WORKING WITH DISTRESSED ADOLESCENTS AND PROFESSIONAL INTERVENTION

Adolescent Suicide and Professional Response in New Zealand

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ABTSRACT

This thesis shows in the first part an analysis about the reasons why in particular adolescents are vulnerable for suicidal and self-destructive behaviour. It also shows what helping possibilities, prevention and intervention ideas can be found. This review of international and national literature about adolescence, suicide and prevention creates the theoretical framework for the research project. It shows that the youth suicide rate in New Zealand ranges amongst the highest of many OECD countries. During the past few years much research on risk factors and possible prevention strategies has been undertaken. Mental health problems, antisocial behaviour, problems with the family, at schools or with peers and low self-esteem have been identified by many studies as risk factors for teenage suicidality. As a responsem, the Ministry of Health, the Ministry of Youth Affairs as well as Te Puni Kokiri pushed further research and projects forward to investigate recommendations for projects and services to support young people and to reduce risk factors for suicidality.

Based on this literature review the qualitative research of this thesis explores a developmental group (N.E.X.T) of a non-governmental youth-oriented organisation (Youthline) as one way of supporting adolescents concerning a healthy development into adults by strengthening them, improving their self-esteem and reducing the risk for untreated mental health problems. These are all factors identified within the literature review as risk factors for suicidality. By this example the thesis shows what the needs of teenagers are, whether an organisation like Youthline can meet these needs and which skills professionals at Youthline therefore need to have. It further explores whether the theoretical prevention ideas can be realised within a service like Youthline and what limitations can be found.

Findings of the research suggest that most of the adolescent participants involved have really enjoyed the group and almost all of them realised significant changes in their behaviour, attitude, especially their own self-esteem, which can be understood as a

protection factor against suicidality. That the statements of the professionals further fit perfectly together with the teenager's statements suggests a good basis for real youth-oriented assistance which has the potential to strengthen young people in New Zealand and therefore reduce risk factors for suicidality.

The thesis concludes with recommendations for policy and future research, especially concerning the funding of social services.

Dedicated to the Memory of my Cousin

Sveni

who killed himself during the writing of this thesis
and therewith gave this thesis
a very personal meaning.

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When I turn out the light
and go to bed
I lie hoping for a new and better tomorrow.
But thoughts of reality creep from the shadows
in which I try to keep them hidden
during the brightness of my days.
They tell me there are no promises, no guarantees
and no assurance.
There is emptiness, loneliness, fear,
guilt, shame.
And I allow no tears, though they do want me.
Tomorrow is new
but will it bring peace and laughter and acceptance?
I will get lost in tomorrow,
like today, like yesterday.
I will cry where no one can see – inside.
And drown a little more beneath those tears.
I will hold them tightly and safely,
and will not let them go
like I wish someone would do to me.
- Tanya (a teenager)
(adapted from a longer poem).
(Crook, 1997: 108)

Introduction

Distressed adolescents, especially suicidal adolescents, are a problem, an especially tragic one, as young people have so much ahead of them, could experience so many adventures, which life provides if they gave themselves a chance. Working with these teenagers is a challenging very necessary task. Young people are the future of a society, their well-being and successful dealing with life tasks is an important basis for the surviving of a society as well as it is a moral task for all of us to provide an environment, in which young people feel good.

Intervention and prevention programmes can help save lives and knowledge about adolescence and about suicide in general provide the best guide for those who live or work with teens as well as for those who make decisions.

There have been some changes in the society in the last few years that affect teens. More adolescents appear as at risk as reflected in the statistics. The suicide rate is high. Although research has been done to help us understand why young human beings try to kill themselves, this tragedy creates again and again new questions. The awareness of suicidality among teenagers as a social problem might be higher now. More people have realised during the past few years that teenagers are particularly at risk, but few people take responsibility and help. Therefore there is still need to have a close look at reasons for such self-destructive behaviour, as it is not enough to recognise, but one must help in the form of concrete youth-oriented offers. And it is especially necessary to ask young people themselves, what they need, what they suffer from and what they think about this issue, as they are the ones who are concerned (Crook, 1997: xi and xii). It cannot work that adults on round tables in safe rooms decide what might help teenagers and what not. It is necessary and indispensable to include adolescents in the development and evaluation of prevention strategies to make sure that their needs are really met.

This thesis is written to provide information about adolescence and suicide in general as well as to provide statements about concrete needs and wishes of our youngsters, about actual prevention and intervention programmes and their effectiveness concerning suicidality among teenagers, and about special skills, which adults, who deal and work

with distressed teenagers should have.

Outline of the Thesis

Chapter I explains what adolescence is about, it shows theoretical material from the literature about the typical developmental circumstances of adolescents and gives an explanation as to why young people are particularly vulnerable and at risk for harming themselves.

Chapter II tries to create an idea, what suicide exactly means from different perspectives, where suicidality comes from, which reasons and risk factors have been found and gives the reader an idea of the actual situation of available research findings and statistics through investigating the literature. It is the basis for the next chapter.

Chapter III then turns to general prevention and interventions ideas and shows what programmes and strategies exist in New Zealand. This chapter is also a theoretical one which investigates the existing literature.

All three chapters are the basis of knowledge necessary for the last chapter, Chapter IV. This chapter is the practical part of the thesis, the investigation as to whether the theoretical data goes together with the statements of people "out there". It shows through a research project with an organisation which works with young people, like Youthline, what needs young people really have and in which ways the theoretical prevention ideas, described within the former chapters, can be realised. It can further be understood as a kind of feedback for Youthline, which shows whether the service indeed meets the teenager's needs or not and as a small test of the effectiveness of one concrete offer for youths at Youthline, that is the N.E.X.T course.
Qualitative research was chosen as the most effective and appropriate methodology. Chapter IV further gives information about Youthline, explains the research design, the methodology, the sampling, the investigation-technique, key ethical issues as well as a presentation and discussion of the results.

The final Conclusion offers a short summary of the result of the whole thesis and gives an outlook as to which kind of further research could be based on this thesis and would

be necessary for constant development of current youth-oriented offers, aimed at reducing the suicide risk among teens.

Importance of this Study

The whole thesis tries to do justice to a topic, which is particularly in New Zealand a very tragic one and which has been identified during the last few years as serious concerning which we all have our responsibility. The first three chapters especially are based on the assumption that knowledge is the essential basis for successful intervention and handling of a complex problem like this. One can only help if one has enough information about the theories, standing behind the phenomenon of adolescence as well as suicide. It is only possible to really meet their needs if people in contact with youngsters have an idea what it is like to be young in a modern society, what tasks teenagers during their process of growing have to deal with successfully. And it is further not useful to develop prevention concepts without investigating risk factors. But beside all these theoretical statements and ideas this research wants to give the practice out there a voice, and that of course includes the teenagers themselves.

The national literature about prevention projects and strategies often asks for further research, particular concerning the effectiveness of projects. As the sample of this research was just a small one, and only one single programme at Youthline – beside many other offers available there - was looked at, it cannot be understood as a generalisable testing of the effectiveness of Youthline, but it nevertheless is a first step in this direction as it is a feedback from some clients. It is therefore a sign as to whether Youthline is working in the right direction, whether Youthline is achieving improvement (at least among the interviewees) and whether there are lacks or first wishes for changes within the service. Positive results could then be used for further demands of more services like Youthline, of more offers like the N.E.X.T course, of more funding and so on. Negative results could be used as a starting point for changes. And all together this work should be one little stone in the way to improving the situation and circumstances for young people in New Zealand.

Chapter I - Adolescence

1.1 Definition of Adolescence

At the beginning of this work, it is necessary to make the themes as clear as possible, especially as the idea of puberty and adolescence is the basis to show how adolescent development is relevant for adolescent suicide (Group for the Advancement of Psychiatry, 1996: 21). Therefore one has to define the terms which are used.

> The Society for Research on Adolescence, for example, construes adolescence as encompassing the second decade of life - that is, ages 10 through 19. The *Journal of Adolescent Research* invites manuscripts concerning individuals 11 to 22 years old. In ordinary discourses, adolescents are, roughly, teenagers. All of these definitions reflect a widely shared sense that an adolescent is an individual who is no longer a child but is not yet an adult.

(Moshman, 1999: 5).

The Group for Advancement of Psychiatry, which is a committee on adolescence, defines adolescence as "a constructive stage in human development, not only for the adolescent but for society as a whole" (Group for the Advancement of Psychiatry, 1996: X). There adolescence is described as a "psychosocial sequel to puberty", which the Group defines

> as the biological and physical changes that transform a child's body into that of an adult in size, function (including mental function), and procreative capacity.

(Group of the Advancement of Psychiatry, 1996: 21)
So "Adolescence is, [...], an immature stage of human development"(Group for the Advancement of Psychiatry, 1996: 21).

Virginia Rutter notes in an article that adolescence is defined by biological, social, and cultural factors (Rutter in Meehan, 1997/1998: 6f.).

Wilhelmina J. Drummond defines adolescence as

> a precocious, unstable time in the life of a young person because of rapid growth and changes in

> all domains of human development - physical, cognitive, psychosocial/moral, accounting for their experiences of storm and stress (Hall, G. Stanley, 1916), identity crisis (Erikson, Erik, 1968), genitality (Freud, Sigmund, 1925), imaginary audience, personal fable, believing in their indestructability (Elkind, David, 1967) expanded cognition and moral reasoning (Piaget, Jean, 1980; Case, R., 1985; and Kohlberg, Lawrence, 1986).

(Drummond, 1998: 3)

It is a time of major transitions, of major physical changes like for example the growth of the heart, of the lungs, the muscles and the sexual development. It is a time in which the changes are profound. Suddenly everything is different: the look, the feelings, even how they sound and how they behave. This time is a search for a new self identity (Robins, 1998: 47), as there are also fundamental cognitive changes in the intellectual competence[1], social changes like, for example, an increase of the peer-group focus[2] and educational changes, as in this period there is mostly the change from primary education to secondary education (Moshman, 1999: 5).

Adolescence is a period full of changes, full of questions and doubts, as everything is different from what it was a short time back.
These definitions show how unstable young people are during the time of adolescence that places them in general at risk and makes them vulnerable.

[1] See Chapter I: 1.2.1 Psychological and Intrapsychic Factors
[2] See Chapter I: 1.2.2 Relational Aspects

1.2 Adolescent Development and Developmental Deviations: Relevance to Suicide

To understand what adolescence means, what impact this period of life has on individuals and what the reasons are why especially individuals in this stage of life are particularly vulnerable and at risk for suicide, it is necessary to think about what exactly happens during that life span. It is a phase of development.
The sorts of developmental changes that happen during adolescence will be described in the following sections.

1.2.1 Psychological and Intrapsychic Factors

All adolescents are engaged in a process of psychological development. To understand adolescents it is very necessary to understand this process.
The psychological development depends on nature (especially the genes) and nurture, and on environment. Both interact in influencing this development. Other psychologists believe that individuals play an active role in their own development. This idea is called Constructivism (Moshman, 1999: 1 to 4).

Now every human being has its own capacity to cope. Coping means, he or she deals with a problem, task or difficult situation successfully. During adolescence such coping strategies must be developed. The development itself depends on genetic and constitutional characteristics as well as on physical and anatomic realities (size and vigor) and past or present illness states. The intrapsychic-self, which develops during the adolescence, includes all "innate areas of strength and vulnerability that [again] reflect genetic and constitutional makeup" (Group for the Advancement of Psychiatry, 1996: 22).
Even the family relationships, the particular childrearing, other adults and peers have an influence on the development of the intrapsychic self as well as on the development of interpersonal relatedness and expectations, and have an influence on the adolescent's potential for mastering the tasks of adolescence.
All these factors lead to the alternatives and to the flexibility, which an adolescent has or does not have to cope successfully. For this development adolescents have to

integrate the new physical and psychological capacities (Group for the Advancement of Psychiatry, 1996: 22).

In the developmental stage of adolescence teenagers are confronted with important transitions, with important changes. Life changes again often cause stress. To handle the stress in a healthy way, calls for coping skills, otherwise the individual becomes depressed (Robins, 1998: 49).

That is why it is especially hard for adolescents as they are on the one hand in a stage in which such coping skills should be developed and on the other hand it is a life period with a high level of stress to cope with. As the time "of being shepherd through the mini-crises of daily existence by one's parents give way to coping by oneself or checking things out with one's friends" (Robins, 1998: 48), adolescence can be a time of increased vulnerability.

Robins mentions another psychological task, which young people have to cope with: becoming independent. So "the child must learn how to cope with the problems that come with increased freedom and increased responsibility" (Robins, 1998: 47).[3]

Here again one can see that adolescence is an immature developmental stage. That immaturity places adolescents at risk, especially at risk for suicide as an escape from the tasks the adolescents do not feel able to deal or cope with.

Intrapsychic Aspects

Within this paragraph we look at the cognitive development, at the cognitive capacity, at the development of morality and of identity.

According to Piaget this cognitive capacity is called "formal operations" or "propositional thought", which means that a child becomes able to think about propositions and possibilities one has never experienced. He or she becomes able to fantasise or imagine the future consequences of different ideas or courses of action without having to live them out in reality. This realisation is fully capable about ages 14 to 16, whereas before that age a child can only think at the level of concrete operations that have been part of direct personal experience (Group for the Advancement of

[3] See Chapter I: 1.2.2 Relational Aspects: the topic of development of autonomy

Psychiatry, 1996: 23).

Moshman also quotes Jean Piaget to explain the cognitive development more in detail. During childhood and adolescent development there can be seen "qualitative changes in the nature of their cognition, that such changes are internally directed, and that such changes are progressive in the sense that later cognitive structures represent a higher level of rationality than earlier ones" (Moshman, 1999: 7).

Piaget found that children show different patterns of reasoning than adolescents and adults. These later forms of reasoning and understanding are more coherent, adaptive, and fundamental, at least it is a higher level of rationality.

This process of gaining a higher level of rationality does not end in different but in better structures. Piaget calls the final stage of this cognitive development formal operations, which could be understood as operations on operations. That means that an individual is now able to "elaborate combinations and permutations of elements systematically, to identify correlations, and to manipulate variables independently so as to determine their individual effects" (Moshman, 1999: 13).

Formal operational thinking also includes the facility to see all the different possibilities of reality as a routine part of cognition. Reality can then be understood as the "realization of a particular possibility". If a person is able to think in formal operations, this individual should be able to "imagine a wide variety" of different arrangements and possibilities. Another factor of formal operational thinking is this of being able to differentiate logic from truth, and of being able to "formulate and evaluate arguments independent of the truth or falsity of their premises" (Moshman, 1999: 12f.).

Piaget points out that the development of the formal operations begins at approximately age 11 or 12, and is completed by approximately age 15 (Moshman, 1999: 11f.). Studies about formal operational thinking indeed suggest that it begins at about 11, but one found that Piaget's supposition of being concluded at the age of approximately 15 is not true. Operational thinking can still in some cases be observed as very difficult and inconsistent, even in adulthood (Moshman, 1999: 15 and 17). That is why

> [age], however, is a necessary but insufficient criterion for achieving propositional thought. [...], propositional thought [formal operational thinking] must be fostered, valued, and taught by both the culture and the child's family or it will not develop

(Group for the Advancement of Psychiatry, 1996: 23).

This statement makes clear how important the family as well as the cultural

circumstances are for the development of a child into an adult.[4]

The propositional thought also has to do with the skill to know how to reach a successful future based on suitable preparation for it in the present. Cognitive incapacity on the opposite means, that the person cannot realise the future consequences of his or her actual behaviour without having had to experience them. If an individual is not able to be aware of this capacity to have influence on one's own fate this can lead to the acceptance that something external controls everything in life. In such cases the individuals feel that they have no chance to change things anyway, which can make them feel hopeless and helpless.[5] In such an expedientless situation people may have the feeling that the only "solution" for their problem is suicide to escape (Group for the Advancement of Psychiatry, 1996: 24).

However, a greater cognitive capacity of course does not result in immunity against suicidal thoughts or behaviours. As Borst et al. says there is also "evidence that ego development enables the maturing personality to internalize emotional states and to experience more self-blame; this increases suicidal risk (Borst et al. 1991)" (Group for the Advancement of Psychiatry, 1996: 24).

"Another normal characteristic of adolescent cognition is the persistence of magical thinking and primitive grandiosity" (Group for the Advancement of Psychiatry, 1996: 24). If these cognitions are highly developed a youngster may often feel immune against real consequences. That means that things, which happen in one's life are not be taken seriously. "Even death is somehow magically not real and permanent" (Group for the Advancement of Psychiatry, 1996: 25). Cognitions like this set the adolescent at a high risk, as he or she might behave carelessly because of not being able to think about the real consequences.

Morality must also be developed during adolescence, however this development begins in the earliest childhood. The development of morality can be called the development of "principled thought" or at least the development of the capacity for "postconventional

[4] See Chapter I: 1.2.2 Relational Aspects and 1.2.3 Sociocultural Aspects
[5] See Chapter II: 2.3.4 Psychological Perspective (topics hopelessness and helplessness)

principles". That means that people have moral principles that are logical, reasonable and serious and that has its importance apart from the authority, the person, the group he or she got it from. But they can only be developed when one has the capacity of propositional thought, when one is able to fantasise or imagine the future consequences of his or her behaviour, attitude. Only then the further step can be done, and postconventional principles can be developed. So this is not possible until adolescence as noted above. However, only 10 percent of 16 year olds in a study by Kohlberg and Gilligan show postconventional principled thinking (Group for the Advancement of Psychiatry, 1996: 25).

Now how does this development concern the suicidal behaviour of adolescents?
The achievement of principle thinking and of morality does not allow an egocentric interpretation of personal problems or dilemmas whereas adolescent suicide often has a very egocentric cast, and this principle thinking may prevent suicidal behaviour. The problem for adolescents is now, that they have not yet developed such a principle thinking, as Kohlberg, for example told us with this figure of only 10 percent (Group for the Advancement of Psychiatry, 1996: 25).
Kohlberg also

> found significant differences between the sexes. In the original description of postconventional thought, even at that level of moral thinking, the males revealed an individualistic approach that tended more rigidly to respect abstract principles and to take social relationships less into account. At the comparable level of moral development, females' solutions to moral dilemmas were more contingent, less dogmatic, and tended to place greatest emphasis on how decisions and solutions took into account and affected the relationships between people. By implication, even high-functioning males appear more isolated and inflexible in approaching moral dilemmas, of which suicide is certainly one. One may wonder whether there is some correlation between females' greater relatedness and the generally lesser rate of adolescent female suicide.

(Group for the Advancement of Psychiatry, 1996: 25f.)

Another important psychological factor is the development of identity. It is a very complex issue and influenced by the cognitive development, which is already described. This process demands "an extended period of modifying one's relationship with, often involving distancing oneself from parents and usually other adults as well" (Group for the Advancement of Psychiatry, 1996: 26). The result then can be the loss of emotional

support by the parents at times, which are especially difficult and characterised by many crises. Youths try to disassociate themselves from their parents, which is a normal and healthy process but can have the side effect of isolation and than depression as the self-identity is not yet developed to support them on themselves. A "confident sense of one's probable future cannot be held onto as support through difficulties" (Group for the Advancement of Psychiatry, 1996: 26). That again sets the adolescents at risk.

Erikson describes adolescence as a "time of crisis and for consolidation of a psychosocial sense of identity" (Group for the Advancement of Psychiatry, 1996: 26).
In this process everything is questioned: the feelings, thinking and the behaviour of the parents as well as society and cultural issues. The goal at last should be to find "a sense of self-in-the-world that is truly his or her own" (Group for the Advancement of Psychiatry, 1996: 26). Therefore the principled thought is a supposition. If someone in this process fails the result will be identity diffusion. Such diffusion again means stress. As adolescents sometimes do not know how to cope with stress, this can lead to vulnerability to despair and at least perhaps to a suicide attempt.
"However, even in the ... healthiest course of adolescent identity formation, [...], the adolescent is at risk [...]" (Group for the Advancement of Psychiatry, 1996: 27) as it is a very unstable period of changes, insecurity, and a period of loss.

Another part of identity development is the evolution of sexual identity which of course starts in the fetal hormonal environment but however has its highest point in adolescence as in this period sexuality is "put to the test and ... acted out, in the evolution of genitally mature sexual relationships" (Group for the Advancement of Psychiatry, 1996: 27).
Combined with cultural issues and peer group pressure (for example, that you should not be older than 14 years for your first sexual experience) this development can also be very stressful.

Summarising, adolescence is

> characterized by the resurgence of primitive self-regards with its associated problems. Adolescents may be brash and grandiose, or intimidated and self-depreciating. They may be preoccupied with the beauty or ugliness of their bodies, with their power and grace, or their

> weakness and dumsiness. They aggrandize themselves, or hate themselves. They may desperately seek others to sustain them and to reassure them, or isolate themselves, [...]. They may be capricious in their crushes, their friendships, their feelings about parents, and their wanting to be alone. [...] [It is] a time of special vulnerability to injuries to self-esteem and disappointments in valued persons. [...] Shame or rage may result when the adolescents no longer feel powerful or when their attachment to an idealized other is thwarted. Shame and rage are complex emotions, which often include intolerable somatic responses that may lead to suicidal behaviors. Shame and rage may result from how adolescents perceive their experiences with others, not always from how others actually behave. Nonetheless, the behavior of others does have its impact.

(Group for the Advancement of Psychiatry, 1996: 28f.).

1.2.2 Relational Aspects

Adolescence is a period of separation and distancing from parents and other adults to find one's own identity. It is a normal process, which does not mean that parents no longer have any influence on or importance for their youths. Parents still have influence and are important supporters during this period of life. There are many studies that prove the importance of psychological ties to parents for the achievement of healthy self-identity and self-regulation during adolescence.

It is important and necessary for adolescents that their development of autonomy[6] and identity is respected by their parents, that parents tolerate the healthy and necessary fights and struggles, the rebellion as well as they should be able to set limits when the adolescent behaviour becomes dangerous for others or themselves (Group for the Advancement of Psychiatry, 1996: 28f.).

> Parents are the most powerful objects of identification and role models at the core of a youngster's identity. Much of an adolescent's capacity to cope with stress will have been built from observing and internalizing the parents' responses and their use of resources during difficult times

(Group for the Advancement of Psychiatry, 1996: 29).

Another important factor as to whether the youngsters have an optimistic or pessimistic view towards their being in the world, is the integration of their parents into a culture or

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[6] Autonomy means to be self-directed or self-governed to make one's own choices and to be responsible for the consequences (Moshman, 1999: 30).

community.

The theory beyond this topic is the family system perspective, which

> views the family as an interactional whole composed of sets of patterned relationships and communication processes that reflect the particular family's unique organization and structure. [...] Causality is viewed as circular, complex, and the product of multiple influences and interdependent processes

(Group for the Advancement of Psychiatry, 1996: 30).

Robins describes the family as a "*cohesive* social unit rather than as a disorganized collection of individuals" (Robins, 1998: 74). The influence, which life events have or not, depends on different variables. One very important one is the organisational pattern and coping responses of a family. In this view, symptoms of one family member are seen "as an expression of family dysfunction, an inability to respond adaptively to external stress" (Group for the Advancement of Psychiatry, 1996: 30). Robins mentions studies that suggest that families with suicidal adolescents do not function as well as other families, the parents often show problem behaviours of their own, the relationships among the family members are often poor and the emotional support is often not strong enough (Robins, 1998: 73, Beautrais, 1998 and 1999, Drummond, 1996, Bagley, 1997).

However, every development, every change in a system brings stress, as it means a "structural reorganization" and "the renegotiation of relationship rules and roles". It means a "destabilization" of a system like the family system. Adolescence is such a development, such a change in the family system, as "family functioning must change to provide a context in which the adolescent may accomplish the development tasks of that stage" (Group for the Advancement of Psychiatry, 1996: 30). It is often a period in which family members are likely to become symptomatic.

> Symptoms in the individual family member are seen as an expression of family dysfunction, an inability to respond adaptively to external stress and developmental challenge while providing protection and nurturance to family members

(Group for the Advancement of Psychiatry, 1996: 30).

Suicidal thoughts or attempts, depression, aggression, mental illness and so on can all be seen as symptoms. Of course symptoms like this cannot all be understood as an expression of family dysfunction. Such a point of view would be too narrow to do

justice to this complex issue. There are also many other reasons like for example biological, genetic dispositions that may also have their impact on this issue, but this does highlight that the family system plays a very important role concerning becoming symptomatic. Therefore it is important to have a look at the tasks, with which a family system has to deal during adolescence.

Adolescence means for the family system a development from a phase of protection, socialisation and nurturing of the child into a phase, which prepares the adolescent for an adult world of responsibilities. The adolescence contains three major tasks for the family, which the family must deal with, that is sexuality, identity formation, and autonomy. The family should be able to create an atmosphere in which the youngsters may cope with all the biological, cognitive, and social changes (Group for the Advancement of Psychiatry, 1996: 30f.).

Adolescent sexual development "demands a new level of openness and directness as parents and adolescents discuss the adolescent's sexuality and related topics in an atmosphere of acceptance" (Group for the Advancement of Psychiatry, 1996: 31). How the family, and the parents react on the sexual behaviour of their youths has positive or negative influence on the attitude, the behaviour, the feelings the adolescent will develop concerning this central aspect of an adolescent's life.

Identity formation means "processes of differentiation of the self from the family matrix, exploration of new relationships, and the development of a more complex perception of the self, others, and the social world" (Group for the Advancement of Psychiatry, 1996: 31). To achieve this status adolescents often use the way of putting themselves in the opposite from their parents. In this phase of development it is very important that the family tries to be stable, flexible and supportive.

> Hauser et al. (1984) have reported research that has shown that family interactions emphasizing warmth, acceptance, and understanding tend to support higher levels of ego development and identity formation in the adolescent family member.

(Group for the Advancement of Psychiatry, 1996: 31)

Another task is that of autonomy development. In this period the family should try to

create a balance between setting limits and offering enough opportunities for independent activity.

> Families that provide too little (permissive) or too much (rigid) supervision, structure, or containment seem to contribute to increase risk of adolescent acting out of conflicts. Optimum containment maintains connectedness, and optimum connectedness provides a secure space for exploration and autonomy.

(Group for the Advancement of Psychiatry, 1996: 31)

What attitudes among a family are the most supportive ones in the development of the adolescent? Walsh and Scheinkman speak of some key dimensions. The first one is the adaptability of the family. That means

> the family's ability to balance between maintaining structure and allowing for flexibility in response to developmental challenge. [...] Dysfunction in this dimension is characterized by rigidity or chaos with resulting acting-out and risk-taking.

(Group for the Advancement of Psychiatry, 1996: 32)

The second key is the cohesion, the

> ability to balance needs for closeness and connectedness versus respect for separateness, privacy, and difference. [...] Dysfunction in this dimension may lead to enmeshment, where families hold on and make it difficult for individuation to develop [...]. Well-functioning families are respectful of individual boundaries between parents and children associated with age-appropriate privileges and responsibilities and maintain a clear sense of family-community boundary that defines the family as a unit open to the larger social community.

(Group for the Advancement of Psychiatry, 1996: 32)

And the third key is affect regulation and communication. It means the

> family's capacity to balance a need to regulate, modulate, and contain affects with support for the articulation and expression of each family member's subjective experiences. [...] Dysfunction in this dimension is characterized by family patterns of externalization, such as critical, blaming, scapegoating interactions, and an absence of the empathy, interest and warmth necessary for mutual problem solving and trust.

(Group for the Advancement of Psychiatry, 1996: 32f.)

Another thing, which has much more negative influence on the adolescent development than bad relationships within the family is that of physical and sexual abuse. A study in the Netherlands for example reports that 33 percent of the youths who attempted suicide reported sexual abuse compared to 5 percent of the normal controls (Robins, 1998: 75-79). Robins mentions the importance of social support. It means that the adolescents

have somebody in the family, to whom they can talk when they have stress or problems and who will then be able to offer help. To have such a person with whom they can share their personal problems can be an important help against stress. And he notes again, that there are studies that show that suicidal adolescents report less social support than non-suicidal adolescents. This seems to be an issue, which sets the adolescents at a higher risk of thinking about suicide (Robins, 1998: 75-79).

Beside these important family relational aspects there is the peer group, which also has an important influence on the adolescent development. Adolescents spend less time in the family circle but more and more time with peers. Therefore it is another challenge for the youngsters to develop good peer relationships, what is often not as easy as it seems to be (Robins, 1998: 47).
It is for example one of the basic issues at times of crisis whether an adolescent is an insider or outsider. That means whether being an accepted member of a group or not. And it "is often a shock to discover that one has gone from being a big fish in the somewhat limited and familiar peer group(s) at home, to being a little fish in a vast new environment" (Group for the Advancement of Psychiatry, 1996: 47f.).

Now what are the characteristics of peer groups:

> Each peer group has its own characteristics in terms of its preferred coping techniques and shared adaptive or maladaptive mechanisms, its values, its future orientation, its integration into or isolation from, the imminent adult world, and its capacity to provide nurturance and support to its members when needed. These qualities in one's group influence the outcome when an individual youngster faces a perceived crisis that seems to render the value of living questionable.

(Group for the Advancement of Psychiatry, 1996: 33f.)
These characteristics have influence on the behaviour and the coping skills which an adolescent develops. They have influence on the point of view which an adolescent has towards his or her future, towards the being-in-the-world, towards the society and the adult world. And it depends not only on the issue of whether an adolescent is integrated in a peer group or not, but it is also important how the peer group itself is integrated into the adult world as an adolescent can even be isolated within such a peer group.

Another important task is to learn how to relate easily to members of the opposite sex.

"In recent years this problem has been vastly compounded by pressure to become sexually active at very early ages" (Robins, 1998: 48). As adolescents are relatively unstable personalities that effects of course their relationships, too. Therefore the loss of a boy- or a girlfriend is quite common among many adolescents. However, loss is always a risk factor, especially for those who have not yet developed a strong self-identity and who have not yet found a positive place where they stand in the world. So these problems are still frequent precursors of adolescent suicide (Group for the Advancement of Psychiatry, 1996: 34).

It is especially difficult for adolescents with atypical gender identities or sexual orientations.

> *Confusion* and *self-loathing* are frequent, if not typical, and are compounded by isolation when there is peer rejection. *Suicide* and *suicidal ideation* are high among adolescents (especially males) upon newly discovering a homosexual orientation.

(Group for the Advancement of Psychiatry, 1996: 34)[7]

Here can be seen again that the loss of parental ties and the process of finding new stable relationships is a central process in the adolescent experience (Robins, 1998: 48). This can mean stress, loneliness, unsteadiness, even helplessness and hopelessness which at least may end in a tragic despair and a suicide attempt as the wish to escape and "solve" all the problems which seem not solvable while living.

1.2.3 Sociocultural Factors in Adolescent Development

"What happens during adolescence is to a large extent defined by the culture in which one lives, by the expectations society places on its young" (Robins, 1998: 47).

This quotation makes clear how important society is for adolescent development, too. That is why one has to have a close look at the tasks of, the pressure from, and the circumstances of the society in which a child should become an adult. As every human being as well as the family of this human being is part of a society, is part of a complex system, one cannot talk about the development of an adolescent as a separate part without discussing the influences of other parts of such a system. And that is why even

[7] See more details within Chapter II: 2.5.3 Homosexuality and Suicide

in the definition of adolescence by the Group for the Advancement of Psychiatry it is mentioned that adolescence is not only a constructive stage for the adolescents but also for the society as a whole (Group for the Advancement of Psychiatry, 1996: X).[8]

Sociocultural contains the two words: sociological or sociology and culture. It is fisrtly discussed, what sociology means. It is a science, which "studies the external social forces as causes of or reasons for behavioral differences in groups of people" (Group for the Advancement of Psychiatry, 1996: 6). In this science there are different representatives. I would like to quote Durkheim. For him society is a system

> that constrained and regulated the individuals behavior by means of societal integration and regulation. [...]. Integration was defined in terms of the society's efforts and success in bringing its individual members to subordinate their individual interests in favour of such socially positive qualities and endeavors as ties to religion, family, and politics. Regulation was defined as the legitimate economic or domestic discipline or control that the society could exert over the individual

(Group for the Advancement of Psychiatry, 1996: 7).
The two most important factors which have an influence on individuals and likewise on adolescent development, are the regulation and integration as they are defined above. Durkheim expresses that societies with a very high or very low level of regulation and integration have higher suicide rates than those who have a normal level of both (Group for the Advancement of Psychiatry, 1996: 7).

In summary: the degree of integration in a society has its influence on suicidal behaviour.

The culture of a society has an influence on the institutions of that society, on the philosophies for childrearing for example, on the normative expectations of children and adults, as well as on the characteristic patterns of interpersonal relations and reactions to the perceived realities of life. So every culture is distinguishable from one another, and it is that difference reflecting different constellations of psychodynamic patterns (Group for the Advancement of Psychiatry, 1996: 11). It is these different patterns like for example the culture-specific childrearing, which lead to different

[8] See Chapter I: 1.1 Definition of Adolescence

developmental levels of ego strengths, weakness, and defences.

Today many cultures are changing so rapidly that they cannot offer enough stability and predictability of the life course for which to prepare children and adolescents. That makes the developmental process of adolescence very difficult as parents often no longer know which way they should show their children, which course should be the best in the future, as everything changes so fast. So there is another factor beside the psychological, intrapsychic and relational aspects that sets the youngsters in an especially vulnerable and unstable position, which at least again may set adolescents at special risk for suicide. So if the childrearing experiences and/or the cultural realities cannot offer a healthy way for psychological development or realistic options for successful adult function, adolescents are particularly at risk for suicide (Group for the Advancement of Psychiatry, 1996: 14-17).

Generally

> most industrialized cultures foster thinking about the consequences of actions through their educational institutions. However, in any large culture such as the Judeo-Christian, its achievement varies enormously according to actual quality of education, subcultural and ethnic differences in emphasis, and status and familial differences in what is valued

(Group for the Advancement of Psychiatry, 1996: 35).

How the issue of thinking about the consequences influences the adolescent behaviour is shown earlier in this chapter when discussing magical thinking. There the fact of not being able to think about the real consequences of an action is discussed. In this case the view is more likely on the issue that some cultures foster different consequences for a special behaviour. To make this clear an example is quoted here: The topic is adolescent intercourse and pregnancy. In most developed countries the main focus is on avoiding the consequences of intercourse, like for example teenage pregnancy. This educational philosophy recognises the real and actual behaviour of adolescents as they are in a period of life in which sexual activity is tested. However in the United States of America for example, the educational institutions/the culture focus much more on the avoidance of teenage intercourse itself and focus less on the prevention of the consequences. This attitude does not recognise the adolescents' needs. The result is in fact a higher rate of teenage pregnancy as American teenagers too have their experiences with intercourse but are not as well prepared to think about the

consequences as in other cultures (Group for the Advancement of Psychiatry, 1996: 35). With this example can be seen that there are big differences between even industrialised countries in the way the adolescents are fostered to think about the consequences of how they behave. And it can also be seen that this way of thinking has in fact an influence on the behaviour which is shown by the higher rate of teenage pregnancy in the United States of America.

1.3 Conclusion

As Moshman shows, an adolescent is no longer a child but he or she is not yet an adult (Moshman, 1999: 5). Adolescence is a phase of being "between", it is a phase of development and of biological, physical, cognitive, psychosocial and morality changes. It is the phase in which the youth has to search for a new self-identity, which causes identity crisis and stress. Adolescence is a period full of changes, full of questions and doubts, as everything is different from what it was a short time back. That makes young people very unstable, vulnerable and places them in general at risk especially as coping skills to deal with stress and problems might not have been developed as yet. This fact increases the vulnerability and the risk for suicidal behaviour as an attempt to "escape" from overwhelming tasks, which seem to be not solvable.

Cognitive and morality development is another issue of adolescence. As described above to develop propositional thought it is necessary to know how to reach a successful future. As this must also be developed during adolescence some are not yet able to do so and therefore still have a sort of "cognitive incapacity". That means that they cannot realise the future consequences of their actual behaviour, which creates the feeling of not having any influence on their fate, of not having any chance to change things. This may lead to the feeling of deep hopelessness and helplessness. In such a situation suicide might seem to be the only "solution" to escape.
Further, as the achievement of principle thinking and of morality does not allow an egocentric interpretation of personal problems or dilemmas whereas adolescent suicide has often a very egocentric cast, this kind of thinking may prevent suicidal behaviour. The problem for adolescents is now, that they have not yet developed such a principle thinking, as Kohlberg, for example states with this figure of only 10 percent (Group for the Advancement of Psychiatry, 1996: 25). Therefore they may behave in a more egocentric way, which means at last a greater risk of killing themselves as they may see their problems only in an egocentric way.

Furthermore, as noted above the fact that magical thinking is not yet developed among some adolescents, things might not be taken seriously so that even death is somehow magically not real or permanent. This condition may cause risk as adolescents may

behave carelessly.

Also parents, peers and the social environment generally have their influence on the development of adolescents. In this vulnerable phase of life emotional support and healthy relationships are especially important. It is a period of big tasks for a family as adolescence means a reorganisation of family structure. Such reorganisation may cause the loss of parental ties and lead into a process of finding new stable relationships, what can mean stress, loneliness, unsteadiness, and helplessness, which at last may end in a tragic despair and a suicide attempt as the wish to "escape" and "solve" all the problems and tasks which seem while living not solvable and overwhelming.

This chapter also shows the influence of the culture and the society on the development of adolescents and their well-being. It is the question of integration or disintegration of an individual and its family in a society. Disintegration, for example, may also cause loneliness and a dark future perspective. The culture also has an influence on normative expectations, which the youth has to face and which can create high pressure to succeed in such a culture. Generally cultural changes during the past few years have led to instability and future fear as one cannot imagine how the future could look like, which way to go would be the best. Adolescents may then feel unsure and lost, unable to think of a successful and satisfying future.

All these factors make young people particular vulnerable and set them generally at risk, especially at risk for suicidal behaviour. However, fortunately not all adolescents try to end their lives or have suicidal thoughts and ideation. The causes for suicide are very complex. Adolescence on its own as a special phase of life, which is surely a stressful one and causes vulnerability and increases the risk for suicide, cannot be the only explanation. Therefore one has to have a closer look at the phenomenon of "suicide" itself, and at other special risk factors.

Chapter II - Suicide

2.1 Definition

If one wants to discuss suicide among adolescents it is necessary as described above to define the terms, which are used. Therefore this part of the work starts with some definitions of the term suicide. What makes the difference between suicide and homicide? When can you speak of suicide?

Robins for example describes a suicide attempt as "a willful, self-inflicted and life threatening act" (Robins, 1998: 15). He also mentions that there is no one single reason, which leads young people to that decision.

> Suicide is a complex human behavior and is the final common pathway for many human problems. This self-destructive act can reflect many motivational determinants – personal and interpersonal, biological, familial, and cultural.

(Robins, 1998: 50)

For him suicide is further "an international health issue. [...] Clearly, the problem is a global one" (Robins, 1998: 7f.). Such a statement makes clear that we all have our responsibilities concerning this topic, no matter where we are from and how high the rates of one's personal country are.

Fanslow describes in her report about suicide and parasuicide in the Auckland Region that

> suicide refers to purposefully self-inflicted injury resulting in death. Parasuicide is used to describe non-fatal instances of deliberate self-harm. These definitions are used to cover a range of incidents and intent, such as those actively intending to die or those engaging in risk taking behaviour for reasons such as attention seeking. In most cases the data do not permit separation of such incidents.

(Fanslow, 1993: 1)

In this work the term parasuicide is not used but the term suicide attempt is applied, which is explained below. It makes more sense to speak of three categories as described below (suicide ideation, suicide attempt and completed suicide) which have a relationship and are parts of the same process than to talk about suicide and parasuicide

as two really different terms which create the impression of two totally different events not one belonging together.

Taylor points to a discussion about one possible definition, which is quite common. Suicide is often described

> as 'the conscious decision to end one's life'. By a conscious decision, it is meant that the person has a understanding of the outcome or consequences of their action and has a desire to obtain that outcome.

(Taylor, 1990: 10)

But as also described within chapter one adolescents are sometimes not yet able to understand the outcome, to understand that death is something final. As during adolescence the cognition is developed some teens still show some levels of cognitive incapacity, which means that they cannot realise the future consequences of their actual behaviour. The ability for magical thinking may further lead to a more casual interpretation of things happening.[9] That is why Taylor mentions that this definition of suicide "does not accurately reflect the total phenomenon of suicidal acts or ideation that young people experience." (Taylor, 1990: 10). Some young people "often do not appreciate the finality of death" (Taylor, 1990: 10). Further some young people

> may actively and consciously carry out an act which is likely to end their life; [but] others may engage in self-destructive behaviours that they know have the possibility of being fatal, but their attitude is one of 'who cares if I die?'

(Taylor, 1990: 10)

Therefore Taylor prefers to see suicide not only as the "end goal" for the adolescent but also as "a means to a greater end, i.e. the ending of pain" (Taylor, 1990: 10). In many cases the suicidal adolescent does not really want to die but wants to get rid of all the problems for which he or she cannot see any other "solution" but suicide.

In summary, a "too strict definition of suicide may mean the exclusion of young people who are in fact highly suicidal as well as inhibiting the development of effective prevention strategies" (Taylor, 1990: 10). A broad analysis of this issue is necessary to do justice to that topic. Therefore suicide "should not be looked at in isolation but rather in the context of the other youth social problems such as substance abuse, violence and crime" (Taylor, 1990: 13). For Taylor suicide is not just a psychiatric problem but it is

[9] See Chapter I: 1.2.1 Psychological and Intrapsychic Factors

much more a psycho-social one (Taylor, 1990: 13).

However, there are also many authors who focus on psychiatric problems, presented under point 2.5.1 General Risk Factors within this chapter. There exist figures, which show that in many cases of completed suicide there can be found a psychiatric disorder, a mental illness, like, for example, depression.[10]

Both views are important, and Taylor's desire is more on focusing on other factors than only psychological or psychiatric ones. Suicide is a very complex issue, which cannot be viewed only from one perspective but must be seen as a multi-causal problem. Therefore it is necessary to look at social factors and circumstances, too. To deal with and handle this serious problem helpfully and healthily it is important to include as many perspectives as possible and not be focused on just one direction.

Another topic, which should be clarified before discussing adolescent suicide is the different categories, which are again mentioned by Robins. He divides the issue into three main categories: a) the completed suicide, b) the suicide attempt, which means that it did not result in death (like parasuicide, described above), and c) the suicidal thoughts or ideation. These three categories can also be seen as different steps in one whole process. Most attempters would have thought about it, before they attempt suicide and often some attempts go on before a suicide is completed.

To use these three categories if one talks about suicide is helpful as they expand the possibilities for carrying out research, because if "research on suicide were restricted to acts of completed suicide, investigation would be limited to postmortem analyses – trying to reconstruct why things happened after the fact" (Robins, 1998: 7). The researcher cannot question the suicide victim who completed suicide but can ask directly a suicide attempter (Robins, 1998: 7).

Another advantage of looking at suicide in terms of these three categories is that of relating these categories. Some researchers (Fanslow, 1993 and Robins, 1998) believe that suicide ideation, suicide attempt and the completed suicide are parts of one and the same process. This idea leads to the fact that a person who thinks about suicide is more likely to make an attempt at suicide and that a history of suicide attempts increases the risk of completed suicide.

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[10] References therefore see Chapter II: 2.5.1 General Risk Factors: *Psychiatric and Psychological Risk Factors*

In summary this "relationship can help us identify persons at risk for suicide, which is important in targeting suicide prevention programs to those who are in greatest need" (Robins, 1998: 7).

2.2 Rates and Distribution

As Robins mentions, suicide, especially youth suicide, is a global problem and the rates have increased during the last few years in many countries. The World Health Organization (WHO) has published suicide rates for many European countries. In 1982 the suicide rates were especially high in Hungary (with 45 suicides per 100,000), Czechoslovakia, Denmark, Austria, Finland, Germany, Sweden and Switzerland, followed by the USA with 12 suicides per 100,000 people. The lowest rates with below 5 suicides per 100,000 had Italy, Spain, Greece, and Northern Ireland (Robins, 1998: 8).

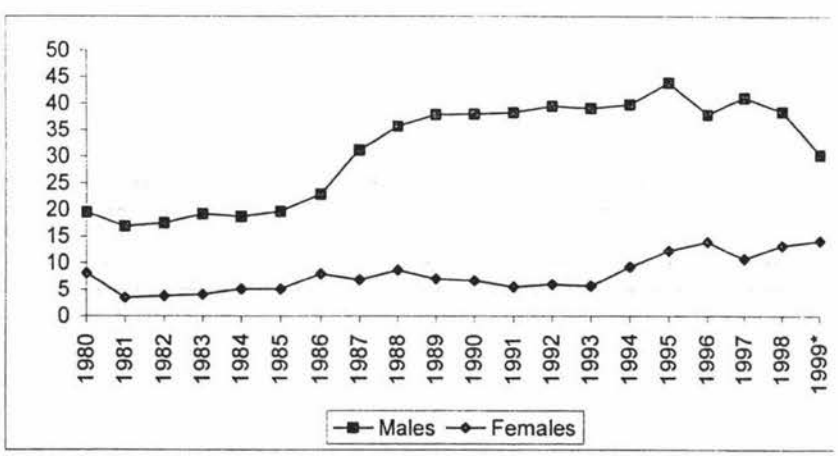
Among the general population of the USA, suicide ranks ninth, as a cause of death, whereas among fifteen to twenty-four-year olds in 1991 suicide ranked as the third leading cause of death and about 5000 suicides are reported in this age group in a given year (Robins, 1998: 13).

Robins further mentions that it is necessary to have a look at the three categories of suicide: suicide ideation, suicide attempt, and completed suicide. Suicide ideation, thinking about ending one's life is not that uncommon and there are studies (Robins, 1998) which show that a large number of adolescents have entertained thoughts about suicide at one time or another. However, this is very difficult to measure and therefore it is not clear how many precisely are involved (Robins, 1998: 10, 11).
Concerning suicide attempters Robins mentions some figures (USA) from studies from 1985 by Maria Gisbert, who found that a quarter of the youths she interviewed denied ever having any suicidal intent (Robins, 1998: 11), from a large national adolescent student health survey in 1989, which reported that 18% of the girls and 11% of the boys had attempted suicide at least once. Another report, done in 1991 showed an increase among these rates, as at this point 19% of the girls and 12% of the boys reported that they had attempted suicide (Robins, 1998: 11, 12). The number of completed suicides is fortunately smaller than the number of attempted suicides. However, as noted above, it ranked in the USA as the third leading cause of death among teenagers.

Another statistic for the USA, from 1992 shows that 13.0 per 100,000 teenagers killed themselves, which is an increase of more than 300 percent compared to 1957, where the

rate was at its lowest level (Stillion, 1996: 101). Suicide rates in the USA have differed over time and by age, sex, and race: Suicide statistics for 1970, 1980, and 1990 for younger and older, male and female, and black and white adolescents show that older adolescents (20- to 24-year-olds) of both sexes and races have higher suicide rates than younger teens (15- to 19-year-olds). The male suicide rates for both races are significantly higher than the female rates (approximately five to one), and suicide rates for white adolescents are higher than those for black African Americans. However, young black males have shown the largest increase in suicide rates over the past two decades (Stillion, 1996: 102). As described by Hill, the UK has also seen increases in youth suicide since the 1960s. In 1990, for example, suicide killed 70 young people (aged 15 to 24) a month, at least 55 of whom were male (Hill, 1996: 21).

The following statistic, published by the New Zealand Health Information Service (www.nzhis.govt.nz), compares the youth suicide rates of selected OECD (Organisation for Economic Cooperation and Development) countries. Looking at this statistic one should keep in mind that it is problematic comparing international rates as the different countries use different methods to classify suicide and classification itself is to some degree culturally determined. However, within this statistic New Zealand showed in 1999 the highest suicide rates among female youths and the highest among male teenagers, compared with the other selected OECD countries.



Youth Suicide Rates (aged 15-24), 1980-99
Minsitry of Health, Suicide Facts – Provisional 1999 Statistics (all ages), Wellington: Ministry of Health, 2002

2.3 Theories of Suicide

> When we ask for explanations for suicide, we are in a real sense asking for theories, for the question *why do people kill themselves*? is far from settled. A theory states what someone believes might be happening. If a theory is useful, it can suggest avenues for research that investigators can pursue. A theory provides a guide for where to look and what to study

(Robins, 1998: 34).

In the literature there are different perspectives from which suicide is viewed, and theories for suicidality have been proposed from several academic disciplines. Psychologists, for example focus more on the psychological or psychiatric perspective, on emotional and cognitive conflicts within one individual whereas biologists focus more on a biological perspective, on the influence of genes and brain chemistry. As described above, suicide is not a one-causal event and the reasons cannot be found within only one science. To do justice to the complexity of this issue it is helpful and useful to have a look at different existing theories within different existing sciences. However I have focused more on the ones which seem to produce interessting information concerning my research question, described within Chapter IV.

2.3.1 Cross-Cultural Perspective

That the culture has still influence on suicide is an actual fact, too. How do specific cultural institutions, childrearing philosophies, and expectations influence adolescent development and what accounts for the fact that some adolescents attempt or complete suicide, and some do not?

As described within Chapter I: Paragraph 1.2.3 the culture of one society influences the institutions of a society, like for example on the childrearing philosophies, on the expectations which parents have towards their children and so on. These institutions make every culture distinguishable from another and create different constellations of different psychodynamic patterns. These different patterns again lead to different developmental levels of ego strengths, weakness, and defenses.

Now what have these special psychodynamic patterns and the following different developmental levels to do with culturally different suicidality?

> The social conditions in different cultures that may have relevance to culturally differential suicidality are the outgrowth of beliefs, persistent magical thinking, attitudes, defenses, and preferred modes of coping that are shared by the members of the culture. These shared psychodynamics give rise to culture-specific institutions, including culture-specific childrearing philosophies and techniques, normative expectations of children and adults, and characteristic patterns of interpersonal relations and reactions to the perceived realities of life

(Group for the Advancement of Psychiatry, 1996: 11).

These cultural institutions lead to culture-specific patterns of adaptive or maladaptive behaviour. "Suicide is one behavior that can be understood more clearly in the light of culturally shared psychodynamics" (Group for the Advancement of Psychiatry, 1996: 11). There are cultures that create institutions that lead to psychodynamic patterns, which create a maladaptive behaviour. This phenomenon should be clarified within the following examples concerning the culture specific institution of childrearing.

Culture-specific Childrearing

There are a number of studies, which investigate the influence of culture-specific childrearing on adult ego development. These influences have their impact on the wellbeing of adolescents during their development into healthy adults. The manner of childrearing forms an environment in which teenagers can grow up healthily or creates stress and sometimes even suicidal or self-destructive behaviour. The following example of different childrearing styles in Scandinavia make this clearer.

Hendin (1978), for example, found within his studies about Scandinavian Suicide that the difference in suicide rates between Sweden, Denmark and Norway has something to do with differences in childrearing. In Denmark, for example, there is more family dissolution then in Norway:

> There is great mother-child dependency and little encouragement of autonomy; the father is often distant and of little influence. Children are taught to restrain strong emotions, particularly anger, and they are imbued with a strong obligation to perform and succeed to gratify and reward their hard-working and self-sacrificing parent

(Group for the Advancement of Psychiatry, 1996: 11).

Such demand for competitive success can lead to suicidal behaviour as an attempt to "escape" the overwhelming demands, especially as the child is not allowed to show fear, anger or other emotions and then may feel guilty and ashamed if he or she fails in

hiding these emotions. Because of this upbringing their emotional coping skills are really restricted. This can end again in incapacity to deal with feelings and stress and lead then to feelings of frustration and hopelessness which can end in suicidal behaviour.

In Norway, where the adolescent suicide rates are much lower, the children are not faced with such a competitive childrearing, as there the focus is not on competition but on acceptance. On the other hand Norway's educational patterns focus more on individualism, development of autonomy, assertiveness and cooperation instead of competition (Group for the Advancement of Psychiatry, 1996: 12). This leads to a greater measure of coping skills and provides a healthier environment for growing-up.

Jilek-Aall's (1988) cross-cultural study of suicide among adolescents confirms Hendin's study.

> She points out other aspects of Danish and Norwegian childrearing and culture that correlate with their differential suicide rates. Norway is more sparsely populated; survival has always demanded family and community cooperation. Because of this caring interdependence in addition to their childrearing experiences, children have more optimistic outlook, they believe there is always some way out of difficulties, and they can always count on a close kin and social network for support.

(Group for the Advancement of Psychiatry, 1996: 12)

Whereas in Denmark the milieus consist largely of strangers, and therefore the anonymity is higher. That leads to a lack of "social support network" (Group for the Advancement of Psychiatry, 1996: 12). Such a lack on the other side can create isolation. And isolation on itself can lead to suicidality.

Cultural Deconstruction and Acculturation

Two factors, which have also influence on suicidality are cultural deconstruction and acculturation. This means that small, less technologically developed cultures have little chance to survive against big and highly technologically developed cultures. That often leads to deconstruction and disruption of such small cultures. Cultural deconstruction leads to a destruction of the traditional socio-economic institutions and family structures that both reflect and help to structure childrearing practice, which itself impacts on suicidal behaviour as described above. One found that "the forced disruption of a culture results in increased suicide incidence within the original culture" (Group for the

Advancement of Psychiatry, 1996: 9).

> Financial hardship and parental maladaptive responses to loss of cultural identity result in children deprived of conditions necessary for the development of trust, a secure identity and self-worth, and the intrapsychic tools for successful adaptation. The real-life obstacles facing such children often leave few options other than magical escapes and regressions

(Group for the Advancement of Psychiatry, 1996: 14) .

A maladaptive "repair" of such a situation is sometimes triggered through suicide.

The best way to explain this phenomenon with an example is to have a look at suicide rates among Indian groups in America. Forced acculturation can especially "be very hard on groups with a traditional ethos of internalizing emotions, such as the Arapaho and Shoshone tribes" (Group for the Advancement of Psychiatry, 1996: 19). Indeed the suicide rates among adolescents of these tribes were very high. Studies found that all

> had been isolated since childhood, were generally noncommunicative, and had poor peer social skills; none had significant lovers or peer friends. They were therefore excessively dependent on parental families for their needs, yet all had experienced family discord, alcohol abuse, and loss and denigration by family members shortly before suicide. Their own main coping mechanism had been withdrawal, internalization, and alcohol abuse.

(Group for the Advancement of Psychiatry, 1996: 19).

These are all factors, which may, in the worst case, end in a suicide attempt or a completed suicide.

To sum up, cultural differences put adolescents at generally differential suicide risk but the real actual occurrence of suicide also depends on other factors like the influence of the individual's family (concerning the creation of an atmosphere in which the adolescents can feel loveable and valuable), the influence of peer groups as well as psychological and biological factors.

However, it is useful to have a close and critical look at the sorts of cultural differences, which may create different suicidality within one society as it uncovers "unconstructive familial and cultural expectations that bear on adolescents in ways that conduce self-destructive behavior" (Group for the Advancement of Psychiatry, 1996: 19) and must therefore also be addressed in an effective suicide prevention strategy.

2.3.2 Biological Perspective

As mentioned above and to do justice to the complexity of this issue it is also necessary to have a look at biological factors that may also have an influence on suicidality. These facts can lastly also be used in a prevention strategy, as one of several options of treatment.

> The likelihood of suicide depends on the interplay of innate as well as environmental factors. *Innate* factors include both genetic predisposition as well as specific biochemical abnormalities (serotonin, dopamine, or norepiphrine metabolism).

(Group for the Advancement of Psychiatry, 1996: 46)

There have been controversial discussions whether genetic factors have a real influence on suicidality or not. But what has been noticed, for example, is that there are many suicide attempters who have families with a history of suicide. However, this does not automatically imply a genetic disposition, as suicide has also to do with learning and modelling by the parents and the child may pick up behavioural patterns from parents (Robins, 1998: 44). However, one line of evidence for any genetic influence comes from twin studies. Whereas old twin studies from 1946 for example found no concordance for suicide and concluded that genetic factors could not play a significant role, there exist twin studies today, which suggest that there is some genetic influence on suicide. In 1970 Juel-Nielsen and Videbach, for example,

> found that a significant number of monozygotic [sharing identical genes] twins had committed suicide. [...] In a Danish study of adopted twins living apart, Schulsinger et al. (1979) found 4.5% incidence of suicide in biological relatives of adoptees who had committed suicide compared with 1% in the biological relatives of the comparison group. [...] Tsuang (1983) and Roy (1983) both found significantly higher rates for suicidal behavior in the families of patients who committed suicide than in control groups. Thus a genetic predisposition to suicide may exist although evidence from genetic studies is inconclusive-perhaps the genetic predisposition for impulse-dyscontrol and depression in an individual challenged by stressful life circumstances can result in suicidal behavior

(Group for the Advancement of Psychiatry, 1996: 47).

However, there is evidence that there is a relation between genetic factors and affective and bipolar disorder, which as could be seen later in the text is a risk factor for suicidality. Such a disorder is for example depression. Studies of depressed patients

> consistently showed suicide rates of 30% and at least a 30% incidence of serious attempts. A high proportion of suicide completers had a first- or second-degree relative who had previously

> attempted or committed suicide (Schaffer and Gould 1987). [...] Gershon et al. (1987) determined that for the child of one bipolar parent the risk of bipolar disorder is 27% whereas the risk figure for the child with two bipolar parents is from 50% to 75%. Twin studies also suggest a genetic contribution for major depression and bipolar disorder. [...] Although definite genetic markers have not yet been found, genetic linkage studies point to several chromosomal abnormalities [...] in bipolar patients.

(Group for the Advancement of Psychiatry, 1996: 48).

Concerning the neuroendocrine factors there have also been found some irregularities in the levels of insulin, cortison or serotonin, for example. A neurotransmitter like serotonin is a substance, acts as a sort of messenger substance for the brain. It is one part of many different mechanisms responsible for the transmission of a provocation of a nerve to the brain, leading at the end to a reaction of the body or to a special behaviour.

Now researchers found that for example dysfunction of this serortonergic system

> has been associated with major depression (Meltzer and Lowy 1987). The likelihood that the serotonin system is also associated with suicidal or impulsive aggressive behavior has been postulated by Asberg et al. (1976) who found low concentrations of the serotonin ... [in the bodies] of suicide attempters and completers

(Group for the Advancement of Psychiatry, 1996: 49).

Such a low serotonin concentration has also been found in children and adolescents who have a history of aggression and impulsive behaviour (Group for the Advancement of Psychiatry, 1996: 49).

Such an impulsive or aggressive behaviour can easily change towards a self-destructive behaviour, which then may result in suicide. It could be understood as a sort of possible basis for a self-destructive behaviour. Depression on the other side is also a risk factor for suicide.[11]

In summary, there still do not exist special technical mechanisms to measure the influence of genetic factors on suicidal behaviour, but there are many studies, which prove that there is a relation between some genetic abnormalities and aggression, impulsiveness, depression and at least as a consequence of these feelings of suicidal behaviour. This is a fact, which should be kept in mind while dealing with suicidal

[11] See Chapter II: 2.5.1 General Risk Factors: *Psychiatric and Psychological Risk Factors*

patients as it may show one possible medical way of treatment, in addition to other interventions.

2.3.3 Psychiatric Perspective

At the beginning of this paragraph it is necessary to clarify the idea of psychiatry. In contrast to psychology, psychiatry is only concerned with mental disorders, is based on medicine and deals with the diagnosis, treatment, and prevention of mental disorders. A psychiatrist must therefore firstly study medicine and then specialise in psychiatry. So psychiatry is a medical specialism, whereas psychology, as mentioned below, is not a medical specialsim and is normally more concerned with normal behaviour and mental life rather than with mental disorders. However there is a part of psychology, too, which is also concerned with mental disorders and clinical psychologists, for example, are indeed involved in the treatment of mentally disordered patients. But psychiatrists are more medically oriented and choose more physical forms of treatment (Coleman, 1994: 8). A psychiatrist is "a medical doctor with a speciality in abnormal psychology who is engaged in the diagnosis, treatment, and prevention of mental disorder" (Chaplin, 1985: 362).

This paragraph has now a look at adolescent suicide under a more psychiatric, and medical perspective, however,

> [...] the medically extreme view that everyone who commits suicide has a mental disorder is remarkably shortsighted in its failure to recognize many people in virtually all cultures who are subjected to such oppressively devastating and irremediable conditions of life that it would require some degree of mental disorder in such circumstances to be unaware of or to deny the extent of the hopelessness of life

(Group for the Advancement of Psychiatry, 1996: 11).

This quotation above should once again make clear that one perspective is not enough to discuss this complex issue or to deal with suicidal adolescents. Among the general population, but also among many doctors and psychologists, suicide is frequently seen as resulting from a psychiatric disorder. This is not true and would be too short-sighted. There are suicide attempters and completers without any psychiatric disorder and those

who have one have often also to deal with stressful life events or the real social hopelessness of life. Taylor, for example, quotes in his report a statement from The World Health Organisation (WHO), which says that ""**in the majority of young people who commit suicide, ... there is no diagnosable mental disorder and personal and social factors play the major role.' (WHO 1989, Pg 28)"** (Taylor, 1990: 13). It should be clear at this point that there is more and more support for a psycho-social approach analysing youth suicide, as using only the psychiatric model would be too narrow in its focus and would not take social and environmental issues into account.
However, the psychiatric model has had its influence for many years and all authors quoted within this work point out that there is a high prevalence of psychiatric disorder in suicide attempters and completers. That is why this issue is pointed out here.

Robins found, for example, in a study of a sample of adult individuals who committed suicide that 94% could be given a psychiatric disorder, such as for example an affective disorder (47%), alcoholism (25%), organic brain syndrome (4%), or 2% schizophrenia (Group for the Advancement of Psychiatry, 1996: 50).
The DSM-III, which is a very important book for psychologists as it includes all criteria and symptoms of all existing psychiatric disorders, says that the criteria, which are associated with a high suicidality are self-damaging acts, impulsivity, and inordinate anger (Group for the Advancement of Psychiatry, 1996: 51).
"Fyer et al. (1988) found that the combination of borderline personality disorder and affective disorder carries a high risk for suicidal behavior particularly when combined with substance abuse" (Group for the Advancement of Psychiatry, 1996: 51f.). And Friedman noted in 1982 that if a patient carries the diagnosis of a major affective disorder and substance abuse the lethality and frequency increase (Group for the Advancement of Psychiatry, 1996: 52).

Fergusson and Lynskey (1994) identified early unsatisfactory family circumstances as an increased factor for vulnerability to psychiatric disorder, like depression and substance abuse, and argued that these disorders increase the possibility that the adolescent will attempt to kill himself or herself (Rivers, 1995: 11, 12).

Another figure from two American Researchers, Garland and Ziegler, also goes up to

90% of young people who complete suicide have suffered from any psychiatric illness. For New Zealand Fergusson and Lynskey, quoted by Rivers, also presented a figure of 90%. But they showed in addition to this high prevalence of psychiatric disorders among suicide attempters a high prevalence of other problems of adjustment, like for example juvenile offending, police contact, substance use, school dropout and low self-esteem (Rivers, 1995: 12).

This relationship between psychiatric disorders and suicidality, which has generally been found among adults, can also be found among adolescent suicide attempters. Weissman, for example,

> described the typical adolescent at risk for suicide as a male between ages 15 and 19, who had either an effective disorder or schizophrenia, who had a history of behavior problems (conduct disorder, substance abuse, or alcohol), and who exhibited frequent suicidal ideation or suicidal behavior

(Group for the Advancement of Psychiatry, 1996: 52).

Major depression is the mental disorder, which could be found most often among suicide attempters and completers. Its prevalence among young people has risen during the last few years within many countries (such as for example, Canada, the United States of America, Germany, and New Zealand). Another psychiatric factor, which can be associated with suicidality is aggression and antisocial behaviour. Gould found in 1990 that one half of a group of young suicide completers had histories of aggressive and antisocial behaviour (Group for the Advancement of Psychiatry, 1996: 52).

Rivers mentions another aspect of the problem of psychiatric disorder, the low level of acceptance of mental disorders especially among young people. That sometimes causes an inability to recognise the own emotional state and to seek help as early as possible (Rivers, 1995: 31).

2.3.4 Psychological Perspective

A definition of psychology, given by the Oxford English Dictionary and quoted by Coleman (1994) says, that

> psychology is the science of the nature, functions, and phenomena of behaviour and mental experience. Underlying this definition is the fundamental assumption, [...], that behaviour and mental experience are governed by rational laws that we can discover and understand

(Coleman, 1994: 3, 4).

Related disciplines are psychiatry, which is already mentioned above, psychoanalysis, and philosophy.

Psychology as a science includes topics like biological aspects of behaviour, sensation and perception, cognition, learning and skills, emotion and motivation as well as personality issues, like intelligence and cognitive styles. The whole science can further be divided into different specialised directions. Here only three are mentioned, as these three are especially able to provide explanations and responses for suicidal adolescents. The first one is developmental psychology, which deals mainly with issues of cognitive, social, adolescent development and which has already been used within Chapter I[12]. Secondly social psychology, which deals with social influences on personality development and behaviour, social cognition, prejudice and intergroup conflicts, also already mentioned within Chapter I[13]. And thirdly abnormal psychology, which deals particularly with mental disorders, like depression, anxiety disorders, psychotic disorders (schizophrenia or paranoia), autism, eating-disorders, and alcohol and drug addiction (Coleman, 1994).

Among the whole profession of psychologists, one has also to distinguish between different professions of psychology. Two of them are stressed here, as they can contribute to the suicide issue. Clinical and counselling psychology focuses on mental disorders, thus on abnormal psychology, and is aimed to help people with behavioural, cognitive or emotional difficulties gain mental and physical health as well as psychosocial well-being. This means an inclusion of social psychology, too (Coleman, 1994: 1179, 1180). These sorts of psychological professionals work with different models and approaches, like for example, behaviour therapy, cognitive therapy, social

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[12] See Chapter I: 1.2 Adolescent Development and Developmental Deviations
[13] See Chapter I: 1.2 Adolescent Development and Developmental Deviations

learning therapy, based on Bandura, personal construct theory (PCT), person-centred therapy, based on Rogers, systemic approaches, or therapeutic approaches, which are based on Freud's psychoanalytical ideas (Coleman, 1994: 1180-1188).

Some of these different therapeutic approaches of clinical and counselling psychology can also be used as therapy approaches for suicide attempters and some are mentioned below.[14]

The clinical approach "is the largest field of professional psychology primarily concerned with the development and application of diagnostic and therapeutic techniques for the identification and treatment of behavioural disorders" (Chaplin, 1985: 372).

One last clarification needs to be done.

> Psychoanalysis is a theory of mental structure and function and a method of psychotherapy based on the writings of Sigmund Freud [...]. As a theory, psychoanalysis focuses primarily on unconscious mental processes and the various defence mechanisms that people use to repress them.

(Coleman, 1994: 8)

However one can understand psychoanalysis as a separate discipline beside psychiatry and psychology. Elements of Freud's ideas are used in approaches of the clinical psychology. For this reason Freud is included here within the paragraph of psychological perspective.

In a discussion of psychological explanations for suicidal behaviour there are a number of famous psychologists. Some of them are quoted here. One of the most famous psychologists who developed a special theory about suicidal behaviour is Sigmund Freud.

Sigmund Freud

His basic idea concerning suicidal behaviour is the one of turning anger, which is originally directed towards others, inwardly in an unconscious process. For him nobody has generally the energy to kill him- or herself except this person

> is doing this at the same time killing an object with whom he [or she] has identified himself [or herself], and, in the second place, is turning against himself [or herself] a death-wish which had

[14] See Chapter III: 3.1 Tertiary Prevention: Ongoing Treatment and Principles of Therapy from several Perspectives

been directed against someone else.

(Freud, 1920/1950: 220, in Robins, 1998: 40)

So the different steps, which according to Freud are psychologically "necessary" to develop suicidality are first of all anger, which a person feels towards another person. Secondly this anger must be turned inwardly against oneself, a behaviour which is commoner among depressed people, and ultimately results in acts of self-destruction. At last according to Freud people are unaware of this process.

Edwin Shneidman

Shneidman has also studied suicidal adolescents for many years and found ten common features of suicide, quoted by Robins (1999: 42).

- The purpose of a suicidal act is to seek a solution: suicide is not random to the victim, it seems to be the only "solution for a problem".
- The goal is to end consciousness.
- The release is intolerable psychological pain, which Shneidman describes as the centre of suicide.
- The source of stress is frustrated psychological needs, like, for example, lack of positive feedback from parents, feeling of loneliness and loss of parental ties.
- The emotion experienced is hopelessness and helplessness.
- The cognitive state is ambivalence.
- The perceptual state is constriction, what means that the options, which an individual can see are very narrowed, he or she has a "tunnel vision, and the range of choices seem to be very limited.
- The action is escape.
- The interpersonal action is communication of intention: Shneidman mentioned that some suicide victims do not show some verbal or behavioural signals of being suicidal.
- The consistency is lifelong patterns of coping

(Robins, 1998: 42)

To sum up, according to Shneidman one main reason for suicide is the wish to "escape" from and to end overwhelming psychological pain. This kind of suicide, escape-

oriented, has been described in more detail by Roy Baumeister.

Roy Baumeister

Baumeister proposes a model for better understanding escape-oriented suicide. He, too, recognises however, that "escape" is not the only motivation for suicide, but he "cites research that found ' that escaping an aversive situation and obtaining respite from a terrible state of mind' were by far the most common reasons that people give for taking overdoses" (Baumeister, 1990: 91, in Robbins, 1998: 43). His model includes six major steps:

1. The suicidal person experiences an unsatisfying event, which causes disappointment as the event is far below expectations.
2. This event is then interpreted by blaming oneself.
3. The person begins now to feel unattractive, incompetent, or guilty.
4. These feelings then cause depression and a very unhappy emotional state.
5. The next step is an attempt to "escape" from this unhappy emotional state "by entering into 'a relatively numb state of cognitive deconstruction.'" (Baumeister, 1990: 91, in Robins, 1998: 43). That means an inability to make meaningful, integrative forms of thoughts and awareness, which may lead to the experience of total emptiness and passivity.
6. In this last step the result of the development, described above, is a reduction of inhibitions, which may contribute to an increased willingness to attempt suicide.

(Baumeister, 1990: 91, in Robins, 1998: 43).

In summary, suicide according to Baumeister is "'an escalation of the person's wish to escape from meaningful awareness of current life problems and their implications about the self'" (Baumeister, 1990: 91, in Robins, 1998: 43).

Psychological Profile

After the presentation of some representatives of psychological theories about suicide, it is also interesting to have a look at Robins' idea of a psychological profile of suicide attempters or completers, also mentioned by Rivers, who says that there are personality traits, which are associated with suicide, like for example, perfectionism, poor impulse control, aloofness, aggression, rigidity, and hopelessness (Rivers, 1995: 32). But as

described in the beginning of this paragraph, not everyone who attempts suicide fits this profile and others may fit quite well and may not at all be suicidal. However, this psychological model is based on statistical material, on statistical differences between those who are suicidal and those adolescents who are not. The basis of this model is the high prevalence of some mainly psychological factors among suicidal adolescents, such as for example hopelessness, anger, or lacking self-esteem. But Robins also includes in his psychological profile psychiatric factors, which are often found within suicidal adolescents, like depression for example, and which has its impact on an individual's personality, on other psychological factors like self-esteem, impulsiveness or the coping skills of a person. Depression is therefore mentioned here again.

So one typical factor within Robin's profile is *depression,* which seems clearly related to suicidal behaviour. Studies by Brent's group in Pittsburgh for example show that 40% of the adolescent suicide victims had suffered from a major depression, which is far higher than the incidence of major depression in the general population. These figures show that depression is a factor in many suicides of youngsters, though clearly not all (Robins, 1998: 60). The rate of depression among suicide attempters is also very high (between 25% to 40%). So depression can frequently be seen in suicidal youngsters but it is not a necessary condition. However if it occurs it has great influence on the individual's attributional style[15] and well-being.

Another factor is *hopelessness*, which is especially a very typical attitude of many young people contemplating suicide. "It can be seen as a symptom of depression or as a response to environmental difficulties" (Drummond, 1996: 63). Researchers report, for example, that adolescent suicide attempters show higher levels of hopelessness than "normal" teenagers (Robins, 1998: 63).

> Hopelessness encompasses both an emotional state and a perception of one's circumstances. [...] the perception is not only that things are terrible, but that there is no hope that they will ever get better. The person sees no clear path open that could alleviate the problem and in the worst case, he or she cannot even admit the possibility that there could be ways of making things better.

(Robins, 1998: 62)

It can at last be seen here that hope is an important factor of protection against

[15] See more details about attributional style within this paragraph further below

suicidality. Hope, and that includes a perspective for the future, is an important feeling, which has great influence on the wish to live or to die. And the other way round, hopelessness "places individuals in a high risk presuicidal situation" (Drummond, 1996: 63).

The third factor within this model is *anger*. How do suicidal people handle their angry feelings and how specific is anger to suicidal behaviour? As Robins mentions anger is also very common among teenagers who attempt to kill themselves. A study by Gisbert, for example, of suicide attempters shows that more "than one-third admitted to intense verbal outbursts, and another third demonstrated physical aggression by throwing objects, fighting, or injuring themselves when angered" (Gisbert, 1987: 392, in Robins, 1998: 64). They further found that open expression of anger was related to repeat suicide attempts, and that attempters as well as those with suicidal thoughts "score higher on the turning against the self defense than the other [non-suicidal] patients" (Robins, 1998: 64). And if anger is innate, as described above by Freud, the suicide risk increases, too.

Attributional Style is another factor, which has influence on the suicidality of a person. The attributional style of an individual is a kind of mind-set, a cognitive framework "that help us make sense out of things that happen to us" (Robins, 1998: 65). It is the way we interpret or explain events. We therefore normally use attributional styles, which we have developed over the years. Psychologists have now observed,

> that people who are depressed tend to have a distinctive attributional style. Whenever something unpleasant happens, people who become depressed are more likely to persist; the causes are seen as stable rather than as transitory. [...] Finally, the depressed person is more likely to view the causes of the unpleasant situation as something he or she has brought about rather than attributing the cause to the actions of other people or to external events. Because of overgeneralization, unpleasant events may not be perceived for what they are but as catastrophes.

(Robins, 1998: 65)

As described above, suicidal adolescents are more likely to be depressed and therefore are more likely to have a negative attributional style, which leads them to the conclusion that unpleasant events are stable features of their environment and not changeable. This attitude itself leads again to feelings of helplessness and hopelessness. A sort of evil circle arises and the individual may get worse and worse and at the end may only see one "solution" to escape, namely killing himself or herself.

The fifth important part of this model is *self-esteem.* Self-esteem first of all generally means, "the way we look at ourselves and feel about ourselves" (Robins, 1998: 65). It is an intuitive concept, which can be broadly divided into two different extreme forms: high self-esteem (if somebody thinks very highly of himself or herself) and low self-esteem (when somebody has a very low opinion of oneself). Pressure by parents, for example, can cause big problems in one's self-concept. There exists the hypothesis that an individual with a very low self-esteem is more likely to attempt suicide than a person with a very high opinion of himself or herself. And indeed Robins mentions a number of studies, which show that suicide attempters tend to have low self-esteem (Robins, 1998: 66).

The next factor, mentioned by Robins is the *impulsivity* of a person. Impulsivity means that a person acts hastily without adequate consideration, acts on impulse without adequately weighing the possible consequences, which has been linked in theory to both depression and suicide. As described in Chapter I it is necessary during adolescent development to developed cognitive capacity, principle thinking or morality. Some adolescents may not yet have developed such thinking and they are therefore more likely to behave carelessly as those teens are not yet able to think about real consequences (for example, that death is something real and permanent).[16] Figures show that "almost as many adolescent suicides are caused by impulsiveness as by depression" and it "has been demonstrated that more than half of adolescent suicidal behavior occurs with less than 30 minutes' deliberation and a quarter with less than 15 minutes' deliberation" (Robins, 1998: 67).

The seventh factor in Robins' psychological model of a suicidal person, and also mentioned by Rivers (1995: 32), is the idea of *Perfectionistic Standards.*

> Perfectionism is a mind-set characterised by a requirement that one has to do things without error, an intolerance of mistakes and a tendency to set impossible standards and goals for oneself. [...] Psychologists have reasoned that people who operate with such perfectionistic standards would be chronically frustrated, overly self-critical, and easily depressed – an unhappy combination that could lead to suicidal thinking and behavior.

(Robins, 1998: 68)

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[16] See Chapter I: 1.2.1 Psychological and Intrapsychic Factors

Researchers indeed were able to show a link between perfectionist thinking and suicide ideation (Robins, 1998: 68).

A final important factor is *coping Techniques*, described by Robins as active problem-solving approaches, like, for example, the ability to turn to friends or family for support, or the development of morality, which enables an individual to solve conflicts (Moshman, 1999: 48f.).[17] Ineffective coping skills are fantasising, narcotising, anxious and depressed feelings with alcohol or drugs, ruminating about the problem, which means turning it over and over in one's mind, or dealing with a problem by getting angry but not saying anything (Robins, 1998: 69). Further, if morality has not yet been developed, the youth is not yet able to reflect on problems from an impersonal perspective but still remains in a more egocentric interpretation of the problems. Suicide is often such an egocentric event.[18]

In a research project at Columbia University (USA) the team had a close look at the problem-solving skills of a group of young girls who had attempted suicide. The result was that these girls had poorer interpersonal problem-solving skills and fewer alternatives to solve stressful life events than any other group (Robins, 1998: 70).

Robins reports a similar result. He establishes in a study that students with

> high stress in their lives and whose responses to an inventory of coping behaviors tended to be dysfunctional (e.g., 'spending endless hours thinking about things') had higher levels of depression than other students.

(Robins, 1998: 71). And depression itself, as described above, increases the risk of suicide.

To sum up, suicidal adolescents seem to employ coping strategies that are not adaptive. In conclusion, if a person has most of these eight characteristics he or she is "likely to be more vulnerable in regard to suicidal behavior than a person who does not have these characteristics" (Robins, 1998: 72). The risk appears greater.

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[17] See Chapter I: 1.2.1 Psychological and Intrapsychic Factors
[18] See Chapter I: 1.2.1 Psychological and Intrapsychic Factors

2.4 Suicide and Problem Behaviours

Robins argues that there is a connection between suicide attempts and other problem behaviours. These behaviours are difficulties at school, the use of alcohol and drugs, and running away from home. One explanation for this connection can be that both sorts of behaviours, suicide and problem behaviours, include elements of alienation and escape (Robins, 1998: 51).

2.4.1 School Experiences

School can generally be a very stressful experience, as there is often great pressure by parents, teachers, by the culture or society, as well as other peers to succeed and do well at school. Performance in school is important to feeling successful and precious.

> Poor performance at school can impact negatively on a young person's self-image, which increases the chances of suicidal thinking [Butler et al. (1994): 625]. And indeed, research points to a link between suicidal behaviors and difficulties experienced at school

(Robins, 1998: 52).

Paluszny, for example, found in one of her studies, "that almost twice as many young people who had attempted suicide reported problems relating to school than was true for a control group" (Paluszny, 1991, in Robins, 1998: 52). And conversely adolescent suicide ideators are according to Butler,

> less motivated to perform in school, less confident about their academic abilities, less optimistic about their prospects at school and less apt to feel in control of their own destiny at school

(Butler, 1994: 632, in Robbins, 1998: 52).

School is viewed as a loosing situation, without hope or the feeling that this is changeable. This may cause feelings of hopelessness and helplessness, of anger or aggression, which may cause bad grades at school and increase the feeling of not being precious. That itself may cause low self-esteem. Here again an evil circle is starting and the teenager feels worse and worse and may at least see only one way to "escape", suicide.

2.4.2 Alcohol and Drug Use

> There is an association between the use of alcohol and drugs by young people and suicidal thoughts and behavior. This association holds across national boundaries and in different cultures. The data indicate that although most people who use drugs and alcohol will never attempt suicide, drugs and alcohol users are more likely to both think about suicide and attempt suicide than their nonsubstance-using counterparts

(Robins, 1998: 54).

A study of teenage suicide in Oxford, for example, notes the result that 18% of the young men were habitual drug users, and alcohol was very often consumed during the hours before the suicide attempt (Hawton and Fagg, 1992, in Robins, 1998: 54). In the USA it was further found that one-third of youth suicide victims abused alcohol and one quarter abused drugs (Brent et al., 1988: 583, 584, in Robins, 1998: 54).

What reasons can be found for this?

1. One aspect could be the similarity in some of the effects of alcohol/drugs and suicide: both often have to do with a wish to escape. So all these sorts of behaviour can be viewed in some cases as escapist coping mechanisms.[19] However, for many people it may be a symptom of underlying psychological difficulty. The only big difference is that the relief and escape provided by alcohol and drugs are temporary, whereas suicide is something permanent (Robins, 1998: 55). To sum up, people who do not deal with their problems in a healthy direct way, but who try to solve things by escaping tend to be more likely to use alcohol, drugs and in the worst case suicide.
2. Drug use as well as suicidal behaviour, is for some people a manifestation of a lifestyle, a rebellious behaviour against the society, the family, life, school and so on. In such a case these behaviours are a sort of non-conforming lifestyle, a fight against the expectations, which may seem to be too high, not reachable. This behaviour often includes feelings of being different, alienated, and on the margins what can be very uncomfortable and at last lead to a fall in self-esteem and a rise in both destructive and self-destructive behaviour (Robins, 1998: 56).
3. At last another reason for the connection between alcohol and drug use and suicide is the fact that some drugs and even alcohol "may have specific effects

[19] See Baumeister's theory

that can increase the likelihood of self-destructive acts" (Robins, 1998: 56).

2.4.3 Runaways

A Canadian Research of suicidal adolescents clearly shows that "suicide ideation is associated with a very clear cut form of escapist behavior – running away" (de Man et al., 1993, in Robins, 1998: 57). In this study about 13% of the boys and 17% of the girls were runaways, and both boys and girls were more likely to show suicide ideation than their counterparts who had not run away. It was further reported a cluster of different behaviours, which were found together: suicide ideation, running away and depression. Runaways generally have to face many different problems. They often have been sexually abused, many are school dropouts, and many live on the street where they often have to become prostitutes to survive. So one can easily imagine that these kids have thought about or even attempted suicide, as their options are totally narrowed so that these runaways can sometimes not see any positive perspective for their life future and feel unworthy and hopeless (Robins, 1998: 58).

2.5 General Epidemiology

2.5.1 General Risk Factors

The presentation of generally valid risk factors for suicidality among teenagers, careless from which country they are, is a very complex task. Some are already mentioned earlier in this work, others are mentioned here and some are mentioned later, within the section about special risk factors found in New Zealand.
As noted above, suicide, suicide attempts, and ideations are very complex issues. Suicide behaviour in young people is the endpoint of a multi-causal process in which different risk factors accumulate to influence risk, and as everybody is unique, there is no single reason why young people choose to end their life. Therefore, one cannot expect finding any one single reason why somebody kills himself or herself. It is the composition of many factors that sets an adolescent particularly at risk. However, researchers state that there are several factors that may contribute to a person engaging in any suicidal behaviour, as already mentioned within this Chapter.

Suicide, as described above, can be viewed at from different perspectives, a historical one, a cultural, biological, and sociological one, as well as a psychiatric and psychological one.[20] Risk factors can also be linked to these different perspectives. That means, there are, for example, biological and psychiatric risk factors (like mental diseases), psychological (and cognitive) risk factors as well as environmental (sociological) risk factors. Beside these different factors there are often triggering, stressful life events, which also play a role concerning somebody's suicidality as well as somebody's individual temperament and vulnerability.

Biological Risk Factors
As already described within this Chapter: 2.3.2 there have been discussions about genetic factors or dispositions, and special levels of neurotransmitter, such as for example, serotonin, which may increase the risk for suicide or at least have some influence.

[20] See Chapter II: 2.3 Theories of Suicide

Another biological factor, mentioned by Stillion is that of being an adolescent itself. This period of life means many biological changes, such as for example increased production of hormones.

> Although there is no direct evidence that the onset of puberty increases suicide risk, the fact that the suicide rate for postpubescent teenagers is higher than that for preteens strongly suggests at least an indirect influence.

(Stillion, 1996: 104)

Generally one can suppose that adolescence with all its typical characteristics has its impact on the individual, on the well-being, the self-esteem, the coping-skills, the cognitions, the psychological condition and so on. These factors again have their influence on suicidal ideation and suicidality. In this way adolescence can be viewed at as a general risk factor for suicidality. However, and fortunately, not all adolescents are suicidal, but this special phase of an individual's life sets young people generally at an increased risk.

Psychiatric and Psychological Risk Factors

As noted above, mental illness or any mental disorder, especially depression, personality disorder, especially the type: antisocial behaviour, substance abuse, as well as anxiety disorder and borderline personality disorder, although less frequently, have been identified as general risk factors for suicidality by many studies during the last few years. The occurrence of such mental illnesses increases the risk for suicidal behaviour, suicidal thoughts as well as suicide attempts.[21]

The Ministry of Health, New Zealand, also notes that the Canterbury Suicide Project in Christchurch found that those who have made a serious suicide attempt often have some underlying psychological distress or mental illness and that they display some recognisable mental health or adjustment difficulty before the suicide attempt. The most important risk factor seems to be depression (Ministry of Health, 1999: 14).

Depression is seen as a cofactor to suicide, and combined with a deep sense of hopelessness and other triggering events as for example unemployment, it can contribute to a spiral of hopelessness and depression which may end in the worst case in a suicide attempt as a sign of deep despair (Taylor, 1990: 15). Major depression is

[21] See Chapter II: 2.3.3 Psychiatric Perspective

described within international literature as the most predominant characteristic among young people who complete suicide (Barwick, 1992 and Public Health Group, 1996: 17).

> Comparative national data from Canada, Germany, United States, and New Zealand indicate that major depression rates have been increasing, and that the onset of depression has been occurring at a younger age for each cohort born since the Second World War

(Public Health Group, 1996: 18).

This statement shows that depression as a mental health problem is increasing internationally and as there is a link between depression and suicide one can imagine that this increase also relates to an increase of suicide rates.

Antisocial behaviour, for example, often a result of a personality disorder, leads to a failure to develop adequate internal controls over one's behaviour. These teens then often engage in antisocial behaviour which may bring them into conflict with legal authorities. In such cases the living circumstances may seem completely overwhelming for such young people and lead to the idea of "escaping" by killing oneself.

> It is likely that the impulsive and aggressive nature of these young people may enhance the likelihood of a self-destructive act, especially when their antisocial behavior increases their stress by bringing them into conflict with legal authorities

(Stillion, 1996: 107).

It is further found, that teenagers who show two of these mental illnesses, noted above, are at greater risk for suicide than those who show only one of these mental illnesses, and those who show none, are at the lowest risk level (Stillion, 1996: 107). This does not mean that adolescents without any mental disorder are generally not at all at risk, as well as it does not mean that all teens with one or even two mental disorders always try to kill themselves. As already discussed above, the factors are complex and suicide is a multi-causal act and it is not possible to find only one main reason. It is always the summary of different factors, which leads at last to suicide ideation, to a suicide attempt or in the worst case to a completed suicide.

Further, adolescence is a phase in which the individual has to develop his or her self-identity, as described within Chapter I: 1.2.1 Psychological Development. As Erikson explains,

> the establishment of a **sense of identity** is a major developmental task of adolescence. Teenagers

> who develop some consistent understanding of who they are and who they are becoming will have a foundation of competence in coping with the stresses of this period. In contrast, adolescents who struggle with their identities are less likely to develop the coping skills needed to deal effectively with these challenges

(Stillion, 1996: 104).

The second main psychological risk factor for suicidality, beside the more psychiatric one of mental illnesses (abnormal psychology)[22], is the lack of identity. This is a typical circumstance during adolescence as it has to be developed during this period of life and is therefore often not yet totally established. Stillion further mentions a characteristic, which is also typical for adolescents, and that is moodiness. She states that moodiness is associated with depression and suicidality among this age group (Stillion, 1996: 104). Another psychological state, which is also mentioned above in this work as one element of this model by Robins, is that of hopelessness. Stillion says for example that "feelings of hopelessness constitute an important variable linking depression to suicide" and "that feelings of hopelessness are stronger determiners than generalized depression of lethality of intent among suicide attempters." (Stillion, 1996: 106). That means firstly, that hopelessness itself is a risk factor for suicide and secondly that hopelessness also increases the lethality of intent.

Another psychological risk factor, stated by Stillion, Remafedi and others, is the development of a homosexual identity during adolescence. This psychological task may cause psychosocial stressors, which are believed to be factors contributing to the high rate of suicides among this special group (Stillion, 1996: 108). The United States Department of Health and Human Services, for example, found that 30% of suicides under the age of 21 years occurred among homosexual youths (Public Health Group, 1996: 20f.). They of course "may not commit or attempt suicide because they are homosexual, but rather because of the isolation and turmoil that often results from this discovery, including social isolation and lack of support" (Public Health Group, 1996: 20f.). As the impacts of discovering a homosexual identity have been discovered as a possible risk factor for suicide, and as this factor is often not really discussed in

[22] See Chapter II: 2.3 Theories of Suicide: 2.3.4 Psychological Perspective

explanations about that topic this special issue is discussed in more detail later, within this Chapter: 2.5.3 Homosexuality and Suicide.

Cognitive Risk Factors

Within Chapter I: 1.2.1 Psychological and Intrapsychic Factors, adolescent development is explained within different levels. One level is, for example, the development of cognitions, of formal operational thinking, magical thinking, morality and so on. Teenagers often hold an illusion of invulnerability that can contribute to risk taking behaviour, as they, for example, do not yet realise that death is something final and unchangeable.

These cognitions further reflect individual variations in temperament or related factors, which may act to encourage the development of suicidal behaviour. Concerning the cognitive development during this life period it has been found that many adolescents have not yet developed a healthy way of problem solving skills and it is also quite common that many have not yet been able to establish a positive future perspective (Ministry of Youth Affairs, 1999: 16). Some researchers "have speculated that adolescents with limited problem-solving skills are at greater risk for suicide when experiencing significant life stress than those who are better problem solvers" (Stillion, 1996: 109). And one can further easily imagine that "suicidal adolescents have been found to have a reduced future-time perspective and goal orientation [...], they do not believe that the situation will improve" (Stillion, 1006: 110).

Environmental Risk Factors

As shown above, the culture, the society, and the environment play a big role concerning somebody's well-being, and especially concerning adolescent developmental tasks.

Researchers found that many suicidal adolescents come from conflicted homes that are not able to offer the things which a young person needs. The incidence of family dysfunction among families of suicide attempters and completers is higher than the average. These families "are more likely to be disrupted by parental separation and divorce than the national average" (Stillion, 1996: 112). It was further found that these families have a higher incidence of medical and psychiatric problems, and of alcoholism and drug abuse among the parents (Stillion, 1996: 112). While these familial

factors have their impact, parental demands, expectations, rejection, emotional or physical abuse, non communication within the family, or rigidity of relationships within a family also have their influence on the self-esteem and well-being of an adolescent (Taylor, 1990: 15). And as Taylor further describes, some "young people have picked up messages that their parents did not want them." (Taylor, 1990: 15). Changes within the family structure are further identified by Rivers (1995) as possible risk factors for suicidality. These changes include death of a parent, caregiver or other family member, separation or partnership dissolution, new family relationships because of remarriage, geographic and social mobility, which often results in an increase of movement and therefore loss of supportive social networks for the youngsters and problems with friendships:

> Another environmental risk factor is **social isolation**[23] and **poor peer relationships**. Modern-day youth, who generally live in nuclear or single-parent families, do not enjoy the support that was provided for earlier generations by extended families, neighborhood churches, and small communities. Contributing to this sense of social isolation is the fact that family mobility is at an all-time high

(Stillion, 1006: 113).

These movements from one place to a totally new environment cause a breakdown of friendships and family ties. So youngsters of our society often have to deal with poor parental or family relationships, the ties are often broken because of separation, divorce or moving. Therefore these young people spend little time with other family members and often have a negative view of their parents. Combined with poor peer relationships, as found among many suicidal adolescents (Stillion, 1996: 113 and Drummond, 1996: 30), these teenagers feel isolated and very lonely, which causes stress and hopelessness, and a big lack of communication and support possibilities, all factors which set an adolescent at risk for suicide.

Rivers further stresses the problem of inconsistent parenting, physical or psychiatric illness within the family, family violence, including sexual abuse and other power relationships, suicidal behaviour within the family and poverty (Rivers, 1995: 33). Suicidal adolescents tend to come from socially disadvantaged backgrounds characterised by low socioeconomic status, limited educational achievement and low income (Ministry of Youth Affairs, 1999: 15).

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[23] See Durkheim, Chapter I: 1.2.4 Sociocultural Factors in Adolescent Development

As briefly noted here by Rivers in this coherence it is also necessary to have a look at the painful phenomenon of sexual, physical and emotional abuse within a family.

> There is a growing body of evidence that **sexual abuse** is an environmental stressor that may affect suicide risk among adolescents. A number of studies have shown that adolescents who report a history of sexual abuse have a higher incidence of suicidal ideation and suicide attempts than those who have not been sexually abused (Harrison, Hoffmann, Edwall, 1989; Kienhosrt, DeWilde, Diekstra, & Wolters, 1992; Shaunesey, Cohen, Plummer, Berman, 1993). [...] We do know, for example, that sexually abused adolescents show a higher incidence of depression, substance abuse, and conduct disorder, all of which have been shown repeatedly to be associated with suicidality (Bayatpour, Wells, & Holoford, 1992; Sansonnet-Hayden, Haley, Marriage, Fine, 1987).

(Stillion, 1996: 112f.)

These ideas are also supported by the Ministry of Health (NZ), which mentions that suicide attempters or completers generally tend to come from "disturbed or unhappy family and childhood backgrounds [and] from socially and educationally disadvantaged backgrounds" (Ministry of Health, 1999: 14). Beautrais also notes poor parental or familial communication skills and extremes of high and low parental expectations and control as additional risk factors (Ministry of Health, 1998a: 4).

Triggering Events

A triggering event is a stressful life event, which has great negative importance for an individual and which seems not solvable and overwhelming. Such an event can generally be everything, as it really depends on the interpretation of an individual and on the personal impact of the event on the afflicted ones. That is why sometimes events which are triggering for adolescents seem trivial to adults. Such events can be failure at school or in any other case, problems with peers, parents, with a boy- or a girlfriend, problems with the law, the police, a personal loss and so on. So studies from Brent et al., (1993) show that

> adolescent suicide completers were more likely than the control group to have experienced (1) interpersonal conflict with parents and with boyfriends or girlfriends, (2) disruption of a romantic attachment, and (3) legal or disciplinary problems.

(Stillion, 1996: 115)

So such life stressors are significant variables associated with suicide in this age group.

Also requiring mention here is the phenomenon of cluster suicides. The central idea

here is a sort of outbreak, suddenly there is a "rash of suicides" (Robins, 1998: 85). "In each of these situations, a single or group suicide served as a prelude to others in a tragic episode of adolescent conformity." (Stillion, 1996: 117). Where cluster suicide really comes from is not yet understood, but it exists. Some researchers believe that "perceived similarity between the model and the cluster victim and the victim's interpretation of the model's behavior as granting permission are significant factors" (Stillion, 1996: 117). Robins describes the causes of cluster suicide as follows:

> One person commits suicide. The second person becomes aware of the suicide through knowing the person or by hearing about the act and follows suit. In essence, the second suicide is an imitation of the first one. [...] In cluster suicides, the model of a completed suicide provides both a stimulus and a justification for someone already very vulnerable to move a little bit further and take that final step. The reasoning could be something like, 'If it's okay for that person to do it, it's okay for me to do it, too.'

(Robins, 1998: 88).

An important role concerning cluster suicide and suicide itself is the media and the way suicide news are published. The Ministry of Health, for example stresses that "there is significant evidence to show media reports of suicide may increase the risk of further suicides for a period of time after that media publicity" (Ministry of Health, 1999: iii). So there are studies, which show a clear link between media coverage of suicide and a subsequent increase in suicides and suicide attempts. "Evidence suggests if suicide is communicated publicly then some vulnerable individuals may consider it as an option" (Ministry of Health, 1999: 1). Adolescents are especially vulnerable and therefore in danger to be at greater risk for suicide by the way in which the media reports a suicide. These studies make clear that the media has its responsibilities concerning this issue, as on the other hand a number of researchers

> have also noted that appropriate reporting of suicide can minimise adverse effects if reports include explanations of how to identify persons at risk of suicide, or present information about risk factors for suicide and positive alternatives to suicidal behaviour

(Ministry of Health, 1999: 3).

2.5.2 Demographic Factors: Gender and Race

Gender Differences

There is a gender difference in thinking about suicide, attempting suicide, and a gender difference in completing suicide, described internationally by many different authors, such as Beautrais (NZ), Bagely (England), Rivers (NZ), The Ministry of Health and The Ministry of Youth Affairs (NZ), or Robins (USA).[24]

Concerning suicide ideations or the thinking about harming oneself researchers found that more girls think about harming themselves than boys, but that many of these girls who report that they have thought about suicide would not act on the thought. This result is not really an unexpected one as females tend to suffer more often from depression or depressive feelings, linked to increased thinking about suicide, than do males (Robins, 1998: 25).

Concerning suicide attempts however, girls, report more frequently than boys that they have made a suicide attempt. This gender difference again has been found in many studies and shows that girls are more likely to attempt suicide than boys (Robins, 1998: 26). So even if the research result mentioned above shows that many girls who think about suicide would not act on the thought their number of suicide attempters is still higher than that for boys.

But concerning completed suicides males have higher rates than females. "Looking at adolescent males (aged 15 to 19), the 1988 suicide rate for males was over four times as high as it was for females." (Robins, 1998: 26).

To sum up, it

> looks as if girls are more likely than boys to take the steps leading toward suicide, but they stop or are discovered before the outcome is fatal. Boys are less likely to engage in suicidal steps, but when they do so, the outcome is much more likely to be fatal

(Robins, 1998: 26).

Reasons therefore may be, that boys generally choose more lethal methods to kill

[24] See Bibliography

themselves and that girls are perhaps more willing to "cry for help", dangerous as this is, whereas boys seem more likely to make the act a decisive and final one (Robins, 1998: 26).

Stillion (1996) further mentions some research concerning the gender difference from Linehan (1973), which emphasises some thoughts about suicide and suicide attempt from female as well as male college students. One common attitude, which was found there was, that those who complete suicide are generally seen as more masculine and more potent than those who attempt suicide. That means that attempted suicide was seen among this group of college students as weaker and less masculine. Stillion suggests that this attitude may be one reason why males

> would be more likely to structure any suicide attempt in such a way as to reduce the likelihood of surviving, while females would feel less stigma from surviving an attempt and might, therefore, be more likely to engage in less lethal suicidal actions

(Stillion, 1996: 200).

Another explanation, noted by Hill (1996), concerned the gender-models of a society. She suggested that in societies where girls are still brought up with classical feminine qualities, like being more passive, dependent and generally more expressive whereas boys have to be more decisive, independent and stoical these social prescriptions clearly affect the freedom of the sexes to express different emotions. Boys for example are more allowed to express aggressive feelings than depressed feelings but are generally more encouraged in hiding emotions. It is easy to imagine that these aggressive feelings may cause more lethality if a boy is trying to kill himself. Further the fact that they are not taught how to express their emotional feelings and their need for help may place them generally at higher risk for a serious suicide attempt. Girls on the other side, as a result of parental education, tend more to suppress their anger to the point where it atrophies into depression, which, as noted is one risk factor for suicide attempts (Hill, 1996: 40, 41). On the other hand they are more likely to express themselves, which could be an explanation why women seek more help concerning a suicide attempt than men, as women more often use a suicide attempt as a "serious form of expressing their need" (Stillion, 1996: 215).

Racial Differences

Here we concentrate on figures and findings from the United States and Great Britain,

whereas the special racial differences among Maori and Pakeha New Zealanders are discussed later.[25]

In the United States different suicide rates have been found between young white men (15 to 19 years) and young African American men. In 1988 the rate for white males was 19.6 per 100,000, the rate for African American males 9.7 per 100,000 (Robins, 1998: 26). The reasons for this racial difference are not clear but possible explanations are reported as the possible bias in reporting suicide, greater religious involvement among African Americans, which may act as a protection factor, and a difference in the way aggression is expressed. Robins states that there are speculations, which suggest that

> there may be a greater tendency for inner-city African American youth to direct their angry feelings outwardly – towards others – than for their suburban white counterparts, who may more frequently internalize their angry feelings, leading to higher rates of suicide among white youth

(Robins, 1998: 27).

Another explanation could be the experience of academic stress. Perhaps white men feel more academic stress and pressure from their parents than African Americans. However, there is still no clear explanation (Robins, 1998: 27).

The highest rates of youth suicide exist among the Native Americans, and there are big differences between the different tribes, as already described within Chapter II. [26] "There is some evidence that the highest rate occurs among young people in tribes undergoing faster cultural assimilation." (Robins, 1998: 27). However, for a better understanding of the high suicide rates among Native Americans one has to have a close look at the individual culture of such tribes to see what factors seem to promote or inhibit suicidal behaviour. This issue is described and looked at in more detail concerning Maori suicide rates in New Zealand, which are also higher than the rates among European New Zealanders.

Hill mentions, that in Britain in 1992, the rate of suicides among Asian women between 16 and 24 years was three times higher than among young females of British origin (Hill, 1996: 44). One explanation therefore to be noted is cultural pressure, as some Asian women cannot bring together the conservative expectations of their parents with

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[25] See Chapter II: 2.6.2 Bicultural Differences
[26] Also see Chapter II: 2.3.1 Cross-Cultural Perspective

their actual life as a British teenager (Hill, 1996: 45).

2.5.3 Homosexuality and Suicide

Introduction

One special group, which should be mentioned here because the suicide rates among them are especially high, is the group of homosexual youths. "Unfortunately, the potentially important link between suicide and homosexuality has been overlooked until recent years" (Remafedi, 1994: 8). However, there are a number of studies today, which all show that homosexual youths are particularly at risk of suicide. Gibson, for example, mentions that homosexual youths belong to two groups at high risk of suicide: youth and homosexuals. He found that gay youths are 2 to 3 times more likely to attempt suicide than other young people. Some researchers suggest that the numbers may go up to 30% of completed suicides annually (Gibson, 1989: 15f.). However, some may find this figure too high. What was found in the USA was, that suicide is the leading cause of death among gay male, lesbian, bisexual, and transsexual youth, and gay males were 6 times more likely to make an attempt than heterosexual males. Lesbians were more than twice as likely to try committing suicide as heterosexual women. The Institute for the Protection of Gay and Lesbian Youth in New York, and the Los Angeles Suicide Prevention Center

> consistently show that 20-35 percent of gay youth interviewed have made suicide attempts. [...] Statistics from Minneapolis, Los Angeles, and San Francisco find that more than 50 percent of gay youth experience suicidality including serious depression and suicidal feelings.

(Gibson, 1989: 17).

These figures are relatively old and one can hope that the situation for homosexual youths is better today and that the acceptance within a society is higher now, which may decrease the suicide rates among gay youths. Nevertheless, there are new figures for New Zealand, for example, from the Christchurch Health and Development Study, presented by David Fergusson on the "Symposium: Youth Suicide Prevention Research Aotearoa", Wellington, August 2002, that show that among the cohort of 1,265 children, who have been observed since 1977, 2.8% were classified as GLB (gay, lesbian, bisexual), and that among this GLB group the prevalence of suicide was higher

than among their heterosexual counterparts. So homosexuality can in a way be understood as a risk factor for suicide. Old figures as well as current research results from New Zealand (Fergusson, 2002) show that gay, lesbian and bisexual youth are more likely to attempt suicide than their heterosexual counterpartners. What are the reasons for that?

Generally many gay youth have to face problems in accepting themselves as what they are, which may end up in low self-esteem, which, as described above, is a risk factor for suicide.[27] They often have to face a huge lack of information. They do not have adult role models, who could show them, that it is possible to live a happy life and to find stable relationships. Further many gay youth have to

> face extreme physical and verbal abuse, rejection, and isolation from family and peers. They often feel totally alone and socially withdrawn out of fear of adverse consequences. As a result of these pressures, lesbian and gay youth are more vulnerable than other youth to psychosocial problems including substance abuse, chronic depression, school failure, early relationship conflicts, being forced to leave their families and having to survive on their own prematurely. Each of these problems present a risk factor for suicidal feelings and behaviour among gay, lesbian, bisexual, and transsexual youth

(Gibson, 1989: 15).

Gay youth comprises, for example, as many as 25 percent of all youth living on the streets in the United States (Gibson, 1989: 22). Gibson points out that the main problem for gay youth is "a society that discriminates against and stigmatises homosexuals while failing to recognize that a substantial number of its youth has a gay or lesbian orientation" (Gibson, 1989: 15, 16).

Remafedi, for example stresses that 28% of his report subjects "were forced to drop out [school] because of conflicts about their sexual orientation" (Gibson, 1989: 20). This may fortunately be better today, as the acceptance of homosexuality within our society is better now than previously, but there can still be found harassment and verbal as well as physical abuse, which may negatively influence self-esteem and create pressure and isolation, all factors, which are identified as risk factors of suicide.

[27] See Chapter II: 2.5.1 General Risk Factors

Better Understanding of the Issue

"Homosexuality is not a mental illness or disease. It is a natural and healthy expression of human sexuality" (Gibson, 1989: 24). However while it may not be necessary any more to note that homosexuality is not an illness, there are still people who cannot accept homosexuality as something natural. Therefore many teens still have great fear and feel insecure when they discover their bisexuality or homosexuality. These feelings even get worse when they recognise negative comments and reactions about homosexuality or bisexuality among their peers, their family, and other adults. These experiences can result in an attempt to hide or even deny their own sexual orientation.

> Youth who try to change a homosexual orientation and are unable to do so are at high risk of emotional and behavioral problems. They often develop feelings of hatred and rage that can be turned against themselves or others

(Gibson, 1989: 29).

This places them at greater risk of self-destructive or suicidal behaviour. Others just try to hide their homosexual identity, which causes the problem of having to deal with everything on their own. These teenagers "suffer their fears and low self-esteem in silence" (Gibson, 1989: 31). For them it is also very difficult to meet other homosexual youth, and to find relationships, which again creates isolation and the feeling of no positive future perspective, all factors which may end in a suicidal behaviour as an attempt to "escape". Those who try to live their homosexuality openly have to face the fact that the society still offers little support during the process of developing a stable and healthy homosexual identity. There exist still only a few role models. Homosexual teachers at schools, for example, often are afraid of coming out, so their homosexual students do not have any adult role models. Those who try to live their homosexuality openly often have to face harassments and rejection at schools and within their families. They are sometimes discriminated against in finding housing and employment because of their sexual orientation, which puts them again particularly at risk for suicide. And on the other side there are not enough youth programmes that are focussed particularly on homosexual youths which creates a "sense of isolation due to not being accepted and to being different" (Kourany, 1987: 92).

Reducing Suicide among Homosexual Youth

The risk for homosexual youth of killing themselves can be reduced. Therefore one has to face problems such as the lack of information for homosexual youth, the lack of acceptance of homosexuality in our society, the lack of support for homosexual adolescents as well as concrete discrimination and the inability to recognise that there are homosexual teenagers in every society. So the society as well as the families, schools, professionals, even religion can make contributions to reduce the level of risk for suicide through showing acceptance, openess and support. Accurate and positive information is needed. This includes more research about the connection of homosexuality and suicide to break the wall of silence.

Summarising, everybody within a society is responsible for the well-being of our youth, especially homosexual youth who still suffer from discrimination and harassment. We all can contribute to an atmosphere of acceptance, which is open-minded, trustworthy and non-judgmental. We must show them that we accept them for who they are and support them in solving their problems and fears. Sexuality needs therefore generally to be included in educational programmes, counselling, therapeutic settings, and so on, to break the wall of silence. Therefore it is necessary to

> assure them it is a healthy and positive form of human expression. [...] Assure them there is nothing wrong with being gay and that it is the response of others to homosexuals that is the source of the problem. [...] Assure them that sexuality is only part of who they are. Explore other areas of potential growth that give them a broader understanding of themselves as individuals

(Gibson, 1989: 63, 64, 65).

Lastly it is necessary to support families in dealing with homosexuality among their teenagers. It is important to help every family member to express its own feelings to improve understanding among them. Gay youth need to be patient in gaining acceptance and need to be told that parents sometimes have trouble in accepting their sexual orientation, but this can improve and become better in the future (Gibson, 1989: 65).

2.6 Youth Suicide in New Zealand

As could be seen in the graph, presented within this Chapter: 2.4.1 Rates and Distribution, New Zealand has a very high suicide rate among adolescents, especially if one compares the data with other countries. This part of the work should light up the topic adolescent suicide in New Zealand. Available figures and statistical material is presented below, as well as a discussion about the special issue of bicultural differences and Maori suicide in New Zealand.

2.6.1 Demographic Trends in New Zealand

At the beginning of this chapter information is given about rates and distribution within different countries, like for example the United States of America or England. Different selected OECD countries are also compared with each other. This paragraph is now only focused on the situation in New Zealand.

> New Zealand is a country in the South Pacific consisting mainly of two islands with a total land area of 270,500 square kilometers (New Zealand Yearbook 1994), similar to that in size of Japan and Great Britain. The country is politically bicultural in that, historically it recognizes two main groups in the population – 9.4% Maori (of which there were 324,000 in 1991) (Statistics NZ, 1995), and the rest of the population classified as mainly the European ethnic group, other groups including the Pacific Islanders, Indians, Chinese, and more recently the Asian migrants. Persons of Pacific Island descent made up the third largest group (4.5%) in the last 1991 Census (Public Health Commission, 1994: 12). It is nevertheless increasingly becoming recognized as a multicultural society with the recent increase in immigrants from Europe, South Africa, Pacific Islands, and Asia

(Drummond, 1996: 3).

Now before one can speak about rates and distribution it is necessary to define terms like rate. So, the suicide rate is the frequency with which it occurs relative to the number of people in a defined population, whereas the number of suicides is the actual number of suicide deaths (www.spinz.org.nz).

Suicide is, beside death because of motor vehicle accidents or crashes, the second leading cause of death for adolescents. Compared internationally suicide in New Zealand ranks among the highest in the OECD countries (Finland, Australia, Canada, USA, Norway, France, Sweden, Germany, Japan, UK, and Netherlands). Even in 1999 New Zealand's youth suicide rate is still among the highest (www. spinz.org.nz) and is therefore still a major public health concern, especially as one can expect that there are many more suicide attempts than completed suicides. Many who work in the field of suicide prevention guess that there are "a hundred suicide attempts for every one completed suicide in the teen population (Crook, 1989)." (Drummond, 1996: 6). However, it must also be clarified that such an international comparison is problematic as different countries use different methods to classify suicide and the classification is, to some degree, culturally determined (www. spinz.org.nz).

Number of Youth Suicides New Zealand

Actual data, published in May 2002 by the New Zealand Health Information Service are statistics from 1999. These statistics show a clear decrease of the suicide rate compared with the years before. "In 1999 a total number of 120 young people aged 15-24 years died by suicide, compared with 140 in 1998, and 142 in 1997. [However], [y]oung people still have higher rates of suicide than other age groups." (Ministry of Health, 2002: 1). Of these 120 young people, 83 were male and 37 were female, and 33 were Maori, compared to 43 in 1998 (Ministry of Health, 2002: 5).

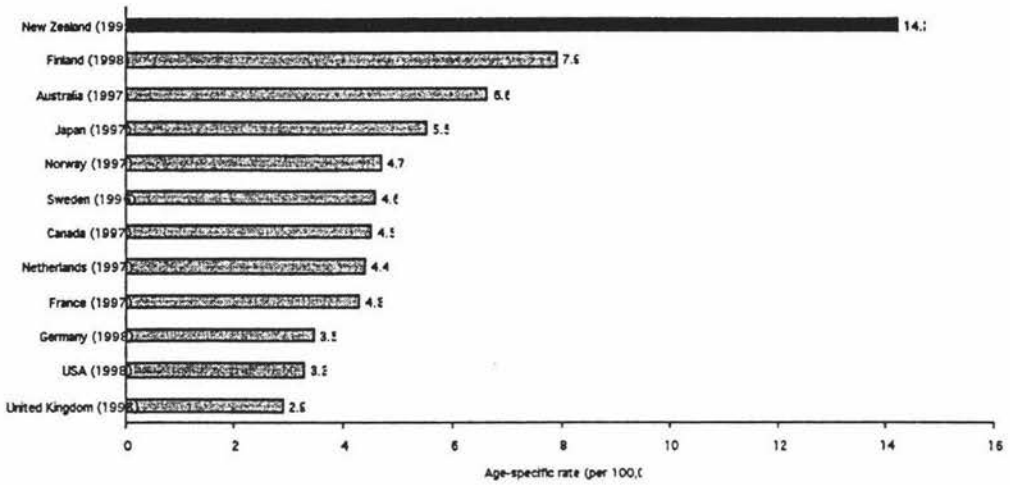
Rate of Youth Suicide New Zealand

> [The] total rate of youth suicide in 1999 was 22.6 per 100,000 compared to 22.5 per 100,000 in 1990. These are the most current figures.
>
> The rate of youth suicide for males (aged 15-24) in 1999 was 30.6 per 100,000, compared with 38.0 per 100,000 in 1990.
>
> The rate of youth suicide for females (aged 15-24) in 1999 was 14.2 per 100,000, compared with 6.7 per 100,000 in 1990.

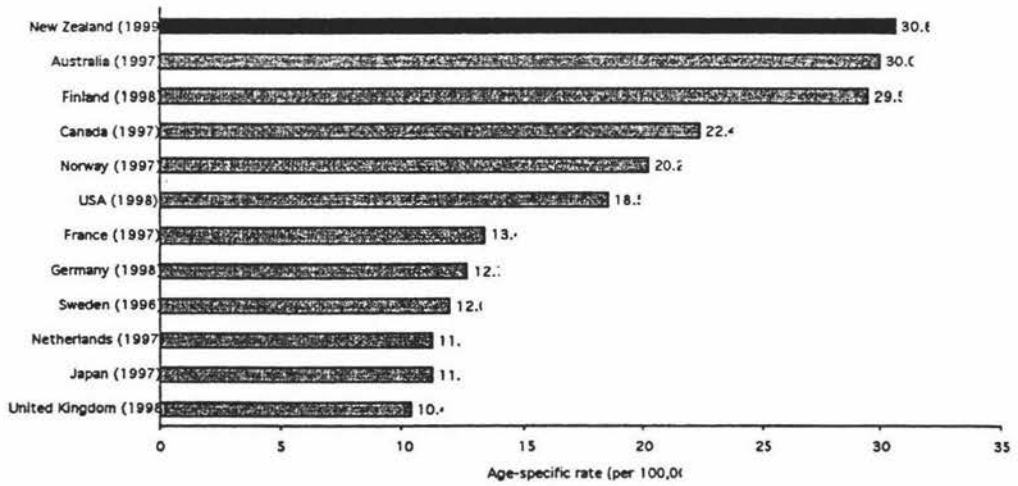
(Ministry of Health, 2002: 5).

These figures show again that the rates of completed youth suicide are higher among males than females, what is mentioned above within this Chapter.[28]

[28] See this Chapter: 2.5.2 Demographic Factors: Gender and Race



Female youth suicide rates (15-24 years) for selected OECD countries (1999 New Zealand)
Ministry of Health, Suicide Facts – Provisional 1999 Statistics (all ages), Wellington: Ministry of Health, 2002



Male youth suicide rates (15-24 years) for selected OECD countries (1999 New Zealand)
Ministry of Health, Suicide Facts – Provisional 1999 Statistics (all ages), Wellington: Ministry of Health, 2002

In 1999, the rate of suicide for Maori youth was 30.6 per 100,000, compared to the non-Maori rate of 20.5 per 100,000.

In 1999, the rate of suicide for young Maori males was 42.4 per 100,00, compared to the non-Maori rate of 27.7 per 100,000.

In 1999, the rate of suicide for young Maori females was 18.7 per 100,000, compared to the non-

> Maori rate of 13.1 per 100,000

(Ministry of Health, 2002: 5).

Compared with the past the suicide rate for Maori also decreased during the last few years, however, Maori continue to have higher rates of suicide among youth (www.spinz.org.nz), which goes with the international findings, mentioned above, which show for example that Native Americans have higher youth suicide rates than others.

Summarising, the overall

> youth suicide rate has now decreased for four consecutive years. The 1999 numbers and rates are the lowest for many years. Total youth suicide deaths are the lowest since 1987 and the total rate is the lowest since 1991. Youth suicide numbers and rates have dropped for both Maori and non-Maori. There was a slight increase for females from 1998 (due to an increase among non-Maori females).

(Ministry of Health, 2002: 6).

Number and Rates of Youth Suicide Attempts

Generally, youth have the highest hospitalisation rate for attempted youth suicide within New Zealand population.

> In 1999/2000 there were 356 male hospitalisations (rate of 131.4 per 100,000) compared to 402 hospitalisations (rate of 147.4 per 100,000) in 1998/1999.
>
> In 1999/2000 there were 698 female hospitalisations (rate of 268.3 per 100,000) compared to 645 hospitalisations (rate of 244.6 per 100,000) in 1998/1999.
>
> In 1999/2000, the hospitalisation rate for Maori females was 224.4 per 100,000, lower than the non-Maori female rate of 279.6 per 100,000. For Maori males the hospitalisation rate was 158.6 per 100,000, higher than the non-Maori male rate of 124.6 per 100,000.

(Ministry of Health, 2002: 7).

Gender Differences

The gender difference concerning suicide ideation, suicide attempts, and completed suicide, found internationally and stated above, is also valid for New Zealand. New Zealand shows higher rates of male suicide than female suicide whereas the rates of attempting suicide are higher for females than for males.

On the actual homepage of SPINZ, which is a national youth suicide information service with the aim to assist communities and services to prevent youth suicide by providing them with high quality information, is published that there can be found three male suicides to every female suicide (www.spinz.org.nz).
Explanations for this phenomenon have already been described within section 2.5.2 Demographic Factors: *Gender Differences.*

2.6.2 Bicultural Differences

Before bicultural issues are discussed within this paragraph I want to make clear that during the research process[29] of this thesis it became clear that my focus is not on bicultural issues. During the planning phase of this paper it was firstly planned to include a brief and detailed discussion about the special topic of Maori youth suicide as in the literature this issue is described as a major problem within New Zealand, as already mentioned above. However, within my research project I decided to focus on a sort of feedback for Youthline as described within Chapter IV and during the research process it has become obvious that my interviews would not include any Maori youths, so I decided to focus more on general needs of young people in New Zealand and not so much on cultural issues or particular needs of Maori youth. I however still want to include this issue, as it is an important one within New Zealand.

The basic idea is that history has any influence on the actual socio-cultural position and on actual behaviour of adolescents is nothing new and exists for indigenous people the world over. As Lawson-Te Aho, a famous researcher on suicide among Maori teenagers, mentions, one

> of the responses to enforced acculturation and colonization for Maori was the establishment of negative behaviours as coping mechanisms for the trauma of colonisation. These have been transmitted inter-generationally through role modeling so that over time adverse behaviours have become normalized. Histories of colonisation for indigenous people show the removal and breakdown of cultural institutions that would have once modified and controlled individual behaviour for the collective good and collective behaviour for individual good. The removal of

[29] Described in detail within Chapter IV

> land, the forced impoverishment of Maori, and the removal of Maori control over Maori destinies have had profound effects on Maori in contemporary New Zealand society. [...] The result of constructed relations of inferiority and dominance is that many Maori struggle to maintain an identity as Maori and to have access to the institutions of Maori culture which provide strength and a source of psychological, spiritual, cultural and physical well-being for themselves, their families, and the broader social networks of which they are an integral part

(Lawson-Te Aho, 1998: 14).

Assimilation and colonisation have to do with recreation of Maori as non-Maori by removal of Maori cultural traditions, and with cultural superiority and dominance of the European culture. There exist evidence that these led to problems like inter-generational violence and abuse, drug and alcohol abuse, depression, mental illness, physical illness, rising youth suicide rates, which can all be understood as symptoms of a traumatised culture (Lawson-Te Aho, 1998: 14f.).

As described above the youth suicide rate among Maori was and still is higher than the rate among European New Zealanders. However, their rate also increased during the last few years, Maori still continue to have higher rates of suicide among young people. However a comparison of non-Maori suicide rates and Maori suicide rates is flawed for two reasons:

> First, the definitions of Maori used in the numerator and denominator data do not match. The comparison of two different data sets results in considerable under-counting of Maori ethnicity. Second, the process of recording and reporting Maori deaths is susceptible to front line collectors of ethnicity data making a judgment about ethnicity, often from the physical appearance of the deceased

(Lawson-Te Aho, 1998: 8).

That leads to the suggestion that there is a significant discrepancy between official statistics and actual numbers of suicides.

Nevertheless in

> the ten years to 1994, the suicide rate for taitamariki Maori [taitamariki is used throughout this document to refer to the age group 15-24 years] increased significantly. Suicide is now the second largest cause of death, after road accidents, for young Maori aged 15-24 years. The concern is not limited only to completed suicide. In 1995, Maori females aged 15-19 years had the highest rate of intentional self-injury/attempted suicide ... of all population groups. In the 20-29 year age group, Maori men are at greatest risk of mental illness

(Lawson-Te Aho, 1998: 5).

So youth suicide among Maori teenagers has risen significantly since 1984. The reported numbers of Maori suicides increased from 17 to 31 for Maori males and 5 to 12 for Maori females over the period 1984 to 1994. In 1994 there was a total of 43 Maori youth suicides reported in official statistics (Lawson-Te Aho, 1998: 8). These figures and facts give cause for concern and for the necessity to give special attention towards the needs and concerns of Maori youth. As their history and culture is different from the European one it is necessary to have a look at their special situation.

As a result of this realisation, there has been considerable research and these projects are still going on, like, for example, research about Maori suicide by Nicole Coupe. Further it was decided that it is not enough to create just one prevention programme valid for all youth, but to think about a special programme for Maori youth, which addresses their special needs and focuses much more on the relationship between culture and behaviour, especially suicidal behaviour than does the actual suicide prevention strategy for non-Maori. However, both parts of the main national youth suicide prevention strategy, "In our Hands", mainly focused on European youth and "Kia Piki te Ora o te Taitamariki", mainly focused on Maori youth, must be understood as two complementory parts of one strategy.[30] This fact shows that there has been emphasis on doing justice to the needs of Maori, too, during the last few years, and not only to focus on an European vision of prevention, as such a vision may help European youth, but may not automatically help Maori youth, as their needs may differ and their problems must be seen in a more cultural and historical way. Therefore many Maori researchers, like Lawson-Te Aho or Nicole Coupe have been fighting to be heard during the last few years.

2.6.3 Causes of Adolescent Suicide in New Zealand

Generally the risk factors, which are mentioned above within this Chapter, 2.5.1 General Risk Factors, can also be found among adolescents in New Zealand. Within this paragraph should be discussed whether there are any special factors, which may be found more often or concentrated or which probably may only be found in New Zealand

[30] See Chapter III: 3.4.3 Kia Piki te ora o te Taitamariki

and which then may have anything to do with the high rates of adolescent suicide in New Zealand.

Described within Chapter I and II, two broad directions of thoughts have shed light on suicide, the sociological model (especially the ideas of Durkheim) and the psychiatric and psychological perspective. The Mental Health Services, New Zealand, have required a review of this thinking to incorporate the context of the social, cultural and economic environment of New Zealand.

> In a sense this is a shift from a purely psychiatric or sociological model to that of a model considering an interactive interplay between the internalised psychological processes of the individual and the social, environmental forces shaping the individual

(Drummond, 1996: 31).

As all over the world (Rivers, 1995), New Zealand's adolescents who attempt or commit suicide show very high prevalence of mental illness or any psychiatric disorder, especially depression, substance abuse, and antisocial personality disorder. As Rivers mentions one additional problem in New Zealand is that

> psychiatric illness has a low level of acceptance within our society, particularly among young people. There are many psychiatric disorders that can increase the risk of suicide. [...] Those who are intent on suicide are unlikely to be able or willing to recognise their own emotional state

(Rivers, 1995: 31).
This can be understood as a result of an underlying non-acceptance of such sorts of illness.

The Public Health Group mentions that conduct and adjustment problems increase the suicide risk. They quote results from the Christchurch Health and Development Cohort Study (Fergusson and Lynskey, 1995), which show a strong association between self-destructive behaviour and adjustment problems. Adolescents with such problems were identified as 22 times more likely to attempt suicide. The most significant adjustment problems resulted in juvenile offending, police contact, dropping out of school and a very low self-esteem (Public Health Group, 1999: 18).

Antoniades completed research between 1961 and 1988 concerning the special New Zealand issues, which may set adolescents particularly at risk. He noted the following

high-risk indicators for the past: sociodemographic factors, such as overseas born, separation, sickness beneficiary and being an inpatient, illness and psychological problems, such as relationship problems, psychiatric illness, life related problems, depression, physical conditions and alcohol abuse (Drummond, 1996: 38).

> Approximately half of both the completed suicide and the attempted suicide study populations in the Canterbury Suicide Research Project (Beautrais et al 1994) had lifetime histories of substance abuse, compared to just 10 percent of the control group

(Public Health Group, 1996: 18).

More recently as the data mentioned by Antoniades (1961-1988), Barbara Disley, Director of the Ministry of Mental Health in New Zealand (1994), stresses that many

> reasons for the increasing rate have been put forward including unemployment, breakdown of traditional social institutions including families and the church, increasing rates of violence, including child and sexual abuse, alienation because of culture and race, family and interpersonal conflict and unresolved grief

(Drummond, 1996: 39).

She also believes, that there is an interplay of personal and social factors (Drummond, 1996: 39).

Barry Taylor, an Adolescent Mental Health Consultant (1994) further points out

> something very specific about New Zealand society: We also need to address the fatalism that young people have, and the strong male macho culture. We have to question why New Zealand and Australia have suicide rates among the highest in the world. It is often to do with cultural factors of not being able to express yourself. We have to look at suicide in the context of the overall increase of violence in our society, because it is a form of internalised violence' (In Townsend, 1994: 8)'

(Drummond, 1996: 41).

Concerning societal factors, which might have something to do with suicidality, Drummond mentions the decade of change in New Zealand society between 1980 and 1990. These years were characterised by a major restructuring of economy. This caused changes on many fronts, aimed mainly at improving the international competitiveness and encouraging foreign investment in an effort to develop a stable base for future economic growth and job creation. But these changes have been accompanied by major social changes, such as an increase of unemployment, of two or more families living together, an increase of health risk of unemployed youth, decline of income in some

sectors of the population, less access to health services, increase in violence, and drug and sexual offenses (Drummond, 1996: 41).

Unemployment is mentioned among many authors as a circumstance, which increases the suicide risk for adolescents. However, this relationship is not at all clear and studies on individual levels from Beautrais, Fergusson, or Goldney have all tended to suggest

> that associations between suicidal behaviour and unemployment are likely to reflect common adverse social, family and personal factors which are, independently, related to risks of both unemployment and suicidal behaviour

(Ministry of Youth Affairs, 1999: 17).

Rivers also mentions some specific social and cultural factors, which set New Zealand adolescents particularly at risk of suicide.

1. Increased rates of violence.
2. Marriage dissolution, remarriage, and changes in family structure.
3. Increased mobility with disruption of friendships and social networks.
4. Uncertainty through changes in employment, residence, access to education, and concern about more global issues of environmental change and the existence of weapons capable of mass destruction
5. Changing roles of men and women.
6. Larger and less personal communities (Rivers, 1995: 32).

> Suicide rates have increased as these changes occur. These social and cultural factors do not explain suicide but there is a direct correlation with the increase in the rate of young person suicide.

(Rivers, 1995: 32)

The Public Health Group, too, identifies social changes, such as for example, "the gradual secularisation of society, the increase in divorce rates, violent crime, alcohol consumption, [...] and changes in the patterns of family structure" (Public Health Group, 1999: 20) as possibly impacting on youth suicide rates.

Beautrais found a correlation between suicidality and mental health care in New Zealand. She reports

> that 67% of young people who made serious suicide attempts had a lifetime history of outpatient consultation for mental health problems and 22% had been admitted to a psychiatric hospital within the year prior to the suicide attempt

(Ministry of Youth Affairs, 1999: 16).

> These findings imply that most young people with serious suicidal behaviour are, in fact, known

> to a range of agencies and services and that effective interventions to reduce suicidal behaviours perhaps need to focus less upon attempting to identify those young people at risk of suicide in the general population and more upon improving the treatment and management of those already known to services

(Beautrais, in Social Work Now, 1997: 19).

Beside the factors which are already mentioned, Drummond focuses on two additional factors, truancy and teenage pregnancy, which she notes as special risk factors for suicide among New Zealand teenagers.

"Truancy is defined as absenteeism without justifiable cause" (Drummond, 1997: 7). It is widely acknowledged that truancy is a problem in New Zealand. However there are no particular figures available. But Fergusson and Lynskey found within their longitudinal study of the 1977 birth cohort of 935 Christchurch born children that rates of truancy rising almost exponentially from 12 to 16 years with 16 year old truancy rates (30.2%) ten times higher than 12 year olds (3%) (Drummond, 1997: 9). The relationship between truancy and suicidality can be related to the following results of truancy. First of all it creates the danger of failing within the education system and secondly these teenagers may not reach optimal social and personal development.

In summary, adolescents

> are therefore unable to benefit effectively from the school system, and this can lead to, or be associated with behavioural problems, antisocial behaviour across a range of different settings, and perpetuate cycles of disadvantage

(Drummond, 1997: 9)

These disadvantages again can increase the risk for suicide as noted above.

Teenage pregnancy, a result of often unplanned, unprotected sexual activity, has also been identified as a potential risk factor for suicidality. The teenage pregnancy rate in New Zealand is compared with other Western nations relatively high (34 per 1000 in 1995, and only 5.4 per 1000 in the Netherlands, for example). Especially the rates for Maori teenage girls are more than double of those of other OECD countries (Drummond, 1997: 12). Reasons for all New Zealanders may be sexual and physical abuse, which may lead to sexual risk-taking, unplanned sex and lack of contraception as well as a lack of information on contraception. Concerning Maoris and Pacific Islanders Drummond mentions that it has something to do with the fact that they generally tend to

have their children at a younger age (Drummond, 1997: 12).

> Apart from the health issues, teenage pregnancy is associated with disadvantage that perpetuates disadvantage in socioeconomic status, social security benefits, educational and training opportunities, adult health and achievement outcomes.

(Drummond, 1997: 13).

Lastly some risk factors are noted which especially contribute to Maori youth suicide. As showed within this Chapter: 2.6.2 Bicultural Differences, Maori youth have to face special historical and cultural circumstances, which may put them particularly at risk of suicide.

Keri Lawson-Te Aho should be quoted therefore here. She mentioned that one risk factor for Maori is the cultural breakdown and the loss of identity as Maori. Both can be understood as a result of colonization because on the one hand

> the removal of land rendered Maori unable to maintain cultural traditions which had for centuries been based around the identification with land as the source of spiritual and physical identity for individuals, whanau, hapu and iwi

(Lawson-Te Aho, 1998: 15).

It further caused poverty among the Maoris. Poverty among Maori, which can be seen in the high rates of Maori ill-health, lack of home ownership, poor educational outcomes, is another problem, that Lawson-Te Aho sees not as a cause of the situation for Maori as it is, but as a symptom of Maori disadvantage (Lawson-Te Aho, 1998: 15). On the other hand the process of assimilation also rendered Maori values, traditions, practices, beliefs and world-views as these things were all treated as irrelevant to the beliefs and values of the dominant, European culture.

The second risk factor is the social isolation. Colonisation caused landlessness among the Maori and resulted in a large movement of Maoris into the cities. This urbanization again caused social isolation in that new environment, in which social support from families and the tribe could not be found as this movement split many whanau, hapu and iwi.

Another special problem for Maori youths is the loss of Maori authority and control. This loss of control over the conditions of Maori lives

> at the individual and collective levels is also a direct outcome of colonisation. The

> individualisation of land saw the breakdown of the collective authority of whanau, hapu and iwi, and the inability to exercise management and control over the lives of individual Maori within the collective. The loss of Maori authority and control continued to break down centuries of tradition and further alienated Maori from the land and from their collective and individual realities as Maori

(Lawson-Te Aho, 1998: 15).

Now how do these factors influence the psychological personality and issues such as suicidality within Maori youth?

Identity and affiliation with cultural values influences youth suicide rates for indigenous people and Lawson-Te Aho mentions, that "it is proposed that identity within a collective culture is important for Maori youth." (Lawson-Te Aho, 1998: 16). However, it is also important to understand that teaching Maori youth to speak Maori, for example, will not necessarily decrease the Maori rate of youth suicide. But as it is evident that Maori youth see themselves as different from non-Maori youth it is necessary to show them ways of develop a healthy Maori identity. Therefore one has to ask, whether there are remnants of traditional Maori cultural values which can be used to strengthen and support Maori youth. And it is necessary to see the outcomes of history at an individual level to understand many of the problems of Maori youth today, which may lead to suicidal feelings or a suicide attempt (Lawson-Te Aho, 1998: 16).

There is further "increasing support for the existence of a form of cultural depression" (Lawson-Te Aho, 1998: 16), also called acculturative stress, cultural grief and collective post-traumatic stress disorder. This form of mental illness is characterised by

> self-destructive behaviour (such as drug and alcohol abuse) and negative ideation (thinking) (such as low self-esteem, feelings of worthlessness, feelings of inadequacy, feelings of hopelessness, and depression). This is plausible when considering the rates of mental illness and alcohol and drug abuse for Maori and other indigenous populations

(Lawson-Te Aho, 1998: 16).

One explanation for cultural depression is its relation to the outcomes of trying to live in two worlds and fitting into neither. Acculturation (when two cultures come into contact, with changes in the original cultural patterns of either or both) and assimilation (forcing of one culture into another as part of the acculturation process) cause further stress with all its consequences such as lower mental health, feelings of marginality, identity confusion and a high level of psychosomatic symptoms. Lawson-Te Aho mentions that

acculturation is still a process which impacts on Maori today (1998: 17).

She further notes the problem of racism at schools, as well as marginalisation of Maori cultural values, for example, which she sees as responsible for many failures of Maori youth at school. As New Zealand's educational system still embraces mainstream New Zealand cultural values, and Maori content and process is generally marginalized, the education system is not a place that effectively serves many young Maori. This places Maori students at significant risk.

> Risk from a process that batters self-esteem and confirms a sense of failure and worthlessness for many Maori youth, risk from process that confirms that the uniqueness that they bring with them as Maori has no place in mainstream education in New Zealand, risk from a process that confirms indirectly – and at the most fundamental of levels – that being Maori is the same as being a failure

(Lawson-Te Aho, 1998: 17).

2.7 Conclusion

Summarising, Chapter II shows that suicide is firstly a global problem and secondly especially in New Zealand still a serious one, although the youth suicide rates have decreased slightly.

There are different theories of suicide, established from different perspectives, like the cross-cultural one, which points out that cultural differences in childrearing and other philosophies as well as cultural deconstruction and acculturation put adolescents at different levels of risk of suicide. The biological perspective is still a controversial one. Nevertheless there is evidence today that some biological factors like the serotonin level or genetic dispositions have influence on an individual's behaviour and at least also on self-destructive behaviour, which may end in a suicide attempt or completion. Another important perspective is the psychiatric one, which proves that mental illness has something to do with suicidality and that mental disorders like depression or antisocial behaviour increase the suicide risk. The psychological one at last can show that there are psychological characteristics, which can be directly linked with suicidal behaviour, like for example, lack in coping skills, low self-esteem, impulsivity, hopelessness and so on.

All these theories try to explain from their point of view why young people kill themselves or attempt to do so. The general statement, what can be found as a summary of all the different perspectives is, that suicide ideations, attempts, and suicide completion are very complex and multi-causal problems and one can only do justice to that complexity if one has a close look at the problem from different perspectives. There are biological dispositions which may increase the suicide risk for an individual, but there are also psychological characteristics, which make an individual especially vulnerable, as well as environmental, social, and cultural circumstances, or other triggering events, like loss of a loved one, which all together make the situation for an individual serious enough to think or even attempt to kill him- or herself.

Concerning the gender issue, we found that females are generally more likely to attempt suicide whereas males are generally more likely to succeed in killing themselves. This is mainly explained by different authors with the lethality of the method, used by

females and males and by some general gender differences concerning psychological characteristics, such as, for example, females are generally more likely to ask for help than men and show generally better coping skills concerning communication skills.

Further, indigenous people are identified in many studies as more vulnerable and at greater risk for suicide, especially those who have to suffer from colonisation, like First Nations people in the United States or Maori. For those the tragedy of youth suicide must be linked with cultural factors, colonisation and contemporary results or effects of these historical events on the Maori youth today.

The suicide rate is especially high among homosexual youth, because of their special circumstances often not being accepted by peers, parents and sometimes the society as a whole.

Although youth suicide rates have decreased in many countries, the rates for New Zealand are still among the highest, compared with other OECD countries. Therefore youth suicide is still an actual and serious issue in New Zealand. Although, the overall youth suicide rate for NZ has now decreased for four consecutive years, the figures are nevertheless still high and society, the government, researchers, parents, teachers and so on are still concerned.

Most general risk factors, mentioned within the international literature, such as, for example mental illness, family dysfunction, low self-esteem and so on, can also be found among young New Zealand suicide attempters and completers.

Chapter III - Prevention and Intervention

After exploring the literature about adolescence and suicide it is time to ask what can be done to prevent such self-destructive behaviour, to prevent suicide among teenagers. As emphasised within the previous chapters, suicide among adolescents is a very complex issue and many different risk factors interact together. This complexity creates multiple points that adults, parents, counsellors can use to intervene or prevent self-destructive behaviour. And some believe that

> suicide prevention can best be accomplished by examining the multiple causes of suicide and finding ways to intervene and change one or more of these so as to decrease the probability of immediate suicide and increase the time available for working with suicidal people

(Stillion, 1996: 197).
On the other side this complexity and diversity make it also difficult to identify policies that have the potential to reduce the frequency of suicides among teenagers (Steering Group, 1994: 9).

There are generally three levels or phases of suicide prevention, the primary, secondary, and tertiary prevention. They are also called pre-event, event, and post-event prevention. These three types of prevention can further be subdivided into passive or active prevention. Passive means that protection is provided without requiring any individual action, like for example reducing the availability of the means of suicide, for example, legislation restricting access to firearms. Active prevention requires individuals to take some action to protect them, for example, health education programmes (Steering Group, 1994: 10).

The following sections cover all three types of prevention, as each is in its own way an important one. However, as particularly the primary and secondary prevention ideas are focused firstly generally on individuals and secondly particularly on suicidal individuals. The main focus here is on these two sorts of prevention. The idea of postvention, which is more focused on working with the bereaved ones after a suicide has occurred, is mentioned only briefly, as working with this group is not the main focus of this research.

The last paragraphs of this chapter show a kind of historical development of some prevention ideas with the examples of Barry Taylor who has worked on this issue more then ten years ago and who collected suicide prevention ideas from the USA, and the Steering Group, convened by a Minister of Youth Affairs and Minister of Health. The last paragraph within this chapter sets out the most current national youth suicide prevention strategy, within which one can find many parallels with the findings and statements of the former researchers and projects. Chapter four then shows that a youth-oriented service like Youthline[31] indeed works on the basis of this national youth suicide prevention strategy.

[31] See details about Youthline within Chapter IV: 4.1 Information about Youthline

3.1 Primary or Preventive Interventions

Primary Prevention includes everything that determines whether a person will make an attempt at suicide or not. The aim is to reduce the risk factors within a population. Therefore it involves family, school and society. That includes strategies that maintain good health, and prevent mental health problems from developing (Steering Group, 1994: 10 and Rivers, 1995: 36). Further it is necessary to enhance the environment of young people which will clearly reduce the likelihood that suicide risk factors will develop. Such enhancement can and must happen concerning childhood (prevention in the family), school experiences, social conditions in general and mental and physical health. Primary prevention of suicide means all efforts to improve social and cultural circumstances, which may lead to suicide (Stillion, 1996: 1999). To reduce the possibility of developing suicidal risk factors, it is necessary to provide stable and happy early childhood experiences within the youngsters' family, to provide school experiences that encourage young people to stay in education, as well as social conditions that are attractive alternatives to substance abuse and law breaking. Therefore it is further necessary as a primary prevention strategy, to create concepts, which ensure that all young people are valued and cared about. That includes "pastoral care, effective guidance networks, and school policies that ensure individual recognition" (Rivers, 1995: 36, 37).

The whole primary prevention can also be structured, as Stillion (1996) describes, within the different fields in which prevention should take place. As mentioned above these fields are the family, the school, as well as the society as a whole.

That is why families, for example do not only have to be educated in the way described above by the Group for the Advancement of Psychiatry, but also have to "help their children to understand the problems involved in living and the inevitability of experiencing some failure, disappointment, and loss in life" (Stillion, 1996: 213). It is necessary that children are better prepared concerning these life events, which adults cannot avoid happening to their children. Therefore it is necessary to teach children how to cope with failure instead of internalising. They must learn how to cope with loss, and disappointment in the way to show them that these things can be understood as

temporary, which can, dealt with in the right way, later lead to greater capacity. It is further important to help the children finding their own best-working coping strategies to improve bad feelings, like for example writing things in diaries, talking to friends and parents, listening to music, taking long walks. Most children naturally have these varieties of coping techniques but they are not aware of them. As a parent it is important to explore these techniques, to make the child aware of them, which is the base for the development of further stronger coping strategies concerning dealing with stress (Stillion, 1996: 214).

It should further not be forgotten, that the family is the best place to develop a healthy sense of humor within a child. Stillion describes humor as a good prevention strategy as suicide "is deadly serious" (Stillion, 1996: 214):

> People who can laugh at themselves and at many of life's problems can rarely sustain such negative thinking for very long. It is difficult to remain depressed if you can see humor in a situation. Young children generally appreciate humor. It is only as they grow older that they begin to lose their natural sense of laughter and play. Parents can help children greatly by setting aside some time for lighthearted play and by modeling for them an appreciation for humor

(Stillion, 1996: 214).

The family is also the base for children to establish achievable goals. If the goals are realistic children can experience achievement and competence, which are both necessary to establish a positive self-esteem (Stillion, 1996: 214, 215).

Finally communication between the family members is essential. Parents should tell their children that there is "a sense of unconditional acceptance". This sort of communication creates the feeling of uniqueness and self-worth within the child. This is again the base for a positive self-concept and a high self-esteem, both powerful tools in preventing self-destructive behaviour (Stillion, 1996: 215).

Especially during adolescence teenagers spend more time at school than at home which creates responsibility towards suicide prevention at schools, too. As also mentioned by the Group for Advancement of Psychiatry, schools should offer staff special training concerning this issue. Special programmes and guidelines should be available at schools, especially because of the danger of cluster-suicides[32] at schools (Stillion, 1996: 219).

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[32] See Chapter II: 2.5.1 General Risk Factors (*Triggering Events*)

Beside the family and schools, society has its responsibility on a more global level. The base for suicide prevention, described by Stillion (1996), is public health. Public health elements concerning suicide include firstly the isolation of suicide patterns, and secondly research approaches to discover risk factors and their relationships. It includes thirdly intervention strategies, which must be developed and evaluated. Finally it contains the implement of proven intervention programmes (Stillion, 1996: 226). Stillion also notes that some societies publish some general recommendations about how by changing social conditions the suicide rate should be decreased. This societal effort is important as it shows a "nation's recognition of suicide as a major social problem and focus[es] on education as one of the most important tools for addressing that problem" (Stillion, 1996: 227). An example for such recommendations and the way, in which a society as a whole can and should react on adolescent suicide is described below, within this Chapter (Recommendations of the Steering Group).

3.2 Secondary or Acute Intervention

Secondary prevention or acute intervention includes all treatment of actual suicidal individuals, all actions relating to those who are known to be at risk of suicide. The idea is that a swift response on self-destructive tendencies can prevent serious injury (Steering Group, 1994: 10). So first of all secondary prevention has to identify those at risk and secondly establish programmes aimed to help young people at risk (Rivers, 1995: 37). The basic belief behind all these intervention concepts is, that "suicidal action is generally the product of a temporary, reversible, ambivalent state of mind" (Stillion, 1996: 238).

3.2.1 Evaluation of the Adolescent

One first step within secondary prevention is the evaluation of the adolescent. That means, a psychiatrist, a friend, counsellor, or whoever is in contact with a suicidal person has to check whether the teenager is at real risk for killing him- or herself. One way to see if an adolescent is generally at risk, mentioned by Rivers, is to check the four important dimensions: happiness, progress, behaviour, and friendships. Happiness for example "is usually an indicator of their emotional state. Where there is consistent unhappiness there is probably a need for intervention" (Rivers, 1995: 38). The second dimension, progress, goes back to the fact that adolescence is a period of development and changes and teenagers have to

> learn to do things today that they could not do yesterday. Progress and happiness usually go hand in hand. Where an individual's progress is varied or halted there may be a need for intervention

(Rivers, 1995: 38).

Behaviour, that falls out of the normal behavioural framework, like drug abuse or antisocial behaviour, is usually the expression of inner pain. Such behaviour is also a "sign of personal unhappiness or lack of progress and intervention is warranted" (Rivers, 1995: 38).

Friendship at last is something necessary against loneliness, unhappiness, lack of progress, and challenging, antisocial behaviour. As mentioned above within Chapter II

isolation puts adolescents at risk of suicide and so, if a teenager has no friendships and seems to be more and more isolated from other peers and social life there is again a need for intervention (Rivers, 1995: 38).

It is then further necessary to determine the seriousness of the suicide intent. The best and easiest way is to ask directly in a thoughtful way. If the helping person is an untrained individual, a friend of the suicidal person for example, he or she should ask, like:

> 'I can see that you're very upset. How bad are you feeling? Bad enough to consider harming yourself?' A positive response to the last question should lead the confidant to ask for specifics (e.g., 'Have you considered how you would do it? When you might do it? Where?')

(Stillion, 1996: 239).

It is known that individuals with more concrete plans and preparations are more at risk than a person who just expresses a dead wish but has not yet made any concrete plans. That is why it is an important step within a prevention process to assess the actual level of danger. An untrained helper should then assure, if the level of danger seems to be high, that the suicidal person is not be left alone and that professional help is coming as soon as possible. It is therefore useful to find out which sort of professional help is accepted best by the suicidal individual. Example are counsellors, psychologists, psychiatrists, medical doctors, pastors, police, or a member of a social service agency (Stillion, 1996: 239).

A professional on the other side also has to find out what degree of danger of suicide ideation the suicidal person shows and whether there was any former suicide attempt. How lethal was the attempt? It is further necessary to know, if the suicide attempt was done impulsively or premeditated over days or weeks. What does the teenager say and think about the attempt? Was there a suicide note? Was there a chance to be found or was the attempt made in isolation? Was it unlikely that intervention could happen? Was there any alcohol or drug influence at the time of the attempt? What are the teenager's thoughts and fantasies about suicide and death? Is the individual able to distinguish fantasy from reality? What emotions does the attempter express? Is he or she depressed, angry, emotionless? (Group for the Advancement of Psychiatry, 1996: 80).

All these questions again are aimed at discovering the level of actual danger for suicide.

They should assess suicide risk. The risk increases with every further step, from just some thoughts about killing him-or herself, towards serious plans about how and when, towards attempts, which can be less or more serious (Group for the Advancement of Psychiatry, 1996: 81).

A psychiatrist further has to evaluate if there is a current or past mental disorder, as the past as well as the current existence of mental disorder symptoms increases the suicide risk. Also the risk factor risk-taking behaviour has to be checked. Does the suicidal person have any drug or alcohol problems or have they had these problems previously? Is there a history of antisocial behaviour? (Group for the Advancement of Psychiatry, 1996: 81).

In a next step environmental stressors must be assessed. Is there, for example a history of sexual or physical abuse? Have there been any problems at school, within the family? Has any loss or relationship-break-up happened, or any other traumatic events, like separation of parents, movement, loss of a close friend? Has there been any trouble with the police or peers? These so called triggering events[33] also increase the risk of suicide, described by the Group for the Advancement of Psychiatry as follows:

> Adolescents who have poor relationships with their peers and thus feel isolated either chronically or through some specific recent event that has made them feel humiliated or ostracized lack the supportive structure to weather and resolve the stress. Teenagers are particularly vulnerable to sexual problems because of their great insecurity in this just-emerging and insufficiently consolidated area. Sexual difficulties can range from inability to develop and maintain a sexual relationship, or the breakup of one; inability or unwillingness to live up to the boasted sexual activity of one's peers or the perceived sexual standards of the peer group; fears of homosexual or other peer-devalued sexual impulses or fantasies; to simple confusion and helpless feelings in coping with one's own emerging sexuality. [...] All of these aspects must be considered and when present must be included in the treatment plan

(Group for the Advancement of Psychiatry, 1996: 81).

3.2.2 Evaluation of the Family and Others

As noted within Chapter II, the family plays an important role concerning the seriousness of an individual's risk. Therefore it is necessary to check not only the

[33] See Chapter II: 2.5.1 General Risk Factors

individual him- or herself, but also to have a look at the family circumstances. Is there any source of support available? What is the relationship between the suicidal person and his or her family members? What family history can be found? It is further important to hear both versions, the one of family members as well as the version of the afflicted adolescent. These two versions may differ and the adolescent may not know things about mental illness within his or her family. Family members may on the other hand not be honest concerning topics like sexual or physical abuse, drug abuse or any other behaviour that would create an unsafe environment. Here it is important to recognise that the patient's versions is the one which counts, as he or she is the one at risk and if he or she may not feel comfortable at home and may not see any support from home this should be the decisive reason for further treatment (Group for the Advancement of Psychiatry, 1996: 82). However, the family should still be heard, too and therefore a psychiatrist or counsellor should try to get in contact with parents and siblings to check whether the environment of a patient is able to be supportive or is on the other side perhaps even dangerous.

The same has to be done with friends, if they are available or in contact with the suicidal teenager. It sometimes happens, for example, that an adolescent is brought to hospital with a friend. In such cases the friend can eventually be a source of support. However, one has still to check that there is a caregiver adult available in the adolescent's environment as friends may also be overwhelmed by the situation and at last also be set at risk, if one burdens too much responsibility on the youngster's friend.

3.2.3 Acute Disposition

The disposition, which at last has to be made, should be made as the most conservative and safe approach. This could become more difficult if financial and insurance issues come along "or when family is insistent on an approach that is contrary to the evaluator's understanding" (Group for the Advancement of Psychiatry, 1996: 83).
The safest decision is generally hospitalisation, as this creates enough time for intensive evaluation of mental health status, family circumstances, the seriousness of the attempt and to work out the most useful treatment while the adolescent is under professional

control of hospital staff members. So if there is any doubt about the safety of a suicidal teenager at his or her home place, hospitalisation should always be mandatory (Group for the Advancement of Psychiatry, 1996: 83). If hospitalisation seems not necessary a

> follow-up visit should be scheduled usually within 24 hours. As much as possible, the evaluator should try to make a contract with the adolescent and the family regarding safety

(Group for the Advancement of Psychiatry, 1996: 83).

Further treatment, like for example, psychotherapy or family therapy can also be decided at this point. Available services for suicidal teenagers must be offered. It could further also become necessary that a social worker or counsellor of any service visits the family and the patient at home, which often brings light in an unclear situation (Group for the Advancement of Psychiatry, 1996: 83).

These evaluation tasks are the first steps of secondary prevention or intervention treatment whenever a teenager seems to be seriously suicidal. If such evaluation confirms the seriousness of an individual's suicidality further therapeutic treatment is necessary. In cases, where substance abuse, for example, is part of the patient's history and actual situation, abuse therapy may become the primary aspect of an ongoing therapy, as substance abuse is often directly linked with suicidality (Group for the Advancement of Psychiatry, 1996: 83).

3.3 Tertiary Prevention: Ongoing Treatment and Principles of Therapy and Postvention

Tertiary prevention, which is sometimes also called postvention includes all the work with survivors of a suicide attempt, as well as with the family and friends of suicide completers (Stillion, 1996: 199). It contains all the therapeutic activities, which are aimed to

> reduce the after effects of a traumatic event in the lives of the survivors. Its purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise

(Stillion, 1996: 229).

This sort of prevention occurs after the crisis of a specific suicide attempt. "It may take many forms and use the full existing gamut of psychotherapeutic and pharmacological modalities" (Group for the Advancement of Psychiatry, 1996: 85). Tertiary prevention focuses on those factors that determine the severity and final outcome of injury (Steering Group, 1994: 10). These programmes are further "mainly concerned with the aftermath of suicide and the efforts that should be made to create safe environments for suicide survivors" (Rivers, 1995: 19).

Within this point it is necessary to make clear that we are talking here about two different "types" of tertiary prevention. The first direction is the ongoing therapy, the treatment of survivors of a suicide attempt. The second direction is the work with families and friends of those who killed themselves, which is mostly called postvention and which focuses more on dealing with the aftermath and protecting the bereaved ones.

3.3.1 Ongoing Treatment and Principles of Therapy

To help someone who survived his or her suicide attempt "the therapist must begin to plan day-to-day treatment" (Stillion, 1996: 243). The sort of therapy chosen depends on the attitudes, beliefs and therapeutic background of each therapist as well as on the particular needs and diagnosis of the young patient. The different modalities of therapy are not discussed in detail here as the main focus of this research is not on the classical setting of a psychological or psychiatric therapy.

Many suicidal teenagers are not able and do not know how to create normal relationships with other peers, how to listen, how to behave in a group appropriately. They may not know how to express appreciation. Therapy must offer a way in which the youngster first of all reflects his or her own behaviour in such peer interaction situations and secondly must then offer ways of learning

> interpersonal problem-solving skills in terms of enabling the adolescent to assess problems, to explore different scenarios of solutions and the consequences of different solutions, and to anticipate the degrees of control possible with the various scenarios

(Group for the Advancement of Psychiatry, 1996: 89).

The aim is thereby to improve the patient's sensitivity to interpersonal problems, his or her willingness to think about the consequences of different behaviours. It is the aim to improve his or her ability to see different solutions for a problem and not only in one just narrow black or white way as well as his or her ability to set appropriate step-by-step goals (Group for the Advancement of Psychiatry, 1996: 89).

In summary, ongoing treatment must discover poor social skills and offer a way of learning healthy useful social skills which lead to normal social interaction and help against isolation.

3.3.2 Postvention

After having described the first focus of tertiary prevention, that is the ongoing therapy and treatment of survivors of a suicide attempt, which is mainly focused on preventing further suicide attempts, the second focus of tertiary prevention is described, named postvention. Postvention is more focused on dealing with the aftermath and protecting the bereaved ones because as noted in chapter two they are identified as at higher risk for suicide than others.

Postvention includes a "systematic involvement with the survivors over several months in order to help them work through their special kind of grief." (Stillion, 1996: 230). Grief is able to change everything including physiological condition and that may have negative influence on the health of a bereaved one. Concerning Stillion there is

evidence that it is especially difficult to work through the loss of a loved-one through suicide. "When the cause of death is suicide, the trauma experienced may be greatly increased" (Stillion, 1996: 230). The survivors suffer in a different kind and greater intensity because they not "only" have to deal with feelings of sorrow, loneliness, and loss but often also with feelings like shame, fear and anger towards the deceased, guilt, powerlessness, deep rejection, punishment and abandonment, feelings of responsibility, and self-blame. Consequences of these feelings are often a disturbed self-concept, self-destructiveness, reality distortion, identification with the suicide victim, search for meaning, and incomplete mourning (Stillion, 1996: 231). Children and adolescents of parents who committed suicide have shown increased incidence of emotional problems and a wide range of psychological problems, "including 'psychosomatic disorders, obesity, running away, delinquency, fetishism, lack of bowel control, character problems and neurosis'" (Stillion, 1996: 231). To sum up, suicide is an event, which causes danger to the mental and physical health of the bereaved ones of the suicide victim.

As mental health is a protection factor against further suicides, the suicide of a loved-one, of a parent or a best friend is a real danger and risk factor for the survivors. Therefore it is necessary to help those bereaved people to deal with such an event in a healthy way to prevent further suicides among them. It is further necessary to change the conditions in society so that surviving loved-ones have a chance to cope with this situation. It does not help to blame them, to make them responsible for the suicide or to isolate them in the case that most people in our society refuse to talk about such events. But the need of these people to talk about their feelings and their grief is often very big. So in "addition to individual and group therapy approaches, survivors can be helped by breaking down the stigma attached to suicide. This can only be done by education" (Stillion, 1996: 232). Education means discussions about suicide without moralising or searching for guilt or responsibilities. Only then the social stigma of bereaved ones can be removed and they may then be able to recover, to come to terms with what has happened (Rivers, 1995: 46).

Postvention can and must also happen on a societal level. As noted in chapter II among adolescents there is always the danger of cluster suicides and that a suicide among young people has an impact on the environment. Therefore it is also necessary to

establish postvention programmes at a more societal level like at schools and universities subsequent to a traumatic incidence. Schools and universities must be prepared for the case of a suicide among their students. Communities should develop policies for schools that include both traumatic incident management concepts and specific guides. There should be a concrete plan as to what to do in a case of suicide, who should be informed and in which way (for example, telephone trees, letter for parents, meetings). There should be specially trained teachers or social workers who can then run groups or provide individual counselling. A crisis team should be developed, so that not one single staff member has the full responsibility for managing the aftermath. Close friends of the suicide victim should be checked for suicide risk factors. There should also be a special room, where students can go if they feel that they cannot stay in class. In such a room should be space for grief and tears, a staff member should always be there and it should always be open during the first few weeks after a suicide occurred. Further suicide should not be romanticised. It is important to tell other students that death ends a life and is permanent. Suicide is not a good choice and help is always available. Staff members, who talk about the suicide completer must carefully think about which aspects of the suicide victim can be celebrated and what were the problems. Both sides must be noted, the positive one but the negative one, as well, to avoid romanticising the event (Rivers, 1995: 48-52). All these efforts can be put in order to postvention.

3.4 Suicide Prevention Programmes in New Zealand

In the past chapters a wide range of theoretical material about risk factors for adolescent suicide as well as about general prevention and intervention ideas is covered. The following paragraphs describe how a country like New Zealand tries to respond to the high suicide rate among its teenagers. They show what efforts New Zealand makes to reduce the rate and if there is a special prevention strategy.

During the last few years, after recognising the high number of adolescent suicide attempts and completions, New Zealand has made a great effort to figure out why the rate is that high (research about risk factors) and to establish helpful and useful prevention programmes with which one wants to meet the needs of New Zealand's youths and reduce risk factors and the suicide rate. Therefore many studies have been done to discover risk factors and to establish prevention strategies as I discovered through the huge amount of literature and as I relaised on the Symposium about Suicide Prevention in Wellington, August 2002. A very important supportive part has been played by the Ministry of Health and the Ministry of Youth Affairs as well as the Ministry of Maori Development, Te Puni Kokiri. These political institutions have financed and supported research projects about risk factors and convened different groups to discuss these risk factors and to develop ways in which government agencies as well as other services "could work to reduce this concerning trend" (Steering Group, 1994: 5). One of these groups is for example, the "Steering Group on Youth Mental Health and Suicide Prevention", convened by the Ministry of Health. Their recommendations were published in 1994.

Another report, done by Barry Taylor from the Ministry of Youth Affairs is named "Something to Live for – Youth Suicide Prevention and Intervention". This is a report of the "Winston Churchill Fellowship 1990", which enabled Taylor to travel overseas and to visit Dr. Rotheram (USA), who worked on youth suicide risk assessment. Taylor was there trained further in the "Imminent Danger Risk Assessment Manual", with the idea of providing such a training programme throughout New Zealand (Taylor, 1990: 4).

Rivers, supported by "The Special Education Service He Tohu Umanga Matauranga" released a book about "Young Person Suicide" in 1995, which should be a guideline to

understand, prevent and deal with the aftermath.[34] Many quotations from him are used throughout the whole thesis. The current national youth suicide prevention strategy is mostly based on the findings of two researchers, Dr. Annette Beautrais and Keri Lawson-Te Aho. Both did research on youth suicide.

Within the following paragraphs of this chapter these different reports and ideas about adolescent suicide prevention strategies in New Zealand, their results and recommendations are described to give some examples of what has been done during the last few years to address and meet teenagers' needs and to reduce youth suicide. This coverage is not intended to be exhaustive, but some important and central efforts are described here.

3.4.1 Report of the Winston Churchill Fellowship

This report is one of many existing examples for suicide prevention and intervention ideas in New Zealand. As already described above, Barry Taylor from the Ministry of Youth Affairs wrote this report after visiting Dr. Rotheram (USA), who worked on youth suicide risk assessment.

> The main emphasis of this report is the urgent need for a youth suicide prevention strategy for New Zealand so as to provide a co-ordinated response to a growing tragedy among New Zealand's young people

(Taylor, 1990: 5).

This report is now more than 10 years old and of course there have been more current approaches concerning youth suicide in New Zealand as well as a national youth suicide prevention strategy, described below. However, Taylor is mentioned here, as he brought some basic ideas about youth suicide prevention and mental health issues from overseas to New Zealand. His report provides an interesting overview about general basics and most of these basic ideas still have their validity and their realisation can indeed be found in current prevention approaches. The report starts with some facts about youth suicide statistics in New Zealand[35], and gives then a definition of suicide.[36] In a next

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[34] See Bibliography
[35] Statistical Material see Chapter II: 2.6.1 Demographic Trends
[36] Definitions see Chapter II: 2.1 Definition

step Taylor explores some risk factors and causes for suicide[37] before he focuses on suicide prevention.

Policy Issues

Taylor points out that the social and economic environment has its influence on the mental health of young people. That is why in his eyes it is necessary that within primary prevention one needs "to identify how the social policies contribute directly or indirectly to the underlying causes of suicide" (Taylor, 1990: 18). For him one cannot see suicide just as an individual problem but as a "symptom" (Taylor, 1990: 18) of unhealthy political circumstances for young people, for example. It is further also necessary that prevention strategies are translated into social policies (Taylor, 1990: 18).

His idea was heard by the New Zealand Government, as for example The Ministry of Health, The Ministry of Youth Affairs, as well as Te Puni Kokiri have all included youth suicide prevention as one main issue of interest in their policies. These ministries all further contributed in different ways to the development of the actual suicide prevention strategy, mentioned below and in detail within the Report of the Steering Group (see Bibliography).

Mental Health Promotion

For Taylor many suicidal adolescents show a significant lack in life skills, particularly in problem-solving-skills. Therefore he suggests that it is helpful to put more emphasis on mental health promotion and education, which he sees as the basis for further skill development. In his opinion prevention programmes which just focus on one problem behaviour, like for example self-destruction or alcohol abuse, are less likely to be successful and it has been further found that many problem behaviours have the lack of life skills in common, mentioned above within Chapter I and II. So "a broad based skill development model" would be more effective and successful (Taylor, 1990: 19). Such a development model can today be found at Youthline.[38]

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[37] Risk Factors and Causes see within Chapter II: 2.6.3 Causes of Adolescent Suicide in New Zealand

[38] See details about that model within Chapter IV: 4.1 Information about Youthline and 4.8 Representation and Interpretation of the Results

Training of Workers

Youth workers must be trained appropriately in how to assess the level of risk and how to deal with suicidality. It is therefore necessary not only to know about risk factors, prevention and intervention strategies but also to deal with the own fears concerning working with suicidal teens. Such training programmes should therefore not only train youth workers in knowledge and skills but should also address "the workers' attitudes and fears about suicide" (Taylor, 1990: 20). It is further necessary that such programmes help to understand teen culture. Workers must be trained in how to communicate with adolescents, and which methods can be used in a crisis. The different systems, which have influence on adolescents, must be known (Taylor, 1990: 20).

Taylor points out that especially concerning this issue there should be more attention in New Zealand:

> The Ministry of Youth Affairs' document on youth worker training highlights many of the deficiencies that currently exist. There is particular concern about the training of youth workers in the area of mental health. Workers are often placed in the position of giving counseling without the necessary skills to help. While I am not advocating that it should be left to people such as psychiatrists, I am advocating that youth workers need to be assisted in their work through the availability of counselling training

(Taylor, 1990: 20).

Target Groups

Research has shown that there are special risk groups, teenagers, which are more vulnerable than others. Suicide prevention strategies must therefore be able to meet the special needs of these groups. In one first step it is necessary to identify these groups. Only then can special prevention strategies be developed and youth workers particularly be trained (Taylor, 1990: 20). This perception can also be seen as being taken very seriously in New Zealand. As described above there has been considerable research done concerning risk factors and special vulnerable groups to investigate reasons for their suicidality and enable the country to react and develop prevention strategies.

Groups which tend to have higher risk factors for self-destructive behaviour, mentioned by Taylor, are those with disabilities, who generally have been identified as more likely to become depressed and suicidal than those without any disabilities. Another group are those who identify themselves as lesbian or gay. They have been identified as high risk group for suicidality and self-destructive behaviour during the last few years as a result

of an environment of non-acceptance and a lack of services, which help these young people to accept and integrate their sexuality.[39] Another group are young males. They generally are more likely to commit suicide[40], and therefore suicide prevention needs to offer special mental health promotion for males. Another group, mentioned by Taylor are young prison inmates (Taylor, 1990: 20, 21).

Suicide Risk Assessment

Taylor's main purpose of visiting Dr Rotheram-Borus was being trained in the use of a suicide risk assessment model. Risk assessment is an essential part of secondary prevention as showed and explained above. The manual in which Taylor was trained, called "The Evaluation of Imminent Danger for Suicide Manual", should help to identify at-risk teenagers as early as possible. "[I]t gives the counselor a framework from which to make an assessment of the mental condition of the young person" (Taylor, 1990: 22). How to use of the manual should be covered in a training course for all who work with suicidal youth. However, one also gets a good idea by reading the manual on one's own (Taylor, 1990: 22).

After Taylor's return to New Zealand he developed a training programme which was appropriate for New Zealand. It included sessions on "Understanding Youth Culture and Youth Issues", "Introduction to Youth Suicide", "Attitudes of Course Participants About Suicide", "Suicide Prevention", "Introduction to the Risk Assessment procedure", and lastly "Practical use of the Procedure" (Taylor, 1990: 23). Twenty-nine workshops were held in 1991 throughout New Zealand and teachers, counsellors, GPs, school guidance counsellors, public health nurses, youth workers, social workers, community health workers, sexual abuse and addiction counsellors were trained (Taylor, 1990: 23).

This manual is still used by many services, which work with at-risk adolescents, such as for example Youthline, Lifeline or the Aids Foundation and offers a helping plan for youth workers in assessing whether an adolescent is in imminent danger or not. It offers therefore frameworks as well as theoretical material about teenage suicide, prevention strategies and risk factors as well as some questionnaires about one's own attitude towards suicide and death (Bradley, 1991).

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[39] See Chapter II: 2.5.3 Homosexuality and Suicide
[40] See Chapter II: 2.5.2. Demographic Factors: Gender and Race

Mental Health Services

Another important factor in every suicide prevention strategy is a good mental health system, which is easy for young people to get access to and which is able to meet the special needs of teens, who need counselling or support in any other ways. Taylor mentions in his report that there is a big deficiency of mental health services for young people (Taylor, 1990: 27) in NZ. That was in 1990 and may be better today. However mental health services are still an important factor of prevention and these services still need further development, particularly concerning appropriate offers towards young people.

Taylor further mentions the necessity of variety of services, as the mental health needs of adolescents "are very diverse", too. Most may need just counselling because of emotional or developmental stress, whereas others with a serious psychiatric disorder may also need a proper therapy. In some cases even residential care. To do justice to these very different needs the mental health system must be able to offer different sorts of support, hospitals with the possibilities of residential care or day care, crisis services as well as small community services, which offer short term counselling (Taylor, 1990: 27).

Here Taylor mentions another lack in New Zealand's proceeding. In many cases the suicide attempters are medically treated in an emergency or by GPs, but no follow-up treatment is organised, "and it is often left up to the young person to take up follow up counselling" (Taylor, 1990: 28). However some may not be stable and psychologically fit enough to organise that for themselves. That this is still a problem in 2002 should be illustrated through an example, I experienced myself. During my research I got privately in contact with a very suicidal young woman, aged 20. After a serious suicide attempt in September this year she was hospitalised, where she was treated medically for one night. The next day she was sent back home. However her family was on a holiday trip to Europe and nobody was at home to look after her. Fortunately in this case the young woman was able to ask a tutor at her university for help. Of course that is only one case and therefore not generalisable but it still shows that there is a lack of effective services and that it still happens that young suicidal teenagers fall through the prevention network.

Concerning counselling one major task is to get young people to use counselling

services, to reduce fears of being stigmatisised and to reduce barriers of finding someone they can turn to and trust and who does not cost much (Taylor, 1990: 29).

Lastly Taylor mentions that such services in New Zealand

> are severely under resourced and stretched to the limit. The waiting times for appointments for public funded services are unacceptable and may increase the likelihood of young people in crisis falling through the cracks. The provision of youth counseling services must become a much higher priority and is an important part of a suicide strategy

(Taylor, 1990: 29).

This problem, too, is still an actual one, as can be seen later within Chapter IV: 4.8 Representation and Interpretation of the Results. One common statement of the professional participants of the research project was that Youthline, for example, still has not the capacity to deal with all callers. Only one out of ten callers can get through to a telephone counsellor because of too less funding from the Government.

3.4.2 Report of the Steering Group

As described above, the Steering Group was convened by Hon. Katherine O'Regan (Associate Minister of Health) and Hon. Roger McClay (Minister of Youth Affairs) in 1992 to "identify ways in which Government agencies could work to reduce this concerning trend" (Steering Group, 1994: 5). The basic agreement beyond the project was that prevention must also address mental health issues to be successful, as suicide and mental disorder have been identified as interacting parts within the issue of adolescent suicide. Therefore the project brought together mental health professionals, researchers, people who work with youths in educational institutions and communities as well as policy makers and experts in the causes and prevention of youth suicide (Steering Group, 1994: 8). The aim was to establish specialist mental health services for youth or to reach an increase in funding and developing of such services to increase the emphasis on youth mental health. The suggestion beyond that strategy is, that mental health improvement results in a reduction of the incidence of suicide. The Government therefore has an important response to the issue. However funding alone is not enough as everybody has his or her responsibility and parents, friends, teachers, youth workers, general practitioners, as well as politicians have a part to play in helping young people

living a positive and happy life. The report is more focused on governmental agencies and not so much on private ones. However it is recognised that these private agencies are important too (Steering Group, 1994: 5). But as New Zealand is a welfare state the government takes accountability of the well-being for all members and it plays a key role in funding social welfare services, either by providing services directly, by making subsidies available to other service providers, or by giving either tax exemptions or subsidies to consumers. As can be seen later within Chapter IV when discussing the interviews[41], there are still services like Youthline, which clearly have the potential to do wonderful and successful prevention work, but which still get not enough funding to fulfil these recommendations in the form of establishing a 24-hour-crisis-phoneline, for example.

The Steering Group further believes

> that greater progress on improving youth mental health and preventing youth suicide will be made when there is commitment and action from government and all sections of the community in relation to the mental health needs of our young people. We believe that many of those aged 15-24 are under-served, and in some cases overlooked, in a number of areas of social policy. Society as a whole needs to place more priority on the needs of young people and to commit resources to meet these needs

(Steering Group, 1994: 7).

The final report of this suicide prevention project describes the work of the Steering Group and the process of developing policy recommendations for governmental agencies. Some of these recommendations as well as the responses of the different institutions to whom the recommendations were addressed to are summed up here as an example of how New Zealand has been responding to the high suicide rate among teenagers during the past few years on a political, governmental level. The whole statements can be found within the original report.[42] The idea and structure of the project is described below.

Description of the Youth Mental Health and Suicide Prevention Project

The project can be divided into different steps. The starting point was given by a review

[41] See Chapter IV: 4.8 Representation and Interpretation of the Results
[42] See Bibliography

of national inpatient and outpatient mental health services for young people in New Zealand by the Ministry of Health, followed by a strategic planning workshop, which brought the different professions (as mentioned above) together. The result of this workshop was a wide agreement that prevention has to address youth mental health issues too and cannot be focused only on the suicide issue.

In a third step the results of the workshop were published and further literature about prevention and risk factors was reviewed. Among this review the Canterbury Suicide Project has had particular influence, based at the Princess Margaret Hospital in Christchurch. This project is a case control study to identify risk factors.[43]

In a last step the Steering Group was established to work on concrete recommendations for different institutions with responsibility towards young people in New Zealand. These are for example the Ministry of Health, the Ministry of Youth Affairs, Te Puni Kokiri, the Ministry of Pacific Island Affairs, the Ministry of Women's Affairs, the New Zealand Police, the Department of Labour, the Department of Justice as well as the media. Except for the media, all are government agencies with responsibility for teenagers and young people (Steering Group, 1994: 7-9).

The Steering Group then worked out a report of recommendations which was sent to all the agencies and institutions mentioned above. The report, called "Preliminary Report of the Steering Group on Youth Mental Health and Suicide Prevention", has been supported by most of the agencies and institutions and their response was "overwhelmingly favourable" (Steering Group, 1994: 11).

The general themes of the recommendations are summed up below:

1) Provision of good Mental Health Services for Youth

With this recommendation the Steering Group generally stresses the fact that young people have special needs, which must first of all be identified and then an integrated mental health service must be developed to meet the needs concerning mental health. The Steering Group further points out that there are services which provide mental health for teenagers, but that the different available services sometimes do not co-operate enough in addressing special needs of adolescents (Steering Group, 1994: 12).

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[43] See Chapter II: 2.6.3 Causes of Adolescent Suicide in New Zealand

This problem of co-operation can also be found later within Chapter IV, when one professional participant of Youthline talks about co-operation problems between mental health institutions and Youthline.[44]

2) Protocols for the Care of those known to be suicidal

Here the Steering Group requires the use of protocols and/or guidelines in assisting in the care of those, who are known to be suicidal (Steering Group, 1994: 12).

3) Support for Families, Friends and Others affected by Suicide

This theme goes back to the perception that families, friends and others affected by suicide also need support and an environment which enables them to recover, as they otherwise may easily become vulnerable and suicidal themselves (Steering Group, 1994: 12). This recommendation goes perfectly together with the theoretical idea of postvention, described earlier in this chapter.

4) Training Programmes for those who work with Teenagers

The Steering Group discovered a "lack of people with specific training to deal with youth mental health issues, including suicide risk assessment" (Steering Group, 1994: 13), which leads to their recommendation that more trained people in agencies are needed and that therefore more training programmes have to be developed and published. As already described, this knowledge can also be found within Barry Taylor's statements and was one of his efforts as he introduced a special risk assessment programme for all those who have to do with teens.

5) Culturally appropriate Policies, Programmes and Services

Young people from minority ethnic groups, like Maori teenagers or Pacific people have been identified as a special risk group of concern. So the Steering Group demanded special culturally appropriate mental health services for these groups, which have to be in a way that makes access for young people of these minority ethnic groups easy. Ideally these services are developed and run by the members of the ethnic group themselves as they are the experts concerning their special cultural needs. It is further

[44] See Chapter IV: 4.8 Representation and Interpretation of the Results

important that the information material about mental health of these agencies is presented in an appropriate way for youth with different cultural backgrounds. Such programmes and agencies can be an important factor in reducing the cultural alienation, which was identified as a possible cause for low self-esteem and mental health problems among members of these ethnic groups. Both these factors make individuals vulnerable and set them at risk for suicide (Steering Group, 1994: 13).

6) Education and Training Institutions

Because most of the teenagers spend a lot of time at school, the Steering Group believes that the Ministry of Education has a very important

> role in supporting schools and other educational agencies to provide a supportive environment that will improve youth mental health and lead to a reduction in New Zealand's currently high rate of suicide in young people

(Steering Group, 1994: 14).

That means for schools and the Ministry that the health, including mental health, of students, should always have priority.

7) Good Data, further Research and Evaluation of Interventions

The Steering Group mentions that further on-going research about mental health and risk factors of suicide is necessary, especially concerning Maori youth and their special circumstances. Further intervention programmes must be evaluated to see whether they work successfully or whether they must be improved. It is important to check if developed protocols and guidelines work in the way they were expected to (Steering Group, 1994: 15).

This recommendation is today more or less fulfilled and there are many research results available. However there can still be done more, particularly concerning Maori youth suicide or suicide attempts among homosexual youth as well as concerning the effectiveness of actual programmes.

Recommendations to Different Institutions in NZ

The concrete recommendations and responses of all different institutions in detail can be found within the original Report of the Steering Group.[45] That is why a brief

[45] See Bibliography

summary of the key issues is given here. This makes clear how New Zealand, on a political level, reacted to the tragedy of such a high youth suicide rate. In summary it can be said that all involved agencies supported the Steering Group and its recommendations and each tried to fulfil the ideas and knowledge within their possibilities and limitations.

The report has further at least been the base document for establishing attention within political agencies concerning their responsibilities towards the issue of mental health and youth suicide. In particular the idea that mental health is a central basis for well-being among people, particularly young people, is still politically supported and mental health services and agencies are still financially supported by the Ministry of Health. However, more can be done. The interviews below show that the most limiting issue of the daily work of a Youthline co-worker has to do with funding as well as with co-operation with other services, which is not at all satisfying.[46]

However, the report and the actual situation out there today show that particularly the Ministry of Health, the Ministry of Youth Affairs and the Ministry of Maori Development have done a lot and have worked hard on supporting mental health services as well as on providing funding and on developing a national youth suicide prevention strategy. Projects, which have been established and supported by these Ministries are listed within the original report (see Bibliography) and can be read there. A national youth suicide prevention strategy, as can be seen within the next paragraph, was finally finished and published in 1998 and it is still operational, as can be seen within Youthline[47]. This is the basis for the practical work. Other results of the recommendations were publications by the Ministry of Youth Affairs, like the "Suicide Action Plan", concerning awareness improvement and the "Youth Health Needs Assessment Project" (Steering Group, 1994:24). Much further research has been done on the special risk group that is the group of young Maori, discussed more fully below.

Concerning the identification of young prison inmates as a specially high risk group for suicide and the recommendations of the Steering Group for this group, the police staff is trained today to assess risk as early as possible and to know how to handle suicidal teenagers in prison. The police have started to work, together with schools, to prevent criminal, antisocial and self-destructive behaviour (Steering Group, 1994: 36, 37). The

[46] See Chapter IV: 4.8 Representation and Interpretation of the Results
[47] See Chapter IV: 4.8 Representation and Interpretation of the Results

Department of Labour has published a document "Managing Inmates who are a Risk to Themselves" (Steering Group, 1994: 39) which should help prison staff to manage young prison inmates who become suicidal.
Another example should be given from the Ministry of Education. It also reacted to the recommendations very positively and explained that its contribution is based on its belief that schools are not only responsible for the education but also for the health and physical well-being of their students. To ensure this conviction, health and physical well-being have been included in the curriculum framework (Steering Group, 1994: 40, 41). Handbooks for schools have been developed, like "Young People at Risk of Suicide". This handbook is based on findings from Beautrais, Fergusson and Rivers and gives advice on best practice for prevention at schools (Ministry of Education, 1998: 3).

Altogether, this example of the Steering Group with its recommendations and the responses of the governmental agencies make it clear that New Zealand has been working on the problem of youth suicide for many years. The government has tried to support research and projects which should translate the research results into practice. In summary one can see here that all agencies take their responsibility towards young people very seriously and many current booklets, programmes and projects are based on these early findings.

3.4.3 In Our Hands – Non-Maori-Youth Suicide Prevention Strategy

As heard above, there has been strong demand for a nation-wide youth suicide prevention strategy and co-ordinated research to understand risk factors and to develop prevention and intervention ideas.
Beautrais is one of many researchers who has been doing much investigation on risk factors, methods of killing oneself, and the prevalence of suicidal ideation, attempts and completed suicide. Based on her and other findings, one part of the first national youth suicide prevention strategy was published in March 1998, called "In Our Hands – The New Zealand Youth Suicide Prevention Strategy". It was developed and published by an office of the Ministry of Youth Affairs, with "key input from the Ministry of Health and Te Puni Kokiri" (Ministry of Health, 1998a: 7). To stress the necessity of such a

national prevention strategy, Beautrais published a review of evidence, which is a background document and firstly "provides a brief review of research findings about risk factors for suicidal behaviour among young people". It secondly "links the research evidence identifying risk factors for suicidal behaviour to the strategic approaches outlined in the *New Zealand Youth Suicide Prevention Strategy*" (Beautrais, 1998: 3).

As noted several times during this work, youth suicide is a tragedy, behind which one can always find many different factors and causes. Youth suicide is a very complex problem and therefore one cannot expect finding just one single answer for reducing youth suicide. As the rates in New Zealand have been increasing during the last few years, especially during the 1980s, there has been great effort researching risk factors and causes to then be able to reduce these risk factors and lastly to reduce the high number of youth suicides, "and where this is not possible, minimise the harmful effects on young people. This will require action at government, community, and individual levels" (Ministry of Health, 1998a: 4). This strategy is now based on the research findings of the past few years and on the major realisation that there is always "a range of biological, cultural, economic, social and psychological influencing factors", but that most suicides, can be prevented (Ministry of Health, 1998a: 6).

"In Our Hands" is a strategy, which can be understood as a framework to help government agencies, communities, services, families, and individuals to identify risk factors and prevention and intervention possibilities, and acting together to reduce youth suicide (Ministry of Health, 1998a: 4, 5).

The strategy is "based on five goals which relate to the different levels of suicide prevention". These include actions and initiatives, which "enhance the resilience of young people" and which should reduce their vulnerabilities as well as initiatives, which "provide support to people affected by a suicide" (Ministry of Health, 1998a: 6).

Ten Principles of Youth Suicide Prevention

To do justice to the complexity of youth suicide, the strategy contains ten major principles, on which concrete goals are based:

1. The Treaty of Waitangi

   It forms the "constitutional basis to enable Maori to achieve their full social and economic potential. Suicide prevention policies and programmes must be accessible to, and appropriate for Maori" (Ministry of Health, 1998a: 11).

2. Collective responsibility

   As suicide is very complex there is not one single organisation or individual responsible for suicide prevention, but all institutions and individuals working with teenagers. They all should "participate in suicide prevention initiatives, and be empowered to act as part of a community-wide suicide prevention project" (Ministry of Health, 1998a: 11).

3. Co-ordination and collaboration

   All activities must be co-ordinated and integrated to be effective and the different sectors, which are involved, should collaborate with each other (Ministry of Health, 1998a: 11).

4. Research and information

   "Accurate information about the nature of the problem, protective factors for suicide, and effective prevention programmes, is a fundamental basis for youth suicide prevention" (Ministry of Health, 1998a: 11).

5. Cultural relevance

   Prevention programmes must also be able to meet special needs of special groups, like Maori youth or Pacific Islanders (Ministry of Health, 1998a: 11).

6. Responsive to a diverse youth population

   Teenagers are very diverse and therefore the programmes must be wide ranged, too, to meet all the different needs and realities of their target group. So issues like culture, sexuality, gender, disability, and ethnicity must be covered by such programmes when they want to be effective (Ministry of Health, 1998a: 11).

7. Focus on the family/whanau

   As noted within Chapter I and II, the family plays an important role to the well-being and healthy development of an adolescent. Therefore the family, too, "must be acknowledged and supported in all prevention activities" (Ministry of Health, 1998b: 11).

8. Preventing both death by suicide, and suicide attempts

   That means, that it is not enough to try to prevent suicides generally but that it is also necessary to develop strategies which deal with the poor health conditions and "negative effects of non-fatal suicide attempts" (Ministry of Health, 1998a: 11), as it is known, that the suicide risk increases with every suicide attempt.

9. Long-term approach

"Public Health initiatives will require both investment and long-term evaluation before any clear trends in reducing suicide can be concluded" (Ministry of Health, 1998a: 11).

10. Reducing risk

    All initiatives must be accompanied by research to ensure that they are really helpful and do not harm those at risk (Ministry of Health, 1998a: 11).

Five Goals to Help Reduce Youth Suicide

1) Promoting Well-being

To reduce the risk of becoming suicidal, research has discovered the importance of support for families, young people and communities and identifying and supporting healthy and positive ways in which young people are treated by their families and communities. This goal is based on research findings that many suicidal teenagers come from disadvantaged social and familial backgrounds with negative childhood experiences. Therefore one important prevention goal is to strength families, as well as communities (Ministry of Health, 1998a: 14).

This goal can be realised by:

- Supporting families (Ministry of Health, 1998a: 14).
- Supporting mental health promotion initiatives, like for example programmes at schools, problem-solving and interpersonal skills- programmes, "peer support training for students", as well as promotion about "how to avoid drug and alcohol related harm, and supporting personal choice over peer pressure" (Ministry of Health, 1998a: 14). The peer pressure issue is particularly stressed within the interviews of Chapter IV in this thesis.
- Supporting further initiatives to eliminate the stigma of mental illness by education and information (Ministry of Health, 1998a: 14).
- Encouraging teenage participation "in all aspects of community life and in decisions which impact upon them", which is a possibility to ensure that their needs are really met (Ministry of Health, 1998a: 14)
- Enabling young people to develop their own identity, which includes many different aspects, like culture, gender, ethnicity, and sexual orientation. The basis for well-being is a positive feeling towards all these different identity

issues. Youth can be supported during this process by several initiatives about cultural and gender issues, as well as through school environments, which support gay and lesbian students for example (Ministry of Health, 1998a: 15).

- Supporting "initiatives which address social inequality, discrimination and abuse where they impact on young people", like for example through anti-bullying programmes in schools (Ministry of Health, 1998a: 15).

2) Early Identification and Help

This goal should help to identify young people at risk of suicide as early as possible. As mental disorders, especially depression, anti-social behaviours and substance use disorders are high risk factors, which can be found among nearly 90% of suicidal teenagers[48], it is an obvious need to address this problem and to improve services which have the capacity to meet the needs of those as well as to create an environment in which mental health problems are not a stigma and in which young people do not have to be afraid to ask for help. This goal further includes restrictions concerning access to means of suicide (Ministry of Health, 1998a: 15).

This goal can be realised by:

- Training of those who work or have to do with teenagers in identifying and responding effectively to suicidal behaviour (Ministry of Health, 1998a: 15, 16).
- Offering enough current information to those in contact with teenagers through publishing "'user-friendly' pamphlets for parents, caregivers, kaumatua and community elders, explaining possible warning signs" and information flyers about helpful agencies (Ministry of Health, 1998a: 16).
- Supporting health promotion campaigns, culturally appropriate sexual health services, and others to reduce young people's risk-taking behaviour, concerning for example alcohol and drug use or sexual behaviour (Ministry of Health, 1998a: 16).
- Ensuring, that all youth services, no matter if related to problems like alcohol and drug abuse or unsafe sexual behaviour, are appropriate to the culture, sexual orientation, and the gender (Ministry of Health, 1998a: 16).
- Reducing "messages in the media that suggest suicide as an acceptable problem-

[48] See Chapter II: 2.6.3 Causes of Adolescent Suicide (NZ) and 2.5.1 General Risk Factors

solving option" (Ministry of Health, 1998a: 17).

3) Crisis Support and Treatment

As research has shown that those who have already attempted suicide are at higher risk to complete suicide, it must also be a prevention goal to "improve support and treatment" for those young people (Ministry of Health, 1998a: 17).

This goal can be realised by:

- Making crisis support services available, accessible and effective for young suicidal people through enough advertised, trained, acceptable and accessible telephone crisis services and psychiatric emergency services (Ministry of Health, 1998a: 17).
- Ensuring "that all hospitals and emergency health services respond effectively and appropriately to young people who have attempted suicide" (Ministry of Health, 1998a: 17).
- Ensuring that suicide attempters really have access to follow-up treatment (Ministry of Health, 1998a: 18).
- Encouraging co-operation between the different services, involved in assisting a suicide attempter "to ensure that young people receive an effective and seamless service" (Ministry of Health, 1998a: 18).

4) Support after a Suicide

As mentioned within Chapter II, suicide is a tragedy, which can itself become a triggering event for those who are bereaved, for siblings, parents and friends. More mental health problems, depression and suicidal behaviour can occur. Therefore it is necessary that prevention also includes support for those who are left behind after a suicide occurs (Ministry of Health, 1998a: 18, 19). This idea of prevention is called postvention and its elements have already been described within Chapter III.

This goal can be realised by:

- Ensuring "that responsive and culturally appropriate support and grief counselling are available to those bereaved by suicide" (Ministry of Health, 1998a: 19).
- Ensuring that those who have to do speeches after a suicide happen or have any

other official role "are informed about appropriate behaviour and approaches that will minimise the likelihood of further suicides." Those people should therefore avoid glorifying or sensationalizing death and should try to make clear that suicide is not an option. Guidelines for those who speak at funerals and memorial services should therefore be available (Ministry of Health, 1998a: 19).

- Encouraging groups at schools or cultural groups within a community to identify and support those at high risk, like close friends, or siblings to minimise the likelihood of further suicides (Ministry of Health, 1998a: 19).
- Making sure that the media is informed and aware of its responsibility of minimising the risk of further suicides through the right way of reporting[49] (Ministry of Health, 1998a: 19).

5) Information and Research

The basis for every prevention strategy is knowledge, especially knowledge about risk factors, but also about the effectiveness of prevention initiatives. Therefore further research and as much information about the issue as possible is necessary. Concerning the effectiveness there is still a big lack. To change this lack of knowledge about the effectiveness, school-based mental health awareness and suicide awareness programmes must be evaluated. It must be investigated how services can be made really appropriate for young people, especially for special risk groups like young men and Maori. Concrete treatment must be evaluated, early intervention and family support programmes must be designed and evaluated as well as culturally specific prevention initiatives (Ministry of Health, 1998a: 20). More research must be done concerning specific risk groups like Maori or Pacific Island youth, as well as sexual orientation-focused research. One has to guarantee that all those, who are in any way involved in suicide prevention, are always aware of the latest international and national data. An information resource centre like SPINZ is therefore a good opportunity. Lastly, data about suicide mortality and morbidity as well as the effectiveness of suicide prevention strategies must be as accurate, timely and systematic as possible. Annual data is necessary (Ministry of Health, 1998a: 20).

[49] See Chapter II: 2.5.1 General Risk Factors: *Triggering Events*

As a summary, Dr Annette Beautrais, the Principal Investigator of the Canterbury Suicide Project, is quoted here again. She "was contracted to provide a review of the evidence of the suicide prevention initiatives in *In Our Hands*. This includes an examination of both, New Zealand and international research" (Ministry of Health, 1998a: 34). She wrote a paper reviewing the evidence, based on research about general adolescent developmental issues, risk factors and causes for suicide. She was able to show that the ideas of "In Our Hands" could therefore all be linked with research results and therefore has its evidence and is reasonable. She also mentions that further research and more information on youth suicide is indeed necessary, and there "is well-acknowledged need for accurate, timely, systematic data collection for suicide and attempted suicide" (Beautrais, 1998: 20). Especially concerning evaluation of intervention and prevention initiatives, further exploration of risk factors for suicidality for both Maori and non-Maori, as well as on cluster suicide and the effects of contextual factors is needed (Beautrais, 1998: 20 and 22). It is further necessary to have a general "comment at a national level about research priorities, evaluation of preventive approaches and best practice guidelines" (Beautrais, 1998: 20). Suicide morbidity and mortality data must be presented in a timelier manner as it is now approximately two to three years before data is available. This makes an immediate response on such figures impossible. The policies of "In Our Hands" are all "well founded on the available research evidence, are theoretically justified, and are consistent with expert opinion contained within major reviews of youthful suicidal behaviour, and with international approaches to suicide prevention" (Beautrais, 1998: 25).

Beautrais stresses again that research has shown that most suicide attempters and completers suffer from a psychiatric disorder, particularly depression, substance use disorders and antisocial behavioural disorders. These research results create evidence for special attention towards mental health issues within a prevention strategy. She points out that therefore the demands of "In Our Hands" for improvement of mental health education is necessary. More services which are specialised on the needs of this particular group, more education programmes for professionals, who work with youth, for teachers, counsellors as well as parents, more community mental health awareness programmes were identified by her as of necessity. Provision of crisis services and postvention guidelines are necessary and reasonable (Ministry of Health, 1998a: 34, 35).

The next major research result, found within a large percentage of suicidal youth is social disadvantage and dysfunctional family backgrounds. Therefore the inclusion of special support for families in crisis and teenagers of at-risk families within a prevention strategy is also reasonable. The improvement of health, social well-being and life opportunities for children and teenagers in those families may lead to a reduction of the number of teenagers at risk of mental health problems and suicidal behaviour (Ministry of Health, 1998a: 35).

Another part, worth stressing here, goes through the issue of social circumstances, social equity and public issues about suicide. Research results show that "young people with suicidal behaviour are frequently characterised by social, educational and economic disadvantage" (Ministry of Health, 1998a: 35). Therefore goal one of "In Our Hands", the promotion of well-being, has to include the provision of "more equitable opportunities for education and employment" (Ministry of Health, 1998a: 35). This will also reduce the risk of mental health problems and suicidality for teenagers. However there is no research evidence that providing social equity directly reduces the suicide risk, but there is widespread agreement that this will create at least a social environment which is more likely to promote well-being than an environment full of discrimination, disadvantages and inequity (Ministry of Health, 1998a: 35).

These statements of Annette Beautrais, quoted in "In Our Hands" are just a brief summary of her reviews of evidence, but nevertheless show in a clear way that the recommendations and prevention strategies of "In Our Hands" are all based on research and are well founded.

3.4.4 Kia Piki te ora o te Taitamariki: Maori-Youth Suicide Prevention Strategy

The national youth suicide prevention strategy consists of two main parts. The first one, already described above, "In Our Hands", and the second one "Kia Piki te ora o te Taitamariki". This second one forms the second important component of the strategy

and is a specific response to the high suicide rate amongst Maori youth[50] and should address Maori youth's needs. It "aims to provide opportunities to ensure taitamariki Maori are affirmed so that ending their life is not an option" (Ministry of Health, 1998b: 5). The whole strategy is further aimed to strengthen the Maori community, "and in partnership with the government, to channel that strength to nurture the life-force of taitamariki" (Ministry of Health, 1998b: 5).

As explained within Chapter II, the main focus of this thesis is not on the Maori issue and it is only possible to give a short overview of the Maori youth suicide prevention strategy here. More about the strategy and its ways of realisation can be found within the original document (see Bibliography). This part of the national prevention strategy is mainly based on research evidence, published by Keri Lawson-Te Aho. She also wrote a review of evidence for that second part of the strategy.

Key Considerations

This Maori part of the national strategy is based on some key considerations:

- The Maori youth suicide rate "is unacceptable high" and there is probably a link between the high rates and the consequences of colonisation (Ministry of Health, 1998b: 6).
- The strategy is further based on the belief " that all taitamariki Maori have whakapapa [family tree], whether or not they know or acknowledge it, which binds them to a potentially caring whanau and community" (Ministry of Health, 1998b: 6).
- The basis of a Maori society is the whanau, family, which is the smallest unit which should provide care and support for its family members and is therefore "the care unit of Maori development." So a prevention strategy must be able to support and strengthen whanau (Ministry of Health, 1998b: 6).
- Beside whanau, hapu and iwi, there are other groups within a Maori community, like schools, workplace, urban marae (meeting places), for example, which should address and meet the needs of taitamariki and which must therefore be supported too (Ministry of Health, 1998b: 6).
- Better information base is necessary to enable Maori whanau and communities

[50] See Chapter II: 2.6.2 Bicultural Differences

to develop appropriate prevention strategies for their youth (Ministry of Health, 1998b: 6).

Five Goals to Help Reduce Maori Youth Suicide

Within this specific prevention strategy, Keri Lawson-Te Aho and the Maori Reference Group developed five main goals:

1) Strengthening Whanau, Hapu, Iwi and Maori

Strengthening Maori families, sub-tribes and tribes is necessary to enable these groups to offer their taitamariki a social environment, which makes healthy growing-up possible, which provides security and support and promotes identity in young Maori (Ministry of Health, 1998b: 10). Maori communities must be engaged to be concerned about their youth, to support them, to offer youth appropriate programmes and services. The strategy further stresses that these should also and especially include traditional Maori cultural issues. Only then will Maori communities be able to monitor the causes and respond to the suicides of Maori youth (Ministry of Health, 1998b: 10).

There have been a couple of governmental and private initiatives during the past few years to address this goal. Some examples can be found in "Kia Piki te ora o te Taitamariki" (page 10 to 12). But there is still the need to initiate more of such systems, to establish good functioning networks, to develop further appropriate mental health programmes and especially to address cultural issues within all these programmes, as culture forms one of the bases to develop a healthy Maori identity.

2) Taitamariki Development

The aim of this goal is the strengthening of the role of Maori youth "by enabling them to provide a valued contribution to Maori development" (Ministry of Health, 1998b: 12). The basic idea here is that a "strong sense of Maori identity" helps the youngsters to find their place in the broader community. Such an identity can only be realised if young Maori people, too, have access to "cultural markers such as whanau, land, marae, knowledge of ancestors, Maori language, and opportunities for associating with other Maori people" (Ministry of Health, 1998b: 12). It is the conviction of Kia Piki te ora o te Taitamariki that those young Maori who realise their important role in their community and who know strategies with which crisis and traumas can be dealt with

are less likely to see suicide as an option (Ministry of Health, 1998b: 12).

3) Cultural Development

Culture is seen as a protective factor for young Maori to strengthen their self-identity on a cultural base. That includes that policymakers and communities as well as whanau, hapu, and iwi have to respond to suicide and attempted suicide in a culturally appropriate way. That also includes the "legitimacy of Maori methodologies and knowledge in healing", for example (Ministry of Health, 1998b: 14).

4) Mainstream Responsiveness

The aim here is to "encourage and assist mainstream services to respond appropriately and effectively to the needs of taitamariki Maori through the establishment of partnership with Maori" (Ministry of Health, 1998b: 15).

5) Information and Research

There is still a lack of research and information about Maori youth suicide. More research on Maori youth suicide is needed to improve the understanding of the causes and the true level of Maori youth suicides. Under-reporting and incorrect ethnic classifications limit the ability to find solutions for the problem. More research is needed on the question of whether there are special risk factors for Maori youth. Current prevention initiatives must be further evaluated (Ministry of Health, 1998b: 15).

As well as Beautrais, Keri Lawson-Te Aho was contracted, too, to provide a review of evidence of the suicide prevention strategy Kia Piki te ora a te Taitamariki. She also wrote such a review paper of evidence based on research about why a specific Maori approach about youth suicide prevention is necessary. Lawson-Te Aho also used international research on indigenous people and indigenous suicide prevention programmes from the United States and she met with different groups, involved in the work with Maori youth, researchers, as well as with Maori youth groups. Lawson-Te Aho identifies specific needs among Maori youth, which must be met in a successful prevention strategy. She further mentions that the Maori youth suicide rates have

increased during the last ten years[51] and that "reports of Maori youth suicide suggest a significant discrepancy between official statistics and actual numbers of suicide" (Lawson-Te Aho, 1998: 8).

Her basic idea is that Maori youth suicide has something to do with the effects of the history of colonisation is already described within Chapter II. Some of her findings and statements are mentioned here to show the ideas and research results on which Kia Piki te ora o te Taitamariki is based. Lawson-Te Aho stresses in her review that "cultural alienation is a valid explanation for indigenous experiences of being at higher 'risk' for drug and alcohol abuse, mental health problems including depression and suicide, and other adverse behaviours" (Lawson-Te Aho, 1998: 11). Therefore researchers have also linked the cultural alienation of Maori teens to increased suicide risk (Lawson-Te Aho, 1998: 11).

Studies in the United States on indigenous youth suicide further found that

> less traditional tribes have higher rates of suicide than traditional tribes. The reason for this is thought to be related to a greater sense of belonging and greater support of adolescents

(Lawson-Te Aho, 1998: 11).

Research done for and in New Zealand identified a relationship between culture and health and identified that cultural inputs in mental health programmes are important and necessary if prevention efforts want to be effective (Lawson-Te Aho, 1998: 11).

To sum up, Lawson-Te Aho is able to show within her review of evidence that firstly the Maori youth suicide rate has increased, but that an exact number of Maori youth suicides "is not able to be identified" as coronors still often do not carefully assess if the dead person is Maori or not (Lawson-Te Aho, 1998: 31). She further mentions that the educational needs and health needs are still not met by mainstream services. This can be seen particularly in the fact "that 25% of all Maori suicides occur in a mainstream setting – in prison" (Lawson-Te Aho, 1998: 33). That is why these services must be encouraged to create a safe and healthy atmosphere, particularly for Maori youth.

Another factor, which shows a clear loss of cultural identity, is that Maori youth do not participate in whanau, hapu, iwi life, they do not go to marae, and most do not speak Maori. As for Lawson-Te Aho "cultural identity is integral to good mental health". Loss

[51] See Chapter II: 2.6.2 Bicultural Differences

of cultural identity often ends in mental health problems including suicidality (Lawson-Te Aho, 1998: 31).

Lawson-Te Aho is able to show that "Maori youth suicide is an issue for Maori communities" which must be solved "through the development of Maori communities' capacity to respond effectively and appropriately" (Lawson-Te Aho, 1998: 31). Therefore Maori communities must be adequately resourced to enable them to achieve goal one. And it is further essential that Maoris themselves try to address this problem and try to help their youngsters (Lawson-Te Aho, 1998: 32). Maori youth must re-learn that they can be proud to be Maori, that they are unique and worthwhile as Maori, because many identity problems result from the alienation from cultural values (Lawson-Te Aho, 1998: 33).

Research further proved that there is a lack of information about New Zealand youth suicide. However, there has been done a lot of research during the last few years, but there is still need for further research on causes of Maori youth suicide, on the effectiveness of current prevention strategies, and on the impact of historical factors on the development of teenagers (Lawson-Te Aho, 1998: 33, 34). It is further necessary that more and more Maori are included in research projects and participate in research initiatives as

> non-indigenous experts often fail to recognise the limitations of their own expertise where indigenous populations are concerned and then wonder why their strategies, research and approaches fail to reach indigenous people, or why there may be discrepancies between theory and practice. Fundamental to any indigenous youth suicide prevention strategy is the need to validate indigenous expertise. This means recognising that indigenous experts in indigenous youth suicide prevention do know what they are talking about – and that part of validating indigenous expertise necessarily challenges the expertise of non-indigenous experts

(Lawson-Te Aho, 1998: 34, 35).

3.5 Conclusion

Summarising, Chapter III shows that there are general prevention and intervention ideas, based on the knowledge about risk factors for suicidality, as well as several projects and efforts within New Zealand to reduce the suicide risk among young people.

The whole prevention idea can be divided into primary, secondary and tertiary prevention.

Primary prevention aims to reduce the risk factors within a population, and to enhance the environment of young people to reduce the likelihood that suicide risk factors will develop. Such prevention must therefore be established at schools, within families and the society on a more global and political level through peer education programmes, 24-hour hot lines for adolescents, support of and programmes for families, and so on.

Secondary prevention is not addressed to all young people but particularly at-risk youth to prevent serious suicide attempts or further suicide attempts. Therefore within this prevention level one has firstly to identify the ones at risk and measure their level of risk and then secondly make up an appropriate treatment. To assess at-risk youth; it is necessary to have wide knowledge about risk factors like isolation, lack of friendship, family problems, hopelessness, triggering events or psychiatric disorders, and so on, all described within Chapter II. In a next step the risk-level must be investigated for then deciding which further treatment is necessary, in the worst case, hospitalisation, as this is the safest approach.

Tertiary prevention covers the whole range of further ongoing treatment as well as postvention. This includes all work with survivors of suicide attempts as well as those bereaved by suicide to ensure that the survivors live longer and to help the bereaved ones to deal with a tragedy like suicide in a healthy way (postvention). The ongoing treatment must address suicide risk factors like for example mental illness, hopelessness, social isolation and must ensure a development of social skills. In every therapeutic setting or counselling it must however be clear that nobody has the total power to prevent suicide.

Postvention means the support of bereaved family members, friends, colleagues, and so on. It should be stressed here, that these efforts must include a societal level, too, as healthy coping with suicide is only possible, if the environment, the society, gives the

bereaved ones the chance to cope with such an event. The stigma, which those people still have, often stops those people from asking for help, creates again isolation and may cause even more harm and new risk factors for the surviving dependants. The same is valid for suicide attempters, too, who often feel afraid of being stigmatisized as sick and useless and therefore are often not able to seek help. On the other side one has also to be careful that suicide is not publicly presented as an option and should not be romanticized through the media, for example, as this could lead to imitation.

In practice in New Zealand, where the youth suicide rates are relatively high, these theoretical prevention ideas have been translated into many different prevention programmes and activities. Especially the Ministry of Health, Ministry of Youth Affairs and Te Puni Kokiri have played an important role as these institutions fund many research projects about risk factors and convened groups to discuss different prevention ideas and to develop a nation-wide prevention strategy. During the developmental process of the current national youth suicide prevention strategy, which consists of two parts, there have been many researchers and projects which contributed with their results and recommendations to the development of the current strategy.
The ones, mentioned within this chapter, such as the one of Barry Taylor from the Ministry of Youth Affairs, demand mental health promotion within, for example, peer education, special training of youth-workers, special prevention projects for special target groups, like Maori or homosexual youth, and a good working mental health system. He further revised a risk assessment-training programme from the United States of America and adapted it to the New Zealand needs. The manual of this training programme can still be found within many services of New Zealand, like for example Youthline or the Aids Foundation.

The Steering Group on Youth Mental Health and Suicide Prevention investigated what governmental agencies should contribute to gain better mental health for young people in New Zealand, as they discovered mental health as one of the most important protection factors against suicidality and they suggest that mental health improvement results in a reduction of the incidence of suicide. The Group demanded that progress on improving mental health and preventing youth suicide can only happen when the government and all sections of the community work together. The Steering Group then

published recommendations for different governmental agencies. All of these agencies reacted very positively and in an open-minded way and showed mostly great readiness to try to realise the recommendations wherever possible. This is a sign that the political level in New Zealand takes this issue very seriously and tries to improve the situation with their available means as much as possible.

"In Our Hands" and "Kia Piki te ora o te Taitamariki" can be understood as the answer to the strong demands of former researchers, like Taylor, the Steering Group, or Rivers and so on for a national prevention strategy. This prevention booklet is still the most current and used by many services. Both parts of the national strategy include five main goals, which have their similarity with former findings and recommendations.
"In Our Hands" focuses on promoting well-being, which includes support of families, young people as well as the community, as well as offering mental health promotion initiatives, eliminating the stigma of mental illness as this hinders afflicted ones from asking for help, and anti-bullying programmes at schools. It further focuses on early identification of those at risk and helps through special intensive training of those in contact with young people (an idea which has already been mentioned by Taylor, ten Years ago), through offering enough information, through ensuring that the media is aware of its responsibility of preventing further suicide through the right way of publishing stories about suicide and suicide victims in a non-romanticizing way. The third goal includes the demand for effective crisis support services and helpful treatment of suicide attempters, as research has shown that every suicide attempt increases the suicide risk. This is also value for those bereaved by a suicide, what leads to goal four, and demands for support after a suicide. Goal five also demands, like Taylor and the Steering Group, for further research as data is an important part of prevention.
"Kia Piki te ora o te Taitamariki" is particularly aimed at Maori youth as research pointed out that the Maori youth suicide rate is unacceptably high. The whole prevention idea is based on the conviction that the high rate has something to do with the colonisation and the alienation of Maori people from their land and their culture subjects, which leads to a fragmentation of identity and a loss of spirit. The strategy is therefore aimed at strengthening the participation of young Maori in healthy Maori whanau and communities to provide a unique Maori identity, safety and security. This strategy also has five goals as described above. The suicide prevention strategy must

include cultural and traditional Maori issues and therefore be developed by Maori or at least in co-operation with Maori as they are the ones who really know what their needs, especially their cultural needs, are. It does not make sense that those, who in a way caused the current problems among Maoris with their colonisation, try to prevent suicide among young Maori people. It is necessary that such prevention efforts come from Maori themselves as only they can really address the needs of Maori.

In the next chapter the research project is introduced and described. This chapter is build up on the theoretical material of the former chapters and investigates of how the practice looks like and what a youth-oriented service can do to improve the situation for adolescents.

Chapter IV - The Research Project

This Chapter explains in detail what the practical part of this thesis paper is about, what kind of investigation was used to test the theoretical material through a research project within an organisation, called Youthline.
In the beginning of this chapter it is firstly explained what Youthline exactly is what it does and its aims. This is necessary to understand what the service is about and why this service was chosen, as Youthline creates the basis for the investigation. The next section shows the introduction of the research project itself, what it is about and what it should show in the end. This chapter further discusses issues like the trustworthiness of the research, describes the methodology, the whole research process and recruitment of the participants. It further discusses ethical issues and processing of data and ends with a final discussion of the statements and results of the investigation.

4.1 Information about Youthline

Youthline is a non-government agency, which receives a certain amount of funding each year from the government. This funding is meant for a certain purpose and has to be used as described in specific contracts. Youthline needs to keep up statistics to show that they spent the money on purpose for what it was meant for.
Other financial resources that Youthline has, are sponsors who make donations, mostly in return from promoting and/or advertising reasons.

Youthline was established in late 1969. It started as a crisis-line, mainly focused on youth, as it was noticed that youth were under serviced by the existing telephone counselling services. Youthline wanted to provide a service especially for dealing with all issues that young people in New Zealand have to face. The counsellors were therefore trained through an internal Youthline programme. It became very clear that Youthline fulfilled a great need to the New Zealand youth. It also became clear that there was a need for other services, too, regarding the well-being of youth.

Since 1970, Youthline has greatly expanded the services it offers to the community.

There are three locations in Auckland: Ponsonby, which is the head location, Manukau and North Shore. Youthline also focuses on networking with other agencies within Auckland and New Zealand, offering a wider range of support and options for Youthline clients.

Services, which are now available from Youthline are:

- Crisis and support line, available 12 hours a day 7 days a week, which should be expanded to a 24 hours service and which provides trained telephone counsellors to people of all ages, gender and ethnicity;
- Training and development programmes;
- Activity based development programmes;
- Personal and communication skills development programmes, which build self-awareness and trust;
- Information resources for volunteers and clients;
- Team building services for community organisations;
- Facilities available for community groups;
- Youth peer leadership programmes;
- Young women's programme;
- Face to Face counselling service (short and long term and also open for people of all ages, gender and ethnicity);
- Programmes for young people at risk;
- Pregnancy counselling service;
- Group leadership training and development programmes;
- Family and parenting resource services, family linking and counselling services, available to all families to assist in dealing with such issues as anger and violence, truancy, change within the family unit, new relationships, problems around young adults and teenagers, problems with sexuality and cultural values;
- Stress management programmes for individuals and groups;
- Community education and training programmes for other community organisations;
- Group counselling services and youth seminar programmes;

Most of these programmes are run at Youthline House itself but there are also

programmes that are run in the client's environment, for example intermediate schools, high schools, prisons and community agencies. The organisation that is responsible for this is called "Action Education", which has the same government body as Youthline, started in 1981 and is a comprehensive individual, group and community resource providing a range of short and long-term interactive programmes, aimed to promote self worth and to increase the personal skills of the participants.

In summary all the youth-oriented services mentioned above can be put into order at the following five levels, which Youthline has identified as important to improve the well-being for many young people:

1) Crisis Services for those at immediate risk of self harm or harm to others
2) At Risk Services for those who are identified "at risk"
3) Developmental Services for mainstream Youth: that means interactive seminars, recreation, sport, information provision to build life skills, teamwork and personal abilities
4) Training Services for young people to be effective first point of contact helpers
5) Community Services, Promotion and Development

Youthline builds a supportive community to reduce the isolation, fear and violence too apparent in todays' world. It wants to be "an accessible resource for all people providing an environment, which fosters honesty, responsibility and potential." (Youthline: Our Statement of Purpose).

The "N.E.X.T" group can be put into the third area of services, the Developmental Services. The aim of this group is personal development, self-awareness, and building up new friendships. This is the group, which the Youthline Director suggested that I should work with.

4.2 Introduction of the Research Project

Therefore the main question behind this research is, what are the needs of teenagers, particularly distressed and suicidal teenagers in New Zealand, what can a youth-oriented organisation like, for example, Youthline[52] offer to improve the adolescent's situation and does such an organisation meet the needs of the teenagers? This is investigated through one concrete example what Youthline offers, that is the N.E.X.T[53] group.

So this thesis firstly examines the needs of young people in New Zealand, who are linked with an organisation like Youthline, particularly based on the focus of preventing suicidal and self-destructive behaviours and secondly examines what a service like Youthline provides for them. What could be done to prevent self-destructive behaviour and what are the chances and limitations of actual prevention programmes within a service like Youthline and an offer like N.E.X.T? So the first aim is to explore special needs and concerns of the youths, to explore their perspective and secondly to explore whether these needs are met by the programmes of Youthline, investigated within one particular example at Youthline, that is the N.E.X.T group. Lastly this research offers a critical look to see if an organisation like Youthline has influence on the improvement of adolescents and in the end perhaps exercises an influence on risk factors for suicidal behaviour or ideation.

The research part of this thesis provides a further opportunity for feedback for Youthline and young people who use Youthline, about the service they receive, and explores elements of the material to examine the extent of the linkage between what young people are seeking and what the organisation is offering, particularly concerning suicide.

[52] See 4.1 Information about Youthline
[53] See 4.1 Information about Youthline

4.3 The Nature of Qualitative Research and its Appropriateness for this Study

The most appropriate method for this research is qualitative research, as a qualitative perspective has its focus "more on understanding individuals' perspectives of the world, more on seeking information than on proving a hypothesis" (Bell, 1999: 7). Such project sees the purpose of social research as interpretation and understanding of the world and the way people interact together. Reality is considered to be subjective and inquiry can often be inductive, simply exploring what is there without preconceptions. Qualitative research is concerned with understanding reality as defined by the research subject, in this case the realities of the professionals and the adolescents.

4.3.1 Features of Qualitative Research

Qualitative research can be defined as "'systematic investigations that include inductive, in-depth, non quantitative studies of individuals, groups, organizations, or communities'" (Thyer, 2001: 257).

Qualitative research is concerned with non-statistical methods of inquiry and analysis of social phenomenon and with understanding the perspective of the research subject in a non-threatening, relational way. The aim is for communication and understanding between the researcher and the respondent and the relationship is not at all hierarchical. Qualitative Methods can be understood as a humanization of data complementary to the abstractions of statistical data of quantitative methods (Critcher, 1999: 71 and Thyer, 2001: 258), as the emphasis of qualitative research is on "human-as-instrument". This means, that

> the qualitative researcher has the added responsibility of being both the collector of relevant data – data whose relevance changes as the study proceeds – and the culler of meaning from the data, which most often is in the form of people's words and actions

(Maykut, 1994: 46).

So qualitative research is concerned with understanding the experiences of individuals from their point of view and it is aimed "to produce descriptive data in an individual's own written or spoken words" (Thyer, 2001: 266).

The focus is not on proof or testing hypothesis but on exploration. Therefore it is typical

of qualitative research that the sample size is small, as the focus is not on proofing any hypothesis but on exploring the reality from the respondents' point of view. The construction of reality is considered by the qualitative methodology to be a process that employs "patterns of meaning and action" (Sarantakos, 1994: 50). The aim of social qualitative research is to identify these patterns, to understand the process of reality construction and to understand the perspective of the respondents. Qualitative research methods

> are based on 'an approach to the social world which seeks to analyse the culture and behaviour of humans and their groups from their point of view of those being studied' (Bryman 1988: 46).

(Critcher, 1999: 72).

Therefore qualitative methods can offer more detailed information

> 'about surrounding circumstances, beliefs and personal values is crucial for understanding the meaning and emotional impacts of negative events in identity domains that are important to the individual' (Thoits 1995: 59).

(Critcher, 1999: 71).

And the "outcome of any of these studies is not the generalization of results, but a deeper understanding of experience from the perspective of the participants selected for study" (Maykut, 1994: 44).

The most useful and typical ways of gathering qualitative data are those which "allow the researcher to capture language and behavior" (Maykut, 1994: 46). One method therefore, which is mentioned by Maykut and others, is the in-depth interview[54] (Maykut, 1994: 46).

4.3.2 Appropriateness for this Study

As described above, the main purpose of a qualitative research is not to prove but to explore how the respondents view their world, and to receive information about surrounding circumstances, beliefs and personal values. This research is qualitative because it explores the perspective of professionals and adolescents of an organisation, which deals and works with teenagers and topics like suicidality and offers prevention and intervention programmes. My purpose is to understand their point of view, their

[54] See more details about interviews within this Chapter: 4.5 The Interviews

needs and their experiences and to compare the perspectives of these two different groups, the professionals and teenagers of Youthline. I identified the patterns of meaning and action of the professionals and the patterns of the adolescents, and I compared these two patterns and tried to find out, whether they, in working with each other, go together or not.

With this research both perspectives were understood and interpreted and the investigation was focused on understanding the way these two groups interact together, all elements of qualitative research as mentioned above. At the end the investigation should create a picture whether the work of an organisation like Youthline and the concrete offer, the N.E.X.T group can meet the adolescents' needs and can improve their situation. So the respondents are further as important as the researcher itself as they produce the data from their point of view and the relationship between researcher and respondent was not at all hierarchical.

There were further no preconceptions, a typical element of qualitative research too, as the research was designed to investigate and explore a hypothesis[55], not to prove anything. Further quantitative and evaluative research can in the future then be based on the results of this investigation and this research project can be understood as a sort of practical guide of my inquiry rather than testing of a hypothesis.

[55] See description of the results within this Chapter: 4.8 Representation and Interpretation of the Results

4.4 Accessing and Recruiting Participants

4.4.1 General Steps of the Recruiting

The first thing to do was to find an organisation, which works with adolescents and specifically with the suicide issue. My supervisor linked me to the Director of that organisation, called Youthline. The next step was an appointment with the Director to discuss my research project and to ask if he agreed to take part and to link me to adolescents and co-workers of his service. It was therefore also necessary to persuade him that the researcher is trustworthy and capable which I realised through several meetings with the Director. So he offered me his support and was very encouraging and introduced me to one co-worker, who became my research-supervisor from Youthline. In meetings with her we discussed the purpose of the study, potential harm for especially adolescent participants and the sorts of questions with which I would get the information, discovered through the previous Chapters as of interest and at the same time to avoid harming anybody.

Furthermore it was necessary to get approval from relevant authorities such as the University Ethics Committee.[56] In accordance with the Massey University Ethics Committee recommendations I also gave out two Information Sheets[57] (one for the professionals and one for the teenagers) with all the necessary information about nature and purpose of the study, about myself, my supervisor from University, about duration, using data, potential risk for the participants, confidentiality and anonymity, security of data as well as about participant's rights. These sheets also included my email-address as well as my phone number so that volunteers could contact me if they want to take part as well as asking questions about the research. If anybody then decides to take part the volunteers had to sign a consent form, which made sure that they wanted to take part.[58] However all participants had the right to decline to take part at any time.

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[56] See the Ethics Proposal within Appendix J
[57] See Information Sheets in the Appendices E and F
[58] See Information Sheet Adolescents and Consent Form in Appendices E and I

4.4.2 Recruiting Adolescents

To make contact with the adolescent participants I needed the help of the institution. Because of data protection and anonymity it was not possible to get names or addresses of actually vulnerable clients from Youthline directly, as their policy does not allow them to link clients to any research or media project because of ethical reasons. However, Youthline offered me the possibility of linking to adolescent members of a group, who are not particularly at risk and in a more stable mood, like the members of the N.E.X.T group. To make contact with them I joined one of their weekly meetings at the beginning of August to introduce myself and the topic of my research project. I also handed out the Information Sheet.
After a couple of weeks six members contacted me, all teenagers between the age of 16 and 21 who have been more or less distressed and more or less with a history of depression, low self-esteem and suicidality.

4.4.3 Recruiting Professionals

Concerning professional participants I asked some of the co-workers if they were interested in participating and I also handed out the Information Sheet with the details described above. Four professionals were finally interviewed.

In summary the sample included a balance of gender (two professional women, two professional men, four adolescent girls and two adolescent boys). Unfortunately it was not possible to include a balance of ethnicity as there were, except one, only Europeans volunteering. One reason therefore may be that there are generally not many Maori or Pacific people working at Youthline and not many clients with this cultural background either.
After all that, a date for the interview was arranged. The location was a neutral one that was quiet, and offered privacy, good acoustics, and was safe from any disturbance. Youthline offered me a room, which also had the advantage that if further assistance was needed it was immediately available. However no further assistance was necessary during the interviews.

4.5 The Interviews

Given the nature of the issue of this research and the nature of the participants, interviews seemed to be the most useful method as they offered a direct contact between the respondent and the researcher. As this topic is a sensitive and personal one, other methods like for example questionnaires would be too "cold", too impersonal. "Such things call for careful handling and perhaps some coaxing in order to get the information to be open and honest" (Denscombe, 1999: 111). For such a sensitive and personal topic more detailed and rich information can be expected with a direct contact. Also concerning the nature of the participants, especially the adolescents, "face-to-face" interviews create a better rate of response as the researcher has the opportunity to "'sell' the project to the potential respondent in a way that use of questionnaires and telephones does not" (Denscombe, 1999: 8). Adolescents in particular may need a special way of "selling" as they are often not really interested in any sort of "adult-thing".

Interviews as described above are further the method of choice for qualitative research, as they offer a direct involvement with the participants and the production of extensive data from the participant's point of view (Thyer, 2001: 269). They enable the researcher to gain the in-depth information which is needed in this sort of research.

Another advantage is its adaptability.

> A skilful interviewer can follow up ideas, probe responses and investigate motives and feelings, which the questionnaire can never do. The way in which a response is made (the tone of voice, facial expression, hesitation, etc.) can provide information that a written response would conceal

(Bell, 1999: 135).

As an interview is more than a normal conversation, it has to be well prepared. That means that topics need to be chosen[59], questions devised[60], methods of analysis considered[61], and a detailed schedule has to be developed (Bell, 1999: 136).

Therefore I developed some topics and questions, based on and constructed out of the reading, review and knowledge described within the Chapters I to III, which are of interest and seem to produce the data I would like to collect. I then discussed these

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[59] See this Chapter: 4.2 Introduction of the Research Project
[60] Also see Appendices G and H: Question Framework Adolescents and Question Framework Professionals
[61] See this Chapter: 4.7 Processing Data

topics and questions with my supervisor from University as well as with my supervisor from Youthline, especially concerning the risk that any question may cause harm for the adolescents. Both felt the questions were fine and that I covered a good range of material.

In both interview groups, the one with the professionals as well as among the adolescents, I started with introductory questions, which made the entrance into the interview easier, as they are very general. The aim here was to establish in the beginning an atmosphere of warmth and well-being, and to make sure that the participants felt comfortable, as this increased the worth and amount of data. After these introductory questions the main guidance questions introduced.[62]

It was also important to choose the type of interview.
In the case of this research the semi-structured or as Bell calls it, "guided or focused interview" (Bell, 1999: 138), seemed to be the most appropriate one. It is a mixture of completely formalized and unstructured interviews, as it does not have a clear checklist of questions, but a framework with which special topics of interest are selected and around these the interview is guided. That means that certain "questions are asked, but respondents are given the freedom to talk about the topic and give their views in their own time" (Bell, 1999: 138).

> With semi-structured interviews, the interviewer still has a clear list of issues to be addressed and questions to be answered. However, with semi-structured interviews the interviewer is prepared to be flexible in terms of the order in which the topics are considered, and, perhaps more significantly, to let the interviewee develop ideas and speak more widely on the issues raised by the researcher. The answers are open-ended, and there is more emphasis on the interviewee elaborating points of interest

(Denscombe, 1998: 113).
One general advantage of semi-structured interviews is the framework, which is established beforehand and makes the analysis of the data easier, which is especially useful for time limited research.
In this study this type of interview was especially appropriate because of the nature and

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[62] See Question Frameworks in the Appendices G and H

purpose of the research and the nature of the participants. This sort of interview was necessary to avoid any harm to adolescent participants. As they were especially vulnerable and might be remembering sad and stressful life events through the interviews, it was useful to give them the freedom to talk about the topic in their own way and time.

On the side of the professionals this type of interviewing was useful as they were the key-players, experts concerning the research topic and therefore should also get the freedom to elaborate their points of view.

One general problem of interviews is that of objectivity.

> There is always the danger of bias creeping into interviews, largely because, as Selltiz *et* al. (1962: 583) point out, 'interviewers are human beings and not machines', and their manner may have an effect on the respondents.

(Bell, 1999: 139).

This problem cannot really be avoided but as Bell says, the awareness of this problem and self-control can help to be as objective as possible (Bell, 1999: 139). These interviews and with them this research in general cannot and should not be representative, especially as the way of sampling created a special shape of participants. However it created a framework for further discussions.

To collect the data, the interviews were tape-recorded with the permission of the participants.[63] These tapes were then transcribed by a transcribing person, who also had to sign a confidentiality agreement.[64]

[63] See further details within this Chapter: 4.7 Processing Data
[64] See Appendix K: Confidentiality Agreement

4.6 Key Ethical Issues

4.6.1 Anonymity and Confidentiality

To find participants for a sensitive issue like this, it was important to offer them anonymity and confidentiality, through for example changing their names. This has to be done unless the researcher has the explicit permission to reveal the person's identity. To affirm that anonymity and confidentiality were looked after, this was also written down in the informed consent, which was then signed by the researcher. The researcher has a responsibility that she has to take very seriously. To the fullest extent possible, nothing was written in any publication, which would allow identification of participants, thereby protecting anonymity. No information provided by participants was disclosed to a third party.

That is why the original transcripts cannot be put in as an appendix, as then it might be possible to identify the participants, especially as it is just a small sample and the adolescent participants know each other quite well. Also as I offered all participants a copy of this thesis it is not possible to put in the whole transcripts. That is also why I decided to use pseudonyms and not the real names of the participants.

4.6.2 Potential Harm to Participants

This is a very important and serious issue as the adolescents among the participants may experienced some degree of instability, or the interview might make them remember the painful feelings they suffered from. Adolescence is generally a period of life, which is characterised by change, self-development, and unsteadiness.[65] It is a phase in which an individual is sometimes unstable and therefore reactions and behaviour cannot readily be foreseen. In the case of this research it was even worse as the researcher was faced with young people who have had a number of difficulties. To talk about such fundamental feelings and thoughts was difficult and the researcher had to be as sensitive as possible.

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[65] See Chapter I

To reduce the risk of distressing the teenagers I decided to concentrate on the N.E.X.T group with members who are not particularly at risk, who perhaps have had suicidal feelings or thoughts when they were younger, but are now stable and not any longer in an actual advice situation. However there might have still been the possibility that the remembering made the interviewee feel sad again. I planned with my supervisor at Youthline that in such a case, when I recognize such a sudden sadness I would link this adolescent to his or her supervisor and encourage him or her to use the assistance available at Youthline. Fortunately that was not at all necessary and all six adolescent participants told me that they were fine and not at all distressed after the interview. Further I interviewed the youths in an interview structure, which was very open and offered the interviewee the freedom to refuse to talk about still painful issues. I concentrated on indirect questions, which means, for example, that I did not ask them directly why he or she felt suicidal but what he or she could imagine generally might be reasons for feeling distressed and suicidal. This kind of question should avoid a direct and stressful confrontation with personally stressful feelings and gave the interviewee the opportunity to answer in a more neutral and general way.

The professionals themselves should be professional enough to deal quite well with such an interview situation, particularly as they did not have to talk about personal issues. For them it was work related. However, even with them it was necessary to create a warm, friendly and open-minded atmosphere full of trust. That was an important task for the researcher, which was taken very seriously. That included punctuality, friendly and polite behaviour as well as a proper, respectable appearance. It was further necessary to ensure that there was no individual feedback from these interviews given to the agency.

In summing up, no participant was distressed in any way after the interview. The feedback from all of them was very positive and they felt, that it was interesting to talk about this "stuff".

4.6.3 Use of Information

The collected data was used in form of this thesis, in which the statements were analysed and interpreted as described below. After discussions with the participants it was decided that this thesis be given to Youthline, which can use it as a feedback file concerning its services and as an information paper about studies concerning risk factors, summarised information about prevention and intervention as well as about adolescence in general. At the Youthline library all participants have access to the whole draft and can have a look at the results. I am also going to stay in contact with all participants who want to communicate via email for further discussions about the results. The research can further be understood as a platform for further research about questions like, whether those who do not access Youthline might have needs which the organisation does not meet and which might be the reason for staying away. It would be further interesting to investigate issues like the social class characteristics of those who use Youthline and if there is a more active advocacy role which Youthline could take alongside its counselling role. So the research project for this thesis with its results is an invitation for further research in directions as described above.

4.7 Processing Data

The interviews were recorded on audio-tape as long as the interviewees agreed, which all of them did. Audio tape-recording offered a record, which was complete in terms of speech, and objective as these "*research instruments do not interpret the events, they simply store them*" (Denscombe, 1999: 124). However, even the tape-recording could have an impact on the interviewees, as its presence could make some participants shy or nervous. Nevertheless I think it had less impact on the behaviour of the interviewees than video tape-recording, as human beings are usually more nervous in front of a camera. That is why I decided to use the audio tape-recording.
Then the data on the tapes was transcribed, as it is far easier to analyse written down material than it is to do so with an audio-tape. This process "brings the researcher 'close to the data'." (Denscombe, 1999: 130). The data was transcribed by a transcribing person with whom contact was built through University. In the first version of the transcripts each line had a unique line number as it made it easier to identify and locate parts of the data in a quick and precise way. Copies of the transcripts were then sent to the participants and marked confidential to ensure their validity. They were sent via email and some with stamped addressed envelopes so the participants could return the transcripts to me with any clarification they wished to be made.

The next step was to analyse the material. The data was analysed with the main questions in mind. When analysing it was very important to recognise that the identity of the researcher has its impact on the analysis as the interviewer uses his or her personal interpretation skills and judgmental ideation, as stated by Denscombe (1999: 176):

> The researcher's self (his or her social background, values, identity and beliefs) will have a significant bearing on the nature of the data collected and the interpretations of that data.

The analysis was done by reading the transcripts and making some headings, which went together with the questions of the framework. As I used two different frameworks for the two different interviewee groups, one question framework for the adolescents

and one for the professionals[66], I started analysing with two different sources. Once this was done I compared the main statements of these two groups and had a look whether these two dimensions go together.

For analysing I used the cut and paste method of data by cutting up all the interviews of each group and assembling them in groups of one theme. All data from all the interviews was put under a theme heading which can be called category and which is doing justice to the main questions of the whole thesis. I therefore highlighted the statements on the transcripts in different colours. So all statements of the interviewees were collected under different headings and lastly put into different categories, which are presented in the Appendices A-D.

The last step was the writing up, as Denscombe for example says:

> the research procedures and findings need to be recorded in writing if they are to be of any value. The process of research is not completed until the findings have been written up.

(Denscombe, 1999: 224).

To write the findings up means that the researcher at last has to produce a formal record so that others can evaluate the research. This final report should include an explanation of the purpose of the research, a description of how the research is done, both as described above, a presentation of the findings, a discussion and an analysis of the findings, as well as a conclusion, which follows below (Denscombe, 1999: 226).

[66] See Question Frameworks within the Appendices G and H

4.8 Representation and Interpretation of the Results

Within this section data produced through six interviews with adolescents from the N.E.X.T Group/Youthline and four professionals of Youthline, who work in different positions is brought into order through building categories and summarising with the aim of creating a reviewable corpus of the amount of data. These categories do justice to the question framework.[67] During the research process four main categories were identified as being of central interest, based on the main research questions. The first one is called "Needs of New Zealand's youth", the second one is identified as "Prevention and Intervention (offered by Youthline) and Skills of the Staff to meet the Needs", the third one is called "Improvement" and the last one "Limitations and Boundaries". These four categories were identified as useful to produce the answers on the central questions of this research project[68]. Statements from the interviews are then firstly put in order within these categories on two levels or from two perspectives, the first one is the perspective of the adolescents and the second one is the perspective of the professionals. (For fuller details see Appendices A-D). So the whole material is divided into smaller units through putting the answers in order to these four main categories as well as the two different perspectives.

The interpretation is then mainly done by the comparison of these two perspectives as well as by a comparison under the focus to see if these perspectives also go together with the theoretical material of the former chapters. Within the following paragraph the data in form of the analysis of the answers of the participants is presented in summary under the headings of the four categories, "needs", "prevention", "improvement", and "limitations".

4.8.1 Needs of New Zealand's youth

Views of Adolescents

Needs, which can be found within the statements of all the adolescent participants are firstly the need for friends, close and really good friendships, which they can rely on,

[67] See Question Frameworks: Appendices G and H
[68] See this Chapter: 4.2 Introduction of the Research Project

the need to meet people and have contact to other young people, as well as especially the need of talking about "stuff". They need someone they can talk to, bond with, share things. They need friends who support them, encourage them, and really look after them, where they can just be themselves, friends who believe in them and where they can find trust, honesty, confidentiality, loyalty and where they can get things out of their system as "*sometimes adults are not always as understanding*" (Kim). Trust was a major statement among five out of six of the adolescents' statements about what makes a friendship a good one. Mark further mentions that friends have a big influence on you, but can also cause problems, where many of his close friends were really depressed, he got depressed as well.

For their future all of them have the deep wish to travel, to go overseas, to work there, to meet new people and experience new cultures, even, as in Robin's case if her "*mum would cry*" and she uses the term "*unfortunately I feel pulled to go overseas*". This need seems to be a really strong and intense one, "*... and it just felt really strongly in my heart to go over there ... I don't think I have much choice*" (Robin). They want to "*get out for the understanding of what the world is like*" (Mark).

They further want to learn as much as possible, to finish university or school, find a good place to work, earn good money. They want to be happy and be able to love themselves. Only John and Becks are quite lost concerning their future plans, but still they wish to be successful, rich (Becks), happy, and they want to have a family. Robin, the only one who has never had suicidal thoughts and did the N.E.X.T course mainly to become a phone counsellor herself has very sharp visions of her future and has discovered "*her passion early on in life*" (Robin), which seems to give her hope and a positive attitude towards her future.

Another main need, which can be discovered especially within the statements about suicidality among teenagers, is acceptance of who they are. This includes as in Mark's case sexuality. They think they need more to be taught that it is ok to be who you are (like being bisexual, for example). So they told me that they need to be taught that you do not have to live up to a standard of being beautiful, skinny and cool, presented through the media, up to an unrealistic image. Such images often come from TV from overseas and create a picture of young people, which does not fit in the circumstances teenagers in New Zealand have to face. John for example mentions that New Zealand

more and more becomes an American society and that therefore teens in New Zealand suddenly want things like big parties, concerts and events, which they cannot have as the country is just too small. This creates dissatisfaction and unhappiness. Or as Robin says, "*girls always want to be loved and affirmed that they are attractive*" (Robin), which then leads so often to careless behaviour concerning sexual relationships and in Robin's eyes to the high rate of teenage pregnancy. Therefore she thinks New Zealand's teenagers need more contraception education. They need education about body image. They need to be taught to accept themselves, instead of always being shown these unrealistic images on television or magazines. Guys need to be taught more about communication. Boys further, as Robin expresses, need more education about how to discover one's own passion, which would create hope about the own future. Most of the adolescent participants therefore think more services like Youthline and the N.E.X.T group would be helpful, more programmes for schools, workshops, and counselling to be supported on the way of growing up, which Sue, for example, describes as really stressful. Places where they can hang around, meet people, where teenagers are accepted as being young and who they are. They need places where they can talk to people if they want to, where young people do not have to be bored and/or be alone, but where they can learn communication skills. That is, as Robin says, especially necessary for guys, who often are not able to open up and talk about stuff. They think therefore about places like drop-in centres (Kim), parks for car races (Becks), like a community talkback radio station (John), or something like a "*teenage Salvation Army*" (Kim).
Kim further mentions the need for stability at home and a loving family, which supports and accepts its adolescents.

Something which also has to do with the need of being accepted is the statement about peer pressure. There is great fear of being different from everybody else, of not belonging, being an outsider, of having to live up to the expectations of a group to be "in". This pressure, mentioned by four out of six of the adolescent participants, can lead to trying drugs or behaving or acting in ways which one normally does not want to. It again has something to do with image appearance and the fear of not being able to say no to certain things. This is caused because self-esteem is sometimes low and many young people have not yet developed their own strong way of living or behaving.
Fortunately not all of the adolescent participants (five out of six) have had to deal with

suicidal thoughts. But those among them who have had to also have had to deal with problems with their self-esteem. This has, for example, been low or goes up and down and makes unsure or self-conscious about the way one looks and what people think of them. In Beck's case this phenomenon even leads to a deep fear of "*not being able to do things, not being right*" (Becks). John has had to deal with paranoia in the way of being really worried about how things will turn out (like his professional career as an artist). Some of the participants also have had to deal with triggering events, like the break-up with the boy- or girlfriend (Sue and John). A triggering event for John has been trouble at school, where the art teacher did not believe in John's talents and that he would be able to make it to the art school he wanted to go to and where his school had further big problems with accepting his new piercing. Other triggering events mentioned by the adolescent participants are the loss of very close friends through an accident or illness, as in Sue's case, and through suicide as in Kim's case, who then felt "she *had not been good enough to protect her* [friend]". Becks further has had to deal with depression and drugs and Mark with the discovery of his bisexuality. This discovery was very confusing and caused trouble at home and at school, where it could not have been accepted immediately and caused a deep feeling of being different and alone in Mark, as well as depression.

Except for John and Robin all of the teenage participants have to deal with separated or divorced parents and all have trouble with at least one family member, the mother, dad, or step-mother. In Mark's case, for example, his step-mother just recently told him that she hates him. Kim stopped contacting her mother because "*she is just an alcoholic and a drug addict*" (Kim). Beck's father just "*does not listen and understands things in the wrong way*" (Becks). It is hard for her to get on with him. Sue is really missing her dad, who is working overseas at the moment, probably particularly as she and her mother got on "*but there is still a barrier between*" (Sue) them. It is just John and Robin whose parents are still together and who describe their relationships as good and very close: John's relationship is "*really good with everyone*" (John) and he can talk if he needs to. Robin describes her family as really close and her parents as "*really incredible people*", "*the best people* [she] *ever met*" (Robin). She is the only one who has never had any suicidal thoughts.

These facts about the family background suggest the need for close relationships with family members and a healthy atmosphere at home, full of acceptance, support and an

open-minded contact with the parents.

Views of the Professionals

All these statements about needs and wishes of teenagers are covered by the statements of the professionals. The professionals also talk about acceptance and acknowledgement, particularly Mike, who says young people need someone who is really proud of them, who is proud of what they do. That also means including them community-wise in the way that young people must be heard. One must give them a voice to show them that their input is necessary and good. At Youthline young people are heard and their input is taken seriously. It is important to use them as a resource and concentrate on their strengths and not to see them just as a problem (Mike). Only then can young people feel acknowledgement and worth and only then they will bother. Therefore on the professional side (Mike) drop-in centres are also mentioned as a place where young people can meet, hang out and build up effective peer-relationships, which Tom describes as very important and as a central need. Peer-relationships and being a member of a group is necessary to develop an identity through identifying with or separating from such a group. Adults must therefore create such meeting places, where such relationships can be built up in a healthy and safe atmosphere. That means also that adults must be around, but that young people can still be themselves, separately, but still part of the society (Tom). Tom mentions that New Zealand does not do this, also confirmed through Mike's statement that there are no such places, that there is no space for young people where they can hang around without spending money and where help or counselling would be available if needed. So Mike also talks about drop-in centres as a need of New Zealand's youth, a statement which goes perfectly together with statements of the adolescents, who also express the need for drop-in centres.

The reasons why teenagers come to Youthline and/or why young people are suicidal, mentioned by the professionals, also cover the range of reasons named by the adolescents. These are reasons like isolation, depression and the inability to talk, which creates an evil circle. Further reasons are feeling lonely, being distressed, disconnected from a social system or setting, hopeless and helpless, or just wanting to develop themselves more. Reasons like alcohol or drug problems, like peer pressure and bullying at school, knowing someone who has killed him- or herself, or family dysfunction and anger, which is then often directed against themselves, as they do not

have anywhere to go to express their anger are also mentioned by the professionals (Tom, Mike, Christine, Megan). They therefore cover the range of reasons for suicidality which the teenagers mention.

Behind all these reasons also stay some needs, especially the need to, as Christine says "*fit in*" and find a positive future perspective. Also the need to find acceptance and acknowledgement (Mike), to get help with developmental issues, to be supported on the way of growing up, to find someone to talk to, to open up, who the teens can really trust. All these needs, mentioned above by the teenagers are met with the offers, which Youthline can make, are met through a group like N.E.X.T, as this is a place, where adolescents just can meet, build up peer-relationships, can talk about their fears and stuff in an open-minded non-judgmental atmosphere and where they get the feeling, as Mike describes, that someone is proud of them. Or as Christine says, "*where young people can come and be themselves and be accepted within a safe context*" (Christine). Megan states they can just open up and experience that "*there is someone just there for them, and that they do not have just to get on with their stuff*" (Megan). That creates a sense of hope and purposefulness, described by Tom as a need. This can also be found within the statements of the teenagers, like for example Robin's expression of how necessary it is to discover one's own passion to find sense for one's life and to have hope for one's own future.

The need of being accepted among peers as well as adults is also covered and investigated by the professionals, who mention that there exists pressure among teens in the area of alcohol and drugs, for example. This pressure often leads to risk-taking behaviours. However, Tom also mentions that a normal level of risk-taking behaviour is also a natural and very normal part of being young and must therefore in some ways also be "*socially understood*" (Tom) by adults, too. A fully sanitised world would in Tom's eyes create "*a whole lot of mental illness*" (Tom).

There are many pressures coming from outside where young people need to get through in a healthy way and that is why young people need to "*be shown defined pathways to travel through*" (Tom). This is particularly true as the sense of future direction has changed and young people today have many unclear options and often no stability, which Kim also describes as a problem of concern. Even gender roles are not clearly defined anymore, and particularly for young men it is not that easy today to find their role as a man in modern society (Tom). These problems also include the media, which

brings all that "*stuff about all these opportunities ... and in reality some of them* [young people] *are struggling just to get through school*" (Christine). As already mentioned through the teenagers, the professionals, too, note that it is necessary that television and the media create a realistic picture of being young and of the world. Christine for example says that "*it is all very well to see all these amazing role models, but that often seems so distant*" (Christine). There are so many images presented through the media about being cool, sexy, tough and staunch which are presented as ideal images "*but which are very hard to live up to when you are just a kid and you have no resources and are still living under your parents' roof*" (Christine). These images create insecurity where to fit in, how to fit in and if ever to fit in.
Christine also covers the need for more and different support at schools. She thinks that there is at the moment not enough social work type of support to address the psychological and emotional problems that most young people are dealing with. She also mentions the problem of lack of confidentiality with school counsellors, a statement which clearly meets the intense need of trust, stated by the teenagers. She is further the only one who mentions the need of acceptance concerning the sexuality issue, the fear of being different and an outcast when other peers discover the own homosexuality or bisexuality, an issue which also concerns Mark.

Teenagers in New Zealand definitely need more support community-wise in, like Megan describes for example, the way of self-care education. Tom makes clear once again that New Zealand is not a very youth centered society and many young people think that the environment has a negative view of them. This has influence on them, especially on their self-esteem and does not meet the need to be accepted and acknowledged. Tom argues that services are not necessarily youth friendly and even at Youthline nine out of ten people who ring them up do not get through, an experience which makes the feeling of disconnection even worse. However the state still does not support an anonymous help line. So young people are, in Tom's eyes, quite marginalized in New Zealand.

What can be seen within all these statements is that the professionals discover almost the same needs as the adolescents. Their attitudes about what young people in New Zealand today need to live a happy life go very well together with what the adolescents

themselves think and express. This agreement is the first and central basis for the development of services, programmes and offers which then indeed will have the ability to meet the real needs of teens.

Arguments from the Literature

Compared with the literature one can also find many parallels and agreements between the theory and the statements of the professionals as well as of the youngsters.

As described within Chapter I adolescence is a period full of changes and development. This causes stress, instability and vulnerability. Many different things like the intrapsychic self, identity, including cognitions, operational thinking, morality, sexuality and coping skills must be developed in this difficult life span. This leads to immaturity. In some cases teenagers still show some kind of cognitive incapacity (described and explained within Chapter I) which can create feelings of hopelessness and helplessness, as young people sometimes do not yet have any idea how to influence their personal future but that something external controls everything.[69] The teens in the interviews describe this process of growing up as stressful too. The literature shows that to develop an identity and morality and to find a sense of self-in-the-world young people need the interaction and contact with peers as well as adults. This need is expressed withing the statements of the adolescents as well as the professionals. Both groups point out that teenagers need support during their growing-up process. They need someone they can trust and rely on, someone who cares and to whom they can build contact. The interviews show the necessity of peer-relationships to develop an identity. Robin mentions the need to discover their own passion. And Tom stresses this need through his statement that teenagers need support, help, talks, acceptance and adults who show them defined pathways, and realistic pictures of opportunities, especially as so many often unrealistic opportunities and pathways are presented through the media today. Christine discovers the problem of the question where to fit in and how to fit in and if ever to fit in.

Chapter I further expresses the role of parents and the family. During this period of life parents remain important. However puberty creates changes in the family system, a fact that can create stress. As described within Chapter I, adolescence brings three major tasks for a family system: sexual development of the child, identity formation, and

autonomy development. All three tasks may create conflicts within a family system and at least need discussion, movement, and changes. Therefore the whole family as a system sometimes needs support.[70] As statistics and research show, many suicidal teenagers have divorced or separated parents, many even have parents with alcohol and drug problems. Therefore a relation is to be seen between familial conflicts and suicidal ideation. Authors like Robins (1998) emphasise the importance of social support for healthy development of an adolescent into an adult.[71] The research of this study shows too that four out of six adolescent participants have divorced or separated parents and many of them have trouble with at least one of their parents. In two cases this includes also problems with alcohol and drugs at home. Within all interviews a deep need of close and positive relationships with parents can be discovered, which goes perfectly together with the theoretical assumptions within Chapter I.

Beside the social support within the family the theoretical material within Chapter I also show that peer-relationships are important too. During adolescence, young people turn more and more to peers and spend more and more time out of home with peers. That is why the peer group has a big influence on the well-being and identity development of young people. To be accepted within such a group is a deep need and being an outsider can easily create depression, loneliness and hopelessness. The quality of a peer group has further influence on coping mechanisms as well as the behaviour of its members.[72] That this is true in real life as well can be seen in Beck's case, where her circle of friends got her into drugs, as "*you have to live up to the expectation of your group to be 'in'*" (Becks). As all of the adolescent participants stress the need of close friendships and acceptance it is obvious how big the influence of others, particularly peers, is. The participants mention peer pressure, the deep fear of being different (sexuality-wise, for example), which creates enormous stress to live up to a standard, which in some cases is not a healthy or one just does not fit.

In the next step the importance and the influence of the society as a whole and cultural circumstances should be taken up. Chapter I shows that particular factors like integration and regulation (Durkheim) as well as cultural changes have their influence on the well-being of young people. Cultural changes can create insecurity and may end

[69] See Chapter I: 1.1 Definition of Adolescence and 1.2.1 Psychological Factors and Intrapsychic Factors
[70] See Chapter I: 1.2.2 Relational Aspects
[71] See Chapter I: 1.2.2 Relational Aspects

in an accumulation of many different possibilities and options. Many of them are not realistic and do not fit the mass of ordinary people.[73] This phenomenon is expressed by the participants as well who describe New Zealand as a not very youth-centered society and many young people think that the environment has a negative view of them. As described above this has influence on them, especially on their self-esteem and does not meet at all the need of being accepted and acknowledged (Tom). So young people are, in Tom's eyes, quite marginalised in New Zealand. Tom further points out that the sense of future direction has changed and young people today have many unclear options and often no stability. As described above, even gender roles are not clearly defined anymore, and particularly for young men it is not that easy to find their role as men in modern society (Tom). With this statement Tom corresponds with Rivers, quoted within Chapter II, who discovers massive changes in the roles of men and women, which are found to have an influence on suicidality.[74] These statements make clear that the society has indeed an important role and carries responsibility. It is necessary to show young people that they are wanted in a society and that they are resources for a nation and not a problem. Durkheim's idea of cultural deconstruction and acculturation[75] can also be found within New Zealand concerning the problems of the Maori population.

Further cultural circumstances, described within Chapter II, which have direct influence on the adolescent's well-being and, for example, the way of coping, are found to be the specific childrearing philosophies. A special upbringing (like in Denmark) or very normative expectations of parents can lead, for example, to restricted emotional skills. One can speculate if there are childrearing philosophies in New Zealand as well which lead to the phenomenon, described within the participants' statements above, that many young men in New Zealand are not able to talk, to show their emotions. Even one of the teenage participants realises the need of boys to be taught how to express their feelings and emotions to cope with them in a healthy way as they "*often are not able to open up and talk about stuff*" (Robin). This realisation comes up to the findings of Taylor, who is quoted within Chapter II and who speaks from a strong male macho culture in New Zealand and the problem for men of expressing themselves.

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[72] See Chapter I: 1.2.2 Relational Aspects
[73] See Chapter I: 1.2.3 Sociocultural Factors in Adolescent Development
[74] See Chapter II: 2.6.3 Causes of Adolescent Suicide (NZ).

Concerning risk factors, presented within the literature and Chapter II and the statements of the interviewees one can see that almost all theoretical risk factors can also be found in the data. Suicide is a psychosozial and psychiatric problem. It is a very complex issue and a multi-causal phenomenon. So suicide is a composition of many factors that set an adolescent particularly at risk.[76] Presented within Chapter II depression and other mental illnesses for example are clearly related to suicidal behaviour, as well as hopelessness, anger, and low self-esteem. Many studies show that suicide attempters tend to have a low self-esteem.[77] All adolescent participants in this study express problems with their self-esteem, some clearly have been depressed in the past, and one even has had to fight with paranoid thoughts in the past.

The literature also mentions perfectionism as another possible risk factor, as it can result in an intolerance of mistakes. Those people set themselves impossible, unrealistic standards and goals so that they can only fail. That is why they are then chronically frustrated, over self-critical and therefore easily become depressed.[78] One teenage participant shares these characteristics and knows how much pressure it creates, how stressful such an attitude can be and how easily you can become sick, depressed, even suicidal (Kim).

School problems[79], peer pressure and bullying, alcohol and drug problems[80], lack of identity as well as the lack of positive future perspective and productive coping skills[81], can be found within both the literature (see all the footnotes) as well as the interviewees' statements. Also factors like family dysfunction (discussed above), social isolation and poor peer relationships are identified as risk factors within the literature,[82] as well as within the participants' experiences. Almost all teenage participants express the experience of triggering events (described above within this paragraph) which goes again together with the presentations within Chapter II. Homosexuality or bisexuality, discussed theoretically within Chapter II is described as another factor which can cause stress and insecurity during adolescence and if not accepted by other peers, the family

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[75] See Chapter II: 2.3.1 Cross-Cultural Perspective
[76] See Chapter II: 2.1 Definition
[77] See Chapter II: 2.3.5 Psychological Perspective: *Psychological Profile*
[78] See Chapter II: 2.3.5 Psychological Perspective: *Psychological Profile*
[79] See Chapter II: 2.4.1 School Experiences
[80] See Chapter II: 2.4.2 Alcohol and Drug Use
[81] See Chapter II: 2.5.1 General Risk Factors

and the society as a whole, can even cause deep frustration, depression and in the worst case suicidality. One out of six teenage participants has had to deal with these tasks and describes indeed that the discovery of one's own homo- or bisexuality can turn into a risk factor if the environment makes it impossible to live their own affection. So the practice out there shows that this topic is indeed one of many issues, which has to be taken seriously if one wants to talk about reasons for suicidality in an extensive way. It is not tolerable that many researchers still leave this issue out of their discussions about risk factors and as a result often do not include homosexuality and bisexuality in prevention programmes. This is short-sighted and not only theoretically false but can also be seen within the interviews of this research project.
One last agreement between the literature and the interview statements is the idea of teenage pregnancy as a risk factor, especially in New Zealand, where the pregnancy rate among teenagers is very high (Drummond)[83]. Robin also stresses this phenomenon and is sure that this causes immense stress and hopelessness, which can lead to suicidality.

What can be seen here in summary is that the theoretically described causes of adolescent suicide internationally as well as nationally correspond with the experiences and statements of the adolescent as well as the professional participants. Behind these causes and risk factors needs can be discovered, which are identified in the previous theory chapters about adolescent development as well as within the interviews. So altogether the interviews can indeed be understood as a confirmation of the theoretical ideas presented in the previous chapters of the practice.

4.8.2 Prevention and Intervention and Skills of Staff Members to meet the Needs

All the statements within the second category about prevention and intervention and the skills of staff members to meet the needs of the participants, which can be seen within Appendix B, show prevention and intervention ideas and actual prevention offers and programmes at Youthline, again from two different perspectives, the one of the professionals and the one of young people. In the following analysis of these statements

[82] See Chapter II: 2.5.1 General Risk Factors
[83] See Chapter II: 2.6.3 Causes of Adolescent Suicide (NZ)

both sides are again compared with each other and lastly the statements are also compared with the theoretical material about prevention and intervention ideas and current prevention strategies in New Zealand, mentioned within Chapter III. That means that it is investigated within this paragraph whether Youthline meets the theoretical ideas of prevention and the national guideline of youth suicide prevention or not.

Views of Adolescents

One of the first questions within this paragraph is which helping possibilities young people know and wish to receive if they are distressed, depressed or suicidal. The most common answer is talking, talking to friends, to counsellors, therapists, to people who are open, understanding, who accept them and are just there for them. The described aim is to get things out off their system. Kim, for example thinks that it is much easier to talk to a professional counsellor about her grief and sorrow because of her loss of her friend than to do so with friends. During this period she needed someone who dealt with those situations on a professional level, not someone so close to her circle of friends. After she came out of the session for the first time she "*felt so much better*" (Kim). Becks talks about a similar experience with her therapist: "*I felt like big weights had been lifted off my shoulders because I had told someone*" (Becks), and for John it is just "*easy to talk to her* [his counselor]" (John).

They further express the need of people around them who care and who support them, which also includes the family. Mark and Robin both mention as one of the most useful helping possibilities for teenagers the N.E.X.T course. They both think that more groups like this should be available and offered as "*I think it is more helpful than anything [...], because when you are in a group therapy you are learning so much of other people*" (Robin). Through these group sessions people can get new input and more of a purpose (Robin). Open discussions about everything of concern are possible. In Mark's case, for example, he could for the first time have really open discussions about his sexuality and his thoughts about being bisexual in a non-judgmental and open-minded atmosphere.

Sue and Kim both mention poetry, whereas Becks and Robin are both more focused on the need of just getting out, getting into public, being around people that make you happy. For Becks it is especially helpful to "*go out do something that gets* [her] *mind out of things*", not too much thinking and more relaxing and forgetting about things.

Concerning their wishes for help, Sue, Mark, and John further think that Youthline should get the 24-hour phone line to be able to answer more calls, and that it should get more funding to realise that. Except for Becks, all of the teenagers think that there should generally be more groups, to "*get out and get more people in more groups*" (Kim) and for John the meetings should be longer, not only 2 hours per week. Mark particularly mentions the need for more groups like "*boys to men*", and Kim thinks that more groups about the sexuality issue would be useful. All these offers from Youthline should in their eyes be more advertised so that more people know about it and so that "*young people do not feel that they are alone*" (Mark). Therefore Robin thinks it would be particularly necessary to go more out into schools to get more people into such groups because "*it* [N.E.X.T] *is just fantastic*". Sue can imagine that another Youthline building would be helpful, as she just knows Youthline, which is helping teenagers. Kim also thinks about something like a Salvation Army for teenagers and a Teenage Forum, where young people can meet, talk and be heard. All these things would in the eyes of the teenagers help to reduce depression, isolation, loneliness and even suicidality among teenagers. Only Becks has no clear idea what could be done and does not mention Youthline.

Views of Professionals

Now what does Youthline on the other side try to offer, which programmes and resources do Youthline generally and the professionals at Youthline particularly have to meet these needs and to prevent self-destructive and suicidal behaviour?

For Tom, for example, the most important basis of his work and the service is that Youthline is known out there, a statement, which goes perfectly together with the wishes of the teenagers of more advertising. Only then one can try to establish easy access to the service, which was done through the establishment of the phone line. From there it must then be investigated which sort of further help the callers need, that can include an individual therapy at Youthline, a link to other services, hospitalisation and later family therapy. When the teenage callers later have developed enough robustness they can then move through into the development programmes, which they can also just be led straight into through schools or parents or just themselves.

For Tom development programmes "*are really good if you have skilled workers because you are actually hitting a developmental need which is about identifying as*

part of something, having peer relationships ..." (Tom). Such programmes provide information and "*encourage them* [teenagers] *to have the information they need but also to encourage them to link up*" (Tom) with further services they may need. This can be understood as primary as well as tertiary prevention. This statement makes it further perfectly clear, that here the needs of the teenagers to have a place to go to, to meet other people, to talk and lastly to find their identity is met by this kind of offer at Youthline. Especially the need of being not alone, being part of something, not an outsider is fully met here.

Also Mike expresses his thought that what young people need is just being there for them, accepting them as who they are, being with them, talking about things, further being clear and straight up and support them through figuring out what they need and want, which is indeed a kind of figuring out their "*passion*", as Robin asks for. Therefore in Mike's eyes the N.E.X.T group is a good way of prevention in form of strengthening young people and helping them through developmental periods as well as crisis, particularly as those in a real deep crisis can then also be referred from such a group to the face-to-face counselling, to family therapy and so on.

Christine represents the opinion that there are no "*real special prevention programmes*" (Christine) available but that there are offers like the N.E.X.T group and the face-to-face counselling with the main aim of becoming more acceptable of yourself and hopeful, which is also mentioned by the adolescents as one of the most useful helping offers for teenagers. Christine also states at this point that one's own philosophy is an important part of the work. For her, for example, suffering is part of life and everyone suffers and somehow it is necessary to accept a certain amount of that. For her it is necessary

> *to be able to sit with other people suffering and accompany them with it because sometimes one of the big things that gets in the way of getting help is that nobody else will be able to tolerate them in their suffering or that no one understands it or that will make him unloveable or awful to be around so that is a big part of therapy, for* [her] *is really being there for someone and what they are going through and to show them that* [one] *can handle it [...]. Holding hope for them [...] really believe in them*

(Christine).

This kind of optimism, of just being there, being available, being with them as Megan says, too, is the focus of three out of four professionals from Youthline and can also be found within the statements about needs and wishes of the adolescents, of not being

alone, being understood and accepted, getting friends and being treated as equal partners and not only as problems. Megan further mentions that building a relationship with them is essential, which is something that all the teenagers express as a need. They need adults who care, adults who understand and accept them. Tom talks about the relationship based model as well as it is "*extremely important*", because "*developmental young people are about who am I with you, who am I with the world*" (Tom).

Concerning the teenagers' wish that groups like N.E.X.T should be more advertised and more groups should be run, more adolescents should be brought into the groups, Tom also mentions that there is very little advertising, as Youthline has no resources. There is still a big lack of knowledge within the population about the word "Youthline". However, in a study with 400 young people 80% knew Youthline. And Christine says, at schools half of the students (European ones) know about the service, particularly about the phone line, not so much about the other programmes. Mike says, "*generally young people know about us*" (Mike). The main problem is in Mike's eyes that most of them are not exactly sure what Youthline is about, what it means and that it is not only something where you can go to or call if you are in a deep crisis, "*it does not have to be a big thing to get in contact*" (Mike):

> *They are not sure... they know the name Youthline but they are not sure exactly what it is that we do. They think, oh yeh, it is a line that you ring up if you are going to kill yourself or if you have problems give us a call. They don't really know what it is that we do*

(Mike).

Tom as well would love to see the name Youthline more used as synonymous with youth development, youth creativity, youth culture, in a sense of Youthline being a normal part of the world followed by the sense of being a place where one can also seek help. Because of financial limitations this has not yet been possible, an issue which is discussed in more detail below. That may also be one reason, why, as Megan mentions, Youthline is very present in Auckland "*but there is always that extra step of actual ringing up*" (Megan). Many people think you must be in a really deep crisis to ring up and it is something shameful to call, because for them this means, you cannot get on with anything, and they "*might feel like a loser*" (Mike). This kind of stigma and a "*huge barrier to call*" (Tom) has in Tom's eyes something to do with the culture, as in New Zealand very much is about "*'we will just get on with it*'" (Tom) or like Mike

mentions "*New Zealand has a real hard time asking for help, because you are supposed to be staunch and able to handle things*" (Mike), which is in Mike's eyes still extremely valid for guys. Megan also experiences that kids in New Zealand "*have learned that they should deal with things by themselves*" (Megan). That is why would it be in Tom's eyes helpful to change the Youthline name and its meaning "*to being a real funky and cool place*" so that it is more "*like ringing for a Pizza*" (Tom), because "*then we would be getting a little further*" (Tom). But there are, concerning Tom, structural barriers, barriers to a youth based, community based organisation. Money is held by government agencies rather than money going into community agencies. There is also too much focus on working with issues like drug addiction, alcohol abuse, or suicide, and there is no real concept about what to do with young people who carry multiple issues. That is why Youthline wants to be a "*generic service*" (Tom). However, Tom also stresses that Youthline already has managed to get a name which stands for an environment where old and young are comfortable, which is safe and still acceptable for young people.

In Christine's eyes the stigma has also something to do with confidentiality. Many teenagers are sent to Youthline by their parents, who often pay for the counselling, so that the professional co-worker easily is getting into conflict of interest and the question is for whom he or she is now really working. As all teenagers mention trust as one of the most important things in a relationship or friendship, and as one works on the basis of relationships at Youthline, Christine's statement clearly meets here the need for trust and confidentiality:

> *I have come to an approach where I am really clear with parents from the start that what the adolescents tell me is between them and me and the only reason that I would break confidentiality would be if it was a safety issue. And even then my obligation is to do something with it, to get supervision and that sort of thing, not necessarily to tell the parents ... but whatever I do would be considering the client's needs both in the short term and long term.*
>
> *Because I have been in situations where young people are doing some pretty dodgy stuff, which is quite risky. But when they are very distrustful of adults, and when I have just managed to get their trust in order for them to tell me and they haven't told any other adults and then I go and tell the parents, it's going to stop them telling me and so they are just going to get more closed. So the less they trust, the less they tell, and the more secretive they are, the more likely it is that they will get more isolated and more unsafe*

(Christine).

So in summary, what resources does Youthline have to meet the teenagers' needs?
Youthline offers a very skilled workforce that is able to create stable and intense relationships, understood as the basis of youth-work (Tom). It is further connected with other services and centres and ensures therefore networking within the community (Tom). It offers a variety of programmes, aimed to meet a variety of problems or needs among teenagers, not just one or two particular issues. Therefore Youthline offers face-to-face counselling, family therapy as well as a pregnancy centre.
Pregnancy is an issue which Robin is particularly focused on, as among her friends there are many teenage pregnant girls. Further programmes are the alternative school for young people with behavioural problems or those who have been kicked out of the normal school, or camps, stress management and/or anger management programmes and anti-bullying programmes at schools. In particularly bullying and going to schools is identified by all the teenagers as a big need and problem. Youthline also has the phone line and of course the development groups like V.O.I.C.E. and N.E.X.T, from which with more funding "*we could do 3, 4, 5, per year*" and not only one or two per year (Tom, Christine). Christine stresses that Youthline further provides a huge resource of information material to understand what is going on out there in the world and this is resulting in the "ripple effect":

> *I think what we create with our training programme, a lot of young people and older people come through the programme and get a lot more experience and understanding of what is going on out there in the world and I do believe that even if they don't stick around with Youthline and work as counsellors here, they are going to create a ripple effect of more people getting out there in the community and understand and are helpful*

(Christine).
Christine's statement that Youthline can offer information material and courses for a better understanding of what is going out there in the world, clearly meets a very deep need within all the teenagers. All of them want to get out and see the world via travelling: They want to "*get out for the understanding of what the world is like*" (Mark). A first step on the long path of understanding the world and themselves, can offer Youthline.
This ripple effect also leads according to Mike to the following phenomenon:

> *There are young people that kind of come in and do the training, personal development and then do the basic training to become a counsellor and then you see this 18,19,20 year old person standing up in front of people and talking from their heart and are really self aware of what is*

> *going on for them and you are like, man, you have got such a head start in this life, you have got such a head start to all these people around you! There are men that are 45 years old that are not as on to it right now as you are. They are still living in the developmental age of ... you know, when they are old. When you see young men and young women that have got a lot of personal strength and are really self aware of themselves you think WOW, that is what we are doing well as an organisation. That is what we are doing really, really well. It is really making leaders and people who are thinking really well and really caring people. People who are able to do things inside that whole ripple effect thing*

(Mike).

So Youthline creates caring people for a world, which John complains about as very careless:

> *We are not that much of a community, we are very ... if you look at the driving around here, it is just terrible, people pull out in front of people, and if you saw someone lying on the side of the street, no one would really care and that idea is built through how you grow up. It gets passed from elders down to the children all the time and if they have that sort of idea there is obviously going to be corruption*

(John).

It is this circle of carelessness that obviously worries John. Youthline can, as Mike described (riffle effect), break through and meet the teenagers' need for caring people out there in the world.

In a next step it is investigated which sort of skills a professional youth-worker needs to have to address the young peoples' needs. As noted above, a central point of working successfully with teenagers is the ability to establish a trustworthy relationship. Therefore, as Tom stresses, the staff need to be able to manage a number of functional relationships. To ensure that, Youthline works on a relationship based model, which contains five different levels of relationships:

> *What does a person need to be able to work with a young person, they need to be able to manage a number of functional relationships of which I will detail, and then they need to be able to manage assessment planning, intervention and evaluative processes. Because developmental young people are about, who am I with you, who am I with the world, the relationship based model becomes extremely important and there are ... one model we draw upon is written up by a therapist, Patricia Clarkson, and the five relationships that a skilled worker needs to develop is the ability to work with the real relationship, so regardless whether you are a counsellor, a social worker, and what ever, there is you and there is me and the real relationship is very important with young people. If I went into a programme and pretended to be a 16 year old, my*

> *creditability would be shot, but if I went into a programme and I was me and I was up front, respectful but clear, then we would develop a real relationship. The real relationship is the corner stone. But it is not enough, they also need to understand the developmental reparative relationship. So if you are working with young people, particularly at risk young people, there are developmental issues, either earlier or current that need processes that will help enhance their development. Part of their relationship mix is about working through a developmental reparative experience. The third issue that they need to understand is the transferential and countertransferential model of work. It is in all ages but particularly in young people the issue of who's in charge, authority figures, and if you are working with young people you represent that and what it gets going in you, needs to be able to be managed. The fourth relationship is about being able to create an effective working alliance. So I am working with you, we might be friendly, we might be at war, there might be a bit of a struggle but we are here for a reason. There is a reason for all those ... overtly or covertly but the therapist or the counsellor or the youth worker needs to understand that it is not just about having fun, though you might spend all your time having fun, but there is actually a purpose and a working alliance is about how skills the individual worker is at ensuring the relationship and the experiences are working to suit the purpose, and the fifth one is the x factor one, which is about the spiritual or transpersonal, whatever it is that wraps around and within those five relationships are important*
>
> (Tom).

Beside the relationship, which is essential and covers the deep need among the teenagers to be understood and to have someone who cares and they can bond with, stands the factor of knowledge, which is also essential. Tom makes clear that at Youthline it is a central interest that all staff are "*suitably qualified*" (Tom). This includes knowledge about mental illness, cross cultural needs, early identification, intervention, healthy relationship skills, counselling, therapeutic skills and systemic family work. Everybody needs a clear defined methodology as well as a tool-box of tricks and games (Tom). To ensure that among its staff, Youthline ensures that all co-workers are in an ongoing training supervision process. Christine also mentions the need of knowledge about warning signs, risk factors, mental health issues, family suicide history, and peers. With her focus on the skill of just being there, giving them the experience of being present and accepting them she again clearly meets the need of acceptance, which is investigated as one of the major and central needs among young people, described above. This need is also clearly met by Mike, who particularly stresses the skill of being respectful, being a good listener and encourager without telling them directly what to do, but showing them the good things of themselves to

improve their self-esteem. Tom confirms that with his statement:

> *I think our therapists are very personable with young people and have a lot of respect of young people and again research shows that what a young person at risk needs is a well skilled, well meaning adult involved in their relationship long term*

(Tom).

Also Megan, who mentions the ability of being patient and caring, being real, sometimes funny, creative, spontaneous, clearly meets the need among the teens of having someone who cares, so that they do not have to feel alone and hopeless. They, however, also need clear boundaries and consistency, which does justice to the need of stability, mentioned by Kim. To be able to be clear and real and set clear boundaries, it is in Christine's eyes necessary to be able to manage one's own anxiety about the future, as only then you can be optimistic for the youngsters.

The best way to show whether an offer like the N.E.X.T group is able to meet the needs of young people is to see what they directly think about it. Therefore some of their statements are quoted here.

> *The N.E.X.T Group was wonderful. Really good. Really good support, everyone is quite close already. You can go there, whatever mood you are in and people just accept you anyway. If you have any worries you can talk to anyone there. Specifically with our group, what I have experienced, they give you time to express how you feel, even on paper. We did a big collage of what we thought of ourselves. I think it is really beneficial for people our age, older and younger people*

(Sue).

> *I think it is great. It's great. It's an environment in which I feel really, really comfortable and yet you can talk about personal things and stuff like that and not feel bummed out or feel that it is such a bad thing*

(Mark).

> *I think it is great. I think the V.O.I.C.E. and the N.E.X.T. group are brilliant to help people's self esteem and show their own potentional.*
>
> *It was so good for my self-realism. To show myself that I am not what the world revolves around, there is so many personalities and influences and ideas and stuff that you can't base something on your own knowledge. You have to understand other people before you can understand yourself*

(John).

> *I love it* [N.E.X.T]. *A lot of our group this year is from the group last year. I have met so many ... cause I am quite young to be on there, but I wasn't 15 when I started, I was 14, but they let me in because there wasn't enough people, the majority of them are 17, 18 so they are kind of like my role models. I have met some really amazing people and some of them are just really, really good friends and I don't know where I would be without the support that I have had from them*

(Kim).

> *N.E.X.T is fantastic. I think I am probably a bit old for it this time. Not because everyone is real young and stupid but I kind of wanted to be ... I didn't really want to be doing the same stuff that I was doing. I wanted to be more focusing on doing basic counselling so that I can move into that stuff later on. It is so cool. Just as a support network for other people that have problems with depression. Honestly, it gave me such a better perspective on what it must be like for the people that actually have to deal with that stuff because I don't have to deal with it. Part of the reason that I do Youthline is because one of my best friends had really bad problems with depression when she was younger and that made me want to do it more because I wanted to look out for people that were like her.*

(Robin)

Only Becks is not that satisfied:

> *At the beginning I found it really pointless. I didn't learn anything from it but at the end it was kind of getting better, but personally I think that it wasn't the greatest. Maybe it was me not being open to learning new things but I did not find it that useful myself.*

(Becks)

But even she mentions somewhere else during the interview, that the group was good, but that she was not "*in the right space of mind*" (Becks).

All except Becks describe their relationships with the facilitators as very good, trustworthy, supportive. For Robin, the feminine facilitator is even like a "*role model*" (Robin) and the male facilitator like a "*good mate*" (Robin). Sue says: "*I feel that I can talk to them more than I could to someone else*" (Sue).

So it is definitely true what the professionals mention, that the relationships at Youthline are like "*a partnership between two people within a bigger organisation*" (Christine) and that "*choice, enthusiastic, and passionate people*" (Mike) work there.

> *I think we do wonderful work, I really do ... I think the quality and education programmes here*

at Youthline are of a very high standard

(Megan).

These statements speak for themselves and show very clearly how positive five out of six participants have experienced the membership of a development group at Youthline during different periods of their lives, how much this group helped them to grow up, helped them through different crisis, helped them to build new, trustworthy and supportive relationships with adults and peers, something so necessary for a healthy development into adults as shown within Chapter I.

A part of this success is due to the very skilled, well-educated and trained professionals, who work with amazing enthusiasm, often even without getting paid for their work, on the basis of trustworthy and open-minded relationships. They manage to create an environment of caring and support for vulnerable young people who in many cases do not have such circumstances at home, at school or within their circles of friends. Youthline is a place where they can meet in a safe environment, where they can have contact with adults as well as with peers, where they are not isolated or alone and where everybody takes their issues very seriously and shows them that there are people out there in the world who are caring. These elements are identified as successful protecting factors against suicidality within the previous theoretical Chapters.

Arguments from the Literature

At the end of this category it is also investigated whether Youthline knows about and works with the official national prevention guidelines, presented within Chapter III.

The three steps of help-assessment at Youthline, described above, go perfectly together with the theoretical idea of primary, secondary and tertiary prevention, described within Chapter III. Primary prevention is aimed at determining whether a person will make an attempt or not. So the aim is to reduce the risk factors within a population. Therefore it involves family, school and society, what is done at Youthline through the development programmes, family therapy, and all the programmes, which are run at schools. That includes strategies that maintain good health, and prevent mental health problems from developing. Secondary Prevention or acute intervention includes all treatment of actual suicidal individuals, all actions relating to those who are known to be at risk of suicide, which Youthline does through a) the phones and b) the face-to-face counselling.

Tertiary prevention contains of the therapeutic activities, which are aimed to reduce the after-effects of a traumatic event in the lives of the survivors. Its purpose is to help survivors live longer, more productively, and less stressfully, which Youthline also does through the face-to-face counselling as well as through the development groups.

Further it is found that Youthline is more focused on the non-Maori prevention strategy "In Our Hands", as the service mainly works with non-Maori youth. "In Our Hands", as described within Chapter III, is generally aimed at enhancing the resilience of young people, to reduce their vulnerability and provide support to people affected by suicide. All three goals are also aims of Youthline as it is a service to strengthen young people, to help them through crises as well as to support them during their development into adults.

The strategy is further, as also described within Chapter III, based on 10 principles. Here again Youthline meets most of them, like the one that co-operation between different services is an important factor to ensure effectiveness: Youthline also works as part of a big network, within which clients are referred. The principle of research and information as well as the one about the responsiveness to a diverse youth population which leads to the need for a wide range of programmes is also fulfilled at Youthline. Youthline offers such a wide range, it is even a particular statement for Tom, that Youthline tries not to focus only on one special issue, like many other services do, but tries to include all teenage-related issues. That is why the range of offers at Youthline is indeed very wide and covers developmental needs as well as actual crisis treatment, therapy, family therapy, education programmes, even at schools, and so on, as described within the beginning of this Chapter. The next principle, which is met, is the one of long-term approaches. As Tom says: "*We are here not talking about a five minute fix*". He states that long-term relationships are the basis on which Youthline works. Family therapy at Youthline tries to do justice to another principle of the national strategy and that is supporting families, as dysfunctional families have been identified as a special risk factor. Another parallel is the issue of former suicide attempts, discovered within the literature as a risk factor, which is why another principle asks for support after a suicide attempt: Here again Youthline fits perfectly as they have special programmes and face-to-face counselling for suicide attempters.

So if one looks again at the five main goals of the national prevention strategy, promoting well-being, early identification, crisis support and treatment, support after a

suicide, and information and research[84] it is true, as Tom mentions, that Youthline fits in this strategy:

> *So if you look at Youthline promoting well-being, the foundation of Youthline is about a community development process of building health in the community, involving community, the second one about early identification health, the fact that our core service was about making every phone in New Zealand an accessible point of contact and then equipping a workforce to be able to deal with that interface. The third one about crisis support and treatment, well we do it every day of the week. Support after suicide, there is two ways, it is for the family and significant others around that we do quite a lot of work in that area, but it is also for our workers. If our workers are working in this area and there is a situation where a young person has killed themselves that they have got very close to, then we have ongoing supporting structures to ensure that our team is also taken care of and then the other one about researching information, we have a lot of information, we undertake research and again as we can with what resources we have got and we draw upon research in order to understand our work and deepen our work, so the issue of research in this country has been that there has been a lot of population based studies and very little about individuals, so it is a lot about understanding what is happening and who it is happening to, but virtually nothing about what you are supposed to do about it. But there is a lot of anecdotal and there is certainly a lot of theoretical models that we draw upon*

(Tom).

So Tom mentions the national strategy and that Youthline fits within as it not only works with the actual at-risk ones, but also with the developmental aspects, which means Youthline is a public health service, as well as a mental health service, as well as a youth development initiative. Tom himself further tries to be involved in consultations and lobbies to ensure that Youthline is involved in a network of prevention planning and activities.

Youthline also trains its co-workers and improves their awareness of risk factors. The service provides a wide range of information material, runs anti-bullying programmes, problem-solving programmes and interpersonal skills programmes at schools. It works against the stigma of mental illness in New Zealand through information campaigns, enlightenment and their daily work. Youthline enables young people to develop their identity through their development programmes (like N.E.X.T and V.O.I.C.E). It runs initiatives to reduce risk-taking behaviours concerning drug and alcohol abuse, makes crisis support accessible and available through the phone line and the face-to-face counselling, which is also the insurance of follow-up treatment as demanded within the

[84] See all details about these goals within Chapter III: 3.4.3 In Our Hands – Non-Maori-Youth Suicide

strategy. The service runs support groups for family members after a suicide and co-operates with SPINZ, which is an organisation, as mentioned above, that provides actual information material and research.

All these are elements which can be found within Chapter III: 3.4.3, as ways of realising the five goals. So the national youth suicide prevention strategy is for Youthline, too, the guiding document. However, Youthline structured its response slightly different. That may be the reason why all the other three professionals do not mention the strategy in detail. Only Mike also mentions the strategy and SPINZ and claims that he has had a look at it, but that for him, whether you use it or not is more on an individual level:

> *Yeh, there is SPINZ, there was the Ministry of Youth Affairs, they brought out a youth development strategy and I had a look through that and it came very much from using the strengths approach perspective and putting things in place and things like that.*
>
> *I think it has been more of an individual thing. I don't think we have all got together and, oh, this is how we can address it within our organisation, which I think we might need to do. From what I have read and what I have seen, it looks really, really healthy and really, really good*

(Mike).

Christine only mentions SPINZ as a good source of information material, but

> *alongside our general suicidality management strategies, a lot of it is having to work on an individual basis to find out what it is about for this particular person, whether it is anger, hurt or isolation or whatever.*

(Christine)

And Megan even states:

> *I haven't used much of the governmental stuff really. More the Youthline and my course, my Masters, that is where I got my information from.*
>
> *I guess in the group work we work more on getting them to brainstorm what they can do for themselves and I think if it is in their own words and their ideas it is much more powerful than when I give them a handout from the government on what to do.*

(Megan)

However, the information, mentioned by Megan, which she got from Youthline is based on governmental material and all the research, which has been done to establish a nationwide youth suicide prevention strategy and even if these three co-workers do not use the strategy on purpose they all work within the guideline and aims of Youthline, which mesh perfectly with the national strategy as well as international prevention ideas.

Prevention Strategy: *Five Goals to Help Reduce Youth Suicide*

However one thing does not seem to work that well and that has something to do with money. "In Our Hands" requires action at government, community and individual levels, and which therefore comes from the Ministry of Youth Affairs, Ministry of Health and Te Puni Kokiri, that is from a governmental level. But in practice Tom mentions that government is not supporting the 24-hours phone line, one important part of the crisis support, which is again one important goal of "In Our Hands". So that seems to be not logical as on the one side the government is requiring services and programmes to prevent youth suicide as offered by Youthline but on the other hand it is not supporting programmes like the 24-hours phone line which is an important first prevention step.

4.8.3 Improvement

The statements within this category show what adolescents think about taking part in a group like N.E.X.T and if such participation improves their situation. It also explores what professionals think about improvement among their teenagers because of their work. In the following analysis of these statements both sides are again compared with each other, which gives an indicator as to whether offers from an organisation like Youthline can meet the teenagers' needs and improve their situation or not.

Views of Adolescents

The first measuring instrument for improvement is whether the group has had any influence on its members or not and whether this influence was a positive or negative one.

Among the adolescents five out of six answer with yes, "*quite a big influence*" (Sue), and "*a really good one*" (Kim) in the following ways:

> *Definitely gives me energy. Down the week you start to get dragged down and slower and then suddenly you come to the N.E.X.T and you feel better ...*

(Mark).

> *Self-realism. To show myself that I am not what the world revolves around, there is so many personalities and influences and ideas and stuff that you can't base something on your own*

knowledge. You have to understand other people before you can understand yourself

(John).

It has a really good one. Quite a few of us that have different aspects of ... like lead different lives so it gives you a broader view how people live and their beliefs, their cultural beliefs, their spiritual beliefs and especially the sexuality, it lets you have a more open mind.
Yeah, cause there was a bisexual guy and I think it was really good that we created an environment and they were able to say I am gay and not be discriminated. The influence that the group has had on me is probably that you can believe in yourself, not letting others get to you

(Kim).

I think more than anything it made me more tolerant of people from different walks of life. When I was younger I got into the really hard-core scene, which was hard-core and punk music and the kids there are very dismissive of anyone that is not in their scene. So for me to come to this group when everyone is on the same level and they all get on really well and they hang out, I don't understand, why are they all so nice to each other. I thought that was really cool

(Robin).

Only one of the participants says, that the group has not had any particularly positive influence on her:

There was a bit of an influence, like from other people as well. Also, just learning new things in the group as well. I did learn some stuff, but some nights I just felt like it was a waste of time.

(Becks)

In summary the majority were very satisfied with what the group made out of them and how the membership influenced them.

The second measuring factor is the question whether there has been any particular changes within, for example, the attitude of the young people. And again for five out of six the membership has changed things in a way of having made imporvements such as in Sue's case, where the membership let her become a much more caring person through realising that people out there generally care. The group helps her realise who she really is and helps her grow. For Mark the most important thing is the improvement of his self-esteem and his communication skills: "*My self-esteem is so much better and I find it a lot easier to communicate with people*" (Mark).

John mentions his attitude towards females, which has changed through the group:

> *Actually towards females. Our group was mainly females and I thought I had it rough, but they go through a lot. One of my friends who is in there has gone through a lot because she is female and sometimes you have to respect that*

(John).

Also for him the membership is further a healthy thing for the improvement of his self-esteem, which is better now, than it was before the group. The group further shows him "*what* [he] *was really interested in*" (John):

> *They helped me look into myself and to other people and see what was really there. One of our group members decided that he was gay during the thing and I thought that was great that we helped him decide that and tell his parents and stuff*

(John).

For Kim it has more to do with her problem of being very perfectionistic and her great fear to fail. The group teaches her, that it is normal to fail and that one can always try again, so it improves her passion:

> *My attitude towards passion. The beginning of this year was really good. I was looking forward to it but it has really taught me that you have to take chances to ... like you are not going to get anyway if you don't take those chances and part of taking chances is that if you fail you can always try again. It has made me really brave to say, okay I may as well take the chance and if I don't succeed I can succeed later. I guess it has helped me mature faster. I am growing up faster because I have been with these other group members, two or three years older than me.*
>
> *I don't know. I used to be really freaked out about trying things because I never used to like to fail. I was like a perfectionist, but it has taught me that part of life is failing. I am not scared of failing anymore*

(Kim).

And Robin sums up her membership with the following statement:

> *I think it changed who I am and the way that I approach people now. They are a person and it has really helped me to see that a lot better, you get to meet people and understand them individually and what makes them tick and where they are from and you don't judge them on their appearances or what they might come across as at first. That is the thing my mum said to me the other night, it has made me more tolerant. It is definitely a good thing because I was bloody awful when I was younger*

(Robin).

So all together everybody has had his or her own experiences and improvements, except Becks, who says, that for her nothing particularly changed. She cannot see some kind of

improvement within herself. Unfortunately it was not possible to get any statements from her as to what exactly was the point that made her not satisfied and what improvement she could imagine would be helpful and useful for Youthline.

Views of Professionals

If one has a look now at the statements of the professionals one can see, that their attitude and hope, that Youthline with its offers, particularly with the N.E.X.T course, gives young people "*such a head start compared to other young people*" (Mike) and that "*it does seem to be remarkably effective for them to turn up here once a week even if it is just unloading all the stuff that is on their mind*" (Christine) goes together with the statements of the teenagers, who mainly describe their membership as really good, helpful, positive, even fantastic. Tom mentions, that especially the fact, that at Youthline young people can just be "involved", increases resiliency and decreases risk factors. Mike describes that just the fact of being there for them, no matter if on the phone or directly face-to-face reduces isolation and shows them that someone is caring. So Youthline is a place of "*good supporting of young people*" (Mike). It is a place where self-care skills can be improved (Megan) and:

> *One of the positive things is that there only has to be one positive person in someone's life to be able to make it, that is what research has shown. Even if everything is against them, that one person makes a difference.*

(Megan)

Youthline offers persons and programmes for young people that have the ability to make this difference, to improve the adolescents' situation, their self-care skills, their communications skills, and their self-esteem. That creates hope and a positive future perspective and as shown within Chapter II therefore reduces risk factors, such as isolation, loneliness, hopelessness and helplessness, depression, poor peer-relationships, a negative attitude towards the own future and so on increase the risk for self-harm and suicide. Therefore Youthline with its offers has the power to equip young people with the necessary skills for a healthy development into an adult, a period, which, as described within Chapter I, is a stressful phase and creates vulnerability and insecurity. Youthline creates an environment in which young people can get support for their development and meet caring people and therefore clearly has the power to reduce the risk for suicide.

Arguments from Literature

As described within the previous Chapters, suicide is a multiple and very complex issue and many different risk factors often interact together. That is why Stillion (1996), for example, identifies the necessity of suicide prevention programmes that are able to address these multiple causes of suicide. Youthline with all its different services, described above, clearly meets this challenge. The service also manages to include primary, secondary as well as tertiary prevention, described within Chapter III, as it works as a crisis support centre, also offers therapy and thirdly also works as a developmental support centre. With these different programmes Youthline clearly can contribute to a general improvement of the situation, the circumstances and the well being of young people and therefore do justice to their responsibility of protecting young people.

4.8.4 Limitations and Boundaries

The statements within this next category show what the participants imagine that could be necessary or helpful to improve the current offers for youth, again from the two different perspectives. In the following analysis of these statements both sides are again compared with each other. The result of this analysis can then be understood as a sort of future outlook and starting point for further research and discussions about the effectiveness of programmes and services like Youthline.

Views of Adolescents

Four out of six teenagers mention the 24-hour phone line which would be so good and helpful as one cannot choose in which hours one feels depressed or suicidal and therefore needs access to such a help line 24-hours a day 7 days a week. But as John makes clear, it is known among the teenagers, too, that this is a funding problem and that Youthline is working hard on realising it. Except Becks, who just has no idea what could be changed, all adolescent participants express the wish for more advertising, as all except Becks think that such groups like N.E.X.T and all the other offers should be more out there and publicly known, as they are so helpful and good (shown above) and

therefore many more teenagers should be informed to get the chance to take part in the programmes. Sue further mentions, that she for example only knows of Youthline. This is on one side a sign, that Youthline has a good name and is relatively well-known out there among teens, but on the other side it shows, that there do not exist many different services for young people, or rather if there are, these services are not as known as Youthline. Sue therefore thinks that Youthline should have another building to be present in a wider area. Mark, too, mentions that generally out there at schools there is too little knowledge about help lines and organisations like Youthline, Mensline and Gayline. John also expresses the need for firstly, generally more groups and secondly, particular groups for younger kids, as they go in his eyes through the same stuff and also need support. Kim again mentions her idea of a Salvation Army for teens, a kind of drop-in centre. She further stresses the problem of getting through the very busy phone line, why she thinks it is necessary to get more phone counsellors. And Robin mentions the money problem, which prevent Youthline going more into schools. She also expresses the wish of "*more of the group stuff,* [as] *it is just fantastic*" (Robin). It is again only Becks, who does not know what could be changed to improve the offers, even if she is the only one who is not satisfied with the programme.

So in summary almost all the adolescent participants express the wish and need of an increase of the services. That means more groups, the 24-hour phone line, more advertising, more phone counsellors, and more knowledge about services out there, particularly at schools. All these wishes for more support are limited through the money issue, which leads exactly to the main point of concern among the professionals.

Views of Professionals

The fact of not getting enough funding from the government, for example, creates several limitations, described in detail by the professionals. One major problem, mentioned by Tom, is to retain people, as so many co-workers cannot be paid and therefore especially the experienced ones often leave the organisation after a couple of years as they naturally want to get paid and in Tom's eyes also should "*get paid reasonably well*" (Tom). So Youthline's "*workforce, though highly skilled, is young developmentally and* [Youthline] *has trouble retaining the most experienced because of the resource issue*" (Tom). So Youthline has to try to earn its own money, as Youthline

is not going to get it given, which "*costs so much energy*" (Tom). In Tom's eyes the main limitation is "*a resource thing*" (Tom). Youthline, for example, gets no money from the mental health area, which would be helpful and would change a lot. That is why at the moment only about 24 people are full-time and get paid from Youthline, whereas 560 are working as volunteers.

The funding problem is also mentioned by Mike, who focuses in his statement, as well as the adolescents', on the problem of getting the 24-hour phone line through. He further mentions that the lack of money makes it difficult to go into schools which would need it the most, as those schools often cannot afford the programmes, described above within this chapter. This creates frustration among the stuff and an expansion of the gap between rich schools, which can afford such anti-aggression, anti-bullying and stress-management programmes and therefore have a better stand than those that cannot. So government funding would be really helpful to realise the wishes, also mentioned by the adolescents of further programmes and more support at schools.

Concerning the money issue, Christine adds the problem of having young people in therapy, that is often paid by the parents. This leads to the problem, that as soon as the parents realise any small improvement they often withdraw their children from therapy, even if it is necessary for them to stay longer. But because of the confidentiality the therapist then cannot really talk with the parents about it. More funding would help to reduce this problem, as then more young people could come without their parents have to pay.

Megan at last stresses the structural problems as a result of the money issue:

> *I think this is a good place to work. It is just very busy. There is structural problems because we have grown so quickly. We have expanded so fast that some of the systems are not in place. In my day-to-day work I usually work around it really. It affects the people holding me*

(Megan).

For her the building should be better, as for her clients she thinks it is just not good enough.

Further things, which are mentioned by the professionals as being necessary to be established or changed, are first of all a change of the Youthline name concerning the meaning. Youthline should in Tom's eyes become a synonym for youth, creativity, potential and help and should be as well known as the yellow arches. He further

mentions the need

> *to strengthen the interactional ability between our departments, out of that we will achieve a sense of Youthline serving its mission, which is to provide community training and development and service provision, so that young people have the opportunity to reach their potential and get help on the help line*

(Tom).

Youthline should in his eyes further be in a position where it can "*influence government to make decisions that would be helpful to young people and helpful to the sector*" (Tom).

To do good and effective work it is necessary to have a multidisciplinary team with "*well skilled workers working with young people on an ongoing basis*" (Tom).

For Mike, beside more funding from the government, a drop-in centre would be good, which goes perfectly together with Kim's wish. A better link between the different services would in Mike's eyes also be helpful to create a wider community of youth-workers, which can also be supportive and create spirit. Mike further expresses an idea of an exchange programme, within which young people could stay in other towns and regions: "*And once you do start travelling you get to see what you have got in your own place as well*" (Mike). This idea of exchange programmes fully goes together with the intense need of all the adolescent participants of travelling, seeing the world, other people and cultures.

Christine focuses further on the fact that Youthline does not have a wide range of counsellors with different cultural backgrounds, which would be in her eyes necessary, as there are more and more Asian students, for example, with a completely different cultural background and far away from home without any support. There are also not many Maori or Pacific Island counsellors, which would also be helpful, especially as Chapter II and III shows that the suicide problem is particularly serious among these ethnic groups.

Another limitation is the fact that in Christine's eyes there are not enough psychiatric services and the co-operation with the ones, which exist does not work well:

> *I have often tried those people in Community Mental Health Services and stuff and just find them incredibly difficult using them. They are quite uncooperative*

(Christine).

A limitation on a very personal level is mentioned by Megan:

> *I can only do as much as they can take on board, you can give them lots and if they do not take that on board then that is a limitation*

(Megan).

To sum up, the most painful limitation, mentioned by the professionals as well as the teenagers is the lack of funding and lack of money, which leads to the limitations described above and makes it impossible at the moment to realise the adolescents' wishes for more support in form of more programmes, more groups, more activities at schools, the 24-hour phone line, as well as enough phone counsellors, so that young people then get through when they have overcome the stigma of calling such a help line and not being again disconnected. All the needs, described above through the statements of the adolescents and well covered through the statements of the professionals, can only be realised when money is available to establish more groups, which is one of the main wishes among the teenagers, to do more programmes at schools and to enable all people and all schools to use the service, without any money issues.

The second big limitation is the one of too few counsellors with different cultural backgrounds to meet the special needs of Maori, Pacific Islanders, or Asian young people. However, all together, the actual services at Youthline are, as Robin says "*just fantastic*" and "*it is a good place to work*" (Megan). So, as a whole, Youthline manages to do wonderful work within its limitations and really creates a youth-friendly and supportive environment, in which the professionals seem to really know, what teenagers need and therefore, combined with enough theoretical knowledge, are able to meet the teenagers' needs and to improve their development.

4.9 Conclusion

In summary Chapter IV describes the practical part of this thesis and gives the voice in form of interviews to the practice. That is why one can understand this research project firstly as an investigation whether the theoretical material, presented within Chapters one to three, can in real life be found. And it is secondly an investigation of two different perspectives (adolescents and professionals) and the comparison of these to create an idea as to whether Youthline's offers are effective in preventing self-destructive behaviour and suicide through strengthening young people. On the basis of a qualitative small-scale research it is investigated, what the needs of teenagers in New Zealand, particularly distressed and suicidal young people, are met, and if so how these results then go together with the theoretical part about adolescence and suicide. The analysis of the interviews further discovers if and how the needs are met by a youth-oriented organisation like Youthline. To avoid harm to adolescent participants with such a sensitive topic the main focus was on one particular programme at Youthline, that is the N.E.X.T course, as its members are not acutely at risk and therefore not as vulnerable.

As the whole project tries to understand the interaction between and the perspective of the participants and seeks to gain information about the effectiveness of programmes like the N.E.X.T course, instead of proving any preconceptions, the research is clearly identified within this Chapter as a qualitative one. As shown within this Chapter, anonymity and confidentiality are guaranteed and the participants are well-informed through the information sheets, is based on the instructions of the Massey University Ethics Committee.

After audio-taping and transcribing, the data is organised through reading and making headings, which go together with the question framework. So the whole interview material is put in order to theme headings which can be understood as the main categories of interest. The four main categories, identified as from central interest are

1) Needs of New Zealand's youth
2) Prevention and Intervention and Skills of the Staff to meet these Needs
3) Improvement
4) Limitations and Boundaries

Through comparing the statements of both groups as well as with the previous chapters

the material is analysed within these four categories.

In summary concerning category (1) the results show that the statements of the teenagers and those of the professionals go perfectly together with each other as well as with the literature. Things like friendship, peer-relationships, trust, acceptance, acknowledgement and understanding as well as establishing one's own passion (identity), are discovered within all three perspectives (teenagers, professionals, literature) as central needs of young people. Also issues like sexuality, the responsibility of the media and the importance of the family and so on can be found within all three perspectives.
These agreements show that firstly all the theoretical findings and ideas are not far away from the practice and investigate reality quite well. Secondly it creates the central basis for the development of services which indeed have the power to work successfully against suicidality through reducing risk factors amongst teenagers.

Concerning category (2) and (3) the analysis shows again a wide agreement between the teenagers' statements and wishes and the professionals' thoughts. N.E.X.T and Youthline in total are identified by both sides as a helpful resource against many risk factors for suicidality. Its programmes enable young people to get contact, support, to meet caring, non-judgmental people, to talk, to get crisis support, and so to reduce risk factors like isolation, loneliness, depression and, as a result, suicidality. The investigation proposes therefore that Youthline should become as well-known as possible among the population through advertising and a youth-oriented name. And easy access should be guaranteed, 24-hours on seven days a week. Both are still funding-wise not supported enough by the government. This fact is identified throughout this research as a clear contradiction to the nation-wide youth suicide prevention strategy "In Our Hands", published by the Ministry of Health, of Youth Affairs and Te Puni Kokiri, all governmental agencies[85], which clearly define crisis support as one very important prevention goal.
The wide range of programmes at Youthline, identified throughout the interviews, do further not only cover the wide range of needs among the youngsters themselves, but

[85] See Chapter III: 3.4.3 In Our Hands – Non-Maori-Youth Suicide Prevention

also go together with the demands of the international literature about primary, secondary, and tertiary prevention[86], as well as with the national youth prevention strategy "In Our Hands". However the interviews also show that "In Our Hands", the national guideline for youth suicide prevention could be presented and discussed at Youthline with its staff more officially. At the moment it becomes clear that Youthline generally does justice to the ideas of this strategy through its programmes and policies, but that many youth-workers themselves do not directly know, discuss or reflect the nation-wide guidelines.

The investigation further shows that Youthline comprises a highly skilled and well-trained staff, but that again a lack of funding and money makes it almost impossible to keep experienced youth-workers. The majority cannot get paid, so many co-workers leave after a couple of years, after they have earned experience, because of the money issue.

But, however, five out of six teenagers are fully enthusiastic about the N.E.X.T course. They stress its very positive effects on their own self-esteem, identity development, on their ability to build new healthy friendships and to deal with their own development stress in a productive way through establishing a healthy personality with a positive future perspective. The only girl who is not that satisfied also mentions that the group itself was good but that she was not "*in the right space of mind*" (Becks). All except Becks describe a very positive and productive improvement, particularly concerning their self-esteem, their own sexuality, their tolerance towards themselves and others. The group helped them realise who they are and helped them grow. This increases resiliency and decreases risk factors and therefore contributes in a successful, preventive way to protection in the form of strengthening young people in New Zealand's society.

Nevertheless it has to be made clear here, that it is a pity that not all participants' needs were met and that the girl with the most serious suicidality among the adolescent interviewees was the only one who was not that pleased by this kind of service. And it is a task of such a group and its supervisors to evaluate the reasons for such dissatisfaction among its members, even if it is just one member.

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[86] See Chapter III: 3.1 Primary or Preventive Interventions, 3.2 Secondary or Acute Intervention, 3.3 Tertiary Prevention: Ongoing Treatment and Principles of Therapy from several Perspectives and Postvention

Category (4) finally shows in summary that much more could be done, that the ideas have already been developed among the Youthline staff, and that these ideas could easily be realised if only more funding and money was available.

Final Conclusion

The final conclusion of this thesis is a summary of the theoretical findings within Chapter I to III and a summary of the findings of Chapter IV. It tries to give an idea about the result of the whole work. It also provides an outlook on what else could be done following the results of this work.

The first three chapters show us that much literature is available and research has been done world-wide concerning the phenomenons adolescence as well as suicide among teenagers. And it becomes obvious that adolescence is a very stressful period full of changes and loss. Self-identity, sexual identity, cognitive capacity, morality and coping strategies must be developed. The child becomes an adult, has to become independent and to connect with peers and a sexual partner. That all means a huge amount of work and stress where coping skills to deal with stress on the other hand have not been developed as yet. The result can be extreme vulnerability and insecurity and the risk for suicide as a "way of escaping" from an overwhelming world seems to be an "option". Institutions that have influence on the development of our youth include family, society, culture and peers. This is why we all have our responsibility to create an environment where a healthy development is possible and where acceptance of that difficult way of development is guaranteed.
Even adolescence can increase the risk for suicide, it can not be understood as the only reason. Suicidality among teenagers is a very complex issue and that is why someone has to have a closer look at the problem "suicide" itself.

Suicide is first of all a global problem and secondly especially in New Zealand it is still a serious one. Compared with other OECD countries New Zealand's teenage suicide rate still ranks among the highest, however it has been decreased for four consecutive years now.
Suicide is discussed in different sciences and from different perspectives and every perspective tries to give answers on why a person kills him- ore herself or attempts to do so. So there are cultural caused risk factors, environmental, biological as well as psychiatric and psychological factors that put teenagers at risk for harming themselves.

One can see here that suicide is a very complex and multi-causal issue. That is why researchers all over the world have identified many different risk factors, like mental illness, family dysfunction, low self-esteem and so on. All the factors found internationally are also valid for New Zealand. Special factors which can especially be found in New Zealand are discussed here through quotes from different authors and researchers from New Zealand. The breakdown of social institutions like family, church or tribes among Maori, as well as an increased rate of violence is identified as special risk factor for New Zealand. Alienation caused by culture and race as well as the decade of economy restructure between 1980 and 1990, which caused a decline of income in some sectors of the population and unemployment and therefore increased the uncertainty and the health risk, are also mentioned by some authors. Taylor for example speaks of the fatalism and the strong male macho culture in a world where classic roles of men and women are changing rapidly as something which has to do with the high suicide rates among teenagers in New Zealand. Drummond on the other hand found a relation between the high rates of teenage pregnancy, truancy and adolescent suicide in New Zealand.

Two other special risk groups in New Zealand are Maori tennagers and homosexual adolescents. Both groups have to face the problem of social isolation and racism. Maori also have to face the cultural breakdown and poverty which often results in the loss of identity and Maori authority control - factors that can increase the suicide risk. All over the world indigenous people as well as homosexual people have been identified as a special high risk group of suicide – this is the same for New Zealand.

As a result of discovering all the different risk factors the literature shows that many prevention and intervention ideas have been developed internationally and nationally. Primary, secondary and tertiary prevention are the three different parts of a successful prevention strategy which are also valid for and can be found in New Zealand. Since 1990 many reserachers as well as the government have worked hard on that issue in New Zealand and many programmes have been developed. All the efforts have finally ended in the development of the national prevention strategy which includes two different parts. One is focused on the special issues and needs of Maori youth and the other one on non-Maori teenagers. What can finally be seen within chapter three is that New Zealand took this challenge and the ministries of the government including the

Ministry of Health, the Ministry of Youth Affairs and Te Puni Kokiri established different projects to investigate risk factors and to develop a prevention startegy.

The research finally shows that a service like Youthline indeed works on the basis national prevention ideas, nevertheless three out of four have not yet had a look at the booklet. But they all know about it and the whole organisation is based on ideas which can be put in order to this theoretical document. So Youthline is doing justice to the theoretical ideas of prevention as the interviews show, but only focused on non-Maori teenagers. So two points can be critisised here, firstly the focus on non-Maori youth as the rate is particular high among Maori teenagers. Special services for Maori at Youthline could be helpful and might be necessary. Secondly one co-worker mentioned that it might be usefull to get the national prevention strategy taught or directly presented in any way through the organisation.

The final result of the analysis of the interviews through comparing the three different perspectives (teenagers, professionals and literature) with each other makes clear that Youthline is doing a wonderful work and is working in the right direction concerning suicide prevention among teenagers. Almost the same needs were discribed by the youths themselves as well as the staff as well as the literature which is the basis for succesful programmes. With programmes like the N.E.X.T course, a developmental service for young people, the majority of the interviewees were really satisfied. Improvement of self-esteem and well-being was reached. Contact to other peers as well as adults was established. Strengthening young people and protecting them from social isolation are identified as one of the best protecting factors against suicidality and self-harm as can be seen within the previous chapters. The group helped them grow up through showing them who they are, accepting them the way they are and just being there for them, which increases resiliency and decreases the suicide risk all described within the previous chapters. Youthline therefore comprises a highly skilled, well-trained and enthusiastic staff, which is very close to the needs of the young people; however the majority cannot get paid. This indeed causes a big problem as many of the experienced youth-workers leave after a couple of years as they cannot earn money at Youthline. There is further not enough funding to establish more services and groups like N.E.X.T or the 24-hours phone line, which is a clear wish of the majority of the interviewees and would also do justice to the theoretical prevention considerations

described within Chapter III. There is a clear demand for more funding to establish more services and groups so that everyone who rings up comes through at any time or finds a place in a group or gets counselling if needed. Further advertising and the establishment of the synonymous of Youthline as a place of youth development, youth creativity and youth culture in a sense of Youthline being a normal part of the world were discribed by the interviewees as things to improve. But here again the money problem becomes obvious as the central limitation. If the government does not only want to help on a theoretical level through supporting research and booklets but also wants to help on a practical level out there, organisations and services like Youthline with a great potential to improve the situation of young people in New Zealand must be better supported - at least money-wise. Youthline creates the environment which the literature and research discovered as necessary to help young people grow up in a healty way. Such an environment is necessary to learn how to deal with stress, how to relate to others and how to find one's own positive place and status of being-in-the world.

To summarize, there is enough international and national literature about adolescence, suicide and prevention available. Nevertheless in some specific areas more information is needed. These issues are the connection between being Maori and suicidality and being homo- or bisexual and suicidality.

It further becomes clear that this research with its small-scale-sample is not representative and therefore not generalisable. But as a feedback concerning the N.E.X.T course it is a starting point for further research and discussions about the effectiveness of organisations like Youthline with its programmes of strengthening young people against self-harm, depression and suicidality. Only if one has concrete representative figures of all clients from Youthline, for example concerning their satisfaction with the service and the improvement of their situations, one would have a stronger argument to ask for more funding and money. Because only than Youthline would have figures to prove what has to be done to improve actual services, what limitations within their programmes could be found and what could be done to change this. And this, as described above would be the starting point for the establishment of more crisis and developmental services and programmes for teenagers, discovered in this research as such a helpful and maybe even necessary way to reach a constant reduction of the suicide rate among teenagers.

Appendix A: Needs of New Zealand's youth

Adolescent Participants

1) How long and why have you had contact to Youthline?

Sue: *It was more ... I just love meeting people. It wasn't really because I needed any sort of real support or counselling, It was more for the friendship thing and just the experience.*

Mark: *I had a lot of difficulty in supporting friends who were really depressed. I didn't feel that I had the skills to cope with it.*

John: *Because I was depressive and stuff and I started counselling other people and then I started to get really interested ... and because I needed to get out of my school because it was a boarding school. I wanted to get involved in a youth group and it sort of just came together really.*

Becks: *Not really any particular reason, just get out and do something and also it is good to put on your CV...*

Kim: *Last year was a really bad year for me and I had been meaning to do it for a while and I just had to do counselling to deal with the stuff that I was going through, or I was going to go in a completely opposite direction and go down hill, so I choose counselling.*

Robin: *I've been involved with Youthline since I was about 16. I took a year off when I was in 7th Form because I had too much stuff to do and then I came back ... the reason I first got involved with it was because I was really interested in becoming a phone counsellor – that was the main reason.*

2) Familial relationships

Sue: *My parents are divorced; they split up when I was about twelve. My father at the moment is in Holland, he has been there since last year, just working, getting money and is coming back at the end of this year. The relationship with my father it is really good. We've always got on very well. I am a daddy's girl. With my mother it is kind of strange, because she is a counsellor and because I've learnt how to kind of counsel someone I can ... I feel that she kind of does it with me, so there is kind of some conflict there and I can't really talk to her as much as I could before. That is also because I am going through tough stuff becoming an adult and ... Me and my mum we got on but there is still a barrier in between us. That my dad is away that is quite sad. I would like to live with him for a while.*

I get on really well with my sister. We are really good friends. My brother – we kind of get along. He is quite an arrogant male. Some things annoy me about him but we still get on.

Mark: *My parents are separated. My dad is a counsellor and mum is unemployed. I live with my dad and my step mum. I've a good relationship with my siblings, my father and my mother, but not so much with my step mum. She really, really doesn't like me. Just recently I wrote her a letter asking her if she did hate me and she replied just today. She said yes.*

John: *My parents are still together, they both work. I am one of four children. My relationship is really good with everyone. It is good, it is like occasional fights, but it is really usual. It is okay, just normal. I can talk to my parents occasionally, it depends what it is really. I can talk ... if I need to talk to someone, I talk to my brother or my sisters.*

Becks: *I live with my mum and sister and I see my father once a fortnight. My mum is working full-time now. My parents are separated. My relationship with my sister, usually pretty good, sometimes we've the odd sibling fight. With my mum it is a pretty good relationship. We got through real bad times. I went through a bad time and at that time we had huge fights, but now we get on pretty well. Just the occasional mother daughter fighting. With dad, I find him quite hard to get on with. I do get on with him, just not all the times. Sometimes we end up fighting. He does not listen. I think he does not listen to me. I just find it hard. It does not get through to him what I am trying to say sometimes. He just takes things the wrong way and that really annoys me.*

Kim: *My parents are divorced and I live with my dad and his fiancée, my dad works really long hours and he got kind of engaged last year. I don't really talk to my mum much anymore, I think she works. I have brothers and sisters, some are half ones. I do not really talk to them much because there is such a big age gap between us, it is really hard, but my oldest brother, he always ringing me so I've quite a strong relationship with him. My relationship with my mum has kind of deteriorated. I do not really talk to her much anymore because she is just an alcoholic and a drug addict and I am really, really close to my dad. I have such an open relationship with my dad. And I'm quite close to my nana.*

Robin: *My parents are both really incredible people. I have much respect for them. They are like ... I would actually describe them as some of the best people I have ever met. They are still together, they have a fantastic relationship. My family is really close. All my extended family see each other all the time. We are very close. That is just what we do. I have always been like that ever since I was very little so I have had a really strong family base. I have one brother who drives me up the wall, but I love him – most of the time. My relationship with my parents is different just because my mum is like one of my best friends, my dad is really cool and we share a lot of similar passion. I really love photography and we do that sort of stuff together. It is such a difference with them, like the female emotional bond and then the male, female child, where you have an activity that joins you together rather than having that emotional thing, because that is not what my dad is like. My dad is really cool, he is an artist and so he is always preoccupied a bit with his own stuff, so when we have activities that we can do together*

it is cool because we end up spending time together. I however do talk to my dad about staff, but he is more likely to challenge me on it and not be so understanding, so I would be more likely to talk to my mum because she is a bit more understanding and mellow about that kind of thing.

3) Peer-group relationships/Friendships

Sue: *There is my sister of course, she is my closest friend as we know everything about each other. I have a few very close friends. I always had many friends but only a few close friends ... I think having close relationships is very important. I reckon that you have to have someone to really open up to and be able to tell things that you are worried about, someone you can really bond with. Just someone that you can share things with ... things that may be worrying you. Important for a good friendship is having trust. I think trust, confidentiality. You are opening up to them and you want them to keep that stuff a secret. Being able to relate to each other. Just being there for each other when you need someone.*

Mark: *I am unsure about my relationship at the moment. We have not talked in a while. But I have really, really good friends. Especially here [at Youthline] and out of the N.E.X.T Group. Friends from when I used to go to school. I have found that friends have a big influence. How you define yourself and ...I had a couple of really close friends earlier who were really depressed and that got me really depressed as well. A positive thing about friendship is support definitely. When you have a problem you can just talk to friends, which is really good, getting things out of your system. It is important to have someone you can relax with and just unwind and whatever is happening at the moment and someone that you can trust. I am quite happy with my friends, I think its rare now days to have friendships that are as healthy as mine and I feel I am very lucky in what I got.*

John: *I have a girlfriend at the moment, it is a sort of casual really, not hugely involved. I have heaps of friends at school and they are like my second family and this [Youthline] is like my third family. Friendship is important. I have had friendships in the past, which just were not friendships. They are just people that hang out with people because they have no one else to hang out with. And no one particularly likes anyone else, so yeh, I reckon the friendships I do have now really impact me, because I know that they are supportive and they actually believe with me and they agree with what I say and it is good to have that encouragement, it is good to know that someone is there for you. I got that a lot at school really. Every one is particular friendly. Important for a good friendship is agreement, loyality and trust and generosity in some cases, because, ye, otherwise things just do not work.*

Becks: *I do not have a boyfriend. Just ended a relationship about 2 months ago. I do not really want another relationship but I am quite close with this guy. It is one of my guy friends at the moment. But it is not like boyfriend/girlfriend relationship cause I just need some time. When I was in that relationship it was a very confined relationship. I did not really get to see my friends I wanted to see. I just need a bit of freedom and time to sort myself out. I do not need someone telling me what to do or something. I do think that friendships are important in ways that you have someone there that you can talk to*

and that you can trust and that you can go and do things with and just act yourself, but then in ways ... yeh, I do think that they are important. I have a very close friend and me and him are really, really good friends and when I started going out with my boyfriend, my ex, we just drifted apart because it just was not right for my boyfriend at the time and so now we are not as good as friends as we used to be but we are still really good friends. Apart from that, not really. I have my friends but it is not like best friends. I have a really good friend but she lives in Tauranga. She moved down last year. We have been friends forever. I really miss her. Because a girls and a guy relationship is different to two girl relationship. It is different having a guy as your best friend. Yeh, I do miss her ...
A good friendship needs trust. Trust is a big one for me. Also that you just get on with each other and you can act yourself and not judgmental of each other.

Kim: *I have got my friends at school but I have got my two best friends that I have been friends with since I started High School. They have got real strong influence in my life because they have just always been there for me. Then I have got Stephen, he is like my best guy friend and it is so good to have that in my life without having a sexual relationship, he is just my friend. It is really good having him there because he gives you so many things about males, like when you have guy trouble. Good relationships are definitely important. As you grow up at this age you are trying to decide what you want to do with your life and on top of that you have all these other issues and it is really good to have people that bond to you and stick with you and sometimes adults are not always as understanding and it is really good to be able to talk to someone who is probably going through exactly the same thing as being with it. It kind of makes you the person you are. Important in a good friendship is trust and honesty, because if you can not be honest with your friends you may as well not be friends with them ... I have got heaps of friends at school that I do not feel trustworthy with, but strong friendships should be based on trust and honesty.*

Robin: *I do not have a boyfriend at the moment but I have lots of really close girlfriends and lots of really close guy friends as well. People that I have been friends with since high school and people that I have been friends with this year at University and people through church. Heaps of really diverse, different types of people, which I enjoy. I think that is cool. It is so important. You learn so much off your friends. You learn through their experiences and they learn off you and they support you and they are people that you can to if you have problems which you cannot talk to your parents about. It is for having fun, letting stiff out. It is so crucial to have friends that look out for you and are close to you. I think a good friendship is a friendship which does not rely on necessarily circumstances. A lot of my girlfriends tend to get serious boyfriends and then they kind of fade away, which really sucks. I think that when they break up with their boyfriends or once they realise that they have not seen you for a while they are like, oh stink. But it does, it sucks. I think that is one of the things that stops ... a lot of my friendships anyway is that your friend gets a boyfriend and then they end up with hanging out all the time and you do not get to see much of them. It happens to me with my guy friends as well. I think that that is the main thing that has actually killed friendships for me.*
A good friendship needs trust. Loyality is really important. Being able to relate. It is not totally important but it is really cool when you do the same stuff. So it is like, you can relate on different levels to different people about different things and that is what

makes a great friendship. Just being about to have a laugh, going out with them and having fun, being able to trust them and ... oh, being able to talk to them about stuff as well. Having someone that is not selfish and is totally open to hearing about your problems as well as you hearing about theirs.

4) Self-esteem/ Personal needs

Sue: *At the moment it is kind of in the middle because I have been through some tough stuff lately, but I would say generally it is quite good.*
In February, my best friend passed away and then...it was a car accident. We had grown up since we were about four together, then she passed away on February 7th, she was seventeen turning eighteen soon. A month after that, a friend died of Leukemia, and then a friend a month later died of another car crash and then lately I just found out that a friend has just got Leukemia, so it is just things like, why does it happen to people so young. I have never really had any one that I knew die and then all of a sudden, all at once. And then going to University, you have to grow up a lot faster. It was really stressful for me.

Mark: *My self-esteem varies from time to time. It goes up and down quite a lot. But at the moment pretty good.*
It can be up and down randomly for no reason whatsoever but when you have a lot on it goes down.

John: *I'm arty, relaxed, bohemian, that is a big word...It is a big word for hippy, basically. Passionate, paranoid ...some-times it just gets too much, paranoia is not a good thing. Like that right there, stuff like that [art]...if it doesn't go smoothly and I don't see it, I get really paranoid about how it is going to turn out and how people are going to see it and whether or not I am going to be able to sell it eventually and I just think too much, basically. I do think negatively quite a lot. ... My self-esteem is getting better, it was terrible ages ago, yeh, but it has been good.*
It's better now, slowly.

Becks: *I think I have a low self-esteem in ways but in other ways it is high. People think that I have a high self-esteem but really it is a cover.*
I am for example very self-conscious about the way I look, especially as what people think of me. Self esteem that I can't do things, not being able to do things, not being right. But I'm a good listener and people think that I am a good listener. That is a good thing about myself.

Kim: *Most of the time I am quite satisfied with myself, but when I get really angry if I have got something to say to someone, I will say it because I would rather then know, than let it all build up and them say it. It escalates to something that is just stupid. But someone's I get into a bit of trouble with what I say, but... I suppose I am a bit too hard on people, but that would probably be the only thing that I would change. But not too much. I think my self-esteem is quite okay.*

Robin: *I would say I was pretty open; I am making an effort with people. Sometimes I maybe try too hard to please people. I am a real people pleaser. Especially with my parents. That is what I have always been like, apart from when I was younger, but I am not like now. Over the past few years that has really developed as a part of my core personality. I really care about people a lot. I have a real heart to serve people. Some of my closest friends, people that I have been friends with for years would describe me as eccentric, but I think that is just because they know me pretty well, and I guess I am pretty friendly most of the time unless if I am in a really grumpy mood or if I am tired.*
I would say that because my parents have been so good to me and so prominent in my life I have a pretty normal self-esteem. I am a pretty confident person.

5) Future Perspective

Sue: *I want to finish university, of course. I want to build my relationship with my family in Holland. I just want to try more ... I like meeting different people from different cultures, seeing new places.*
And try to stay single for a while. Learn about myself more. You learn things when you are with someone, but I have been with someone for a while and that was the major time when I was growing up and now I just want to be by myself. Of course it is nice to be with someone but I am too young.

Mark: *I would quite like to work for myself and do multimedia type stuff, where I hope that I will have a chance.*
I would love to go overseas for a while. Experience cultures and get out for the understanding of what the world is like.

John: *I don't have a clue about the future. I am thinking of staying in school as long as I can, to learn as much as I can. After I have finished this course, which is a four year, I think I might go do the same course, except at a different school, so I get a broader range of teaching and ideas and everything because I know after four years I wont know what I am doing.*
I want to have money and I did have a wish to have dreads but I cut my hair, which wasn't good. But, yeh, it may happen. I don't really know, to have a job basically, getting money. I have been thinking about going to New York, maybe and Melbourne, which has a really good art school.
So my main wishes basically to get money and get married, have kids. I don't really know. To be happy and be doing something I enjoy every day.

Becks: *I am quite lost. I don't know what I want to do in my future. I really don't know. I want to be successful but I am not sure what to do. I want to do something that gets me know, not known in such a way, but that helps people. I really want to help people.*
I am not going back to school next year. I am going to Tonga at the end of this year for two months to work for Air New Zealand over there. When I come back I just want to work. I am not old enough to get into some of the courses that I am thinking I would like to do.
I want to do sociology and psychology but I am not completely sure that I want to do that at the moment. I am really interested in it but I just want to work for a while to get

some money so if I do decide to go to University then I can. I am in no big rush to go to University.
I really like New Zealand. It is really safe. I do want to travel and I have always wanted to live in America. I am not sure yet, I am quite happy in New Zealand at the moment but I would like to travel and work overseas for a while.
I wanted to go to America and do some work over there but I would really like to go to England and earn some money over there. I can live and work over there because my father is English. Just do some nannying and stuff, get some money, different experience, different culture.
I want to be successful and I want to be rich. I want to go somewhere. Have a family, a loving family.

Kim: *I definitely want to travel. I want to travel all over the world. My career, I don't really know what I want to do but I want to be in a career that earns good money, but I don't want to do something that I don't like either. I am going to AUT and I want to do a Diploma in Business and then from there ... I don't know. My career I am not really sure, but I definitely want to travel. New Zealand is such a little country compared to the world and I have got a lot of pen pals from... I have got pen pals in England, America, Canada, Australia. I was going to do an exchange this year but I decided not to.*
I just want to be happy, accept myself, kind of love yourself ... that is what I think, have a job.

Robin: *I just believe that people... you have to discover what your passion is in life to be able to go on with your future. I am really lucky to have discovered early on in life. I know that I am going to be working with people doing occupational therapy and I would love to go overseas. Somewhere like Indonesia or maybe Malaysia, to live over there and work over there. I am particularly passionate about working with little kids in pediatrics or maybe young teenagers. I actually really enjoy all the group stuff we do at church as well. I would love to get into group therapy later on as well as a side career option. But I just want to serve. That is all my concrete plans are as an occupational therapist.*
If the right guy comes along, I would also love to get married. You know how everyone is like, I am not going to have kids until I am 27 and then I will have my house by them and it is like...nothing is really concrete yet so ... I would love to have a couple of kids and I would live to adopt as well but I just want to wait and see how it goes first.
And unfortunately I feel really pulled to go overseas. I think I will probably ... what might happen is I might stay in New Zealand and then when I get older and my kids have left home or something, maybe I will go overseas then or maybe I will go overseas as soon as I have finished my degree. I am actually not very decided on that yet. And my mum would cry if I left overseas with my kids. She would be so gutted. You need your family there to support you. But it is my mind. It is kind of weird because ... I went to Indonesia last year and I was really convicted by the people that I met over there. I just thought that they were amazing and I thought, man I would love to live somewhere like there or maybe the Philippines and it just felt really strongly in my heart to go over there. I don't think I have much choice.

6) General Needs

Sue: *It is ... you wouldn't think that New Zealand has such a high rate. I think a lot of it is to do with images. Magazines ... like everyone is skinny and beautiful, on TV things like that. I think New Zealanders need to be taught more that it is okay to be who you are. If you are a bit overweight that is okay. I think that there is a lot of help in New Zealand. A lot of companies that help young people. I can't really understand why we are different to any other countries.*
I think acceptance to be the way you are. Friendship ... definitely acceptance.

Mark: *I have no idea. Perhaps, ... I think a lot of people do not know about organizations and groups like Youthline and Mensline and Gayline etcetera, all the free help services. So I think more advertsising, knowledge of these issues need to be more out there so that young people do not feel that they are alone.*

John: *I think it is a lot that we get a lot of pressure from looking...I see us becoming an American society really quickly, which is really stupid because we should stay a New Zealand society but...in that sort of idea, teenagers want these things and if they can't have then... I mean things like say, drugs, say, big parties, big concerts, the list goes on. I wouldn't know myself but the pressure from being such a small country with such a need for other stuff, bigger stuff and especially in Auckland. We are not that much of a community, we are very...if you look at the driving around here, it is just terrible, people pull out in front of people, and if you saw someone lying on the side of the street, no one would really care and that idea is built through how you grow up. It gets passed from elders down to the children all the time and if they have that sort of idea there is obviously going to be corruption.*
It is a kind of pressure among teens to have things that they don't have and they can't really have but they want. Our country and even our city is based a lot around TV and a lot of TV we get from overseas and to see it you just ... oh, I wish I had that stuff. The New Zealand culture is sort of being phased out a quite a lot which isn't the best.

Becks: *They need to know that they don't need to live up to anything. I think a lot of it is boredom. There is not a lot out there for young people to do and I think that there needs to be a lot more of that for people to be able to go out and do something and not sit at home. That is not just a big case of depression because there is nothing to do but I think that is part of it.*

Kim: *Not all New Zealanders but many need stability. There is a lot of family violence in New Zealand so we need to break that cycle so it doesn't continue and we need stability as well. A loving family. That is why I think some couples in families are better off separating because a single parent can provide so much more stability than two parents fighting. So stability would be one. Family and friend support, again. I think we need more groups like N.E.X.T cause there are only a few of them, they are so helpful and offer so much. This is to do with the anorexics and people like that, stop showing people things that are unrealistic and putting into people's minds that they need to be like that to be cool. Stuff like that, and violence. I think that is about it.*

Robin: *I think that people...girls anyway, want to be loved and affirmed that they are attractive and that is why we have such a bad problem with teenage pregnancy in New*

Zealand because girls are looking for love through guys and they are having sex with them and...I know this because I know six girls from my high school that got pregnant last year and it is like, it is so sad for that kid because they have to deal with that sort of stuff. I think that one of the problems is that we provide these kids with unrealistic images of what they should actually be like with the media and stuff, so you need better contraceptive education, but they also need to be educated about body image and all that sort of stuff and skills. The needs, that they have is just to be loved and affirmed and that is really tough. Guys, they need to be taught more about communicating, I think. People are like, there is a high level of male suicide so lets build them a skate park and that is just not going to help. It drives me up the wall because they put so much money into crap things, like dressing up the city for the America's Cup when what you really need is to be pouring more money into organisations like Youthline so they can be training people up to go into schools and holding the OP groups for these kids and maybe training up teachers so they can do it. I think we need more stuff for kids to do but I don't see how you would do that, because that is a problem, which is everywhere, all over the world. My friend Linda lives in LA and you would think that there would be so much to do over there but there isn't. It is just the same. I think what kids need to do though is be educated about discovering their passion in life because once they start doing that and they start believing in themselves they are going to be able to feel their own hope about their futures. There is such a need out there for that.
I think that guys in New Zealand are a lot worse with communicating than people in America. Americans just out it all out of the floor. They are really gross. Whereas New Zealand guys are very, I don't want to talk about that, I don't even talk about that with my girlfriend. They don't share that with anybody. I don't know how you would deal with it.

7) What New Zealand teens would ask a politician for

Sue: *More money! (laughs) I am not sure. In relation to this sort of thing, I can't really... of course I would like more money for student allowances and things like that but...I don't know. More services in schools for example workshops, counseling. When I was at school we did a course that was subsidized by the government. We went of to camp with about 5 people from about 10 different schools, we learnt all about things that concerned young people, kind of like what we do at Youthline. We also learnt about sexual transmitted infections and basic counseling skills. Then with those skills and information we were made known at school that we could help if there was any one with any problems. I think that is such a good thing to have in schools, as sometimes in my experience I thought the councelors at school were to old and a stranger. The students that talked to us said it was great that someone their age was there for them. I would ask a politician for every school to have things like that.*

Mark: *I think queer marriage between homosexuals. There is still a lot of discomfort in environments where you cannot really be open with being gay ... like in a workplace where one person makes some comments and I think another thing is the use of the word gay meaning negative. I think that is quite discomforting.*

John: *I am not sure. Probably lower taxes. A community talkback radio station. Like, Bomber who does that thing on Sunday nights, where people can ring up and e-mail*

about stuff and I think if they had something like that 24/7 playing music and telling jokes and stuff I think that would be really good. Or even ... I would ask for them to get rid of John Banks the Mayor of Auckland, he is my nemesis really. Oh, I hate him. Maybe to get a train system going up North. More public transport.

Becks: *I really do not know. It is a hard question to answer to cover everybody. But I know they had a big thing about boy racers and stuff, maybe have a big park or something where people can just go with all their cars and drive around.*

Kim: *Probably more places like Youthline, but more of a drop in centre. So people that can't go home or are too scared to tell someone about it. Somewhere like this. A drop in centre but I would ask them to be situated all over the country, even in little towns. Just a place where teenagers can go where they can talk to other people, and maybe a counsellor there so they can offer to get them help but there is no pressure on them to.*
I have never heard it if there is something like that. There are probably places like the Salvation Army but it is not aimed at teenagers. I reckon there should be somewhere like a teenage Salvation Army ... so that is what I would ask for.

Robin: *Where do I start. If they could actually give you the money I would ask them to pour money into stuff like Youthline. Youthline is a fantastic organisation. The people that work there need to get paid more. They do such an awesome job. I would ask them to put money into something like Bethany House, so that they could have them over on the Shore as well. We need to look after our wounded kids. Instead of shooting them we need to say come in here and we will teach you how to look after your babies that you are all having at this alarming rate. I just found out another one of my friends is pregnant. I guess I would ask them to put money into educating kids about contraception. That is pretty much a concern to me at the moment.*
I can remember lessons at schools about that, but they were stupid and they finished them in fourth form. They didn't continue into 6th and 7th form and that is probably the time when a lot of people start being sexually active. Obviously a lot of kids start being sexually active when they are a lot younger than that but the majority tend to be about 16, 17 in New Zealand, so they need to continue that stuff and it needs to be more emphasized...maybe give out free contraception. I am a Christian, I am not supposed to be advocating people having sex, but I would prefer seeing people having safe sex than getting diseases and getting pregnant and getting hurt. I have seen the consequences of kids that have had abortions and it is so tough on them, it is so hard and I would not want to see any of my friends getting hurt like that.

8) Suicidality among teens

Sue: *I think peer pressure and feelings they are different from everyone else are reasons for suicidality. Especially at High School. I find that a lot of people that might commit suicide. Very low self esteem, problems with their parents. A feeling of not belonging, being an outsider. Getting teased from other peer's, been called names. Pressure from friends to try drugs or things like that. Pressure to be a different person that you really are. Try things that you would normally never think of doing. Maybe getting pressured and not being able to say no.*

Mark: *I think it varies quite a lot depending on the person and what the persons circumstances are, but I think it comes from a spiral when something big goes on, like someone dying or lack of hope about the future or just Not knowing...thinking something is wrong with you or whatever, thinking you are different because of sexuality or ....*

This is a very personal question that you don't have to answer, have you had any suicidal thoughts?
Yeap. Last year. I am not really sure why. I think it is a lot of things. It recently came up as being bisexual and it was spread around the school and practically everyone in the school knew. My father was very supportive, my mum was weird for a long time but she got over that, I suppose. And I had also had quite depressed friends.
I can't remember when it was, but I can remember feeling thoughts towards guys and wondering if I was gay or not, because also because I liked girls as well it was quite confusing and then I heard it on that same talk radio show about bisexuality and...This was the first time I heard about it and it was 'oh my god, that's me!' I was very confused. I am not really sure. But now it feels good, I'm quite comfortable with it.

John: *It depends on a person really. I myself would say paranoia would be a big one [risk factor] but I have only just done an assignment on an artist who killed himself and there is loads of reasons. It just depends what happens and sometimes people can get the wrong idea about stuff, like paranoia, anxiety stuff, stuff like that and sometimes it is just because people think in a selfish thought that no one loves them and that their life is not going anywhere even if they have years ahead of them.*

Have you ever had suicidal thoughts or feelings yourself?
Sometimes but not really intense ones. I did sometime last year but I know I would never go through with it because it is the most selfish thing you could ever do. I have got years and years ahead of me, why throw it away now.
I think it was just a bad month or something, where I think I might have got into a bit of trouble and... yeh, just bad decisions and stuff like that. I think I annoyed my girlfriend and she decided not to ever talk to me again and also I think there was something at school. Oh yeh, my art teacher, about six weeks before we were about to finish bursary he was telling me that I wasn't going to get what I needed to get into the art school I wanted to get into and he was telling me about that and that my work wasn't good enough.
So now I didn't get into the one that I had hoped to get into, but I am glad that I went to this one really, 'cause from the stories from that one.
Things happen for a reason. So, yeh, it was just frustration and stuff like that. I think the school was also pissed off with me because I got a ...[Piercing].
Yeh, right at the end of the month I got this, just before we left and they [school] didn't particularly like it.

Becks: *I think what other people think of you is important and also the way you are treated and the way you are brought up. Having to live up to expectations. I think a big thing is having to live up to what parents expect of them, what their peers think of them. I find, personally at my school, that because of your groups, you have to live up to the expectation of your group to be 'in'. You have to be cool enough or you have to act in a certain way and I think living up to that is a lot of work, to live up to that sort of*

standard, and personally I think that it is absolute crap that you have to be a certain person to be that sort of thing. Also drugs and alcohol cause a lot.

May I ask you if you have in your personal past or have you ever had depressed feelings or suicidal thoughts?
Yep. I was seeing a therapist for a while.
I wasn't suicidal as such, I was just really unhappy and really depressed and it was because the friendship thing was happening and just for myself not wanting to...I don't know. I got into drugs really badly last year and I went through a really big depression stage then and then I stopped doing them and recently a few months ago I got really, really depressed and unhappy and that is why I ... because I was just so unhappy and mum could see that I was unhappy and life wasn't going my way sort of thing.
I was good friends with this girl and me and her started hanging around with the wrong people and it just got me more and more deeper into drugs and alcohol and I was always out of it and it was horrible. I was such a horrible person at that point, I just couldn't see it, I could see it in ways, and I thought...like, my best friend was saying, no, you have changed so much and I don't like the way you are. It is like he runs my life sort of thing, my life revolves around him. He was really good.

Kim: *I think a lot of it has got a lot to do with personal things that they are not able to get out. Self Esteem would be one of them. Peer pressure and bullying has to be another one. It will always be a problem, but some of it escalates to so much, it is...there is no point in it.*
Peer pressure concerning drugs, alcohol, image, appearance. Typical teenager stuff really. If you have got low self esteem and you are kind of pushed to the side because you don't agree with what they are doing, yeah. Personal, family problems. Personal problems, especially if you are not one of those people that can open up to people. I guess it depends on the kind of person that you are.Probably the more sensitive kind of person is more vulnerable. I don't know. In some cases it would be, but in other cases it could be a person that everyone likes. It is hard to describe, ... when parents divorce, and rape victims, another one is death.

May I ask you if you have in your personal past or have you ever had depressed feelings or suicidal thoughts?
When I was about 13-14 ... at the beginning of fourth form my friend she committed suicide. She was not really one of those people that was withdrawn she had heaps of friends. I don't know but she told me that she had been thinking of it and I told my counsellor and she was getting counselling, but I kind of felt that when she did kill herself, she wrote all of us a letter and told us not to blame ourselves but it is kind like we knew about it and no matter what we did we couldn't stop her, but I felt it was my fault because I hadn't done what I should have as a friend. I felt hat I hadn't succeeded in our friendship ... I felt I hadn't been good enough to her.

Robin: *I think that there are hugely diverse amounts of reasons for youth suicide. I think that there are issues like self-esteem, your economic circumstances, your family circumstances, just your general mental health, like depression or someone that has a chemical imbalance, which causes them to feel depressed about their situation. So many different reasons. Maybe with guys it is because they are not able to talk about their problems as much as girls do and so they don't seek help and it leads them to greater*

depression and they end up attempting suicide. With girls it could be body issues and image and lots of self esteem stuff, which is tied up in that.

Professional Participants

1) What are the main reasons for your clients to contact you?

Tom: *It depends a little on age brackets. The younger youth clients, that would be the 13 – 16 are much more likely to engage in our face to face service because supportive people around them to come or gave encouragement or were told to, the 17 – 24 age group, there is two areas of engagement, one is when things get bad enough and the other one is where young people are wanting to be involved in order to provide service to the community and/or develop themselves. The work is very much in those two camps, either young people who are distressed, disconnected from their social setting or young people who want to further develop themselves and also be involved in the different services we provide. Within both those there is a whole lot of motivating factors, sometimes motivating factors in the development side maybe about wanting to provide service but underneath that maybe about wanting to connect more into relationships and increase their own sense of skills and that is either an unconscious or conscious process.*
The area of young people who are distressed are a combination of :
that people around them are having difficulty with them so they encourage them to engage or again the sense of disconnection and out of that various behaviours and experiences from anxiety to depression to self harming behaviours, addictive behaviours, issues around lifestyle developmental things like trying to find work or not, trying to find direction or not.

Mike: *Um, they are isolated, depressed, lonely, feel like there is no one else that they can turn to or talk to. There is no one else around them. Stuff around bullying or if they are having trouble with drugs and alcohol stuff. Bullying is a problem, it is a big problem. Another big problem is kids getting in trouble fighting and stuff. Especially for boys when they get in a situation where they are getting hassled or whatever and they just stand up and fight and if they don't fight they get called a drop nuts or a sissy or whatever and then they are going to get hassled twice as much if they don't do that, so they are caught in a really hard position. Even if they don't want to fight they have to stand up for themselves so they don't get picked on as much. That causes a lot of trouble, a ripple effect with the teachers and the principal, their parents, getting in trouble, that causes more stress.*
Yeh, or they see their counsellor at school and they say why don't you try doing this [counselling] or whatever. When we do programmes working in schools as well, we get to introduce ourselves and they think, oh yeh. Sometimes when they have got stuff to talk about and they haven't got anyone that they can really trust to talk to, that is just going to leave it there. There is no obligation for them to tell someone or whatever.

Christine: *The majority of my clients are there for trauma, abuse victims. Predominantly sexual abuse histories and usually the sexual abuse happened when they were younger and now they have hit their teenage years and it is coming back to them in a new way. They may have had counselling at the time, when they were young, maybe when they went through courts or something and...but they are starting to have*

difficulties now, which ranges from depression, anger issues, eating problems, sexuality, relationship concerns, anxiety, sometimes relationship difficulties with their parents. We often have connections with what happened to them in the past and needing to get a new understanding of that with who they have become.

Megan: *Mainly my adolescent clients are self-cutting and suicidal clients.*

2) General needs

Tom: *One way of understanding that besides all your basic human needs of eating, drinking, having shelter, the developmental things that are international but each country's ethnicity has its own particular flavour of that, young people – what is important and what they need* ***is effective peer relationships****. They need to have a* ***sense of identifying*** *with a group, and with that maybe identifying against a group. There is all that formation of self in the world. And so young people need the opportunity to develop those relationships develop those workings widely around them. They need an* ***environment, which acknowledges that and supports*** *those things to happen and an environment where there are also adults around so again you are talking levels. A young person needs food, shelter, he needs more* ***security in financial and health****, he needs peer relationships, he needs some sense of joining in and some sense of moving away and often it is about moving away from family so you can identify yourself away, then you go out into the world, you need to go out into the world where you are with your peers, but in order to provide safety those places need to be where there are adults around in that so again you are developing environments which are just a natural part of growing old but where you can be yourself separately but still part of it and again in New Zealand I think we don't do that. Environmentally geographical young people are often mobile they will find their place outside of where the community is.* ***Intimate relation-ships*** *are important, acquiring what that means, a sense of teacher direction and some sort of* ***hope*** *and* ***purposefulness*** *developing is important, so that is all the things that a person needs as you grow, along that are the influences that take you away from that and there are marked ones. If you take how young people are used as commodities, there is lots of difference pressures about what is the right way in what you need and alongside that of course is financial difficulties and challenges, the ease of credit and what that actually creates in a persons life and maybe the lack of income. Young people have a high employment rate. Alongside that is other pressures in the area of alcohol and drugs, both legal and elicit and again recognizing the continuum of being at risk but taking risks, the taking risks part of being young is a very natural part of the world and in some ways needs to be* ***socially understood****. The at risk is when a person is vulnerable to harm, but in a different way to taking risks so young people will always take risks, so if you sanitized the world so much that they don't we will create a whole lot of mental illness. So you have influences there you have influences around gambling, you have influences around pornography, you have got influences around the whole thing around gender and what that means, let alone music and sport, so there is a cauldron of pressures that a young person needs to go through and a lot of those will be normal and be around where ever so we need to have much more defined pathways for young people to travel because a multitude of choices does not necessarily equate to a sense of inner peace.*

Mike: *They need to be more included community wise. They need a place where they can go. Drop-in centres where young people can ... like a space or like some more parks or somewhere where old people and young people can meet. It seems if you look around the city and there is nowhere for young people to be where they can't spend money or...there is no space for them. Yeh, where they are safe or ... even some pool tables or a weight room and .... And the option of seeing a counsellor was there, so it is not a place that you went to, to get help but a place that you could go to, to hang out and that help was available there. There are things like Youth Town, but they are not as accessible as somewhere that you can just turn up. I think their needs to be a real recognition of young people as well. I have heard of people putting it on the young people to try and .... Some sort of thing where you could do a treasure hunt or a scavenger hunt, like one day maybe get young people to go out and look for youth services and critique them and see how assessable they are for them. Get them to...give them a list of places to go and they interview the people and suss out and then give their opinion about what works and what isn't working. So they can give a voice and an opinion to what they need, and so they can feel as though they are being listened to as well. A lot of stuff that goes wrong is that young people get told a lot what to do and they automatically get their back up about authority. There is not a lot of ... that is the good thing about here [Youthline], a lot of people just listen to what they are saying and acknowledge what input they are giving, using them as the actual resource and not as a problem because that is how things are going to start changing. I thought too, when young people don't do that well at school and they leave school and they get into crap jobs, like really shitty jobs where ... like factory work or working in a supermarket or working in the warehouse or being a laborer and all these jobs and you get stuck in that cycle, not going anywhere with it. There is no opportunity to go higher in that. You don't get to broaden or develop your skills. I was thinking, if there was some kind of programme where if you left school or you weren't sure what you wanted to do or you didn't have the qualifications, you could go on a programme where you did a different job every couple of months and didn't have to do anything real good, but just because of the change and you are constantly challenging new skills in yourself and maybe if you had two months doing retail work at the Warehouse or another two months working at a petrol station and then two months working in a warehouse, two months working in a factory, just so you broaden and develop your skills. I think that is what a lot of young people get depressed about, when all they do is have a real shit week and then they get drunk and out of it for the weekend and they put all their energy into the weekend and then go back to the week again.*

Yeh, that is horrible. And they have no idea how to change this, they feel stuck and when people feel stuck that is when the suicide, depression comes from. Especially when so much around them is driven on success. If you are in a place where you don't feel that you can succeed and everyone else.... And you perceive everyone else to and time is ticking and when you get to a certain age, you get to 25, 30 and you haven't sorted your shit out, it almost feels like you are never going to sort it out and so why bother. There needs to be more effort put into the strengths perspective. You know the strengths approach, concentrating on the young peoples strengths more. What I really think young people need is for ***people to be proud of them****. To be proud of what they do. When you come to any relationship, whether it is with your girlfriend or wife or your grandma or whatever, you do stuff so that people thing better of you, the way you kind of do things, you think, be real nice and you want to kind of do a job to impress people and for them to say, Oh wow, you are cool, you are good. That is what young people*

crave, is people they respect to say, oh wow, you did a cool job doing that man, that was cool, what you did there. That is what they really thrive on. They might not say it but that is the juice that they need. If they are not getting that acknowledgement, then why bother. Why should they bother to do well at school, or why should they bother to be responsible if they are not getting that acknowledgement back.
Many of my clients don't have anyone behind them giving them that support. All they get is crap, they get school reports saying you must try harder, you have the potential, you have all these things and yet they are not acknowledging what they are doing well.

Christine: *Tricky, because I think New Zealand culture is in a bit of a transition at the moment, in a number of ways. I think people are a bit caught between whether we are part of this global community or whether we are just an isolated little island - and kind of they are both true. I think that is a little unclear to people. They don't know whether they are a small fish in a small pond or a small fish in a big pond. Their sense of what their potential is in life and what options are, because we get this stuff in the media and on TV and stuff about all these opportunities ... and in reality some of them are struggling just to get through school.*
It is all very well to see all these amazing role models, but that often seems so distant. I think the education system in schools works fairly well for the majority of kids but there is quite a significant minority it doesn't work well for. I don't think there is enough social work type ***support in schools to address the emotional, psychological problems*** *that most young people are dealing with.*
I think there are a lot of images in the media about being sexy and cool and tough and staunch and all these sorts of things which are apparently ideal images but are very hard to live up to when you are just a kid and you have no resources, and are living under your parents' roof. There are many contradictions in the world for people. What I see a lot of are people that are ***unsure about where they fit in and how they fit in and if they ever will fit in****. Not knowing if they want to or if they want to be individualistic and risk being isolated.*
There are ***differences around sexuality*** *and around feeling different and being afraid that the way they feel and think is not the way everyone else feels. That sort of thing. I think* ***Auckland is isolated*** *from the rest of the world where there is a lot of trouble, wars and stuff, can create a bit of a sense of detachment and things being bland. Not that I think it is good for young people to be exposed to horrible things, but I think when it is hard to stay alive and when you see evidence of people that are really facing the challenges, they are right into protecting their families and communities and beliefs, life becomes much more precious. These things that are worth fighting for, are* ***things that are worth*** *loosing your life for, if it comes to that. So I think holding onto life, and why it's worth doing that, also becomes much clearer.*
New Zealand in a way is quite safe, there is nothing much to fight for here. It is 'okay' - things can be not good, but they don't get ***that*** *bad. No one needs to starve here, there are services available. The community is fairly tolerant of differences and I think sometimes we* ***need to struggle to feel alive****. It is like a need for a boundary, something to fight against, something to push against and New Zealand is fairly liberal and yet not liberal enough to allow them to really kind of do want they want.*
Further one that comes to my mind at the moment is the need to get ***more support into schools****. What I get a lot of is young people coming to me, who have been to a school counsellor and have had bad experiences with it. Particularly around things like...the biggest problems seem to be* ***lack of confidentiality****. They will tell things in school*

counselling and the school counselors will tell the teachers, which is obviously an agreement within the school but it makes it rather difficult for the kids to trust them. Other things is the reputation that school counsellors get sometimes of being a cop out, a way of getting out of school, so they feel like it gets labeled, like you are just dodging work. You don't really have a real need. Do I want to look like a person who is dodging out of stuff, or do I want to look like someone whose is really needy and that is a factor as well, people are going to want to know why I am taking time out of class, what is wrong.
That is not very confidential either because it is within school hours (though it needs to be, I suppose). Some of the other schools, like Epsom Girls have had connections with Youthline, they had a drop-in counsellor where it can be done in study times and stuff so it is not so obvious and it is good just to go and check things out. Also, as Epsom Girls have links in with us, it is much easier to set up counselling outside the school or programmes and that sort of thing if they need it. That is definitely a need I think. One other school I deal with has got a support worker who actually works in the school and she drives the girls to counselling in school hours if their parents cant or wont do it.
I think there's a ***need for more group programmes*** *with good facilitation. I think the V.O.I.C.E. programme here is great and there is a real need for more of that kind of stuff,* ***where young people can come and be themselves and be accepted within a safe context.***
If they belong to churches they can often get some of that community support, but then again, they have got to know 'the rules' in church group, and might not feel they can speak freely about some things in that context. Lots more ***community programmes*** *and that sort of thing, which are really supportive.*

Megan: *I think the suicidal rate in Maori boys is really high. I don't work too much with Maori but a lot of Pacific Island boys are suicidal and I think that one is that change of culture and it is quite big from Pacific Island to here. And for Maori boys I would say it is the colonisation process. They lost their* ***culture****: their parents lost their culture so they didn't pass on their pride in their own culture.*
I think that it is really a big problem. If you grow up without being dark and being Maori in a Pakeha society then something says that something about you is wrong or something doesn't belong and there is ***no belonging*** *in the family – it is really black and white, the parents don't often feel a sense of belonging with Maori. You know that pride that we get from Europe, that is not there. So a kind of* ***lack of identity****. And that is very strong in adolescents. That is on top of all the other issues that adolescents have and poverty, because of the cultural ... these are all generalizations but a lot of Maori have nowhere else to go,* ***proper support****. Here there is not many Maori counsellors so where do you go. They are often with a Pakeha counsellor as well.*

3) Suicidality among teens

Tom: *First of all we could look at the structural issues within New Zealand. Why is it that New Zealand has a high suicide rate, and then we could look at it in a more individual basis, so I will answer it to both.*
In an individual basis, the predominately driving force is the experience the young person has of themselves in their world and that is either added to by the addition of alcohol or drugs – adds another level of ***chaos*** *and distress and maybe added to by a*

significant sense of ***hopelessness*** *and* ***helplessness****. It certainly will be added to by a sense of* ***disconnection****, either from family, friends or future and at times it is also of course* ***a significant event that has happened****. So, one way that I understand what happens for a young person when they are suicidal or harm, reduction of some of the behaviours on the way to killing themselves are actually anxiety producing behaviours and that can be in the area of eating, disorderly addictions, alcohol or drug disorder addictions, cutting behaviours and then social conduct behaviours, so acting out, crying, are all perhaps one way of viewing it. There is a number of ways. Anxiety producing activities to cope with an increasing building or sense of* ***disconnection****, despair,* ***hopelessness and helplessness****. So on an individual level there is a number of factors,* ***alcohol or drugs****,* ***mental illness, depression, some disconnection from social systems, maybe family dysfunctions****. Often knowing a person or family* ***who have killed themselves*** *is part of the history. Another layer of that is just the standard developmental issues of young people that we all go through, but then you add another layer of pressure and stress and moving towards that. At a macro level I think there is a whole number of factors. Some of these have been documented and some of these are more antidotal through my work, factors that influence why we have such a disastrous level of suicide in this country. A couple of bases I talk from, one is that if suicide is the ultimate way of removing yourself from society what are the factors in our society that influence a young person to move away from being involved. There is a number of influences I think. They are not in any sequential or priority order they are just as they come of the top, one of the issues in New Zealand is that* ***we do not have a very youth centered society****. Some of the research that we have done at Youthline is for instance we have asked 150 young men, what do you think the world thinks of young men. 99.9% of the responses were that young men assessed that the world thinks that young men suck. So if you grow up in an environment that you feel has a negative view of you perhaps that has an influence on you maybe an attitudinal things I think that add another level of pressure. I think there is a social culture, which is emotional illiterate in our culture. If we look at the ability for families and therefore individuals to deal with emotional distress we do have a strong* ***theme of we should just get on with it****. If you break your leg you can seek help, but if you break your heart or mind, somehow you are supposed to get over it. The other things that have influenced this is there has been a lot of* ***gender role definition changes*** *over the years. So for instance when I was a teenager what I had to do in order as a young man was a little more clearly defined than say young men now growing up. In addition there have been a number of other pressures added, economic pressures, pressures to families, family functioning pressures, the way the families are made up and managed have shifted over the last 20-30 years.* ***The sense of future direction has changed****. Once upon a time you would leave school, you would get a job, you would work alongside older people while you learn and you might stay in the job for a significant period of time. Those sorts of stability things have changed. In addition* ***young people have also become one of the biggest commodity groups*** *so if I am looking at the environment we create which defines pathways for a young person to grow and develop, those* ***pathways have become much more multiple and maybe less clear****. Not all this stuff is backed up by research but it is what I have seen in work. The other thing is that an interesting factor is that if you look at some of the population based research that has happened in this country, if you are involved in a study around suicide you are more likely to kill yourself. Maybe that is every five years somebody comes and asks you whether you have been suicidal, maybe it creates something, but it*

is very interesting to notice that the figures in the population based values are actually higher than the general population.
It is just an aside. At a structural level there is an immense ***fragmentation of service response to young people****. Young people are a speciality age group with their own unique health issues and the* ***services*** *offered to them* ***are not necessary youth friendly services****. We have a very silo and disconnected and disjointed way of responding. If you think of a young person fragmenting, family fragmenting, community fragmenting, there is a lot of gaps for young people to fall through, and even in our service, 9 out of 10 people who ring us don't get through, so if you are already feeling disconnected, hopeless and helpless and you take that, get over that stigma, the amount of stigma around mental illness and emotional distress and pick up the phone and you get an answer phone, then you are actually at another level of disconnection, another barrier to help setting behaviour. There is also an inertia to a governmental level to actually deal with it and when there are processes to deal with it, they are often fragmentary in nature as well, so again the organisation that I work for which provides a youth help line which under the United Nations Charter for the rights of children, one of the ways of auditing that is,* ***does the state help support an anonymous help line for young people and in this country the answer is no****. At various levels it is like* ***young people are quite marginalized in this country*** *with the results that we see. You asked me a question about what are the influences, there is the internal experience that drives young people and there is the external world around them, which marginalizes too, which creates quite a volatile cocktail.*

Mike: *At the beginning of the year I facilitated a personal development group of 16 – 20 year olds and we did a brainstorm around why people kill themselves and one of the big things that came out of it for me was when someone said when you are really depressed you do a whole lot of thinking and not much talking, that things just cycle around in your head and there is nothing to break it. You are just thinking and thinking and you go into a spiral where you are not reaching out and talking to somebody or talking to your friends and it makes you less inclined to do that* ***the more depressed you get, the less you are able to talk to people*** *about it. It gets worse and worse.*
More and more ***isolation****. The more that you do that, the more isolated you become and the more less contact you want with other people. Reasons like you may have to be happy to contact them or you don't want them to see you depressed. Things like that. Sometimes when young people are already depressed or susceptible to depression when they go out and drink a lot and they do something really embarrassing or they do something to really make a fool of themselves. I talked to a few people that they wet themselves or they have done something really bad and been so depressed about it, the Monday after they are really scared that they are going to do something to themselves or they think, I don't really want to leave the house.*

Christine: *With the group that I have got, a lot of it is around their abuse. I was going to say a lot of it was around their past, but that is probably not really very fair because it is not that simple. Good question actually. It is actually more about the* ***future*** *than the past. Where the thing that will trigger them most in relation to suicide tends to be that they start thinking about the lack of future that they believe they would have had. With some teens who do have an abuse history it is sometimes around the feeling of hopelessness that they will ever build good relationships. Perhaps that their friendships*

can't survive all that they carry with them; and that they'll never have families, children, the lot.
With others it is problems with depression or kind of verging on the mental health fields really. It is worrying that they won't ever be happy and relaxed and be able to fit in like normal people. That they won't be able to pursue careers and training or something that they feel passionate about because they'll never cope. Yeh, that sort of thing. There's the hurt and anger, and rather than sending it out to people that have hurt them or angered them or whatever; they just turn it on themselves.
No, not so much revenge, more of the way of expressing their anger. They don't know ... it becomes so intense inside themselves, and being young they often don't have any real outlets for it, they are meant to be good. You cant really get angry at your parents because you are relying on them to back you up and if have an absentee parent who lives somewhere else, you don't want to get angry at them because it is very easy for them to totally ignore you and get nothing from them. That anger can become quite a problem. They often don't quite understand what it is about and just know they feel angry, or lost or confused or invisible. They don't have anywhere they can go and let it out, express it, share it ... and that is why I see a lot of self-harming and 'drowning out' problems with drugs, alcohol, fighting and that sort of thing.

Megan: ***Loneliness*** *and* ***unresolved anger***, ***feeling bad*** *about themselves,* ***useless***, *and lot of* ***controlling anger***.
I start with ***just being there*** *and being available, showing them where to go, they can ring Youthline crisis phone they can come in every week. Giving them resources when they get really anxious and suicidal and wanting to cut, what to do instead - so I lot of* ***self-care***.
I try to show them what to do instead like ***talking to someone***, ***opening it up*** *and opening up that fear, is one. Visualization is another, books, remembering a safe place, imagining that here gives them a ... having time for themselves, drawing, writing, listening to music that* ***makes them feel better***.

Appendix B: Prevention and Intervention and Skills of Staff Members to meet the Needs

Adolescent Participants
1) What helping possibilities do you know or/and would you wish?

Sue: *Talk about it. Definitely talk to someone about the way you are feeling. Try to figure out why you are feeling that way. You could try writing down your feelings or poetry or do something creative, join ... I think getting help, just talking to someone about it is the best way. I would wish to get support, but then not always asking what is wrong, what's wrong every second. Just being there for me. Yeah, just them being there for that person.*

Mark: *Personally it was coming down doing the N.E.X.T course, having friends that accepted you and who you could talk to about stuff. I could talk to them that I'm bisexual and stuff.*
Having friends who are open and understanding. And that open discussion about sexuality, including gay and bi in places like school would be really good, because that would help homophobia plus it's a really interesting topic.
I think it would be a lot better if school was more of an open ... mix of friends. The whole group thing is quite negative. I don't know how you could change it. I think the environment needs to be changed, but I can't see that happening because changing environment seems sort of un-natural.

John: *Telling myself that it was just stupid to think about that and things will pass and sometimes you can't listen to yourself, but sometimes it's just telling yourself that is the wrong idea. Like, sometimes just sleep it off and stuff like that.*
I could talk to ... I think at one point I had this big crisis and at that point I went to my counsellor, but while I was at school I didn't feel that I could talk to anyone because I didn't trust any of my school mates because I had been there for nine years.
Yeh, and I don't think I talked to anyone else about it. Oh, I talked to my best friend about it.
And with my counselor, ... I hadn't been to her for a while. I just went to her occasionally. I used to have an occasional visit and at the time when I left she became really busy but, yeh, it was pretty easy to talk to her. Like, when I first, when I had the big crisis I went straight to her and she was ... she had someone at that time and she asked the person if I could come in, halfway through the other persons session. So, yeh, she was really supportive.

Becks: *Just to be around people that make me happy and just go and...I can't think, if I am depressed I don't want to think, I want to go out and do something that gets my mind*

off things. If you go for a walk and think sometimes it gets you more depressed. You are thinking more in depth.

Okay, contact with therapists, counselors, what do you think about that kind of help?
I think counseling and therapy is good, because sometimes at the time I don't really want to talk about it, I just want to forget about it. I always tell people, you have to talk to people and then I contradict myself, I am such a hypocrite I do the exact opposite.
Talking about stuff during therapy, ..., it was difficult but it was easy as well. I just felt like I could talk about everything with her. I felt like big weights had been lifted off my shoulders because I had told someone.
I wouldn't really wish to receive anything in that sort of way. Just being able to have friends that I can go out with and forget about everything and relax.

Kim: *Counselors for one, your friends, talking about it also. Poetry would be another one, just writing. If you have that family bond, friends, counselling – some one you can trust.*
For myself It was not really hard to make some contact with a counselor, it was more because of my friend when she died because I was too busy blaming myself and blaming my friends as well. I blamed our whole group for not being there. Eventually I got past that and I didn't want to go back into it to let her go and eventually it hurt so much – I was just so angry with people for no reason and got really emotional and ... and like one of my friends said ...he said to me, you haven't ... I don't know what he said to me, but he said something to me and I was like, oh, god. He was really good to talk to but I kind of knew that I needed someone that dealt with those situations, not someone so close to my circle of friends. Someone who hadn't seen and experienced it, he was kind of in the midst of it and it was like, it was very hard to talk to him. So that was when I got counselling. I rang up and thought it might not hurt to talk to someone who deals with this stuff everyday and after I came out the first time I felt so much better.
So yeah, just support from my friends. Just knowing that they are there and just knowing that if I still need to talk or communicate in any way they are there for me...not help me but at least try to and just the support of knowing that I have people who care. Family support with them understanding that I wasn't going through such a good time and trying to offer to help.

Robin: *Do you know what I think is the best is actually what Youthline does with the kids with the N.E.X.T Programmes. I think that is more helpful that anything. Well not anything, but for me anyway ... I have never had a problem with depression but I just feel with the kids, when you are in group therapy you are learning so much off other people and I think ...obviously you could have a counsellor and group therapy and that would probably to the ultimate best thing that you could do with somebody because you can learn off other people and you can learn about yourself and you enjoy yourself and it gives you more of a purpose. If you just go to a counsellor and off-load all the time, maybe you are not getting enough input back, and it is not cool for the counsellor either.*
They [Youthline] *should be doing more of those groups. They should be getting them into schools and getting at risk kids and hooking them up with group support things, because I reckon that would be the ultimate. That would be so helpful for people struggling.*

So, I would definitely seek counselling. That is so important to have someone to talk to about that stuff. I think that the group therapy thing is really helpful. It is also even just the act of getting out and going out into public. Joe was saying, (one of the guys from the course) he said that he had a problem with going out, he had a phobia of it and it is like, just going out and being with people is so helpful it just heals you a little bit every time you go, because you are interacting with others and you are getting the energy and you are getting their energy. It is really good.

2) Evaluation of the N.E.X.T Group

Sue: *The N.E.X.T Group was wonderful. Really good. Really good support, everyone is quite close already. You can go there, whatever mood you are in and people just accept you anyway. If you have any worries you can talk to anyone there. Specifically with our group, what I have experienced, they give you time to express how you feel, even on paper. We did a big collage of what we thought of ourselves. I think it is really beneficial for people our age, older and younger people.*
The Group had quite a big influence. Just for the fact that they were and are always supportive and always asking, how have you been doing ... yeah, just really good friendships. A lot of caring.
It has helped me realise that people generally care. It has helped me grow. It has helped me realise more who I am. Also the facilitators as well as the people in our group. It has definitely helped me to think of other people more and what could be behind ... you know what they really show – the mask. You know, if you wear a mask, what could be behind that. Why we feel things, what we can do about it, what we usually do about it.
I've been in the Group when all these things with my friends happen. Not right in the beginning. It was I think maybe two weeks after the first one died and then I think the group started and I think it really, really helped. Because what happened was, I was still going out with my boyfriend then and because he wasn't there for me when she passed away. Therefore, I had to break up with him but he was the person I really wanted to have for support and things like that but I honestly couldn't. And therefore I could talk to the whole group. I could say I am really down at the moment and in the break they would come up to me and give me a hug or whatever and just say they were there for me and things like that. It helped. Yeah, lots of support.

What sort of relationship do you have with the facilitators?
Not that close obviously because of the age difference, but I feel that I could talk to them more than I could to someone else, because they know what I have been through and I can trust them.

And the other side, what sort of relationship do you have with the other members?
Quite close, because we all now what each other have been through. We have kind of grown up with each other. We have been with each other for nearly two years and we have seen each other grow up in the last two years. It is very special.

Do you think that you will have contact in the future after finishing the group?
Yeah. Definitely.

Mark: *I think it is great.*

It's great. It's an environment in which I feel really, really comfortable and yet you can talk about personal things and stuff like that and not feel bummed out or feel that it is such a bad thing.
The Group definitely gives me energy. Down the week you start to get dragged down and slower and then suddenly you come to the N.E.X.T and you feel better ... My self-esteem is so much better and I find it a lot easier to communicate with people now, and because I feel a lot more comfortable about myself.

Which kind of relationship do you have with the facilitators?
A very good relationship. It is a lot like the relationship I have with members.

That was my next question, which kind of relationship do you have with the other members?
Pretty good relationship, we can talk about stuff.

Do you think that you will have contact in the future after finishing the group?
Yeah. I hope so.

John: *I think it is great. I think the V.O.I.C.E. and the N.E.X.T. group are brilliant to help peoples self esteem and show their own potentional.*
It was so good for my self-realism. To show myself that I am not what the world revolves around, there is so many personalities and influences and ideas and stuff that you can't base something on your own knowledge. You have to understand other people before you can understand yourself.
My attitude actually towards females for example has changed a lot. Our group was mainly females and I thought I had it rough, but they go through a lot. One of my friends who is in there has gone through a lot because she is female and sometimes you have to respect that. I've learnt something new of life, because they get it so differently to males.
Yeh, and my self-esteem has changed, and ...
The whole group, it was so positive. I think they showed me what I was really interested in. They helped me look into myself and to other people and see what was really there. One of our group members decided that he was gay during the thing and I thought that was great that we helped him decide that and tell his parents and stuff.

Which kind of relationship did you have, or do you have with the facilitators?
It is just the same as I have with the group, 'cause they are part of the group really. In the V.O.I.C.E we called them mum and dad. They told us off when we were talking and stuff like that. That was with Marsh and Marlene. They were really good, they were really supportive. They were part of the whole group, they weren't separate. They were part of the group doing the same things as we did.

And how is your relationship like with the other members?
Most of them, they are all my friends, I don't hate anyone in any of the groups.

Do you still have contact?
Yeh, with Mark, who is in the V.O.I.C.E and the NE.X.T. He came to a birthday that I had and I see Sue occasionally. I wont see they all the time that that is because we live so far away really. I am planning a barbeque sometime.

Becks: *At the beginning I found it really pointless. I didn't learn anything from it but at the end it was kind of getting better, but personally I think that it wasn't the greatest. Maybe it was me not being open to learning new things but I did not find it that useful myself.*
There was a bit of an influence, like from other people as well. Also, just learning new things in the group as well. I did learn some stuff, but some nights I just felt like it was a waste of time. Nothing particularly has changed.

So the group didn't have much influence on you, not changed you?
Not really.

So which kind of relationship did you have with the facilitators?
I knew Megan from V.O.I.C.E, so it was quite nice to see her again. I got on quite well with her and Mike and Rachel I didn't really know. Only Mike, sort of through mum, but apart from that I didn't have a big relationship with them, I just saw them on the night and if I talked to them ...

So you wouldn't really describe it as a friendship or closer relationship, it was just a facilitator.
Facilitator, yeh.

So which kind of relationship did you have with the other members?
They were all friends from the V.O.I.C.E last year, so I didn't really know anyone except another girl who I knew from the V.O.I.C.E that I did, but they weren't big deep friendships. If I saw them I would say hi, but just friendships in the group, not really out of the group.

So you don't see some of the members ... It has finished, the group has finished.
Yeh

Kim: *I love it [N.E.X.T]. A lot of our group this year is from the group last year. I have meet so many ...cause I am quite young to be on there, but I wasn't 15 when I started, I was 14, but they let me in because there wasn't enough people the majority of them are 17, 18 so they are kind of like my role models. I have meet some really amazing people and some of them are just really, really good friends and I don't know where I would be without the support that I have had from them.*
It has a really good influence on me. Quite a few of us that have different aspects of ... like lead different lives so it gives you a broader view how people live and their believes, their cultural beliefs, their spiritual beliefs and especially the sexuality, it lets you have a more open mind. Yeah, cause there is a bisexual guy and I think it was really good that we created an environment and they were able to say I am gay and not be discriminated. The influence that the group has had on me is probably that you can believe in yourself, not letting others get to you.
My attitude towards passion has further changed. The beginning of this year was really good, I was looking forward to it but it has really taught me that you have to take chances to ... like you are not going to get anyway if you don't take those chances and part of taking chances is that if you fail you can always try again. It has made me really brave to say, okay I may as well take the chance and if I don't succeed I can succeed

later. I guess it has helped me mature faster, I am growing up faster because I have been with these other group members, two or three years older than me.
I used to be really freaked out about trying things because I never used to like to fail. I was like a perfectionist, but it has taught me that part of life is failing. I am not scared of failing anymore.

What kind of relationship do you have with the facilitators?
This year it has been kind of different. Our last years facilitator ... I think our group was actually quite close, but this year it has been kind of different. I can always go to them but it is not like we sit down and have conversations with them. I don't really know how to describe my relationship with them.

So it is not like a friendship or something like that?
I don't know.
Compared to the facilitators last year.
Yeah. Last year we definitely had a friendship, they had a bond with us. Our group was really open, but this year our facilitators ...I think this group is more serious than last year. Last year was just getting to know yourself and this year it is kind of a bit serious and we are still ... most of us were not prepared for that so it comes across like ... not no fun but really serious about it so I guess it is more of a teacher/student thing, even though it is not. But our relationship is pretty good but it is a bit more formal.

What kind of relationship do you have with the other members?
I am friends with all the group but I have two people who I am quite close to. We have become quite close friends she went to Australia and I still write to her and I am quite close to another guy, he is 18 and goes to Auckland Grammar and we have become really good friends this year as well. My relationship with our group members is really good. It is really open and easy going.

Robin: *N.E.X.T is fantastic. I think I am probably a bit old for it this time. Not because everyone is real young and stupid but I kind of wanted to be... I didn't really want to be doing the same stuff that I was doing. I wanted to be more focusing on doing basic counselling so that I can move into that stuff later on. It is so cool. Just as a support network for other people that have problems with depression. Honestly, it gave me such a better perspective on what it must be like for the people that actually have to deal with that stuff because I don't have to deal with it. Part of the reason that I do Youthline is because one of my best friends had really bad problems with depression when she was younger and that made me want to do it more because I wanted to look out for people that were like her.*
I think more than anything it made me more tolerant of people from different walks of life. When I was younger I got into the really hard-core scene, which was hard-core and punk music and the kids there are very dismissive of anyone that is not in their scene. So for me to come to this group when everyone is on the same level and they all get on really well and they hang out, I don't understand, why are they all so nice to each other. I thought that was really cool. I think it changed who I am and the way that I approach people now. They are a person and it has really helped me to see that a lot better, you get to meet people and understand them individually and what makes them tick and where they are from and you don't judge them on their appearances or what they might come across as at first. That is the thing my mum said to me the other night, it has made

me more tolerance. It is definitely a good thing because I was bloody awful when I was younger.

Okay, so which kind of relationship did you have with the facilitator?
I guess I look up to Megan a lot. She is really amazing. She is just really centered and balanced. Mike, he is really cool. He is kind of like a good mate. It is kind of hard to see him in an authoritative positive because he is so like a kid most of the time. I didn't really talk to Rachel that much but I really liked her, I had a lot of respect for her. She is a really gentle sort of person, she has a gentle spirit and really kind. I think the only one I looked up to – definitely Megan. I felt I have always looked up to her because I had her as one of my leaders for my first group as well.

And your relationship to the other group members?
I had a couple of friends in the group that were really good friends and the rest of the kids were like kids that you kind of hang out with and talk to casually, but they weren't best friends. It was kind of different for me because most of the girls that were in the group weren't my age. I was kind of like ... they were really cool but I tend to get on better with girls that are my age. You feel alienated because they have their friends there who are their age, but they were pretty cool.

So it was a good atmosphere?
Yeh, a great atmosphere. Everyone got on and hung out together and stuff. It wasn't stressful or alienating me all the time.

3) Wishes for more or different support

Sue: *I only know of Youthline. I don't know of any other organisations like that. Maybe another building somewhere. There is only one in Manukau or Ponsonby. Maybe one out more this way, or North Shore that we could go into. They are working on the phone line at the moment to try and get it 24 hour. They need to advertise more for the groups and things.*

Mark: *I think it needs to be 24 hours, which they are trying to do at the moment and I think there should be more groups like boys to men.*
I think we are doing the N.E.X.T group next year and I think it is just for us and for personal development.
Yeah, I think more advertising, but that would be after they had the 24/7 thing Youthline needs to be able to answer more calls. I think knowledge of these issues need to be more out there so that young people don't feel that they are alone.

John: *I would love the thing to go 24/7, which is what they are trying for.*

They have the phone line open for 24 hours?
No they don't yet, but they want to. They don't really have enough funding. I think that would be really good 'cause you can't really control what time of the day ... and more courses 'cause I know that there is young people that go 9,8,7 that go through the same stuff as us and we never realise it and they need the same things.

Now was there anything within the group anything that you would say is not that good or could be changed?
No. Oh, maybe the length could be longer. Need more hours in the day.

Becks: *I don't know. I think that it was just me. I think that it was a good group, but I think it was just me, not in the right space of mind.*

So no particular wish that you could imagine, I am talking about general things for the N.E.X.T Group, something you would wish from an organisation like Youthline for yourself?
No.

Kim: *I think they need to be more advertised and like I said about the Salvation Army teen type things and I think if they were more advertised and more ... they really need to get out there to bring people in to create a bigger organization, because we are too less phone line counselors ... cause like if you ring up, cause my friends have rung up a number of times, it is so hard to get in because there is only so many, but if they actually brought people in, we would be able to have more phone counseling. But overall I think they are really good. I think they should have more groups, a sexuality group, a teen pregnancy group, more stuff to do with sexuality transmitted diseases, alcohol and drugs ...*
And kind of Teenage Forums where everyone comes in. But I think that they are really good, they cover such a wide range of things.

Robin: *I think not so much for myself but I think what I was saying before, I think they need to pour money into it so that it can go into schools so they can further what they are doing here because it is a really good thing. More of the group stuff, it is just fantastic.*

Professional Participants

1) Official Guidelines

Tom: *There is a national strategy that was developed by the Ministry of Youth Affairs with the input of Health and Te Puna Kokori and that is the New Zealand Youth Suicide Prevention Strategy so that is the guiding document and there have been umpteen dozen other reports but this is where is has got to. This is supposed to influence government as well as non-governmental organisation and how they function. I think it is a good document. We structured our response slightly different, but we fit within. You are probably aware that there are five key goals. So if you look at Youthline promoting well being, the foundation of Youthline is about a community development process of building health in the community, involving community, the second one about early identification health, the fact that our core service was about making every phone in New Zealand an accessible point of contact and then equipping a workforce to be able to deal with that interface. The third one about crisis support and treatment, well we do it every day of the week. Support after suicide, there is two ways, it is for the family and significant others around that we do quite a lot of work in that area, but it is also for*

our workers. If our workers are working in this area and there is a situation where a young person has killed themselves that they have got very close to, then we have ongoing supporting structures to ensure that our team are also taken care of and then the other one about researching information, we have a lot of information, we undertake research and again as we can with what resources we have got and we draw upon research in order to understand our work and deepen our work, so the issue of research in this country has been that there has been a lot of population based studies and very little about individuals so it is a lot about understanding what is happening and who it is happening to, but virtually nothing about what you are supposed to do about it. But there is a lot of antidotal and there is certainly a lot of theoretical models that we draw upon.
Well we work within that strategy, we also have our model of approach which fits within that, but our model of approach is community development processes, training and development processes and then an integrated range of services, covering crisis, at risk, developmental so that we are working, not only with the at risk and the crisis, but also the developmental. So *it is very much a public health initiative as well as it is a mental health initiative, as well as a youth development initiative and it is a multidisciplinary approach to work.*

Have you been informed about the guideline?
I can answer that a bit more, Youthline are consulted by government agencies many times and that particular strategy I was on the expert reference panel at the Ministry of Affairs, trying to, and I add the word 'trying to' influence the development of it. I am also on the advisory board of SPINZ which is Suicide Prevention Information New Zealand, again trying to influence their approach to how they support organisations across the country and so again Youthline's core which is about youth development is also about being involved in Networks, also being involved in consultation and lobbies and research is a very important part of our work.

Mike: *Yeh, there is SPINZ, there was the Ministry of Youth Affairs, they brought out a youth development strategy and I had a look through that and it came very much from using the strengths approach perspective and putting things in place and things like that.*
So, there is that SPINZ one, they have a youth prevention strategy and then the Ministry of Youth Affairs, have you seen that ...

I have seen the strategy booklet. Do you work with it at Youthline or have you all as co-workers at Youthline had a look at these booklet? How did it work?
I think it has been a more of an individual thing. I don't think we have all got together and, oh, this is how we can address it within our organisation, which I think we might need to do. From what I have read and what I have seen, it looks really, really healthy and really, really good.

Christine: *Internally, strategies have been provided, particularly by SPINZ, so they give quite a lot of good guidelines of what things to look for and things.*
SPINZ is government funded. There is plenty of information around and from that information we have designed strategies to use on the phone lines - that is the best working model we have found so far. But alongside our general suicidality management

strategies, a lot of it is having to work on an ***individual*** *basis to find out what it is about for this particular person, whether it is anger, hurt or isolation or whatever.*
It is also difficult too, theoretically we follow the NZAC guidelines, the New Zealand Association of Counsellors Code of Ethics, so we have got our basic principals that we use from that. It does say confidentiality holds up to the point of safety issues, which is where there is a fair indication that the person or someone they know is going to be harmed. It sounds fairly straight-forward but even that is difficult. If you have got someone who finds suicide is something that has been on their mind and continues to be on their mind a lot, you have got to start finding a way of, in a way, accepting that that is part of their world. You may need to focus on the other things and not constantly be reacting to that aspect because in some situations that is not helpful.
And I think that can get confusing because it is a safety aspect but it is an ***ongoing*** *safety aspect and if you keep breaking your rules (of them being able to speak confidentially to you) all the time, because of a safety issue involved, you can't do the work. People have the technique of signing contracts where the person has to agree that they wont kill themselves while they are in counselling. It is worth a try. For some people it works. But for really unwell people who are very disturbed and distressed it often doesn't really.*
They will do it to just please you, and it can actually get in the way of them being honest with you because they know they can't do that. It becomes a game where they think, "Okay you want me to lie to you, I will lie to you" and it can create a whole atmosphere, which is really avoiding accessing what really goes on in their mind. I don't use it.

Megan: *I haven't used much of the governmental stuff really. More the Youthline and my course, my Masters, that is where I got my information from.*
I guess in the group work we work more on getting them to brainstorm what they can do for themselves and I think if it is in their own words and their ideas it is much more powerful than when I give them a handout from the government on what to do.

2) Special Programmes

Tom: *If we look at a young person who is at risk of self harm and a risk of killing themselves, first thing they need to be able to do is have ease of contact. To be able to get to a place where they are able to interface with someone who can support them. Our programme is first of all making sure that Youthline is known out there, second is the youth line and the internet based services so that they can have an interface accessible first point of contact. Part of the youth help line role is to help facilitate young people in engaging specialist services that they may need. Those specialist services may be provided by any number of organisations or they may involve our specialist teams. From the youth help line they may see an individual therapist who works with them, at times when they are critically at risk we engage often with A & E, sometimes with the crisis team at Mental Health but we have always had trouble with that interface so sometimes it is much more effective to go, take the young person straight to the hospital. On the help line at times we will send an ambulance to the young person. We also have young people who work with our therapist, who work with them on an ongoing basis with intervention and any significant others, so alongside that is the family working with family therapy work and as they develop through that individual work enough robustness, enough sense of being anchored they can then move through into our*

development programmes. We run a range of group programmes, some where young people might just lead straight into them from schools, some we run in our centers where a young person can enter into a personal development programme or our younger development programmes, still seeing our individual counsellor, maybe still using the help line to support them and then alongside that maybe family work. Of course other aspects of the service is the alternative school where young people who come in to Youthline and there is a school based here in our school. We have 11 students here at our school on a fulltime basis and they would fall into the at risk category, some would be at the suicidal aspect of that, others might be in the acting out behaviours, but still there is a number again of finding relevant... and the good thing about the individual is that becomes the supporting structure, that relationship with an ongoing assessment, maybe linking in with medical to see if there is any medical interventions required. As that develops the group based programmes are really good if you have skilled workers because you are actually hitting a developmental need which is about identifying as part of something, having peer relationships, its an effective developmental, so it is not a psycho-therapeutic...you are not trying to open it up, you are trying to build experience. We have a number of ranges, as well as the internet based information and the information we provide to the young people, again to encourage them to have the information they need but also to encourage them to link up.

Mike: *If they are in a real crisis at that point, all you have to do is really just be with them and get them through that time. It is just like client centred counselling really, getting them on side and talking about things and seeing where they are, how serious they are about it, being real straight up with them, like saying, Are you going to commit suicide, have you got a plan, what are you going to do, how do you plan on doing it and just being real straight up and clear, not skipping around it, because that is what they get all the time, they will try and say to people and skip around it and they will skip around it as well and it kind of colludes with that. If you say, oh, are you going to kill yourself, they kind of think, oh, and they can step back from it a little bit and then look at it better. Then seeing what they need and how they can feel need, what tools they might need to get on with waking up tomorrow and getting on with that day and probably make a contract with them to ring back and all those things, procedural kind of things and then to support them, ask them if they would like to see a face to face counsellor or if they want family therapy or whatever it is or maybe a youth programme that they might want to be involved in, there is like the personal development one that we have got here or...There is a N.E.X.T and VO.I.C.E group. I am running the V.O.I.C.E group next year. Even though we aim that a bit more at functioning young people, trying to develop leadership skills, so they can ...mediation skills and things like that, but we do offer things like that as well and then you have got ... we have got lots of resources here, where we can ask a young person if that is what they would like to be involved in, like in different areas. There are things where they can go, like out west they can go on a journey to the caves, where they go on a big mission with an adult in their life. There is a certain amount of wilderness treks or different things that we can offer them. If they are really in a hard place we really try and push the face-to-face counselling because you can't get through that stuff on the telephone. It is cool to have us as a backup when things are really hard, where they can ring up and then we can take them through those hours that they need us, but we really try and get them to get some face-to-face counselling.*

So that is the main interaction thing when they are in a really big crisis or whatever?
Yeh.

And the second phase, as I understand it now is the personal development thing, which is a kind of prevention, if you have tried to give them strength, I mean that is prevention.
Yeh, it is a big prevention and also there is the advanced personal development as well and you get ... there is a lot in those programmes, as well as we have got the Unity and Standing Tall programmes for 13-17 year olds, which are stress and anger management and personal development and... yeah those are the ones we run in schools, where the schools approach us and then the school counsellor asks the young people if they want to be involved in a group of 8 – 10 people, then we go in and run it there at the school.

Just once or..?
No, it goes over eight weeks and it is two hours a week over eight weeks. We can run that here as well or we can go out to the community and run it and that is something that really helps.

And techniques you use there are mainly role-plays...?
Yeh, role-plays and action methods, art, drawing, sharing personal stories, making the group really solid to begin with. Then they can feel safe and held and then being able to use that as a base to check in each week and talk about what is actually going on, where they can't talk in other places. They have got these 8 – 10 people that are really.... so lots of action method stuff and group sharing and teaching them skills and tools to see how their stress levels go up and how they can calm them down, early warning signs and things like that.

And you learned this kind of stuff in the courses before?
For those two programmes there, for the 13-17 year olds, you join the Action Education Team here and then they take you through the programme and then you just have to go out with someone who is quite experienced and run it with them. You have to have had quite a bit of experience running groups and stuff before that. We do like a group dynamics course here, but you have outside training as well.

Christine: *I don't think there are any special programmes actually. Generally the programmes we run here are addressing personal development. Personal development groups that are well run and emotionally 'containing', and when the facilitators really understand the psychological processes people can go through, can really assist people moving on and changing - becoming more accepting of themselves and hopeful.*
Face-to-Face counseling is a kind of therapy. I loosely call it 'face to face counselling' because that is what the department is called. But often, with those who have got to the point of feeling seriously suicidal, what really needs to be attended to is deeper levels of self awareness and trust and building real relationships, and that's more 'therapy' territory.

Is there a special prevention and intervention programme, which you work with, special methods or techniques which you use concerning the suicidal issue?

Not really technique wise. I guess it is more about my philosophy really that I use and that have been partly the kind of person that I am and partly my psychotherapy training and partly my experience. I am just coming to certain decisions about what is real, like that suffering is not necessarily...that suffering is part of life and everyone suffers and to some how accept a certain amount of that and for me to be able to sit with other peoples suffering and accompany them with it because sometimes one of the big things that gets in the way of getting help is that nobody else will be able to tolerate them in their suffering or that no one understands it or that will make him unlovable or awful to be around so that is a big part of therapy for me is really being there for someone and what they are going through and to show that I can handle it and it is familiar territory for me and it is not scary and everything else doesn't need to crumble. Holding hope for them. They often get very hopeless and so that is the thing that I do, really believe in them, good things to come and promoting the ideas that the adolescence is a really difficult time, that they do not have freedom of access to the world, they don't have a whole lot of life experiences about what is possible out there. Often they have not been given the group skills or understanding why their parents have got (……..) and that things should get a lot better and if they can divide a stage of their mind and do their very best then they can manage their circumstances and the more independent they get and the more they can set their lives up for the future the better it will be in the future and that kind of optimism that I hold ...I believe that people do want to live and they do want to have a (…….) connection. I carry that believe even when people tell me otherwise. I believe that truth in them and I believe it is what they want. I kind of work as an advocate for the parts of them that want to live and want things to improve and reconnect with joy and passion. So I guess my tools come a lot from my philosophy rather than actual techniques and sometimes that will be met (…….) but I think sometimes it is just a (……) of holding it for them they can't....

Megan: *I give them my phone number and I give them Youthline's phone number to ring in any time of crisis or having a contract, they won't commit suicide until I see them at the next session. That often helps with the self-harm as well. I use Linehan you know that DBT, Dialectical Behaviour Therapy and she has a workbook and there is lots of self care stuff in there that I can give handouts to young people and lots of ideas on what they can do to care for themselves and other than that just building a relationship with them. Being available and nurturing themselves and their ideas and being with them.*

So they can ring you privately at home too?
Yeh, I sus them out first, but yeh.

So I use a combination of what I just said. DBT is good, it is straightforward. I try to get them in a group as well here, because often they are isolated and alone, so one of the groups like Voice or Next really helps them with their social skills as well and realizing that they are not alone and there are other people that are making positive friendships.

3) Resources

Tom: *Fundamentally again it is about having a very skilled workforce. Skilled, motivated and supportive workforce because whatever you do, again the relationship is*

fundamental in this area, so you need people that are not just operating from good intentions, not just operating from a text book but processes in place that constantly support your workers give places of review and places of development, that is the first thing that you need, second thing you need is that you need a name that is accepted by young people. The organisation as a whole...on the Help-line for instance you talk about the brick mother, not on the phones, but the understanding is that Youthline becomes the internalized object. It is not Tom that answers the phone, because it maybe Jo who answers the phone next, or Sue, but overall the young person is at risk and they get into the process of ringing Youthline and they get on going good enough experiences and it starts building something which will help them take the next step, but the actual entity itself needs to have a good name and a name that has got validation in the community. You need to have...when we developed the centre we could have gone to the youth club and we decided that we wanted a youth centers community centre not a youth club because youth clubs traditionally get patched, become unsafe places for vulnerable young people. A community centre where there is old people young people, where you would be comfortable with a briefcase or a skateboard enough, is what we are trying to create, so the venue, the environment that you create is very important. To have the process of being able to have the ongoing development, human resources, upskilling, your workforce connected enough with the other sectors is very important and of course money. Money alone wont do it, you can have money and spend it in a dumb way and it is not that useful but also you have wages to pay, rates to pay, insurance to pay, training and development to pay and so money is a very necessary part of the mix.

Mike: *We have got the family therapy as well and the pregnancy centre and the alternative school that we have here. That is for young people with behavioral problems or people who have been kicked out of school and not been able to be allowed back in. They come here and do school here and we try and get them back into mainstream again. Right now we have 12 students.*

And they can really make a degree there too?
What we do is we bring in correspondence work but we provide them with a timetable and a structure in which they have to get those topics covered. We also take them out and do sports and teach them cultural stuff and do stuff on alcohol and drugs and personal development stuff as well. We have to make it interesting.
So that is it, face-to-face counselling, family therapy, the different groups...

But you just have mainly the N.E.X.T and the V.O.I.C.E group?
For young people, yeh. Also we have got our Waitakere Police Youth Club, where that is from intermediate aged kids, 10-15 year olds will meet up there on a Tuesday night and we play sports and games and stuff and then we run a few programmes there around stress management and things like that as well and give them a chance to check in how their week has been. We have Youthline people working there alongside the police. Then we go out on camps and they have got people from Youthline there, like me and a collegue to check in with every week. We do a lot of, oh, so what has been up, or like maybe one of them has been uplifted by CYPS, their mum is sick and then ... you know, just supporting them that way. Maybe ringing them up during the week. So there is that as well.

So that is kind of like the youth centre you mentioned before, kind of, where they can just meet and hang around.
Yeh, they feel really safe there, in a way.

Christine: *Mostly we have created resources for ourselves. (……..) we are trying to create something, teacher education for schools and setting up new links for long term (…….) pregnancy counselling services, networking a lot with other organisations and we do know what is out there and we can use (……..) we have got a fairly good library, not just books and videos but huge filing cabinets full of information that we can tap into. I think what we create with our training programme, a lot of young people and older people come through the programme and get a lot more experience and understanding of what is going on out there in the world and I do believe that even if they don't stick around with Youthline and work as counsellors here, they are going to create a ripple effect of more people getting out there in the community and understand and are helpful.*

Megan: *There is a group who goes in and does role plays in schools, there is an alternative education group who go out to schools as well and do 8 or 10 sessions on specific topics like if there is a lot of bullying in the school they do bullying or anger management or standing tall...*

How does that work, is the school just asking for such a group or is Youthline going to every school asking if they need something like that?
We send information to every school, every year or so often and then the school rings up and asks for what they want specifically and then we have the alternative school as well for adolescents that can't manage staying in the normal school, that have been expelled lots, drugs, alcohol, that sort of thing and they can come here and we have a school system, we have ten kids, that is another support and then we have the phone and we have the youth groups as well.

Do you know how many groups you run during one year?
The young peoples groups, there is only two a year.
Actually V.O.I.C.E and N.E.X.T last year and I don't know about next year.

And how many members does such a group normally have?
About 14 – 16. Something like that.

How many want to join such a group. Do you have to say to someone, no the group is full?
They have both been quite new, just two years. V.O.I.C.E has gone two years and N.E.X.T, two years. We haven't even advertised much because it is just a trial and we don't have the funding, but I am sure if we advertised and had the funding we could do 3, 4, 5 per year.
And funding comes from the Government normally, how does that work?
The funding for those groups is ... Tom would know more about it but CYFS gives us some money and some schools help us pay for it and some money comes from the kids, not much.

4) Special skills of youth-workers

Tom: *We have a couple of models we work with here. There are some principals that we work from, first of all that if a person is working with at risk young people they must work from a clear methodology, they must know their basis of their work, that it is not okay just to think that you have the answer - so one of our policies is that all people that working with young people need to be suitably qualified and in on-going training, supervision processes. What does a person need to be able to work with a young person, they need to be able to manage a number of functional relationships of which I will detail and then they need to be able to manage assessment planning, intervention and evaluative processes. Because developmental young people are about, who am I with you, who am I with the world, the relationship based model becomes extremely important and there are...one model we draw upon is written up by a therapist Patricia Clarkson and the five relationships that a skilled worker needs to develop is the ability to work with the real relationship, so regardless whether you are a counsellor, a social worker, and what ever, there is you and there is me and the real relationship is very important with young people. If I went into a programme and pretended to be a 16 year old, my creditability would be shot, but if I went into a programme and I was me and I was up front, respectful but clear then we would develop a real relationship. The real relationship is the corner stone. But it is not enough, they also need to understand the developmental reparative relationship. So if you are working with young people, particularly at risk young people, there are developmental issues, either earlier or current that needs processes that will help enhance their development. Part of their relationship mix is about working through a developmental reparative experience. The third issue that they need to understand is the transferential and countertransferential model of work. It is in all ages but particularly in young people the issue of whose in charge, authority figures, and if you are working with young people you represent that and what it gets going in you, needs to be able to be managed. The fourth relationship is about being able to create an effective working alliance. So I am working with you, we might be friendly, we might be at war, there might be a bit of a struggle but we are here for a reason. There is a reason for all those...overtly or covertly but the therapist or the counsellor or the youth worker needs to understand that it is not just about having fun, though you might spend all your time having fun, but there is actually a purpose and a working alliance is about how skills the individual worker is at ensuring the relationship and the experiences are working to suit the purpose, and the fifth one is the x factor one, which is about the spiritual or transpersonal, whatever it is that wraps around and within those five relationships are important. The reason I started with the relationship model is because the relationship is an extremely important part of the work, but on the back of that a worker needs to understand mental illnesses, needs to understand cross-cultural, needs to be able to...early identification, intervention, needs to have healthy relationship skills or advanced counselling therapeutic skills, depending on the model, they need to understand the power relationship and how they manage the power relationship, they need to be able to do good family linking, linking with the social structures around a young person because the social context is incredible important when you are working with a young person, it is not in isolation, being able to do art and drama, being able to have a tool box of tricks and games that you play, being able to have a process which is about evaluating some of the best practice models that constantly come in, nationally and internationally, so there is a whole range of skills that is required, but I think that gives you an idea.*

Mike: *I think the main one is just respect really. Just the ability to be really respectful of the person, not make any judgment calls, but really be there to listen and just to feed back what you are hearing. It is alright to come in with a thing, 'oh yeh, I want to help this person out and I want to show them that there is a different way of being able to be' but do it very respectfully, so that they know that you are not someone else in their life trying to tell them what to do. Just to be a good encourager and to back them up and really show them all the good things that they are doing as well and to be really passionate about the work, you have to be, because if you don't, young people meet the energy that you provide, if you make them really fucked off, then they are going to be really fucked off too. If you are really enjoying working with them, then they are going to be enjoying that as well. You have to be really passionate about what you are doing and really into it and I think respect is the biggest thing.*

Christine: *Well certainly there are certain knowledge things that are essential. You need to know what the warning signs are, that indicate that there is a problem and to know what can often contribute to someone being suicidal. So things like mental health issues, family suicide history, family suicides, peers, because I use art and creative processes, symbolism that comes up there, that shows that something is going on and certain ways they present them, care and how they present themselves, use of language, what they do with their objects, how they view the future, hope, dreams. So...knowledge definitely, I think just that unconditional positive regard of just being there for them, just giving them the experience of being present. Sometimes they feel invisible in the world and that people are looking for something in particular that they don't fit and so really giving them the idea that I can fit with my own fears for their safety or future and whatever and still be here for them and I can accept them in here whatever they do, whether they are angry or upset or hopeless or whatever. People being able to manage their own anxiety about the future because it can get very scary and it can get infuriating. When people are just constantly in and out you can get really sick of it. It is like (.....) having good resources to be able to pull yourself through those times when you are in too much of a (.....).*

Is there any support from the organisation, like supervision or...?
Yep, everyone is in a supervision process. So we have someone that we can turn to.

Megan: *Patient and caring, you know the role model things, but also consistent, making clear boundaries, what is okay and what is not. Often I think they grow up in a family where there are no clear boundaries, that you are intruded upon or not and it makes it really hard, so if you are really clear they know where they stand and they like that being real rather than being a blank screen. Funny is helpful, if you are funny, and creative and spontaneous. A lot of the boys especially like to express themselves in their body so if you go for a walk or play basketball while you are working with them it is really useful.*

5) How much do teens know about the service?

Tom: *Well there is a number of ways that I answer that. First of all McDonalds is known by everybody and yet they spend a lot of money of advertising each year, why,*

because they want to hold their market position and also the youth area and the child area continues to grow so they have a new generation to get to. Youthline spends very little directly on advertising because we don't have the resources; though through various means get our name out there. We did a research where we interviewed 400 young people, 80% knew of Youthline. I think that Youthline is known, but if I had the financial resources, how we brand Youthline and how Youthline is understood by the world, I would like to do a lot more, because Youthline, what we are trying to do is the Youthline is synonymous with being able to seek help but it is also needs to be synonymous with youth development and youth creativity and the youth culture, so it needs to be a normal part of the world primarily followed by the place that you can also seek help because that is what we do, we work with providing help but we also work with providing opportunity, so we need to be involved with both, so I think it is known in a low key sort of way, I think the research done shows that young people do know of it as a service far more than virtually any other youth service in the country. However, it is not something that we have been able to be really proactive in getting our message out and that is very much a financial thing.

Mike: *I think that we have got a good name. Generally young people do know about us. They are not sure ... they know the name Youthline but they are not sure exactly what it is that we do. They think, oh yeh, it is a line that you ring up if you are going to kill yourself or if you have problems give us a call. They don't really know what it is that we do. When you go into a school and you say, well you can talk about anything, you can ring up and say, man I have had a real stressful week because my parents ... I had an argument, I can't do my homework and things like that. When you get to know that you don't have to wait for it to be a big thing before you ring up, it can be anything and I think that is part of the stigma that we need to break down. That it is not just for people ringing up who are in crisis, it is for anyone as well of the youth programme and stuff that we run. Sometimes I wonder too, like our client base, who we perceive our clients to be is whether it is the people that we train to be telephone counsellors. There are young people that kind of come in and do the training, personal development and then do the basic training to become a counsellor and then you see this 18.19.20 year old person standing up in front of people and talking from their heart and are really self aware of what is going on for them and you are like, Man, you have got such a head start in this life, you have got such a head start to all these people around you! There are men that are 45 years old that are not as on to it right now as you are. They are still living in the developmental age of ...you know, when they are old. When you see young men and young women that have got a lot of personal strength and really self aware of themselves you think WOW, that is what we are doing well as an organisation. That is what we are doing really, really well. It is really making leaders and people who are thinking really well and really caring people. People who are able to do things inside that whole ripple effect thing. I think that is what we do really well and I think that there needs to be a lot more to try and let young people know exactly what we are about. Although they do know about us and they do ring up all the time, it would be good ... yeh, so it is more of a preventative thing.*

Christine: *Because I do go out there to schools and do workshops and stuff, I always check out at the beginning who has heard of Youthline and, if it is a white (European) bunch, at least more than half of them have. With other cultural groups they might not*

have. Particularly Asian and Pacific Islands. It seems to be quite well known at least about the telephone service. Not so much about the other services.
More than half, but then with some of the schools we might go out to, it might be less, especially in ones predominantly Pacific Island or Maori if they already have strong community support networks.

Megan: *In Auckland, Youthline is very present. I think a lot of the schools have heard of Youthline and we have done some workshops there so I think a lot of the youth know about Youthline but there is always that extra step of actually ringing up or actually asking for help, but I think they know about it.*

6) Stigma

Tom: *We have done a little bit of a review again but generally there have been a whole lot of work in New Zealand around stigma. Stigma is about what people think about things, what other people think about things and how that influences us, but it is very much an internal process too, about what is okay for me to do and what is not okay for me to do. Our culture is very much about, 'we will just get on with it.' Pioneering sort of stock, conquering the world, dominating the world. That has produced some wonderful self reliant skills in New Zealanders but it has also added an internal barrier, so you could ask 100 people in Youthline who are actually on the phones, would they use the phone service and they are all encouraged at various stages in their training to see what it is like being a client, many would find it extremely difficult to use the service. Even people who really know what we are on about carry a barrier. So one of the biggest barriers to the utilization of the service at an individual level is the stigma we have about reaching out, even though no-one will need know that I have done it, is the shame attached and certainly again if we had the resources to be able to work to counter that, to create a culture that is much more ... it actually takes a strength to reach out, rather than a weakness would be a useful thing to do or if we could change the Youthline name to being a real funky cool place to be, more than it is, so that you are ringing in and it is like ringing for Pizza then we would be getting a little further. Structurally there are all sorts of barriers so why can't we do advertising, why don't we have the resources to provide the phone, because there are barriers to a youth based, community based organisation in our country and in fact when you think at that level, what Youthline experiences in relationship to the structures to be are sometimes similar to what a young person faces when they try and seek help. In the mental health industry the money is very much controlled by Psychiatrists and in the health area it is controlled by doctors and medical associated interventions. Structurally it is very much held by government agencies rather than money going into community agencies and then there is a high focus in this country on working with issues. We work with alcohol and drugs, we work with sexual abuse, we work with suicide, and then we start tailoring services to work with the issue, where young people, people generally, but young people we focus on carry multiple issues so the way ... Youthline's model is to be a generic service with young people and then equipping our workers with the specialisms as a back up to the generalisms, so there are a lot of barriers structurally that also affect the ability of the individual young person to access our service.*

Mike: *I think it is...they might feel like a looser or something ringing up. They might think, oh no, that is for people with problems or I don't want to have problems or they ... I don't know. I think we have a real hard time in New Zealand asking for help. I think it is because you are supposed to be staunch and be able to handle things.*

So that is what you have been taught or what you have learned that you should handle things on your own?
Yeh. Pretty sure that you should be tough enough to be able to handle it by yourself. Especially like that guys are supposed to be real staunch and tough and not show emotions or cry. Women aren't supposed to be angry and guys aren't allowed to be sad. They only acceptable emotion there is for a guy is for them to be angry, when they are at school they might do something that they are really sad about or get embarrassed or shamed about, but the only appropriate thing to do by people around them is to react to it with anger or fight or swear at a teacher, because they can't express that emotion, they use a counterfeit one to deal with it, like anger.

And you think that is still an issue?
Oh for sure. It is a massive one.

Christine: *Confidentiality is a big fear among those, who contact us. Particularly with their parents and that is a very difficult one because the majority of my clients are coming here through a parent requesting face to face counselling assistance for their child. Usually their parents are paying for the counselling, or at least contributing, and I have to work out am I working for the parents or am I working for the adolescent and who gets my fidelity in that. I have come to an approach where I am really clear with parents from the start that what the adolescents tell me is between them and me and the only reason that I would break confidentiality would be if it was a safety issue. And even then my obligation is to do* ***something*** *with it, to get supervision and that sort of thing, not necessarily to tell the parents ... but whatever I do would be considering the client's needs both in the short term and long term.*
Because I have been in situations where young people are doing some pretty dodgy stuff, which is quite risky. But when they are very distrustful of adults, and when I have just managed to get their trust in order for them to tell me and they haven't told any other adults and then I go and tell the parents, it's going to stop them telling me and so they are just going to get more closed. So the less they trust, the less they tell, and the more secretive they are, the more likely it is that they will get more isolated and more unsafe.
So what seems to work best is kind of collude with the adolescent so they are clear that I am on their side and the most common approach is where I kind of scheme with them about how to get adults on their side, which works the same in the long run. It works towards getting better communication with the adults and gets them the help that they need and getting more honest about what is going on. It doesn't work if I try and do it too fast, if I make that shift in communication go faster than they are willing to.

Megan: *The clients I have seen are mainly ... they have tried to commit suicide and then they are referred on. It is very hard to answer that. There is a stigma in New Zealand.*
I think these kids have often learned that they should deal with things by themselves and then asking for help if someone outside is really difficult.

I think New Zealand has a big thing about, 'she will be alright', 'I will be okay', and it is really strong here, I think that is from when people came here first they had to struggle really hard to get on living and work on the lands and I think it was from there, just a really harsh environment to start with and it is still prevalent.

7) Relationship between staff and teens

Tom: *I think, because it is part of the community which is quite youth centered ever though it is not about being a youth club, I think our therapists are very personable with young people and have a lot of respect of young people and again research shows is what a young person at risk needs is a well skilled, well meaning adult involved in their relationship long term. Mentoring through a long-term relationship is what is required. So we are not talking about a five-minute fix, and people say doesn't that create dependency, and I would say, I hope so. A young person who is at risk doesn't have a sense of being able to depend on the world or on themselves, so they need to have that dependent relationship for a while as they build their independence, that they can depend on one person that is consistent and skillful and that is well meaning. To me it is a fundamental mentoring role but with very high skilled people and an environment which is safe.*

Mike: *Yeh, I think there probably does need to be more* [advertising] *so that young people are more aware of the type of people are that are here. I remember when I first thought about doing the training, I was like, oh shit, maybe they are all geeks or they are all 'God' people or something. I didn't know what sort of people were here, and once I started here and saw all these really cool people and like real passionate, enthusiastic, really choice people that have become my friends now, it is like, wow, this is something totally different. I think there does need to be that stuff. Whether it happens with people visiting schools or going to ... I don't know just hanging out or... I don't know how you would do that though? I don't know how that might happen. I would be awesome to have a drop-in centre here, where people could come in and have like, spacey machines or a pool table or whatever. That would be a cool thing, where you could get Youthliners going in and then talking to people, so there is no pressure. I think that does need to happen but I am not sure how we can get that to happen.*

Christine: *It seems to work quite well to be...like a partnership between two people, so within a bigger organisation. I get supervision here and (.....) so they know that it is not something secret between them and me. Also knowing that we can link in with the other (.....) in Youthline can be quite containing that if they need to ring Youthline between sessions to get them through or on track, it doesn't feel that they are ringing somewhere else. They know we are all connected, like a community. I have had quite a few clients that prefer (.....) so they have done group training. Particularly ones who have had troubles in social issues, relating to other people and then they have been able to have a session with me and then a group session every week and they are going to get a lot of coaching and support through that process so that seems to work quite well.*

Megan: *I think we do wonderful work, I really do. I went to a conference in Wellington about youth development a couple of months ago and I saw what other work has done*

and I think the quality and education programmes here at Youthline are of a very high standard, compared to the other ones I saw there. I do think that we do wonderful work. If we had more money we could just do more, that's all.

Appendix C: Improvement

Adolescent Participants
1) Influence, which the Group has had on its members

Sue: *Quite a big influence. Just for the fact that they were and are always supportive and always asking, how have you been doing... yeah, just really good friendships. A lot of caring.*

Mark: *Definitely gives me energy. Down the week you start to get dragged down and slower and then suddenly you come to the N.E.X.T and you feel better ...*

John: *Self-realism. To show myself that I am not what the world revolves around, there is so many personalities and influences and ideas and stuff that you can't base something on your own knowledge. You have to understand other people before you can understand yourself.*

Becks: *There was a bit of an influence, like from other people as well. Also, just learning new things in the group as well. I did learn some stuff, but some nights I just felt like it was a waste of time.*

Kim: *It has a really good one. Quite a few of us that have different aspects of ... like lead different lives so it gives you a broader view how people live and their believes, their cultural beliefs, their spiritual beliefs and especially the sexuality, it lets you have a more open mind.*

You can talk about this and you talk about this stuff too.
Yeah, cause there is a bisexual guy and I think it was really good that we created an environment and they were able to say I am gay and not be discriminated. The influence that the group has had on me is probably that you can believe in yourself, not letting others get to you.

Robin: *I think more than anything it made me more tolerant of people from different walks of life. When I was younger I got into the really hard-core scene, which was hard-core and punk music and the kids there are very dismissive of anyone that is not in their scene. So for me to come to this group when everyone is on the same level and they all get on really well and they hang out, I don't understand, why are they all so nice to each other. I thought that was really cool.*

2) Changes in the attitude of the adolescents and effects of the Group

Sue: *It has helped me realise that people generally care. It has helped me grow. It has helped me realise more who I am. Also the facilitators as well as the people in our group.*
It has definitely helped me to think of other people more and what could be behind ... you know what they really show – the mask. You know, if you wear a mask, what could be behind that. Why we feel things, what we can do about it, what we usually do about it.

Mark: *My self-esteem is so much better and I find it a lot easier to communicate with people.*

So, kind of communication skills?
Yeah and because I feel a lot more comfortable about myself.

John: *Actually towards females. Our group was mainly females and I thought I had it rough, but they go through a lot. One of my friends who is in there has gone through a lot because she is female and sometimes you have to respect that.*

So you have learnt some new things about this other perspective.
Yeh, of life, because they get it so differently to males.
Yeh, and my self-esteem and ...

So you would say the V.O.I.C.E. group and the N.E.X.T. group had a positive effect on you?
Oh yeh, definitely. I think they showed me what I was really interested in. They helped me look into myself and to other people and see what was really there. One of our group members decided that he was gay during the thing and I thought that was great that we helped him decide that and tell his parents and stuff.

Becks: *Not particularly.*

So the group didn't have much influence on you, not changed you?
Not really.

Kim: *My attitude towards passion. The beginning of this year was really good, I was looking forward to it but it has really taught me that you have to take chances to ... like you are not going to get anyway if you don't take those chances and part of taking chances is that if you fail you can always try again. It has made me really brave to say, okay I may as well take the chance and if I don't succeed I can succeed later. I guess it has helped me mature faster, I am growing up faster because I have been with these other group members, two or three years older than me.*
I don't know. I used to be really freaked out about trying things because I never used to like to fail. I was like a perfectionist, but it has taught me that part of life is failing. I am not scared of failing.

Robin: *I think it changed who I am and the way that I approach people now. They are a person and it has really helped me to see that a lot better, you get to meet people and*

understand them individually and what makes them tick and where they are from and you don't judge them on their appearances or what they might come across as at first. That is the thing my mum said to me the other night, it has made me more tolerance. It is definitely a good thing because I was bloody awful when I was younger.

Professional Participants

1) In which way do your offers improve the adolescent's situation

Tom: *If I look in the issue...one of the key strategies around In Our Hands is about having processes that involve young people. I think Youthline is incredibly successful in involving young people, a cross section, those really at risk as well as those doing really well and want to get in and develop themselves, so involvement over the phones, involvement in programmes, involvement in centers across the country. I think that is the fundamental. Research again shows that if you involve young people then the resiliency increases and the risk factors decrease.*

Mike: *I think, a big thing is just that we are here. You can talk to someone who has rung up in tears and they are just really at the end of their tether and an hour later they can be laughing and you put down the phone and they can be alright. We have had a couple of people who have rang up quite a few times who are in a really isolated and depressed way of being and if we weren't here they wouldn't be alive now. I know that they wouldn't be. Also just knowing that we are here and that when they ring up that there is someone here just to listen to them and to go, right. So often young people spend all their day being told what to do and where to be and what is appropriate and what is not appropriate, judgment calls, they spend most of their day going through all that crap and then they can ring up and there is someone going, oh yes, how did you feel about that? Or what do you think about it? Suddenly they have the power, it has changed around a bit. They get a lot out of it, especially the stuff we do in schools, we get amazing feedback from those Unity and Standing Tall programmes. We get some awesome feedback from the people and we have got some awesome feedback from our alternative school here and what I was saying about the personal development groups and how people get trained to go through, they have such a head start compared to other young people that it really is amazing, they think wow, what are you going to do in your life now. It is really quite amazing. And you are going to different conferences and spending time with other youth organisations, the standard of training that we have here is really far ahead. When you look at the Youth Development Strategy and when you go in to conferences, we are all those things we have in place. A lot of those things we have in place, we are doing and we have done them and it feels really good. Just that we are here to support, I think that we do a lot of good supporting of young people.*

Christine: *It may be idealistic but I do believe that I do make a difference. People (.....) working on the phones being people ringing who often don't seem to have ... or don't believe that they have any other options and they are feeling desperate, someone to talk to so that a connection can be made and get them reassurance and a positive response from the schools. One of the effects is (.....) kids that wouldn't get counselling if they had to go and pay (.....I) think it does make a significant difference.*

Megan: *Well I hope it works well. It depends how long they can stay too. I think if they can stay for long enough the risk will go down. But it is hard to say.*

It is hard to answer, sure. How long do you think they should stay?
That also depends on them, how fast they pick it up and how deep seated their problems are, how much support they get from their family and how easy they mix with others and build up a network. Networking I think is really important. I think the suicidality usually goes down quite quickly the self-harm often stays longer. I don't know if they stop therapy and then something happens and they will go back to it or...

Do you have sometimes contact with your clients after finishing therapy. Have you ever heard how somebody is doing after the therapy?
Yeh, because I have seen some kids off and on over three years. I know some of the boys, they are still around, they are internalized some of the stuff which we are working on so that they have better self-care skills.

2) Possibilities of the professional's work

Tom: *Youthline is an organisation that has been very good at starting the development of people and in most youth services across the country is a Youthline person who was involved here or maybe started in Youthline.*
The possibilities, are that the model that Youthline has grown over 32 years, that we get so clear about that we can actually help other groups develop similar pathways of development, the possibility of us becoming very effective entrepreneurialy in business and therefore get the resources we need and therefore develop the processes across the country supporting all the other Youthlines that are struggling more than us, and why do I focus on the organisation and the business, because if the business is successful and it has what it needs and the people that it needs then we can work with young people. The issue for us is not about getting more clients because we have more clients than we can handle. It is about how we equip ourselves to deal with the people who contact us.

Mike: he just focused on the limitations during his answer.

Christine: *With the (.....) if I could make an initial connection with them and it doesn't always work (.....) it does seem to be remarkably effective for them to turn up here once a week and even if it is just unloading all the stuff that is on their mind, sometimes I don't need to do much except be here and let them do that, (.....) that does tend to be quite helpful and being able to provide them with certain ideas or ways of thinking and things, teaching them some skills how to reach their parents or teachers or (.....)*

Megan: *I feel that if I change one person's life then it is worth living and I know that I have. One of the positive things is that there only has to be one positive person in someone's life to be able to make it, that is what research has shown. Even if everything is against them, that one person makes a difference.*

Appendix D: Limitations and Boundaries

Adolescent Participants
Wishes for more or different support from an organisation like Youthline or any other organsiation

Sue: *I only know of Youthline. I don't know of any other organisations like that. Maybe another building somewhere. There is only one in Manukau or Pon-sonby. Maybe one out more this way, or North Shore, that we could go into. They are working on the phone line at the moment to try and get it 24 hour. They need to advertise more for the groups and things.*

Mark: *I think it needs to be 24 hours, which they are trying to do at the moment and I think there should be more groups like boys to mens.*
I think a lot of people don't know about organizations and groups like Youthline and Mensline and Gayline etc, all the free help services.
Yeah, and I think more advertising, but that would be after they had the 24/7 thing Youthline needs to be able to answer more calls. I think knowledge of these issues need to be more out there so that young people don't feel that they are alone.

John: *I would love the thing to go 24/7, which is what they are trying for. They don't really have enough funding.*
I think that would be really good 'cause you can't really control what time of the day... and more courses 'cause I know that there is young people that go 9,8,7 that go through the same stuff as us and we never realise it and they need the same things.
Oh, and maybe the length [of the group meetings] could be longer. Need more hours in the day.

Becks: *I don't know. I think that it was just me. I think that it was a good group, but I think it was just me, not in the right space of mind.*

So no particular wish that you could imagine, I am talking about generally for the next group, something you would wish from an organisation like Youthline for yourself?
No.

Kim: *I think they need to be more advertised and like I said about the Salvation Army teen type things and I think if they were more advertised and more ... they really need to get out there to bring people in to create a bigger organization, because we are ... phone line counselors ... cause like if you ring up, cause my friends have rung up a number of times, it is so hard to get in because there is only so many, but if they actually brought people in, we would be able to have more phone counselors. But overall I think they are really good. I think they should have more groups, a sexuality group, a teen*

pregnancy group, more stuff to do with sexuality transmitted diseases, alcohol and drugs.
Teenage Forums where everyone comes in. But I think that they are really good, they cover such a wide range of things.

Robin: *I think not so much for myself but I think what I was saying before, I think they need to pour money into it so that it can go into schools so they can further what they are doing here because it is a really good thing. More of the group stuff, it is just fantastic.*

Professional Participants
Limitations and changes, being necessary or helpful in their daily work

Tom: *Youthline is an organisation that has been very good at starting the development of people and in most youth services across the country is a Youthline person who was involved here or maybe started in Youthline. What we have not done well and again it is a resource and also a retention thing, is being able to retain people. We have got some people here that are long term, but generally we need to be able to retain the most skilled at the coalface. Our team is developmentally young, which means that they maybe incredibly experienced but developmentally as far as being a professional in the wider world, it is a young think and part of the issue of being able to hold and retain people who provide a lot of years of volunteering work, put a lot of years into external study, is that they want money now, and naturally so, and if you have put all that sort of work in you should get paid reasonably well. We have a challenge to meet that and therefore we have a challenge to retain the people that we need. One of the issues on our limitations is that our workforce, though highly skilled is young developmentally and we have trouble retaining the most experienced because of the resource issue. The other issue is that again, alongside that, I believe one of our limitations is that...and it could of course be the opposite as well, is that Youthline, because of what it is, because of its marginalisation with money, we also need to be a very good business, we need to be entrepreneurial, we need to be able to identify ways of earning our keep because we are not going to get it given to us, so one of our limitations is that we have to put so much of energy into earning our money. The flip side of that is that if we develop a team that can do that, we end up with an incredibly creative and powerful and functional team, but certainly at this point in its development, it is more of a limitation, that people would prefer the money issue to go away and just give me my money and I could do my work. So that is another developmental issue is again...a lot of these are about resources is that we have various services and programmes and one of our limitations is how they work collectively together so in some ways we are still reflecting the wider world and its fragmentation of services, maybe not so spread out as the wider world, we still have a developmental edge of being able to work the interface between our services.*

How many staff do you pay and how many volunteers work here?
24 fulltime and employed and paid staff, spread out over about 100 people. So some are only paid for a few hours some are paid more. That is 24 fulltime equivalents and about ... in the Auckland region 560 volunteer staff and about 800 national. It is very interesting, we are a small organisation, but in another way we are a large

organisation, we have 800 personnel. The limitations are about our development and embracing what we need to be and our limitations are also the things, the hurdles that we need to jump that are imposed by the structures that are out there. For instance Youthline gets no mental health money, from the mental health area. If we even got enough to employ 2 or 3 fulltime staff, what we could actually create here would be tremendous.
The vision that Youthline is a name that is synonymous with youth, creativity, potential, passion and help and if that was as well known as the yellow arches, then we would achieve what we are actually on about.
Well there is a few things that we need to do and I will start at a personal level, we need to people replace with people that are very excited about the possibility of being an entrepreneurial business that services a charity purpose. Secondly we need to strengthen the interactional ability between our departments, out of that we will achieve a sense of Youthline serving its mission, which is to provide community training and development and service provision, so that young people have the opportunity to reach their potential and get help on the help line. Broader than that, to be in a position where we can influence government to make decisions that would be helpful to young people and helpful to the sector, would be good. I think that developmentally there are things that we need to do internally and when we get to that point, then we need to be able to influence the world better.
I just underline the need for multidisciplinary teams, well skilled workers working with young people on an ongoing basis is the key to success when working with young people.

Mike: *The big one that we are working on at the moment is to get the phone line 24 hours. That is a big one. Funding is a big pain in the arse.*

Are you a volunteer or do you get paid here?
All the stuff I do on the phones is voluntary but the stuff I get paid to do the programme in schools, I get paid for working at the alternative school and I do a bit of administration stuff here too and get paid for that. Some things I get paid for and some things I don't. It is really sad, the schools that can't afford to have the programmes put in place there are the ones that really need it. They are really struggling but we have to draw the line somewhere and say we can't do that. It is so frustrating not being able to source funding from places to try and put those programmes in place when they are needed. The more higher decile schools and schools that can afford it, that is all good but it widens the gap because less people start going to those schools and go to the other schools and then they can afford to do that more and they get better and then the other schools slowly start fading away and getting in to trouble. It is really quite frustrating.

What improvement or wish changes could you imagine being necessary or helpful in your work and what wishes concerning your daily work?
To get some government funding would be good. To have a drop-in centre would be really choice.
To link stronger nationally, would be really good. We usually have a national conference once a year, and it is really cool, it is just hard to keep in contact during the year, you feel quite separate even though you can hook into the e-mails, it is really choice getting to know all the...you get a really stronger sense that there is so many

other people out there doing the same thing and it makes you feel really good. It makes you feel that things are going to be able to change. It would be cool to have exchange programmes where you have young people in Otago coming up and staying in Auckland and have people in Auckland going and staying down the South Island on a farm. To have those different experiences, have things like that. Go stay there in the holidays or whatever or maybe even having half a semester at school there or something and have that exchange thing happening, just to see different walks of life, to totaling spin around and change things, that would be really cool. And once you do start traveling you get to see what you have got in your own place as well.

Christine: *Boundaries ... a lot of occasion's money is still a problem. Once you get some indication about their parents paying, parents can find it difficult paying, sometimes the parents see an improvement and then want to withdraw them and it is very hard to explain to the parents why it is important for them not to be withdrawn when you can't tell them what you are seeing in therapy, so it has been very frustrating having young people who have started to improve and then they have been pulled out of therapy and I can't tell parents what you don't know (.....) and if you pull her out of therapy she will probably go back to doing that. But I can't say that, so those sorts of things get frustrating. It would be good to have a wider range of counsellors from different cultural groups. We have got very few Asian resources and there is a lot of Asian students out there who don't have much support. They are away from their family, away from their cultures, struggling with English. Maori and Polynesian kids who have been brought up in their own cultures and yet completely exposed to western cultures and sometimes finding support people in their own cultures is a solution because they can't talk about the conflicts. That can be very tricky, and I don't get their culture either. Not enough psychiatric services and (.....) I have often tried those people in Community Mental Health Services and stuff and just find them incredibly difficult using them. They are quite uncooperative.*

What improvement or which changes could you imagine being necessary or helpful in your work?

More funding. Probably a lot of it comes down to money because we have to really (.....) but it would be better if we had more people on our team. But it is a hard thing to justify because we are doing a portion of our work for free and people have spent a huge amount of time and money on their training and they want to get out there and be earning a living to make up for the time out of the workforce, training. It is quite a sacrifice in an organisation like that where you do end up putting in a lot of time for work you don't get paid for. If there was more money around where they could fund us more it would make a number of things possible. The extra time you put in you could get paid for.

Megan: *What is really hard is letting them go at the end of the session when they are still not feeling well and trusting them that they will ring Youthline or talk to someone, you still have the contract but it is hard to trust that. I can only do as much as they take on board, you give them lots and if they don't take that on board then that is a limitation, when I have to let them go and trust and hold the trust for them ... the other one is my own self care. I need to let it go at the end of the day and live my own life and that is also hard.*

Yeh, and money. I think this is a good place to work. It is just very busy. There is structural problems because we have grown so quickly. We have expanded so fast that some of the systems are not in place. In my day-to-day work I usually work around it really.

It doesn't effect you directly or your work?
It affects the people holding me. I could always use more support really and that is just a matter of asking for it and money is part of that. More supervision, more choice of who our supervisors are.

So do you directly get paid from Youthline?
I don't get paid. I get paid for the groups but not for the face-to-face work. If we were to get paid we wouldn't be here. There is no money to pay us so ... I think if we insisted on pay then we couldn't do the work that we do.
This is a country where 3,500,000 people, it is nothing like Europe, there is no money around. There is not the amount of people to pay for it. We have lots of funding from different organisations but yeh.
And there is a payoff because I am doing this as my placement as well which I wouldn't have been paid for anyway and there are lots of training opportunities and I got into my course because I have my Youthline experience and I will probably get a job because of my Youthline experience, so that is the payoff as well.

What improvement or which changes could you imagine being necessary, what would you just wish for your work?
I wish that this building was better. I work in a different building on the North Shore and this is not really a nice enough area to invite clients into, I find. So my private clients I wouldn't take to these rooms, they are not good enough. The structural stuff, um ... just my own personal trust in my own work. I am over careful but I could be more powerful if I trust myself more, that is developmental.

Appendix E: Information Sheet Adolescents

[Massey University Letterhead]

"Working with distressed Adolescents and Professional Intervention Adolescent Suicide and Professional Response in New Zealand"

Information Sheet for Adolescent Participants

My name is Katja Saumweber. I am a Social Worker from Germany and now studying at Massey University in Albany. I am doing this research for the thesis for the Master of Philosophy (Social Work) degree
My supervisor is Associate Professor Mike O'Brien, Head of School, Massey University, College of Human & Social Sciences.

You can contact me via phone: 9 836 6130 or email: katjasaum@gmx.de, as well as Mike O'Brien via phone or email: Phone: 9 441 8161, email: M.A.Obrien@massey.ac.nz

1. What's the study about?

The issue of my research is "Working with Adolescents at risk – Adolescent Suicide and Professional Responses". With this research I want to collect some information on the risk factors associated with youth suicide and what could be done to prevent this self-destructive behaviour. You will be able to talk about your needs and concerns and what you expect from an organisation like Youthline.

2. Nature and Duration of your Involvement

I am interviewing you for approximately one hour. The interview will include questions about yourself, your family and friends, your thoughts about the future, and questions about things to do with suicide. The interviews will be hold at Youthline.

3. How I obtained your name to ask for participation in the project

I contacted Youthline, and contacted the director who linked me to other co-workers. They then offered me the opportunity to join your weekly meeting so that I can meet you and ask you if you would be interested in participating in my project

4. Is there any risk for you?

This interview is a chance for you to be heard, to say what you think about the topic, to talk about what concerns you the most.
It is also possible that, the interview and the discussion about these issues may lead to some upset and distress. If this happens I will talk to you about what assistance you need and encourage you to use any services you feel comfortable with, like for example Youthline. You will also have the opportunity to talk before and afterwards to your supervisor at Youthline.

5. What am I doing with the information?

The information, which I will get from the interviews will be written down in my thesis. I may also write an article about the results.
I will offer you a summary of the results. Another possibility is a seminar at Youthline, in which I will talk about the results in front of all interested participants and other co-workers of Youthline.
You will not be identified in any publications.

6. How is your privacy protected?

No names or any other identifying features will be included in the final thesis, the summary or any article
The interviews will be audio-taped if you feel comfortable with it.
The transcription will be done by a transcription service, which has to guarantee anonymity and confidentiality by signing an agreement.
No information will be given to Youthline about your comments. The only information that will be provided will be a summary of the comments. You will be shown any of you quotations, which I want to use and will have the opportunity to request that these be changed at any time until the final draft is finished.

7. Security of Data

As long as the data is required it will be stored safely. Once I finished my thesis you can decide whether you want it to be destroyed or to be returned to you.

8. Your Rights

I would like to invite you to take part in this research project. You have the right to decline to participate, to decline to answer any questions, to withdraw from the study until the transcription has been completed, to ask any questions. Further your name will not be used unless you give permission. I will send you a summary of the findings.

This project has been reviewed and approved by the Massey University Regional Human Ethics Committee, Albany Campus, Protocol MUAHEC 02/061. If you have any concerns about the conduct of this research, please contact Associate-Professor Kerry Chamberlain, Chair, Massey University Regional Human Ethics Committee, Albany, telephone 09 443 9799, email K.Chamberlain@massey.ac.nz.

Appendix F: Information Sheet Professionals

[Massey University Letterhead]

"Working with distressed Adolescents and Professional Intervention Adolescent Suicide and Professional Response in New Zealand"

Information Sheet for Professional Participants

1. Introduction

My name is Katja Saumweber. I am a Social Worker from Germany and now studying at Massey University in Albany. I am doing this research as part of a thesis for the Master of Philosophy (Social Work) degree.
My supervisor is Associate Professor Mike O'Brien, Head of School, Massey University, College of Human & Social Sciences.

You can contact me via phone: 9 836 6130 or email: katjasaum@gmx.de, as well as Mike O'Brien via phone or email: Phone: 9 441 8161, email: M.A.Obrien@massey.ac.nz

2. Nature and Purpose of the Study

The topic of my research is "Adolescents at Risk and Professional Intervention." With this research I want to collect some information on the question of the risk factors associated with youth suicide and what could be done to prevent this self-destructive behaviour. I will further explore special needs of the youth and have a look at the extent to which the needs are being met by the services provided by Youthline. What resources do an organisation like Youthline commit to meet the needs of adolescents. How well do professionals and the adolescents work together, and are the needs and expectations of the adolescents met by them? In what ways can the assistance provided by Youthline improve the adolescents' situation? Does this contact have any influence on the risk factors (like for example, on low self-esteem or the problem of social isolation) for suicidal ideation?
The research interviews will explore risk factors and needs of adolescents and offer a close and critical look at actual prevention and intervention programmes, at their possibilities and limitations.

3. Nature and Duration of the Participant's Involvement

You will be asked to participate in an interview, which should not last longer than 1 hour. In the interview you will be asked about your work with adolescents especially concerning suicidal issues and the work of the organisation. How does your work and the work of the organisation fit with the needs and expectations of the adolescents? What experiences do

you have, what kind of prevention and intervention programmes do you use or offer? What kind of skills do you have to handle such problems carefully and helpfully? And, lastly, what opportunities, challenges and limitations do you face during your work, and what ideas for improvement do you have. The project is not evaluating your work, but seeking your experiences and ideas in order to contribute to the development of the Youthline programme.

4. How I obtained your name to approach you about participation in the project

Firstly organizations were contacted, which work with adolescents providing counselling, which work with prevention and intervention, and address problematic behaviours in adolescents. With the help of my supervisor I contacted Youthline, and it's director and was linked in to other co-workers.
To make contact with the adolescents I prepared an extra information sheet for them, which was handed out at a group of adolescents at Youthline. If the adolescents then wished to participate they could contact me via email.
This information sheet for service professionals invites you to participate in an interview to discuss your experiences as a worker at Youthline and to talk about the services offered.

5. Use of Information

The information will be reported in the form of a thesis. I may also publish an article about the results. These results will may serve as a form of feedback for Youthline.
I will offer a summary of the results to all participants. There is also the possibility of a seminar at Youthline House, in which I could talk about the results to all interested participants and other co-workers of Youthline.

6. Confidentiality and Anonymity

I ensure anonymity and confidentiality and I will take particular care in respect of these two issues. Therefore no names or any other identifying information will be used in the thesis, the summary or an article.
The interviews will be audio-taped if you feel comfortable with it. I know that audio-taping leads to special attention to protect confidentiality and security of data. Priority always is the protection of privacy of individuals and institutions.
The transcription will be done by a transcription service. To ensure anonymity and confidentiality a Confidentiality Agreement will be obtained from the person transcribing tapes. This person will have to sign this agreement so that all original data as well as the transcripts will be returned to me and confidentiality will also be guaranteed by the transcribing person.
You will not be identified in any way. You will be shown any of your quotations, which I want to use and will have the opportunity to request that these be changed at any time until the final draft is finished.

7. Security of Data

To secure the data I will separate records at remote sites, some at a box in the university and some at home.

I will also store taped information from the transcripts separately.
Once the data is no longer required for this particular research project the participant may choose whether the material should be destroyed or whether the data should be returned to them.

8. Participant's Rights

You have the right to decline to participate, to decline to answer at any time, to withdraw from the study up to the point that the transcription has been completed, and to ask questions at any time. I will provide access to the findings in the way, described within point 5.

This project has been reviewed and approved by the Massey University Regional Human Ethics Committee, Albany Campus, Protocol MUAHEC 02/061. If you have any concerns about the conduct of this research, please contact Associate-Professor Kerry Chamberlain, Chair, Massey University Regional Human Ethics Committee, Albany, telephone 09 443 9799, email K.Chamberlain@massey.ac.nz.

Appendix G: Question Framework Adolescents

Generally I will do these interviews in a semi-structured way. That means I will have these questions in mind but let the interviewee speak as freely as possible. He or she should really feel at case and should only talk about things, which they feel comfortable to discuss.

I. Introductory Questions about the person

1) How old are you?
2) Which ethnicity/cultural background do you have?
3) Do you still go to school or do you work? Which kind of school? Which kind of work? Unemployed? If yes, how long? How does this feel like?
4) How long have you had contact to Youthline and why?
5) How did you make contact to Youthline?

II. Family

1) Can you please tell me something about your family background? (Parents still together? Siblings? What do your parents do for work? Etc.)
2) How is your relationship like with your parents/siblings?
3) Is your family very religious?
4) Are you very religious?
5) Does the religion or any other cultural norms have any direct influence on your daily life?

III. Peer-group

1) Do you have any other close relations- or friendships? (Boy- or girlfriend)

2) Do you generally think such a friendship is important? Please explain your answer (why).
3) What do you think about your friendships? Can you "count" on them? What do you think is generally important concerning a good friendship?

IV. Yourself – Your Future Perspectives

1) Now if you have to describe yourself with 5 or 6 words, what would you say? What do you think about yourself? (Self-esteem)
2) What do you think about the future? Do you have any concrete plans/wishes?

V. Suicide

1) What do you think could be reasons for any suicidal thoughts or feelings in young people?
2) What helping possibilities do you know in such a case?
3) What helping possibilities would you wish to receive in such a case?
4) What do you think are the general needs of young people in New Zealand society to live a happy life?
5) If you had the opportunity what would you ask a politician for?

VI. Now some questions concerning your contact to Youthline

1) What do you generally think about the "N.E.X.T." group?
2) Which kind of influence does the group have on you?
3) Has anything changed in your attitude since you joined the programme? What effects has the group had on you?
4) Which kind of relationship do you have with the facilitators?
5) Which kind of relationship do you have with the other members?
6) What wishes could you imagine for more, or different support from Youthline or any other organisation?
7) What wishes do you have for your personal life future?

Do you now have any completions to make, any ideas, what else could be interesting here?

Thank you very much for your support, your openness and your time. I'll send you a copy of the transcripts, so that you can check them and if necessary make any changes.

Now before I let you go one last question: How do you feel now? Distressed in any way?

Appendix H: Question Framework Professionals

I. Introductory Questions about the person

1) What is your profession?
2) What is your professional career?
3) Since when have you been working with distressed adolescents?
4) Since when have you been working for Youthline?

II. Guidance Questions

5) What are the main reasons of your clients to contact you?
6) How often do you have to deal with a suicidal issue (per week for example)?
7) Which reasons for suicidality have you recognised in your past work?
8) What are generally needs of teenagers (probably especially New Zealand teenagers)?
9) Which are special needs of suicidal youth?
10) How much do the adolescents know about your organisation/service?
11) In which way is normally a contact built?
12) How long have they been suffering from any kind of problem till they call or contact your organisation?
13) Do you know anything about fears concerning contacting you/your organisation?
14) Are there any official guidelines from the Government concerning suicide prevention?
15) If yes, in which way has Youthline been informed about it and in which way does Youthline try to meet governmental recommendations?
16) What programmes can you offer to a suicidal adolescent?

17) Is there a special prevention and intervention programme, with which you work? (A special methods/techniques)?
18) What skills do you think a staff member (social worker) should have to work successfully (especially concerning the suicide issue)?
19) What resources/offers do an organisation like Youthline have to meet the adolescent's needs?
20) In which way do you think your offers improve the adolescent's situation (again concerning suicidality and risk factors)?
21) What do you think about the connection, the contact between professional Youthliners and adolescents?
22) What possibilities and boundaries do you see in your daily work?
23) What improvement, which changes could you imagine, being necessary or helpful in your work (concerning for example, prevention and intervention)? What wishes do you have concerning your daily work?

Appendix I: Consent Form

Working with distressed Adolescents and Professional Intervention
- Adolescents Suicide and Professional Response in New Zealand -

CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions.

I understand I have the right to withdraw from the study until the transcriptions have been made and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.
(The information will be used only for this research and publications arising from this research project).

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio/video tape to be turned off at any time during the interview.

I understand the potentially sensitive nature of this study and I will arrange appropriate support for myself if my involvement causes me any discomfort.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: .....

Name: .....

Date: .....

Appendix J:

Massey University Ethics Committee Approval

Massey University

Office of the Principal
Massey University
Albany Campus
Private Bag 102 904,
North Shore MSC,
Auckland, New Zealand
Principal: 64 9 443 9700 ext 9517
Regional Registrar: 64 9 443 9700 ext 9516
Facsimile: 64 9 414 0814

2 September 2002

Katja Saumweber
C/o Associate-Professor Mike O'Brien
School of Social & Cultural Studies
Massey University
Albany

Dear Katja

HUMAN ETHICS APPROVAL APPLICATION – MUAHEC 02/061
"Working with Distressed Adolescents"

Thank you for your application. It has been fully considered, and approved by the Massey University, Albany Campus, Human Ethics Committee.

If you make any significant departure from the Application as approved then you should return this project to the Human Ethics Committee, Albany Campus, for further consideration and approval.

Yours sincerely

Associate-Professor Kerry Chamberlain
Chairperson,
Human Ethics Committee
Albany Campus

cc Associate-Professor Mike O'Brien
School of Social & Cultural Studies

Appendix K: Confidentiality Agreement

Confidentiality Agreement

From: Katja Saumweber (Owner)

To: Transcribing Person

Dated: 30/08/02

"Working with distressed Adolescents and Professional Intervention"
- Adolescent Suicide and Professional Response in New Zealand -

With this agreement the transcriber guarantees that all information, all the data, which he or she will get for transcribing will be kept confidential. All tapes, hard copies, computer discs and transcripts will be completely returned to the researcher.

Yours faithfully

.....

Agreed and Accepted:

.....
Signature

Date:

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