Suicide:

A Youthline position paper

BACKGROUND

Suicide rates in New Zealand have decreased from a high in the late 1990s of 15.1 deaths per 100,000 to 12.2 deaths per 100,000 in 2006 (Ministry of Social Development, 2009). Teen suicide accounts for about 10% of these deaths. A range of factors contributing to the likelihood of suicide have been identified. Beautrais (2003) organised the risk factors for suicide into the following categories:

- *Genetic and biological factors:* A family history of suicidal behaviour increases the likelihood of a young person committing or attempting suicide (although it is not established whether this is a genetic or environmental determinant).
- *Social and demographic factors*: Social, economic and educational disadvantages predispose young people to suicidal behaviour.
- *Childhood adversity*: Factors include the separation or divorce of parents (particularly where the separation involves a lot of fighting, and the following period is marked with uncertainty and change), family violence, and sexual, physical or emotional abuse.
- *Personality characteristics*: Characteristics associated with suicidal behaviour include neuroticism, hopelessness, impulsivity, risk taking, and low self-esteem.
- *Mental health factors*: Four factors are consistently associated with suicidal behaviour: mood disorders (particularly depression), substance use, anxiety disorders, and conduct disorders or antisocial and offending behaviours.
- *Psychosocial stresses*: Factors include negative short-term life events, unemployment, and sexual orientation.

It is imperative to note that while these factors are associated with an increased risk of suicide, none of these should be considered causes of suicide. Most people who experience these risks are not suicidal. Those who are suicidal are likely to be exposed to many of these risks in addition to ongoing life difficulties and current 'triggers' or serious stressors. These factors, along with the effect of media coverage will be discussed below.

GENDER

Young women are less likely to die from suicide than their male counterparts, even though they experience a higher level of suicidal ideation and are more likely to make an attempt to end their lives. The higher rate of male suicide can be explained by their propensity to use more lethal methods to kill themselves (Ministry of Youth Affairs, Ministry of Health, & Te Puni Kokiri, 1998).

ETHNICITY

Young Maori are more likely to die from suicide. Cultural alienation and socio-economic disadvantage are seen as contributing to the higher suicide rates among Maori people (Ministry of Youth Affairs, Ministry of Health, & Te Puni Kokiri, 1998). In 2002, suicide by Maori aged 15-24 years accounted for

42% of all Māori suicides; whereas, suicide rates of the same age group among non-Maori accounted for just 16% of suicides (Beautrais & Fergusson, 2006). However, there are also protective factors for older Māori. Suicide in Māori aged over 35 years is far less common than that of young Māori. By age 60, suicide among Maori is rare – in 2002, there were no suicides in this group (Beautrais & Fergusson, 2006). Beautrais and Fergusson (2006) suggest that in Māori society, older people are generally treated with higher regard and have more important roles than is the case for non-Māori.

SEXUAL ORIENTATION

The longitudinal Christchurch Health and Development Study found that young people who identify as gay, lesbian or bi-sexual are more at risk of experiencing depression, anxiety, substance abuse issues, suicidal ideation and suicide attempts than the heterosexual population (Fergusson, Horwood, & Beautrais, 1999). A number of other studies have also indicated a link between sexual orientation, depression, and suicidal thoughts (Faulkner & Cranston, 1998; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999). This is likely to be a result of the alienation inherent in being a non-heterosexual member of a predominantly heterosexual society, where homophobic and/or hetero-sexist attitudes are commonly encountered (Kitts, 2005).

MENTAL HEALTH

The relationship between mental health difficulties and the increased risk of suicide is well documented (Beautrais, 2003; Hider, 1998; Fergusson, Woodward & Horwood, 2000). Young people who are at most risk of suicide experience mental health difficulties, especially depression and substance abuse (Hider, 1998).

Depression tends to first appear in early to mid-adolescence and commonly occurs with other psychiatric disorders. Depression may arise as a response to another disorder or precede the development of an associated condition, for example, substance abuse (Kessler & Walters 1998). Accordingly, depressive symptomology and deliberate self-harm have been shown to correlate with the balance of risk and protective factors in young people's lives (Bond, Thomas, Toumbourou, Patton, & Catalano, 2000).

The majority of adolescents experiencing a major depressive disorder will, in all probability, be struggling with other difficulties, for example, anxiety, substance abuse and/or conduct problems (Angold & Costello, 1993; Anderson & McGee, 1994). These difficulties are also risk factors for suicidal behaviour (Hider, 1998; Beautrais, 2003).

The Christchurch Health and Development Study found that the factors most likely to predict a depressive disorder can be directly related to the individual's immediate environment, i.e. family, school, and peers (Horwood & Fergusson, 1998). Childhood adversity, low socio-economic status, poor family relationships, persistent suicidal ideation, and previous suicide attempts complete the picture of those most at risk (Hider, 1998).

Protective factors that have been shown to mitigate the risks of suicidal behaviour include; having an adaptable temperament, possessing a healthy self esteem, being able to solve problems in a positive way, having social support and networks, creating a positive emotional relationship with one person in the family, positive school experiences, and for some people, having a spiritual faith (Beautrais, 2003).

Importantly, attitudes towards seeking help remain a substantial barrier to young people experiencing mental health issues such as depression. Further, it is young people with the highest levels of suicidal ideation who are the least likely to seek help (Carlton & Deane, 2000). Barriers to help-seeking behaviours can be reduced through the provision of health information via youth friendly and anonymous mediums. The World Health Organistion has identified that young people often prefer to seek help and information via brochures, the internet, and telephone helplines (Barker, 2007).

MEDIA

Suicide is a deeply sensitive subject. Despite this (or perhaps because of this) suicide is frequently commented on in the media. Media even engage in speculative discussions of suicide. For example, the death of actor Heath Ledger in early 2008 was surrounded by rumours about suicide which were broadcasted widely across the mainstream media within hours of his death. A post-mortem later revealed his death was most likely accidental. There was also recent coverage in the mainstream media about 'Bebo' (a social networking site) glamorising suicide and promoting suicide amongst young people. Further investigation suggested this was baseless (Brown, 2008).

There is evidence that media reporting on suicide can lead to misconceptions about the rate of youth suicide. Two-thirds of participants in a New Zealand study believed that youth suicide accounted for more than half of all suicides (Beautrais, Horwood, & Fergusson, 2004). In fact, teen suicide accounted for 11% of suicides in 2004, lower than the rate for people in their 20s, 30s, or 40s (Ministry of Health, 2006). More than 70% of the survey participants overestimated the number of youth suicides, with one-quarter overestimating the number as being more than ten times higher (Beautrais *et al*., 2004). Beautrais *et al.* (2004) found that most participants were primarily informed about youth suicide by the media.

The media has an influential role in forming opinions on youth suicide. Although statistics are unlikely to be misreported in the media, the focus on negative statistics (such as the youth suicide rate in New Zealand compared to that of other developed countries) suggests that rates of suicide in young people dwarf the rates in other sections of the population. This may contribute to a sense that the situation is helpless, or imply that suicide is a common solution when faced with problems.

Research indicates that some media descriptions of suicide increase the likelihood that others will commit suicide (Stack, 2002). This may contribute to the clusters of suicides that have been observed in New Zealand and elsewhere (Gould, Petrie, Kleinman, & Wallenstein, 1994). People may be more likely to identify themselves with a suicide victim if the act is seen as heroic or romantic. Identification with the victim is also enhanced if they are described as healthy or achievement focused and their suicide is

seen as out of character. Such media descriptions are dangerous – even more so if they provide details of the method used to commit suicide and the location it took place (Ministry of Health, 1998).

While media reporting guidelines for suicide are in place, they may not be sufficient. In some cases, where news reports from overseas are used, such as in the case of Heath Ledger's death noted above, guidelines are not necessarily followed. Even when guidelines are followed, reporting still emphasises youth suicide disproportionately. According to Beautrais *et al*. (2004, p.264):

> "The legacy of this history of reporting appears to have been the development of a generation of young people who believe that youth suicide in New Zealand is far more prevalent than, in fact, it is. One of the potential risks of this overestimation of youth suicide by young people is that it may result in suicide becoming 'normalized', that is, as being viewed by young people as a common and prevalent response among youth as a means of addressing life difficulties. The findings from this study suggest that there is a clear need for more balanced media reporting which conveys more accurately to young people that youth suicide in New Zealand is, in fact, an uncommon event."

SUICIDE PREVENTION

Youth suicide is an act of desperation undertaken by young people who have few protective factors to guard against adverse life-course sequences and a culmination of stressors which have been outlined above (Garlow et al., 2008).

The environment and community are fundamental in promoting the health and well being of young people because they play a significant role in the development of their lives. The risk and protective factors noted above are both individual and environmental. However, it can be argued that the individual factors, for example, personality difficulties, are developed as a result of the environment a child/young person develops within (Berk, 2000).

Environmental and community influences have the ability to reduce the risk factors for suicide and increase the protective factors. The importance of environmental and community influences have been covered more fully in another Youthline position paper: Depression – A Major Youth Health Issue. Ecological interventions are essential in promoting positive environmental influences which promote health and decrease the risk factors for suicide.

In addition, since family dynamics are often implicated in the etiology of suicidal behavior and depression, family therapy has been advocated as an appropriate method for intervening in suicidal behaviour (Spirito & Boergers, 1997). Family therapy can provide a supportive environment for the young person, as well as help the family learn how to cope and work together.

The New Zealand Suicide Prevention Strategy 2006-2016 (Associate Minister of Health, 2006) outlines a strategy for reducing and preventing suicidal behaviour. The strategy identifies seven key goals to address suicide rates across all age groups in New Zealand:

1. promote mental health and wellbeing, and prevent mental health problems
2. improve the care of people who are experiencing mental disorders associated with suicidal behaviours
3. improve the care of people who make non-fatal suicide attempts
4. reduce access to the means of suicide
5. promote the safe reporting and portrayal of suicidal behaviour by the media
6. support families/whānau, friends and others affected by a suicide or suicide attempt
7. expand the evidence about rates, causes and effective interventions

These themes seek to highlight the need to deal with environmental influences at the micro-social level i.e. individual and family, and the macro-social level i.e. government policy and media coverage. The need for early intervention with individuals and families is essential given the research, and improvements in mental health awareness, education, and treatment will reduce youth suicide. Equally important in the reduction of youth suicide are macro level changes which alleviate cultural and sexual alienation, and socioeconomic disadvantage.

STRATEGIES FOR REDUCING YOUTH SUICIDE

The Ministry of Youth Health states that "[p]rogrammes to reduce youth suicide need to work towards increasing the awareness of mental health issues among young people rather than focus directly on suicide. As well as developing self-awareness, coping skills, social skills and problem solving skills, young people should be encouraged to recognize mental health problems in themselves and others and know where to get help" (Barwick, 2004, p.8).

Youthline facilitates a number of youth development programmes which embrace the suggested themes outlined above. A more complete description of Youthline's youth development philosophy is given in its position paper: Depression – A Major Youth Health Issue. These programmes complement a range of other services offered by Youthline which deal with the factors thought to increase protection and decrease the risk for suicide. The services and programmes offered by Youthline encapsulate the themes outlined in the New Zealand Youth Suicide Prevention Strategy: 2006 – 2016 (2006), and provide a whole-health youth development approach to dealing with youth mental health concerns.

EFFECTIVENESS OF PARAPROFESSIONAL TELEPHONE COUNSELLING FOR DEPRESSION

In order to evaluate the effectiveness of telephone interventions undertaken by trained but unqualified volunteers, two broad categories of research must be considered. Firstly, we must examine the evidence for the use of non-professionals in the treatment of common issues such as depression. Secondly, we must examine how effective telephone-based counselling is for issues such as depression and suicidal behaviour.

A recent Cochrane review examined how well anxiety and depression can be treated by paraprofessionals – those workers in the mental health sector who hold no qualification in psychological treatment, but treat patients in lieu of professional treatment (den Boer, Wiersma, Russo, & van den Bosch, 2005). The review looked at studies comparing paraprofessional treatment with no treatment (waiting list or placebo) as well as studies comparing paraprofessional treatment with professional treatment. Five studies for each were used. Paraprofessionals were found to be effective at treating patients, and paraprofessional treatment was substantially better than no treatment ($OR=0.30$, $p<0.00001$). Treatment from paraprofessionals was not found to be significantly different to that of professionals ($p=0.63$). However, the authors state that not enough data was available to draw any firm comparisons between professionals and paraprofessionals (den Boer, Wiersma, Russo, & van den Bosch, 2005).

Mishara and Daigle (1997) found that different telephone intervention styles had differential effects on outcomes for suicidal callers. Previous studies have collectively reported mixed results, ranging from positive outcomes to no effect in suicidal populations (Mishara & Daigle, 2001). This may reflect the variety of approaches used by different centres. This provides a clear impetus for telephone interventions to follow approaches shown to be effective. Mishara and Daigle (1997) state the most effective telephone style for non-chronic callers is Rogerian active-listening. This non-directive approach may complement more direct questioning which can be used to establish the risk of the caller. In their study, the use of non-directive responses was significantly related to decreases in depressive mood for callers (Mishara & Daigle, 1997).

Mishara et al. (2007) elaborated on the effectiveness of telephone counselling, stating that empathy and respect are important aspects of helping behaviour. In a study investigating helper behaviours and intervention styles, helpers rated as having low empathy had an average of five times the number of callers hang-up on them compared to those rated with high empathy (Mishara et al., 2007). Collaborative problem solving was also a successful technique, although this was secondary to having a supportive attitude. Overall, a mixed model of directive and non-directive approaches was best. Although this general conclusion is similar to the findings of Mishara and Daigle (1997), Mishara et al. (2007) did not find active listening alone to be a successful approach.

In Australia, an evaluation of suicidal calls to a helpline for young people demonstrated that phone counselling significantly improved the immediate mental state of callers (King, Nurcombe, Bickman, Hides, & Reid, 2003). For the study, 100 calls were recorded and independent raters judged the suicidality and mental state of the callers at the beginning and end of the calls. No medium- or long-term impact of calls could be evaluated as calls were anonymous. While these findings do not demonstrate a lasting effect or an improvement over the course of a series of calls, it does indicate that phone counselling warrants further detailed exploration in terms of its effectiveness.

Little investigation has been undertaken to understand how chronic callers differ from acute callers in terms of their needs, nor responses to conventionally useful techniques. Lester and Brockopp (1970)

found that a small (n=24) sample of chronic callers shared general characteristics with other callers. They offered a range of possible directions for managing long-term callers, including limiting the length and number of calls and developing individualised plans. Barmann (1980) identified two goals in managing chronic callers: reducing the frequency of calls such callers make, and getting callers to be more specific about their issues. However, it remains unclear whether there are differences between chronic and acute callers which can be generalised. Hence, a lack of specificity may contribute to some chronic callers not having their needs met. It is possible that other chronic caller's primary purpose for calling may be contact.

YOUTHLINE SERVICES

The relevant services offered by Youthline:

- Information on services, including health, mental health, education and youth-related issues via the Urge/Whakamanawa website, http://www.urge.co.nz.
- Advice, information and crisis counselling via its 24/7 youth helpline.
- E-mail counselling and text message support.
- Individual, face-to-face counselling.
- Family therapy.
- Alternative education for young people excluded from mainstream education.
- Youth advocacy.
- A youth transition service for young people leaving school heading into further training or work.
- Increasing awareness and community involvement in youth related issues.
- Advice and support to schools, social service agencies and the media on youth-related issues.

YOUTHLINE'S POSITION

Youthline takes the position that:

1. Community awareness and community involvement in youth related issues, especially those which relate to youth development, should be increased, and agencies charged with this task should be adequately funded and resourced.

2. Media must understand the role that reporting has in influencing suicidal behaviour and treat the subject with great sensitivity. Suicide reporting should be approached from an evidence-based perspective of minimising risks of further suicidal behaviour.

3. Barriers to help-seeking behaviours can be reduced through the provision of health information via a youth friendly medium, for example, internet and e-mail services.

4. Suicide cannot be separated from other issues, and the focus of treatment should embrace a whole-health approach that is developmental and ecological. Youth development programmes underpin such an approach.

5. Depression is an important suicide risk factor and programmes dealing with the treatment of this disorder should be accessible and available to young people.

6. Family therapy is a key early intervention approach in the prevention of youth suicide.

7. Telephone services contribute effectively to suicide prevention when helpers follow good practices. Such practices involve an empathetic approach and a mix of directive and non-directive support, for example collaborative problem-solving and active listening.

BIBLIOGRAPHY

Anderson, J. C., & McGee, R. (1994). *Handbook of Depression in Children and Adolescents*. New York: Plenum Press.

Angold, A., & Costello, E. J. (1993). Depressive comorbidity in children and adolescents: empirical and methodological issues. *American Journal of Psychiatry, 150*, 1779-1791.

Associate Minister of Health. (2006). *The New Zealand Suicide Prevention Strategy 2006–2016.* Wellington: Ministry of Health.

Barker, G. (2007). *Adolescents, Social Support, and Help-Seeking Behaviour: An International Literature Review and Programme Consultation with Recommendations for Action.* Geneva: World Health Organistion.

Barmann, B. C. (1980). Therapeutic management of chronic callers to a suicide prevention center. *Journal of Community Psychology, 8,* 45-48.

Barwick, H. (2004). *Young Males: Strengths-Based and Male-Focused Approaches. A Review of the Research and Best Evidence*. Wellington: Ministry of Youth Development.

Beautrais, A. (2003). Suicide in New Zealand II: a review of risk factors and prevention. *Journal of the New Zealand Medical Association, 116,* 1175.

Beautrais, A. L., Horwood, L. J., & Fergusson, D. M. (2004). Knowledge and attitudes about suicide in 25-year-olds. *Australian and New Zealand Journal of Psychiatry, 38*, 260-265.

Beautrais, A. L., & Fergusson, D. M. (2006). Indigenous suicide in New Zealand. *Archives of Suicide Research, 10*, 159-168.

Berk, S. (2000). *Mood Disorders in Children and Adolescents: Depression and Bipolar Disorders*. Farmington, CT: University of Connecticut, Health Centre.

Bond, L., Thomas, L., Toumbourou, J., Patton, G., & Catalano, R. (2000). *Improving the Lives of Young Victorians in Our Community: A Survey of Risk and Protective Factors*. Melbourne: Centre for Adolescent Health.

Brown, R. (2008). *Panic*. Retrieved 27 February 2008, http://www.publicaddress.net/default,4775.sm

Carlton, P. A., & Deane, F. P. (2000). Impact of attitudes and suicidal ideation on adolescents' intentions to seek professional psychological help. *Journal of Adolescence, 23*, 35-45.

den Boer, P. C. A. M., Wiersma, D., Russo, S., van den Bosch, R. J. (2005). Paraprofessionals for anxiety and depressive disorders (Review). *Cochrane Database of Systematic Reviews*.

Faulkner, A.H., & Cranston, K. (1998). Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students. *American Journal of Public Health, 88*, 262–266.

Fergusson, D. M., Horwood, L. J. & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56*, 876–80.

Fergusson, D. M., Woodward, L. J., Horwood, L. J. (2000). Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early adulthood. *Psychological Medicine, 30*, 23–39.

Garafalo, R., Wolf, R. C., Kessel, S., Palfrey, J., & DuRant, R. H. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics, 101*, 895-902.

Garafalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine, 153*, 487-493.

Garlow, S. J., Rosenberg, J., Moore, J. D., Haas, A. P., Koestner, B., Hendin, H., & Nemeroff, C. B. (2008). Depression, desperation, and suicidal ideation in college students: results from the American Foundation for Suicide Prevention college screening project at Emory University. *Depression and Anxiety, 25,* 482-488.

Gould, M.S., Petrie, K., Kleinman, M.H., & Wallenstein, S. (1994). Clustering of attempted suicide: New Zealand national data. *International Epidemiological Association, 23*, 1185-1189.

Hider, P. (1998). *Youth Suicide Prevention by Primary Healthcare Professionals: A Critical Appraisal of the Literature.* Christchurch: New Zealand Health Technology Assessment Clearing House.

Horwood, L. J., & Fergusson, D. M. (1998). *Psychiatric Disorder and Treatment Seeking in a Birth Cohort of Young Adults.* Wellington: Ministry of Health.

Kessler, R. C., & Walters, E. E. (1998). Epidemiology of DSM-III-R major depression and minor depression among adolescents and young adults in the national comorbidity survey. *Depression and Anxiety, 7*, 3-14.

King, R., Nurcombe, B., Bickman, L., Hides, L., & Reid, W. (2003). Telephone counselling for adolescent suicide prevention: changes in suicidality and mental state from beginning to end of a counselling session. *Suicide and Life-Threatening Behaviour, 33,* 400-411.

Kitts, R. L. (2005). Gay adolescents and suicide: understanding the association. *Adolescence, 40,* 621-628.

Lester, D., & Brockopp, G. W. (1970). Chronic callers to a suicide prevention center. *Community Mental Health Journal, 6,* 246-250.

Mishara, B. L., & Daigle, M. S. (1997). Effects of different telephone intervention styles with suicidal callers at two suicide prevention centers: an empirical investigation. *American Journal of Community Psychology, 25,* 861-885.

Mishara, B. L., & Daigle, M. S. (2001). Helplines and crisis intervention services: challenges for the future. In D. Lester (Ed.). *Suicide Prevention: Resources for the Future (*pp. 153-172). Philadelphia: Brunner-Routledge.

Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., Raymond, S., Marcoux, I. ... & Berman, A. (2007). Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? Results from a silent monitoring study of calls to the U.S. 1-800-SUICIDE Network. *Suicide and Life-Threatening Behavior, 37,* 308-321.

Ministry of Health. (2006). *The New Zealand Suicide Prevention Strategy 2006–2016.* Wellington: Ministry of Health.

Ministry of Health. (2006). *Suicide Facts: 2004–2005 Data*. Wellington: Ministry of Health.

Ministry of Health. (2007). *Suicide Facts: 2005–2006 Data*. Wellington: Ministry of Health.

Ministry of Social Development. (2009). *The Social Report 2009: te purongo oranga tangata.* Wellington: Ministry of Social Development.

Ministry of Youth Affairs, Ministry of Health, Te Puni Kokiri. (1998). *In Our Hands: The New Zealand Youth Suicide Prevention Strategy*. Wellington: Ministry of Health.

Stack, S. (2002). Media coverage as a risk factor in suicide. *Injury Prevention, 8,* iv30-iv32.

Spirito, A., & Boergers, J. (1997). Family therapy techniques with adolescent suicide attempters. *Crisis: The Journal of Crisis Intervention and Suicide Prevention 18,* 106-109.