Spirituality and Religion in Youth Suicide Attempters' Trajectories of Mental Health Service Utilization: The Year before a Suicide Attempt

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Abstract

Objective: Youth suicide attempters are high-risk for suicide. Many have untreated mental disorders and are not receiving services. It is crucial to understand potential influences associated with service use. Spirituality/religion are one influence in youths' mental health service trajectories. This study explored youths' experiences of spirituality/religion as it relates to their help-seeking the year before their suicide attempt. **Method:** Fifteen youth (aged 14-18) who made a suicide attempt(s) one to two years prior were consecutively recruited through the Depressive Disorders Program of a psychiatric hospital and interviewed using a mixed-methods design, including an adapted psychological autopsy method. **Results:** Three themes emerged: religious community members acted as a bridge, step, or provider to mental health services; religious/spiritual discourses were encountered within services; and many youths reported changes in spirituality/religious beliefs the year before their suicide attempt. **Conclusions:** Spirituality/religion can have a role in these youths' service trajectories. How this confers protection or challenges needs to be clarified. Our findings can inform policies supporting training religious leaders about suicide intervention to foster coordination with mental health services, and service-providers in judiciously approaching spiritual/religious themes in suicide prevention.

Key words: spirituality/religion, youth suicide attempt, mental health services, qualitative

Résumé

Objectif: Les adolescents qui ont fait une tentative de suicide sont à risque élevé de suicide. Bon nombre d'entre eux souffrent de troubles mentaux non traités et ne reçoivent pas de services. Il est crucial de comprendre les influences potentielles associées à l'utilisation des services. La spiritualité ou la religion est une de ces influences sur la trajectoire de services de santé mentale des adolescents. Cette étude porte sur les expériences spirituelles ou religieuses des adolescents relativement à leur recherche d'aide pendant l'année qui a précédé leur tentative de suicide. **Méthodologie:** Quinze adolescents (âgés de 14 à 18 ans) qui avaient fait une ou plusieurs tentatives de suicide dans l'année ou les deux années précédentes ont été recrutés consécutivement dans un programme des troubles dépressifs d'un hôpital psychiatrique. Ils ont été interrogés au moyen d'une méthode mixte qui incluait une méthode d'autopsie psychologique adaptée. **Résultats:** Trois thèmes sont ressortis: la communauté religieuse servait de pont, d'étape ou de tremplin aux services de santé mentale; les thèmes religieux ou spirituels étaient présents dans les services; et de nombreux adolescents ont signalé des changements dans leurs croyances spirituelles ou religieuses l'année qui a précédé leur tentative de suicide. **Conclusion:** La spiritualité ou la religion peut jouer un rôle dans la trajectoire d'utilisation des services des adolescents suicidaires. Il convient de clarifier la manière dont cette pratique protège ou constitue un obstacle. Ces constatations peuvent servir à définir les règles de formation des leaders religieux qui interviennent avec les adolescents suicidaires, pour favoriser la coopération avec les services de santé mentale, ainsi que la formation des fournisseurs de services à aborder judicieusement les thèmes spirituels ou religieux dans leurs interventions axées sur la prévention du suicide.

Mots clés: spiritualité, religion, tentative de suicide chez les adolescents, services de santé mentale, étude qualitative

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Introduction

Suicide is a major public health concern and, although recently the completed suicide rates in Quebec have decreased, Quebec's rate is still one of the highest in Canada (Gagné, Légaré, Perron, & St-Laurent, 2011). Suicide is the 2nd leading cause of youths' deaths worldwide with rates increasing in many countries (World Health Organization, 2011). Amongst Canadian age groups, youth (aged 15-24) have the highest suicide attempt rates (Statistique Canada, 2005). Moreover, a suicide attempt increases the likelihood that youth will complete suicide by 30 times in boys, and 20 times in girls (American Academy of Child and Adolescent Psychiatry (AACAP), 2001).

A recent Quebec study found 65.5% of youth suicide completers (aged 11-18) contacted their general practitioner (GP) the year before their suicide but only 36.4% of these youth saw their GP for psychiatric reasons and 23.6% saw a psychiatrist (Renaud et al., 2009). The many untreated mental disorders make it urgent to better understand potential influences associated with service use amongst youth. Spirituality/religion are one influence in all stages of youths' mental health service trajectories (Koenig, McCullough, & Larson, 2001).

Religion can influence youths' actual need, perceived need and/or benefit, access, availability, and motivation to seek mental health services (Koenig et al., 2001). Deciding to receive services is rarely made alone, but affected by their parents, peers, teachers, the police, and/or community groups including religious ones (Wu, Katic, Liu, Fan, & Fuller, 2010). In specific ethnic groups, religion has been found to be a gateway to healing (Ellis et al., 2010), and religious leaders act as a bridge, provider, or "barrier" to mental health care (Neighbors, Musick, & Williams, 1998). *Religion* is here understood as an organized system of beliefs, rituals, practices, rooted in an established tradition oriented towards the numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or Reality; whereas *spirituality* refers to personal experiences of, or search for ultimate reality/the transcendent that are not necessarily institutionally connected (Dew et al., 2010).

Religiosity has been shown to be associated with lower levels of aggression and hostility, drug use, and risky sexual activity, which are related to suicidal behavior (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar, 2006; Gearing & Lizardi, 2009; Renaud, Berlim, McGirr, Tousignant, & Turecki, 2008). In a prospective study with depressed youth, Dew and colleagues (2010) argued for a more complex understanding of the relationship between depression and religiousness, finding not all religious beliefs and experiences corresponding with better mental health. Research suggests that only certain aspects of religiosity/spirituality (e.g., importance of religion, sense of connectedness) might be associated with suicidal behaviour (Colucci & Martin, 2008). Research regarding religion/spirituality in youth, requires more exploratory studies to further this understanding (Cotton et al., 2006).

This paper presents a study whose objective is to understand the role of spirituality/religion in youth suicide attempters' trajectories of mental health service utilization, the year before their suicide attempt (the index period).

Methods

This study is a mixed-methods part of an ongoing psychological autopsy study examining the service trajectories of youth suicide attempters. This study adopted the same recruitment site/strategies: youths were consecutively recruited from the Depressive Disorders Program of the Douglas Mental Health University Institute (DMHUI) where they had been referred for services. Fifteen out of 16 youths approached about the study agreed to participate (a 94% response rate). Audio-recorded interviews using open-ended questions and one questionnaire with youths (aged 14-18) having made a suicide attempt (a potentially self-injurious act committed with at least some wish to die, as a result of act) (Oquendo, Halberstam, & Mann, 2003), one to two years before the interview, were conducted between November 2009 and September 2010. Interviews conducted by the first author (English interviews) and a research assistant (French interviews) took thirty minutes of the psychological autopsy study three-hour interview at the DMHUI. Youths were predominantly female, alike usual sampling in such studies where females are overrepresented in suicide attempts and seeking services (Renaud et al., 2009). Written informed consent was obtained from both youth and parents. The Douglas Research Ethics Board approved this study.

The semi-structured interview on spirituality/religion consisted of nine questions developed for the study. Questions regarding the youths' definition(s) of spirituality/religion and their integration within a spiritual or religious community were adapted from Maugans' (1996) SPIRITual History. Most questions were retrospective, focusing on the index period to explore the role spirituality/religion had in the youths' trajectories of mental health service utilization (Appendix).

The verbatim transcripts were entered into ATLAS.ti 6, a qualitative software program (Muhr, 2011). They were analyzed using inductive thematic analysis (where codes are derived from data) at the semantic level of explicit meanings (Braun & Clarke, 2006). After coding transcripts, within- and cross-case analyses were conducted (Yin, 1981). The authors reviewed the original transcripts ensuring multiple coding. Themes related to the research aim provided the main codes. Emerging themes were taken into account to complement these themes and retain a nuanced description of the youths' experiences.

Table 1 Socio-demographic and clinical characteristics of youths		
Characteristic	N	%
Female	13	87
Male	2	13
Number of suicide attempts (SAs)		
Index SA only	9	60
One + index attempt	2	13
Two + index attempt	2	13
Three + index attempt	2	13
Age at index SA (mean ± SD) (years)	15.2 ± 1.4	
Time of interview after index SA (mean ± SD) (months)	11.4 ± 9.3	
Psychopathology		
Axis I (index period)[a]		
Depressive disorder	8	53
Attention-deficit/hyperactivity disorder	2	13
Conduct disorder	3	20
Generalized anxiety disorder	1	7
Adjustment disorder	3	20
Bulimia nervosa	1	7
Alcohol abuse	3	20
Cannabis abuse	4	27
No diagnosis	0	0
Axis II personality disorder		
Cluster A	0	0
Cluster B	5	33
Cluster C	0	0
No pathological traits	10	67
Family religious background (according to youth)[b]		
Catholic	8	53
Protestant	2	13
Orthodox	1	7
Jewish	1	7
Hindu	1	7
Aboriginal spirituality	1	7
Mixed religions (2 religions)	2	13
Mixed non-religious and religious[c]	4	27
None	3	20

[a] Many youth had >1 diagnosis so N will not add to 15

[b] The totals will not add to 15 because of category overlap

[c] Where one parent has religious beliefs/practices and the other doesn't

The Spirituality Scale (SS) (Delaney, 2005; Labelle, Breton, Berthiaume, Royer, & St-Georges, 2008) measuring non-religious spirituality (reliability: 0.95 Cronbach's alpha coefficient); cumulative variance of subscales: 57%), was used (referring to the index period) to contrast with the qualitative data collected, providing a comprehensive understanding of the youths' experiences. This scale is a holistic assessment instrument focusing on beliefs, intuitions, lifestyle choices and practices that represent the human spiritual dimension.

Description of the sample (Table 1) was provided through: (1) The Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (Kaufman, Birmaher, Brent, Rao, & Ryan, 1996) and the Structured Clinical Interview for DSM-IV Axis II (SCID II) (First, Spitzer, Gibbon, Williams, & Benjamin, 1996; First,

Gibbon, & Spitzer, 2001) for retrospective psychopathology (these instruments demonstrate adequate to excellent reliability (0.77 to 0.94 kappa value) (Kaufman et al., 1997; Lobbestael, Leurgans, & Arntz, 2011)); and, (2) the psychological autopsy study for suicide attempt history, socio-demographics, and the mixed-methods component.

Half of the youth had a current depressive disorder in the index period, one-third met criteria for a Cluster B personality disorder; 60% had one lifetime suicide attempt, 40% had multiple attempts. Youths were predominantly Euro-Canadian and from Christian (Catholic, Protestant, or Orthodox) backgrounds. All were Canadian with heterogeneous ethnicities (i.e. mixed European, Aboriginal). One youth was a 2nd generation migrant (no new migrants).

Results

Three themes emerged from analysis:

1. religious community members' role in youths' trajectories;
2. religious/spiritual discourses within services; and,
3. changes in spirituality/religious beliefs during the index period.

Quantitative results from the SS will be corroborated specifically with the third theme.

Religious Community Members' Role in Youths' Trajectories

Some youths had contact with religious community members outside mental health services. Data showed, for these youths, religious community members acted as a bridge, step, or care provider to mental health services.

Bridge

"…there's a woman at the church who is a psychologist and I went to her 'cause I knew she was like that and so I-I talked to her like once or twice and then she recommended like 'go to [a psychiatric hospital]' so actually it really did help me out a lot and so she gave me like an 'in' sort of thing."

The quote highlights how religious community members can be a bridge for youths to receive services, especially if they know members with mental health expertise.

Step

Religious community members with mental health expertise can also act as a step along the way to using mental health services. Youths might not seek services because they are being cared for within their religious community. However, if youths' needs are not completely fulfilled by this care, it may act as a step before mental health services.

"…My whole life, like if ever I had a problem or I was sad it was always a Christian person that I went to see. And I was like, I want to see a *real* person who will underst- who

knows about this so yeah. Then I was like 'kay get me a real therapist'."

The results suggest various factors explaining why youths may view this expertise/care as not meeting their needs: the compatibility between youths and their therapists; the therapeutic setting (religious); and, the role-conflict of family friends and therapists (see quote under Care Provider).

Care Provider

The previous theme suggests religious community members can act as mental health care providers. Care received from members of religious communities coincided with, and was perhaps an adjunct to, mental health services.

"…like if you had a problem like she [the Church youth leader] would come in and bring you out, bring you out for coffee or whatever. […] whenever anything happens y'know she knows right away. So she'll come pick you up after school and bring you out for coffee."

This support can be perceived as accessible and youths' impressions might be that it's cheaper (in Quebec, provincial hospital/community based psychiatric and mental health services are free, private mental health services are not):

"Well they [parents] didn't want to pay. I mean that's understandable they don't have the money for me to talk for an hour so, like the only reason that people who are Christian would do it for free is because they know us."

Religious/Spiritual Discourses in Services

The results show youths may be in contact with religious/spiritual discourses within mental health services at various stages of their trajectory. This was reported with a variety of providers within mental health services: an orderly, their clinician, group home staff, sometimes on multiple occasions.

"I've been in the hospitals and I've had sitters [orderlies] like say like 'Oh yeah you need a Bible and stuff' and I'll get really offended…Like if, if I thought I needed one y'know I would have one…In my group home the people were really really Christian. They wanted me to go to church in the morning with them and stuff…And they would talk a lot about the Bible and stuff and it was just like…"

Results suggest that religion/spirituality are sensitive topics during therapy, yet important:

"Umm, well I remember the psychologist I was seeing at the time umm sometimes went back to like a more Christian theme kind of thing and he talked about his own spirituality and then asked me about mine and how it related to Christianity but and that pretty much annoyed me…[…] it made me feel kind've uncomfortable […] I think that actually discussing spirituality with kids is really important and I-I remember um like the psychologist he'd, he'd kind've barely talked about it he more talked about like God in general and he didn't really talked about what I thought of, …I

think it's important for kids to talk about what they believe in because if they don't believe in anything then that tends to mean that they're kind've a little bitter or angry or it's kind've maybe a sign that something's going and if they do have beliefs then maybe try to work with that y'know?"

Changes in Spirituality/Religious Beliefs during Index Period

The SS showed a trend towards the "very low" to "low spirituality" cut-off ranges (Table 2). This data fits with the interviews. Youths attributed their low spirituality/religion to their mental health and major losses:

"…I believed in it, but at the same time it wasn't really a care I had and especially after my dad passed and I lost my house, it, I started to question everything."

"No I wasn't really in tune with anything at that time. I used to when I was younger, and ever since I got depressed and all."

"It's not more so that the religion affected it, it was more the mental health affected the religion aspect of my life it's that I just wanted to avoid everything and push it out of my life and so it's pretty much just the opposite way."

Exceptions were:

"Yes, I was going to church, I was singing in the choir, Sunday if I didn't want to I didn't go to Mass, but my spirituality was there."

This highlights that some youths participated in public religious practices. Another youth had participated in religious practices despite their reluctance (indicative of the developmental tension between the youth and their parents as they navigate their own views on spirituality/religion). Yet, this same youth highlighted retrospectively the importance of spirituality (as per their definition) in the index period:

"Well spirituality, what I believe it is now, was always important to me. Like your soul like you. But like I've never well, I used to have to go to church, but I hated it. Umm so. Yeah no religion. But spirituality I guess you could say so."

Another youth denied having a spirituality that was important in the index period, but they had core beliefs about human nature:

"…well it wasn't like a spirituality it was more like a basis? That everyone was created good? Like and people were inherently good and that the evil things that happen were like were by people who just weren't right y'know what I mean? Like no sane people could do that but as far as God went I was kind've just pushing that away at the time. "

Another had a period of religious exploration in the index period:

"…I already had like a religious 'trip', Catholic, because I thought I was trying to find answers to my questions, in the end it didn't answer my questions."

Table 2. Spirituality Scale (SS) total scores distribution of 14 youths[a]		
Variable	N	%
SS-23 items (Mean ± SD points)	71±15.2, range 47 to 99	
SS cut-off range[b]		
23-60, very low spirituality	4	29
61-91, low spirituality	9	64
92-117, moderate spirituality	1	7
118-138, high levels of spirituality	0	0
[a] Missing data for 1 youth [b] Used by Delaney (2005)		

Discussion

Our study results point to the potential role of spiritual or religious aspects in mental health service trajectories the year before a youth's suicide attempt (the index period). Religious community members may have key roles for some youths' trajectories, as a bridge as well as an adjunct to mental health services. Regardless of where youths stood in their spiritual/religious beliefs and practices, some encountered religious community members on their own initiative, others because of their parents. And for some, mental health services might not have been considered an option by youths or their parents during the index period.

The contributions of religious community members do not mean their actions are embedded in religious discourses, but demonstrate the importance of belonging for many families. Parents and members of religious communities acted as gatekeepers to mental health care. The results offer an opportunity to understand how different roles of religious community members may be found within a clinical youth suicide attempter sample. Suicide prevention efforts should include, when appropriate, an increase in collaboration with religious communities as they are potentially a resource where people will seek mental health support. This can include consulting with religious leaders, showing openness to complementary care between religious/spiritual and mental health care, as well as educating religious leaders/ members of spiritual communities about suicide warning signs to foster referrals from such communities. Religious communities may offer surveillance and detection of mental health problems in addition to integrative and regulative aspects (Koenig et al., 2001; Pescosolido & Georgianna, 1989).

Quebec is unique to the rest of Canada as the only province where the Roman Catholic religion was historically so influential (Groleau, Whitley, Lespérance, & Kirmayer, 2010). During the 1960s and 1970s formal Roman Catholic religious practices and church attendance dropped significantly in Quebec. This Church also lost much of its influence in

hospitals, schools, politics, government and social services with secularization (Corin & Harnois, 1991; Groleau et al., 2010). Yet, religious/spiritual sensibilities may endure in apparently "secular populations" once characterized by intense religiosity, and whose identity was linked to religious affiliation (e.g. Quebec) (Groleau et al., 2010).

Accounts from the youth of the topic of religion, in various stages of their trajectories within mental health services, contrast with the Quebec context of the secularization of health services (Clark & Schellenberg, 2006; Corin & Harnois, 1991; Groleau et al., 2010), and the observed low religiousness of Canadian health professionals (Baetz, Griffin, Bowen, & Marcoux, 2004). Without taking youths' own religious beliefs and practices into consideration, it is difficult to ascertain how overt expressions of religion will be received. Responses may range from reassurance and support to indifference and discomfort. Spirituality/religion, as one aspect of culture, is a frame that gives meaning (about life and death). To uncover reasons for living, including religious beliefs, is crucial in suicide prevention (American Psychiatric Association (APA), 1990). As adolescence may be a sensitive developmental period for spiritual/religious development (Good & Willoughby, 2008), clinicians might consider exploring these issues, but maintain a balanced stance in order to avoid the imposition of their values (APA, 1990). Spirituality/religion are not inherently positive or negative: one must clarify their meaning for youths and the role they take within their relationship to significant people (parents and others) to understand their potential protective aspects as well as any associated challenges (AACAP, 2001).

Youths reported different levels of spirituality/religion in the index period: e.g. some engaged in religious practice, a period of religious questioning, and endorsing spirituality but not religion for that time period; some attributed a decline in their spirituality/religiosity to the presence of symptomatology (Colucci & Martin, 2008). It needs to be put in perspective with the presence of depressive disorder, substance abuse, impulsive traits, number of suicide attempts, as well as social support and family discord (Dew et al., 2010). The themes highlight the complexity of this area and these youths' diverse experiences.

This study has limitations:

1. it is based on accounts from youths' perspectives only. Parents', service providers', and members of religious communities' views would provide a more comprehensive picture; and,

2. this clinical sample cannot be generalized to a community sample.

Conclusion

Despite the sensitivity of this topic and the youths' mental health challenges, the suicide attempters willingly talked about their experience with spirituality/religion in the year before their suicide attempt, evoking spirituality/religion's role in their service trajectories.

Spirituality/religion are sensitive yet important themes, and the exploration of these themes needs to be timely and judicious to allow the youths' expression of these topics. Research needs to be conducted to further explore contexts and trajectories in which spirituality/religion bring protection or vulnerability for youth suicide attempters, age effects, and changes in youths' spirituality/religion following a suicide attempt. This could include grounded theory methodology.

Our findings can inform policies supporting training religious leaders about suicide crisis intervention to foster coordination with mental health services, and care providers in how to approach spiritual/religious themes in suicide prevention.

Acknowledgements / Conflicts of Interest

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Appendix: Semi-structured interview guide*

1) What does "spirituality" mean for you? What does "religion" mean for you?

2) a) In the year prior to your gesture (SUICIDE ATTEMPT), was any spirituality or religion important for you? (Y/N)
   (After this question will use only spiritual beliefs or religion according to the word used by the youth).

   b) Has it been this way since you were born? (Y/N) (**to elicit question around conversion)** (If NO) When did this change? *(Note whether it was within the year prior to the suicide attempt).*

   c) Is there anyone around you for whom it (referring to spirituality or religion) is important? (Y/N) Who is this person?

3) a) In the year prior to your gesture (SUICIDE ATTEMPT), did you belong to any spiritual or religious group or community? (Y/N)

   b) Has it been this way since you were born? (Y/N) (**to elicit question around conversion)** (If NO) When did this change?
   (Note whether it was within the year prior to the suicide attempt).

   If YES to Question #2a, proceed to Q#3 a)

   If NO to Question #2a, proceed to Q#3 b)

4 a) Did this group or community, provide help or advice in dealing with mental health issues? (Y/N)
   What was their opinion about receiving mental health services?
   Did this affect your attitude about mental health services? (Y/N)
   Did it impact your willingness to use services? (Y/N)

   b) Did your spirituality or religion provide guidance in dealing with mental health issues? (Y/N)
   What was your opinion about receiving mental health services?
   Did your spirituality or religion affect your attitude about mental health services? (Y/N)
   Did it impact your willingness to use services? (Y/N)

5) Is any spirituality or religion important to your parents? (Y/N)

   (If YES) Do you believe in the same spirituality or religion as your parent(s)? (Y/N)

   (If NO), Did this bring about any difficulties? (i.e. Did it impact your willingness to share what's bothering you with your parents? Did it impact your desire to use services?) (Y/N)

6) In the year prior to your gesture (SUICIDE ATTEMPT) were there elements of the services you received that were contrary to your spiritual or religious beliefs? (Y/N)

7) In the year prior to your gesture (SUICIDE ATTEMPT), were you in contact with anybody linked to *your* spirituality or religion for help? (Y/N)

   (If YES) What happened?

8) In the year prior to your gesture (SUICIDE ATTEMPT), were you in contact with anybody linked to *your parent's* spirituality or religion for help? (Y/N)

   (If YES) What happened?

9) Are there any aspects of your spirituality/religion that you would like *healthcare providers/the system/mental health services* to keep in mind as they care for you? (Y/N) (If YES), what are they?

Also available in French