge
0 1 2 49. Jeg kan gjøre enkelte ting bedre enn de fleste unge
0 1 2 50. Jeg er for redd eller engstelig
0 1 2 51. Jeg føler meg svimmel
0 1 2 52. Jeg har for mye skyldfølelse
0 1 2 53. Jeg spiser for mye
0 1 2 54. Jeg føler meg oversett
0 1 2 55. Jeg er overvektig
0 1 2 56. Kroppslige plager uten kjent medisinsk årsak:
0 1 2 a. Smerter eller vondt
0 1 2 b. Hodepine
0 1 2 c. Kvalm, føler meg uvel
0 1 2 d. Plager med øynene (beskriv): .....
.....
.....
0 1 2 e. Utslett eller andre hudplager
0 1 2 f. Magesmerter
0 1 2 g. Brekninger, kaster opp
0 1 2 h. Annet (beskriv): .....
.....
0 1 2 57. Jeg kan gå løs på andre med lugging, slag eller spark.

0 = Passer ikke 1 = Passer til en viss grad eller iblant 2 = Passer bra eller ofte

0 1 2 58. Jeg plukker på huden eller andre deler av kroppen min (beskriv): .....

0 1 2 59. Jeg kan være ganske hyggelig

0 1 2 60. Jeg liker å gjøre nye ting

0 1 2 61. Jeg gjør det dårlig på skolen

0 1 2 62. Jeg er klosset og har dårlig samordning av bevegelsene mine

0 1 2 63. Jeg vil heller være sammen med unge som er eldre enn meg enn dem på min egen alder

0 1 2 64. Jeg vil heller være sammen med unge som er yngre enn meg enn med dem på min egen alder

0 1 2 65. Jeg nekter å snakke

0 1 2 66. Jeg gjentar visse handlinger om og om igjen, tvangshandlinger (beskriv): .....

0 1 2 67. Jeg rømmer hjemmefra

0 1 2 68. Jeg skriker mye

0 1 2 69. Jeg er hemmelighetsfull og holder ting for meg selv

0 1 2 70. Jeg ser ting som ingen andre synes i stand til å se (beskriv): .....

0 1 2 71. Jeg blir lett flau eller forlegen

0 1 2 72. Jeg tenner på — lager brann

0 1 2 73. Jeg er flink med hendene mine

0 1 2 74. Jeg gjør meg til eller spiller bajas

0 1 2 75. Jeg er sjenert

0 1 2 76. Jeg sover mindre enn de flest unge

0 1 2 77. Jeg sover mer enn andre unge om dagen og/eller om natten (beskriv): .....

0 1 2 78. Jeg har god fanatsi

0 1 2 79. Jeg har talevansker (beskriv): .....

0 1 2 80. Jeg står på rettighetene mine

0 1 2 81. Jeg stjeler hjemme

0 1 2 82. Jeg stjeler borte, utenfor hjemmet

0 1 2 83. Jeg samler på ting som jeg ikke har bruk for (beskriv): .....

0 1 2 84. Jeg gjør ting som andre synes er underlige (beskriv): .....

0 1 2 85. Jeg har tanker som andre ville synes var underlige (beskriv): .....

0 1 2 86. Jeg er sta

0 1 2 87. Humøret etter følelsene mine forandrer seg plutselig

0 1 2 88. Jeg liker å være sammen med andre

0 1 2 89. Jeg er mistenksom

0 1 2 90. Jeg banner eller bruker stygge ord

0 1 2 91. Jeg har tanker om å ta livet av meg

0 1 2 92. Jeg liker å få andre til å le

0 1 2 93. Jeg prater for mye

0 1 2 94. Jeg erter andre mye

0 1 2 95. Jeg har et heftig sinne

0 1 2 96. Jeg tenker for mye på sex

0 1 2 97. Jeg truer andre med å skade dem

0 1 2 98. Jeg liker å hjelpe andre

0 1 2 99. Jeg er altfor opptatt av å være ren og ordentlig

0 1 2 100. Jeg har søvnproblemer (beskriv): .....

0 1 2 101. Jeg skulker skolen eller timer på skolen

0 1 2 102. Jeg har dårlig med energi

0 1 2 103. Jeg er ulykkelig, trist eller deprimert

0 1 2 104. Jeg bråker mer enn andre ungdommer

0 1 2 105. Jeg bruker alkohol eller vanedannende stoff (beskriv): .....

0 1 2 106. Jeg prøver å være ærlig og grei mot andre

0 1 2 107. Jeg liker en god spøk

0 1 2 108. Jeg liker å ta livet lettvint

0 1 2 109. Jeg prøver å hjelpe andre når jeg kan

0 1 2 110. Jeg skulle ønske jeg var av motsatt kjønn

0 1 2 111. Jeg passer meg for å engasjere meg i andre

0 1 2 112. Jeg er mye bekymret

Sett et kryss ved det svaret som beskriver deg:

	JA	NEI
Spiser du etter et bestemt mønster hver dag?	☐	☐
Driver du av og til med hard slanking?	☐	☐
Føler du deg mislykket hvis du bryter med slankeprogrammet?	☐	☐
Teller du kaloriene i alt du spiser, selv når du ikke slanker deg?	☐	☐
Faster du en hel dag av og til?	☐	☐

Hvis du svarte ja på forrige spørsmål, hvor ofte?

- ☐ Hver annen dag
- ☐ 2—3 ganger pr. uke
- ☐ 1 gang i uken
- ☐ Av og til
- ☐ Har gjort det en gang

Bruker du noen av følgende til å hjelpe deg å gå ned i vekt?

	Aldri	Av og til	1 gang pr. uke	2—3 ganger pr. uke	Daglig	2—3 ganger pr. dag	Mer enn 5 ganger pr. uke
Slanketabletter	☐	☐	☐	☐	☐	☐	☐
Slankepulver	☐	☐	☐	☐	☐	☐	☐
Avføringsmidler	☐	☐	☐	☐	☐	☐	☐
Vanndrivende medikamenter	☐	☐	☐	☐	☐	☐	☐
Tvinger meg til å kaste opp	☐	☐	☐	☐	☐	☐	☐

	JA	NEI
Ødelegger ditt spisemønster livet ditt?	☐	☐
Ville du si at maten styrer ditt liv?	☐	☐
Spiser du noen ganger så mye at du må stoppe p.g.a ubehag?	☐	☐
Er det perioder hvor du bare tenker på mat?	☐	☐
Spiser du fornuftig i andres nærvær for å få «ta igjen» når du er alene?	☐	☐
Kan du slutte å spise når du vil?	☐	☐
Føler du noen ganger en overveldende trang til å spise?	☐	☐
Spiser du mye når du er engstelig?	☐	☐
Er du veldig redd for å bli fet?	☐	☐
Spiser du store mengder mat veldig fort (mellom måltider)?	☐	☐

	JA	NEI
Skammer du deg over dine spisevaner?	☐	☐
Er du bekymret over å ikke kunne styre spisingen?	☐	☐
Trøstespiser du?	☐	☐
Kan du la noe av maten ligge igjen på tallerkenen etter et måltid?	☐	☐
Lurer du andre mennesker m.h.t. hvor mye du spiser?	☐	☐
Er det sultfølelse som bestemmer hvor mye du spiser?	☐	☐
Fråtser du i store mengder mat noen ganger?	☐	☐
Hvis du svarte ja, føler du deg elendig etterpå?	☐	☐
Hvis du fråtser, er det bare når du er alene?	☐	☐

Hvis du fråtser, hvor ofte skjer dette?

☐ Nesten aldri ☐ En gang i måneden
☐ En gang i uken ☐ 2—3 ganger pr. uke
☐ Daglig ☐ 2—3 ganger pr. dag

Ville du anstrenge deg veldig for å tilfredstille trangen til å fråtse?	☐	☐
Hvis du forspiser deg, får du mye skyldfølelse?	☐	☐
Spiser du i smug noen ganger?	☐	☐
Er dine spisevaner normale, slik du ser dem?	☐	☐
Er du en «tvangsspiser»?	☐	☐
Varierer din vekt med mer enn 2—3 kg i løpet av en uke?	☐	☐

Hva er det meste du har veid? ..... kg

Hvor lenge hadde du denne vekten? ..... måneder

Hva er det minste du har veid de siste årene? ..... kg

Hvor lenge hadde du denne vekten? ..... måneder

Hva er det største vekttapet du har hatt? ..... kg

Skjedde dette vekttapet med vilje? ☐ Ja ☐ Nei

Hva ønsker du å veie? ..... kg

Nå følger en liste over forskjellige plager og problemer som man av og til kan ha. Har du i løpet av den siste uka ikke vært plaget i det hele tatt, litt plaget, ganske mye plaget eller veldig mye plaget av noe av dette? Sett kryss i den ruta som passer for deg.

	Ikke plaget i det hele tatt	Litt plaget	Ganske mye plaget	Veldig mye plaget
Plutselig redd uten grunn	☐	☐	☐	☐
Stadig redd eller engstelig	☐	☐	☐	☐
Matthet eller svimmelhet	☐	☐	☐	☐
Nervøsitet, indre uro	☐	☐	☐	☐
Lett for å gråte	☐	☐	☐	☐
Lett for å klandre deg selv	☐	☐	☐	☐
Følt at alt er et slit	☐	☐	☐	☐
Hatt søvnproblemer	☐	☐	☐	☐
Følt deg ulykkelig, trist eller deprimert	☐	☐	☐	☐
Følt håpløshet med tanke på framtida	☐	☐	☐	☐
Følt deg stiv eller anspent	☐	☐	☐	☐
Bekymret deg for mye om ting	☐	☐	☐	☐
Tenkt på å gjøre slutt på livet ditt	☐	☐	☐	☐

Har du noen gang forsøkt å ta livet ditt? ☐ Nei ☐ Ja

Hvis ja, hvor mange ganger har du forsøkt? ..... ganger

Har du noen ganger i denne forbindelse vært i kontakt med lege, helsesøster, sykehus e.l.? ☐ Nei ☐ Ja

I løpet av **de siste 12 månedene** — har du noen gang forsøkt å ta livet ditt? ☐ Nei ☐ Ja

Har du noen gang i løpet av **de siste 12 månedene** i denne forbindelse vært i kontakt med lege, helsesøster, sykehus e.l.? ☐ Nei ☐ Ja

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Røyker du?

☐ Har aldri røykt
☐ Har aldri røykt fast og røyker ikke i det hele tatt nå
☐ Har røykt fast, men har sluttet helt nå
☐ Røyker, men ikke daglig
☐ Røyker daglig, omtrent ..... sigaretter

Hvor mange ganger har du i løpet av de fire siste ukene drukket mer enn et par slurker alkohol

☐ Ingen ganger

..... (antall ganger)

Sist gang du drakk alkohol, hvor mange «drinker» drakk du da? Som en «drink» regnes ½ flaske pils, 1 stort glass svakvin, 1 glass sterkvin, 1 drink brennevin (ca. 4 cl).

Jeg drakk ca. ..... «drinker»

Tenk tilbake på siste gang du drakk alkohol...

A. Hvor gjorde du det

- ☐ Jeg har aldri drukket alkohol
- ☐ Hjemme
- ☐ På tur/reise
- ☐ I fritidsklubb
- ☐ Ute
- ☐ På diskotek eller restaurant
- ☐ Forsamlingslokale, dansetilstelning
- ☐ Hjemme hos venner

B. Hvem var du sammen med?

- ☐ Alene
- ☐ En venn
- ☐ Flere andre ungdommer
- ☐ Foreldrene
- ☐ Andre voksne

C. Var det ungdom av begge kjønn til stede? ☐ Ja ☐ Nei

D. Var det fest? ☐ Ja ☐ Nei

Drikker faren din alkohol?

- ☐ Nei
- ☐ En sjelden gang
- ☐ Vanligvis omtrent en gang i uka
- ☐ Vanligvis flere ganger i uka
- ☐ Daglig

Drikker moren din alkohol?

- ☐ Nei
- ☐ En sjelden gang
- ☐ Vanligvis omtrent en gang i uka
- ☐ Vanligvis flere ganger i uka
- ☐ Daglig

Har du noen gang sett at dine foreldre har vært beruset?

- ☐ Aldri
- ☐ Noen få ganger
- ☐ Noen ganger i året
- ☐ Noen ganger i måneden
- ☐ Noen ganger i uka

Er du noen gang blitt tilbudt hasj eller marihuana? ☐ Ja ☐ Nei

Har du noen gang brukt hasj eller marihuana? ☐ Ja ☐ Nei

Her kommer noen beskrivelser av følelser folk kan ha. Kryss av for hvordan du selv føler deg.

	Aldri	Sjelden	Av og til	Ofte
Jeg føler meg på bølgelengde med folk rundt meg	☐	☐	☐	☐
Jeg kan finne noen å være sammen med hvis jeg ønsker det	☐	☐	☐	☐
Jeg har følelsen av at ingen kjenner meg særlig godt	☐	☐	☐	☐
Jeg synes at folk er rundt meg, men ikke sammen med meg	☐	☐	☐	☐
Jeg føler meg ensom	☐	☐	☐	☐

Driver du aktivt med sport eller idrett?

- ☐ Nei
- ☐ Nei, men jeg var aktiv før
- ☐ Ja, men jeg driver ikke med organisert trening og konkurranser
- ☐ Ja, jeg driver aktivt og deltar i konkurranser

Dersom du driver med flere idretter, så skriv navnet på disse under hverandre.

Hvilke idrett(er): .....

.....

.....

.....

Hvilket yrke ønsker du deg som voksen? .....

Nedenfor er en del påstander om hvordan det er å gå på skolen, og hvordan skolen burde være.

Kryss av i den ruten som passer best for deg:

	Helt enig	Litt enig	Litt uenig	Helt uenig
Det er kjedelig på skolen	☐	☐	☐	☐
Mye av tida på skolen er bortkastet	☐	☐	☐	☐
Jeg trives på skolen	☐	☐	☐	☐
Jeg gruer meg ofte til å gå på skolen	☐	☐	☐	☐
Lærerne våre er flinke til å lære bort	☐	☐	☐	☐

Også i Finnmark har folk forskjellige kulturer og bakgrunner. Det finnes ulike ord for å beskrive de kulturelle bakgrunnene eller etniske tilhørigheter som folk har.
Noen eksempler på etnisk tilhørighet eller etnisk gruppe er f.eks. norsk, samisk, finsk, kvensk og tamilsk.

Alle mennesker blir født inn i en etnisk eller kulturell tilhørighet, eller av og til to, men det er store forskjeller hvor mye etnisitet betyr, hvilke følelser den enkelte har overfor sin etnisitet og hvor mye deres væremåte er påvirket av denne.
Spørsmålene nedenfor handler om etnisitet eller etnisk tilhørighet og hvordan du føler og handler i forhold til den. De er laget for flerkulturelle samfunn. Fyll ut så godt du kan.

Når det gjelder etnisk tilhørighet, regner jeg meg selv som .....

Kryss av i den ruten som passer for deg:

	Helt enig	Litt enig	Litt uenig	Helt uenig
Jeg har brukt tid til å prøve å finne ut mer om min etniske gruppe, slik som historie, tradisjoner og skikker	☐	☐	☐	☐
Jeg deltar aktivt i organisasjoner eller sosiale sammenhenger som hovedsaklig har medlemmer fra min egen etniske gruppe	☐	☐	☐	☐
Jeg har en klar oppfatning av min etniske bakgrunn og hva den betyr for meg	☐	☐	☐	☐
Jeg liker å møte og bli kjent med folk fra andre etniske grupper enn min egen	☐	☐	☐	☐
Jeg tenker mye på hvordan min etniske tilhørighet påvirker livet mitt	☐	☐	☐	☐
Jeg er glad for å tilhøre den gruppen jeg tilhører	☐	☐	☐	☐
Av og til føler jeg at ting ville være bedre om de forskjellige etniske gruppene ikke prøvde å blande seg	☐	☐	☐	☐
Jeg vet egentlig ikke hvilken rolle min etnisitet spiller i livet mitt	☐	☐	☐	☐
Jeg er ofte sammen med folk fra andre etniske grupper enn min egen	☐	☐	☐	☐
Jeg har egentlig ikke brukt noe særlig tid på å prøve å finne ut noe om min etniske gruppes kultur og historie	☐	☐	☐	☐
Jeg har en sterk følelse av å høre til i min etniske gruppe	☐	☐	☐	☐
Jeg har en ganske god forståelse av hva min etniske tilhørighet betyr for meg, med tanke på hvordan jeg skal forholde meg til både min egen og andre etniske grupper	☐	☐	☐	☐
For å kunne lære mer om min bakgrunn, har jeg ofte snakket med andre om min etniske tilhørighet	☐	☐	☐	☐
Jeg er veldig stolt av min bakgrunn og hva den har oppnådd	☐	☐	☐	☐

Jeg føler egentlig ikke at jeg tilhører noen etnisk gruppe	☐	☐	☐	☐
Jeg prøver ikke å bli venner med ungdom fra andre etniske grupper	☐	☐	☐	☐
Jeg deltar i kulturelle aktiviteter og tradisjoner innen min etniske gruppe, slik som f.eks. tradisjonell matlaging, musikk eller andre skikker	☐	☐	☐	☐
Jeg deltar i aktiviteter sammen med folk fra andre grupper	☐	☐	☐	☐
Jeg føler en sterk tilknytning til min egen etniske gruppe	☐	☐	☐	☐
Jeg skulle ønske at jeg tilhørte en annen etnisk gruppe enn jeg gjør	☐	☐	☐	☐
Jeg liker å være sammen med folk fra andre etniske grupper enn min egen	☐	☐	☐	☐
Jeg er fornøyd med min kulturelle eller etniske bakgrunn	☐	☐	☐	☐
Jeg føler at jeg tilhører flere etniske grupper	☐	☐	☐	☐

Min etnisitet er (skriv et eller flere av numrene nedenfor) .....

1. Norsk
2. Samisk
3. Finsk
4. Kvensk
5. Annet (skriv hvilken): .....

Fars etnisitet er (bruk numrene ovenfor): .....

Mors etnisitet er (bruk numrene ovenfor): .....

Nedenfor er en del spørsmål om foreldrene dine og skolearbeidet.

	Stemmer svært dårlig	Stemmer ganske dårlig	Ikke sikker	Stemmer ganske godt	Stemmer svært godt
Foreldrene mine er svært interessert i skolearbeidet mitt	☐	☐	☐	☐	☐
Foreldrene mine hjelper meg ofte med skolearbeidet	☐	☐	☐	☐	☐
Foreldrene mine synes det er bortkastet å ta en lang utdannelse	☐	☐	☐	☐	☐
Foreldrene mine roser meg ofte for skolearbeidet mitt	☐	☐	☐	☐	☐
Foreldrene mine snakker sjelden med meg om skolen	☐	☐	☐	☐	☐
Foreldrene mine oppmuntrer meg til å fortsette skolegangen	☐	☐	☐	☐	☐

Vi er interessert i hvem du vil ha snakket med eller vært sammen med i forskjellige situasjoner. Nedenfor er en del personer som du kanskje ville ha vært sammen med eller snakket med. Du setter et ett-tall i ruta foran den du aller helst ville vært sammen med eller snakket med (1. plass), et to-tall foran den du nest helst ville vært sammen med (2. plass) og et tre-tall foran den du tredje helst ville vært sammen med (3. plass).

Hvem vil du helst tilbringe en søndag ettermiddag sammen med (1. plass, 2. plass, 3. plass)?

- ☐ Gjøre noe alene
- ☐ Mor
- ☐ Far
- ☐ Mor og far
- ☐ Søster/bror
- ☐ En god venn
- ☐ Kamerater/gjengen
- ☐ Kjæresten
- ☐ Besteforeldre
- ☐ Andre slektninger
- ☐ Andre voksne

Tenk deg at du i morgen måtte velge hva slags skole/utdanning du skulle ha i framtida. Du er svært usikker på hva du skal velge. Hvem ville du gå til for å få råd og hjelp (1. plass, 2. plass, 3. plass)?

- ☐ Ville ikke gått til noen
- ☐ Mor
- ☐ Far
- ☐ Mor og far
- ☐ Søster/bror
- ☐ En god venn
- ☐ Kamerater/gjengen
- ☐ Kjæresten
- ☐ Lærer
- ☐ Yrkesveileder
- ☐ Andre slektninger
- ☐ Andre voksne

Tenk deg at du hadde et personlig problem og følte deg utafor og trist. Hvem ville du snakke med, søke hjelp hos (1. plass, 2. plass, 3. plass)?

- ☐ Ville ikke gått til noen
- ☐ Mor
- ☐ Far
- ☐ Mor og far
- ☐ Søster/bror
- ☐ En god venn
- ☐ Kamerater/gjengen
- ☐ Kjæresten
- ☐ Lærer
- ☐ Skolepsykolog
- ☐ Andre slektninger
- ☐ Helsesøster, lege etc.
- ☐ Andre voksne

Tenk deg at du er tatt i å gjøre noe ulovlig. Du kan bli anmeldt til politiet. Du trenger hjelp og råd. Hvem ville du gått til (1. plass, 2. plass, 3. plass)?

- ☐ Ville ikke gått til noen
- ☐ Mor
- ☐ Far
- ☐ Mor og far
- ☐ Søster/bror
- ☐ En god venn
- ☐ Kamerater/gjengen
- ☐ Kjæresten
- ☐ Politiet
- ☐ Andre slektninger
- ☐ Andre voksne

Ønsker du å bosette deg på hjemstedet ditt når du er ferdig med utdanningen din?

- ☐ Ja, svært gjerne
- ☐ Ja, dersom det faller seg slik
- ☐ Usikker
- ☐ Nei, jeg ønsker å bosette meg et annet sted

Hvis du tror du kommer til å flytte etter at du er ferdig med utdanningen din, hvor vil du helst flytte?

- ☐ Til en større by
- ☐ Til en mindre by
- ☐ Til et sted like utenfor en by
- ☐ Til ei bygd
- ☐ Til et annet land
- ☐ Tilbake til hjemstedet
- ☐ Usikker

Nedenfor er noen spørsmål om hvordan du synes du selv er. Kryss av for det som passer best på deg.

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg synes jeg er like smart som andre på min alder	☐	☐	☐	☐
Jeg synes det er ganske vanskelig å få venner	☐	☐	☐	☐
Jeg er flink i all slags sport	☐	☐	☐	☐
En dag har jeg ett syn på meg selv, en annen dag et annet syn	☐	☐	☐	☐
Jeg har «10 tommeltotter»	☐	☐	☐	☐
Jeg er ikke fornøyd med utseende mitt	☐	☐	☐	☐
Jeg føler at når jeg er interessert i en av motsatt kjønn, så er det gode muligheter for at den andre vil være interessert i meg også	☐	☐	☐	☐
Jeg klarer å få virkelige nære venner	☐	☐	☐	☐
Jeg er ofte skuffet over meg selv	☐	☐	☐	☐
Jeg er ganske sein med å bli ferdig med skolearbeidet	☐	☐	☐	☐
Jeg har mange venner	☐	☐	☐	☐
Jeg tror jeg kan gjøre det bra i nesten hvilken Som helst ny sport	☐	☐	☐	☐
Jeg trives godt på hjemstedet mitt	☐	☐	☐	☐
Jeg ønsker at kroppen min var annerledes	☐	☐	☐	☐
Min oppfatning av meg selv pleier å forandre seg en god del	☐	☐	☐	☐
Jeg er flink med praktiske ting	☐	☐	☐	☐
Jeg prøver å sjekke opp de som jeg er virkelig interessert i	☐	☐	☐	☐
Jeg har en nær venn som jeg kan dele hemmeligheter med	☐	☐	☐	☐
Jeg liker **ikke** den måten jeg lever livet mitt på	☐	☐	☐	☐
Jeg gjør det svært godt på skolen	☐	☐	☐	☐
Andre ungdommer har vanskelig for å like meg	☐	☐	☐	☐
Jeg synes at jeg er bedre i sport enn andre på min alder	☐	☐	☐	☐
Jeg ønsker at jeg så annerledes ut	☐	☐	☐	☐
Jeg har merket at mitt syn på meg selv kan forandre seg	☐	☐	☐	☐
Jeg er flink til å sette sammen eller reparere ting	☐	☐	☐	☐

Jeg føler at andre unge (av motsatt kjønn) vil kunne bli interessert i meg	☐	☐	☐	☐
Jeg har en venn som jeg kan dele ting med	☐	☐	☐	☐
Jeg er stort sett fornøyd med meg selv	☐	☐	☐	☐
Jeg har vansker med å svare riktig på skolen	☐	☐	☐	☐
Jeg er populær blant jevnaldrende	☐	☐	☐	☐
Jeg gjør det ikke så godt i nye øvelser i gym-timene	☐	☐	☐	☐
Jeg synes jeg ser bra ut	☐	☐	☐	☐
Jeg er ikke særlig flink med hendene	☐	☐	☐	☐
Jeg tror at jeg er spennende og interessant for de av motsatt kjønn	☐	☐	☐	☐
Jeg synes det er vanskelig å få venner som jeg virkelig kan stole på	☐	☐	☐	☐
Jeg liker meg selv slik jeg er	☐	☐	☐	☐
Jeg tror jeg er ganske intelligent	☐	☐	☐	☐
Jeg føler at jevnaldrende godtar meg	☐	☐	☐	☐
Jeg synes ikke at jeg har så sterk kropp som andre på min alder	☐	☐	☐	☐
Jeg liker utseende mitt veldig godt	☐	☐	☐	☐
Av og til har jeg et positivt syn på meg selv, av og til et svært negativt syn	☐	☐	☐	☐
Jeg har ganske god praktisk sans	☐	☐	☐	☐
Jeg forsøker vanligvis **ikke** å få den jeg er interessert i til å bli interessert i meg	☐	☐	☐	☐
Jeg har ikke noen god venn som jeg kan dele virkelig personlige ting med	☐	☐	☐	☐
Jeg er svært fornøyd med hvordan jeg er	☐	☐	☐	☐

Hvordan stiller du deg til kristendommen?

- ☐ Jeg er personlig kristen
- ☐ Jeg tror det finnes en Gud, men religion betyr ikke så mye for meg i det daglige
- ☐ Usikker
- ☐ Jeg tror ikke det finnes noen Gud
- ☐ Jeg tilhører en annen religion, nemlig; .....

.....

.....

Har du og dine foreldre/foresatte tilhørighet til noe spesielt trossamfunn?
Kryss av for det som passer for deg og dine foreldre/foresatte.

	Meg selv	Mor	Far
Statskirken	☐	☐	☐
Læstadianismen	☐	☐	☐
Pinsemenigheten	☐	☐	☐
Jehovas vitne	☐	☐	☐
Annet	☐	☐	☐

Hvor mange bøker tror du det er hjemme hos dere?

- ☐ Ingen
- ☐ Mindre enn 20
- ☐ 20—50
- ☐ 50—100
- ☐ 100—500
- ☐ 500—1000
- ☐ Mer enn 1000

Når du ser på deg selv nå, mener du at du er tidligere eller senere fysisk moden enn andre på din alder?

- ☐ Mye tidligere
- ☐ Noe tidligere
- ☐ Lite grann tidligere
- ☐ Akkurat som andre
- ☐ Lite grann senere
- ☐ Noe senere
- ☐ Mye senere

Da du begynte å bli fysisk moden, mener du at dette startet tidligere eller senere enn hos andre på din alder?

- ☐ Mye tidligere
- ☐ Noe tidligere
- ☐ Lite grann tidligere
- ☐ Akkurat som andre
- ☐ Lite grann senere
- ☐ Noe senere
- ☐ Mye senere

Går foreldrene dine på foreldremøter og andre møter som har med skolen å gjøre?

- ☐ De går som regel på slike møter
- ☐ De går av og til
- ☐ De går aldri

The North Norwegian Youth Study:

Questionnaire in Sami 1994-95

Norges forskningsråd

NUORRAN NORGGAS

Gažadanskovvi nuoraid várás Norggas

Dát gažadanskovvi manná 10.000 nuorra olbmui Norggas. Iskkadeami áigumuš lea fidnet buoret dieđuid das mo Norggas lea odne šaddat ja leat nuorra. Mii sávvat eambbo diehtit nuoraid dárbbuid, sávaldagaid ja eallindilálašvuođaid. Ulbmilin lea maid joksat dieđuid mat sáhttet leat veahkkin buoridit nuoraidpolitihka Norggas.

Iskkadeami duohken lea Program for ungdomsforskning (UNGforsk). Norgga dutkanráđđi ja Mánna- ja bearašdepartementta Nuoraidossodat dat ovttasráđiid vuođđudedje UNGforsk.

Min doaivu lea ahte don deavddát dán skovi. Jos leššet gažaldatgat mat du mielas orrot menddo persovnnalaččat, dahje maid it dáhto vástidit, de sáhtát daid diktit orrut vástitkeahttá. Muhto mii gale dáhtošeimmet ahte vástidat buot gažaldagaide.

Du iežat dáhtu duohken lea searvvatgo oskkadeapmái. Dat mearkkaša ahte dus ii leat bággu leat mielde. Jos maŋŋá háliidat geassádit iskkadeamis, de dieđit skuvlii. Skuvla de dieđiha midjiide du kodanummira, vai mii sáhttit sihkkut du vástádusaid.

Buot vástádusat leat luohtehahtti rájus. Dat mearkkaša ahte ii ***oktage*** *oaččo diehtit maid jure justa* ***don*** *vástidit.*

Eanaš báikkiid sárggastat russolas sárgá dan gažaldaga ruktái mii dutnje buoremusat heive. Muhtun sajiid leat dušše čuoggát. Dakko don ieš fertet čállit vástádusa.

Go leat geargan deavdimis skovi, de ieš bija skovi dan reivegokčasii maid ožžot ja liibme gitta.

Boahtte diimmus oaččut ođđa skovi. Dan gálggašit deavdit seamma láhkai, ja bidjat reivegokčasii ovdalaš go diibmu nohká.

Giitu veahki ovddas!

Ustitlaš dearvvuođat

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Leatgo nieida vai gánda?

☐ Nieida
☐ Gánda

Man boaris don leat?

Mun lean ..... jahkásaš

Man skuvlaluohká don váccát?

☐ Vuođđokurssa
☐ Joatkkakurssa I
☐ Joatkkakurssa II
☐ Oassekurssa

Man oahpposuorggi don váccat?

☐ Oppalaš fágaid
☐ Gávpe- ja kantuvrafágaid
☐ Giehtaduoji ja industriijafágaid
☐ Ruoktoduoji ja estehtalaš fágaid duoji
☐ Dállodoallofágaid
☐ Valáštallanfágaid
☐ Dearvvašvuoda ja birasfágáid
☐ Guolástusfágaid
☐ Mearrajohtolatfágaid
☐ Eanandoalu ja luonddu geavaheami fágaid, boazodoallu
☐ Teknihkalaš fágaid
☐ Eará (čále mii dat lea): .....

Man giellaluohká don vázzet nuoraidskuvllas?

☐ Dárogiel
☐ Sámegiel
☐ Eará, mii dat lea .....

Mii dál lea 1. giellan skuvllas?

☐ Dárogiella
☐ Sámegiella
☐ Eará, mii dat lea .....

Leatgo riegádan Norggas?

☐ Lean
☐ In leat

Man guhká don leat ássan Finnmárkkus?

☐ Oppa eallima
..... jagi

Gos du vánhemat leat eret?

Eadni
☐ Norggas
☐ Eará riikkas, nammalassii .....

Áhčči
☐ Norggas
☐ Eará rikkas, nammalassii .....

Leatgo biebmománnán boathtán eará riikkas? ☐ Lean ☐ In leat

Geainna don orut ovttas ruovttus?

- ☐ Etniin ja áhčiin
- ☐ Etniin
- ☐ Áhčiin
- ☐ Etniin/áhčiin ja ođđa guimmiin dahje beallalaččain
- ☐ Sullii ovtta maðe ollu eatni luhtte go áhči luhtte
- ☐ Biebmovánhemiiguin
- ☐ Áhkuin ja ádjáin, eará fulkkiiguin
- ☐ Eará (čále mii dat lea): .....

Gos don orut go váccát skuvlla?

- ☐ Ruovttus
- ☐ Áhku ja ádjá luhtte, eará fulkkiid luhtte
- ☐ Orun láigolanjas, internáhtas d.s.
- ☐ Muđui (čále mii dat lea): .....

Mii du ruovttugielda lea? ..... gielda

Man nuoraidskuvlla don vázzet? ..... skuvlla

Galle viclja/oappá dus leat? Mus lea(t) ..... (lohku) vielja/oappá

Makkár fitnut du vánhemiin leat?
Čále fitnu nama, oanehaččat maid soai bargaba, ja leabago barggus dál, bargabago dievas beaivvi vai oasseáiggi. Jos juogo áhčči dahje eadni lea ruovttus dahje oažžu oaju, de čále dange. Jos nubbi du vánhemiin lea jápmán, de mii háliidat ahte muitalat dange.

Leago áhčči, barggus dál

- ☐ Lea, dievas beaivvi
- ☐ Lea, oasseáiggi
- ☐ Barggu haga
- ☐ Ruovttus
- ☐ Oažžu oaju
- ☐ Vázzá skuvlla, kurssa, d.s.

Áhči fidnu: .....

Čále oanehaččat maid son bargá: .....

.....

Leago eadni dál barggus?

- ☐ Lea, dievas beaivvi
- ☐ Lea, oasseággi
- ☐ barggu haga
- ☐ Ruovttus
- ☐ Oažžu oaju
- ☐ Vázzá skuvlla, kurssa, d.s.

Eatni fidnu: .....

Čále oanehaččat maid son bargá: .....

.....

Jos don orut dahje leat orron dušše nuppi vánhema luhtte, de galle jagi lea nu leamaš buohkanassii?

Jagiid lohku .....

Makkár oahppu lea áhčistat ja eatnistat? Sárggo nu galle russolas sárgá go heive:

	Áhči	Eadni
7-jahkásaš vuođđoskuvlla (dahje unnit)	☐	☐
Nuoraidskuvlla/Realskuvlla	☐	☐
Joatkkaskuvlla oppalaš fágaid (gymnasa)	☐	☐
Joatkkaskuvlla fidnofágaid (fidnoskuvla)	☐	☐
Fidnooahppu giehtaduojis, industriijas, eanandoalus d.s.	☐	☐
3-jahkásaš allaskuvla (oahpaheaddji, buohcciiddikšu, guovloallaskuvla d.s.)	☐	☐
Universitehta dahje eará guhkes oahppu	☐	☐
Eará oahppu	☐	☐
Eahpesihkkar/in diede	☐	☐

Man guhkki don leat iežat jáhku mielde? .....cm

Man lossat don leat iežat jáhku mielde? .....kg

Jos don smiehtat vássán vahku — maŋimuš 7 beaivvi — man ollu de leat leamaš ovttas eará rávis olbmuiguin go vánhemiiddátguin? «**Rávis olbmuiguin**» mii oaivvildat olbmuid gudet leat badjel 25 jagi boarrásat. Ale rehkenastte fárrui oahpaheaddjiid geaiguin don leat ovttas skuvlaággi. Alege rehkenastte rávis olbmuid geaiguin don orut ovttas, vaikko sii eai leatge du vánhemat. Geahčča1 muitát **sullii** galle diimmu don leat leamaš ovttas rávis olbmuiguin dán vahku.

	In veahâge	Vuollil 1 diimmu	1—2 diimmu	2—3 diimmu	4—6 diimmu	Eambbo go 6 diimmu
Valáštallanjodiheaddji, lášmmudeaddji	☐	☐	☐	☐	☐	☐
Astoáigesearvvi jodiheaddjit, šilljovázzi veahkeheaddjit	☐	☐	☐	☐	☐	☐
Ránnjáť	☐	☐	☐	☐	☐	☐
Rávis olbmot gudet jodihit astoáigedoaimmaid (eaige gula astoáigesearvái eaige leat oahpaheaddjit)	☐	☐	☐	☐	☐	☐
Oahpaheaddjit eará áiggi go skuvlaáiggi	☐	☐	☐	☐	☐	☐
Fuolkkit	☐	☐	☐	☐	☐	☐
Eará rávis olbmot	☐	☐	☐	☐	☐	☐

Man dávjá don lávet guođđit báikkálaš birrasa astoáiggistat deaivvadit eará nuoraiguin, dahje iehčanassii dahkat juoidá?

- ☐ 4 geardde vahkkui dahje dávjjit
- ☐ 2—3 geardde juohke vahku
- ☐ Sullii oktii juohke vahku
- ☐ Sullii juohke 14. beaivvi
- ☐ Sullii oktii mánnui dahje hárvvit

Dá vulobealde leat muhtun gažaldagat das man duhtavaš don leat iežat rupmašii ja dasa mo don leat olgguldasat oaidnit.

Man duhtavaš dahje duhtamcahttun don leat:	Hui duhta-meahttun	Viehka duhta-meahttun	In áibbas duhtavaš	Duhtavaš	Hui duhtavaš
Ámadadjui	☐	☐	☐	☐	☐
Spirraliidda ja bahtii	☐	☐	☐	☐	☐
Čoavjái	☐	☐	☐	☐	☐
Raddái	☐	☐	☐	☐	☐
Dehkiide	☐	☐	☐	☐	☐
Šaddui	☐	☐	☐	☐	☐
Guhkkodahkii	☐	☐	☐	☐	☐

Man čáppisin dahje fávdnádin don navddát iežat leat skuvlaskihpáriiddát mielas?

- ☐ Hui čáppisin/fávdnádin
- ☐ Viehka čáppisin/fávdnádin
- ☐ Dábálažžan
- ☐ In nu čáppisin/fávdnádin
- ☐ Uhccán čáppisin/fávdnádin

Dajašitgo iežat hárrái ahte leat:

- ☐ Hui gassat
- ☐ Viehka gassat
- ☐ Sullii nugo earátge
- ☐ Viehka seaggi
- ☐ Hui seaggi

Dá vulobealde leat muhtun cealkagat biepmu ja boradandábiid birra. Sárggo dákko gokko dat dutnje heivejit.

	Álo	Dávjá	Hárve	In goassege
Mun áŋgirušan seaggut	☐	☐	☐	☐
Mun geahččalan borrat dušše buoidutkeahtes biepmu	☐	☐	☐	☐
Mun dovddan unohisvuođa go lean borran njálgáid	☐	☐	☐	☐
Mun lášmmohalan vai geahpun	☐	☐	☐	☐
Mun vuovssán go lean boradan	☐	☐	☐	☐
Go vuos boradišgoađán, de lea váttis heaitit	☐	☐	☐	☐
Mun menddo ollu smiehtadan bicpmuid	☐	☐	☐	☐
Mu mielas biebmu orru stivremin mu eallima	☐	☐	☐	☐
Go mun boradan, de čuohpadan biepmu unna bihtážin	☐	☐	☐	☐
Mun geavahan eambbo áiggi boradeapmái go earát	☐	☐	☐	☐
Earáid mielas mun lean seaggi	☐	☐	☐	☐
Mus lea dat dovdu ahte earát bággejit munnje biepmu	☐	☐	☐	☐

Leatgo jurddašan vázzit skuvlla dahje oahpahallat go leat geargan joatkkaskuvllas?

- ☐ In diede jotkkežango
- ☐ In, in mun joatkke
- ☐ Juo, muhto in dieđe makkár skuvlla
- ☐ Juo, mun lean jurddašan vázzit

..... (makkár skuvlla)

Galle diimmu don gaskamearálaččat geavahat skuvlabargguide beaivái?

- ☐ In bargga bihtáid dahje in báljo goassege
- ☐ Unnit go diibmobeale
- ☐ Diimmu
- ☐ 1—2 diimmu
- ☐ 2—3 diimmu
- ☐ 3—4 diimmu
- ☐ Eambbo go 4 diimmu

Jos don dál fidnešit barggu, de barggašitgo go baicce go skuvlla vázzit?

- ☐ Juo
- ☐ In

Goappá anát **canemus jáhkehahtti** bargun dahje fidnun alddistat go leat 40-jahkásaš? Vaikko it leat sihkkar, de čále dan maid don jáhkán dahje navddát.

Ovddimusas: .....

Nubbin: .....

Man sihkkar don leat dan hárrái maid bidjet ovddimussii?

- ☐ Hui sihkkar
- ☐ Viehka sihkkar
- ☐ In nu sihkkar

Dákko leat namahuvvon muhtun dagut mat rihkkot skuvlla ja servodaga njuolggadusaid. Nuppit gažaldagat váldet ovdan lobihisvuođaid dahje daguid mat leat rájáid alde, ja maid ollugat dattetge dahket.

Leatgo searvan dása/dahkan ná dán jagi — **maŋimuš 12 mánu?**

	In goassege	Oktii	2—5 geardde	6—10 geardde	10—50 geardde	Eambbo go 50 geardde
Riidalan issorat oahpaheaddjiin?	☐	☐	☐	☐	☐	☐
Bijahallan olggos skuvlalanjas?	☐	☐	☐	☐	☐	☐
Suoládan ruđaid dahje juoidá iežat olbmuin?	☐	☐	☐	☐	☐	☐
Váldán mávssekeahttá gávppis dahje kioskkas dakkáriid maid ruhtaárvu lea vuollil 500 ruvnnu?	☐	☐	☐	☐	☐	☐
Gárrudan oahpaheaddjái?	☐	☐	☐	☐	☐	☐
Ieščáhtolaččat billistan dahje cuvken lássaruvttuid, bussestuoluid, telefuvdnakioskkaid, poastakássaid dahje sullasačča?	☐	☐	☐	☐	☐	☐
Gohčohallan rektora lusa dannego dahket juoidá mii lei boastut?	☐	☐	☐	☐	☐	☐
Njáhkan mássekeahttá kinoi, bussii, togii dahje sullasažžii?	☐	☐	☐	☐	☐	☐
Jávkan skuvllas?	☐	☐	☐	☐	☐	☐

Leamaš ija eret vánhemiiddát dieđikeahttá gos don leat, dahje sin jáhkedettiin ahte don leat dan báikkis maid muitalit, vaikko ii leange nu?	☐	☐	☐	☐	☐	☐
Vuodján biilla dahje mohtorsihkkeliid vuodjinkoartta haga?	☐	☐	☐	☐	☐	☐
Suoládan biilla dahje mohtorsihkkeliid?	☐	☐	☐	☐	☐	☐
Suoládan juoidá man ruhtaárvu lea eambbo go duhát ruvnno?	☐	☐	☐	☐	☐	☐
Billistan dahje dahkan vahága eambbo go duhát ruvnno ovdii?	☐	☐	☐	☐	☐	☐
Gaikon vistti suoládan nammii?	☐	☐	☐	☐	☐	☐
Leamaš doarus vearjjuin (omd. niibbiin)?	☐	☐	☐	☐	☐	☐
Čorbmadan dahje áitán čorbmadit olbmo?	☐	☐	☐	☐	☐	☐
Ožžon bolesiiguin dahkamuša man nu lobihisvuoda geažil, maid dahket?	☐	☐	☐	☐	☐	☐
Juhkan nu ollu ahte leat eahpitkeahttá dovdan ieżat lea gárremin?	☐	☐	☐	☐	☐	☐
Atnán hášša dahje marihuána?	☐	☐	☐	☐	☐	☐
Mirkkuid susttašan (havssašan)?	☐	☐	☐	☐	☐	☐
Atnán eara gárreheaddji ávdnasiid, nugo kokaina, LSD, morfina, amfetamina, heroina, dahje juoidá eará?	☐	☐	☐	☐	☐	☐

Jos vástidit juo, de makkár ávdnasat dat ledje? .....

Jos ieśdáhtolaččat goasge jávkkat skuvllas, de mii lea dábáleamos sivva dasa? Sárggo dušše ovtta russolas sárgá deháleamos siva nammii.

- ☐ Mun in skuvllas jávkka goassege
- ☐ Oahpahcaddjit meannudit muinna eahperehálaččat
- ☐ Mu hidjidit nuppit oahppit
- ☐ Duššái manná áigi go olmmoš skuvlla vázzá
- ☐ Mun in nagat diimmuin čuovvut fárus
- ☐ Muhtumin mus lea cambbo miella cará dahkat go skuvlla vázzit?
- ☐ Mun ráhkkanan máhttoiskkademiide dahje barggan makkár nu skuvlabargguid?
- ☐ Eará sivat, nammalassii .....

Manimuš hávi go jávket skuvllas, mo de geavahit áiggi? Sárggo russolas sárgá dákko gokko heive buoremusat.

- ☐ In leat goassege ieśdáhtolaččat jávkan
- ☐ Okto
- ☐ Earáiguin ovttas geat maid jávke skuvllas
- ☐ Nuoraiguin ovttas geat eai vácce skuvlla
- ☐ Eará, čále mii dat lea: .....

Dás vulobealdc leat moadde cealkámuša das mo olmmoš sáhttá meannudit iežas ja nuppiid kultuvrra ektui.

(Sárggo rieggá logu birra mii dutnje heive)

	Áibbas ovttamielas				Áibbas eará mielas
Mun háliidan alccesan dušše norgalaš ustibiid	1	2	3	4	5
Mun ovdal guldalan oarjemusihka (norgalaš, eŋgelas, amerihkálaš)	1	2	3	4	5
Munnje ii leat dehálaš makkár biepmu mun boran	1	2	3	4	5
Munnje lea buoret leat ustibiid haga	1	2	3	4	5
Mun háliidan leat sihke norgalaš ja sápmelaš/ kvenalaš/suopmelaš jovkkuin ja servviin mielde	1	2	3	4	5
Mun háliidan alccesan sihke sápmelaš/kvenalaš/ suopmelaš (sárgul sáni vuollái mii heive) ja norgalaš ustibiid	1	2	3	4	5
Mun millosepmosit boran norgalaš biepmu	1	2	3	4	5
Mun millosepmosit lean mielde dušše norgalaš joavkkuin ja servviin	1	2	3	4	5
Mun millosepmosit boran sihke norgalaš ja sápmelaš/suopmelaš/kvenalaš biepmu	1	2	3	4	5
Mun liikon sihke oarjemáilmmi ja sápmelaš/ suopmelaš/kvenalaš musihkkii	1	2	3	4	5
Mun oaivvildan ahte mii berret oahppat sihke Norgga/máilmmi historjjá ja sámiid/kvenaid/ suopmelaččaid historjjá skuvllas	1	2	3	4	5
Mun millosepmosit guldalan dušše sámi/ kvenalaš/suopmelaš musihka	1	2	3	4	5
Mus leat millosepmosit dušše sámi/kvenalaš/ suopmelaš ustibat	1	2	3	4	5
Mun boran sihke norgalaš ja sámi/kvenalaš/ suopmelaš biepmu	1	2	3	4	5
Munnje ii leat makkárge musihkka nuppi buoret	1	2	3	4	5
Mun in háliit leat mielde maŋge joavkkus dahje searvvis oppnassiige	1	2	3	4	5
Mun oaivvildan ahte mii berret oahppat dušše Norgga/máilmmi historjjá skuvllas	1	2	3	4	5
Vaikko mun ásange Norggas, de oaivvildan ahte mun berren eallit sápmin/suopmelaššan/kvenan	1	2	3	4	5
Mun oaivvildan ahte mii eat berre oahppat eat Norgga, eat máilmmi eatge sámiid/kvenaid/ suopmelaččaid historjjá skuvllas	1	2	3	4	5
Go juo ásan Norggas, de lea buoremus ahte ealán dážan	1	2	3	4	5
Mun mielastan gulan dušše sámi/kvenalaš/suopmelaš joavkkuide ja servviide	1	2	3	4	5
Mun liikon eallit sihke norgalaššan ja sápmin/ kvenan/suopmelaššan	1	2	3	4	5

Mu lea váttis gávnnahit dáhtungo eallit sápmin/suopmelaššan/kvenan vai norgalaššan	1	2	3	4	5
Mun oaivvildan ahte mii berret oahppat dušše sámiid historjjá skuvllas	1	2	3	4	5

Man dávjá don barggat čuovvovačča?	In báljo goassege				Mealgadii álo
Mun boran eanaš norgalaš biepmu	1	2	3	4	5
Mun guldalan millosepmosit norgalaš musihka	1	2	3	4	5
Ii leat dehálaš makkár musihka mun guldalan	1	2	3	4	5
Mun dajašin ahte eanaš ealán notgalaššan	1	2	3	4	5
Ii daga munnje maidige makkár biepmu mun boran	1	2	3	4	5
Mun dajašin ahte eanaš ealán norgalaššan ja sápmin/suopmelaššan/kvenan	1	2	3	4	5
Mun guldalan sihke norgalaš ja sámi/kvenalaš/ suopmelaš musihka	1	2	3	4	5
Mun dajašin ahte eanaš ealán sápmin/suopmelaššan/kvenan	1	2	3	4	5
Eanaš áiggi in dieđe mo mun ealán (dahje makkáraššan mun ealán)	1	2	3	4	5
Mun eanaš boran sámi/suopmelaš/kvenalaš biepmu	1	2	3	4	5
Mun millosepmosit guldalan sámi/suopmelaš/ kvenalaš musihka	1	2	3	4	5

Dá vulobealde leat muhtun gažaldagat giela ja kultuvrralaš gullevašvuođa birra. Sárggo russolas sárgá nu bures go sáhtát dákko gokko dutnje heive.

	Heive hui bures	Heive viehka bures	In leat sihkkar	Heive viehka hejot	Heive hui hejot
Mun lean iežan mielas:					
Norgalaš	☐	☐	☐	☐	☐
Sápmelaš	☐	☐	☐	☐	☐
Kvenalaš	☐	☐	☐	☐	☐
Suopmelaš	☐	☐	☐	☐	☐
Eará, čále mii dat lea	☐	☐	☐	☐	☐
Mun navddán earáid (ustibiid, ránnjáid d.s.) mu atnit:					
Norgalaššan	☐	☐	☐	☐	☐
Sápmelaššan	☐	☐	☐	☐	☐
Kvenalaššan	☐	☐	☐	☐	☐
Suopmelaššan	☐	☐	☐	☐	☐
Eará, čilge dan	☐	☐	☐	☐	☐
Mii gielaid adnojuvvo ruovttus **eanemusat**?					
Dárogiella	☐	☐	☐	☐	☐
Sámegiella	☐	☐	☐	☐	☐
Kvenagiella	☐	☐	☐	☐	☐
Suomagiella	☐	☐	☐	☐	☐
Eará, čilge dan	☐	☐	☐	☐	☐

Ustibiiguin hálidan geavahit:					
Dárvgida	☐	☐	☐	☐	☐
Sámegiela	☐	☐	☐	☐	☐
Kvenagiela	☐	☐	☐	☐	☐
Suomagiela	☐	☐	☐	☐	☐
Eará, čilge dan	☐	☐	☐	☐	☐

Sárggo russolas sárgá ovtta dahje eanet vejolašvuodaid nammii, nu mo buoremusat heive.

Ruovttus ohppen čuovvovaš giela:
- ☐ Dárogiela
- ☐ Sámegiela
- ☐ Kvenagiela
- ☐ Suomagiella
- ☐ Eará, čilge dan .....

Eatni giella lea:
- ☐ Dárogiella
- ☐ Sámegiella
- ☐ Kvenagiella
- ☐ Suomagiella
- ☐ Eará, čilge dan .....

Mu áhkku ja áddjá eatni bealde geavahit:
- ☐ Dárogiela
- ☐ Sámegiela
- ☐ Kvenagiela
- ☐ Suomagiela
- ☐ Eará, čilge dan .....

Áhči giella lea:
- ☐ Dárogiella
- ☐ Sámegiella
- ☐ Kvenagiella
- ☐ Suomagiella
- ☐ Eará, čilge dan .....

Mu áhkku ja áddjá áhči bealde geavahit:
- ☐ Dárogiela
- ☐ Sámegiela
- ☐ Kvenagiela
- ☐ Suommageila
- ☐ Eará, čilge dan .....

Skuvllas mun ohppen:
- ☐ Dárogiela
- ☐ Sámegiela
- ☐ Kvenagiela
- ☐ Suomagiela
- ☐ Eará, čilge dan .....

Man dehálaččat leat du mielas vulobealde momeanttat iežat eapmogova (ideálagova) ollašuvvamii?

	Hui dehálčcat	Dehálaččat	Viehka dehálaččat	Eai nu dehálaččat	Eai leat dehálaččat
Rumašlaš návccat	☐	☐	☐	☐	☐
Balakeahttáivuohta váralašvuođain	☐	☐	☐	☐	☐
Lášmatvuohtā/johtilvuohta	☐	☐	☐	☐	☐
Leat buorre ovdamearkan earáide	☐	☐	☐	☐	☐
Rumašlaš sávrivuohta	☐	☐	☐	☐	☐
Iešbirgejupmi/sorjákeahttáivuohtta	☐	☐	☐	☐	☐
Deaividandáidu/deaivilvuohta (omd. meahcis)	☐	☐	☐	☐	☐
Leat «nástin»	☐	☐	☐	☐	☐
Leat attáldagat maid earátge sávvet	☐	☐	☐	☐	☐

Dá vulobealde leat muhtun vuogit mo nuorat leat iežaset govahallen. Loga juohke vealkaga dárkilit, ja muital man muddui dat heivejit du iežat jurdagiidda ja dovdduide. Jos cealkagis leat máŋga oasi, de muital iežat dovdduid oppa cealkaga hárrái. Čále gažaldaga gurutbeal ruktái dan bustáva mii buoremusat govvida du.

A = Áibbas ovttamielalaš
B = Viehka ovttamielalaš
C = Ovttamielalaš
D = Veahá sierremielalaš
E = Viehka sierremielalaš
F = Áibbas eará oaivilis

..... Leat máŋggalágan olbmot. Mun ain iskkadan buot vejolašvuođaid vai gávnnan dakkár ustibiid maid sávan alccesan.

..... Muhtumin mun searvvan astoáigedoaimmaide go jerret, muhto hárve mun ieš feahččalan juoidá.

..... Mun in leat áibbas oadjebas politihkas, go visot rievdá nu johtilit. Muhto mun oaivvildan ahte lea dehálaš váldit beali politihkalaš áššiin.

..... Mun ain geahččalan gávnnahit masa mun dohkken olmmožin, ja mat fitnuid munnje heivejit.

..... Sáhttet leat ollu sivat manne ustitvuohta čuožžila, muhto mun válljen iežan ustibiid dihto árvvuid vuođul ja oktasašvuodaid geažil mat mu mielas leat dehálaččat.

..... Ii leat dihto astoáigedoaibma maid mun ovddemusat vállješin — mun iskkan iešguđetláganiid vai gávnnan ovtta mas duođai sáhtán beroštit.

..... In smiehta nu ollu politihka. Ii dat mu mielas leat miellagiddevaš.

..... Mun lean gale smiehtadan iešgudetlágan fitnuid, muhto in leat dan rájis eahpidan go mu vánhemat dajaiga maid soai sávvaba.

..... Mu vánhemat buoremusat diehtiba mu ávkki ustibiid dáfus ja geiguin mun berren leat ovttas.

..... Mun lean mearridan alccean ovtta dahje eanet astoáigedoaimmaid árvvostalladettiinan máŋga dakkára, ja mun leat hui duhtavaš daidda.

..... Mun in nu ollu áŋgiruša gávdnat rivttes fitnu — juohke bargu lea dohkálaš. Mun dego golggan rávnnji mielde.

..... Mus eai leat duođai lagaš ustibat, inge leat ohcamin dakkáriid justa dál.

..... Muhtumin mun searvvan astoáigedoammaide, muhto in dovdda dárbbu doaibmat juoidá jeavddalaččat.

..... Leat nu catnat iešguđetlágan politihkalaš bellodagat ja oaivilat. Mu lea váttis searvat man nu bellodahkii ovdalgo lean dárkileappot smiehtadan áššiid.

..... Mun lean smiehtadan ovdan ruoktot, ja dál mun dieđán makkár bargui mun áiggun geavahit návccaidan.

..... Mun válljen ustibin dušše dakkáriid geaid mu vánhemat sáhttet dohkkehit.

..... Mun lean álo válljen daid astoáigedoaimmaid maid mu vánhematge inge leat goassege árvvoštallan eará.

..... Mun lean suokkardan iežan politihkalaš oaiviliid ja gávnnahan ahte muhtun sajiid lean oavttamielalaš iežan vánhemiiguin ja nuppiid sajiid fas sierramielalaš.

..... Mu vánhemat mearridedje juo áigá makkár fidnu munnje heive buoremusat, ja mun čuovun dan.

..... Mus leat leamaš iešguđetlágan ustibat, ja dál mun dieđán makkár árvvuid mun háliidan gávdnat iežan ustibiin.

..... Mun lean geahččalan máŋga iešguđetlágan astoáigedoaimmaid, ja lean gávdnan ovtta dahje moadde maidda duođai liikon.

..... Mun in áibbas sihkkarit dieđe gosa gulan politihkalaččat, muhto mun geahččalan gávdnat vuođu mii munnje heive.

..... Ádjánin gávnnahit, muhto dál mun diedán makkár fidnui mun háliidan rahčat.

..... Mus eai leat lagaš ustibat. Háliidan buoret jávkat earáid gaskii.

..... Lean geahččalan iešguđetlágan astoáigedoaimmaid ja doaivvun dainna lágiin gávđnat ovtta dahje moadde maiguin háliidan joatkit.

..... Mun in leat goassege nu garrasit searvan politihkkii ahte lean duođas váldán beali.

..... Mu mielas lea váttis mearridit alccesan fitnu. Leat nu eatnat miellagiddevaš vejolašvuođat.

..... Mun in dieđe makkár ustibiid sávan. Lean geahččalan gávnnahit maid ustitvuohta mearkkaša munnje.

..... Mun lean eanaš astoáigeberoštumiidan ožžon vánhemiinnán, inge várra leat geahččalan maidege eará.

..... Mun in leat gávnnahan makkár fitnus mun háliidan leat boahtteáiggis, ja mun válddán dan mii fállojuvvo dasságo juoga buoret ihtá.

..... Mu vánhemiin leat álo leamaš iežaska politihkalaš ja morálalaš miellaguottut abortta, árkkálmastingoddima ja dakkáraččaid hárrái, ja mun lean álo leamaš ovtta mielas sudnuin.

Galle árvočuoggá dus ledje go heitet skuvlla? Árvočuoggáid lohku: .....

Norges forskningsråd

NUORRAN NORGGAS

Gažadanskovvi nuoraid várás Norggas

Dát lea gažadanskovi nubbi oassi,
ja dan galggat deavdit nu mo dahket mannan diimmu.

Gittu veahki ovddas!

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Dá leat muhtun gažaldagat du ja du vánhemiid birra. Jos leat dušše du nuppiin vánhemiin dahje eanaš suinna ovttas, de váldde aivvefal su vuhtii dás. Muhtumat orrot ovttas rávis olbmuin gii ii leat vánhen. Don oaččut ieš mearridit leago son du iežat mielas vánhen.

Dá vulobealde leat muhtun cealkagat maid nuorat sáhttet dadjat iežaset ja vánhemiiddiset birra (rávis olbmuid birra geaiguin ovttas orrot). Mii dáhttut du sárgut russolas sárgá dán ruktái mii buoremusat govvida dili ruovttustat:

	Heive ollásit	Heive bures	Heive viehka bures	Heive sullii	Ii heive nu bures	Ii heive oppan-assiige
Mu vánhemat lávejit diehtit gos mun lean ja maid mun barggan basiid (vahkkoloahpaid)	☐	☐	☐	☐	☐	☐
Mu vánhemat dihtet viehka bures geaiguin mun servvoštalan astoáiggistan	☐	☐	☐	☐	☐	☐
Mu vánhemat dovdet eanaš mu ustibiid geaiguin lean ovttas astoáiggistan	☐	☐	☐	☐	☐	☐
Mu vánhemat lávejit diehtit gos mun lean ja maid mun barggan árgabeivviid	☐	☐	☐	☐	☐	☐
Mu vánhemat liikojit eanaš mu ustibiidda geaiguin lean ovttas astoáiggistan	☐	☐	☐	☐	☐	☐
Mu vánhemiidda lea dehálaš diehtit gos mun lean ja maid mun barggan astoáiggistan	☐	☐	☐	☐	☐	☐

Dá vulobealde leat govviduvvon iešguđetlágan vuogit mo nuorat bajássattadettiineaset sáhttet leat vásihan iežaset vánhemiid.

	Heive hui bures	Heive viehka bures	Heive viehka hejot	Heive hui hejot
Áhčči lea liikon dasa go ieš lean mearridan	☐	☐	☐	☐
Áhčči lea diktán mu mearridit ieš	☐	☐	☐	☐
Áhčči lea geahččalan geahču vuolde atnit buot maid barggan	☐	☐	☐	☐
Áhčči lea meannudan muinna dego livčče ollu nuorat go oppa leange	☐	☐	☐	☐
Áhčči lea menddo ollu suodjalan	☐	☐	☐	☐
Áhčči ii leat olus háleštan muinna	☐	☐	☐	☐
Áhčči lea leamaš láđis munnje	☐	☐	☐	☐
Áhčči lea ipmirdan mu váttisvuodaid ja vuorjašuvvamiid	☐	☐	☐	☐
Áhčči lea veahkehan mu no ollu go lean dárbbašan	☐	☐	☐	☐
Áhčči ii leat ipmirdan mu dárbbuid ja sávaldagaid	☐	☐	☐	☐
Eadni lea liikon dasa go ieš lean mearridan	☐	☐	☐	☐
Eadni lea diktán mu mearridit ieš	☐	☐	☐	☐
Eadni lea geahččalan geahču vuolde atnit buot maid barggan	☐	☐	☐	☐

Eadni lea meannudan muinna dego livččen ollu nuorat go oppa leange	☐	☐	☐	☐
Eadni lea menddo ollu suodjalan	☐	☐	☐	☐
Eadni ii leat olus háleštan muinna	☐	☐	☐	☐
Eadni lea leamaš láđis munnje	☐	☐	☐	☐
Eadni lea ipmirdan mu váttisvuođaid ja vuorjašuvvamiid	☐	☐	☐	☐
Eadni lea veahkehan mu no ollu go lean dárbbašan	☐	☐	☐	☐
Eadni ii leat ipmirdan mu dárbbuid ja sávaldagaid	☐	☐	☐	☐

Leago dus bissovaš irgi dahje moarsi?

☐ Juo, mus lea dál
☐ Ii leat, muhto lea leamaš ovdal
☐ Ii leat, mus ii leat goassege leamaš

Leago dus goassege leamaš sohkabealoktavuohta geainnage? ☐ Juo, de leamaš ☐ Ii, ii leamas

Jos vástidit juo, de man boaris ledjet go dakkár oktavuohta lei vuosttamuš geardde? Mun ledjen ..... jagi

Gallásiin dus lea leamaš sohkabealoktavuohta buohkanassii (gallis sii leat)? .....

1. Sullii galle ustiba leat dus?

☐ Ii oktage ☐ 1 ☐ 2 dahje 3 ☐ 4 dahje eanet

2. Sula mielde gallii vahkus leat singuin ovttas?

☐ Hárvvit go 1 ☐ 1 dahje 2 ☐ 3 dahje eanet

Iežat ahkásaččaid ektui, man bures orut iežat mielas:

	Heajubut	Sullii seamma bures	Buorebut
a. Soabadeamen iežat oarbinaččaiguin (oappáiguin ja vieljaiguin)	☐	☐	☐
b. Soabadeamen eará mánáiguin?	☐	☐	☐
c. Soabadeamen iežat vánhemiiguin?	☐	☐	☐
d. Sáhttimin okto bargat áššiid?	☐	☐	☐

Doallevaš skuvlaolahusat

☐ Mun in vácce skuvlla

	Hui ollu heajut go gaskamearri/ sihkkašupmi	Heajut go gaskamearri	Gaska-mearálaš	Buoret go gaska-mearri
a. Dárogiella	☐	☐	☐	☐
b. Matematihkka	☐	☐	☐	☐
c. Eŋgelasgiella	☐	☐	☐	☐
d. Sámegiella	☐	☐	☐	☐
Eará fágat (omd. servodatfágat, kemiija, fysihkka, ránska, duiska) e.	☐	☐	☐	☐
f.	☐	☐	☐	☐
g.	☐	☐	☐	☐

Dá lea listu mas mii geardut dakkár olmmošlaš ieŠvuođat mat dávjá leat mánáin ja nuorain unnit eanet. Mii dáhttut du sárggastit rieggá guvtteža (2) birra juohke olmmošlaš ieŠvuoda nammii mii heive dutnje **dál dahje lea heiven dutnje maŋimuš 6 mánu,** jos dat **bures heive dahje dávjá.** Sárggas rieggá ovtteža (1) birra jos govvádus **heive muhtun muddui dahje muhtumin.** Jos govvádus **ii heive dutnje,** de bija rieggá nulla (0) birra. Leage nu buorre ahte vástidat buoremus lági mielde buot gažaldagaide, vaikko muhtumat dain eai dáiddege heivet dutnje.

0 = Ii heive **1** = heive muhtun muddui dahje muhtumin **2** = heive bures dahje dávjá

0 1 2 1. Mun láhtten dego livčče n nuorat go oppa leange

0 1 2 2. Mun lean allergialaš (merkes masa ja mo dat boahtá oidnosii):.....
.....
.....

0 1 2 3. Mun riidalan ollu

0 1 2 4. Mun lea ástma

0 1 2 5. Mun láhtten dego gulašin nuppi sohkabeallái

0 1 2 6. Mun liikon ealliide

0 1 2 7. Mun rábmon

0 1 2 8. Mu lea váttis čohkket jurdagiiddán dahje leat gozuid alde

0 1 2 9. Mus leat bággojurdagat, erenomáš hutkagat (čilge dárkilcappot):.....
.....
.....

0 1 2 10. Mu lea váttis čohkohallat jaska

0 1 2 11. Mun lean menddo gitta rávis olbmuin

0 1 2 12. Mus lea oktovuoda dovdu

0 1 2 13. Orun leamen oaivejorgásis, dahje dego suova siste

0 1 2 14. Mun čirodan ollu

0 1 2 15. Mun lean viehka vuoiggalaš

0 1 2 16. Mun lean ilgat nuppiid vuostá

0 1 2 17. Mun gohcci dilis niegadan

0 1 2 18. Mun geahččalan dihtodáhtolačča t vahágahttit iehčan, lean geahččalan goddit iehčan

0 1 2 19. Mun ollu geahččalan fuomášuhttit iehčan caráide

0 1 2 20. Mun billistan iežan biergasiid

0 1 2 21. Mun billistan earáid biergasiid

0 1 2 22. Mun in jeagat iežan vánhemiid

0 1 2 23. Mun lea jeagoheapme skuvllas

0 1 2 24. Mun in borat nu bures go berrešin

0 1 2 25. Mun in soabat eará mánáiguin

0 1 2 26. Mun in dovdda siva jos vel dagange boasttuvuođa

0 1 2 27. Mun álkit balahišgoađán ja gáđaštan nuppiid

0 1 2 28. Mun mielas veahkehan nuppiid go dárbbašit veahki

0 1 2 29. Mun balan dihto calliin, dialálašvuođain dahje báikkiin mat leat olggobealde skuvlla (čilge): .....
.....
.....

0 1 2 30. Mun balan vuolgimis skuvlii

0 1 2 31. Mun balan jurddašeames boastut dahje meaddádeames

0 1 2 32. Mu dovdu lea ahte berren leat dievaslaš

0 1 2 33. Mu dovdu lea ahte ii oktage ane mu árvvus

0 1 2 34. Mu dovdu lea ahte nuppit bivdalit mu

0 1 2 35. Mun dovddan iehčan heajubun dahje unnitárvosažžan

0 1 2 36. Mun bavčča gan dávjá, lean hui bártái

0 1 2 37. Mun dávjá šattan doarrut

0 1 2 38. Mu dávjá hárdet

0 1 2 39. Mun servvoštalan ustibiiguin gcat šaddet moivviid sisa

0 1 2 40. Mun gulan dakkáriid maid earát eai sáhte gullat (čilge): .....
.....
.....

0 1 2 41. Mun barggan áššiid jurdilkeahttá

0 1 2 42. Mun liikon leat okto

0 1 2 43. Mun gielistan dahje verrošan

0 1 2 44. Mun gáskkán gaccaid

0 1 2 45. Mun balastalan dahje lean čcarggos mielaid

0 1 2 46. Mus leat balešis lihkadeamit dahje muohtoilmmit (čilge): .....
.....
.....

0 1 2 47. Mus leat deattámat ihkku

0 1 2 48. Munnje eai liiko eará mánát

0 1 2 49. Mun máhtán muhtun áššiid buorebut go eanaš mánát

0 1 2 50. Mun lean menddo baleš dahje árgi

0 1 2 51. Mus jorrá oaivi

0 1 2 52. Mu moaittán iehčan menddo ollu

0 1 2 53. Mun boran menddo ollu

0 1 2 54. Mun orun leamen jámas váiban

0 1 2 55. Mun deattán menddo ollu

0 1 2 56. Mus leat rumašlaš váivvit almmá doavterdieđalaš sivaid haga:

0 1 2 a. Bákčasat dahje seargumat

0 1 2 b. Oaivebákčasat

0 1 2 c. Málttas, illáveaje

0 1 2 d. Čalbmeváivvit (čilge): .....
.....
.....

0 1 2 e. Ihttomat

0 1 2 f. Čoavjebákčasat

0 1 2 g. Váibmogákkahat, vuovssán

0 1 2 h. Eará (čilge): .....
.....
.....

0 = Ii heive 1 = Heive muhtun muddui dahje muhtumin 2 = Heive burcs dahje dávjá

0 1 2 57. Mun sáhtán nuppiid fallehit, gaikut vuovttaid, čiehčat dahje čorbmadit

0 1 2 58. Mun čuvddástalan čárvvodan iežan liikki dahje eará rumašosiid (čilge): .....

0 1 2 59. Mun sáhtán leat viehka uatitlaš

0 1 2 60. Mun liikon ođđa áššiid bargat

0 1 2 61. Mun hejot birgen skuvllas

0 1 2 62. Mun lean donji ja lihkadan čurbbet

0 1 2 63. Mun ovdal servvoštalan dakkár mánáiguin geat leat boarráseappot go mun, go iežan ahkásaččaiguin

0 1 2 64. Mun ovdal servvoštalan dakkár mánáiguin geat leat nuorat go mun, go iežan ahkásaččaiguin

0 1 2 65. Mun biehttalan jienádeames

0 1 2 66. Mun gearddun dihto daguid ođđasis ođđasis, bággodaguid (čilge): .....

0 1 2 67. Mun lovpedan ruovttus

0 1 2 68. Mun riežun ollu

0 1 2 69. Mun lean čiegustalli ja doaladan áššiid iežan duohken

0 1 2 70. Mun oainnán dakkáriid maid ii oktage oro sáhttimin oaidnit (čilge): .....

0 1 2 71. Mun heahpanan álkit dahje skámaskuttan

0 1 2 72. Mun cahkkehan dolaid — biolláhan

0 1 2 73. Mun lean giehtačahppi

0 1 2 74. Mun almmáštalan/gában doalan dahje dagan iežan jallan

0 1 2 75. Mun lean hudju

0 1 2 76. Mun áđán unnibut go eanaš mánát

0 1 2 77. Mun oađán eambbo go eará mánát beaivet ja/dahje ihkku (čelge): .....

0 1 2 78. Mun lean buorre hutkat

0 1 2 79. Mun leat dadjanváttisvuođat (čilge): .....

0 1 2 80. Mun doaladan iežan vuoigatvuodain

0 1 2 81. Mun suoládattan ruovttus

0 1 2 82. Mun suoládattan olgun, olggobealde ruovttu

0 1 2 83. Mun čoakkán biergasiid maid in dárbbaš (čilge): .....

0 1 2 84. Mun dagan áššiid maid earát imaštallet (čilge): .....

0 1 2 85. Mus leat jurdagat maid carát anašedje ovddolažžan (čilge): .....

0 1 2 86. Mun lean čeaggái

0 1 2 87. Mokta ja dovddut rivdet mus fáhkka

0 1 2 88. Mun liikon leat nuppiiguin ovttas

0 1 2 89. Mun lean vihkolas (navdálas)

0 1 2 90. Mun gárrudan ja dajan fastes sániid

0 1 2 91. Mun lean smiehtadan goddit iehčan

0 1 2 92. Mun liikon nuppiid čáimmahit

0 1 2 93. Mun solžidan menddo ollu

0 1 2 94. Mun ollu givssidan nuppiid

0 1 2 95. Mun lean hui hohppui

0 1 2 96. Mun smiehtan sohkabeláššiid menddo ollu

0 1 2 97. Mun áittán nuppid lábmet

0 1 2 98. Mun liikon nuppiid veahkehit

0 1 2 99. Mun dárkiluttan menddo ollu iežan buhtisvuođain ja čorgatvuođain

0 1 2 100. Mus leat oađehisvuoda váivvit (čilge): .....

0 1 2 101. Mun jávkkan skuvllas dahje skuvladiimmuin

0 1 2 102. Mus lea unnán álša

0 1 2 103. Mun lean lihkoheapme, šlundi dahje deddojuvvon

0 1 2 104. Mun riejan eambbo go eará nuorat

0 1 2 105. Mun geavahan alkohola dahje ávdnasiid maidda olmmoš álkit dárvánna (čilge): .....

0 1 2 106. Mun geahččalan leat vuoiggalaš ja buorredáhtolaš nuppiid vuostá

0 1 2 107. Mun liikon buori leaikkastallamii

0 1 2 108. Mun liikon álkkástallat

0 1 2 109. Mun geahččalan nuppiid veahkehit go sáhtán

0 1 2 110. Sávašin ahte gulan nuppi sohkabeallái

0 1 2 111. Mun váruhan vuodjudeames iehčan nuppiid áššiide

0 1 2 112. Mun vuotjašuvvan hui ollu

Sárggo russolas sárgá dan vástádusa buohta mii govvida du:

	JUO	IN
Boradatgo dihto minstara mielde juohke beaivvi?	☐	☐
Seaggudatgo iežat garrasit gaskkohagaid?	☐	☐
Orutgo iežat mielas eahpelihkostuvvan jos heaittát seaggudanprográmma?	☐	☐
Logadatgo kaloriijaid buot das maid borat, vaikko it seaggutge iežat?	☐	☐
Anátgo borakeahttáivuoda muhtumin olles beaivvi?	☐	☐

Jos vástidit juo viđat gažaldahkii, de man dávjá?

- ☐ Juohke nuppi beaivvi
- ☐ 2—3 vahkus
- ☐ oktii vahkus
- ☐ Muhtumin
- ☐ Lean dahkan nu oktii

Geavahatgo čuovvovaš ávdnasiid dahje vugiid veahkkin vai gehpošit?

	In goassege	Muhtumin	Oktii vahkus	2—3 vahkus	Beaivválaččat	2—3 beaivái	Dávjjibut go viđa geardevahkus
Seaggudantableahtaid	☐	☐	☐	☐	☐	☐	☐
Seaggudanbulvoriid	☐	☐	☐	☐	☐	☐	☐
Luhčudanávdnasiid	☐	☐	☐	☐	☐	☐	☐
Guččahanávdnasiid	☐	☐	☐	☐	☐	☐	☐
Vuovssihan iehčan	☐	☐	☐	☐	☐	☐	☐

	JUO	IN
Billistitgo du borranvierut eallimat?	☐	☐
Dajašitgo ahte biebmu stivre eallimat?	☐	☐
Boradatgo goassege nu eatnat ahte fertet heaitit lusttuhisvuođa dovddu geažil?	☐	☐
Lea go aiggit gos jurddašat duššefal bilpmuid?	☐	☐
Boradatgo jierpmálaččat earáid oaidnut ja badjelmearástalat dasto go leat oktot?	☐	☐
Nagadatgo heaiti boradeames goas ieš dáhtut?	☐	☐
Dovddatgo goassege mearehis borranmiela?	☐	☐
Boradatgo ollu go leat árgi?	☐	☐
Balatgo issorasat buoidumis?	☐	☐
Boradatgo stuorra mcriid hirbmat johtilit (boradanbottuid gaskkas)?	☐	☐

	JUO	IN
Heahpanattatgo ieżat borranvieruid geažil?	☐	☐
Vuorjašuvatgo dainnago it hálddaš ieżat liiggálaš borademiin?	☐	☐
Boradatgo jeđđen dihtii ieżat?	☐	☐
Sáhtátgo guođđit biepmus veaháge dallerkii naŋŋá boradeami?	☐	☐
Filletgo eará olbmuid vai eai dieđe man ollu borat?	☐	☐
Nealgedovdu go mearrida man ollu don borat?	☐	☐
Boratgo muhtumin badjelmeari ollu biepmu?	☐	☐
Jos vástidit juo, de muital veajátgo hejot maŋŋá.	☐	☐
Jos badjelmearástalat borrat, dagatgo nu dušše dalle go leat okto?	☐	☐

Jos badjelmearástalat borrat, man dávjá de geavvá nu?

☐ Ii báljo goassege
☐ Oktii vahkus
☐ Juohke beaivvi
☐ Oktii mánus
☐ 2—3 vahkus
☐ 2—3 beaivái

Ražašitgo duhtadit ieżat háliidusa badjelmearástallat borramiin?	☐	☐
Jos borat menddo ollu, boahtágo dalle dutnje heajos oamedovdu?	☐	☐
Boradatgo suoli muhtumin?	☐	☐
Leatgo du boradanvierut dábálaččat, ieżat mielas?	☐	☐
Leatgo «borastuvvalas»?	☐	☐
Rievdágo du deaddu cambbo go 2—3 kilo vahkus?	☐	☐

Man ollu leat deaddán eanemusat? ..... kg

Man guhká dus lei dat deaddu? ..... mánu

Mii lea leamaš du unnimus deaddu dáid maŋimuš jagiid? ..... kg

Man guhká dus lei dat deaddu? ..... mánu

Man ollu deattu leat eanemusat massán? ..... kg

Geavaigo nu du ieżat dáhtu mielde? ☐ Juo ☐ Ii

Man ollu háliidat deaddit? ..... kg

Dá čuovvu listu mas leat iešguđetlágan váivvit ja váttisvuodat mat sáhttet leat olbmos muhtumin. Leatgo maŋimuš vahku váivašuvvan daiguin ollenge, veaháš, viehka ollu dahje hui ollu? Sárggo russolas sárgá dan ruktái mii dutnje heive.

	In leat váivašuvvan ollenge	Veaháš váivášuvvan	Viehka ollu váivašuvvan	Hui ollu váivašuvvan
Fáhkka ballán siva haga	☐	☐	☐	☐
Ohpit lean balus dahje vuorjašuvan	☐	☐	☐	☐
Veajuheapme dahje oaivejorgásis	☐	☐	☐	☐
Hearkkas, siskkáldas ráfehisvuohta	☐	☐	☐	☐
Álkit čierrugoađán	☐	☐	☐	☐
Álkit sivahan ichčan	☐	☐	☐	☐
Buot orru leamen rahčamuš	☐	☐	☐	☐
Leat leamaš oađđinváttisvuođat	☐	☐	☐	☐
Dovddan iehčan lihkoheapmin, šlundin dahje lossesmielalažžan	☐	☐	☐	☐
Lean hearddohuvvan smiehttat boahtteáiggi	☐	☐	☐	☐
Dovddan iežan sojakehttáivuođa ja čearggos miela	☐	☐	☐	☐
Lean áššiiguin vuorjašuvvan menddo ollu	☐	☐	☐	☐
Lean smiehttan loahpahit iežan heakka	☐	☐	☐	☐

Leatgo goassege geahččalan iežat goddit? ☐ In leat ☐ Juo, de lean

Jos juo, de man gallii leat geahččalan? ..... geardde

Leatgo goassege dán oktavuođas leamaš oktavuođas doaktárii, buohccidivššárii, buohccivissui d.s.? ☐ In leat ☐ Juo, de lean

Maŋimuš 12 mánu — leatgo goassege geahččalan iežat goddit? ☐ In leat ☐ Juo, de lean

Leatgo maŋimuš 12 mánu goassege leamaš oktavuođas doaktárii, buohccidivššátii, buohccivissui d.s.? ☐ In leat ☐ Juo

Duhpastalatgo?

☐ In leat goassege duhpástallan
☐ In leat goassege duhpástallan bissovaččat inge dál oppa duhpástalage
☐ Duhpástalan, muhto in juohke beaivvi
☐ Duhpástalan beaivválaččat, sulli ..... sigareahta

Gallii maŋimuš njealji vahkus leat juhkan eambbo go moadde jugástaga alkohola?

☐ In oktiige

..... (lohku) geardde

Maŋimuš hávi go juhket alkohola, galle «drinkka» de juhket? «Drinkan» rehkenastojuvvo lihtterbeale pilsa, 1 stuorra lássa geahnohis viidni, 1 lássa garra viidni, 1 jugástat buolli viidna (sullii 4 cl.)

Mon juhken sulli ..... «driŋkka»

Smiehta mat manimuš hávi go juhket alkohola...

A. Gos juhket

- ☐ In leat goassege juhkan
- ☐ Ruovttus
- ☐ Tuvrras/mátkkis
- ☐ Astoáigesearvvis
- ☐ Olgun
- ☐ Diskotehkas dahje restauránttas
- ☐ Čoahkkinlanjas, dánsundoaluin
- ☐ Ustibiid geahčen

B. Geaiguin ledjet ovttas?

- ☐ Okto
- ☐ Ustibiin
- ☐ Ollu eará nuoraiguin
- ☐ Vánhemiiguin
- ☐ Eará rávis olbmuiguin

C. Ledjego goappašiid sohkabeliid nuorat das? ☐ Juo, de ledje ☐ Eai lean

D. Leigo feasta? ☐ Juo, de lei ☐ Ii lean

Juhkágo áhččát?

- ☐ Ii juga
- ☐ Hárve
- ☐ Sullii oktii vahkus
- ☐ Sullii mánjgii vahkus
- ☐ Beaivválaččat

Juhkágo eadnát?

- ☐ Ii juga
- ☐ Hárve
- ☐ Sullii oktii vahkus
- ☐ Sullii mánjgii vahkus
- ☐ Beaivválaččat

Leatgo goassege oaidnán iežat vánhemiid gárrenoaivvis?

- ☐ In goassege
- ☐ Aiddo moatte hárvves geardde
- ☐ Moddii jagis
- ☐ Moddii mánus
- ☐ Moddii vahkus

Leatgo goassege ožžon fállojupmái hášša dahje marihuána? ☐ Juo ☐ In

Leatgo goassege atnán hášša dahje marihuána? ☐ Juo ☐ In

Dá vulobealde govahallat makkár dovddut olbmuin sáhttet leat. Sárggo dakko gokko heive du dovdduide.

	Ii goassege	Hárve	Muhtumin	Dávjá
Mun orun iežan mielas leamen dovddadandásis olbmuiguin guđet leat mu birra	☐	☐	☐	☐
Mun gávnnan olbmo geaiina servvoštallat jos nu háliidan	☐	☐	☐	☐
Mus lea dat dovdu ahte earát eai báljo dovdda mu	☐	☐	☐	☐
Mu mielas olbmot leat mu birra, muhto eai muinna ovttas	☐	☐	☐	☐
Mun lean iežan mielas okto	☐	☐	☐	☐

Váláštalatgo aktiivvalaččat dahje lášmmohalatgo?

- ☐ In
- ☐ In, muhto mun lávejin ovdal
- ☐ Juo, muhto in mun leat organiserejuvvon lášmmohallamis fárus inge gilvvohallamiin
- ☐ Juo, mun lean aktiivvalaš ja searvvan gilvvohallamiidda

Jos dus leat máŋga váláštallansuorggi, de čále daid vuollálagaid

Makkár váláštallansuorgi dahje -suorggit: .....

.....

.....

Makkár fitnu sávat rávis olmmožin? .....

Dá vulobealde leat muhtun čuoččuhusat skuvlavázzimis ja das makkár skuvla berrešii leat.

Sárggo dan ruktái mii dutnje buoremusat heive:

	Áibbas seammalágan	Veahážseammalágan	Veahážearalágan oaivilis	Áibbas earalágan oaivilis
Skuvllas ii gola áigi	☐	☐	☐	☐
Skuvlaáiggis lea ollu duššálaš	☐	☐	☐	☐
Mun bures loavttán skuvllas	☐	☐	☐	☐
Mu mielas dávjá lea soaiggus vuolgit skuvlii	☐	☐	☐	☐
Min oahpaheaddjit leat čeahpit oahpahit	☐	☐	☐	☐

Finnmárkkusge leat olbmuin iešguđetlágan kultuvrralaš duogážat. Leat iešguđetlágan sánit maiguin válddahit olbmuid kultuvrralaš duogážžiid dahje čearddalaš gullevašvuođa. Moadde ovdamearkka čearddalaš gullevašvuođas dahje čearddalaš joavkkus leat dakkár sánit go omd. dárru, sápmelaš, suopmelaš, kvenalaš ja tamilalaš.

Buot olbmot riegádit ovtta čerdii dahje kultuvrii gullevažžan, dahje muhtumin guovtti čerdii dahje kulturii, muhto leat stuorra erohusat das man ollu čearddalašvuohta mearkkaša, makkár dovddut olbmuin leat eižaset čeardda hárrái ja man muddui sin čearddalašvuohta váikkuha sin láhttenvuohkái.
Gažaldagat dás vulobealde guoskkahit čearddalašvuođa dahje čearddalaš gullevašvuođa ja mo du dovddut leat ja mo don doaimmat dan ektui. Dat leat hábmejuvvon mánggakultuvrralaš servodaga várás. Deavdde nu bures go sáhtát.

Iežan čearddalaš gullevašvuođa dáfus anán iehčan .....

Sárggo dan ruktái mii heive dutnje:	Áibbas scammalágan oaivilis	Veaháš scammalágan oaivilis	Veaháš earalágan oaivilis	Áibbas earalágan oaivilis
Mun lean geavahan áiggi gávnnahit eambbo iežan čeardda, nugo historjjá, árbevieruid ja dábiid	☐	☐	☐	☐
Mun searvvan aktiivalaččat organisašuvnnaide dahje sosiálalaš dáhpáhusaide main eatnašat leat mu iežan čearddalaččat	☐	☐	☐	☐
Mus lea čielga oaidnu iežan čearddalaš duogážis ja das makkár árvu das lea munnje	☐	☐	☐	☐
Mun liikon deaivvadit caračarddat joavkkuid olbmuiguin ja oahpásmuvvat singuin	☐	☐	☐	☐
Mun smiehtadan ollu mo mu iežan čearddalašvuohta váikkuha mu eallimii	☐	☐	☐	☐
Lean ilus go gulan dan čerdii masa juo gulan	☐	☐	☐	☐
Muhtumin mu mielas orru buoret jos čearddalaš joavkkut geahččalivčče bissot sierra vai eai seahkan guhtet guimmiidasaet	☐	☐	☐	☐
In vuigestaga dieđe man ollu mu čearddalašvuohta váikkuha mu eallimii	☐	☐	☐	☐
Mun lean dávjá eará čeardda olbmuiguin ovttas ..	☐	☐	☐	☐
Mun in leat vuoiga geavahan ollus áiggi gávnnahit áššiid iežan čeardda kultuvrras ja historjjás	☐	☐	☐	☐
Mun garrasit dovddan iežan gullevašvuođa čeardasan	☐	☐	☐	☐
Mun viehka bures ipmirdan iežan čearddalaš gullevašvuođa, mo mun galggan meannudit iehčan sihke iežan čeardda ja eará čearddaid ektui	☐	☐	☐	☐
Vai oahpašin eambbo iežan duogáža birra, de lean dávjá háleštan earáiguin iežan čearddalaš gullevašvuođa birra	☐	☐	☐	☐
Mun lean rámis iežan čearddalašvuođa geažil ja dan geažil maid dat lea nagadan buktit áigái	☐	☐	☐	☐

Mus ii leat vuoiga dat dovdu ahte gulašin man nu čearddalaš jovkui	☐	☐	☐	☐
Mun in geahčča šaddat ustibin eará čeardda nuoraiguin	☐	☐	☐	☐
Mun searvvan kultuvrralaš doaimmaide ja árbevieruide iežan čeardda siskkobealde, omd. árbevirolaš biebmoáhkadeapmái, musihkkii dahje eará vieruide	☐	☐	☐	☐
Mun lean eará joavkkuid olbmuiguin serválagaid doaimmain	☐	☐	☐	☐
Mu čatnet nana dovddut iežan čearddalaš jovkui	☐	☐	☐	☐
Vare gulašin eará čearddalaš jovkui	☐	☐	☐	☐
Mun liikon servvoštallat eará čearddalaš jovkkuid olbmuiguin go iežan	☐	☐	☐	☐
Mun lean duhtavaš iežan kultuvrralaš dahje čearddalaš duogáži	☐	☐	☐	☐
Mun orun dovdduidan dáfus gullamin máŋgga čearddalaš jovkui	☐	☐	☐	☐

Mu čearddalašvuohta lea
(čále ovtta dahje eanetge loguid dain loguin mat leat dás vulobealde) .....

1. Norgalaš
2. Sápmelaš
3. Suopmelaš
4. Kvenalaš
5. Eará (čále makkár): .....

Áhči čearddalašvuohta lea (geavat bajábeal loguid): .....

Eatni čearddalašvuohta lea (geavat bajábeal loguid): .....

Dá vulobealde leat muhtun gažaldagat vánhemiiddát ja skuvlabargguidat birra.

	Doallá hui bures deaivása	Doallá viehka unnán deaivása	In leat sihkkar	Doallá viehka bures deaivása	Doallá hui bures deaivása
Mu vánhemat berošteaba hui ollu mu skuvlabargguin	☐	☐	☐	☐	☐
Mu vánhemat dávjá mu veahkeheaba skuvlabargguinan	☐	☐	☐	☐	☐
Mu vánhemiid mielas lea dušši vázzit guhkes oahpu	☐	☐	☐	☐	☐
Mu vánhemat dávjá mu rábmoba skuvlabargguidan geažil	☐	☐	☐	☐	☐
Mu vánhemat hárve hálešteaba muinna skuvlla birra	☐	☐	☐	☐	☐
Mu vánhemat movttiidahttiba mu joatkit skuvlavázzima	☐	☐	☐	☐	☐

Mii dáhtošeimmet diehtit geainna don háliidivččet servvoštallat iešguđetlágan dilálašvuođain. Dá vulobealde leat muhtun olbmot geaiguin don várra dáhtošit leat ovttas dahje háleštit. Don čálistat ovtteža dan ruktái mii lea ovddabealde su geainna don ovddimusat háliidivččet leat ovttas dahje háleštit (1. sadji), guvtteža dakko gokko son lea geainna nuppádassii háliidivččet leat ovttas (2. sadji) ja golmmeža dakko gokko son lea geainna goalmmádassii háliidivččet leat ovttas (3. sadji).

Geainna ovddimusat dáhtošit leat ovttas sotnabeaivvi eahkeda (1. sadji, 2. sadji, 3. sadji)?

- ☐ Dahkat juoidá okto
- ☐ Etniin
- ☐ Áhčiin
- ☐ Etniin ja áhčiin
- ☐ Oappáin/vieljain
- ☐ Buriin ustibiin
- ☐ Skihpáriiguin/joavkkuin
- ☐ Moarsiin/irggiin
- ☐ Áhkuin ja ádjáin
- ☐ Eará fulkkiiguin
- ☐ Eará rávis olbmuiguin

Smiehta mat ahte ihttin fertet válljet makkár skuvlla/oahpu galggat vázzit boahtteáiggis. Don leat eahpesihkkar das maid válljet. Gean lusa manašit ráđi jearrat ja veahki (1. sadji, 2. sadji, 3. sadji)?

- ☐ In geange lusa
- ☐ Eatni lusa
- ☐ Áhči lusa
- ☐ Eatni ja áhči lusa
- ☐ Oappá/vielja lusa
- ☐ Buori ustiba lusa
- ☐ Skihpáriid/joavkku lusa
- ☐ Moarsi/irggi lusa
- ☐ Oahpaheaddji lusa
- ☐ Fidnobagadeaddji lusa
- ☐ Eará fulkkiid lusa
- ☐ Eará rávis olbmuid lusa

Smiehta mat ahte dus lea persovnnalaš váttisvuohta ja leat šlundi ja láittas. Gean lusa manašit háleštit, ohcat veahki (1. dasji, 2. sadji, 3. sadji)?

- ☐ In geange lusa
- ☐ Eatni lusa
- ☐ Áhči lusa
- ☐ Eatni ja áhči lusa
- ☐ Oappá/vielja lusa
- ☐ Buori ustiba lusa
- ☐ Skihpáriid/joavkku lusa
- ☐ Moarsi/irggi lusa
- ☐ Oahpaheaddji lusa
- ☐ Skuvlla psykologa lusa
- ☐ Eará fulkkiid lusa
- ☐ Buohccidivššára lusa, doaktára lusa jna.
- ☐ Eará rávis olbmuid lusa

Smiehta mat ahte don leat lobihis dagus gávnnahallan. Lea vejolaš ahte váidet du bolesii. Don dárbbašat veahki ja ráđi. Gean lusa manašit (1. sadji, 2. sadji, 3. sadji)?

- ☐ In geange lusa
- ☐ Eatni lusa
- ☐ Áhči lusa
- ☐ Eatni ja áhči lusa
- ☐ Oappá/vielja lusa
- ☐ Buori ustiba lusa
- ☐ Skihpáriid/joavkku lusa
- ☐ Moarsi/irggi lusa
- ☐ Bolesiid lusa
- ☐ Eará fulkkiid lusa
- ☐ Eará rávis olbmuid lusa

Háliidatgo ásat ruovttubáikái go geargan skuvllaid vázzimis?

- ☐ Juo, hui mielas
- ☐ Juo, jos nu heive
- ☐ Eahpesihkkar
- ☐ In, mun háliidan eará báikái ássat

Jos don šattat fárret go leat geargan skuvllain, gosa de millosepmosit fárrešit?

- ☐ Stuorit gávpogii
- ☐ Unnit gávpogii
- ☐ Báikái mii lea olggobealde gávpoga
- ☐ Gillái
- ☐ Eará riikii
- ☐ Ruovttoluotta ruovttubáikái
- ☐ Eahpesihkkar

Dá vuolobealde leat moadde gažaldaga das mo don iežat mielas leat. Sárggo russolas sárgá dákko gokko heive dutje buoremusat.

	Heive hui bures	Heive viehka bures	Heive viehka hejot	Heive hui hejot
Mun lean iežan mielas scamma jierbmái go earát mu ahkásaččain	☐	☐	☐	☐
Mu mielas lea váttis fidnet ustibiid	☐	☐	☐	☐
Mun lean čeahppi buotlágan valáštallamiin	☐	☐	☐	☐
Muhtun beaivvi mus lea duot oaivil alddán, nuppi beaivvi fas áibbas nuppelágan oaivil	☐	☐	☐	☐
Mus leat «logi bealggi»	☐	☐	☐	☐
Mun in leat duhtavaš dasa mo lean olgguldasat oaidnit	☐	☐	☐	☐
Mun orun vávjimin ahte go beroštan geas nu gii gullá nuppi sohkabeallái, de lea hui vejolaš ahte duot nubbi maid berošta mus	☐	☐	☐	☐
Mun lihkostuvan gávdnat hui lagaš ustibiid	☐	☐	☐	☐
Mun dávjá beahtahalan alcccsan	☐	☐	☐	☐
Mun lean nu njoahci gearggahit skuvlabargguid	☐	☐	☐	☐
Mus leat ollu ustibat	☐	☐	☐	☐
Mun jáhkán ahte mun sáhtán buresge lihkostuvvat vaikko makkár ođđa valáštallamis	☐	☐	☐	☐
Mun bures loavttán áiggi ruovttubáikkistan	☐	☐	☐	☐
Mun sávašin ahte mus livčči earalágan rumaš	☐	☐	☐	☐
Mus láve oaivil iežan hárrái rievdat viehka ollu	☐	☐	☐	☐
Mun lean čeahppi gieđalaš bargguide	☐	☐	☐	☐
Mun geahččalan morránahttit sin dovdduid geain mun duodai beroštan	☐	☐	☐	☐
Mus lea lagaš ustit geainna sáhtán juogadit čiegusvuođaid	☐	☐	☐	☐
Mun in liiko dan vuohkái mo ealán iežan eallima	☐	☐	☐	☐
Mun birgen hui bures skuvllas	☐	☐	☐	☐
Eará nuoraid mielas lea váttis liikot munnje	☐	☐	☐	☐
Mun orun iežan mielas čeahpit valáštallat go earát mu ahkásaččain	☐	☐	☐	☐
Mun sávašin ahte livččen earalágan olgguldasat	☐	☐	☐	☐
Mun lean fuomášan ahte mus sáhttá oaidnu rievdat iehčan hárrái	☐	☐	☐	☐
Mun lean čeahppi čoahkkái bidjat ja divvut biergasiid	☐	☐	☐	☐

Mun orun vávjimin ahte nuorat (nuppi sohkabealis) sáhttet beroštišgoahtit mus	☐	☐	☐	☐
Mus lea ustit geainna juogadit áššiid	☐	☐	☐	☐
Mun lean eanaš duhtavaš alccesan	☐	☐	☐	☐
Mu lea váttis riekta vástidit skuvllas	☐	☐	☐	☐
Munnje bures liikojit sii guđet leat mu agis	☐	☐	☐	☐
Mun in birge nu bures go lášmmohallamis leat ođđa hárjehallamat	☐	☐	☐	☐
Iežan mielas mus lea čáppa olgguldas	☐	☐	☐	☐
In leat miige giehtačehpiid	☐	☐	☐	☐
Mun jáhkán mun lean nuppi sohkabeali mielas geasuheaddji ja miellagiddevaš	☐	☐	☐	☐
Mu mielas lea váttis gávdnat ustibiid geaidda lea vejolaš luohttit	☐	☐	☐	☐
Mu liikon alccesan nu mo lean	☐	☐	☐	☐
Mun jáhkán ahte mun lean viehka jierbmái	☐	☐	☐	☐
Mun orun dovdamin ahte mu ahkásaččat dohkkehit mu	☐	☐	☐	☐
Mus ii leat iežan mielas nu nana rumaš go earáin	☐	☐	☐	☐
Mun liikon iežan olgguldassii hui bures	☐	☐	☐	☐
Muhtumin mus lea positiivalaš oaidnu alddán, muhtumin fas hui negatiivvalaš oaidnu	☐	☐	☐	☐
Mus lea viehka buorre praktihkalaš dáidu	☐	☐	☐	☐
Mun in dábálaččat geahčča geasuhit su geas lean beroštišgoahtán	☐	☐	☐	☐
Mus ii leat oktage buorre ustit geainna sáhtášin juogadit áššiid mat duođai leat persovnnalaččat	☐	☐	☐	☐
Mun duđan hui bures dasa mo lean	☐	☐	☐	☐

Makkár miella dus lea kristtalašvuođa hárrái?

- ☐ Mun lean kristtalaš
- ☐ Mun jáhkán ahte Ipmil lea, muhto religiuvdnan osku ii mearkkaš munnje nu ollu juohkebeaivválaš dilistan
- ☐ Eahpesihkkar
- ☐ Mun in jáhke ahte Ipmil lea
- ☐ Mun gulan eará religiuvdnii nammalassii; .....

.....

.....

Leago dus ja du vánhemiin gullevašvuohta dihto oskku sierrasearvái?
Sárggo russolas sárgá dákko heive du ja du vánhemiidát hárrái.

	Mun ieš	Eadni	Áhčči
Stáhtagirku	☐	☐	☐
Lestádialaš	☐	☐	☐
Hellodatoskkolaš	☐	☐	☐
Jehovalaš	☐	☐	☐
Earát	☐	☐	☐

Galle girjji navddát leat ruovttustat?

- ☐ Ii oktage
- ☐ Unnit go 20
- ☐ 20—50
- ☐ 50—100
- ☐ 100—500
- ☐ 500—1000
- ☐ Eanet go 1000

Go dal geahčadat iežat dál, oaivvildatgo de ahte don leat rumašlaš láddama dáfus ovdaleappos vai maŋŋileappos go duot nuppit du ahkásaččain?

- ☐ Ollu ovdalis
- ☐ Veaháš ovdaleappos
- ☐ Hui veaháš ovdaleappos
- ☐ Nugo earát
- ☐ Hui veaháš maŋŋeleappos
- ☐ Veaháš maŋŋelcappos
- ☐ Ollu maŋŋelis

Go don láddagohtet rumašlaččat, de geavai go dat du oaivila mielde árabut vai maŋŋeleappot go duoin nuppiin du ahkásaččain?

- ☐ Ollu ovdalis
- ☐ Veaháš ovdaleappos
- ☐ Hui veaháš ovdalcappos
- ☐ Nugo earáin
- ☐ Hui veaháš maŋŋeleappos
- ☐ Veaháš maŋŋeleappos
- ☐ Ollu maŋŋelis

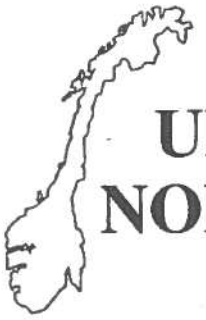
Fitnabago du vánhemat skuvlačoahkkimiim ja earát čoahkkimiin mat gusket skuvlii?

- ☐ Soai fitnaba dábálaččat dakkár čoahkkimiin
- ☐ Soai fitnaba muhtumin
- ☐ Soai eaba fina eaba goassege

The North Norwegian Youth Study:

Questionnaire in Norwegian 1997-98

PREMIE:
Kr. 10.000,– til valgfri ferie. Alle som fyller ut skjemaet er med i lotteriet.



UNG I NORGE

Spørreskjema til ungdom i Nord-Norge

Dette er andre gangs undersøkelse i UNG I NORGE. Takk for at du var med forrige gang!

Over 90% av de forespurte deltok i første runde, og det synes vi er svært bra. Vi ønsker å se om livssituasjonen til deg og annen ungdom har endret seg i løpet av de to årene siden sist. Derfor ber vi deg om å være med i denne oppfølgingsrunden.

Vi håper at du vil fylle ut dette skjemaet. Hvis det er noen spørsmål du synes er for personlige, eller som du ikke vil svare på, så kan du hoppe over dem. Men vi vil helst at du svarer på alle spørsmålene.

Alle svarene vil være konfidensielle. Kodenummeret vil bli oppbevart slik at ingen vil få vite hva akkurat du har svart.

De fleste stedene setter du et kryss i den ruta som passer for deg. Noen steder står det bare prikker. Da må du skrive ut svaret selv.

Når du har fylt ut skjemaet, legger du det i den svar-konvolutten som følger med og poster det til oss. Adresse står på og porto er allerede betalt.

Takk for hjelpen!

Vennlig hilsen

Siv Kvernmo *Lars Wichstrøm*

NTNU
Norges Teknisk-Naturvitenskapelige Universitet
Det samfunnsvitenskapelige fakultet
Psykologisk institutt

UiTø
FAGOMRÅDET MEDISIN
Avd. for barne- og ungdomspsykiatri

Er du jente eller gutt?

- ☐ Jente
- ☐ Gutt

Hvor gammel er du? Jeg er ..... år

Dersom du går på videregående skole,

- ☐ Allmenne fag
- ☐ Handels- og kontorfag
- ☐ Håndverks- og industrifag
- ☐ Husflids- og estetiske fag, duoddji
- ☐ Husholdningsfag
- ☐ Idrettsfag
- ☐ Helse- og miljøfag
- ☐ Fiskerifag
- ☐ Sjøfartsfag
- ☐ Landbruksfag og naturbruk, reindrift
- ☐ Tekniske fag
- ☐ Annet (skriv hva): .....

.....

Hvilket klassetrinn går du på?

- ☐ Går ikke på skole
- ☐ Grunnkurs
- ☐ VK I
- ☐ VK II

SKOLEGANG

Vi vil gjerne vite hvilke skoler du har gått på , hva slags utdanning du har fullført (fått avgangsvitnemål fra), hva slags utdanning du planlegger å ta seinere og eventuelt hva slags skole du går på nå. Sett så mange kryss som passer.

	Går på nå	Påbegynt, men sluttet før endelig eksamen	Fullført	Planlegger å begynne på
Ungdomsskole	☐	☐	☐	☐
Videregående skole, AF/HK	☐	☐	☐	☐
Videregående skole, YF	☐	☐	☐	☐
1–2 års utdannelse etter videregående	☐	☐	☐	☐
3-årig høgskole	☐	☐	☐	☐
4-årig høgskole	☐	☐	☐	☐
Grunnfag eller mellomfag på universitet ..	☐	☐	☐	☐
Cand.mag. grad	☐	☐	☐	☐
Hovedfag, embedsstudium på universitet, diplomstudium på høgskole	☐	☐	☐	☐

HOVEDBESKJEFTIGELSE

Vi vil gjerne vite hvilke noe om hvilke arbeidserfaringer du har hatt de siste to årene. Vennligst kryss av for hvert år om du i mars måned og september måned var:

	September 1995	Mars 1996	September 1996	Mars 1997
I heltidsstilling (35 t eller mer pr. uke)	☐	☐	☐	☐
I deltidsstilling (mellom 15 t og 35 t pr. uke)	☐	☐	☐	☐
I mindre deltidsstilling (mellom 5 og 15 t pr. uke)	☐	☐	☐	☐
Arbeidsløs	☐	☐	☐	☐
På sysselsettingstiltak	☐	☐	☐	☐
Hjemmeværende	☐	☐	☐	☐
I militæret (verneplikt)	☐	☐	☐	☐
Under utdanning	☐	☐	☐	☐

Har du noen gang vært arbeidsløs?
☐ Nei
☐ Ja, tilsammen ..... måneder

Dersom du er i arbeid nå (1 time eller mer pr. uke), hvilket yrke har du? .....

Fortell hva du gjør på jobben .....

Hvem bor du sammen med nå?
☐ Mor og/eller far
☐ Alene/For meg selv eller i bokollektiv
☐ Ektefelle/samboer
☐ Annet, hva .....

Har du barn?
☐ Nei
☐ Ja, jeg har ..... (antall) barn

Har de voksne du bodde sammen med før, flyttet fra hverandre? ☐ Ja ☐ Nei

Hvis ja, hvor lenge siden? ..... år ..... måneder

For to år siden, bodde du da i tettbygd eller spredtbygd strøk?
☐ I eller like utenfor en mellomstor eller liten by
☐ Større tettsted (ikke by)
☐ Lite tettsted/bygdesamfunn
☐ Spredtbygd strøk

Bor du et annet sted nå enn våren -95?
☐ Nei
☐ Ja, jeg er flyttet til en bygd/tettsted
☐ Ja, jeg er flyttet til en by
☐ Ja, jeg er flyttet til en annen bygd/tettsted
☐ Ja, jeg er flyttet til en annen by
☐ Annet, hva .....

Det stedet du bor på nå, hvilket språk snakkes det mest der?
☐ Norsk
☐ Samisk
☐ Omtrent like mye av begge
☐ Annet, hva .....

Bodde du på internat da du gikk på barne- og/eller ungdomsskolen? ..... ☐ Ja ☐ Nei

Hvis ja, i hvilke(n) klasse? ....

Hvor lenge? .... år ..... mnd.

Har noen av dine foreldre bodd på internat da de gikk på barne- og/eller ungdomsskolen?

☐ Nei, ingen
☐ Ja, mor
☐ Ja, far
☐ Ja, begge
☐ Vet ikke

Hvis ja, hvor lenge .... år

Hvor mye tror du at du veier? .... kg

Hvor høy tror du at du er? .... cm

Hvor gammel var du da du begynte å vokse raskt? .... år ..... mnd.

Virker det som du er ferdig med å vokse? ..... ☐ Ja ☐ Nei

Hvis ja, hvor gammel var du da du sluttet å vokse? .... år ..... mnd.

A. Har du noen gang med vilje tatt en overdose av piller eller på annen måte forsøkt å skade deg selv? .....

☐ Nei, aldri
☐ Ja, en gang
☐ Ja, flere ganger

Dersom du svarte «ja» på dette spørsmålet, vil vi gjerne at du besvarer spørsmålene fra B til F nedenfor. Dersom du svarte «nei», kan du hoppe over disse spørsmålene.

B. Hvor lenge er det siden du sist forsøkte å skade deg selv? .... år ..... måneder

C. Har du noen gang forsøkt å ta ditt eget liv? .....

☐ Nei, aldri
☐ Ja, en gang
☐ Ja, flere ganger

Hvor mange ganger? ....

D. Hvis du svarte «ja» på C, hvor lenge er det siden du sist forsøkte å ta ditt eget liv? .... år ..... måneder

Dersom du svarte «Ja, flere ganger» på spørsmål A, ber vi deg om å tenke på siste gang når du svarer på spørsmålene E og F.

E. Var du beruset da du forsøkte å skade deg? .....

☐ Nei, ikke i det hele tatt
☐ Ja, litt beruset
☐ Ja, temmelig eller veldig beruset
☐ Vet ikke

F. Har du etterpå fått hjelp eller behandling? .....

☐ Ja, hos foreldre
☐ Ja, hos andre i familien
☐ Ja, hos en eller flere venner
☐ Ja, på sykehus
☐ Ja, hos lege
☐ Ja, hos psykolog/psykiater
☐ Ja, hos andre
☐ Nei, ikke hos noen

Har du noen gang hatt samleie? ..... ☐ Ja ☐ Nei

Hvis du svarte ja, hvor gammel var du da du hadde samleie første gang? ..... Jeg var ..... år

Hvor mange har du hatt samleie med til sammen (antall partnere)? .....

Nedenfor er en del utsagn om mat og spisevaner. Kryss av for hva som passer deg.

	Alltid	Ofte	Sjelden	Aldri
Jeg er opptatt av å bli tynnere	☐	☐	☐	☐
Jeg prøver å holde diett	☐	☐	☐	☐
Jeg føler ubehag etter at jeg har spist søtsaker	☐	☐	☐	☐
Jeg trimmer for å gå ned i vekt	☐	☐	☐	☐
Jeg kaster opp etter at jeg har spist	☐	☐	☐	☐
Når jeg først har begynt å spise, kan det være vanskelig å stoppe ..	☐	☐	☐	☐
Jeg bruker for mye tid til å tenke på mat	☐	☐	☐	☐
Jeg føler at maten kontrollerer livet mitt	☐	☐	☐	☐
Når jeg spiser, skjærer jeg maten opp i små biter	☐	☐	☐	☐
Jeg bruker lengere tid enn andre på et måltid	☐	☐	☐	☐
Andre mennesker synes at jeg er for tynn	☐	☐	☐	☐
Jeg føler at andre presser meg til å spise	☐	☐	☐	☐

Nedenfor kommer en del spørsmål om språk og kulturell tilhørighet. Kryss av det som passer for deg så godt du kan.

	Stemmer svært godt	Stemmer ganske godt	Ikke sikker	Stemmer ganske dårlig	Stemmer svært dårlig
Jeg oppfatter meg som					
Norsk	☐	☐	☐	☐	☐
Samisk	☐	☐	☐	☐	☐
Kvensk	☐	☐	☐	☐	☐
Finsk	☐	☐	☐	☐	☐
Annet, beskriv hva	☐	☐	☐	☐	☐
Jeg tror andre (venner, naboer e.l.) oppfatter meg som:					
Norsk	☐	☐	☐	☐	☐
Samisk	☐	☐	☐	☐	☐
Kvensk	☐	☐	☐	☐	☐
Finsk	☐	☐	☐	☐	☐
Annet, beskriv hva	☐	☐	☐	☐	☐

Hvordan er helsa di nå? (Sett et kryss for det som passer for deg)

Dårlig ..... ☐ Ikke helt god .... ☐ God ..... ☐ Svært god ..... ☐

Har du hatt noen av disse plagene i løpet av de siste 12 månedene? (Sett ett kryss på hver linje)

	Alltid	Ofte	Sjelden	Aldri
A Hodepine (uten kjent medisinsk årsak)	☐	☐	☐	☐
B Nakke- og skuldersmerter	☐	☐	☐	☐
C Ledd- og muskelsmerter	☐	☐	☐	☐
D Magesmerter (uten kjent medisinsk årsak)	☐	☐	☐	☐
E Kvalme	☐	☐	☐	☐
F Treg mage	☐	☐	☐	☐
G Diare, magesyke	☐	☐	☐	☐
H Hjertebank	☐	☐	☐	☐
I Bronkitt eller lungebetennelse	☐	☐	☐	☐
J Ørebetennelse	☐	☐	☐	☐
K Bihulebetennelse	☐	☐	☐	☐

Hvis du har svart «aldri» på alle plagene nevnt ovenfor: Har du hatt noen av disse plagene ofte tidligere (dvs. før de siste 12 månedene)?

☐ Ja ☐ Nei

Hvis ja: Hvilke plager (se ovenfor) var det? (Skriv navn eller bokstavene som passer) .....

Når fikk du denne sykdommen/skaden? ..... år gammel

Har du i løpet av de siste 12 månedene vært hos: (Ett kryss på hver linje)

	Ja	Nei
Almenpraktiserende lege (lege utenom sykehus)	☐	☐
Lege på sykehus eller poliklinikk (uten at du var innlagt)	☐	☐
Psykiatrisk poliklinikk	☐	☐
Psykolog	☐	☐
Fysioterapeut	☐	☐
Kiropraktor	☐	☐
Helsesøster	☐	☐
Homøopat	☐	☐
Annen behandler (naturmedisiner, fotsoneterapeut, håndspålegger, «healer», «synsk»)	☐	☐

Hvis ja, hvilket problem/plager førte til kontakten: .....

Hvor lenge varte kontakten? ..... år ..... mnd.

Hvor gammel var du da du begynte å få hår på kroppen (under armene, i skrittet)?

Jeg var ..... år og ..... mnd.

SPØRSMÅL BARE FOR JENTER

Hvor gammel var du da du begynte å få bryster? Jeg var ..... år og ..... mnd.

Hvor gammel var du da du fikk din første menstruasjon? Jeg var ..... år og ..... mnd.

Har du noen gang etter en blødning vært blødningsfri i flere måneder (uten å ha vært gravid)? (Sett ett kryss)

Ja, 2–5 mnd. .... ☐ Ja, 6–12 mnd. ... ☐ Ja, mer enn 1 år . ☐ Nei, aldri ..... ☐

Har du noen gang fått behandling av lege for: (Ett kryss på hver linje)

	Ja	Nei
Seksuelt overført sykdom (kjønnssykdom)	☐	☐
Underlivsbetennelse (eggstokkbetennelse, eggleder betennelse)	☐	☐
Utflod	☐	☐
Menstruasjonssmerter	☐	☐
Har du noen gang brukt p-piller eller minipiller?	☐	☐

Hvor gammel var du første gang du brukte p-piller? ..... år

Hvor lenge har du brukt p-piller i alt? ..... år

SPØRSMÅL BARE FOR GUTTER

Hvor gammel var du da du begynte å komme i stemmeskiftet? Jeg var ..... år og ..... mnd.

Hvor gammel var du da du begynte å få skjegg? Jeg var ..... år og ..... mnd.

Har du vært behandlet hos lege for: (Ett kryss på hver linje)	Ja	Nei
Seksuelt overført sykdom (kjønnssykdom)	☐	☐
Trang forhud	☐	☐
Utflod fra urinrøret	☐	☐
Betennelse i forhuden eller pungen (testiklene)	☐	☐

	Ja	Nei
For JENTER: Har du noen gang vært gravid uten at du ønsket det?	☐	☐
For GUTTER: Har en jente noen gang blitt gravid med deg uten at det var meningen?	☐	☐

For BÅDE gutter og jenter:

Hvis ja, hvor gammel var du da dette skjedde? Jeg var ..... år

Ble det utført abort? ☐ Ja ☐ Nei ☐ Vet ikke

Hvis du er seksuelt aktiv, bruker du noen form for prevensjon?

- ☐ Aldri
- ☐ Av og til
- ☐ Nesten alltid
- ☐ Alltid

Hvilken form for prevensjon bruker du?

- ☐ Ingen
- ☐ Avbrutt samleie
- ☐ Kondom
- ☐ P-pille/mini-pille
- ☐ Sæddrepende krem
- ☐ Pessar
- ☐ Spiral
- ☐ Annet, beskriv hva .....

Hvis du er seksuelt aktiv og ikke bruker prevensjon, kan du forklare hvorfor?
(kryss gjerne av for flere alternativer)

- ☐ Uventet/ikke planlagt samleie
- ☐ Flau over å bruke prevensjon
- ☐ Partneren ønsker ikke at vi bruker prevensjon
- ☐ Vanskelig å få tak i prevensjon
- ☐ Har ikke tenkt på prevensjon
- ☐ Ønsker meg barn
- ☐ Ikke redd for å bli gravid
- ☐ Annet, beskriv hva .....

Alder: ..... Kjønn: .....

Her er en liste over egenskaper som barn og ungdom kan ha i større eller mindre grad. For hver egenskap som passer på deg **nå eller siste 6 måneder,** ber vi deg sette en ring rundt 2 hvis beskrivelsen **passer bra eller ofte.** Sett en ring rundt 1 hvis beskrivelsen **passer til en viss grad eller iblant.** Hvis beskrivelsen **ikke passer på deg,** sett en ring rundt 0. Vennligst svar så godt du kan på alle spørsmålene selv om noen ikke passer på deg.

0 = Passer ikke 1 = Passer til en viss grad eller iblant 2 = Passer bra eller ofte

---

0 1 2 1. Jeg oppfører meg som yngre enn det jeg er
0 1 2 2. Jeg utnytter mulighetene mine bra
0 1 2 3. Jeg krangler mye
0 1 2 4. Jeg bruker evnene mine
0 1 2 5. Jeg oppfører meg som det motsatte kjønn
0 1 2 6. Jeg kommer overens med de fleste mennesker
0 1 2 7. Jeg skryter
0 1 2 8. Jeg har problemer med å konsentere meg eller være oppmerksom
0 1 2 9. Jeg kan ikke få visse tanker ut av hodet (beskriv): .....
0 1 2 10. Jeg har problemer med å sitte stille
0 1 2 11. Jeg er for avhengig av andre
0 1 2 12. Jeg føler meg ensom
0 1 2 13. Jeg føler meg forvirret eller fjern
0 1 2 14. Jeg gråter mye
0 1 2 15. Jeg er ganske ærlig
0 1 2 16. Jeg er slem mot andre
0 1 2 17. Jeg dagdrømmer mye
0 1 2 18. Jeg prøver å skade meg selv med vilje eller har forsøkt å begå selvmord
0 1 2 19. Jeg prøver å få mye oppmerksomhet
0 1 2 20. Jeg ødelegger tingene mine
0 1 2 21. Jeg ødelegger ting som tilhører andre
0 1 2 22. Jeg er bekymret for fremtiden
0 1 2 23. Jeg bryter regler på skolen eller jobben
0 1 2 24. Jeg spiser ikke så bra som jeg burde
0 1 2 25. Jeg kommer ikke overens med andre
0 1 2 26. Jeg har ikke skyldfølelse etter å ha gjort noe jeg ikke burde
0 1 2 27. Jeg er sjalu på andre
0 1 2 28. Jeg er villig til å hjelpe andre når de trenger hjelp
0 1 2 29. Jeg er redd for visse dyr, situasjoner eller steder (beskriv): .....
0 1 2 30. Jeg er bekymret for mitt forhold til det motsatte kjønn
0 1 2 31. Jeg er redd jeg kanskje tenker eller gjør noe galt
0 1 2 32. Jeg føler at jeg må være perfekt
0 1 2 33. Jeg føler at ingen er glad i meg
0 1 2 34. Jeg føler at andre er ute etter meg
0 1 2 35. Jeg føler meg mindreverdig eller underlegen
0 1 2 36. Jeg slår meg mye, ulykkesfugl
0 1 2 37. Jeg kommer ofte opp i slagsmål
0 1 2 38. Jeg blir ofte ertet
0 1 2 39. Jeg henger sammen med kamerater som kommer opp i bråk
0 1 2 40. Jeg hører lyder eller stemmer som andre ikke synes er der (beskriv): .....
0 1 2 41. Jeg handler uten å stoppe opp for å tenke
0 1 2 42. Jeg vil heller være alene enn sammen med andre
0 1 2 43. Jeg lyver eller jukser
0 1 2 44. Jeg biter negler
0 1 2 45. Jeg er nervøs eller anspent
0 1 2 46. Deler av kroppen min rykker eller lager nervøse bevegelser (beskriv): .....

0 1 2 47. Jeg har mareritt
0 1 2 48. Jeg blir ikke likt av andre
0 1 2 49. Jeg kan gjøre visse ting bedre enn andre
0 1 2 50. Jeg er for redd eller engstelig
0 1 2 51. Jeg føler meg svimmel
0 1 2 52. Jeg har for mye skyldfølelse
0 1 2 53. Jeg spiser for mye
0 1 2 54. Jeg føler meg overtrett
0 1 2 55. Jeg er overvektig
56. Kroppslige plager uten kjent medisinsk årsak:
0 1 2 a. Smerter eller vondt (ikke hodepine)
0 1 2 b. Hodepine
0 1 2 c. Kvalme, føler meg uvel
0 1 2 d. Plager med øynene (beskriv): .....
0 1 2 e. Utslett eller andre hudplager
0 1 2 f. Magesmerter/magekramper
0 1 2 g. Brekninger, kaster opp
0 1 2 h. Hjertebank
0 1 2 i. Nummenhet, prikking i deler av kroppen
0 1 2 j. Annet (beskriv): .....
0 1 2 57. Jeg kan gå løs på andre fysisk
0 1 2 58. Jeg plukker på huden eller andre deler av kroppen min (beskriv): .....
0 1 2 59. Jeg får lett venner
0 1 2 60. Jeg liker å prøve nye ting
0 1 2 61. Skolearbeidet mitt eller prestasjonene mine på jobb er dårlige
0 1 2 62. Jeg er klosset og har dårlig samordning av bevegelsene mine
0 1 2 63. Jeg foretrekker å være sammen med folk som er eldre enn meg
0 1 2 64. Jeg foretrekker å være sammen med folk som er yngre enn meg
0 1 2 65. Jeg nekter å snakke
0 1 2 66. Jeg gjentar visse handlinger om og om igjen (beskriv): .....
0 1 2 67. Jeg mister fort venner
0 1 2 68. Jeg roper/skriker mye
0 1 2 69. Jeg er hemmelighetsfull eller holder ting for meg selv
0 1 2 70. Jeg ser ting som ikke andre synes er der (beskriv): .....
0 1 2 71. Jeg blir lett flau eller forlegen
0 1 2 72. Jeg tenner på – lager brann
0 1 2 73. Jeg utnytter mulighetene mine bra
0 1 2 74. Jeg gjør meg til eller spiller bajas
0 1 2 75. Jeg er sjenert
0 1 2 76. Jeg har problemer med å få sove
0 1 2 77. Jeg sover mer enn de fleste i løpet av dagen og/eller om natten (beskriv): .....
0 1 2 78. Jeg våkner for tidlig
0 1 2 79. Jeg har talevansker (beskriv): .....
0 1 2 80. Jeg står på rettighetene mine
0 1 2 81. Jeg bekymrer meg for jobben eller skolearbeidet mitt
0 1 2 82. Jeg stjeler
0 1 2 83. Jeg samler på ting jeg ikke trenger
0 1 2 84. Jeg gjør ting som andre synes er underlig (beskriv): .....
0 1 2 85. Jeg har tanker som andre ville synes var underlige (beskriv): .....
0 1 2 86. Jeg er sta
0 1 2 87. Humøret mitt eller følelsene mine forandrer seg plutselig
0 1 2 88. Jeg liker å være sammen med andre
0 1 2 89. Jeg er mistenksom
0 1 2 90. Jeg drikker for mye alkohol

0 1 2 91. Jeg har tanker om å ta livet av meg
0 1 2 92. Jeg liker å få andre til å le
0 1 2 93. Jeg snakker for mye
0 1 2 94. Jeg erter andre mye
0 1 2 95. Jeg har et heftig sinne
0 1 2 96. Jeg tenker for mye på sex
0 1 2 97. Jeg truer andre med å skade dem
0 1 2 98. Jeg liker å hjelpe andre
0 1 2 99. Jeg er altfor opptatt av å være ren og ordentlig
0 1 2 100. Jeg har søvnproblemer (beskriv): .....
0 1 2 101. Jeg har problemer med å bli ferdig med ting jeg skulle gjøre
0 1 2 102. Jeg har dårlig med energi
0 1 2 103. Jeg er ulykkelig, trist eller deprimert
0 1 2 104. Jeg bråker mer enn andre
0 1 2 105. Jeg gjør ting som gir meg problemer med loven (beskriv): .....
0 1 2 106. Jeg prøver å være rettferdig med andre
0 1 2 107. Jeg liker en god spøk
0 1 2 108. Jeg liker å ta livet lettvint
0 1 2 109. Jeg prøver å hjelpe andre når jeg kan
0 1 2 110. Jeg ønsker jeg var av motsatt kjønn
0 1 2 111. Jeg passer meg for å engasjere meg i andre
0 1 2 112. Jeg er mye bekymret
0 1 2 113. Jeg er for opptatt av hvordan jeg ser ut
0 1 2 114. Jeg har problemer med å bestemme meg
0 1 2 115. Jeg betaler ikke gjeld eller passer ikke på andre økonomiske forpliktelser
0 1 2 116. Jeg er for mye bekymret for helsen min

Hvis du har en fast jobb (eller hadde fast jobb i løpet av de siste 6 månedene), vær så snill og svar på følgende spørsmål:

0 1 2 117. Jeg har problemer med å få gjort arbeidet mitt
0 1 2 118. Jeg er fornøyd med arbeidssituasjonen min
0 1 2 119. Jeg gjør ting som kan føre til at jeg mister jobben
0 1 2 120. Jeg er borte fra arbeidet selv om jeg ikke er syk

Hvis du går på skole eller studerer på universitetet eller høyskole (eller har gått på skole/studert de siste 6 månedene), vær så snill og svar på følgende spørsmål:

0 1 2 121. Jeg har problemer med å studere
0 1 2 122. Jeg er fornøyd med skole-/studiesituasjonen min
0 1 2 123. Jeg har problemer med å komme overens med lærere/forelesere/veiledere
0 1 2 124. Jeg skulker skolen/studiene når jeg ikke er syk

Hvis du er gift eller i et fast forhold, vær så snill å svare på følgende spørsmål:

0 1 2 125. Jeg er fornøyd med partneren min
0 1 2 126. Partneren min og jeg er uenig om penger
0 1 2 127. Partneren min og jeg er uenig om hvor mye tid vi skal tilbringe sammen
0 1 2 128. Partneren min og jeg er uenig om hva vi skal gjøre når vi er sammen
0 1 2 129. Partneren min og jeg liker de samme aktivitetene
0 1 2 130. Partneren min og jeg er uenig om seksuelle forhold
0 1 2 131. Partneren min og jeg er uenig om samlivsfohold f.eks. slikt som hvor vi skal bo o.l.
0 1 2 132. Jeg har problemer med min partners familie

133. Hvor ofte har du drukket alkohol de siste 6 månedene?

- ☐ Aldri i løpet av de siste 6 månedene
- ☐ Ikke mer en et glass pr. uke
- ☐ 2– 6 glass pr. uke
- ☐ 7–14 glass pr.uke
- ☐ 14–21 glass pr. uke
- ☐ Mer enn 21 glass pr. uke – ca. hvor mange glass? .....

131. Hvor ofte har du vært beruset de siste 6 månedene?

- ☐ Aldri i løpet av de siste 6 månedene
- ☐ 1 eller 2 ganger
- ☐ 3 eller 4 ganger
- ☐ 5 eller 6 ganger
- ☐ Mer enn 6 ganger – ca. hvor mange ganger? .....

135. Er du bekymret for mengden alkohol du drikker?

☐ Nei ☐ Ja

136. Er familien din eller venner bekymret for mengden alkohol du drikker?

☐ Nei ☐ Ja

137. Hvor ofte har du i løpet av de siste 6 månedene brukt narkotiske stoff til ikke-medisinske formål (amfetamin, beroligende medikament, hasj, heroin, kokain, etc)?

- ☐ Aldri i løpet av de siste 6 månedene
- ☐ 1 eller 2 ganger
- ☐ 3 eller 4 ganger
- ☐ 5 eller 6 ganger
- ☐ Mer enn 6 ganger – ca. hvor mange ganger? .....

Sett et kryss ved det svaret som beskriver deg:

	Ja	Nei
Spiser du etter et bestemt mønster hver dag?	☐	☐
Driver du av og til med hard slanking?	☐	☐
Føler du deg mislykket hvis du bryter med slankeprogrammet?	☐	☐
Teller du kaloriene i alt du spiser, selv når du ikke slanker deg?	☐	☐
Faster du en hel dag av og til?	☐	☐

Hvis du svarte ja på forrige spørsmål, hvor ofte?

- ☐ Hver annen dag
- ☐ 2–3 ganger pr. uke
- ☐ 1 gang i uken
- ☐ Av og til
- ☐ Har gjort det en gang

Bruker du noen av følgende til å hjelpe deg å gå ned i vekt?

	Aldri	Av og til	1 gang pr. uke	2–3 ganger pr. uke	Mer enn 5 ganger pr. uke	Daglig	2–3 ganger pr. dag
Slanketabletter	☐	☐	☐	☐	☐	☐	☐
Slankepulver	☐	☐	☐	☐	☐	☐	☐
Avføringsmidler	☐	☐	☐	☐	☐	☐	☐
Vanndrivende medikamenter	☐	☐	☐	☐	☐	☐	☐
Tvinger meg til å kaste opp	☐	☐	☐	☐	☐	☐	☐

	Ja	Nei
Ødelegger ditt spisemønster livet ditt?	☐	☐
Ville du si at maten styrer ditt liv?	☐	☐
Spiser du noen ganger så mye at du må stoppe p.g.a. ubehag?	☐	☐
Er det perioder hvor du bare tenker på mat?	☐	☐
Spiser du fornuftig i andres nærvær for å «ta igjen» når du er alene?	☐	☐
Kan du slutte å spise når du vil?	☐	☐
Føler du noen ganger en overveldende trang til å spise?	☐	☐
Spiser du mye når du er engstelig?	☐	☐
Er du veldig redd for å bli fet?	☐	☐
Spiser du store mengder mat veldig fort (mellom måltider)?	☐	☐

	Ja	Nei
Skammer du deg over dine spisevaner?	☐	☐
Er du bekymret over å ikke kunne styre spisingen?	☐	☐
Trøstespiser du?	☐	☐
Kan du la noe av maten ligge igjen på tallerkenen etter et måltid?	☐	☐
Lurer du andre mennesker m.h.t. hvor mye du spiser?	☐	☐
Er det sultfølelse som bestemmer hvor mye du spiser?	☐	☐
Fråtser du i store mengder mat noen ganger?	☐	☐
Hvis du svarte ja, føler du deg elendig etterpå?	☐	☐
Hvis du fråtser, er det bare når du er alene?	☐	☐

Hvis du fråtser, hvor ofte skjer dette?

☐ Nesten aldri ☐ En gang i måneden

☐ En gang i uken ☐ 2–3 ganger pr. uke

☐ Daglig ☐ 2–3 ganger pr. dag

	Ja	Nei
Ville du anstrenge deg veldig for å tilfredsstille trangen til å fråtse?	☐	☐
Hvis du forspiser deg, får du mye skyldfølelse?	☐	☐
Spiser du i smug noen ganger?	☐	☐
Er dine spisevaner normale, slik du ser dem?	☐	☐
Er du en «tvangsspiser»?	☐	☐
Varierer din vekt med mer enn 2–3 kg i løpet av en uke?	☐	☐

Hva er det meste du har veid? .... kg

Hvor lenge hadde du denne vekten? .... måneder

Hva er det minste du har veid de siste årene? .... kg

Hvor lenge hadde du denne vekten? .... måneder

Hva er det største vekttapet du har hatt? .... kg

Skjedde dette vekttapet med vilje? ..... ☐ Ja ☐ Nei

Hva ønsker du å veie? .... kg

Nå følger en liste over forskjellige plager og problemer som man av og til kan ha. Har du i løpet av den siste uka ikke vært plaget i det hele tatt, litt plaget, ganske mye plaget eller veldig mye plaget av noe av dette? Sett kryss i den ruta som passer for deg.

	Ikke plaget i det hele tatt	Litt plaget	Ganske mye plaget	Veldig mye plaget
Plutselig redd uten grunn	☐	☐	☐	☐
Stadig redd eller engstelig	☐	☐	☐	☐
Matthet eller svimmelhet	☐	☐	☐	☐
Nervøsitet, indre uro	☐	☐	☐	☐
Lett for å gråte	☐	☐	☐	☐
Lett for å klandre deg selv	☐	☐	☐	☐
Følt at alt er et slit	☐	☐	☐	☐
Hatt søvnproblemer	☐	☐	☐	☐
Følt deg ulykkelig, trist eller deprimert	☐	☐	☐	☐
Følt håpløshet med tanke på framtida	☐	☐	☐	☐
Følt deg stiv eller anspent	☐	☐	☐	☐
Bekymret deg for mye om ting	☐	☐	☐	☐
Tenkt på å gjøre slutt på livet ditt	☐	☐	☐	☐

	Ja	Nei
Er du noen gang blitt tilbudt hasj eller marihuana?	☐	☐
Har du noen gang brukt hasj eller marihuana?	☐	☐

Røyker du?

☐ Har aldri røykt
☐ Har aldri røykt fast og røyker ikke i det hele tatt nå
☐ Har røykt fast, men har sluttet helt nå
☐ Røyker, men ikke daglig
☐ Røyker daglig, omtrent ..... sigaretter

Hvor mange ganger har du i løpet av de fire siste ukene drukket mer enn et par slurker alkohol?

☐ Ingen ganger

..... (antall ganger)

Også i Nord-Norge har folk forskjellige kulturer og bakgrunner. Det finnes ulike ord for å beskrive de kulturelle bakgrunnene eller etniske tilhørigheter som folk har.

Noen eksempler på etnisk tilhørighet eller etnisk gruppe er f.eks. norsk, samisk, finsk, kvensk og tamilsk.
Alle mennesker blir født inn i en etnisk eller kulturell tilhørighet, eller av og til to, men det er store forskjeller hvor mye etnisitet betyr, hvilke følelser den enkelte har overfor sin etnisitet og hvor mye deres væremåte er påvirket av denne.

Spørsmålene nedenfor handler om etnisitet eller etnisk tilhørighet og hvordan du føler og handler i forhold til den. De er laget for flerkulturelle samfunn. Fyll ut så godt du kan.

Når det gjelder etnisk tilhørighet, regner jeg meg selv som .....

Kryss av i den ruten som passer for deg:

	Helt enig	Litt enig	Litt uenig	Helt uenig
Jeg har brukt tid til å prøve å finne ut mer om min etniske gruppe, slik som historie, tradisjoner og skikker	☐	☐	☐	☐
Jeg deltar aktivt i organisasjoner eller sosiale sammenhenger som hovedsakelig har medlemmer fra min egen etniske gruppe ..	☐	☐	☐	☐
Jeg har en klar oppfatning av min etniske bakgrunn og hva den betyr for meg	☐	☐	☐	☐
Jeg liker å møte og bli kjent med folk fra andre etniske grupper enn min egen	☐	☐	☐	☐
Jeg tenker mye på hvordan min etniske tilhørighet påvirker livet mitt	☐	☐	☐	☐
Jeg er glad for å tilhøre den gruppen jeg tilhører	☐	☐	☐	☐
Av og til føler jeg at ting ville være bedre om de forskjellige etniske gruppene ikke prøvde å blande seg	☐	☐	☐	☐
Jeg vet egentlig ikke hvilken rolle min etnisitet spiller i livet mitt	☐	☐	☐	☐
Jeg er ofte sammen med folk fra andre etniske grupper enn min egen	☐	☐	☐	☐
Jeg har egentlig ikke brukt noe særlig tid på å prøve å finne ut noe om min etniske gruppes kultur og historie	☐	☐	☐	☐
Jeg har en sterk følelse av å høre til i min etniske gruppe	☐	☐	☐	☐
Jeg har en ganske god forståelse av hva min etniske tilhørighet betyr for meg, med tanke på hvordan jeg skal forholde meg til både min egen og andre etniske grupper	☐	☐	☐	☐
For å kunne lære mer om min bakgrunn, har jeg ofte snakket med andre om min etniske tilhørighet	☐	☐	☐	☐
Jeg er veldig stolt av min bakgrunn og hva den har oppnådd	☐	☐	☐	☐

	Helt enig	Litt enig	Litt uenig	Helt uenig
Jeg føler egentlig ikke at jeg tilhører noen etnisk gruppe	☐	☐	☐	☐
Jeg prøver ikke å bli venner med ungdom fra andre etniske grupper	☐	☐	☐	☐
Jeg deltar i kulturelle aktiviteter og tradisjoner innen min etniske gruppe, slik som f.eks. tradisjonell matlaging, musikk eller andre skikker	☐	☐	☐	☐
Jeg deltar i aktiviteter sammen med folk fra andre grupper	☐	☐	☐	☐
Jeg føler en sterk tilknytning til min egen etniske gruppe	☐	☐	☐	☐
Jeg skulle ønske at jeg tilhørte en annen etniske gruoppe enn jeg gjør	☐	☐	☐	☐
Jeg liker å være sammen med folk fra andre etniske grupper enn min egen	☐	☐	☐	☐
Jeg er fornøyd med min kulturelle eller etniske bakgrunn	☐	☐	☐	☐
Jeg føler at jeg tilhører flere etniske grupper	☐	☐	☐	☐

Min etnisitet er (skriv ett eller flere av numrene nedenfor): .....

1. Norsk
2. Samisk
3. Finsk
4. Kvensk
5. Annet (skriv hvilken): .....

Fars etnisitet er (bruk numrene ovenfor): .....

Mors etnisitet er (bruk numrene ovenfor): .....

Hvordan stiller du deg til kristendommen?

- ☐ Jeg er personlig kristen
- ☐ Jeg tror det finnes en Gud, men religion betyr ikke så mye for meg i det daglige
- ☐ Usikker
- ☐ Jeg tror ikke det finnes noen Gud
- ☐ Jeg tilhører en annen religion, nemlig: .....

.....

Ønsker du å bosette deg på hjemstedet ditt når du er ferdig med utdanningen din?

- ☐ Ja, svært gjerne
- ☐ Ja, dersom det faller seg slik
- ☐ Usikker
- ☐ Nei, jeg ønsker å bosette meg et annet sted

Hvis du tror du kommer til å flytte, hvor vil du helst flytte?

- ☐ Til en større by
- ☐ Til en mindre by
- ☐ Til et sted like utenfor en by
- ☐ Til ei bygd
- ☐ Til et annet land
- ☐ Tilbake til hjemstedet
- ☐ Usikker

Når du tenker etter, mener du at du ble tidligere eller senere fysisk moden enn andre på din alder?

- ☐ Mye tidligere
- ☐ Noe tidligere
- ☐ Lite grann tidligere
- ☐ Akkurat som andre
- ☐ Lite grann senere
- ☐ Noe senere
- ☐ Mye senere

Da du begynte å bli fysisk moden, mener du at dette startet tidligere eller senere enn hos andre på din alder?

- ☐ Mye tidligere
- ☐ Noe tidligere
- ☐ Lite grann tidligere
- ☐ Akkurat som andre
- ☐ Lite grann senere
- ☐ Noe senere
- ☐ Mye senere

Trykkc Bjørkmanns, Alta

ISM SKRIFTSERIE - FØR UTGITT:

1. Bidrag til belysning av medisinske og sosiale forhold i Finnmark fylke, med særlig vekt på forholdene blant finskættede i Sør-Varanger kommune.
Av Anders Forsdahl, 1976. (nytt opplag 1990)

2. Sunnhetstilstanden, hygieniske og sosiale forhold i Sør-Varanger kommune 1869-1975 belyst ved medisinal-beretningene.
Av Anders Forsdahl, 1977.

3. Hjerte-karundersøkelsen i Finnmark - et eksempel på en populasjonsundersøkelse rettet mot cardiovasculære sykdommer. Beskrivelse og analyse av etterundersøkelsesgruppen.
Av Jan-Ivar Kvamme og Trond Haider, 1979.

4. D. The Tromsø Heart Study: Population studies of coronary risk factors with special emphasis on high density lipoprotein and the family occurrence of myocardial infarction.
Av Olav Helge Førde og Dag Steinar Thelle, 1979.

5. D. Reformer i distriktshelsetjenesten III: Hypertensjon i distriktshelsetjenesten.
Av Jan-Ivar Kvamme, 1980.

6. Til professor Knut Westlund på hans 60-års dag, 1983.

7.* Blodtrykksovervåkning og blodtrykksmåling.
Av Jan-Ivar Kvamme, Bernt Nesje og Anders Forsdahl, 1983.

8.* Merkesteiner i norsk medisin reist av allmennpraktikere - og enkelte utdrag av medisinalberetninger av kulturhistorisk verdi.
Av Anders Forsdahl, 1984.

9. "Balsfjordsystemet." EDB-basert journal, arkiv og statistikksystem for primærhelsetjenesten.
Av Toralf Hasvold, 1984.

10. D. Tvunget psykisk helsevern i Norge. Rettsikkerheten ved slikt helsevern med særlig vurdering av kontrollkommisjonsordningen.
Av Georg Høyer, 1986.

11. D. The use of self-administered questionnaires about food habits. Relationships with risk factors for coronary heart disease and associations between coffee drinking and mortality and cancer incidence.
Av Bjarne Koster Jacobsen, 1988.

12.* Helse og ulikhet. Vi trenger et handlingsprogram for Finnmark.
Av Anders Forsdahl, Atle Svendal, Aslak Syse og Dag Thelle, 1989.

13. D. Health education and self-care in dentistry - surveys and interventions.
Av Anne Johanne Søgaard, 1989.

14. Helsekontroller i praksis. Erfaringer fra prosjektet helsekontroller i Troms 1983-1985.
Av Harald Siem og Arild Johansen, 1989.

15. Til Anders Forsdahls 60-års dag, 1990.

16. D. Diagnosis of cancer in general practice. A study of delay problems and warning signals of cancer, with implications for public cancer information and for cancer diagnostic strategies in general practice.
Av Knut Holtedahl, 1991.

17. D. The Tromsø Survey. The family intervention study. Feasibility of using a family approach to intervention on coronary heart disease. The effect of lifestyle intervention of coronary risk factors.
Av Synnøve Fønnebø Knutsen, 1991.

18. Helhetsforståelse og kommunikasjon. Filosofi for klinikere.
Av Åge Wifstad, 1991.

19. D. Factors affecting self-evaluated general health status - and the use of professional health care services.
Av Knut Fylkesnes, 1991.

20. D. Serum gamma-glutamyltransferase: Population determinants and diagnostic characteristics in relation to intervention on risk drinkers.
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