RESEARCH TO PRACTICE NETWORK

Doing Youth Suicide Prevention Critically: Interrogating the Knowledge Practice Relationship

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The **Research to Practice Network** is a contingent of scholars and researchers working in collaboration with CoreBC and the Federation of Community Social Services of BC to provide practitioners with insight into emerging research relevant to the field of community social services.

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This paper could go a couple of different ways. First, I could stick with the task I understand I have been asked to complete as part of the "Research to Practice Network," which is to provide a concise and accessible review of current research on a topic I am deeply acquainted with, which in my case is youth suicide prevention. If I am successful with my task, so the thinking goes, then readers who work in a range of diverse roles providing care and support to children, youth and families, will be brought up-to-date on what the research says, and by implication, on what they ought to be doing to reduce risks for youth suicide and suicidal behaviour. I have written several versions of these types of papers over the years (see for example White, 2003; 2005) and believe these types of summaries can often be very useful to practitioners.

A second, more appealing option is to use the space I have been given to critically reflect on many of our common sense assumptions regarding the relationship between research and practice, using youth suicide prevention as a site for some of this exploration. Given my longstanding professional and scholarly interests in advancing more inclusive, dynamic and critically conscious models for conceptualizing the knowledge practice relationship (White, 2007a; 2007b), I would like to make this second option my point of departure.

A Different Starting Place

It probably goes without saying that those of us practicing and studying in the suicide prevention field want to engage in and support practices that promote the well-being of youth, families and communities. Ultimately, we want to do those things that have a strong likelihood of reducing suicidal behaviour among young people. While we may all agree with this ultimate goal, the values and ideologies guiding our work, the way we conceptualize and position ourselves as researchers and interveners, and the underlying assumptions regarding the role of empirical knowledge in helping us to achieve desired ends take on widely divergent and unsettled meanings depending on our particular worldview, culture, and intellectual tradition (Fullagar, Gilchrist & Sullivan, 2007; Cheek, 2007; White, 2007b). One of the aims of this paper is to show some of this complexity and unsettledness while never losing sight of the practical need to support practitioners to work constructively and ethically to prevent youth suicide and suicidal behaviours; an orientation that has something in common with Patti Lather's notion of a "double(d) practice" in which we are "doing and troubling" the practice simultaneously (Lather, 2007).

Importantly, doing youth suicide prevention critically does not mean doing your own thing, ignoring the research literature or engaging in distant intellectual theorizing that has no practical benefit "on the ground." It *does* however mean that terms like research, evidence, and knowledge are not accepted as unproblematic givens, and phrases like "research *to* practice" – with their embedded assumptions about the one-way transmission of privileged academic knowledge – are open for scrutiny.

Clarification of Aims

The youth suicide prevention literature is voluminous and reflects the contributions of researchers and scholars working across a number of different disciplines and traditions, including: psychiatry, philosophy, public health, psychology, sociology, medicine, nursing, social work, counselling, education and child and youth care. The burgeoning literature and the existence of varied theories and multidisciplinary approaches attest to the complexity of the problem of youth suicide and underscore the need for comprehensive, multi-pronged strategies. I am going to limit my summary and critique of the current research

literature to two broad areas, incorporating topics that I hope will be of utmost salience to child and youth serving practitioners: (1) conceptualizations of risk and resilience and (2) evidence-based practice in youth suicide prevention. For readers who are interested in accessing a fuller discussion of the current research and recommended practices in youth suicide prevention go to http://www.mcf.gov.bc.ca/suicide_prevention/

In the following sections I will summarize the current knowledge base regarding the prevention of youth suicide while simultaneously attending to the ways in which narrow and traditional notions of evidence bring certain knowledges into view while potentially concealing other ideas and possibilities (Cheek, 2007), including local, cultural and relational considerations (Issacs, Huang, Hernandez & Echo-Hawk, 2005), findings generated from qualitative studies (Gilgun, 2006) or the lived experience of practitioners and/or service recipients. One final point is in order; critique, in the way I am using the term here is not meant to silence, discard or replace other traditions, but instead is conceptualized as an opportunity for revitalization and enrichment (Gergen, 2000).

Conceptualizations of Risk and Resilience

After motor vehicle fatalities, suicide is the second leading cause of death among youth aged 15 to 24 in British Columbia. Over the five-year-period, 2000-2006, there were 137 suicides among B.C. youth aged 15-19 (BC Vital Statistics, 2006). For every female death by suicide there are typically three to four male suicides. Non-fatal suicidal behaviours are also common among youth in B.C. Approximately 7% of all BC youth, grades 7 to 12, have made a suicide attempt in the previous year and 16% have seriously considered it (McCreary Centre Society, 2004).

Recent reviews of the suicidology literature confirm that there are a number of factors that have been strongly linked to suicide and suicidal behaviours among youth. Mental health problems, particularly mood disorders, anxiety disorders, substance use disorders, eating disorders and disruptive disorders have all been associated with elevated risks for suicide and suicidal behaviours (Evans, Hawton & Rodham, 2004; Gould et al., 2006; Steele & Doey, 2007). Previous suicidal behaviour, including prior attempts and behavioural rehearsal are significant risk factors for further suicidal behaviour (Gould et al.; Spirito & Esposito-Smythers,

2006). Hopelessness, aggression, recklessness and impulsivity are qualities that have been strongly linked to suicidal behaviour (Gould et al.; Steele & Doey). Family factors, including high levels of conflict, parental mental illness and a family history of suicidal behaviour can further elevate the risk for suicide among youth (Steele & Doey). Many youth who die by suicide have a history of childhood physical and/or sexual abuse (Spirito & Esposito-Smythers; Steele & Doey). Stressful life events, which typically precipitate suicidal acts, further contribute to suicide risk among youth, especially in combination with existing vulnerabilities. These commonly include: interpersonal conflict, rejection, failure, humiliation, and loss (Gould et al).

While protective factors are less well-established (Berman, Silverman & Jobes, 2006; Steele & Doey, 2007) preliminary evidence suggests that the following factors may serve to protect youth against a range of social problems, including suicide: strong individual coping and problem-solving skills, experience with success and feelings of effectiveness, strong sense of belonging and connection, interpersonal competence, family warmth, support and acceptance, success at school, strong cultural identity, and community self-determination.

Critically Reflecting on Ways of Knowing

Lists and summaries of risk and protective factors can provide us with valuable insights about which clusters of risk factors might warrant vigilance and follow-up in particular individuals. They can also be a useful reference point when thinking about how to conceptualize a research informed, comprehensive, community-wide youth suicide prevention strategy. At the same time, there are a number of cautions we should bring to our reading of these empirical "facts." First, multiple risk factors for youth suicide exist and they interact in complex ways making it impossible to describe a singular profile of a "typical" suicidal youth. Second, our knowledge of risk factors is typically based on statistical generalizations, which tend to conceal the unique and particular circumstances of individual lives and deaths. Third, risk factors are dynamic and they vary in their severity, which means that certain combinations of risk factors may elevate risk in some individuals but not in others (American Psychiatric Association, 2003).

At another level, if we pay close attention to our everyday language in the human service sector, we begin to notice that "risk" is often discussed as if it is located

within individual bodies, like males, or Aboriginals, or gay, lesbian, bisexual, transgendered (GLBT) youth. We see evidence of this way of thinking in the suicide prevention literature when we read about ethnicity, gender or sexual orientation being treated as stable and singular "demographic variables" as opposed to socially constructed relational realities characterized by multiplicity (Gergen, 2000). A critically reflective orientation might lead us to question the conventional way of putting things. Specifically, we might want to ask ourselves, what are the consequences of locating risk within persons or races (e.g. "Aboriginal suicide")? More importantly, what fresh possibilities might be opened up by thinking about risks for youth suicide in other ways? For example, what difference does it make, if any, to understand and locate risk for suicide within oppressive social practices, like racism (Goldston, et al., 2008), colonization (MacNeil, 2008), heterosexism (Scourfield, Roen & McDermott, 2008) or narrow and limiting definitions of masculinity (Smalley, Scourfield & Greenland, 2005)?

From a knowledge generation perspective it is also important to acknowledge that the social, political and historical contexts of young peoples' lives are often not "seen" following their death by suicide due to the limited reach of many retrospective analyses and data collection tools (e.g. the psychological autopsy). These approaches to studying suicide, while valuable, also have limitations. Specifically, they are generally restricted to documenting those risk factors that can be named and/or measured. As Albert Einstein famously said, "everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted."

Finally, like conceptualizations of risk, resilience can be fruitfully viewed in this more complex and dynamic way as well. For example, according to Ungar (2008), resilience represents three overlapping domains: (a) the capacity of individuals to navigate their way to resources that sustain well-being; (b) the capacity of individuals' physical and social ecologies to provide these resources and (c) the capacity of individuals and their families and communities to negotiate culturally meaningful ways for resources to be shared. When we move away from seeing risk and resilience as exclusively individual traits and embrace a view that recognizes risk and resilience as a series of flexible and shifting possibilities (or narratives) that are embedded and enacted within social, political, historical, local, and relational contexts, we bring an expanded view to our work; one that can accommodate an ethic of justice and care (Smith, 2006).

Evidence-Based Practice

Most of us have become intimately acquainted with the highly persuasive idea that our practices should line up with the research evidence regarding "what works," a notion that is at the heart of the evidence-based practice (EBP) movement in health and social care fields. EBP is an approach that is historically rooted in medicine and emphasizes the contributions of science in determining what actions should be taken to reduce risks and effectively treat individuals who are contemplating suicide. Quite simply, EBP means that practitioners are applying the best currently available research evidence in the provision of services (Waddell & Godderis, 2005).

In keeping with trends elsewhere, there is a strong emphasis in the suicidology literature on using the ideas and findings from science to address the problem of youth suicide and suicidal behaviour (Berman, Jobes & Silverman, 2006; Macgowan, 2004). Even though there is a scarcity of any conclusive research evidence there are varying degrees of empirical support for the following suicide *prevention* strategies: social support enhancement and problem-solving interventions for high risk youth (Eggert, et al. 2002; Gould, et al., 2003), youth skill building (Fitzpatrick, Witte & Smith, 2005; LaFramboise & Hayes, 2008); education of health professionals (Pfaff &McKelvey, 2001) peer recognition training (Aseltine et al., 2007: Portzky & Heeringen, 2006), school and community gatekeeper training (Capp, Deane & Lambert, 2001; Chagnon et al. 2008); means restriction (Hawton, 2002) media education (Gould, Jamieson, et al. 2003), and facilitating community self-determination and strengthening cultural identity for First Nations youth (Chandler & Lalonde, 1998; Health Canada, 2003). Given the overall complexity of youth suicide, comprehensive, multi-strategy approaches, which are implemented across an array of settings and contexts, are typically understood to hold the most promise.

Meanwhile, reviews of the *treatment* literature suggest a number of approaches hold the most promise for treating suicidality among youth. For example, therapeutic approaches which emphasize active problem-solving and skill development, like cognitive behavior therapy (CBT) and dialectical behavior therapy (DBT), are generally recommended in the therapeutic care of suicidal adolescents (Berman, Jobes & Silverman, 2006; Klomek & Stanley, 2007; MacGowan, 2004; Miller, Rathus, & Linehan, 2007). Core clinical competencies in the treatment

of suicidal youth include: the capacity to develop a strong therapeutic alliance; crisis management skills; collaborative risk assessment and safety planning skills; knowledge and competence in the use of empirically supported treatments; an ability to constructively involve families in treatment; all of which are provided within a well-coordinated service delivery system (Berman, Jobes & Silverman).

Unpacking Assumptions of EBP

Despite its immense popularity and ubiquitous appearance in the professional literature, the discourse of EBP is not without its detractors. While an extensive review and critique of the concept of EBP is outside the scope of this paper, a few key critical observations are worth summarizing here. First, EBP appears to be predicated on the assumption that knowledge generated through scientific experiments is value-free or neutral, and thus equally applicable to all contexts and clients, irrespective of their particular background, culture or experience; an assumption that has been seriously called into question by those in the mental health and social care fields (Burton & Chapman, 2004; Issacs, et al. 2005; Tannenbaum; 2003). Second, there is a pervasive yet unspoken assumption within the EBP discourse which suggests that preventive interventions, including educational strategies or therapeutic interventions designed to address human suffering and reduce risks for suicide, can be understood as analogous to drug treatments (Bohart & House, 2008). By extension then, the appropriate methodologies for studying the "effects" of a diverse range of complex psychosocial and educational interventions are also assumed to be no different from those used to study drug treatments which privilege quantitative designs, especially the randomized controlled trial. Third, many of the knowledge utilization models through which EBP are designed to be transmitted are problematic, typically reflecting one or more of the following assumptions: (a) only experts possess relevant knowledge, (b) only a single, typically empirical basis for knowledge exists, (c) this knowledge is best transferred from the "top" down to the target audience, and (d) learning is simply a matter of instruction by establishing pipelines for communication (Broner, Franczak, Dye, & McAllister, 2001).

Doing and Troubling Practice

Recognizing the limits of a narrowly constructed, hierarchical definition of evidence, many authors have called for a re-conceptualization of EBP (Waddell

& Godderis, 2005); one that recognizes the place of culture, context, values and relationships in everyday practice (Issacs, et al., 2005) and one that admits qualitative research findings as legitimate sources of knowledge (Cheek, 2007; Gilgun, 2006). By recognizing that practice is more than the application of expert knowledge, it becomes increasingly evident that more culturally responsive and complex approaches to supporting the emergence of "knowing communities" are required. This includes for example the development of "practice-based evidence models" (Issacs, et al., 2005), more participatory and inclusive approaches to knowledge generation (Broner, et al., 2001; Taylor & White, 2000) and a revitalized understanding of accountability:

> Our accountability to the people we serve will come not from efforts to prove the authority of our knowledge, nor from efforts to dismantle it and prove it groundless. It will come instead from a more reflective and dialogic engagement with our knowledge, and with the people served through it–an engagement that seeks constantly to problematize our knowing, to probe and critique it, to trace its origins and assumptions, and explore its implications, to open it to inquiry and transformation (Sellick, Delaney & Brownlee, 2002; p. 493).

With this paper, I hope I have hinted at some of the fresh possibilities that await child and youth serving policy makers, program managers, and practitioners, who commit to a process of critical reflection, dialogue and joint knowledge construction.

References

American Psychiatric Association (2003). Practice guidelines for the assessment and treatment of patients with suicidal behaviours. American Journal of Psychiatry, 160(11), 1-60.

Aseltine, R., James, A., Schilling, E. & Glanovsky, J. (2007). Evaluating the SOS program: A replication and extension. BMC Public Health, 7(161), 1-7.

Berman, A., Jobes, D., Silverman, M. (2006). Adolescent suicide: Assessment and intervention (2nd Ed.). Washington, DC: American Psychological Association.

Bohart, A. & House, R. (2008). Empirically supported/validated treatment as modernist ideology I: Dodo, manualization, and the paradigm question. In R. House & D Loewenthal (Eds), Against and for CBT: Towards a constructive dialogue? (pp. 88-201). Ross-on-Wye, UK: PCCS Books.

British Columbia Vital Statistics (2006). Detailed cause of death by gender and age. Retrieved May 21, 2006 from http://www.vs.gov.bc.ca/stats/annual/2004/pdf/app204.pdf

Bridge, J., Goldstein, T. & Brent, D. (2006). Adolescent suicide and suicidal behavior. Journal of Child Psychology and Psychiatry, 47(3), 372-394.

Broner, N., Franczak, M., Dye, C., & McAllister, W. (2001). Knowledge transfer, policymaking and community empowerment: A consensus model approach for providing public mental health and substance abuse services. Psychiatric Quarterly, 72(1), 79-102.

Burton, M. & Chapman, M. (2004). Problems of evidence based practice in community based services. Journal of Learning Disabilities, 8(1), 56-70.

Capp, K., Deane, F., & Lambert, G. (2001). Suicide prevention in aboriginal communities: Application of gatekeeper training. Australia and New Zealand Journal of Public Health, 25(4), 315-321.

Chagnon, F., Houle, J., Marcoux, I. & Renaud, J. (2007). Control-group study of anintervention training program for youth suicide prevention. Suicide and Life Threatening Behavior, 37(2), 135-144.

Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. Transcultural Psychiatry, 35(2), 191-219.

Cheek, J. (2007). Qualitative inquiry, ethics and politics of evidence: Working within these spaces rather than being worked over by them. Qualitative Inquiry, 13(8), 1051-1059.

Eggert, L, Thompson, E., Randell, B., & Pike, K. (2002). Preliminary effects of brief school-based prevention approaches for reducing youth suicide – Risk

behaviours, depression, and drug involvement. Journal of Child and Adolescent Psychiatric Nursing, 15(2), 48-64.

Evans, Hawton, & Rodham (2004). Factors associated with suicidal phenomena in adolescents: A systematic review of population based studies. Clinical Psychology Review, 24, 957-979.

Fullagar, S., Gilchist, H. & Sullivan, G. (2007). The construction of youth suicide as a community issue within urban and regional Australia. Australian e-Journal for the Advancement of Mental Health, 6(7), 2-12.

Fitzpatrick, K., Witte, T. & Schmidt, N. (2005). Randomized controlled trial of a brief problem-orientation for suicidal ideation. Behaviour Therapy, 36(4), 323-333.

Gergen, K. (2000). An invitation to social construction. Thousand Oaks, CA: Sage.

Gilgun, J. (2006). The four cornerstones of qualitative research. Qualitative Health Research, 16(3), 436-443.

Goldston, D., Molock. S.,Whitbeck, L., Murakami, J., Zayas, L, & Nagayama Hall, G. (2008). Cultural considerations in adolescent suicide: Prevention and psychosocial treatment. American Psychologist, 63(1),14-31.

Gould, M., Greenberg, T., Velting, D. & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry, 42(4), 386-405.

Gould, M., Jamieson, P. & Romer, D. (2003). Media contagion and suicide among the young. American Behavioral Scientist, 46(9), 1269-1284.

Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2006). Youth suicide: A review. The Prevention Researcher, 13(3), 3-7.

Hawton, K. (2002). United Kingdom legislation on pack sizes of analgesics: Background, rationale, and effects on suicide and deliberate self-harm. Suicide and Life Threatening Behavior, 32(3), 223-229.

Health Canada (2003). Acting on what we know: Preventing suicide in First Nations youth. A report of the Suicide Prevention Advisory Group. Ottawa, ON: Health Canada.

Issacs, M., Huang, L., Hernandez, M. & Echo-Hawk, H. (2005). The road to evidence: The intersection of evidence-based practice and cultural competence in children's mental health. National Alliance of Multi-Ethnic Behavioural Health Associations.

Klomek, A. & Stanley, B. (2007). Psychosocial treatment of depression and

suicidality in adolescents. CNS Spectr, 12(2), 135-144.

LaFramboise, T. & & Hayes, L. (2008). The Zuni life skills development program: A school/community based suicide prevention intervention. Suicide and Life Threatening Behavior, 38(3), 343-353.

Lather, P. (2007). Getting lost: Feminist practices toward a double(d) science. Albany NY: SUNY Press.

McCreary Centre Society (2004). Healthy youth development: Highlights from the 2003 adolescent health survey III. Vancouver, BC: McCreary Centre Society.

Macgowan, M. (2005). Psychosocial treatment of youth suicide: A systematic review of the literature. Research and Social Work Practice,14(3), 147-162.

MacNeil, M. (2008). An epidemiologic study of Aboriginal adolescent risk in Canada: The meaning of suicide. Journal of Child and Adolescent Psychiatric Nursing, 21(1), 3-12.

Miller, A., Rathus, J., & Linehan, M. (2007). Dialectical behavior therapy with suicidal adolescents. New York: Guilford Press.

Pfaff, J, Acres, J. & McKelvey, R. (2001). Training general practitioners to recognize and respond to psychological distress and suicide ideation in young people. Medical Journal of Australia, 174, 222-226.

Portzky, G. & Heeringen, K. (2006). Suicide prevention in adolescents: A controlled study of the effectiveness of a school-based psycho-educational program. Journal of Child Psychology and Psychiatry, 47(9), 910-918.

Sellick, M., Delaney, R. & Brownlee, K. (2002). The deconstruction of professional knowledge: Accountability without authority. Families in Society: The Journal of Contemporary Human Services, 83(5/6), p. 493-498.

Scourfield, J., Roen & McDermott (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence ad self-destructive behaviour. Health and Social Care in the Community, 16(3), 329-336.

Smalley, N., Scourfield, J. &Greenland, K. (2005). Young people, gender and suicide: A review of research on the social context. Journal of Social Work, 5(2), 133-154.

Smith, M. (2006). Act justly, love tenderly, walk humbly. Relational Child & Youth Care Practice, 19(4), 5-16.

Spirito, A. & Esposito-Smythers, C. (2006). Attempted and completed suicide in adolescence. Annual Review of Clinical Psychology, 2, 237-266.

Steele, M. & Doey, T. (2007). Suicidal behaviour in children and adolescents. Part

1: Etiology and risk factors. Canadian Journal of Psychiatry, 52, 21S-33S.

Tannenbaum, S. (2003). Evidence-based practice in mental health: Practical weaknesses meet political strengths. Journal of Evaluation in Clinical Practice, 9(2), 287-301.

Taylor, C. & White, S. (2000). Practising reflexivity in health and welfare: Making knowledge. Buckingham, UK: Open University Press.

Ungar, M. (2008). Putting reslience theory into action: Five principles for intervention. In L. Liebenberg & M. Ungar (Eds.), Resilience in action (pp. 17-35). Toronto, ON: University of Toronto Press.

Waddell, C. & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. Evidence Based Mental Health, 8, 60-62.

White, J. (2003). Review of suicide-related research in Canada, Ottawa, ON: Health Canada. Retrieved February 19, 2009 from http://www.phac-aspc.gc.ca/publicat/mh-sm/suicide-research/pdf/suicide_research_e.pdf

White, J. (2005). Preventing suicide in children and youth: Taking action with imperfect knowledge. Vancouver, BC: Mental Health Evaluation and Community Consultation Unit (Mheccu), Department of Psychiatry, UBC.

White, J. (2007a). Knowing, doing and being in context: A praxis-oriented approach to child and youth care. Child and Youth Care Forum,36, 225-244.

White, J. (2007b). Working in the midst of ideological and cultural differences: Critically reflecting on youth suicide prevention in Indigenous communities. Canadian Journal of Counselling, 41(4), 213-227.