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Acculturation, Adolescent Mental Health & Youth Suicide in Modern Ireland

A thesis presented to the University of Dublin, Trinity College for the Degree of Doctor of Philosophy

By

Caroline Smyth

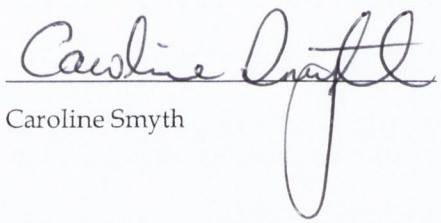
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Acculturation, Adolescent Mental Health & Youth Suicide in Modern Ireland

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Caroline Smyth

Since 1990, Ireland has witnessed a 400% increase in young, male suicide (Beagley, 1999) such that Ireland ranks 24th internationally in terms of its youth suicide rate (WHO, 2002) and 25th highest of 35 countries across Europe (Lyddy, 2004) however, more dramatic than the overall rate of suicide, is Ireland's top ranking in terms of the gender ratio of completed suicides where, for 2002, 4.7 male suicides were seen for every 1 female suicide. This increase in suicide has been seen at a time of extensive social and cultural change where a clear move away from "traditional" Irish values towards "Celtic Tiger" Ireland has been seen. Patterns of modernization, globalization and secularization have been noted to take effect across every sector of society. Despite the general suggestion that this sociocultural redesign *may* be linked to the increase in suicide, both research and clinical investigations of adolescent mental health and youth suicide have, in the main, continued to fail to include social and cultural factors resulting in a dearth of information. Marking a departure from previous investigations, this research specifically took a contextualised, culturally embedded approach to the issue of youth suicide. Youth suicide specifically has been noted to be situational in nature- thus, the result of transient, stressful life events for which adequate coping and problem-solving skills are lacking (Stillion & McDowell, 1996). For this reason, and in order to address the paucity of situational measures in this vein, the *Trinity Inventory of Precursors to Suicide (TIPS)* was developed and validated as part of this research. Extending acculturation theory (Berry, 1997) in a novel manner, and developing and validating the theory of *temporal acculturation*, psychological, situational and cultural factors were considered *in combination* with regard to their impact on youth suicide. Working with a total of 673 participants (219 males, and 454 females), aged between 15 and 19 years (Mean= 16.68 years, SD= .739 years), in Post-Primary schools in the greater Dublin area, the aforementioned issues relating to psychological experience, culture and situational life stressors were examined. Thus, contextual factors were considered at two levels- the level of acculturation experience and at the level of situational precursors to suicidal behaviour. The results clearly demonstrated the value of adopting this Cultural Psychology approach. Significant, gendered pathways, showing a clear role for acculturation were observed. There was no over-lap between the male and the female trajectory to suicide, thus providing some insight into the differential experience of adolescent males and females, possibly linked to the previously mentioned gender disparity in suicide rate. The implications of these findings for the prevention of suicide and the promotion of emotional health in the Irish context are discussed.

List of Publications Arising from Research

Books

MacLachlan, M., & Smyth, C.L. (Eds.). (2004). *Binge Drinking & Youth Culture.* Dublin: The Liffey Press.

Smyth, C.L., MacLachlan, M., & Clare, A. (2003). *Cultivating Suicide: The Destruction of Self in a Changing Ireland.* Dublin: The Liffey Press.

Peer Reviewed Journal Publications

Smyth, C. L., & MacLachlan, M. (2004). The Context of Suicide: An examination of life circumstances thought to be understandable precursors to youth suicide. *Journal of Mental Health, 13* (1), 83-92.

Smyth, C. L., & MacLachlan, M. (2003). *Temporal Acculturation and Mental Health in Modern Ireland.* Paper presented at the Seventh Annual Conference of the Irish Association of Suicidology. Youth Suicide: The Challenge for Prevention., Belfast, September 2002

Mac Lachlan, M., Smyth, C. L., Breen, F., and Madden, T. (*in press*). Temporal Acculturation and Mental Health in Modern Ireland. *International Journal of Social Psychiatry.*

Smyth, C. L., and Mac Lachlan, M. (*in press).* Validation of the Trinity Inventory of Precursors to Suicide (TIPS) in a general adolescent population.

Conference Presentations (presenting author underlined)

Smyth, C.L. (2004). Facilitating Understanding of Youth Suicide: Prevention & Intervention in Ireland. Invited presentation to the Rosmini Adult Education Group.

Smyth, C. L. (2004). *Adolescent Mental Health & Youth Suicide in Ireland: The current situation.* Invited presentation to the Professional Development Group, Dublin City University, School of Nursing.

Smyth, C. L. & MacLachlan, M. (July, 2004). *Symposium on Changing Societies, Changing Cultures: The Impact of Temporal Acculturation on Mental Health,* 17th Congress of the International Association of Cross-Cultural Psychology, Xi'an China.

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Smyth, C. L., & MacLachlan, M. (2003). *A cultural perspective on Irish suicide.* Paper presented at the Critical Psychology Conference, Bath, England.

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Smyth, C. L., & MacLachlan, M. (2002). *Temporal Acculturation and Mental Health in Modern Ireland.* Paper presented at the 7th Annual Conference of the Irish Association of Suicidology, Belfast, Ireland.

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Prelude

Ascension

And if I go,
while you're still here...
Know that I live on,
vibrating to a different measure
--behind a thin veil you cannot see through.
You will not see me,
so you must have faith.
I wait for the time when we can soar together again,
--both aware of each other.
Until then, live your life to its fullest.
And when you need me,
Just whisper my name in your heart,
...I will be there.

- Colleen Hitchcock (1987)

Each year in Ireland, an incalculable number of people are touched by suicide. While it is possible to record the actual number of deaths which occur in this manner, it is not, nor will it ever be, possible to estimate the impact of the ripple effect which emerges in the wake of suicide. It is not just the family of the person, but their friends, co-workers, broader social network and community more widely who are affected.

Following death as a result of suicide, any number of questions result but the most frequently asked is "Why?" Why is it that the person felt such desperation that to stop living appeared to be the only option? While this is difficult for many to understand generally, it becomes all the more difficult in the case of youth suicide.

Suicide has become a most Irish of problems as every year we lose more young people as a result of suicide than we do as a result of *any* other means of death. Slowly but surely, our youth population is being eroded by this complex, multidimensional phenomenon which remains insufficiently understood.

This research attempts to provide some insight into the context which surrounds youth suicide in Ireland.

Chapter 1 opens with information on the origins of the research and goes on to present an overview of relevant literature with the aim of locating the present research. The chapter begins with a brief historical overview on the origins of suicide and follows this with a discussion of contemporary issues relating to the definition of the term suicide. Subsequently, the role of culture in suicide, issues pertaining to adolescent development and mental health and male risk are discussed. Finally, this chapter concludes with a statement of research, that is, the investigation of the cultural, situational and individual elements of youth suicide as it is experienced and understood from an Irish perspective.

Material in *Chapter 2* deals with the development and evaluation of the new measure, the Trinity Inventory of Precursors to Suicide (TIPS), developed specifically for the present research and forming a fundamental cornerstone to the inclusion of contextual elements throughout. The rationale for the development of the TIPS originated from a recognition of lack of standardization in the area of measurement surrounding attitudes towards suicide in youth populations. Those measures which already exist are replete with methodological and theoretical flaws thus providing a clear impetus for the development of a new measure, reflective of and theoretically grounded within the cultural perspective taken here. This chapter also outlines the exploratory factor analytic techniques utilised to investigate the statistical and psychometric properties of the measure. The chapter concludes with a discussion of the role of the examination of contextual factors in youth suicide and the implications this has on suicide prevention efforts.

In *Chapter 3*, details of the materials used in the main study are presented. This includes details of the development of materials and support materials specific to the study, reflecting the professional and ethical approach taken to the work, but also outlines the rationale for the selection of the standardised measures included in the research. Further, the formulation of the measure used in the investigation of individual acculturation strategy is clearly outlined alongside pertinent theoretical issues in the field of acculturation research more generally.

Chapter 4 deals with the procedure employed for the investigation and presents information on participant schools and individuals. Ethical issues relating to the research (such as departmental ethical approval, Garda clearance and issues of safety and responsibility for participants) are outlined.

The logic behind the selection of specific statistical methods and the results of the research are presented in *Chapter 5*. This presentation progresses from the level of descriptive statistics, to the analysis of preliminary gender difference to the more complex and detailed analysis (via Multiple Regression & Correlation techniques) of emergent themes in the data. What results by the end of Chapter 5 is a detailed schematic of gender specific trajectories or pathways towards suicidal behaviour. Each of individual factors, cultural setting, situational triggers to suicide and related psychological experience are investigated and are seen to have a significant impact.

In *Chapter 6*, the concluding chapter, a discussion of the results is presented along with an evaluation of the implications these findings have on suicide prevention generally, but also specifically in the Irish context.

The approach taken throughout is that of Cultural psychology, with the aim of elucidating those cultural, situational and contextual factors which give rise to psychological vulnerability and predisposing risks to suicide. As such, it represents an *emic* approach.

Originating with Pike (1954; 1967) and reflecting an extrapolation from the linguistic distinction between *phonetics* (general aspects of vocal sounds) and *phonemics* (language-specific sounds) a distinction, in cultural research, between *etic* and *emic* levels of investigation has been drawn. The former (etic) approach advocates the universality of experience (inclusive of psychological distress) across cultures, while the latter (emic) calls for phenomena to be examined from *within* a cultural context with the aim of understanding the significance of the phenomenon in question, the associated meanings and experience from within a cultural setting and through the eyes of the culturally embedded individual (Berry, 1999; Helfrich, 1999). Thus, emergent patterns, integrating information on

the individual's psychological experience, relationship with culture (acculturation strategy) and situational experience (in the form of "trigger" events to suicidal behaviour) are the focus of the current research. This approach not only reflects a departure from previous examinations of suicide which, for the most part, failed to include or address in an ecologically valid manner, contextual factors, but also offers the possibility of understanding youth suicide from *within* the Irish cultural setting where individual meaning and experience may be considered as central. Thus, the phenomenon of Irish youth suicide may be considered not as a series of miscellaneous parts but as an embedded whole reflecting the multidimensional complexity of the issue.

Chapter 1- Introduction

Origin & Context of Research

The current research began in the context of a general recognition both within mental and allied health professions, and among the general public of the growing problem of Irish youth suicide, alongside a dearth of information on how such behaviour may be prevented. While much is known regarding psychological and clinical experience related to suicide, there is a paucity of research addressing the social and cultural context in which suicide occurs and which may, in and of itself, contribute to the problem. In Ireland especially, the lack of information on contextual risk factors for suicide was especially salient given the simultaneous increase in suicide and rapid sociocultural change across all areas of life. At a time when there was much to be hopeful about in terms of economic development, employment, higher standards in education and a general pattern of modernisation, many of Ireland's youth, males especially, were engaging in suicidal behaviour. The stark contrast and juxtaposition of such hopelessness against a backdrop of "Celtic Tiger" Ireland clearly reflected the need for a culture-based examination of youth suicide. Thus the "bottom-up" rationale for the structure and method of inquiry of the present research was offered by the sociocultural climate of Ireland as we moved into a new Millennium and were faced with the erosion of a specific youth population as a result self-destructive behaviour.

In 1998, the Irish National Task Force on Suicide released it's final report detailing the increase in suicide seen in Ireland since 1990 and delineating the response of the government, healthboards, research groups and relevant stakeholders to this issue with the ultimate aim of suicide prevention at a national level. A series of recommendations, relating to the issue of suicide in Ireland were presented. One of the principle recommendations was that;

"Young people's suicides be further researched with a view to identifying and understanding the reasons why they occurred so that society may respond accordingly" (Department of Health & Children, 1998, p. 68)

with the additional recommendation that such research;

"break out of a repetitive mould... and employ new methodologies likely to generate innovative responses to the problem of suicide"(ibid).

During this same period, the National Children's Office was established under the Department of Health & Children with the aim of enhancing children's status and improving the quality of life of Ireland's young people. Under the specific national aim that "Children's lives will be better understood" under the sub-heading of "Health and Wellbeing" the current research was undertaken. In the National Children's Strategy document (Department of Health and Children, 2000) through the "whole child" approach, the impact of social and cultural factors on children's and young people's lives was explicitly referred to and attention drawn to the need for research in this vein to be undertaken.

Thus, combining the policy and research aims of the National Task Force on Suicide and the National Children's Office, and answering the call to research; the current project was undertaken with the aim of utilising the alternative methodology offered by Cultural psychology, enabling the inclusion of social and cultural variables in an examination of youth suicide in Ireland. By virtue of its unique approach to the issue of suicide, the requirement for an innovative approach is represented.

Over the last decade and since 1990 especially, Ireland has experienced unparalleled economic growth and has reached a state of prosperity of such proportions as to make our European neighbours envious. In addition, with the introduction of divorce, the decline of the Church as an institution and the consequent decline in the practice of religious worship it may be said that Irish culture has changed at many levels. This change has, however come at a great cost as can be seen from a continued high rate of Irish suicide. In this time of economic growth and prosperity why are so many of Ireland's young people, at a significantly higher proportion than their European counterparts, taking their own lives? What is it about Irish culture, which is either creating or contributing to such a sense of anomie and lack of hope? And what can be learned from a psychological investigation of Irish culture? These are the issues that the present

research addressed; arguing that a culture-based examination of suicide is of considerable importance.

A further recommendation of the National Task Force's report looked to the educational system and the role of the teacher as an important *tool* in the prevention of suicide. The report stated that "programmes should be initiated, aimed at teaching children about positive health issues including coping strategies and basic information about positive mental health at an early age" (Department of Health & Children, 1998, p. 41).

Reflecting this objective, the present research sought primarily to examine some of the numerous contextual elements in suicide with a view towards providing information which may assist the development and implementation of a prevention programme for youth suicide and, given the cultural psychological perspective of the research; is placed in a unique position to provide such information.

In short, the current research carried out a detailed investigation of the particular features of Irish youth suicide with regard to cultural relationships, Irish attitudes towards suicide and relevant psychological factors thus; throughout, it is these themes which will be addressed.

Issues relating to suicide...

Historic perspectives on suicide[1]

Etymologists inform us that the word "suicide" first appeared in the text *Religio Medici* by Sir Thomas Browne (1605-1682) (Shneidman, 1985). Thus, while it was possible to engage in acts of "self-slaughter", "self-killing" and "self-destruction" prior to this, and making implicit reference to what, in modern times would

[1] Some sections from this chapter have previously been published as part of Smyth, C.L., MacLachlan, M., and Clare, A. (2003). *Cultivating Suicide: The Destruction of Self in a Changing Ireland.* Dublin: The Liffey Press.

come to be known as suicide, it was simply not possible to "commit suicide" until a later time (Minois, 1999).

One of the foremost authors in the area, Edwin Shneidman, strongly argues that a secular view of the world was required before "suicide" could come to be. For as long as a medieval perspective was held, whereby the role of God and the reality of an afterlife was unquestioningly accepted, one could end one's corporeal, earthly existence but one could not forever cease to be. Only when a questioning of some of these fundamental beliefs occurred, when humanity came to be seen to play an active role in their own existence, when individual decision-making and motivation were acknowledged and when the centrality of the person's actions in determining their own fate came to be recognised, could suicide be named and the nature of self-harming behaviour be spoken.

From the sociocultural stance adopted here, the writings of Rousseau (1712-1778) and Hume (1783/1929) warrant a brief mention. Rousseau took the important step of transferring responsibility for "sin" from humankind to society- an approach also seen in Hume's writing. Thus, suicide was seen neither as a crime nor a dereliction of duty at any level and sooner than present suicide as a selfish disregard for life, one's responsibility to family or society, it came to be seen (by this group of sociologically-minded philosophers at least) as a logical and reasonable action taken to rid oneself of a life that was no longer worth living, and which had become an unbearable burden.

Important to examine also is the development of the concept of suicide in the Western world. Here, the Christian church had a central role to play in the determination of the understanding of suicide. However; and contrary to popular opinion, suicides *are* reported in the Christian bible (both Old and New Testaments, although less frequent in the latter). The role of the presentation of this information however, has a clear function with suicidal behaviour presented as the most heinous crime imaginable against God (Kelleher, Keeley, Chambers, & Corcoran, 2000). Consequently, the role of human suffering, desperation, hopelessness and the motivation to end an intolerable existence were not recognised by the Church which instead offered a punitive, harsh and

stigmatising stance. As a result of several Church councils, a formal position on suicide was established and became firmly enshrined - the Council of Arles (452AD) censured suicide as murder of the innocent (Silviny, 1957) while the Council of Orleans (533 AD) prohibited the burial of those who died as a result of suicide on consecrated ground (O'Connor & Sheehy, 2000). This was followed in 562AD by the Council of Braga which called for a general denial of burial rites (including the celebration the Eucharist and the singing of Psalms) for those who died by suicide (Grullman, 1971) and subsequently, the Council of Toledo (693 AD) required those who attempted suicide (extended in some circumstances to even the contemplation of suicide) to be excommunicated from the Church in recognition of the depravity of their behaviour.

By the time Thomas Aquinas (1929) came to make a decree on suicide, the sixth commandment ("Thou shalt not kill") had undergone a dramatic extension such that "killing of the self" was deemed equivalent to taking another's life. The argument for this revision was founded on three central tenets; death, fundamentally, is contrary to everything in nature which will naturally strive to survive for as long as possible thus suicide goes against nature (interesting to note that homosexuality was also categorized thus further reflecting the level of stigma and taboo which surrounds suicide). Secondly, that we all exist as part of a broader, Divinely-created whole (e.g. family, community and society) and so, to take one's own life is to deprive others and so, is supremely selfish in motivation. Finally, since all life is created by God it is up to Him alone to take it- thus establishing suicide as personally negligent, socially reckless and contrary to the Divine.

Apart from interest at an academic level, this history can inform contemporary investigations of suicide. While it is widely recognised that the Church has experienced a decline in support in Ireland (O'Connell, 2001) religion, in the form of the Roman Catholic Church predominantly has, up until recent times, determined public opinion on a number of issues not least among which is suicide (Bowers, 1994). While we may fundamentally disagree that suicide should be punished by the institutional Church, it is important to remember the impact that such a stigmatised view has on those who survive parasuicidal

behaviours and the friends and family of those who are left behind in the aftermath of a suicide. Stillion & McDowell (1996) assert that although the modern Church has, in many ways, moved towards a more understanding, humanitarian view of suicide, the fact still remains that the Universal Catechism (1994) states that "suicide contradicts the natural human inclination to preserve and perpetuate life" and is "contrary to the love of a living God" (p. 13) reflecting the continued punitive view on this phenomenon.

When the issue of suicide prevention both within communities and schools at a national level (in Ireland) is considered, the continued importance of the religious perspective becomes apparent. The 2004 Census[2] reports that 99% of Irish primary and post-primary schools are run (both in terms of ownership and through Boards of Management and senior staff) by the Catholic and Protestant Churches. Thus, the willingness to consider issues of mental health generally and suicide specifically, within an educational context and the openness of Boards of Management to participate in school-based suicide prevention must be viewed within this context. Although it became evident through the research process that individual teachers (and in some cases, schools on the whole) were highly motivated to consider the issue of suicide, practical barriers to research and prevention issues became apparent at the institutional level. A further example of the important part played by the Irish educational system and the ideology upon which it is founded, to which attention will later turn (in Chapter 6 in the consideration of prevention issues) with regard to the promotion of emotional health and wellbeing relates to the introduction of the "Exploring Masculinities" programme in some post-primary schools. At a very practical level, health promotion campaigns which are unaware of the political, religious and social context of the contemporary Ireland within which they wish to be established are unlikely to succeed, clearly pointing to the need for an integrated, inclusive approach informed by socioculturally-based examinations such as the current research.

[2] This information was published in preliminary format in the Irish Times, Tuesday, April 13th, 2004.

Definition & Nomenclature

"Surely "suicide" is one of those patently self-evident terms, the definition of which, it is felt, need not detain a thoughtful mind for even a moment" (Shneidman, 1985, p. 6)

Contrary to Shneidman's assertion, the issue of the definition of suicide is one which has a substantial history in the literature and is a point on which current researchers continue to differ. For this reason, it is important to present the rationale for the selection of the definition used in this research.

O'Carroll et al., (1998) comprehensively review the issue of definition and conclude that one of the most substantive problems to date has been the discipline-specific manner in which the full spectrum of behaviours which may be classed as "suicidal" have been operationalised, often with the stated aim of selecting methodological ease over ecological validity. Currently, despite many years of investigation of the topic across disciplines, there is no internationally accepted and widely employed definition of suicide.

Central to the issue is the role of *intent*- an issue many in the area feel is unquantifiable, specifically with regard to the case of completed suicide where the individual is unable to provide information on the nature of the motivation preceding the suicidal behaviour, and as a result intent is determined by an external source. Thus, to require the determination of intent in order for suicide to be defined (and in some settings, for the purposes of official classification) is problematic from the outset. Nonetheless, some of the more commonly used definitions retain this element.

Diekstra (1994) proposes that suicide be defined as "a self-chosen behaviour that is intended to bring about one's own death in the short(est) term". This perspective is echoed by the World Health Organization's chosen definition presented afresh in the "World Health Report, 2001" (World Health Organisation, 2001) which states that suicide is "the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of

outcome". What is perhaps most concerning about these two widely recognised definitions, is the failure to incorporate any social or cultural elements (with the possibility of an expansion of either to enable the inclusion of such elements not being immediately apparent).

The current research however, utilises *neither* of the aforementioned definitions, preferring Shneidman's (1985) alternative due to its unifying, inclusive, flexible and purposive structure making it particularly suitable for use in a sociocultural model. It is;

"currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multi-dimensional malaise in a needful individual who defines an issue for which the suicides is perceived as the best solution" (p. 203).

Several components of this chosen definition are of considerable importance. By defining suicide in this manner, the key role of context is explicitly presented. *"Currently"* and in the *"Western world"* we hold this view of suicide. Over time, and in recognition of an increased knowledge-base this socially constructed definition will need to be altered and updated. Thus, much like the phenomenon under investigation, the definition is malleable and fluid.

That suicide is *"multi-dimensional"* is stated- there is no singular causal factor but rather a cluster of circumstantial factors, which together with individual psychological elements within a cultural setting lead to the point of suicide. To examine but one of these in the absence of the remainder is to fail to grasp the very nature of suicide and limit available information. Further reflected is the individual, phenomenological nature of suicide (*"For which suicide is perceived as the best solution"*). This is not to say that suicide is objectively a positive choice but, for that person, in that situation, at that time, there appears to be no other alternative but to end their own life. By including this sentiment at the level of definition, the individual experience of distress is represented.

In keeping with the theoretical underpinnings of the research, this definition (more than any other available) bestows *meaning* and ecological validity above and beyond a more reductionist desire for the appearance of a scientifically sound, methodologically static operationalisation of the term. Thus, through its explicit recognition of social, cultural and temporal factors it was the chosen definition for the current research.

This said, the phenomenon of suicide is not itself singular and some method of considering the continuum of behaviours which may be classed as "suicidal" is required. To this end, the proposed nomenclature of Kosky, Eshkevari, Goldney, & Hassan (1998) is presented in Table 1.1 in an attempt to provide an overview of the range of behaviours which, from this point on, will be referred to as "suicide related behaviours" while completed suicide will be referred to as "suicide".

A final point on the issue of the usage of the term "suicide" relates to the introduction of media guidelines on the presentation of information to the public of deaths as a result of suicide. The Irish Association of Suicidology (IAS), in conjunction with Samaritans (2000a) issued a proposed set of guidelines to which the media, at present, voluntarily adhere. These best practice recommendations also informed the way in which the current research proceeded with regard to discussion surrounding the issue.

Perhaps the most salient point to emerge from the IAS guidelines is on the use of the term "act of suicide". Such terminology harks back to a time when suicide was considered to be a criminal offence[3] with the conclusion reached that to present suicide in this manner serves only to facilitate stigma surrounding the death. On the whole, this document details the means by which suicide may be

[3] Suicide remained a criminal offense in Ireland until the Criminal Law (Suicide) Act was passed in 1993. Prior to this, as a result of the Coroner's Act of 1962 under subsections 30, 31 (1) and 31 (2), coroner's verdicts were restricted to the process of identifying the deceased & circumstances of the death thus leaving questions of criminal or civil liability to be processed within the bench-court system in Ireland- an option taken up only on rare occasions and most often with regard to insurance claims (see Smyth et al., 2003 for further detail).

responsibly reported in cases deemed worthy of media attention but in such a manner as not to glamorise the behaviour. Thus, in referring to suicide in the numerous documents used as part of the research process, these guidelines were adopted.

The context of Irish suicide

Begely (1999) presented data which show that Ireland experienced a 400% increase in young, male suicide between the years 1990 and 1994. By 1998, the suicide figures had increased to the point that the number of deaths as a result of suicide in that year was equivalent to the total loss of life on board four Boeing 737's, with the number of deaths outpacing death as result of road traffic accident or youth cancer (Irish Association of Suicidology, 2000b) -a rate which has been maintained to the present.

As a result of census analysis, the most recent suicide figures available from the Central Statistics Office (CSO) are for the year 2002. In 2002, a total of 371 males and 80 females died as a result of suicide, representing a male to female ratio of 4.7:1. The gender difference in death as a result of suicide becomes all the more apparent when youth suicide[4] is examined.

[4] The CSO, in keeping with WHO recommendations, group suicides by age category of 15-19 years and 20-24 years. However, within the research literature, as in the current research, the term "youth suicide" refers to the age group of 15-24 years inclusive. The school-based research will refer to "adolescent suicide" and deals only with 15-19 year olds, while more global themes relating to "youth suicide" will refer to the broader group of 15-24 year olds.

Table 1.1 A review of the proposed nomenclature for various levels of suicide-related behaviours (Kosky et al., 1998)

I. Self-injurious thoughts and behaviours

A. Risk-taking thoughts and behaviours
1. with immediate risk (e.g. motorcycling, skydiving)
2. with remote risk (e.g. smoking, sexual promiscuity)

B. Suicide related thoughts and behaviours
1. Suicide ideation
a. Causal ideation
b. Serious ideation
(1) persistent
(2) transient
2. Suicide-related behaviours
a. Instrumental suicide-related behaviour (ISRB)
(1) Suicide threat
(a) passive (e.g. ledge-sitting)
(b) active (e.g. verbal threat, note writing)
(2) Other ISRB
(3) Accidental death associated with ISRB
(b) Suicidal acts
(1) Suicide attempt
(a) with no injuries (e.g. gun fired but missed)
(b) with injuries
(2) Suicide (completed suicide)

In 2002, a total 77 males between the ages of 15 and 24 years (31 in the group 15-19 years and 46 in the group 20-24 years) in contrast to a total of 14 females (6 in the group 15-19 years and 8 in the group 20-24 years) reflecting a ratio of 5.5 male suicides for every 1 female suicide in the total youth category. This gender disparity is also to be seen in the actual numbers of death as a result of suicide since 1990 (see Figure 1.1). This gender disparity reached a high of seven male suicides for every one female suicide in 1998 (Kelleher, 1998) and, when a county-by-county analysis was undertaken an even higher difference emerged in the Southern Health Board area of 10:1 (male: female) deaths as a result of suicide (Irish Association of Suicidology, 2000b).

A further illustration of the extent of the male, youth suicide issue comes from the World Health Organization. Of 100 nations reporting suicide statistics to the World Health Organization (2002) Ireland ranked 24th in terms of the overall

male suicide rate, with a rank of 1st in terms of male to female suicide ratio; while Lyddy (2004) reports that of 35 European nations surveyed in relation to youth suicide, Ireland ranked 25th highest. Thus, although Ireland does not have the highest overall suicide rate in international comparisons, the gender breakdown and age-related risk is noteworthy.

In the National Task Force report of 1998, the financial cost of suicide for the period 1991-1994 to be £ 75, 600, 000 (equivalent to just under €96,000,000). While this in no way manages to convey the human cost of suicide, it clearly represents the economic implications for Ireland of the suicide issue it continues to face.

In Ireland, hanging is the most common method of suicide, followed closely by death as a result of drowning and poisoning (Irish Association of Suicidology & National Suicide Review Group, 2002)- see Figure 1.2. In considering the issue of method, the *availability hypothesis* is frequently mentioned (Jenkins & Singh, 2000). From this perspective, prevention is best undertaken by restriction of access to means of suicide. Thus, in the case of North America, for example, where the majority of suicides occur as a result of the use of a firearm (in the form of a handgun or shotgun) restriction of access relates to legislative issues surrounding firearm licence, ammunition sales and the safe storage of weapons in areas to which children and adolescents can gain access. In the case of Ireland however, access to means does *not* present itself as a viable prevention alternative. In very practical terms, access to rope (or similar) and water cannot sensibly be restricted to the point of effective suicide prevention.

On the point of poisoning, the issue of access to over-the-counter medications (more often used than either illegal drugs or prescription medications) has been tackled with "blister-packs" introduced and a limit placed on the number of tablets sold by a single establishment to any one individual at a time (however, the practical limitations of this, especially in the face of a well thought out suicide plan, are obvious). Further, the use of poisoning (in cases of death as a result of suicide, as opposed to suicidal behaviour not resulting in death) is less common among the youth category than in the general population (Hawton & van Heeringen, 2000). UK studies recorded a second annual decrease in suicide in the

proportion of *non-fatal* overdoses involving paracetamol, attributed to the reduction of pack size and the introduction of "blister-packs" (ibid) thus showing some positive effect in the case of suicidal behaviour but limiting utility in the case of completed suicide.

Where firearms *are* used, they are most commonly employed by males in the youth category. However, even with access restricted there is international evidence of substitution of means - another method to end one's life is employed in the alternative (Hawton, Fagg, Simkin, Harriss, & Malmberg, 1998).

Williams & Pollock (2000) in concluding a review of the utility of employing the availability hypothesis to guide prevention effort, assert that in a small number of cases where suicide is considered in an impulsive way, prevention is possible by these means, but in the majority of cases of youth suicide the aforementioned difficulties remain. Not only does this challenge widely held notions of youth suicide as the result of impulsive, poorly controlled, reckless behaviour but it also informs the way in which we conceive of preventative efforts more generally in the Irish context.

Finally, with regard to reporting issues, in response to the growing concern regarding the increase in youth suicide in Ireland, one of the more frequently posed questions related to whether or not this was a "real" increase, or if the methods of data collection had improved alongside a greater willingness to record a death as "death as a result of suicide" thus accounting for the higher rates seen.

Figure 1.1 Youth Suicide (15-19 years) in Ireland, 1990-2002

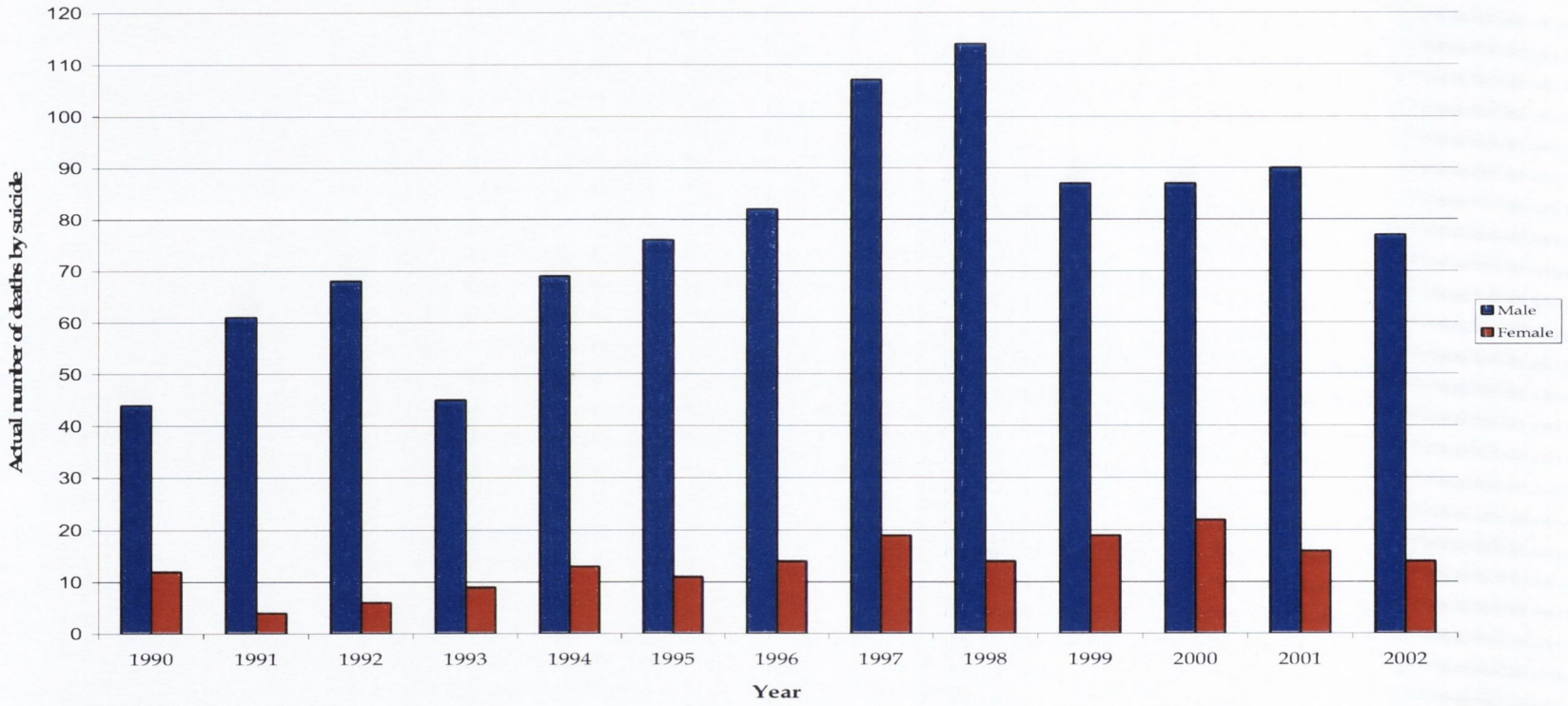
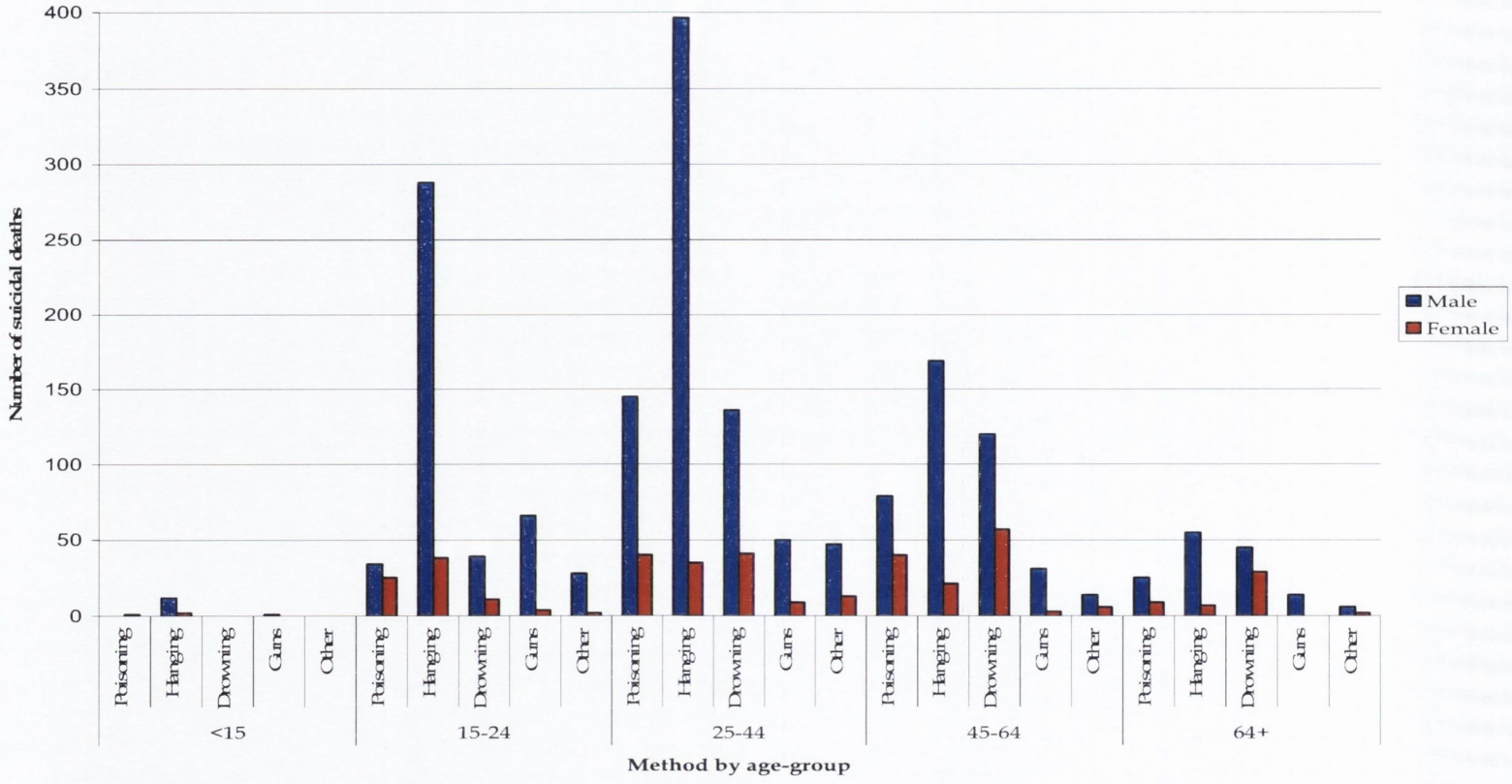


Figure 1.2: Actual number of suicides in Ireland, by method and gender (1996-2000)



Studies of suicide in the Dublin area, suggest that between 1900 and 1968, the true rate was between two and four times the officially reported rate (Brugha & Walsh, 1978) clearly suggesting an issue of under-reporting and calling the use of official statistics, at this, time into question. However, with the introduction of Confidential Form 104 in 1967, County Coroners were, for the first time, able to record a verdict of "death as a result of suicide" and at this time, the Central Statistics Office began a concerted effort to gather official and reliable statistics in the area. With the decriminalization of suicide in 1993, the use of this form increased such that the CSO now report a rate of almost 100% return of this information and themselves acknowledge the reliability of the increase.

Kelleher, Corcoran, Keeley, Dennehy, & O'Donnell (1996) convincingly argue that while there were certainly issues with regard to reporting in earlier times, the increase in suicide seen in Ireland is genuine and not merely an artefact of past inaccuracies This conclusion is shared by others such as Nic Daeid (1997) and O' Connor et al., (2000) resulting in a general acceptance by those across fields that the Irish statistics available are both accurate and reliable.

A further interesting point raised by Kelleher et al., (1996) with regard to the increase in suicide, and one which challenges the standard medical model, is that a comparable increase in clinical conditions has not been seen for the same period as the increase in suicide rate, thus calling into question the theory that suicide and mental illness are *inextricably* linked in all cases. This is not to say that mental illness or psychological distress are unrelated to suicide, for there are a certain number of cases each year in which such links may be confidently drawn -with the importance of depression noted (Fitzgerald, 1999; O'Sullivan & Fitzgerald, 1998). But, for the youth population specifically, suicide may occur in the absence of clinically diagnosed mental illness, and reflects sub-clinical distress which may be better understood by an examination of the *mechanisms* and *contexts* (encompassing social and cultural factors) which underlie Irish suicide (Lynch, 2001).

The role of culture

Building on the work of Kelleher and others, it is argued here that the role of cultural issues in suicide is of central importance however; the inclusion of such factors (or indeed, failure to include them) is grounded in more general ideological and theoretical concerns within psychology which merit some consideration at this point.

When psychology emerged as a discipline in its own right, it was in the unusual and unique position of being able to select elements from already-established domains of study. Medicine, Science, Sociology and Philosophy were among these. In this way, psychology's history was not initially its own but borrowed from the best of its "relations" (Fancher, 1990).

As time passed, the nature of psychological investigation changed, reflecting societal concerns of the time. Attention turned from the study of individual differences and the presumed strengthening of humankind (under Sir Francis Galton among others), to the consideration of those elements of personality that had "allowed" Nazism to develop and genocide be perpetrated (Adorno et al., 1982 for example). More recently still, various "movements" in psychology have been seen, from the popularity of the cognitive approach (and the mind-as-processor view) to the contemporary belief that the investigation of the human brain at all levels holds the key to better understanding the human psyche (Bem & de Jong, 1997).

During all this, battles raged on the nature of psychology itself- was it an "art" or a "science"? Each sub-discipline (of which there are now many) claims to have an answer.

Those approaches which see psychology as a "true" science, akin in many ways to the natural sciences, adopt a positivist, often reductionist approach which adheres to the correspondence theory of truth derived from realism (Bem & de Jong, 1997). In short, truth is seen to be a single entity 'out there', capable of being accurately observed, recorded, reduced and defined. This approach is clearly

useful for dealing with well-defined, highly specified issues. It provides a certainty (albeit illusory), a security, a clear sense of black and white, true and false which is, in many ways, both attractive and appealing.

An alternative perspective (and one which has gained ground in recent years) is that of critical psychology, which encompasses but is not necessarily synonymous with each of cultural psychology, qualitative methods and discourse-analysis among others. Here, the 'grey' areas of humanity's existence are studied. Within this perspective, researchers admit that singular answers are not always knowable. Truth itself is not singular, but plural - frequently making the issue of definition a particular challenge. There are *truths* that are not at all 'out there' but that are actively constructed by individuals, who are impacted by numerous cultural, social, economic and political considerations.

From this perspective, meaning takes on a distinctive importance and the researcher and the 'researched' are seen to collaborate with each being 'expert' and making a valuable contribution.

This latter view leads to a very different set of suppositions and beliefs than the aforementioned approach, and it is here that conflict frequently arises. Despite passionate arguments to the contrary, psychology is itself open to influence by society externally and by its own members internally. It is inherently political and social, and not as clinically scientific as it is sometimes portrayed. It too, is constructed. This however, is not a disadvantage (once it is acknowledged). From this stance, psychology is well placed, perhaps better placed than any other discipline, to consider sociocultural and socio-political questions (Gergen, 1999).

From the Cultural perspective this means asking questions such as, how do we create our worlds? Why are they created the way they are? Do we all participate equally in making these decisions or are some more equal than others? How does society affect our well-being? What are the elements of our cultural background that may be positively used for our benefit? How can we celebrate the variety of cultures and ethnicities we see without making salient the boundaries that

encourage and facilitate prejudice, discrimination and hatred? Why are some of our young people so distressed that to end their life is the only option they see?

One of the specific areas that have been addressed by this approach is the issue of *acculturation*- the individual's response to their culture across geographical boundaries or over time. Culture is thus seen to be actively constructed and is as malleable and resilient as the population it surrounds. It is not easily defined - there are as many interpretations of culture as there are people to construct them, and even if definition in a limited form is possible, it is time and context limited- as the culture changes (which is inevitable) so too will our understanding of it.

This does not mean that the theory of culture is impossibly vague or a poor use of time or resources, for there are well formulated and logically thought out paradigms which can be readily applied and yield rich and rewarding results. In the case of the current research and Irish temporal acculturation, the question of the possible relationship between culture change and the psychological wellbeing of adolescents, and specifically adolescent suicide is posed. Given the newness of the application of cultural theory to within-nation culture change, a causal model is not proposed. Rather, the aim of the research is to establish that such relationships exist and can meaningfully assist our understanding of the phenomenon of suicide and consequently inform prevention strategies.

Cultural issues in suicide

In the main, culture has either not been included in investigations of suicide, or has been included in only the most superficial of ways, adopting what is known as the "transport and test" approach. David Lester in particular, is renowned for this offering a variety of publications on suicide cross-culturally but failing to examine the meaning and role of culture more broadly than at the level of comparison between cultures (Lester, 1984, 1987, 1997, 2001; Lester & Whipple, 1996). The value of this type of work is the creation of an international database on the phenomenon and related issues but, with regard to within-nation culture change and the various ways in which such change may impact on the psyche of

the individual and thus relate suicidal behaviour remains under- (and indeed in many cases, un- investigated.

Here, it is argued that culture- that which organizes and shapes our understanding of reality, the way we interact with the world and those in it, and that which gives meaning to our lives (Gergen & Gergen, 1996)- is a central facet of suicide.

In order to examine the background to this assertion and considering Ireland's short history in the area of suicidology, it is necessary to examine international research. The shared conclusion reached by these research endeavours, is that culture may act either as a *protective factor* or as one that increases risk in already-vulnerable groups and may thus, in the latter case, be classed as a *facilitating* or *pathoplastic factor.* African-American culture and Native American culture will be juxtaposed in the following brief sections in order to further illustrate the protective versus facilitating role of culture in suicide.

African American Culture

Within the health literature relating to cause of death, suicide is marked out as the only condition in which the African-American population exhibit *lower* rates than any other ethnic group in the United States (Allen & Farley, 1986). In this group, the male to female ratio of death by suicide is four to one, with the highest risk (for completed suicide) being for males between the ages of 25 and 34 years (thus similar to Irish statistics). Unlike Ireland, but mirroring the situation with other ethnic and cultural groups in North America, is that suicide most commonly involves the use of firearms. Noteworthy in the investigation of African-American suicide is the inclusion of social, economic and cultural factors. Thus, this particular group is well researched in an embedded framework providing a rich literature on the situational context of suicidal death and offering possible explanations for the lower rate seen in this group.

Looking at African-American culture, it is seen that in many ways, the culture is designed to protect against suicide. Early & Askers (1993) identify an

intermingling of religious condemnatory beliefs which co-exist alongside secular views on suicide that present suicide as an unthinkable sin and define it as a "White thing" antithetical to African-American culture. Thus, at a most fundamental level of individual cultural identity, suicide is unacceptable. Further, the structure of religion and religious worship provides steadfast support to families and reflects a high level of integration among members of this group, bringing with this integration a high level of social support and inter-generational contact. These two factors, taken together, suggest that African-American culture may be classed as protective on the whole in a way in which "White" American culture is not.

Native American (First Nations) Culture

Range et al., (1999) provide a profile of Native American life and the context in which suicide in this group occurs. Approximately one-third of Native Americans live on reservations, another third live in urban settings, while the remaining third co-exist between these two settings. The highest reported rate of suicide in a specific tribe is 150 per 100,000 (compared with a rate of 19 per 100,000 for males and 3.9 per 100,000 for females in 2002). The male to female ratio across tribes has been recorded as 12 to 1 with the typical profile of death by suicide being a young, single male who takes his life by high lethality means (such as use of a firearm) following a drinking session.

In contrast to the aforementioned protective structure of African-American culture, EchoHawk (1997) draws attention to the high levels of poverty and alcohol dependence among Native American groups- both recognised independently as risk factors for suicide; which is higher among this group than any other on mainland North America. As in the Irish context, the most vulnerable group is 15-24 year olds.

Importantly, in considering the high rate of suicide among this group, acculturation is an issue unambiguously referred to (see later section for full detail of acculturation theory). The way in which an individual relates to, both in terms of attitudes and behaviours, and comes to exist within, a cultural context

which may not be the same as the cultural context into which they were socialized (i.e. acculturation) has been found to be of central importance to the understanding of Native American suicide (ibid).

The collective effect of elements of acculturation such as Western education (most often directed by religious groups in the form of missionaries), religious conversion, legislation, language barriers and tribal relocation are all argued to be central to the issue of suicide. Faced with such issues, maladaptive forms of coping (principally, alcohol use and subsequent dependence) are commonly seen. In addition, the absence of a formal rite of passage in contemporary tribal living (further reflecting imposed changes on the structure of Native American culture) from childhood to adolescence, has resulted in the consumption of alcohol beginning at a very early age, with Range et al., (1999) reporting that children as young as six engage in drinking sessions. In this same research, interviews were carried out to investigate individual beliefs on the role of alcohol, with many young males reporting that they drink with the specific intention of becoming intoxicated and use alcohol as an easily-accessible analgesic facilitating an escape (albeit temporary) from life. The similarity between this pattern of alcohol consumption and the current binge drinking trend witnessed among Ireland's youth is clearly apparent (Mac Lachlan & Smyth, 2004).

If culture gives meaning and order to life, then the dismantling of this same culture results in a disordered, personally meaningless context which poses a threat to existence in the form of suicidal behaviour. The overwhelming picture which emerges from research with Native American groups is that their culture is one which has become "pathological" with the traditionally protective safeguards having been eroded over time directly implicating the process of culture change in suicide.

Acculturation Theory

Redfield, Linton & Herskovits (1936) stated "acculturation comprehends those phenomena which result when groups of individuals having different cultures

come into continuous first-hand contact [5] with subsequent changes in the original culture patterns of either or both groups (p.149). This perspective refers, from the outset, to *groups* in contact, requiring not only an examination of the individual's response but also of the cultural milieu in which they are situated. Further, the issue of the acculturative process being bidirectional is also reflected- thus changes occur within *both* groups- those who are acculturating and those for whom the "host" culture is native (Liebkind, 2001). This bidirectionality of the *process* of acculturation and its placement along a continuum (importantly viewed as such) is also referred to by MacLachlan (1997).

Following from Redfield et al's., (1936) definition, Graves coined the phrase *psychological acculturation* which reflected the theory that when friction results from this individual-culture interaction, *acculturative stress* (similar in underlying concept to Furnham et al's., (1986) and Ward et al's., (2001) proposals of *culture shock*) may be experienced with consequences ranging across the physiological, social and psychological aspects of health and wellbeing (Searle & Ward, 1990).

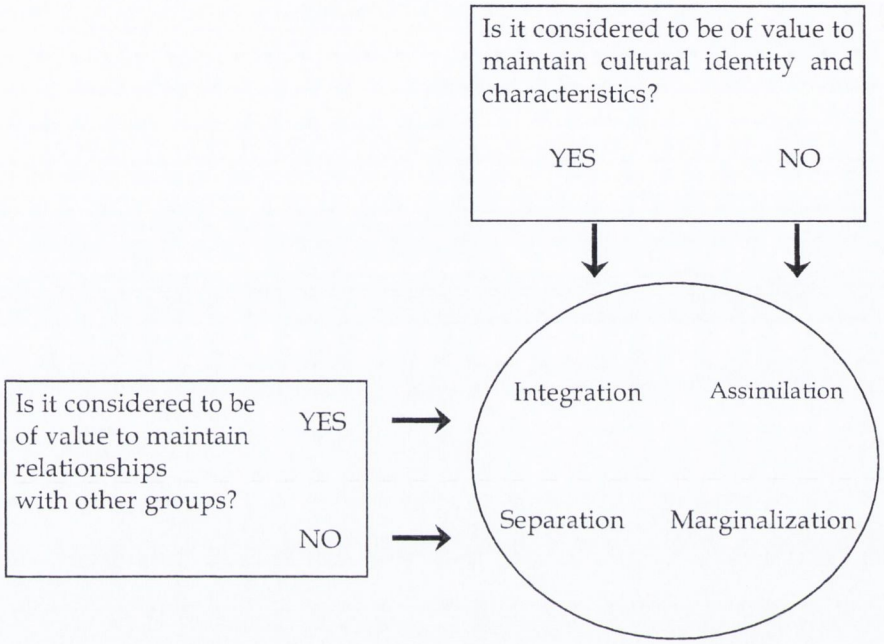
These themes of the individual in fluid interaction with their cultural setting, and the resultant impact on the psyche contingent upon such interaction, have been carried through the acculturation literature generally but are perhaps presented most clearly in the work of John Berry.

Working initially with refugees, sojourners and travellers, Berry (1970; 1997) proposed an integrative framework for the examination of the impact of geographic cultural re-location (whether this re-location be the result of choice or necessity) on psychological health and wellbeing. This came to be known as the process of *acculturation*; referring in short, to individuals' relationship with the cultural context within which they exist and from which they derive identity, self-esteem and personal meaning (Smyth & MacLachlan, 2002, 2003a; Smyth, MacLachlan, & Clare, 2003). Both *home* (that is, the original culture within which the individual existed) and *host* (that is, the culture to which they moved)

[5] The issue of whether or not first-hand contact per se is required in order for the acculturation experience to occur will be addressed in the section on Temporal Acculturation & Anomie.

cultures were included in this framework, reflected in the delineation of four specific acculturation strategies representing different levels of involvement and identification with the two cultures (see Figure 1.3).

Figure 1.3: Berry's (1997) Acculturation Framework



Berry's model focuses on two issues, *cultural maintenance* (operationalised by the question, "Is it of value to maintain cultural identity and characteristics?") and *contact participation* (operationalised by the question "Is considered to be of value to maintain relationships with other groups?") A two by two matrix results, whereby an individual's "answer" to the two central questions may be translated into an acculturation strategy.

The four acculturation strategies outlined by Berry, and represented in his categorical framework, are, *marginalization* (where the individual fails to identify with either culture), *assimilation* (where the individual rejects their home/native culture, in favour of the new/host culture to which they have moved), *separation* (where, despite the fact the individual is living in a new cultural context, identification continues with the home/native culture exclusively) and finally, *integration* (where the individual successfully combines elements from both cultures to which they have been exposed).

Later research, by Berry & Kim (1988) ranked these four strategies in terms of the level of mental health and psychological wellbeing which were significantly related to each of them. Consistently, Integration emerges as the "healthiest" of the strategies while Marginalization emerges as indicative of poorest levels of mental health and social functioning while assimilation and separation fall between levels of functioning (Berry, 1997, 1998; Horgan, 2000). Such patterns have been seen across student populations (Ward & Kennedy, 1994; Zheng & Berry, 1991), immigrants (Allen, Denner, Hirokazu, Seidman, & Aber, 1996; Gil & Vega, 1996; Krishnan & Berry, 1992; Rivera-Sinclair, 1997; Scapocznik, Kurtines, & Fernandez, 1980; Schwarzer & Schwarzer, 1996) and refugee populations (Berman, 1997; Berry, 1997; Cheung, 1995; Donà & Berry, 1994; Liebkind, 1996a, 1996c).

Thus, while the aforementioned themes linking the individual and their psychological health to the social and cultural setting in which they exist are well-established, there has also been some criticism of Berry's approach with the principle proponent of this challenge being Floyd Rudmin. In brief, (and as outlined in a contentious 2001 paper) Rudmin asserts that there are two principle concerns with Berry's framework.

Firstly, Rudmin contends that Berry's framework is etic in structure and thus, restrictive. However, this is a limited perspective and, in many ways, reflects a highly selective interpretation of the literature. While the framework itself *has* been used across cultural settings it has been continuously modified to reflect intra-cultural issues in the vast majority of cases, hence the proliferation of culture-specific acculturation scales. Therefore, although Berry states that "...general issues face all acculturating peoples" (Berry et al., 1989, p. 185) it is the culture-specific response to these issues (of contact, maintenance and participation) which is of interest and underlies the symbiosis of etic and emic approaches in the field (Berry, 1999).

Secondly, Rudmin argues that Berry's framework reflects only the response of the acculturating group (thus leaving the response of the "established" society

un-investigated). While this focus on the acculturating group was characteristic of Berry's early work, more recent revisions of the theory (see for example, Berry et al., 1997 and Berry, 2002) deals specifically with the response of society both in terms of social identification and legislation, addressing general societal response to the issue of multiculturalism and the policy implications of this societal structure. Thus, acculturation theory has progressed to the point of including *both* the acculturating individual and the dominant sociocultural group of the host culture.

Thus, while it may be said that Berry's framework is a deceptively simple representation of the issue of acculturation (see Ward et al., 2001, for discussion of alternative theoretical models) it has been seen to be both valid and reliable across numerous settings, and in this specific case, offers an effective base from which to investigate the impact of Irish cultural change on adolescent mental health and suicidal behaviour. Further, the structure of the framework is such that it can be effectively extended in this case, to include temporal acculturation (see following section) thus enabling examinations of the impact of culture change within a culture.

Temporal Acculturation in Ireland

MacLachlan & O'Connell (2000) on the issue of cultural change in Ireland, assert; "the historical landmarks of the Irish psyche are changing... Ireland is changing" (p.2).

Quite apart from this being a familiar theme in Ireland's media, such change may be charted by an examination of various indices of such change across social, educational, familial and economic fronts.

While in 1960, 7.4% of the population left formal education upon completion of what was then the "Primary Certificate", today nearly 29% continue on to Third

Level Education [6]. In particular, it is the areas of science and technology which have experienced the greatest influx of qualified college graduates with the number of degrees in these fields increasing from 82.000 in 1986 to 158,000 in 1996; with this development having the concurrent effect of a reduction in the proportion of the population involved in agriculture - only 16% of private households in 1997 declared agriculture to be their primary source of income, which was an all-time low for the state (Central Statistics Office, 1997b).

With regard to employment, in the two years between 1998 and 2000, the numbers employed rose from 1,494,500 to 1,670,700 with the additional feature of population increase, above and beyond the natural increase due to the birth rate but as a result of immigration- a phenomenon not seen on any scale in Ireland since before the Famine! (O'Connell, 2001).

Alongside these changes, the traditionally devout nation of Ireland was also witnessing a change in the more spiritual/religious side of life. While the Ireland of 1975 could certainly be seen as firmly committed to the Roman Catholic Church, recent figures show that this is no longer the case with a steady decline in weekly church attendance. O'Connell (ibid) makes the significance of this change clear. While a decline of about two per cent is seen each year, this has an overall significance such that by the year 2007 those attending mass every week will be a minority- again, a fundamental alternation in the landscape of Irish culture. More simply than this change being felt at the level of church attendance (which may possibly be understood in terms of recent church abuse scandals) there has also been a change in the spirituality of the Irish population, with the number of people who state they believe in God falling substantially, reflecting change both at the attitudinal and behavioural levels.

With the advent of divorce, the face of the Irish family has also changed. As Census data for 2004 is as yet unavailable for these figures, the earlier reports of 1997 (Central Statistics Office, 1997a) can be examined, which showed that

[6] Personal communication with Central Statistics Office regarding as yet unpublished Census data for 2004.

between 1986 and 1996 the number of marital separations doubled such that by 1997, the number of lone parent families in the State had reached 130,000 and in this same year, the number of women engaged in paid employment (outside of the home) surpassed the number of men further illustrating the change from the "traditional" family structure so enshrined in the Irish Constitution.

With regard to the impact of changes such as these, specifically on the issue of suicide, it is the work of Emile Durkheim which must be examined. In his seminal work, Durkheim (1897/1951) proposed that the experience of *anomie* placed an individual at greater risk of suicide, as the development of this characteristic indicated the fundamental breakdown of the relationship between the person and their sociocultural setting. The term anomie relates, in short, to the unbalancing of social forces that affect individual wellbeing. It implies a fundamental alteration in the previously accepted way of life. At the level of the individual, Durkheim recognised the infiniteness of human desire, portraying the role of society as regulatory through social expectations and norms and by the demarcation of the means to achieve these goals. In the face of change, society fails to regulate, leaving the individual of a position of desperate wanting but without any possibility of these wants being attained (Begley, Chambers, Corcoran, & Gallagher, 2000).

Although much criticism has been levelled against Durkheim (Taylor, 1982), and many now view this work as more of a demonstration of sociological methodology than a study of suicide per se, it remains one of the key texts referenced in the discussion of social and cultural elements of suicide. In much the same way that Cultural Psychology seeks to challenge positivist notions of truth and knowing, Durkheim proposed that suicide was not so much the "act" of the individual but the responsibility of the society in which that individual was located.

At the time of publication (1897), two schools of thought dominated sucidological research (Taylor, 1982). The first presented suicide as a form of inherited madness while the second utilised comparative methodologies to examine the

role environmental factors (and in this, environmental referred to ecological and biological elements) factors in suicide rate. Thus, either a predisposition to madness or external forces "took over" and resulted in suicidal behaviour.

As an alternative, Durkheim argued for the inclusion of social and cultural elements asserting that the degree of regulation the individual experienced as a result of the type of society in which they lived was seen to influence the likelihood of suicide being considered by them. Thus, societal elements such as religious denomination and economic development were thrust into studies of suicide in ways never before seen. Accordingly, each society was seen to have a "capacity" for suicide dependent on the sociocultural structure of that society at any given time.

Specifically, Durkheim outlined four types of suicide: egoistic; anomic; altruistic; and the lesser-referred to, mixed.

Altruistic suicide, as presented by Durkheim, has until recent times been infrequently seen within Western culture and relates to those willing to end their own lives in the service of a "higher power". Although this behaviour, in the form of suicide bombings has become more salient in the Western consciousness of late, it is not the "standard" model of suicide which relates to the youth phenomenon as it is seen in Ireland, for example.

Egoistic suicide was said to result from the lack of integration of the individual into society. The more the individual is left to depend on his/her own resources the greater the risk of their committing suicide. On this basis, the role of institutions in society was examined. One particular institution Durkheim focused on was the Church. The rate of suicide in Catholic and Protestant communities was contrasted. It was proposed *not* that one religion supported suicidal behaviour while the other did not, but that the essential characteristics of these two denominations were fundamentally different. The Roman Catholic religion does not (traditionally) place the individual in direct contact with God. Rather, Catholics come together in a congregation and, through the medium of

the sacraments, led by a priest, worship God. In contrast, the Protestant faith (and, by extension, Methodist and Presbyterian faiths) encourages the individual (on their own) to read the bible and worship in addition to any congregational involvement. Accordingly and as evidenced by statistical analysis carried out by Durkheim, it was proposed that one of the principle reasons suicide rates were lower among Catholic populations was because this mass integration and support, served as a protective factor against states leading to suicide.

Anomic suicide, in contrast to the outlined conditions above, was said to be a chronic state in the modern world. The needs of the individual and their satisfaction came to be regulated by society. Through this regulation, the individual became the embodiment of the *collective conscience.* However, when society fails to successfully regulate, the individual is left in a disrupted state and the risk of suicide is maximized. General factors which lead to this state of dis-regulation are (predominantly) sudden economic growth and resultant prosperity with the individual's horizon (determining wants, needs, desires and goals) broadened "beyond what he can endure" (Durkheim, 1897/1951, p. 14). According to this reasoning, when there is an increase in suicide rate it is representative of a *fundamental flaw in the social fabric.* In response, society must seek to re-integrate the individual, re-establish the role of institutions and increase the freedom of equality of minority and disenfranchised groups.

With regard to the way in which the suicide "types" may be related to the Irish context, it is argued that the considerable move away from traditional Ireland towards the more modern, so-called "Celtic Tiger" Ireland marks the process inherent in the anomic suicide subtype. The individual has been placed in a more competitive situation where issues of self and identity have become inextricably linked to materialism, consumerism and globalization. In short, who "we" are in Ireland has come to be determined by what we can buy, what we own and the material value of the possessions which surround us. Thus Irish suicide occurs in a context of increased wealth, at a time when national institutions ranging across the government, the Church and the Gardaí are no longer seen to offer guidance and leadership, and where the individual has greater choices and freedom but equally with less direction than ever before.

A brief examination of one of Durkheim's proposals (on the relationship between economic growth and suicide rate) was undertaken with the result that highly significant relationships emerged between youth suicide rate and percentage volume increase in GNP and GDP as indices of economic growth. While these results were significant for both males and females, the significance levels of the correlations were more striking in the male group thus proving support for the relationship between culture and gender-specific suicidal behaviour (Smyth & MacLachlan, 2003b; Smyth et al., 2003). See Figure 1.4 graphic representation of this relationship

Given the considerable evidence of social and cultural change in Ireland, one of the principle aims of the present research was the extension of Berry's model of acculturation to include what is termed *temporal acculturation.* MacLachlan, Smyth, Madden & Breen (in press) investigated this question and offered a theoretical base from which the present research was undertaken. It was proposed that, by similar mechanisms to geographic acculturation outlined by Berry, culture change within a nation, is of importance to mental health and emotional wellbeing. This study showed that 88% of participants (in a sample of over 700) agreed that there had been a "big change in Irish culture over the past ten years" with the relationships between this change and mental health also clearly seen to a statistically significant level.

One issue which should be mentioned at this point relates to the aforementioned definition of acculturation offered by Redfield et al., (1936) which required that "first-hand" contact take place between the individual and the two cultures in question. On this point, research by Sam (2000) is directly relevant. Here, it is argued that through the process of socialization and as a result of family contact and structure, children and adolescents do not require first hand contact with the "home" or native culture in order to have an acculturation experience related to said culture. In a similar vein, Inglehart & Baker (2000) whose World Values Survey (inclusive of some 65 societies) found that even in the context of radical, within-nation culture change, there remains a significant persistence of

traditional values: a "cultural imprint" that continues to exist despite such change.

Also relating to the theory of temporal acculturation and enabling the current research to be positioned within the broader literature, is the idea of "culture shock" examined across each of tourists, sojourners, immigrants and refugees as proposed most recently by Furnham et al., (2001). Here, it is asserted that the interaction between an individual and changed cultural circumstances is an active, yet stressful process with issues of stress and coping to the fore. Elements both "looking outward" and "looking inward" (Furnham et al., 2001, p. 272) are included reflecting adjustment (or lack thereof) both at the individual and wider societal level. Links are drawn between the impact of contact with changed culture and issues of self (identity and self-esteem), anxiety, confusion and a sense of helplessness. Thus, although dealing with a wider group of individuals and drawing on acculturation theory but on stress, coping, culture-learning and social identification theories more generally, some commonality may be seen between the concept of "culture shock" and the impact of temporal acculturation as investigated by the current research.

Thus, it was felt that in light of the substantive evidence of intra-cultural change in Ireland, coinciding with a dramatic increase in youth suicide and clearly significant relationships between these two factors evident even from preliminary research, the concept of temporal acculturation was a justifiable theoretical basis from which the current research project could be undertaken.

Adolescence

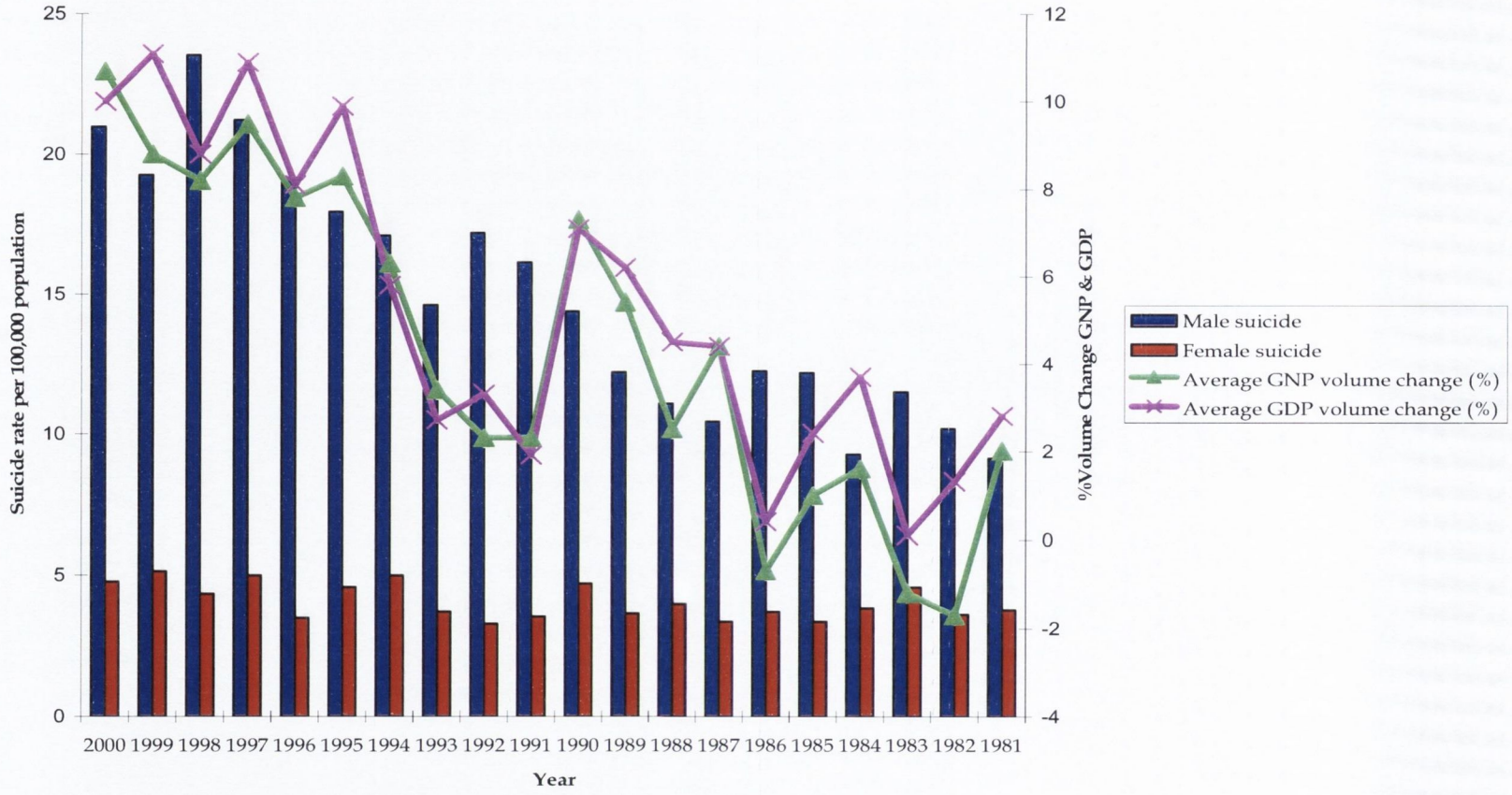
Curran (1987) draws attention to the fact that adolescence as a life-stage is a relatively recent "invention" in Western culture. Prior to the recognition of adolescence as a discrete stage of development, individuals were expected to move from being a "child" to being an "adult" with no distinguishable stage of transition between. Thus, it is argued that the recognition of adolescence is a "luxury" of affluent, predominantly Western societies (ibid). Robertson (1990)

adds a further dimension asserting that it is only since the need for an educated workforce of ever-increasing professionalism emerged that adolescence has been constructed in its full glory.

In relation to the Irish context (although not limited to it) adolescence has been lengthened in recent times; with tasks symbolic of the transition to adulthood (such as leaving home, getting one's first job, marriage and having children) being postponed and thus, occurring significantly later. While on the one hand this may be taken as an indication of societal progress it also presents problematic issues relating to adolescent psychological development. As stated in the previous section on Temporal Acculturation, what has resulted is a challenging mix of an affluent culture which *requires* adolescents to find identity and success (with foremost emphasis placed on the latter) within a society quite capable of marginalizing, alienating and confusing them in the absence of these achievements.

Kenny (2001) and Giddens (1991) examine this mixed message in greater detail and place emphasis on psychological existence in a postmodern world. Kenny, in particular, argues that the contexts in which youth develop and mature have few certainties. Much of the developmental task of adolescence rests on the emergence of self and identity and the establishment of *trust*. It is this essential "leap of faith" that is required if secure social interactions are to be experienced. Unfortunately, there is much to suggest that the postmodern situation of uncertainty, flux and culture change does little to facilitate these cornerstones of development and (in many cases, specifically in the case of suicide) hinders them.

Figure 1.4 Relationship between suicide rate for both genders and economic growth



Adolescent suicide

Although commonality exists in the factors (psychological, social and cultural) leading to suicide across populations, those experiences and variables which relate specifically to adolescent suicide warrant special attention.

One of the key points raised by DeLeo (DeLeo, 2002a, 2002b) is that little is known about *both* risk and protective factors relating to suicidal behaviour in adolescence. With regard to protective elements, he argues that little is known about the way in which issues such as coping, stress management, problem-solving abilities, social support and social and cultural connectedness "behave" in terms of adolescent suicide while equally he asserts, "the factors which place individuals at risk for suicide are complex, interactive, interdependent, and often cumulative" (DeLeo, 2002, p. 23) and thus warrant attention if a more comprehensive understanding is to be reached.

Various factors in the early lives of adolescents may lead to subsequent suicidal behaviour. Some of these include family discord, lack of support and general familial dysfunction (Dubow, Kausch, Blum, Reed, & Bush, 1989; Garrison, Addy, Kirby, McKeown, & Waller, 1991). This unsettled family milieu has long been linked to the experience of major depression but also (and in cases, in the absence of clinical depression) to suicidal behaviour (Reinherz et al., 1993). Another element to consider is the feeling of being valued by the family unit in which one exists, most especially in the context of the experience of violence or abuse within the family. This latter element of abuse has been linked to the development of suicidal behaviours in females only. It is important to note that this suggests certain gender-dependent distal and proximal risk factors (Reinherz et al., 1995).

While this body of literature is clearly useful in the examination of some of the possible origins of suicide, a clear pathway to suicide remains to be determined. Reinherz et al., (1995) took up this challenge by following a group of children from age 5 to 18 and examining those early psychosocial elements (that is,

occurrences at age 5) which were seen to lead to increased risk of suicidal behaviour by mid-adolescence (that is, age 15).

When early risk factors for *males* were examined, it was seen that a clear pattern of behavioural, emotional and interpersonal problems was successfully capable of differentiating between suicidal and nonsuicidal groups. This pattern was identifiable by both mothers and teachers from the age of 5 through to mid-adolescence (age 15). At age 5, those who would later develop suicidal ideation, were rated by their mothers as significantly more dependent than nonsuicidal counterparts. By age 9, both mothers and teachers were able to outline a constellation of behaviours that saw the suicidal group experience higher levels of anxiety and poorer socioemotional adjustment overall. Interestingly, while others were able to observe clear differences in those who would go on to become suicidal (versus those who would not) the boys' themselves showed no differences in their self-perception, perceived unpopularity and levels of anxiety or unhappiness. Thus, the degree to which the children were self-aware of the difficulties they were evidently experiencing was low. Those who would go on to become ideators were also more than twice as likely to have developed one disorder by age 14 and were more than four times more likely to have developed two or more disorders by this age, along with the aforementioned emotional and behavioural difficulties. Specific early-onset disorders experienced included, simple phobia, alcohol abuse and drug abuse/dependence.

For *females* a somewhat different pattern was seen. Early behavioural and emotional problems and poor self-perception (that is, seeing oneself as worthless, having low self-esteem etc.) increased risk of the development of suicidal behaviours by mid-adolescence in females. Female ideators were more than twice as likely to hold poorer perceptions of their role in the family (seen from age 9) and were more than three times more likely to report serious family arguments, which included the occurrence of violence (between the ages of 10 and 14) than nonsuicidal counterparts. While in early childhood both mothers and teachers rated the girls who would go on to be suicidal as more aggressive, shy and dependent, this pattern was not observable by age 9. Thus, the outward

constellation of behaviours seen in boys over all 11 years (age 5- 18) was not seen for the duration in girls. And, unlike the at-risk boys who did not rate themselves any differently than the non-suicidal group, the at-risk girls thought themselves to be more anxious, unhappy and unpopular than counterparts (perceptions which in and of themselves, may have led to the development of depression and/or hopelessness).

Although Reinherz et al., (1995) made brief reference to the significant role played by traumatic or stressful life events, it is the work of Beautrais et al., (1997) which more clearly outlines this link.

These authors (ibid) examined those events which precipitated a serious suicide attempt ("serious" was defined in terms of the individual requiring hospitalization above and beyond the normal, overnight, period of observation following an act of self-harm, and those cases which required more intense medical intervention, such as longer-term hospitalization in a specialized unit such as Intensive Care). Precipitating events are seen to generally fall under four broad themes of interpersonal conflict, economic problems, school-related difficulties and legal or disciplinary problems (Brent & Moritz, 1993; De Wilde, 2000). Despite this, the frequency with which they are variously reported differs, to the extent that Hawton et al., (1982) found a sizeable proportion of their sample unable to clearly articulate any reason for their parasuicidal behaviour. One possible explanation for this lack of reporting may be that this area is replete with methodological difficulties in obtaining motivational information- that there may be a time delay between the suicidal behaviour and questioning regarding motivation may have memory effects, it is also possible that mental state (such as the experience of depression and hopelessness) will affect the likelihood of certain events being reported and finally, the fact that the suicidal behaviour has taken place at all may lead to a degree of "effort after meaning" in order to explain the behaviour to family, medical staff etc.

Beautrais et al., (1997) attempted to overcome these difficulties by obtaining motivational reports not only from the adolescents themselves but also from a

nominated significant other who was sufficiently familiar with their general state and life circumstances to be able to offer a reliable account of those experiences that occurred in the 12 months preceding the suicidal behaviour. Most commonly, these serious suicide attempts were precipitated by relationship breakdowns and other interpersonal problems. Note that although this is in direct contrast to the previously mentioned work by Boergers et al., 1998 research cited above, there is a substantial difference in the populations included in the research such that those included here, where interpersonal issues *were* a feature, were also those exclusively classified as "serious" and so, some variation is to be expected. Difficulties with family, financial difficulties, legal problems and difficulties in school were also commonly reported. The reports given by the individuals themselves and their significant other were remarkably similar, which leads to the conclusion that although the suicide attempt is itself a traumatic life event, people are capable of accurate recollection of those circumstances which led to the point of suicide if given the chance to do so.

Thus, from these findings it can be said that although different in quality for boys and girls, and inherently complex in nature, a clear phenomenological sequence can be traced from childhood to adolescence which leads the individual to the point of suicidal ideation and/or behaviour, both by observers and, more importantly, by the individuals themselves.

In the Irish context, research by O'Sullivan & Fitzgerald (1998) that among 13 and 14 year olds, a similar pattern of antecedent life events or stressors were noted as reasons why someone might take their own life. These included exam pressure, bullying/intimidation, social isolation and home factors. Thus, it may be said that findings among Irish adolescents mirror international research more generally.

If these are some of the experiences that lead to the point of suicidal behaviour, it is also important to examine the 'whys' of suicide, as told by the individual themselves when it is seen to occur. That is, a detailed consideration of the motivations adolescents' ascribe to their own suicidal behaviours is called for.

This type of investigation also holds importance if education and prevention programs are to succeed, as a good 'match' between adolescent needs and program provision is vital if any success is to be achieved.

Contrary to long-held beliefs, the principle motivation for suicidal behaviour is *not* the communication of distress (as in a 'cry for help' that is so often referred to) nor is it an attention seeking behaviour. The vast majority of adolescents who attempt to take their own lives, report that their primary motivation is a wish to die, closely followed by the desire to escape and the need to obtain relief. Rarely were more manipulative motivations, such as making people sorry, endorsed (Hawton et al., 1982). Williams (1986) also links these findings to the level of hopelessness experienced by the individual, such that the higher the level of hopelessness, the greater is the explicit wish to die.

In a detailed study in this vein, Boergers et al., (1998) took a multifaceted approach examining factors across emotional, behavioural and familial spheres. Prior to commencement of the study, these authors thought that those adolescents who reported their motivation as an explicit wish to die, would also be seen to experience higher levels of hopelessness, anger, depression, loneliness, socially prescribed perfectionism and poorer family functioning than adolescents who reported alternative motivations. These expectations were supported.

The most commonly endorsed motivations for their self-harming behaviour were *intra*personal rather than *inter*personal. Thus, the source of their behaviour was described in terms of their own psychological states rather than as a result of their relationships with others. Not only is this an important piece of information for those left behind by the suicide of a loved one, but it points to the extreme and often unobservable internal state of distress of those who take their own lives.

Suicide clearly, cannot therefore ever be reduced to the level of a desperate act of communication, an attempt to evoke a reaction, obtain sympathy or achieve manipulative ends. For the majority of those who progress as far as actively and

intentionally carrying out a suicidal behaviour, the objective is clear- they no longer want to be alive.

Male risk

In the area of mental health generally, there is considerable concern over men's awareness of health issues and help-seeking behaviour; for example, men are significantly less likely than women to recognise a mental health problem (Albizu-Garcia, Alegria, Freeman, & Vera, 2001), are less aware of available services (Rutz, von Knorring, Pihlgren, Rihmer, & Wainder, 1995) and are less likely to make contact with services even if suicidal (Pirkis & Burgess, 1998). Recent research by the National Disability Authority[7] show that young males (under the age of 25) in particular hold the most stigmatized attitudes towards mental health issues by far and further, that this relates to help-seeking behaviour; such that this high-risk group for suicide is also the group least likely to engage with counsellors, general practitioners and mental health specialists in order to obtain help. Thus existing negative attitudes and stigma surrounding mental health (including suicide) in Ireland are recognised barriers to service-uptake (Kelleher, Hope, Barry, & Sixsmith, 2001; McKeon & Carrick, 1991).

In much the same way that culture has not frequently been meaningfully included in suicide research, Canetto (1997) has argued the same to be true of gender; although the gender difference in suicide rates is reported almost without exception and gender comparisons drawn, the specific male "path" to suicidal behaviour remains unknown. Ferree, Lorber, & Hess (1999) argue that if the role of gender in mental health phenomena is to be understood, it must be examined from *within* a social and cultural context thus further clarifying the rationale behind the present research. Cole (1988) too has made reference to this with the proposal that there exist gendered "pathways" to suicide, and specifically that the experience of hopelessness and depression play different

[7] Unpublished report made available from the Mental Health Advisory Committee and National Disability Authority.

roles in male and female adolescent mental health and suicidal behaviour- an issue which will be dealt with in greater detail in both Chapter 3 and Chapter 6.

One of the means by which such social settings and conditions may be understood is to consider why is it that more females *engage* in suicidal behaviour but that more males *die as a result of* suicidal behaviour? Canetto (1997) argues that a good deal of research suggests that in stereotypically "Western" cultures parasuicidal (i.e. non-fatal suicidal behaviours) acts are inherently seen as "feminine" thus making it "appropriate" for a girl/woman to "attempt" suicide. This is in keeping with the suicide as cry-for-help model. Women, according to this stereotype, don't "mean" to end their lives, they "simply" want attention. Despite the fact that this directly contradicts what is known regarding the motivations of those who behave in a suicidal manner (that is, there is a deeply held desire to escape unbearable distress and torment- discussed in detail in the previous section on Adolescent Suicide) this stereotypic belief continues to be widely held. In contrast, it is considered deeply "unmanly" for a boy/man to "cry" for help and so, a suicide "attempt" is less "appropriate" than a completed suicide. Linehan (1973), supporting this gendered distinction, suggests that such stereotypes have long been held. Interestingly, Harry (1983) found that gender role nonconformity during childhood had an impact on later suicidality such that "feminine" boys were more likely than "masculine" girls to behave in a non-fatal suicidal manner in adulthood, further associating parasuicidal behaviours with femininity (irrespective of biological sex).

In relation to the higher number of males who complete suicide Canetto (1997) proposes that there is a certain "draw" towards lethal suicidal behaviours given Western cultural depictions of what it means "to be a man". Thus, men do not "attempt" they "succeed" (note that thus far such terminology has been avoided as to end one's life is in no way to be deemed a "success", but such language is relevant to the current discussion). As Linehan (1973) states "due to social pressures against attempted suicide, males... might 'skip' over the less drastic solution of attempting suicide and go directly to suicide" (p.32). This same

author also notes that individuals who survive a suicide attempt are rated as less masculine than those whose lives end as a result of suicidal behaviour.

Non-fatal suicidal behaviours are, it would seem, generally seen as violations of the stereotypical "male" role expectations that include the attributes of strength, decisiveness, success and *in*expressiveness. Not only may such expectations impede men from openly expressing hopelessness, despair, depression and isolation (a problem in itself) but when behaving to alleviate these experiences the selection of method is also affected. One of the most disturbing findings in this vein was reported by Lewis & Shepeard (1992) who found that men who ended their lives as a result of suicidal behaviour were thought to be more "well-adjusted" than women who behaved in the same manner- in short, to behave in a suicidal manner is "manly" and therefore, not "abnormal" and even "acceptable" in certain circumstances within this cultural depiction of masculinity. The fact that fatal suicidal behaviour and adjustment have ever been coupled is surely concerning. Ellis & Range (1988) summarize "...the traditional development of masculine sex roles in our society is not adaptive in terms of facilitating an individual's belief which would prevent suicide..." (p. 299).

Specific issues relating to male suicide risk are numerous with the most commonly reported being depression (Isometsa et al., 1995) alcohol misuse, drug abuse (Rich, Young, & Fowler, 1986), social pressure, relationship problems , few social supports, and low self-esteem (Ayyash- Abdo, 2002) with interactions between these variables also seen to be significant (North Eastern Health Board, 2001).

Specifically with regard to the role played by alcohol and patterns of binge-drinking frequently seen, Brophy (2004) draws explicit links between this high-risk behaviour, the Irish cultural context and suicide stating;

"In the short term, alcohol increases impulsivity and reduces inhibition, increases aggression and may distort behaviour. It can induce emotional and perceptual

distortion, change one's cognitive set, and exacerbate lowered mood. These acute effects of alcohol are a significant factor in facilitating suicidal acts" (p.94).

While ten of the European Union member states (among them, Italy, Belgium and Sweden) have witnessed a decrease in alcohol consumption in the years 1989 to 1999 Ireland has seen a 41% increase in alcohol consumption during this same period, to the point that our per capita alcohol consumption rate (which is currently 11.1 pure litres of alcohol per person in contrast to the European average of 9.1 litres) is exceeded only by Luxembourg. This figure of 11.1 litres may however give a distorted impression of the *actual* increase we have seen in this ten year period. When adult consumption levels alone are examined (given that children under the age of 15 are predominantly non-drinkers) the annual rate of consumption per person increases to 14.2 litres When the specific type of alcohol being consumed was examined, it was seen that sales of spirits increased by 10% in 1996 with this trend continuing to the present. Much of this increase may be explained by the "new-generation" of alco-pops and drinks aimed primarily at a youth market (Department of Health and Children, 2002).

While experimentation with alcohol (and indeed other, often illegal substances) may be considered a normative part of adolescence, some findings suggest that by the time Ireland's teenagers reach the age of 15, half the girls and nearly two-thirds of the boys may be classed as "current drinkers" with one third of this group reporting "binge drinking" (defined as having 5 or more drinks in a row) three or more times in the last month (Hibell et al., 2000).

The Department of Health's interim report on alcohol (2002) also draws attention to the societal impact such an increase in alcohol consumption by examining each of unintentional injuries/ accidents, personal relationships, interpersonal violence/ public safety, drink driving, alcohol related mortality, mental health problems and economic cost of alcohol-related problems stating that none go unaffected by the rise in alcohol use and abuse that has been seen.

With specific regard to mental health, the report states that "alcohol abuse is a significant risk factor in suicide and *compounds the other factors...*" (Department of Health, 2002, p. 11, italics added). In keeping with the cultural model presented here, this statement adequately summarizes the complex relationship - while alcohol consumption may indeed reduce inhibition and, by this means, increase the risk of suicide, it is not in and of itself a causal factor, but is to be better understood as a maladaptive, (often) socially sanctioned and legally condoned coping mechanism which exists within our culture. Thus alcohol consumption may precipitate a suicidal attempt, rather than being a reason for it. At the same time it is recognized that chronic alcohol use may interact with depression and low self-esteem in a self-destructive spiral that reinforces a person's feelings of hopelessness and despair, and ultimately leads them to attempt to end their life.
The use of maladaptive coping responses such as binge drinking must also be viewed from with the more general context of the "gender revolution" which has occurred in Ireland. Clare (2000) presents a strong argument on the "overthrow of man". He argues that a mere century ago, to be a man meant to be a leader in public life, a patriarch at home, being male was the very definition of health and maturity. The definition of 'successful man' did not simply embody the characteristics of decisiveness, rationality, calmness, discipline, resourcefulness. 'Maleness' was also defined in terms of what it was not that is; fragility, weakness, vulnerability, emotionality, impetuousness, dependence nervousness- the stereotype of the 'weaker sex'.

He goes on to assert that today's man is caste as a shadow of the manhood which, while forged over a number of centuries, came into its own in the nineteenth century- a century of unparalleled male achievement in science, technology, biology, medicine, exploration and imperial expansion. When the inheritance of man is discussed it is not merely his genes or his biological destiny that is being referred to, but the social expectations, the cultural notions of what it means to be 'man'. The men of previous times were in control. Today, men are in confusion. When it comes to work, procreation, family and so many other areas of life, women can perform as well as men, even in the absence of men. There is little left

that is uniquely male and even less that exclusively defines that which is "masculine" except perhaps (and unfortunately) suicide.

Coping in adolescence

Contrary to the traditional stereotype of childhood and adolescence being a carefree time (colloquially referred to as "the best time of your life") children and young people frequently encounter stress across domains of living with which they have to cope (Williams & McGillicuddy-De Lisi, 2000). Further, these same authors report significant gender differences in the ways in which adolescent males and females attempt to cope with stressful situations.

It is important to note that in drawing attention to the need to assess coping in youth populations, current researchers are careful not to revisit the *"sturm und drang"* model of adolescence so common in previous decades. This perspective which held adolescence to be a time of inescapable *"storm and stress"* characterised by moodiness, the tendency to contradict one's parents/care-givers and the emergence of risky behaviour (Arnett, 1999) originated from the developmental psychology writings of G. Stanley Hall in 1904 (cited in Arnett, ibid). While Hall allowed for individual differences and socio-cultural effects (in the proposal that modern Western lifestyles, replete with increasing urbanisation, led to a conflict between adolescents' need for adventure and society's promotion of a sedentary lifestyle), the idea that a "teenage storm" was unavoidable was firmly held within developmental psychology for quite some time, with the model still present in textbooks (Santrock, 2002). Among those who readily adopted this model was Anna Freud (Freud, 1958, 1968, 1969), who proposed that adolescents who *did not* experience "storm and stress" were, in fact exhibiting some form of psychopathology. In this way, adolescence as a developmental stage was, for a time at least, pathologized: if difficulty and disturbance were not experienced, pathology was present; and if disturbances were experienced then obviously (according to this line of thought) pathology was present. The ready adoption of this "deviance model" generally but specifically with regard to adolescent behaviour may be criticised on several grounds, the most important of which (when the issue of suicide is considered)

relates to the accurate recognition of risk-cases. The "storm and stress" model easily results in "real" states of distress being overlooked (as part of "normal" behaviour) and can serve to normalize deviant or unhealthy behaviours (as in the case of binge drinking). Coping remains however, an important area of inquiry for those difficult situations which *are* encountered by adolescents (such as changing family and peer relationships, the emergence of a mature sexual identity, school transitions, career decisions, and social demands (Rice, Herman, & Petersen, 1993).

With regard to the *type* of coping behaviours seen in adolescence, Frydenberg & Lewis (1991) report that younger adolescents tend towards distraction techniques while older adolescents tend towards tension-reduction techniques (similar to emotion-focused responding). This is further supported by Compas, Orosan & Grant (1993) who report the increased use of emotion-focused strategies (such as avoidance) increase in frequency alongside increases in age. Finally, these same authors assert that problem-focused strategies have emerged by mid-adolescence and do not appear to show any age-related effects with regard to frequency of use although gender differences may be seen.

On the point of gender differences, research suggests an important difference in the use of social-support as a form of coping with females more likely than males to engage in these forms of behaviour (Amirkhan, 1994a; Frydenberg & Lewis, 1991) with the most consistently emerging findings being that adolescent females seek social contact and interpersonal support to resolve difficulties more frequently than boys while adolescent males more often use ventilation or avoidance techniques (Fields & Prinz, 1997).

Research on coping and adolescent suicide is limited with the vast majority of studies either failing to include measures of coping (and thus, assess coping behaviour indirectly) or limit the examination of coping strategies to the use of problem-solving methods alone thus, presenting a limited picture of broader coping patters (Spirito, Francis, Overholser, & Frank, 1996; Wilson et al., 1995). Curran (1987) however, reports on the relationship between coping and suicide

in adolescents; positing that the use of avoidant methods (such as social isolation) *or* attempts at the use of social support mechanisms which fail (such as seeking support but not receiving effective or relevant support) are significantly related to suicidal behaviours.

One research study which included the investigation of alternative methods of coping has, to date, been carried out in Ireland (Begley et al., 2000) with the finding that 90% of the sample (which was exclusively male and aged 18 - 34 years old) utilised social support ("talking to someone") as a form of coping when faced with a stressor. A similar proportion indicated they "got angry" while 70% reported the use of alcohol in order to cope when worried or upset. Thus, while it appears that males *do* use social support as a means of coping, ventilation and avoidance techniques are, in an Irish sample, also frequently employed. Interestingly, a low of 4% mentioned any use of problem-solving techniques.

Research Statement

The selection of the target group for the current research reflects a very practical and important issue with regard to such work being carried out with the school-going population. While for males specifically, the risk of completed suicide is higher in the 25-29 year old age group than it is in either of the younger groups, (where, in 2002 for example, a total of 56 males died as a result of suicide in contrast to 31 15-19 year olds and 46 20-24 year olds), the feasibility of collective participation in a prevention programme beyond the point of school-leaving is particularly problematic. Attendance at third-level education is widely noted to be associated with lower risk of suicide completion in males and participation in suicide prevention in a work setting is an area as yet, un-investigated. Therefore, from the perspective of health promotion, the availability of adolescents within the school system and the possibility of integrating suicide prevention and emotional health information into existing curricula (which will be further discussed in Chapter 6) remains the "best option" at present and makes the inclusion of this age-group in research particularly relevant.

Research was thus undertaken with a youth population in the school setting given the particular aim of the provision of information pertaining to the development and implementation of a suicide prevention programme for post-primary schools.

Given the gender disparity in cases of completed suicide in an Irish context, gender differences were analysed both in terms of issues pertaining to mental health but at a broader level in terms of the relationships between acculturation and precursors to suicide.

The research incorporated the variables of hopelessness, depression, coping, self-esteem and anomie in the investigation of youth attitudes towards understandable precursors to suicidal behaviour as they are related within the cultural context of modern Ireland. To facilitate this investigation further, the development and validation of context-based measure (the Trinity Inventory of Precursors to Suicide) was undertaken.

It was the explicit aim of the current research to investigate the proposition that recent social and cultural changes in Ireland were significantly related to the context of youth suicide. Utilising and extending the theory of *acculturation* (Berry, 1997) the role of attitudes and risk factors placing youths in a vulnerable position with regard to negative affective states leading to suicide, were investigated from a theoretically driven perspective, embedded within an empirical framework, including contextual factors throughout.

Thus, in conclusion, it may be said that the specific hypotheses of the present research were as follows;

H_1 That culture would show significant relationships with mental health variables.
H_2 That significant gender differences would be seen across variables.

H_3 That the investigation of contextual factors, as opearationalised by the *Trinity Inventory of Precursors to Suicide (TIPS)*, would result in gendered trajectories to suicide.

Chapter 2 - Development & Evaluation of Trinity Inventory of Precursors to Suicide

Chapter Aims

The objectives of this phase were;

- The development of a new measure for the assessment of predisposing contextual factors to youth suicide.
- Exploratory factor analysis of the psychometric properties of this measure.

Background & Evaluation of existing measures [8]

Despite the considerable increase in youth suicide across nations, attitudinal measures continue to adopt a unidimensional perspective, presenting suicide as a behaviour that is *either* understandable *or* not. Thus, existing measures fail to consider the context and details of those situations where suicide may be seen as a viable option to a youth population. As noted previously, current understandings of suicide reflect that this spectrum of behaviour is multidimensional, complex and illustrative of the interaction between *inter*personal, *intra*personal, social and cultural factors. Despite this, many existing measures of attitudes towards suicide, fail to reflect this. Prior to the development of the Trinity Inventory of Precursors to Suicide (TIPS) an extensive literature review was conducted in order to examine existing measures relating to suicide and suicide-related behaviours.

Given the recent increase in youth suicide particularly in the Western world (World Health Organisation, 2001) and the immediate need for both a more extensive understanding of those situations in which suicide risk is increased and effective prevention programmes, an examination of attitudes towards suicidal behaviours is especially relevant. Looking specifically at the measurement of attitudes towards suicide, two principle measures have, to date, been most frequently cited - the Suicide Opinion Questionnaire (Domino, Moore, Westlake,

[8] Part of this chapter has previously been published under Smyth, C. L., & MacLachlan, M. (2004). The Context of Suicide: An examination of life circumstances thought to be understandable precursors to youth suicide. *Journal of Mental Health, 13* (1), 83-92.

& Gibson, 1982) and that of Diekstra & Kerkhof (1989) - the Suicide Attitude Questionnaire. There are however; others such as the Attitudes Towards Suicide (ATTS) (Renberg & Jacobsson, 1998) the Scale for Suicide Ideation (SSI) (Beck, Kovacs, & Weissman, 1979), Reasons for Living Inventory (RFLI) (Linehan, Goodstein, Nielsen, & Chiles, 1983), Suicide Probability Scale (SPS) (Cull & Gill, 1982) and the Suicide Ideation Questionnaire (SIQ) (Reynolds, 1987) clearly pointing to the lack of standardization of measurement in the area.

Although these measures are relatively well-established, there remain a number of issues of concern which warrant consideration. To consider first, both the Suicide Opinion Questionnaire (SOQ) and the Suicide Attitude Questionnaire (SUIATT)- Dominio's questionnaire, the SOQ, which originally consisted of 100 items was subsequently modified by Rogers & De Shon (1993) to include subscales of acceptability, perceived factual knowledge, social disintegration, personal defect and emotional perturbation. Apart from the sheer length of this measure (which unquestionably reduces its utility in certain research and clinical settings); the initial version included several items which were reverse-scored. Subsequent papers have failed to take explicit account of this, leading to a considerable degree of confusion over the various sets of reported results thus limiting both the reliability of findings and the possibility of cross-sample comparisons.

In addition, translated versions have been used with little information provided on the translation process itself thus violating even the most fundamental methodological considerations, with even the English version suffering from more traditional and no-longer used linguistic descriptions of suicide as it makes specific reference to the *act* of suicide being *committed*, which writers today are advised to avoid as this description is thought to be pejorative in its portrayal of suicide as equivalent to the perpetration of a crime, thus facilitating the unwanted stigmatized perception which has existed in the past (Irish Association of Suicidology, 2000a).

Finally, Range, Leach, McIntyre, Posey-Deters, Marion, Kovac, Banos & Vigil (1999) assert that while the Rogers et al., (1993) modification may represent a

more "meaningful and statistically sound" (p. 425) interpretation of the measure, psychometric findings on the questionnaire are mixed at best with complex factor structures regularly emerging which fail to replicate the original.

Diekstra & Kerkhof (1989) offer an alternative in the form of the Suicide Attitude Questionnaire. This measure consists of 63 items, measured along a five-point Likert scale. It is theoretically based on the social learning theory of suicide and reflects this throughout. Test-retest reliability and internal consistency are reportedly strong (Diekstra et al., 1989). Despite this, several problems have been reported by other authors. Range et al., (1999) argue that much like Domino's measure, although an English translation is available, translation details are again lacking and present similar problems with regard to its use. Furthermore, and as detailed by Jenner & Niesing (2000), items on the translated version are not scored on a continuous scale (as in the original) thus hindering any meaningful interpretation and preventing comparisons being drawn across studies. In short, "what is actually being measured has thus become unknown (and)... is considered too time-consuming and complicated..." (Jenner et al., 2000, p. 140).

One final problem with this measure is one which is ultimately practical in nature but reflects the lack of clarity in the area nonetheless. The Suicide Attitude Questionnaire has been referred to as both the SAQ and the SUIATT making literature reviews, evaluations across measures and general research on the topic problematic. It is unclear from many papers precisely which measure has been employed and whether or not it is the translated version.

Despite the outlined difficulties with both measures, neither is without some value and both reflect the fact that suicide is a multifaceted, multidimensional event, which is not easily conceptualized. Indeed, one of the most valuable insights provided (by Domino's measure) is the idea that suicide is *acceptable* or at least, *understandable* in certain circumstances and so, is not to be viewed as any of moral evil, crime or madness. The implicit message in this is that, given a specific set of circumstances, any one of us might view suicide as a possible option. This is a fundamental element in the development of TIPS.

It is important to note at this point, that suicide risk assessment can never (and indeed, should not) depend wholly on paper and pencil tests, but that an awareness of clinical and sociodemographic aspects and risk elements is fundamental. This is of particular relevance when we consider Shneidman's definition of suicide which places subjective, or personal, perceptions and experiences of distress and *psychache* to the fore. Despite this, the practical need to assess attitudes, beliefs and decisions surrounding suicide remains in each of clinical, educational and research settings and it is within this context that TIPS may be placed.

Range & Antonelli (1990) looked specifically at six instruments which have been used in the assessment of suicidality (in the case of the cited study, with undergraduate students). These six instruments were Beck's Hopelessness Scale, the Zung self-rating scale for depression, Scale for Suicide Ideation (SSI), Reasons for Living Inventory (RFLI), Suicide Probability Scale (SPS) and the Suicide Ideation Questionnaire (SIQ). When a factor analysis of these instruments was carried out, it was found that each of them accounted for unique variance. This accurately echoes the theoretical position that suicide is multidimensional and suggests that those being assessed for suicide risk should complete a battery of tests rather than rely on a single instrument.

Although numerous, a fundamental and shared weakness of many of these measures is that while they assess many cognitive, emotional and behavioural components of suicidal behaviour, they remain abstract in nature (for example the following items are indicative of the abstract, context-free nature of many of the items; "Wish to live" from the SSI, "Have thought of death" from the SIS and "I think of suicide" from SPS). Thus, the context of suicidal behaviour (and indeed, information on the ultimate precursors to suicide) is left un-investigated.

Moving from this more general consideration of existing measures, a detailed review of some of the most commonly used measures is required;

Scale for Suicide Ideation (Beck, Kovacs et al., 1979)

This scale consists of 19 'stems' such as "Wish to live" which may be rated along a Likert-type scale with three options; "Moderate to Strong", "Weak" or "None". The measure consists of three factors; active suicidal desire, passive suicidal desire and preparation. The total score on the SSI can range from 0 to 38. Psychometrically this measure is good with the weakest point being its low predictive validity. On this point however; an important ideological consideration with regard to such measures (and relating more broadly to the issue of prevention, an issue to which attention will later return) warrants consideration. It is widely noted that the low base-rate of suicide limits the predictive power of any such instrument or in fact, any prevention programme/targeted intervention (Hawton & van Heeringen, 2000). In practice, this means moving beyond the standard view of prediction towards a more inclusive, "global health" model of mental health/emotional wellbeing as it is applied to suicide. Nonetheless, in purely psychometric terms, the Scale for Suicide Ideation is not the strongest available and fails to address some of the more complex aspects of suicidal ideation/attitudes towards suicide.

Reasons for Living Inventory (Linehan et al., 1983)

Marking something of a departure from the framework of other measures, the Reasons for Living Inventory (RLI) consists of 48 statements as to why one should *not* behave in a suicidal manner (e.g. "I believe I could cope with anything life has to offer"). Each item is responded to along a five-point Likert scale ranging from "extremely important" to "unimportant". Factor analysis has revealed six underlying subscales- covering each of Survival and Coping Beliefs, Responsibility to Family, Child Concerns, Fear of Suicide, Fear of Social Disapproval and Moral Objections (Linehan et al., 1983; Range & Steede, 1987).

Interestingly, Range et al., (1997) raise the possibility that completion of the measure in itself may have a mental health promoting effect. A unique aspect of the RLI is the positive wording and these authors (ibid) suggest that completing the measure may reduce negative affect thus indirectly reducing the likelihood of suicidal behaviour. This however; is an untested hypothesis, and the "cumbersome" (Range et al., 1997, p. 38) nature of the measure; related to the

wording of questions which requires respondents to differentiate across items between thoughts of killing oneself versus *not* killing oneself, and is in violation of guidelines on the structure of items for questionnaires, (Nunnally & Bernstein, 1994), outweighs any possible benefits and has resulted in the measure being used predominantly in college settings with undergraduate students thus offering little possibility of generalization or use in community-based studies.

Suicide Probability Scale (Cull & Gill, 1982)

This measure, the SPS, was specifically designed to measure suicidality in children and adolescents. It consists of 36 items (e.g. "I think of suicide") scored along a Likert-type range of 1 ("None or a little of the time") to 4 ("Most or all of the time"). In addition to the total score on the measure, scores across four subscales may be calculated. These are; Hopelessness, Suicidal Ideation, Negative Self-Evaluation and Hostility. The SPS was initially developed as a clinical instrument designed to be completed alongside an interview. The substantive problem with this measure is that although it was designed for use with adolescents over the age of 14, the majority of the normative sample used was over the age of 19 thus failing to target the specific group for which it was intended. In addition, subsequent factor analysis has yielded three rather than four subscales which were re-named as Suicidal Despair, Angry Frustration and Low Self-Efficacy (Tatman, Greene, & Karr, 1993). Thus, a significant concern relates to the psychometric properties of the measure. The conclusion reached then, by Tatman et al. (1993) is that it should be used only cautiously with adolescents until further information on the factor structure, reliability and appropriateness of the measure has been gathered across populations. No such research has been undertaken thus far.

Suicide Ideation Questionnaire (Reynolds, 1987)

The Suicide Ideation Questionnaire (SIQ) consists of 30 Likert items (e.g. "I thought it would be better if I were not alive") which examine individuals' thoughts relating to suicide in the *last month.*

Table 2.1.: Overview of listed suicide measures.

Test	Author	Items	Dimensions	α	Data	Validity [9]	Comment
SOQ	Rogers et al.	100	Acceptability Perceived Factual Knowledge Social Disintegration Personal defect Emotional Perturbation	-	285 adults	-	Overly lengthy. Lack of clarity regarding scoring. Lack of validation work.
SUI ATT	Diekstra et al.	63	Social Learning Theory of Suicide	-	100 medical students	-	Failure in translation/back-translation process. Lack of information on validation.
SSI	Beck et al.	19	Active Suicidal Desire Passive Suicidal Desire Preparation	.90	207 suicidal inpatients	†[10]	Norms based solely on clinical, adult sample. Measure of active suicidal ideation, inappropriate to current research.
RFLI	Linehan et al.	48	Survival & Coping Beliefs Responsibility to Family Child Concerns Fear of sin Fear of Social Disapproval Moral Objections	.89-.92	197 adults & 195 inpatients	-	Difficult wording structure, questionable utility with adolescent sample. Lack of research with adolescent & general samples.
SPS	Cull et al.	36	Hopelessness Suicidal Ideation Negative Self Evaluation Hostility	.72	562 adolescents & adults, 260 psychiatric inpatients & 336 general patients	-	Inability to replicate factor structure. Questionable utility with adolescent groups.
SIQ	Reynolds	30	Frequency of Suicidal Thoughts	.59-.70	898 adolescents, 152 undergraduates	-	Measure of active suicidal ideation, inappropriate to

[9] General note: The issue of validity with regard to suicide-related measures is particularly problematic given the low population baserate of completed suciide. As a result, this is an issue which often remains univestigated by means of formal psychometric procedures and is an area which is characterised by a dearth of information (Hawton & van Heeringen, 2000).

[10] † Predictive validity has been examined alongside the use of the BDI and BHS, please see Chapter 3 for details with related populations.

Test	Author	Items	Dimensions	α	Data	Validity [9]	Comment
					& 1383 inpatient adolescents		current research. Inability to differentiate between levels of risk. Psychometric properties questioned.

While the specific time frame is desirable for an acute-risk measure such as this, as with the previously mentioned SPS there is considerable concern over the psychometric properties of the SIQ. Examinations subsequent to the original development of the measure, have found that the SIQ fails to discriminate between high and low risk adolescents (Ritter, 1990). Given that the specific aim is risk assessment in the short-term, this failure is particularly troublesome. There also exists a "junior high" version (specifically for use with 12 to 14 year olds) however this alternate form of the measure performs no better than the general population version.

The inclusion of contextual factors

Whatever the various specifics of each of the aforementioned measures, it can be seen that ultimately they share a reliance on the abstract with little recourse to contextual factors. It is on this specific point that the Trinity Inventory of Precursors to Suicide (TIPS) aims to provide information. It is this situational/ contextual element which was focused upon in order to examine some of the *specific* life circumstances in response to which suicide might be seen as a viable option.

The importance of such focus becomes all the more relevant in light of recent assertions such as that of O'Connor & Sheehy (2000) and De Wilde (2000) that suicide is best seen as but one of a continuum of behaviours, rather than as a singular event which is the sole concern of 'mentally ill' individuals, and with suggestions that elements of our current culture are becoming increasingly *suicidogenic*. Berman (1997) expands on this latter point in stating "culture is the nutrient medium within which the organism is cultivated. Suicidality grows, as

well, when that culture is pathological.... Suicidal behaviour can be designed to protect, to rescue the self from otherwise certain annihilation" (p.6). Thus, the question posed is specifically *what* situational factors are considered, by adolescents themselves, to be "acceptable" precursors to suicidal behaviour.

The idea that suicide is situational is not new with Stone (1999) outlining a number of situational precursors to suicidal behaviour ranging from substance abuse (alcohol or drug-related) and interpersonal problems to the desire to escape from an unbearable situation (be it terminal illness, chronic misery, persecution or abuse) to name but a few. Negative life stress and family financial problems (Pfeffer, Adams, Weiner, & Rosenberg, 1988), family arguments (Reinherz et al., 1995), problems with parents (Wilson et al., 1995), family and personal events (Adams & Adams, 1996), romantic conflicts and school difficulties (Sandin et al., 1998) have each been analysed. While situational elements such as these play a role in suicidal behaviour across ages, De Wilde (2000) points to the special vulnerability of the adolescent population to contextual factors.

A further point of importance, and one which relates to the application and use of the TIPS rests with the nature of suicide prevention. Contemporary prevention research such as that of Garland & Ziegler (1993); Dryfoos (1994); Gutkin (1995) and Miller, Eckert, Du Paul & White (1999) convincingly argues that one of the most fundamental aspects of future programme provision is a practical focus on wellbeing and coping where adolescents are taught how to respond and more effectively cope with *specific challenges and life events*. Prevention programmes which present factual knowledge in the absence of practical advice on how to respond to specific stressors are to be avoided in favour of problem-cantered materials (Kalafat & Elias, 1995), thus further emphasizing the need for examinations of situational precursors to suicidal behaviour.

Thus, in accepting that suicide is situational and that prevention programmes rest on our ability to respond to adolescent concerns related to specific life events, it is necessary to identify *when* and in response to *what* situations does suicide become understandable? The aim was to place focus specifically on this latter

question in order to develop a psychometrically sound measure to facilitate the exploration of those specific situations which make suicidal behaviour "understandable".

A final point is that much of the research undertaken to date has placed almost exclusive focus on high-risk and/or clinical populations. Thus, the groups with which these measures have been developed are highly circumscribed. Marking a move away from such a perspective, the TIPS was designed for use in general population, community and/or school based settings.

Item generation and questionnaire construction

Generation of items for inclusion in the *Trinity Inventory of Precursors to Suicide (TIPS)* was based on an extensive literature review of previous research into those risk factors and events, which are seen to predispose individuals to some form of suicidal behaviour.

A review of the current literature identified predisposing life events which generally fall into four broad themes (a) interpersonal difficulty, (b) illness, (c) familial disruption and (d) loss. Examples of such factors include; child abuse (either physical or sexual), and child neglect (Deykin, Alpert & McNamara, 1985 and Molnar, Shade, Kral, Booth & Watters, 1998); inadequate social connectedness, social support and hopelessness (Lewishon, Rohde, & Seeley, 1996); low self-esteem, excessive emotional reliance on others, poor coping skills, low social support from family and a history of a mental health diagnosis prior to age 19 (Lewishon, Rohde, Seeley, & Baldwin, 2001); unemployment (which, when operationalised included a measure of wealth/economic prosperity such that being poor or having no money resulted in higher risk) and being single (Mortensen, Agerbo, & Erickson, 2000); ever having been a patient in a psychiatric hospital, sickness and absence from work (Ping, Agerbo, Westergard-Nielsen, Erickson, & Mortensen, 2000); loss of attachment figures and perceived failure (personal/academic) (Wagner, 1997) .

The original, "pilot" version of the TIPS consisted of 25 items listed below (see Table 2.2). The listed themes were then transformed into simple, exemplar statements which were developed with the aim of being clear and unambiguous, in keeping with the Nunnally & Bernstein (1994) guidelines for item construction. For example, the idea that familial disruption was adequate justification for suicidal behaviour was operationalised by items 5 ("Parents divorcing"), 11 ("Arguing with your parents"), 19 ("Your partner having an affair") among others. Responses were recorded on a five-point Likert scale ranging from *Very Good Reason* to *Very Poor Reason.*

At this stage, the questionnaire was reviewed by members of the Irish Association of Suicidology, the National Suicide Review Group and clinicians working in the area. No alterations to the questionnaire were deemed necessary.

Description of the questionnaire

The front page of the questionnaire contained the title, concise instructions assuring anonymity and two demographic questions (relating to the age and gender of participants). The remaining two pages contained the 25 items for consideration.

Participants

Participants came from a convenience sample consisting of 100 undergraduate Psychology students (42 males and 58 females). Administration of the measure was carried out by the researcher who was unknown to participants prior to the administration, during two Junior Freshman lectures in Trinity College Dublin, on an anonymous and voluntary basis. Age ranged from 18 to 42 years (M= 21.13, SD= 5.37).

Participants received no monetary compensation or academic credit for participation. No information was collected on participants' prior exposure to or experience with suicide/suicidal behaviours as the measure is not intended to

assess active suicidal behaviour or intent and we felt that seeking such information may have discouraged people to complete the questionnaire.

Table 2.2: Full lit of items in pilot questionnaire

Item	Statement
1	Death of a parent
2	Suffering emotional abuse in a relationship
3	Bowel cancer in a 75 year old man
4	Breaking up with a girlfriend/ boyfriend
5	Parents divorcing
6	Feeling low/ down
7	Becoming unemployed
8	Discovering that you're homosexual
9	Becoming disabled following accident/ injury
10	Suffering sexual abuse as a child
11	Arguing with your parents
12	Death of a close friend
13	Failing an exam
14	Wanting to be with a loved one who has died
15	Being diagnosed as HIV positive
16	Death of a spouse/ lover
17	Not being able to get a girlfriend/ boyfriend
18	Unwanted pregnancy
19	Your partner having an affair
20	Having no money
21	Hearing voices
22	Finding out you can't have children
23	Breast cancer in a 30 year old woman
24	Wanting to "show" someone how much they would miss you
25	Being diagnosed with AIDS

Statistical Analysis

It was determined whether Factor Analysis was an appropriate procedure to use with this data set by using two well established criteria. SPSS offers Bartlett's test

of Sphericity as the default option for this purpose. In the case of the current data set the value was large and statistically significant (V= 562.76, p <0.0001). The second evaluation of the suitability of the data for Factor Analysis was given by the Kaiser-Meyer-Olkin (KMO test) or measure of sampling adequacy (Kaiser, 1970). The KMO test is, in effect, a measure of the degree of inter-correlation among variables, specifying the variance attributable to unique factors relative to that of the common factors. The value obtained (KMO= .84) is well within acceptable parameters (Hair *et al.*, 1998; Kaiser, 1974).

In addition, it was important to ensure that the sample size was adequate for the characteristics of the particular data set. According to the criteria established by Barrett & Kline (1981) and Guadagnoli & Velicer (1988) as long as the number of participants is greater than the number of items, and that a minimum sample of 100 is obtained, the ratio of participants to variables is not as important as the absolute size of the sample and the factor loadings. Such an approach acknowledges the importance of evoking meaningful patterns from the data. Data met the requisite characteristics for it to be subjected to Factor Analysis (see also Hair, Anderson, Tatham and Black, 1998).

As the aim was to summarise most of the original information into a minimum number of factors (thus achieving the most parsimonious factor structure while maintaining statistical robustness), all 25 items in the initial version of the measure were entered into an R-Type[11] exploratory factor analysis, using the Principal Components (PC) method of factor extraction as delineated by Hair et al., (1998). At this point, items which did not load on to any factor (where a cut-off point of .5 was used) were discarded. The remaining items were then re-analysed using the PC method followed by an orthogonal Varimax rotation. In factor analytic procedures, rotation methods are generally employed to aid the meaningful interpretation of factors and assist in the clarification of the overall, underlying factor structure of the data set thus reducing the ambiguity that often

[11] R-Type Factor Analysis relates to the analysis of relationships among variables to identify groups of variables which form latent dimensions or factors. This may be contrasted to Q-Type Factor Analysis which groups cases (or groups of respondents) on the basis of a pre-determined set of characteristics and does not facilitate the emergence of latent dimensions or factors. (McDonald, 1985)

accompanies the preliminary analysis (Child, 1990). Here, Varimax was selected given that the aim was a reduction of the number of original variables to a smaller set of variables, reflecting underlying factors.

Before proceeding with the interpretation and naming of the various factors, item-analysis was performed to investigate the possibility of items being grouped on the basis of their relative intensity (that is, that items which related to more "serious" life events were being more strongly endorsed on the Likert scale and thus, grouped on this basis alone). This was found not to be the case as scoring on each of the final 12 items was across the full range of response options. Furthermore, tests of kurtosis and skew indicated that the distribution of the sample data set fell within normal parameters (Tabachnick & Fidell, 1996).

While the rotated solution (see Table 2.3) of the 19 remaining items on the TIPS (following the removal of six items due to insufficient factor loadings) accounted for 66.4% of the variance, it was decided that a re-analysis was called for in view of the single-item factor (Factor 5). On re-analysis, four factors, consisting of three items each emerged. This final and most parsimonious solution accounted for 69.75% of the variance. After the four subscales had been identified in this manner, the internal reliability of each was assessed by means of Cronbach's Alpha (Cronbach, 1951) with the finding that each of the scales had an alpha greater than .7, meeting statistical requirements (Hair et al., 1998). Results are listed in Table 2.4.

Table 2.3: Rotated Factor Analysis of Trinity Inventory of Precursors to Suicide (TIPS)

Item	Factor 1:	Factor 2:	Factor 3:	Factor 4:	Factor 5:
Having no money	.785				
Not being able to get a girlfriend/boyfriend	.775				
Wanting to "show" someone how much they would miss you	.740				
Becoming unemployed	.719				
Your partner having an affair	.676				
Unwanted pregnancy	.635				
Eigenvalue	3.554				
% Variance Accounted for	15.45%				
Death of a close friend		.851			
Death of a parent		.794			
Death of a spouse/lover		.786			
Suffering sexual abuse as a child		.583			
Suffering emotional abuse in a relationship		.570			
Wanting to be with a loved one who has died		.560			
Eigenvalue		3.510			
% Variance Accounted for		15.27%			
Breast cancer in a 30-year old woman			.761		
Being diagnosed with AIDS			.710		
Finding out you can't have children			.577		
Hearing voices			.570		
Eigenvalue			3.502		
% Variance Accounted for			15.23%		
Discovering that you're homosexual				.802	
Becoming disabled following accident/injury				.677	
Eigenvalue				3.175	
% Variance Accounted for				13.81%	
Bowel cancer in a 75 year old man					.784
Eigenvalue					1.523
% Variance Accounted for					6.62%
M	10.65	17.28	9.76	4.41	3.20
(SD)	(4.39)	(4.84)	(3.24)	(1.58)	(1.22)
Potential Range	6-30	6-30	4-20	2-10	1-5
Observed Range	6-30	6-30	4-20	2-10	1-5
Cronbach's α	.876	.850	.785	.614	-

Table 2.4: Final, rotated Factor Analysis of the Trinity Inventory of Precursors to Suicide (TIPS)

Item	Factor 1: Role Status	Factor 2: Physical Limitations	Factor 3: Nurturing bonds/intimate relations	Factor 4: Death
Not being able to get a girlfriend/boyfriend	.795			
Becoming unemployed	.782			
Having no money	.774			
Eigenvalue	3.967			
% Variance Accounted for	20.88%			
Breast cancer in a 30 year-old woman		.802		
Being diagnosed with AIDS		.743		
Finding out you can't have children		.682		
Eigenvalue		3.569		
% Variance Accounted for		18.78%		
Suffering sexual abuse as a child			.809	
Death of a parent			.748	
Suffering emotional abuse in a relationship			.743	
Eigenvalue			3.124	
% Variance Accounted for			16.44%	
Wanting to be with a loved one who has died				.870
Death of a spouse/lover				.750
Death of a close friend				.579
Eigenvalue				2.591
% Variance Accounted for				13.63%
M	5.33	7.62	8.4	8.88
(SD)	(2.29)	(2.57)	(2.60)	(2.80)
Potential Range	3-15	3-15	3-15	3-15
Observed Range	3-15	3-15	3-15	3-15
Cronbach's α	.79	.77	.74	.81

Discussion

In its final format, the TIPS consists of 12 items with four subscales which have good reliability, construct and content validity, and which can be used easily in a variety of settings. The value of a self-report measure such as this has been outlined by Range et al., (1997) with one of the key attractions being that it may reduce social desirability in responding. This is of particular importance given the issue to which the measure applies is suicide.

One of the specific aims of the measure was the reduction of a possibly infinite number of precursor events to a more manageable group of illustrative exemplars. Thus while the items on the final version of the measure are not exhaustive, they do represent (in the form of context- specific exemplars) each of the four themes most frequently cited as situations which precede suicidal behaviour that is, each of; interpersonal difficulty, illness, familial disruption and loss. In addition, and with regard to the number of items it was felt that brevity (thus facilitating use of the measure) was desirable especially given the criticism that existing related measures of this type are too long.

In naming the factors, the most pervasive theme that emerged was of *loss*. Loss of role status (exhibited as an absence of girlfriend/boyfriend, job and money), loss of physical capabilities (with three serious, although not necessarily life threatening, conditions mentioned), loss of nurturing bonds or intimate relations (as a result of sexual or emotional abuse or as a result of losing the fundamental relationship with a parent), and finally, what is perhaps the ultimate loss - loss of self, as a result of death.

The idea that loss (and the resultant emotions) and suicide are intimately related is one that has previously emerged from the literature with the best illustration coming from Shneidman's (1985) term *psychache,* that is, the desire to escape an unbearable, intolerable situation which is causing psychic pain in the most elementary way. In the case of the current measure, a list of various situations thought to make the consideration of suicidal behaviour "understandable" is presented. This is in keeping with Blumenthal's (1990) statement that suicide "... can reflect many motivational determinants- personal, interpersonal, biological, familial and cultural" (p.516). Items from each of these domains are represented giving coverage to a range of situations. It is important to note that responses to the various items did not require any judgement on the morality, criminality or acceptability of suicide but rather, focused on whether or not it was understandable in the *specific* situation outlined. Also important is the fact that judgement on the severity of situations (that is, not having a girlfriend/boyfriend possibly being less "serious" than breast cancer) was not required, as this is necessarily a relative and personal judgement which cannot be 'objectively'

graded by others. These attributes of the TIPS are particularly important because such 'distancing' may facilitate more accurate responding and increase the general acceptability and user-friendliness of the measure.

Finally, it is important to emphasize that the TIPS is *not* another measure of suicidality or an assessment of active suicidal behaviour or ideation. The bias of existing measures towards a unidimensional conceptualisation of suicide limits our level of knowledge and understanding. Clearly, given recent statistics, suicide is a very real and unfortunately commonplace part of adolescents' experience. For this reason, the value then of asking "is suicide an understandable or fitting act generally?" is limited. It is proposed that a more fruitful avenue lies in the question "*when* is suicide understandable?" By gathering this context-based information more directed, problem-specific prevention programs may be developed. Contemporary prevention research such as that of Garland & Ziegler (1993); Dryfoos (1994); Gutkin (1995) and Miller, Eckert, Du Paul & White (1999) convincingly argues that one of the most fundamental aspects of future programme provision is a practical focus on wellbeing and coping where adolescents are taught how to respond to, and more effectively cope with specific challenges and life events. Prevention programmes which present factual knowledge in the absence of practical advice on how to respond to specific stressors are to be avoided in favour of problem-centred materials (Kalafat & Elias, 1995) further emphasizing the need for examinations of situational precursors to suicidal behaviour.

It is not proposed that items included in the measure are *proximal causes* of suicidal behaviour but rather, that they contribute to the broader phenomenology of the individual and, by their identification may explicate the life trajectory which ultimately leads to the point of suicide. Given the aforementioned findings (see Chapter 1) of gendered pathways to suicide, the structure of TIPS facilitates context-specific investigations of the relationship between acculturation strategy, mental health and the acceptability of suicidal behaviour to a youth population.

Chapter 3 – Details of Materials

Chapter Aims

The objectives of this phase were;

- To develop support materials appropriate for the research project.
- To construct a questionnaire addressing the various research questions.

Given the range of issues outlined in Chapter 1 which relate to the issue of youth suicide, the selection of measures and the development of materials which were both appropriate to a school setting and which were accessible to all students (please see section on Alternate Versions of Materials) was of particular relevance. Further, the issue of the method of assessment of temporal acculturation was of central importance such that the theoretical underpinnings of the theory were maintained alongside the assessment of intra-cultural change.

Support Materials

Support materials for the project consisted of each of the following (please see Appendices, 1-8);

-Letter of contact to schools
- Information pack for schools
- Receipt form
- Letter of contact to parents/guardians
- Information pack for parents/guardians
- Consent form for parents/guardians and participants
- Information sheet for participants

Materials for schools

The initial letter of contact to schools and information pack (Appendices 1 and 2) provided background information on the research project including details of the research team, proposed schedule for administration, origins and aims of the research and areas of inquiry of the research.

Issues surrounding confidentiality contact with parents by the research team and the referral process was also clearly outlined. The request at this point, was for schools to return a stamped, addressed envelope to acknowledge receipt of the information and register interest in participation (Appendix 3). On this receipt form, schools were able to nominate a liaison member of staff to facilitate ongoing contact.

Materials for parents/guardians

The letter of contact to parents/guardians was sent along with a consent form and an information pack on the research (Appendices 4, 5 and 6). This letter, very much like the letter to schools, provided information on the research project including details of the research team, proposed schedule for administration, origins and aims of the research and areas of inquiry of the research. The information sheet however; under the "What support will there be?" section, provided greater detail on the referral process and the implications this had on anonymity. A request for the return of the consent form (signed by both parents/guardians and participating adolescents) was also included. It was necessary to ask parents/guardians to provide a home address and contact telephone number given the specifics of the referral process (please see Chapter 4).

Materials for participants

Materials for participants consisted of the aforementioned consent form, the questionnaire itself and a shorter version of the information pack (Appendix 7) including details of related organizations and voluntary groups, for participants to take with them *following* the administration of the questionnaire.

Description of the questionnaire

The "Adolescent Mental Health in Ireland" questionnaire (see Appendix 8) consisted of eight, numbered sections each dealing with a different area of

inquiry. The front page of the questionnaire contained the title of the research project and concise instructions for questionnaire completion.

Section 1- Biodata

This, first, section consisted of eight items on a single page covering each of name, age, gender, area of residence, religion, year in school, school-type (i.e. single-sex girls, single-sex boys or "mixed") and marital status of parents/guardians. The format for the majority of these items was "tick the box".

Section 2- Coping Strategy Indicator (CSI)

A widely-recognised longstanding weakness with regard to the assessment of human coping behaviour related to the paucity of research examining the psychometric structure, validity and reliability of measures employed (Amirkhan, 1994a). In relation to the creation of such measures, two ideological stances have predominated representing deductive and inductive theorizing on the topic (Amirkhan, 1990). The former approach (deductive) is premised on the notion that there are a limited, finite and mutually exclusive number of coping responses available to and used by individuals. Investigations typically began with the delineation of a range of taxonomies of coping behaviours which were then compared with the actual behaviour of individuals or groups when faced with an event with which to cope. This approach was appealing because of its simplicity and due to the fact that the categories were seen to be all-encompassing with their generality allowing them to cover individual's coping responses in a variety of situations. Despite this admirable aim, little empirical verification was obtained and a fundamental flaw remained- even apparently exhaustive lists proved unable to encompass every coping option or response observed.

The second approach (inductive) begins with the documenting of the coping responses of a group of individuals in response to a particular stressor followed by the statistical analysis and extrapolation to the point that general strategies are

outlined. This method allows details of coping strategies to emerge from the data and so, is thought to be more reflective of actual coping behaviours and responses. It was from this position that the CSI emerged.

Taking a factor analytic approach, the CSI (Amirkhan, 1990) evolved from a series of analyses of coping items followed by extensive exploratory and confirmatory factor analytic methods dealing with large samples taken from a variety of settings (Schwarzer & Schwarzer, 1996). In its complete form this thirty-three item, self-report measure assesses each of three coping styles; Problem-Solving, Seeking Social Support and Avoidance which have been used with regard to a recent (within six months) event in the individual's life.

Each of the thirty-three items may be responded to along a Likert-type scale with response options of "A lot", "A little" and "Not at all" (with regard to the extent to which each individual used the listed coping strategy in response to a life event). A score of three is assigned to each response of "A lot", a score of two assigned to each response of "A little" and a score of one to each response of "Not at all".

With regard to the breakdown of items across the three scales, scoring is performed as follows (see Table 3.1);

Table 3.1 Coping Strategy Indicator Scoring.

Scale	Item Number
Problem-Solving	2, 3, 8, 9, 11, 15, 16, 17, 20, 29, 33.
Seeking Social Support	1, 5, 7, 12, 14, 19, 23, 24, 25, 31, 32.
Avoidance	4, 6, 10, 13, 18, 21, 22, 26, 27, 28, 30.

Scores on the three sub-scales can thus range from eleven to thirty-three. The categorisation of scores is carried out for each scale separately as follows (see Table 3.2);

Table 3.2 Categorisation of subscale scores on CSI.

Scale	Range	Categorisation
Problem-Solving	11-16	Very low
	17-21	Low
	22-30	Average
	31-33	High
Seeking Social Support	11-13	Very low
	14-18	Low
	19-28	Average
	29-33	High
Avoidance	11-15	Low
	16-23	Average
	24-27	High
	28-33	Very high

It should be noted that this categorisation is merely offered as a descriptive guide by the author and, given the psychometric nature of the instrument more generally, it is preferable to treat the data arising from the CSI as interval data however; at preliminary stages of analysis, such broad classifications are helpful. Each of the three scales has good reported reliability (alpha coefficients of .894 for Problem-Solving, .928 for Seeking Social Support and .839 for Avoidance) and test-retest reliability (.83-.77 for Problem-Solving, .80- .86 for Seeking Social Support and .82- .79 for Avoidance). Unlike many measures in the area, the three styles assessed by the CSI are orthogonal and thus not mutually exclusive. This effectively reflects (and indeed measures) flexibility in an individual's coping making the measure particularly useful.

Further, this is a measure which has been validated in a variety of contexts and with an array of groups with results indicating that the initially-proposed three-factor structure generally holds. One subsequent examination (that of Ager &

MacLachlan, 1998) supported a four-factor solution whereby the Avoidance subscale was split into Avoidance-Withdrawal and Avoidance-Distraction. This said, studies across populations and cultural settings (such as those of Amirkhan (1994a, 1994b), Bijettebier & Vertommen (1997) and Glennon & MacLachlan (2000) have found support for the three-factor structure and have used this measure to good effect leading to the possibility that the findings of Ager et al., (1998) may have been an artefact of the alterations made to the wording of some items which were thought to be poorly understood given the alternate language in which this study was conducted.

In an assessment of instruments in this area, Parker & Endler (1992) state that the primary weakness with the CSI is the relatively limited range of coping behaviours assessed. However; and importantly for the purposes of the current study, the measure's good psychometric standing, the inclusion of three alternative coping styles and its brevity resulted in its inclusion as the best available and most relevant measure to address the issues in hand.

Nonetheless, and in recognition of the variety of measures in the area of coping (predominantly used in Health psychology settings), a summary table with details of each of the Ways of Coping-Revised (WOC-R) and the COPE are presented in Table 3.3 (below).

Table 3.3: Overview of Ways of Coping Inventory & COPE

Test	*Author*	*Items*	*Dimensions*	*α*	*Data*	*Validity*	*Comment*
WOC-R	Folkman & Lazarus	66	Problem-Focused Coping Wishful Thinking Detachment Seeking Social Support Focusing on the Positive Self-Blame Tension-Reduction Keep to Self	.61-.79	65 married couples, 108 undergraduates.	The replicability of the initial factor structure has proved difficult, with reports of an alternative factor structure	Unduly lengthy for current research. Questionable applicability to adolescent population.

Test	Author	Items	Dimensions	α	Data	Validity	Comment
						reported (Clark et al., 1995)	
COPE	Carver et al.,	60	Active Coping Planning Suppression of Competing Activities Restraint Coping Seeking Social Support (Instrumental) Positive Reinterpretation & Growth Acceptance Turning to Religion Focus & Venting of Emotions Denial Behavioural Disengagement Mental Disengagement Alcohol-drug Engagement Humour	.69-.75	Undergraduate population	-	Reflects assumption that coping responses are fixed across situations. Lack of psychometric information. Number of subscales.

Section 3- Rosenberg Self-Esteem Scale (RSES)

The RSES (Rosenberg, 1965) was initially developed (with a sample of 5024 high school juniors and seniors from 10 randomly selected New York high schools) to measure adolescents' global feelings of self worth or self-acceptance and has enjoyed widespread use since, to the point that it has come to be recognised as the scale against which other self-esteem measures are evaluated (Robinson, Shaver, & Wrightsman, 1991). Since its development, it has been used with youth populations in regard to a variety of issues including body esteem (Henriques & Calhoun, 1999), drug use (Moore, Laflin, & Weis, 1996), impact of parental alcoholism (Rodney & Mupier, 1999), the role of culture (Singelis, Bond, Sharkey, & Lai, 1999) and attachment (West, Rose, Spreng, Verhoef, & Bergman, 1999).

Consisting of 10 items (five positively worded, five negatively worded) that were designed to optimize ease of administration, economy of time, unidimensionality, and face validity the RSES asks individuals to directly report feelings about the self (Rosenberg, 1965). Although originally designed as a Guttman-type scale, it is now administered along a four-point Likert scale which results in scores ranging from 10 to 40 with higher scores representing higher levels of self esteem.

With regard to the psychometric properties of the RSES, reliability coefficients have been reported in the range of .77 to .88 (Dobson, Goudy, Keith, & Powers, 1979; Fleming & Courtney, 1984). Test-retest reliability was reported by Silber and Tippett (1965) as .85 over a two-week period. Both convergent and discriminant validity have been assessed.

On the point of the former, RSES scores are seen to relate significantly to many self-esteem related constructs. Lorr & Wundelich (1986) reported a correlation of .65 between RSES scores and confidence and of .39 between RSES and popularity. Further, Fleming and Courtney (1984) have reported a negative relationship between RSES scores and several concepts associated with low self-regard. For example, RSES scores correlated negatively with anxiety (-.64), depression (-.54) and anomie (.43). In addition, these same authors report that RSES scores were positively correlated with general self-regard (.78), social confidence (.51), school abilities (.35) and physical appearance (.42).

Considerable discriminant validity has also been demonstrated with Fleming et al., (1984) finding no significant correlations between SES scores and gender (.10), age (.13), work experience (.07), marital status (.17), birth order (.02), grade point average (.01) or vocabulary (-.04).

Several studies have examined the factor structure of this measure with many demonstrating support for the original, unidimensional structure reported by Rosenberg (Hensley, 1977; Simpson & Boyal, 1975). In addressing those studies which have not corroborated this factor structure, an alternative bidimensional model where the two emergent factors are seen to be highly correlated and the

second is seen to arise from the negatively worded questions has been reported (Dobson et al., 1979; Hensley & Roberts, 1976). However; these studies show significant weaknesses, insofar as they failed to use confirmatory analysis techniques and often did not include the complete set of 10 items (Carmines & Zeller (1979); Bachman & O'Malley (1986); and Kaufman et al., (1991)). On the whole, findings in support of the unidimensional factor structure far outweigh and more convincingly explain results than those to the contrary.

Of more recent studies, the most comprehensive examination was carried out by Tomás & Oliver (1999). Here, nine alternative structural models were considered and their strength determined through the use of confirmatory factor analytic models. Those models which investigated the two-factor structure and the possible influence of method effects were seen to have poor fit and did not adequately explain the data with the authors reaching the overall conclusion that a single, global self-esteem factor underlies the RSES.

Similar results were obtained by Marsh (1996) who reached the strong conclusion that a unidimensional factor structure was supported and ought be employed in order to meaningfully reflect theoretical considerations and accurately measure the construct of global self-esteem.

In this case, the ease of administration and scoring and the overall brevity of the measure were positive attributes which resulted in its inclusion.

Section 4- Acculturation

This section consisted of a single acculturation item and two descriptive items (measured along a Likert-type scale) examining the extent to which Ireland was perceived to have changed in the last decade and the degree to which this change was a positive (or indeed negative) occurrence.

The question examining perception of change read;

"I think there has been a big change in Irish culture in the last 10 years"

And, the question examining degree of impact of change read;

"I think that Ireland is a better place now than it was 10 years ago"

With regard to the acculturation item, participants were asked to choose one of four alternatives which best reflected their attitude towards Irish culture. Specific details on the formulation of the measure, and its applicability to acculturation theory more generally, can be found in the following section; "Formulation of the acculturation measure".

Section 5- Trinity Inventory of Precursors to Suicide (TIPS)

The specifics of the development and factor structure of the TIPS has been outlined in Chapter 2. This section of the questionnaire presented the 12 items from the final version of TIPS, accompanied by the standard instructions (printed below) used throughout all stages of the measure's development;

"Given the number of suicides we see today, it is important to try and understand the possible reasons some people may feel that suicide is the only option open to them. Below are various reasons that have been given to explain suicide in **specific circumstances**. Whatever your personal views on suicide, please think of each item in turn and indicate what you think **by circling** whether it is a poor reason, good reason etc. **in that particular situation**, for someone to take their life. "

Section 6- Beck Depression Inventory (BDI)

Within the context of the present research, the issue was not merely finding a psychometrically sound measure of depression, applicable to a non-clinical adolescent population but one which could also be used in the referral process for the project more generally (please see section in Chapter 4). Lasa et al., (2000) assert that although there are over 50 measures for the assessment of depression in use at the present time, the BDI remains the most recognised and best known and, over time, has maintained its place as a "gold standard" in the field. These same authors (ibid) along with Beck et al., (1988) also state that although the measure was initially developed to assess the intensity or depth of depression in

patients with known psychiatric disorders, its use has effectively been extended to clinical and research settings and is well placed for use as a screening tool in non-clinical samples especially given the emphasis placed on general symptomatology thus enabling use in community-based studies.

Based on Beck's cognitive theory of depression, which asserts that an individual's negative and distorted thinking is responsible for both the development and maintenance of depression (Moilanen, 1995), the BDI (Beck & Beamesderfer, 1974; Beck & Steer, 1993a) is a 21-item, self-report measure of depression used to assess the current level of depression experienced by the individual. Each item is scored on a four-point scale (ranging from 0 to 3) with possible total scores thus ranging between 0 and 63 where higher scores reflect greater levels of symptomatology. Scores provide a measure of the severity of depression as follows;

0 – 9Minimal depression
10 – 16 Mild depression
17 - 29 Moderate depression
30 – 63 Severe depression

The 21 items cover each of (a) mood, (b) pessimism, (c) sense of failure, (d) lack of satisfaction, (e) feelings of guilt, (f) sense of punishment, (g) dislike of self, (h) self-accusation, (i) suicidal ideation, (j) crying, (k) irritability, (l) social withdrawal, (m) indecisiveness, (n) distortion of body image, (o) work inhibition, (p) sleep disturbance, (q) fatigue, (r) loss of appetite, (s) weight loss, (t) somatic preoccupation and (u) loss of libido.

While subscale scores for both the cognitive-affective and somatic-performance components of depression may be calculated, a calculation of total score and evaluation on this basis remains more common (Beck et al., 1988).

With regard to the psychometric properties of the BDI Beck et al.,(1979) provided extensive detail; reliability analysis (based on 6 different samples) shows alpha coefficients ranging between .79 and .90 and indicting high reliability across groups-see Table 3.4. Concurrent validity was examined by means of a meta-

analysis and found a mean correlation of .72 between clinical ratings of depression and BDI score for psychiatric patients and of .60 for non-psychiatric groups (Beck et al., 1988).

The BDI may either be self-administered or administered in an individual, face-to-face interview. While the general conclusion is that within psychiatric settings, the BDI performs best within the context of a more detailed extensive interview process (which facilitates a case-by-case response), this approach is open to both intra- and inter-rater variability- problematic in any setting but perhaps especially when working with a non-clinical group in a research setting. For this reason, self-administration is thought to be preferable in research contexts and reduces social desirability in responding (Cochrane-Brink, Lofchy, & Sakinofsky, 2000).

A further issue relates to the use of the BDI with a non-clinical adolescent population. Although the measure was developed for use with an adult population, subsequent investigations have proven its efficacy with adolescent and non-clinical/community groups.

Table 3.4: Reliability Analysis of BDI (Beck et al., 1979).

	(a) Mixed Diagnostic (n=248)[12]	(b) Major Depression Single Episode (n=113)[13]	(c) Major Depression Recurrent (n=168)[14]	(d) Dysthymic Disorder (n=99)[15]	(e) Alcoholic (n=105)[16]	(f) Heroin (n=211)[17]
Mean	23.16	23.35	23.56	17.48	13.88	13.17
SD	9.55	7.83	9.24	7.15	10.60	9.35
Reliability	.86	.80	.86	.79	.90	.88

[12] (Beck & Steer, 1984)
[13] (Steer, Beck, Brown, & Berchick, 1987)
[14] (Steer, Beck, Riskind, & Brown, 1986)
[15] ibid
[16] (Steer, Beck, & Shaw, 1985)
[17] (Emery, Steer, & Beck, 1981)

Lasa et al., (2000) employed the BDI in a general population sample of 1250 participants, aged 18-64 years, and found the measure to be appropriate, useful and valid for use in community surveys. Working specifically with adolescent groups, Canals, Bladé, Carbajo, & Domènech (2001), Moilanen, (1995) and Strober & Green & Carlson (1981) all conclude that the BDI is appropriate for use with adolescents in a general setting (referred to variously as non-referred, non-clinical and non-psychiatric). In each of these studies, females score higher on the measure than males however; the measure remains able to differentiate between depressed and non-depressed adolescents of both genders.

Test-retest reliability and coefficient alpha scores remain high and at lower levels on the scale the BDI is seen to relate to sub-clinical or diffuse experience of depression.

Extending further, Tashakkori, Barefoot & Mehryar (1989) employed the BDI in a non-Western sample (albeit with the slight modification of removing item 21 relating to sex in deference to cultural sensitivity) and reached similar conclusions regarding the measure's value in non-clinical areas of inquiry.

In short, across groups, age-ranges and settings the BDI is consistently proven to be both reliable and valid.

Section 7- Beck Hopelessness Scale (BHS)

The BHS (Beck & Steer, 1993b) is a detailed self-report measure consisting of 20 true/false statements designed to assess an individual's pessimism and negativity about the future. Responses can range from 0 to 20 (0-3 classed as minimal, 4-8 classed as mild, 9-14 classed as moderate and 15-20 classed as severe) where, much like the BDI, higher scores are indicative of increased levels of hopelessness.

Reliability estimates for the BHS are based on the responses of 211 heroin addicts (Steer et al., 1985) and 105 alcoholics (Beck, Steer, & McElroy, 1982) and a sample of psychiatric patients experiencing recurrent Major Depressive Disorder (n =

134), single-episode Major Depressive Disorder (n = 72) and Dysthymic Disorder (n = 177) and ranged between .87 and .93. Beck, Weissman, Lester, & Trexler (1974) examined the concurrent validity of the measure (focusing on clinical ratings of hopelessness and BHS scores) and found Pearson correlations of .74 ($p < .001$) in a general practice sample and .62 ($p < .005$) in a hospital-based sample of recent suicide attempters. In a general sample, these same authors report the overall alpha reliability score to be .93. Test-retest reliability has also been assessed with Holden & Fekken (1988) reporting Pearson correlations of .85 for the entire sample, .94 for males and .67 for females.

With regard to predictive validity, Beck, Steer, Kovacs, & Garrison (1985) detail a study of 1,969 outpatients evaluated between 1978 and 1984 to whom the BHS had been administered. Of the 16 who eventually died as a result of suicide, 15 (that is, 93.8%) had a score of 9 or greater on the measure. When this group was compared with the remainder of those participants involved (but who did not die as a result of suicide) a significant difference was seen with scores for the "non-suicidal" group significantly lower.

The primary use of the BHS has come to be the assessment of suicide risk both generally and in adolescent populations more specifically. As early as 1963, Beck made this connection and suggested that hopelessness and suicide were significantly related. This was later followed up with an investigation of an adult sample (Beck et al., 1974) with the finding that there existed an important relationship between hopelessness (specifically as measured by the BHS) and clinical ratings of hopelessness, depression, serious suicidal intent and experiences of success or failure. Following from this, Johnson & McCutcheon (1981) examined the correlates of the BHS in an adolescent population (the sample consisted of 97 participants; 46 male and 51 female, aged between 13 and 17 years). They found that hopelessness was related to depression and external locus of control. Further, a significant positive correlation was found between BHS scores and an index of general maladjustment. Importantly, the BHS was found to be *unrelated* to a measure of general health.

Results (ibid) indicated that hopelessness scores were significantly correlated with depression, with this relationship found to be higher in this adolescent sample than previous research employing adult participants. Hopelessness was also seen to be related to external locus of control such that adolescents who were high in hopelessness perceived themselves as having less control over environmental events than did participants scoring low on the BHS. Hopelessness scores were also seen to be significantly correlated with general maladjustment. Importantly, a non-significant relationship was found between measures of social desirability and hopelessness scores thus providing support for the discriminant validity of the BHS measure.

Swedo et al., (1991) sought to differentiate between "normal" adolescents, those who were generally classified as being "at-risk" of suicide and those who had made a suicide attempt. Of the numerous psychiatric, psychosocial and contextual elements considered, these authors found that only the BHS and the question "have you ever felt that life wasn't worth living?" were capable of differentiating between the latter two groups. With regard to the specific question, the authors state that this question was also posed as part of the categorization process and may have emerged as a result, leaving the BHS best-placed to evaluate risk and suicidal behaviour in contexts such as these. They also point to the usefulness of the BHS for research settings given its ease of administration, strong psychometric properties and clear and proven ability to assess adolescent suicidal behaviour.

Given the nature of the current research, the BHS was included in the questionnaire both with a view towards evaluating its relationship to other measures but also as part of the referral process (see section in Chapter 4).

It is important to note however; that in many cases, and especially with regard to adolescent suicide, the BDI and BHS are used in conjunction. This issue will be addressed in the following section.

Use of Beck Depression Inventory & Beck Hopelessness Scale in Conjunction

As stated earlier, Beck (1963; 1967) proposed that specific cognitive aspects of depression were more closely linked to suicidal behaviour than others. Namely, that hopelessness played a central role. When clinical predictors of suicidal behaviour were examined it was typically found that when hopelessness was partialled out of the depression-suicide path, correlations were greatly reduced (thus suggesting that hopelessness has a more central role in the path to suicidal behaviour). However; when depression is partialled out in the hopelessness-suicide path, correlations have remained relatively high- indicating a unique role for hopelessness.

Kumar & Steer (1995) investigated this proposed, unique, relationship further with a sample of adolescent psychiatric inpatients. Results indicated that the most powerful predictors of suicidal ideation were the BDI and BHS *when used in conjunction-* more so than any of twelve other psychosocial and clinical indicators included in the investigation. This replicates findings from Beck et al., (1985) who reported on a ten-year prospective study examining death as a result of suicide. Those who would go on to die as a result of suicide (and indeed, those who remained persistent ideators for the duration) had significantly higher scores on both the BHS and BDI from the point of initial assessment. Further, 91% of those participants who scored 9 or greater on the BHS at initial assessment had died as a result of suicide during the decade-long study. This is in contrast to a single suicide in the group who had not scored in this range.

A similar patterning of results has been seen with substance-abuse dependent individuals (Weissman, Beck, & Kovacs, 1979), those dependent on alcohol (Beck, Weissman, & Kovacs, 1976), psychiatric outpatients over a twenty-year period (Brown, Beck, Steer, & Grisham, 2000) and adolescent psychiatric inpatients (Steer, Kumar, & Beck, 1993).

An issue of importance relates to the link between depression, hopelessness and suicide in an adolescent population and whether or not there exists a difference between adolescent and adult populations. While some of the aforementioned

research included or dealt specifically with adolescent groups, perhaps the most comprehensive paper addressing this issue is that of Cole (1989).

While Cole is widely cited as having stated, "hopelessness does not seem to be as critically related to suicidal behaviour for adolescents as for adults" (p. 253) on detailed inspection, it becomes clear that the findings are more complex than this and thus, warrant particular attention.

Examining these links with *both* a general, non-clinical sample of adolescents and a sample of male juvenile delinquents, results indicated that depression, in both girls and boys, appears to play a relatively more significant role in the path to suicide than hopelessness. However; the role of hopelessness is gender-dependent with a greater level of significance in girls. In boys, when depression was controlled for, the role of hopelessness fell to an insignificant level. This was *not* the case for girls in whom the statistically significant relationship was maintained even when depression was controlled for. Thus, hopelessness is seen to play a greater role in girls' experience than boys, while for boys, depression takes the prominent role on the path towards suicide.

An important feature of this research is that it is based on a non-clinical sample offering insight into the links between clinical factors and suicidal behaviour in a more general setting. Thus, and with regard to the selection of measures for inclusion here, use of either depression or hopelessness measures alone was thought to be insufficient, based on current understandings of "paths" to suicidal behaviours. This belief, further supported by the findings from Kumar & Steer (1995) resulted in the inclusion of *both* the BDI and BHS and their subsequent use in the referral process to be discussed in Chapter 4.

Section 8- Anomie

The experience variously spelled *anomia* (Latin), *anomy* (American English) or *anomie* (Greek/European English) which will be referred to here (and throughout) as *anomie* was first investigated as part of Durkheim's seminal work

on suicide, *Le Suicide* (1897/1951) but has since found a place within the literature of sociology, anthropology and, to a lesser extent, psychology.

Despite its "traditional" origins, the formal measurement of anomie and its inclusion in contemporary research has remained something of a rarity with the measure developed by McClosky & Schaar (1965) continuing to be the most frequently used for the investigation of the global construct (Robinson et al., 1991). McClosky et al., (1965) define *anomie* as "normlessness" and in this way revised the traditional sociological model as initially proposed by Durkheim- this earlier approach was based on the assumption that social conditions give rise to anomic feelings which in turn, causes certain types of behaviour. In contrast to this, it was the McClosky et al's intention to describe personality variables that might cause anomie thus introducing a more psychological perspective.

The measure itself consists of 9 items, scored by indicating either agreement or disagreement with each statement (there is no middle point, thus the measure adopts a more true/false approach such as the BHS). One point is given for each endorsement of the agree option. Therefore, the range of scores on the measure is 0-9. Zero is thought of as "low anomie" while 9 is thought of as "high anomie" (Robinson et al., 1991). More specifically, those in the 0-2 range are classed as non-anomic, those in the 3-5 range classed as being the middle group and finally, those in the 6-9 range are seen as highly anomic.

With regard to the reliability of the measure, the internal consistency (as measured by split-half coefficient) was .76. The test-retest coefficient for a randomly selected American sample of 1484 participants was .80 (Robinson et al., 1991).

Although not a widely evaluated concept, anomie (as operationalised as a psychological construct and measured by the McClosky et al., scale) was included in the current research given the interest in the interaction between social and cultural factors and the experience of adolescent suicide.

Formulation of the acculturation measure

The acculturation item included in the questionnaire was designed with the intention of accurately portraying Berry's acculturation framework (referred to also in Chapter 1), where each of Integration, Assimilation, Separation and Marginalization were represented. In order to elucidate this process and the means by which the measure was decided upon, several relevant themes in the acculturation literature warrant consideration.

As noted previously, while this framework comprehensively addresses the issue of geographic culture change, it is important to note that in today's society people may face culture-based challenges without ever leaving their home nation. Ireland presents an excellent test case for such an examination given the considerable social, economic and cultural changes that have occurred, primarily since 1990 (discussed further in Chapter 1).

Unidimensional or Bidimensional?

The debate as to whether acculturation as a concept is unidimensional (an individual is *either* acculturated *or* not) versus bidimensional or multidimensional is long established in the area. The principle difference between these alternative perspectives is the way in which they conceptualise home/native culture and the host culture and individuals' relationships to them. The unidimensional model is founded on the assumption that acculturation and consequent changes in the individual's cultural identity takes place along a continuum over time such that "old" cultural values, beliefs and identity are relinquished while the "new" are taken on simultaneously (Ryder, Alden, Delroy, & Paulhaus, 2000). Within this view, acculturation is associated with the simultaneous acts of relinquishing (the old) and assimilating (to the new) such that the two processes are consistently equated as equivalent (Ward et al., 2001).

In contrast, bidimensional and multidimensional perspectives argue that the *process* of acculturation (importantly viewed as such to represent the interactive, dynamic and flexible nature of the engagement) is more accurately represented and examined when "home" and "host" cultures are viewed as being relatively independent, with the individual thus able to maintain a relationship with both

(hence, the categorical representation in Berry's graphic framework, see Figure 1.3, Chapter 1).

While the unidimensional perspective without doubt assists the ease of measurement of acculturation it represents something of a "vacuum mentality" insofar as the individual is represented in a mechanistic, dichotomous manner thus failing to reflect the complex psychological and social phenomena which are known to accompany the acculturation process and the contextual elements of human social existence. Importantly, it has also been noted that employing this perspective often fails to detect significant links between acculturation, adjustment and wellbeing (Ryder et al., 2000)- an issue of primary concern in many investigations, the current research not least among them.

In the research domain, the implication of adopting the unidimensional perspective results in a "demographic checklist" model of inquiry- age at immigration, gender, ethnicity, years lived in new culture etc. are recorded in the belief that time and exposure will result in the adoption of a new cultural identity. That an individual may retain the cultural values or identity of the "home" culture is beyond the scope of such an approach. Many in the area have remarked that this approach presents no alternative to assimilation since the individual either successfully takes on the new culture or fails in this endeavour (Dion & Dion, 1996).

In contrast, the bidimensional approach proposes that individuals differ with regard to the extent to which culture is internalized and the degree to which personal identity and wellbeing are dependant upon it. Here, it is possible for an individual to have multiple cultural identities encompassed by a global strategy; for example, in the case of Integration where both "old" and "new" simultaneously co-exist. Berry's two "questions" (see Figure 1.3) accurately represent this issue of cultural pluralism. It is the patterning of responses to these two "questions" or issues which results in the emergent strategy and which can, importantly, be achieved without placement of the individual into the reductionist categories of "acculturated" or "not acculturated". This framework more effectively reflects the inclusive nature of psychological acculturation.

The aim of the present research was the extension of Berry's framework to incorporate the element of *temporal acculturation* that is, the impact of culture change *within* a culture *over time*. The contention is that there is no reason to suspect that the psychological impact of culture change is any less distressing for those who are native to the culture undergoing change. People who have, for years existed in one culture, into which they have been socialized and from which they derive (to some extent at least) their sense of self (Furnham & Bochner, 1986; Liebkind, 1996; Schnittker, 2002) who are then faced with a newly-emerging culture to which they must adapt, must surely undergo some form of acculturative experience. *This* is what we term temporal acculturation.

Structure of the Acculturation Question

The structure of initial examinations of temporal acculturation as it may be applied to the Irish context, allowed for the emergence of support for either unidimensional or bidimensional frameworks in recognition of the fact that the theory had not been applied in such a setting previously (Mac Lachlan, Smyth, Breen, & Madden, in press). In addition, the questions employed in this early study referred to "old" Ireland and "new" Ireland without delineating specific elements of what constituted each thus allowing for some degree of individual interpretation. The results obtained clearly supported the bidimensional model with the finding that changes in the extent to which people wish to identify with "old" and "new" Ireland are not mirror images of each other, but are representative of the more encompassing, bidimensional framework. Building on this, vignettes were developed which represented each of the four strategies clearly (please see Appendix 8 for a complete copy of the questionnaire);

To represent Integration: "I think that **both** the "Old", traditional Ireland and the more modern, "Celtic Tiger" Ireland have things to offer. I can see parts of **both** cultures that I can identify with".

To represent Assimilation: "Nothing about "Old", traditional Ireland appeals to me. I can't identify with it at all. Instead, I like the more modern, "Celtic Tiger" Ireland.

To represent Marginalization: "I don't think that the "Old", traditional Ireland has much to offer. Equally, I don't think that the modern, "Celtic Tiger" Ireland has much to offer. I don't really see myself fitting in with **either** of these".

And finally, to represent Separation: "Nothing about modern, "Celtic Tiger" Ireland appeals to me. I can't identify with it. Instead, I like the more traditional, "Old" Ireland.

The rationale for structuring the culture measure in this way was based on several considerations. The first relates to an accurate representation of Berry's aforementioned framework, where a relationship with both, either or neither of the cultural settings of which individual's are aware, is possible. In addition, by clearly representing the alternatives in this way, elements of each were made salient in a straightforward manner with high face-validity, a point on which single-item assessments generally fare well (Wanous & Reichers, 1997). Wanous et al., (1997) also assert that such measures may effectively be used in the assessment of psychological constructs and global factors with the concluding comment that rather than be ruled out, "...their appropriateness for a particular piece of research should be evaluated" (p. 251).

In this case and with an adolescent population, by presenting the two elements within each option (that is, feelings for both "old" and "new") it was felt that the personally relevant wording was most appropriate and easily understood. On this point, previous work in the area of cross-cultural research such as that of Epstein, Gilbert, Dusenbury, & Diaz (1996) and Ranieri, Klimidid, & Rosenthal (1994) dealing specifically with an adolescent population, have suggested that single-item measures of acculturation perform as well as multiple-item measures and that considerations of face validity and ease of administration may make them preferable in some instances, particularly where ease of administration and time constraints are to be considered, as was the case in this instance given the school-based setting.

More generally, evidence exists that for the assessment of "global" constructs single-item measures, which allow for individual interpretation of the various

facets which comprise the more general construct, are valuable (Maryland Office for New Americans of the Maryland Department of Human Resources, 2003). This level of individual interpretation, seen in the initial MacLachlan et al., (*in press*) study was retained in the current research. On the whole, it was felt that the particular structure of items here was most appropriate for the research setting and the specific issue of interest.

Preparation of Alternate Versions of Materials

In recognition of the new equality legislation and in order to facilitate the inclusion of all prospective participants, alternate forms of the project materials were developed for use. The primary concern, given the "text-heavy" nature of the questionnaire was the accessibility of documentation to participants who experience visual impairment.

The alternate versions (presented in Appendices 9 and 10) were prepared in keeping with the recommendations of the National Disability Authority and National Council for the Blind in Ireland. These guidelines, which facilitate access to written documentation, are as follows;

- Use of upper case lettering for isolated letters or in the case of section headings.
- Use of both upper and lower case lettering for the "body" of a document as words retain their shape and enable easy reading.
- Use of plain type letters (i.e. Arial, Sans Serif etc.)
- Italics can be difficult to decipher so, where emphasis is required, use of bold lettering as an alternative.
- "Fat" letters are more easily read than "thin" (relating to use of typeface, as above)
- Use of bold typeface for key words
- Colour and contrast are of importance. Use of pale grey (or similar such as navy, mauve etc.) can increase the readability of text as the amount of reflection is reduced which is especially relevant where some form of magnification will also be required.

- Paper surface should have a matt finish to further reduce reflection and glare.
- The type size requirement is a point of individual variation however, 18-20 point is sufficient in general cases.
- Use of colours, bullets or boxes makes text clearer.
- Large sizing of page numbers for ease of reference.
- Placement of contact names, details and telephone numbers on either first or last page.

Further, The National Council for the Blind in Ireland were consulted in this regard and kindly agreed to evaluate the relevant documents. The materials were also sent for evaluation to the co-ordinator of a special needs programme in one of the participating schools during the development stage. No changes were recommended and the documentation was deemed accessible to participants.

It was also anticipated that oral administration of the questionnaire materials may be required in certain settings. For this reason participating schools were asked to outline any additional requirements prior to administration[18] so that additional arrangements could be made. It was agreed with schools that a private room for individual administration was, in these cases, most appropriate as was allowance of additional time for completion of the questionnaire.

[18] Oral administration of the questionnaire took place with two participants in total. Having obtained additional informed consent from parents/guardians in recognition of the alteration to the administration process. Both sets of parents agreed.

Chapter 4 – Project Procedure & Research Participants

Chapter Aims

The objectives of this phase were;

- To make contact with post-primary schools in the greater Dublin area & establish a liaison contact within each school
- To obtain ethical approval from the Department of Psychology, Trinity College Dublin for the research project entitled "Adolescent Mental Health in Ireland"
- To identify students eligible for participation (that is, all students in 5th and 6th Year in the schools) and obtain their (and their parents'/guardians') informed consent

Ethical Considerations

While the research project broadly dealt with adolescent mental health and the impact of social and cultural factors on psychological wellbeing, one of the primary areas of interest was youth suicide. With this in mind, a number of ethical and professional considerations warrant attention at this point.

Ethical approval for research

Ethical approval was applied for through the University of Dublin, Trinity College; Department of Psychology Ethics Committee. The established process consists of an internal evaluation system whereby five members of staff appraise the proposed research project under the themes of feasibility, utility, value, safety and under the heading of methodological structure.

Specifically, consideration was given to the age of participants, with the following recommendations for working with children/young people;

- A commitment to child's/young person's well-being (Beneficence)
- A commitment to doing no harm (Non-Maleficence)
- A commitment to child's/young person's rights including the right of individuals to take responsibility for him or herself (Autonomy)

- ❖ Being child-centred in its approach to research, listening to children, treating them in a fair and just manner (Fidelity)

The ethics committee expressed concern that participation in the research, and specifically, completion of the questionnaire, may increase risk of participants behaving in a suicidal manner. However, on this very point Cliffone (1993) and Esters, Cooker, & Ittenbach (1998) report *no increased risk* but rather, that participation in research or education programmes which address issues of mental health may in fact be beneficial in increasing awareness of the seriousness of the problem of adolescent mental health difficulties and youth suicide, and serve to increase the likelihood of student's seeking help from mental health professionals either for themselves or in response to a suicidal friend/ family member.

Therefore, it was concluded that the beneficial aspects of the study in raising awareness of mental health issues and sources of help, and the need for information in this area outweighed possible (but unlikely, based on best practice and other research in the area) negative effects. Furthermore, and in recognition of the desirability of balance of issues covered, the questionnaire encompasses each of coping and self-esteem which are neutral constructs.

Informed Consent

Given that the age range of participants was 15 to 19 years, it was essential to obtain the informed consent of *both* the students' themselves and their parents'/guardians'. As outlined in Chapter 2, information packs and consent forms were distributed to each potential participant through the liaison teacher in each participating school. The nature and origins of the research, type of material included, the way in which the data would be used and the process of referral (see section below) was provided.

Only in cases where a consent form was completed by all parties was returned was a student deemed eligible for participation and allowed to complete the

questionnaire. Students were able to withdraw from the study at any point throughout.

Confidentiality

With regard to general issues of confidentiality, it was decided that each of the participating would remain anonymous, thus, they were each allocated a school code (S1, S2, etc.). Prior to the commencement of the research, when this issue was considered, it was felt that the continued stigma which surrounds issues of mental health and suicide specifically would impede participation if schools were identifiable.

This concern proved to be valid as schools themselves reported that their involvement may be taken as an indication of difficulties surrounding student welfare and health and made specific requests that no identifying information be used.

This, it is believed, is an interesting reflection on the current status of mental health issues at a societal level in Ireland, and is an issue to which attention will later return.

At an individual level, confidentiality could not be offered to participating students since, for professional and ethical reasons, it was felt both appropriate and necessary to offer a referral to a professional counselling service on the identification of risk cases. Thus, participating students were asked to provide both their names and the name(s) of their parent/parents or guardian/guardians and contact details, in the event that a referral was deemed necessary. Importantly, unless "caseness" was determined, all identifying information was removed from questionnaire materials and no contact was made.

Referral

A detailed system of referral was established prior to the commencement of research in schools. Contact was established with a professional counselling service (St. Catherine's Counselling Service, Tallaght, Dublin) where the

availability of free referrals was guaranteed. Importantly, the immediate availability of a trained professional was also guaranteed given the seriousness of the question in hand. Thus, there was little delay between participants completing the questionnaire and the identification of possible risk. The research model used, meant that questionnaires were scored the day of or the day immediately following administration. Administration appointments with schools were scheduled in a staggered manner to ensure this rapid response.

It was vital that any counselling provided was free of charge. The kind co-operation and generous support of the research by Martin Boyle and the staff of St. Catherine's is responsible for enabling this.

The only time at which information obtained in the research was disclosed was if a participant was identified as experiencing significant distress and daily dysfunction. In this event, the parent/guardian was contacted directly (the school was unaware of any referrals made) by letter (see Appendix 11) and in certain cases, by telephone contact as well.

The rationale for the use of the BHS and BDI in conjunction was previously outlined in Chapter 3. In addition, and with specific regard to the BHS, psychiatric patients with a score of 9 or above were seen to be 11 times more likely to die as a result of suicide than those with a score below 9 (Cochrane-Brink et al., 2000).

Further support of the use of this cut-off comes from Beck et al., (1985) who described a study of 1,969 outpatients evaluated between 1978 and 1984 who were administered the BHS. Of the 16 who subsequently committed suicide, 15 (that is, 93.8%) had BHS scores of 9 or above. Of the 1,953 patients who did not go on to commit suicide, only 58.5% had scores of 9 or above. The mean BHS score for the suicide group was 15.13 (SD= 4.56) was significantly higher than for the non-suicide group (with a score of 9.99, SD= 5.43)

In relation to cut-off points, only one of the completers had a score below 9 while 90.9% of the completers had a score of 10 or more. And, despite the fact that the

majority of those who scored over 9 did not go on to complete suicide, this level of scoring still leaves open the possibility for early prediction and intervention- a most desirable opportunity.

Beck et al., (1985) worked with a total of 207 patients (96 (46.4%) were male, 111 (53.6%) female) who were, at the time of initial contact, hospitalized due to suicidal ideation but had not made any recent suicide attempts. Both the BHS, BDI were administered alongside other measures. During a follow-up period of between 5 and 10 years, 34 participants died as a result of suicide and of these, 14 were determined as suicidal deaths by the county coroner. Only the BHS (administered at time of first contact) predicted the eventual cases thus exhibiting its ability to differentiate between ideators who do not complete over time and ideators who (at some point) go on to complete a suicide.

In a review, Beck et al., (1990) make the recommendation, based on a replication of earlier research, that a cut-off point of 9 or above on the BHS and 30 or above on the BDI are to be considered clinically optimal.

With a community-based sample, Lasa et al.,(2000) recommended the use of a score of 12/13 as the minimum threshold for the identification of possible "caseness". In this instance, and considering that the BHS was also being administered, the higher level of a score of 30 or greater to determine those participants experiencing significant distress or daily dysfunction was selected. At this level, the predictive value remains high at a level of 98% (ibid). More recent research, based on a non-clinical group of adolescents, finds support for the use of a higher cut-off range (of a score of 30) in the identification on significant impairment (Canals et al., 2001).

Guided by this previous research, clinical guidelines and best practice in the area, a determination on the need for referral was made on the basis of BDI and BHS scores. Any participant who received a score of *9 or greater* on the BHS and/or a score of *30 or greater* on the BDI was offered a referral. A score of 9 or greater on the BHS indicates the experience of *at least* moderate hopelessness (a score of 15 or greater indicates the experience of severe hopelessness) while a score of 30 or

greater on the BDI indicates the experience of severe depression. Further, individual responses to Question 9 on the BDI were examined. This question relates specifically to suicidal ideation - *any* participant who endorsed *either* option 2 *or* 3 (see below) were offered a referral on this basis.

Table 4.1 Question 9, Beck Depression Inventory

Question 9	
0	I don't have any thoughts of killing myself
1	I have thoughts of killing myself, but I would not carry them out
2	I would like to kill myself
3	I would kill myself if I had the chance

At these selected levels and drawing comparisons with a similar research project which was being run concurrently in Dublin-based post-primary schools[19], a referral rate of approximately 10% was expected.

Freedom of Information & Data Protection

Under the Data Protection Rules (as provided by the Data Protection Commissioner) the requirement of the data having been fairly obtained was met by obtaining the signed consent form. Further, the purposes for which the data was to be used were clearly laid out in the information sheets to schools and also to parents/ guardians.

In accordance with the Freedom of Information act, all original data was made accessible by participants upon request. This act does not provide for the production of additional documentation however; all original material and raw data (presented in accessible format) was made available to participants or their parents/guardians.

[19] This research was being conducted through the Child & Adolescent Guidance clinic of the Mater Hospital, Dublin under the leadership of Prof. Carol Fitzpatrick with whom contact was made for consultations regarding the design and implementation of the research project. The average referral rate in the Mater research was 10% and thus, was broadly informative of the rate which could be expected in a similar group.

Further, in cases where clinical assistance was sought, with written permission from participants, questionnaire information was also made available to counsellors/clinicians.

With regard to data storage, all data were kept in password-secured files (stored on floppy disc) which were kept in a locked cabinet when not in use. No labels or individual identification was stored alongside the data set. The only parties having access to this information were those who had been identified to participants as part of the research team (Caroline Smyth, Malcolm MacLachlan and Anthony Clare).

This is in keeping with standard practice and met all requirements of the Department of Psychology Ethics Committee.

Garda Clearance

Garda clearance for working with children/young people was obtained by the researcher through the Central Vetting Unit of the Garda Síochána. Clearance was requested under the "Garda Criminals Database" under the Data Protection Act in order to obtain clearance to work with children or vulnerable groups. The application was accompanied by the €6.35 standard processing fee and took approximately six weeks to obtain.

This clearance letter was made available to all participating schools and participants. Further, a copy was held by the Department of Psychology in the event of requests for confirmation of the researcher's status within the department.

Remuneration

Participants either personally, or through their participating school, were not in receipt of any financial remuneration for participation in the research.

Identification of target group

Given the theoretical background to the current research, the group of interest was adolescents aged 15-19 years. Although the higher rate of completed suicides occurs in the older age group of 24-25 and 24-45 years, the informed development of prevention programmes and the identification of early risk (that is, prior to the acute, proximal stage) is of utmost importance. Thus, every student enrolled in either 5th or 6th class (i.e. senior cycle) in the post-primary school system, within the greater Dublin area was deemed eligible for participation. Thus, in the schools that wished to participate in the research, contact was sought with *all* pupils in the senior cycle years. Despite the fact that the rate of completed suicide is higher in males, both genders were approached for participation so that gender comparisons across measures could be drawn.

Selection of, & contact with participating schools

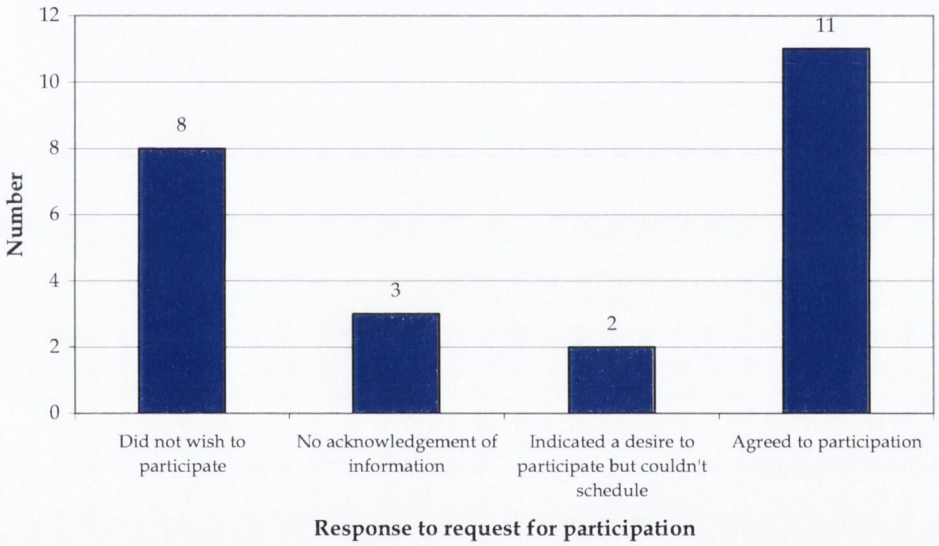
At the outset of the research project, the Department of Education & Science was contacted and a list of all post-primary schools within greater Dublin, encompassed by the Eastern Regional Health Authority catchment area, was requested. This total list is comprised of some 188 schools, which included each of single-sex girls, single-sex boys and co-educational (mixed) schools across each of fee-paying and non-fee-paying groups.

This list was then subdivided into categories by school type (single-sex boys, girls or mixed) and socioeconomic status. On this latter point, since the Department of Education & Science does not record socioeconomic level as categorised by the national register of the Central Statistics Office, each Principal was contacted and asked to nominate a level for their own school (high SES, middle SES and low SES). Factors such as level of financial contribution from parents/guardians, school facilities and infrastructure, extent of required fundraising activity and staffing levels were all included in these considerations.

When this categorised list was prepared, a random number table was used to select a total of 24 schools deemed eligible for participation. These schools were then contacted via an initial contact letter, as described in Chapter 2.

Of the 24 schools contacted, eight returned the acknowledgement slip but indicated that they did not wish to participate (a rationale for this decision was included in only six of these cases and related to timetabling issues, a feeling the subject matter was inappropriate for a school-setting, concern regarding the issue of suicide being discussed with students and lack of resources to facilitate the research). Three further schools failed to acknowledge receipt of the information. 13 schools responded and indicated a desire to participate; of these two were subsequently unable to schedule the research into the timetable and thus did not participate leaving a total of eleven that participated (see Figure 4.1 below).

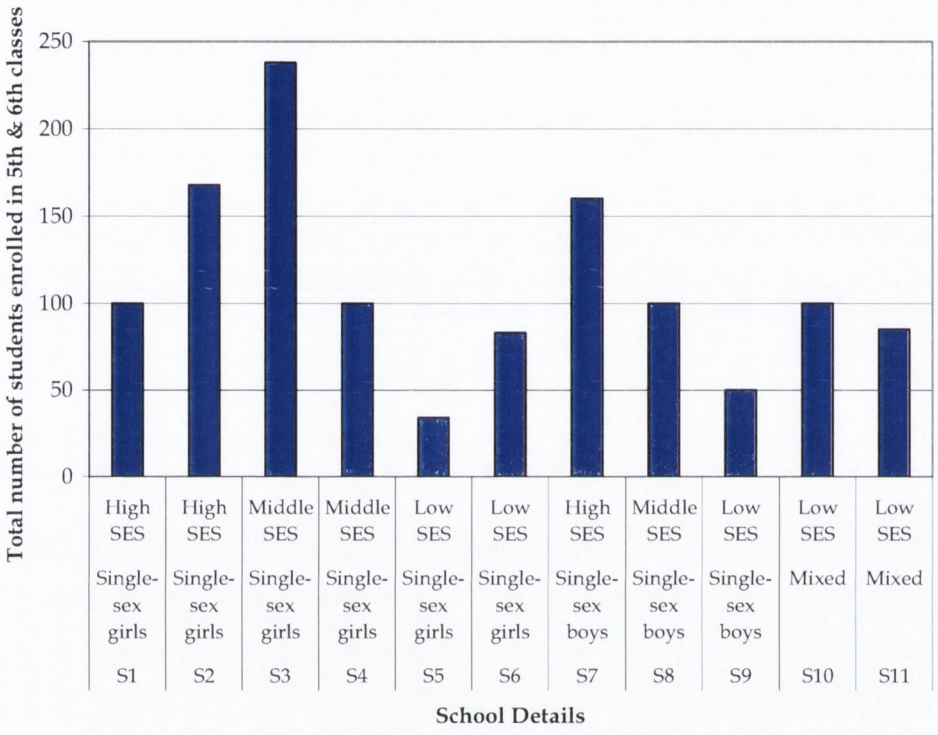
Figure 4.1 Breakdown of school response for participation



In Figure 4.2 which follows, a more comprehensive breakdown of the eleven participating schools is presented. Class size/total number of students in the senior cycle system is represented as contact was sought with all students. As can be seen from Figure 4.2, six single-sex girls' schools, three single-sex boys' schools and two mixed schools participated. While equal numbers of schools (and indeed, in the final sample, equal numbers of males and females) are not represented in each group, this is reflective of the overall demographic spread of the Dublin-based, post-primary population where the male to female ratio is approximately 1.8 female students for every one male student (the ratio of

present sample of 219 males: 454 females does not differ markedly from this general ratio).

Figure 4.2: Breakdown of participating schools.



Questionnaire administration

The questionnaire was administered at participating schools between January 13th 2003 and May 9th 2003. Preceding this, between September 2002 and December 2002, the research project was evaluated for ethical approval.

Establishing contact & initial meetings

A standard approach was taken across schools. Once a school had agreed to participate, they were asked to nominate a liaison teacher with whom contact would be maintained throughout the course of the research. In 10 out of the 11 participating schools, this liaison teacher was the Transition-Year co-ordinator. An initial meeting was held between the researcher and the liaison teacher to

discuss the facilities required, administration procedure and to obtain clarification of the number of consent forms and information packs required. At this point, information was also obtained regarding any special needs within the specific groups (e.g. in the case of participants who experience visual disability).

This initial meeting was followed up with a subsequent meeting one week before questionnaire administration (which included collection of all completed consent forms so that a class-list for attendance on the day of administration could be prepared) and a brief final meeting before the administration took place for the clarification of any additional issues which had emerged in the interim (such as absenteeism due to illness or a "change of mind" on the part of either parents/guardians or the student themselves).

Liaison teachers were asked to distribute the letter of contact to parents/guardians, information sheets and consent forms (which were provided to each school pre-packed in sealed envelopes). This was done two weeks before the agreed date of administration.

Administration of "Adolescent Mental Health in Ireland" questionnaire

Each school set up a classroom large enough to facilitate the entire group. This was a requirement as there was only one researcher present on the day. Each student had access to a table and chair in order to complete the questionnaire in privacy.

Prior to the commencement of each session, a role-call was carried out to ensure that only those students who had completed and returned consent forms were present. For those students who elected not to participate, alternative supervision arrangements were made with the liaison teacher (which consisted of a period of supervised, independent study in another room).

Prior to students completing the questionnaire, a brief "information session" took place where the origins of the research and background to the various elements of the questionnaire were discussed and issues surrounding confidentiality and

the referral process were again clarified. At this point, it was possible for students to opt out of participation.

The questionnaire "Adolescent Mental Health in Ireland" took 45 minutes to complete. This was followed by a de-briefing session (of approximately 10 minutes in duration) where students could discuss any issues the questionnaire had raised. They were also provided with a de-briefing sheet to take away at this point (please see Appendix 7).

Only the researcher was present throughout in order to maintain confidentiality and facilitate the discussion of issues which students' may not have felt comfortable raising in the presence of a known teacher.

Percentage participation based on class size

Details of percentage participation, based on class size across the various schools is to be found in Table 4.2.

Table 4.2 Breakdown of percentage participation across schools.

School Code	School Type	Consents sent out/ Class size	Number of participants	% participation
S1	SSGHSES	100	58	58
S2	SSGHSES	168	71	42
S3	SSGMSES	238	148	62
S4	SSGMSES	100	49	49
S5	SSGLSES	64	29	45
S6	SSGLSES	83	49	59
S7	SSBHSES	160	97	61
S8	SSBMSES	100	61	61
S9	SSBLSES	50	27	54
S10	MLSES	100	40	40
S11	MLSES	85	44	52
TOTALS		1158	673	58%
Average		105	61	53%

The average rate of participation (across schools) was 53% with the highest rate (of 62% obtained in School S3, a single-sex girls', middle SES school), and the lowest being in School S10 (a mixed, low SES school).

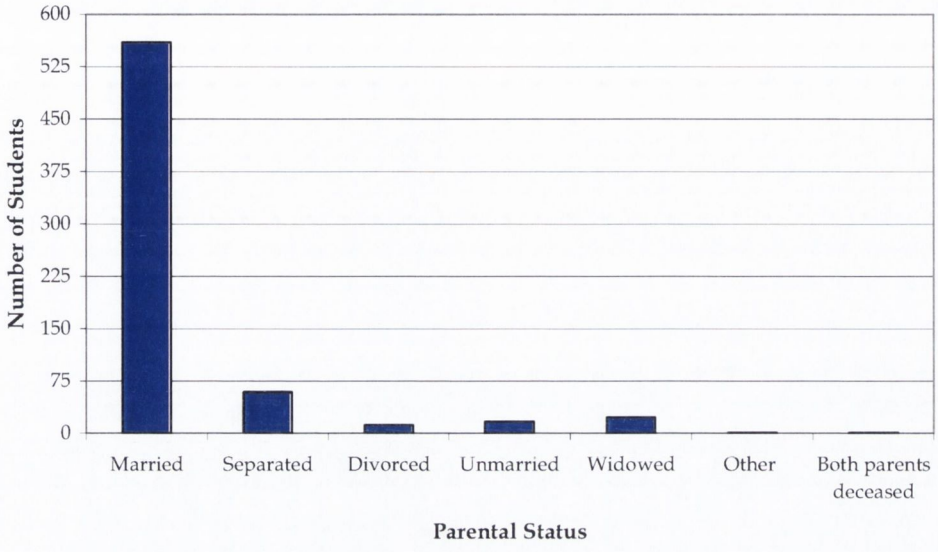
Details of participants

A total of 673 participants took part in the research. Of these, 219 were male and 454 were female. Age ranged between 15 and 19 years (Mean = 16.69 years; SD = .739 years). 72% of the participants were in 5th class (that is, the penultimate year in post-primary education) while the remaining 28% were in 6th class (the final year in post-primary education).

In keeping with general population statistics, the majority of the sample was Roman Catholic (94.8%) with each of Protestant (.6%) and "Other" religions (4.6%) marginally represented.

The most recent data from the Central Statistics Office, Census, 2002 indicates that 88.4% of the total population identify themselves as Roman Catholic with the remaining religions represented at similar levels. However; it should be stated that a change in the format of Census questions (from the 1991 administration) has resulted in a number of problems with regard to the interpretation of this data. In 1996, when the format of the question regarding religion was open-ended, a total of 91.6% identified themselves as being of Roman Catholic denomination. When the format changed to a "tick-the-box" setup, this level fell to 88.4% with some commentators, and the CSO themselves suggesting certain methodological difficulties and the possibility of "distorted" effects (Central Statistics Office, 2003/2004).

Figure 4.3 Breakdown of participants' parental status



As can be seen from Figure 4.3, the majority of participants' parents were married (83.2%), followed by separated (8.8%); widowed (3.4%); unmarried (2.5%) and divorced (1.8%). There was a single case of the both the participant's parents being deceased and a further case of "other" familial structure (voluntarily indicated by the participant as a lesbian parental structure).

CHAPTER 5- RESULTS

Chapter Aims

This chapter is presented in a number of sections intended to elucidate the rationale at each stage of the analysis as an examination of results progressed. The first stage deals with preliminary descriptive statistics (for both the interval/ratio data and for the nominal variable of acculturation strategy)from which clear gender differences emerged, which then informed subsequent stages of analysis which was undertaken for both genders separately. Examinations of the adequacy of data and appropriateness for statistical examination by means of the various techniques were undertaken at all stages. The data were found to be adequate and fall within acceptable parameters for the type of examination performed.

The reliability of the measures used is then assessed, with high levels of reliability seen for each of the measures used- both in terms of the standardised elements of the questionnaire and, with regard to the Trinity Inventory of Precursors to Suicide (TIPS).

A preliminary analysis of gender differences follows, looking at mean differences across measures and post-hoc examinations of the origins of significant differences.

Importantly, the factor structure of TIPS is assessed by confirmatory factor analytic methods before the principle analysis, by means of Multiple Regression and Correlation, is presented.

General note

Data preparation was undertaken by the coding of raw data in line with established criteria for each of the scales and entered into the statistical package, SPSS 11.0. Where necessary (as in the case of the confirmatory factor analysis of the TIPS measure), AMOS 4.0 (Arbuckle & Wothke, 1999) was also used.

Logic of analysis

The statistical analysis of the data began with an initial examination of reliability and descriptive statistics to provide a general view. Given the research question in hand, and issues relating to the inclusion of cultural factors, the primary concern which guided the selection of statistical methods was one of ecological validity. Thus, a fundamental requirement was the prediction of TIPS scores from the range of standardised measures included in the research, used alongside indicators of acculturation strategy.

While analysis of variance methods such as ANOVA, ANCOVA, MANOVA and MANCOVA (used in the early stages of analysis) may have provided statistical convenience, it was felt that in order to fully elucidate existing relationships, to facilitate an examination of underlying patterns of response and to provide not only significant but meaningful results, Multiple Regression methods were preferred.

In a similar vein, Cole's (1989) paper on adolescent suicide and related mental health experience, focuses on related issues. Looking specifically at the issue of gender, Cole sought to examine "pathways" to suicidal behaviour arguing that the differential trajectories taken by males and female to the point of death as a result of suicide ought be examined further in order to more fully understand gender differences in suicide rates. This perspective is one I share and is reflected in my choice of statistical methods.

Descriptive Statistics & Preliminary Analysis

Interval/Ratio variables

The mean scores and standard deviations both for the total sample and for males and females separately are presented in Table 5.1 Regarding direct measures of mental health, it can be seen that the sample on the whole fell into the "Minimum" depression range (BDI score) with females scoring slightly higher than males and more closely approaching the "Mild" range of symptomatology. When hopelessness (BHS score) is considered it can be seen that there is little

apparent difference between male and female scores with the sample on the whole falling into the "Mild" range. Important to note that on these measures, the sample was far from the level of "caseness" as seen in the predictive studies of Beck and colleagues (mentioned earlier in Chapter 3) or indeed, our own cut-off points for referral.

As with hopelessness, scores for males and females appeared broadly similar at this preliminary stage, with the mean score falling into the "Middle" anomie range.

Of the four TIPS subscales, the lowest mean score was observed for suicide in response to role status loss. Mean scores were higher for the remaining three subscales with the "Death" subscale thought to offer the most "understandable" situational precursors to suicidal behaviour. Items on this scale cover antecedent situations such as loss of a loved one, close friend and spouse/lover. A more detailed analysis of responses to TIPS will be presented in a later section on the confirmatory factor analysis of this measure.

The sample as a whole exhibited high levels of self-esteem (a mean score of 30.13 out of a possible maximum of 40). There was only a slight difference between males and females on this, perhaps contrary to expectation however; issues regarding gender differences will be returned to in greater detail in a later section.

Finally, with regard to coping responses, the greatest difference between males and females appeared on the Seeking Social Support subscale, with females more inclined to utilize this form of coping strategy. Across the sample, "Average" levels of avoidance as a form of coping were seen and; in a similar vein, use of problem-solving fell into the "Average" range as (outlined by Amirkhan, 1990).

Table 5.1 Descriptive Statistics for interval/ratio variables.

	BDI	BHS	Anomie	Role Status (TIPS)	Physical Limitations (TIPS)	Nurturing Bonds (TIPS)	Death (TIPS)	Problem-Solving (CSI)	Seeking Social Support (CSI)	Avoidance (CSI)	Self-Esteem
Total Mean	8.46	4.55	4.33	5.79	7.84	8.48	8.74	23.66	23.06	19.02	30.13
(SD)	(7.28)	(3.77)	(1.97)	(2.21)	(2.39)	(2.70)	(2.86)	(4.51)	(5.48)	(4.64)	(5.17)
Male Mean	6.89	4.20	4.12	5.70	7.68	7.70	7.45	24.32	20.92	19.17	31.84
(SD)	(6.58)	(3.81)	(1.92)	(2.24)	(2.31)	(2.50)	(2.67)	(4.40)	(5.51)	(4.73)	(4.94)
Female Mean	9.22	4.72	4.43	5.83	7.91	8.86	8.96	23.34	24.10	18.95	29.30
(SD)	(7.49)	(3.74)	(1.98)	(2.20)	(2.43)	(2.71)	(2.83)	(4.54)	(5.16)	(4.60)	(5.08)

Nominal Variables

The single acculturation item and the two items on extent of cultural change in Ireland in the last decade, and positive/negative feeling towards said change are to be considered separately as the data provided is nominal.

Table 5.2 Percentage breakdown of acculturation strategies

Strategy	Frequency (Total)	Percent (Total)	Frequency (Males)	Percent (Males)	Frequency (Females)	Percent (Females)
Integration	499	74.1	147	67.1	135	77.5
Assimilation	104	15.5	40	18.3	64	14.1
Marginalization	51	7.6	22	10	29	6.4
Separation	19	2.8	10	4.6	9	2.0

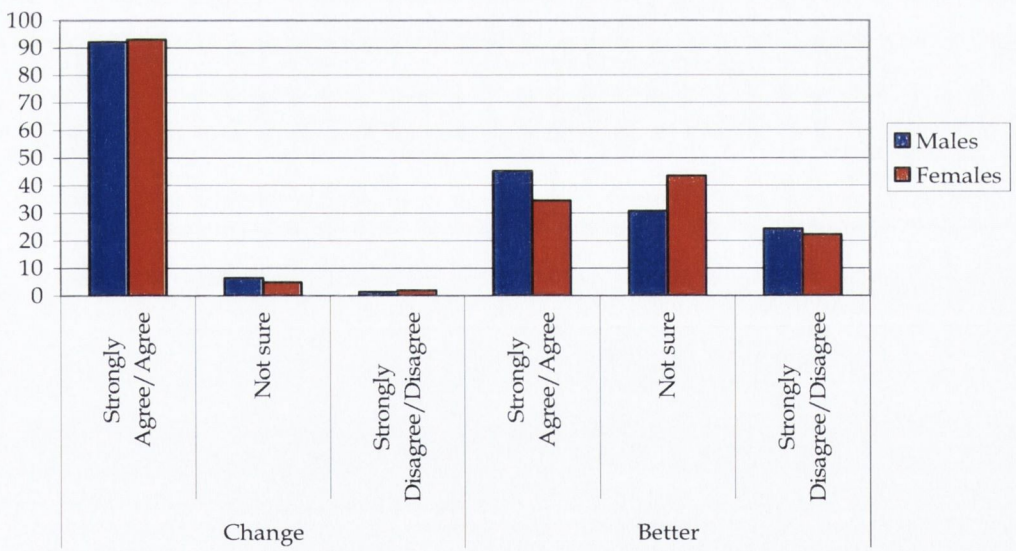
The vast majority of the sample (both males and females) indicated that they experienced an Integrated acculturation strategy (67.1% males and 77.5% females). This is in keeping with research in the area more generally which suggests that integration is by far the most commonly endorsed mode of acculturation (Berry, 1997). At the other end of spectrum, a mere 4.6% of males and 2% of females experienced the Separated mode of acculturation. This, as with Integration is in keeping with findings generally which consistently show that these are the two most frequently occurring strategies. Assimilation and Marginalization can be seen to fall into the "middle" category with 18.3% and 14.1% of males and females respectively endorsing the Assimilation option; and 10% males and 6.4% females endorsing the Marginalized option.

Interestingly, when the perception of change and feelings regarding this change were examined, while the vast majority of both males and females (at 92.2% and 93.1% respectively) either "Strongly Agreed" or "Agreed" that Ireland had in fact changed dramatically in the last ten years, such high levels of consensus were not achieved in relation to the impact of this change- see Figure 5.1 An almost equal proportion of males and females (at 24.2% and 22.1% respectively) indicated disagreement (either as "Strongly Disagree" or "Disagree") with the sentiment

that Ireland is a better place now than it was ten years ago while many indicated a lack of opinion or ambivalence on this item. Thus, while there is widespread recognition that change has indeed occurred, consideration of what such change might mean is more complex. This particular finding is in contrast with recent TNS/mrbi findings which reported that seven in ten of their respondents indicated that "Ireland is still a good place to be"McShane (2004).

Although there is an important difference in the nature of the two questions (with the current study asking about the impact of change over time and the TNS/mrbi question relating *only* to the current situation), this difference is nevertheless of interest. It would appear that although Ireland is still viewed favourably by this age group in general, a clear difference emerges when comparisons are drawn between the actuality of what is, and the possibility either of what might be or what was before.

Figure 5.1 Perception & attitude towards culture change



Indicators of wellbeing & acculturation strategy

Looking first at depression scores across the four strategies (see Table 5.3), it is evident that the maximum score of 64 was not obtained in any case, however; scores which fall into the maximal category of "Severe depression" were obtained

in *all* acculturation strategies but most especially for those participants who were Marginalized. The mean score for each of Integration, Separation and Assimilation fell under the "Minimal" depression category but again, for those who were Marginalized, the mean represents "Moderate" depression suggesting overall higher levels of depression for this mode of acculturation.

With regard to Hopelessness, the maximum score was achieved under the Marginalized acculturation strategy nevertheless; the upper end of the range in the remaining three strategies represents "Severe" hopelessness. When the means are examined however; it becomes clear that, unlike depression, the average score in all four strategies corresponds to "Mild" hopelessness.

The mean scores for anomie were broadly similar across all acculturation strategies, each falling under the category of "Middle" anomie. The full range of scores was seen only for those who were Integrated but with minimum scores in the remaining categories still representing the lowest possible levels (i.e. "Non-anomic).

The full range of scores on each of the TIPS subscales was not seen in any of the acculturation strategy groupings however; the means and standard deviations are broadly similar across groups with the exception of the "Nurturing Bonds" subscale scores for the Separated group which appears somewhat higher than other groups' and where a minimum score of 5 (where the lowest possible score is 3) was also seen. In short, this indicates that no participant in the Separated group believed that loss of nurturing bonds (death of a parent or experiencing either sexual or emotional abuse) was a "very poor reason" for taking one's own life. When boxplots (see Figures 5.2 to 5.5) representing the distribution of scores on each of the TIPS subscales are examined, it appears that the high scores, for males in particular, on the Nurturing Bonds subscale, may be outliers.

Table 5.3 Mental health & wellbeing indicators by acculturation strategy

INTEGRATION	Range	Mean	(SD)
Depression	0 - 34	7.52	(6.42)
Hopelessness	0 - 19	3.81	(3.29)
Anomie	0 - 9	4.17	(1.91)
Role Status	3 - 14	5.57	(2.12)
Physical Limitations	3 - 15	7.69	(2.36)
Nurturing Bonds	3 - 15	8.36	(2.67)
Death	3 - 15	8.31	(2.78)
Problem-Solving	11 - 33	24.07	(4.28)
Seeking Social Support	11 - 33	23.67	(5.34)
Avoidance	11 - 33	18.47	(4.52)
Self-Esteem	11 - 40	30.72	(5.01)
ASSIMILATION			
Depression	0 - 31	8.85	(6.93)
Hopelessness	0 - 17	5.10	(4.00)
Anomie	1 - 9	4.55	(2.08)
Role Status	3 - 13	6.37	(2.35)
Physical Limitations	3 - 14	8.29	(2.61)
Nurturing Bonds	3 - 15	8.79	(2.90)
Death	3 - 15	8.96	(3.07)
Problem-Solving	12 - 33	23.31	(4.69)
Seeking Social Support	11 - 33	22.56	(5.11)
Avoidance	12 - 31	19.96	(4.51)
Self-Esteem	15 - 39	29.37	(5.21)
MARGINALIZATION			
Depression	1 - 43	16.88	(9.56)
Hopelessness	0 - 20	7.37	(4.92)
Anomie	2 - 9	5.51	(1.85)
Role Status	3 - 12	6.43	(2.19)
Physical Limitations	3 - 12	8.08	(2.20)
Nurturing Bonds	3 - 13	8.86	(2.62)
Death	3 - 15	8.96	(3.13)
Problem-Solving	11 - 30	21.29	(5.09)
Seeking Social Support	11 - 33	20.06	(5.91)
Avoidance	12 - 31	22.14	(4.63)
Self-Esteem	12 - 36	26.06	(4.83)
SEPARATION			
Depression	0 - 34	8.42	(9.23)
Hopelessness	0 - 18	5.74	(4.17)
Anomie	0 - 8	4.11	(2.13)
Role Status	3 - 12	6.58	(2.93)
Physical Limitations	3 - 12	8.63	(2.29)
Nurturing Bonds	5 - 13	9.11	(2.23)
Death	3 - 13	8.63	(2.81)
Problem-Solving	15 - 32	21.26	(5.41)
Seeking Social Support	12 - 26	17.95	(4.53)
Avoidance	11 - 29	19.89	(4.57)
Self-Esteem	18 - 37	29.79	(4.91)

However, when tests of kurtosis and skew were performed, it was found that the distribution of scores on all subscales fell within acceptable limits (that is, plus or minus two for skew and plus or minus three for kurtosis, as outlined by Bryman & Cramer, 2001) thus allowing the data to be confidently entered into subsequent analysis.

Figure 5.2 Boxplot for Role Status by acculturation strategy and gender.

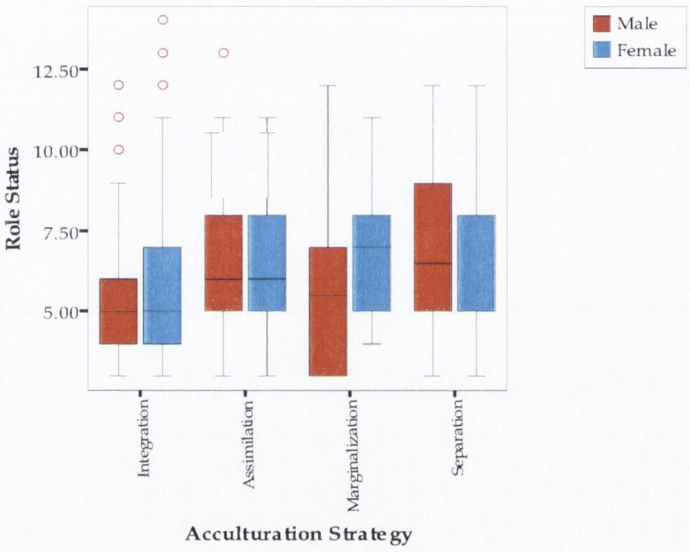


Figure 5.3 Boxplot for Physical Limitations by acculturation strategy and gender.

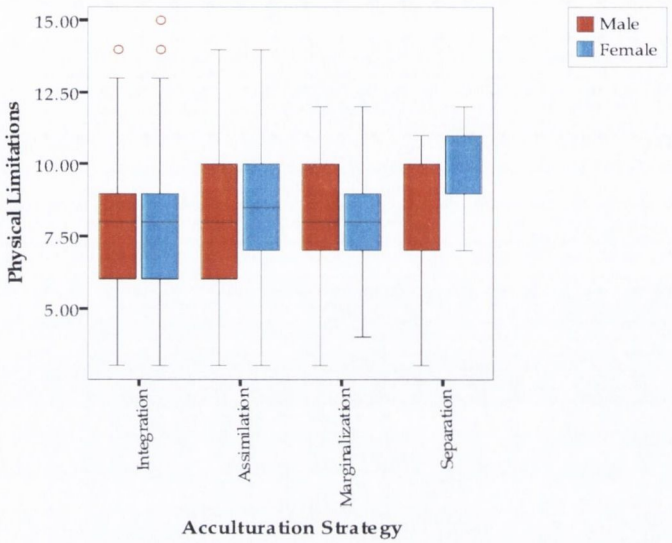


Figure 5.4 Boxplot for Nurturing Bonds by acculturation strategy and gender.

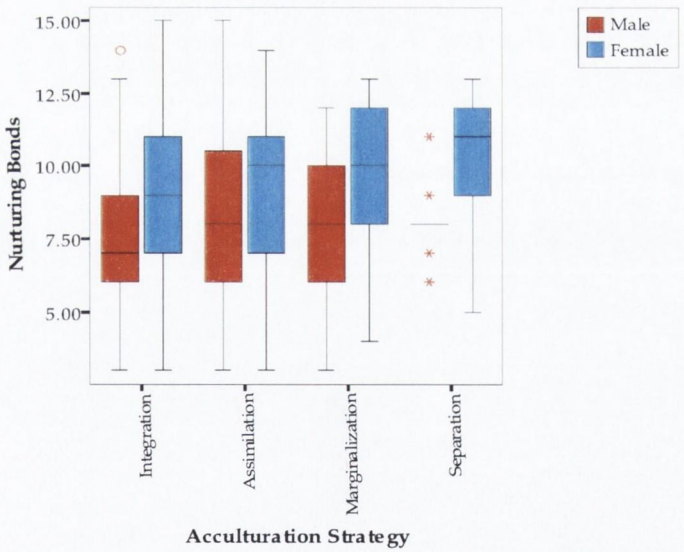
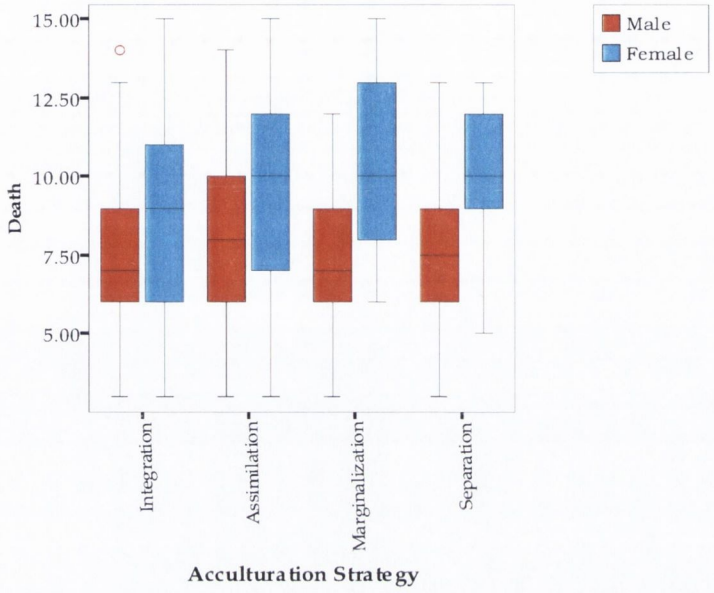


Figure 5.5 Boxplot for Death by acculturation strategy and gender.



Moving to consider the descriptive statistics for the various coping strategies (as measured by the CSI) the greatest deviation from the overall pattern of means is seen for the Separated group utilising Social Support as a method of coping where the mean score of 17.95 differs from the pattern. Examining the possible meaning of this, those who are Separated - who do not identify or find meaning within and have failed to adapt to the current or "new" cultural context, are less likely to cope by means of seeking support from others. Intuitively, this appears reasonable since social links and meaningful supports within a cultural context with which one does not identify are unlikely.

Finally; looking at self-esteem, the full range of scores is seen only for the Integrated group. However; as with the CSI subscales, scores on the RSES are neither skewed nor kurtotic suggesting, perhaps, that acculturation strategy has a notable effect on this aspect of mental health – an issue which will be examined in subsequent analyses.

Reliability analysis of measures

In order to examine the internal consistency of the various measures used, reliability analysis was performed by the calculation of Cronbach's Alpha co-efficients. Results may be seen in Table 5.4

Table 5.4 Reliability analyses of measures

Measure	Alpha Co-efficient
BDI	.857
BHS	.837
Anomie	.778
Self-esteem	.881
Problem-Solving (CSI)	.814
Social Support (CSI)	.891
Avoidance (CSI)	.795
Role Status (TIPS)	.795
Physical Limitations (TIPS)	.791
Nurturing Bonds (TIPS)	.798
Death (TIPS)	.876

With regard to the use of co-efficient alpha as an index of reliability, Henson (2001) clearly outlined the rationale for the selection of acceptable levels of the alpha co-efficient in the assessment of internal consistency. According to this author, an alpha of .7 or greater is deemed acceptable and of high reliability in a general research setting. In the case of measures for which cut-off scores are used (as in the current research where referrals were made on the basis of depression, hopelessness and suicidality responses) an alpha of .8 or greater is preferred. As can be seen from Table 5.4 above, a level of .7 or greater was reached in the case of all measures and in the case of those measures used for referral purposes, the preferred level of .8 was attained.

Intercorrelations among variables

Table 5.5 Intercorrelations among variables

	BDI	BHS	Anomie	Role Status	Physical Limitations	Nurturing Bonds	Death	Problem-Solving	Social Support	Avoidance	Self-Esteem
BDI	1										
BHS	.657**	1									
Anomie	.553**	.407**	1								
Role Status	.226**	.266**	.148**	1							
Phys. Limitations	.211**	.233*	.205**	.463**	1						
Nurturing Bonds	.231**	.236**	.214**	.489**	.587**	1					
Death	.288**	.266**	.230**	.406**	.488**	.721**	1				
Problem-Solving	-.298**	-.298**	-.227**	-.115**	-.105**	-.174**	-.160**	1			
Social Support	-.187**	-.236**	-.155**	-.056	-.095*	.004	.038	.315**	1		
Avoidance	.621**	.442*	.481**	.182**	.184**	.195**	.221**	-.147**	-.219**	1	
Self-Esteem	-.704**	-.625**	-.518**	-.273**	-.259**	-.273**	-.305**	.309**	.194**	-.553**	1

* denotes significance at p<.05; ** denotes significance at p<.01

Table 5.6 Intercorrelations among variables by gender

	BDI	BHS	Anomie	Role Status	Phys. Limitations	Nurturing Bonds	Death	Problem-Solving	Social Support	Avoidance	Self-Esteem
BDI	**1**										
BDI	1										
BHS	**.567****	**1**									
BHS	.697**	1									
Anomie	**.569****	**.381****	**1**								
Anomie	.542**	.415**	1								
Role Status	**.090**	**.233****	**.041**	**1**							
Role Status	.284**	.282**	.196**	1							
Phys. Limitations	**.043**	**.101**	**.050**	**.427****	**1**						
Phys. Limitations	.272**	.282**	.270**	.479**	1						
Nurturing Bonds	**.137***	**.167***	**.129**	**.416****	**.526****	**1**					
Nurturing Bonds	.235**	.257**	.236**	.529**	.617**	1					
Death	**.105**	**.179****	**.168***	**.322****	**.683****	**.683****	**1**				
Death	.325**	.296**	.242**	.454**	.718**	.718**	1				
Problem-Solving	**-.326****	**-.297****	**-.264****	**-.054**	**-.050**	**-.050**	**-.038**	**1**			
Problem-Solving	-.272**	-.292**	-.201**	-.140**	-.204**	-.204**	-.186**	1			
Social Support	**-.106**	**-.126**	**-.125**	**.059**	**.099**	**.099**	**.108**	**.235****	**1**		
Social Support	-.301**	-.337**	-.212**	-.131**	-.127**	-.127	-.100	.419**	1		
Avoidance	**.586****	**.341****	**-.466****	**.073**	**.136***	**.136***	**.128**	**-.140***	**-.108**	**1**	
Avoidance	.654**	.498**	-.494	.237**	.234**	.234*	.283**	-.155**	-.281**	1	
Self-Esteem	**-.669****	**-.561****	**-.524****	**-.200****	**-.218****	**-.218****	**-.233****	**.238****	**.105**	**-.526****	**1**
Self-Esteem	-.708**	-.661**	-.512**	-.309**	-.246**	-.246**	-.277**	.321**	.360**	-.597**	1

*denotes significance at p<.05; ** denotes significance at p<.01

Note: Male correlations are presented in **bold**, while female correlations appear in regular font.

At this early stage of analysis, relationships between variables were assessed by means of a two-tailed Pearson's *r* statistic. As can be seen from Table 5.5 all variables show some degree of inter-correlation, with the exception of non-significant relationships between the Social Support subscale of the CSI, and each of Role Status (TIPS), Nurturing Bonds (TIPS) and Death (TIPS).

However, and as presented in Table 5.6, when inter-correlations are examined for each gender separately, it is clear that differences emerge. This suggests possible gender effects- an aspect which will be examined specifically at subsequent stages of analysis.

Finally, with regard to the inclusion of this data in Multiple Regression Correlation (MRC) analysis and relating to the issue of multicolinearity, *none* of the correlations are greater than the level of 0.8 deemed appropriate by Cohen & Cohen (1983) and Bryman & Cramer (2001) for inclusion in this type of analysis (see later section with MRC results).

Preliminary analysis of gender differences

Given the differing levels of significance obtained by correlational analysis (see previous section) and the relatedness of gender to the topic of research, a one-way ANOVA examining mean differences in scores, by acculturation strategy was performed and then repeated for each gender separately .

Levene's test for equality of variances showed no significant problems with the data set. In addition, tests for kurtosis and skew (mentioned also in previous sections) fell within acceptable limits. Thus, the analysis proceeded with results displayed in Table 5.7 below.

Prior to embarking on ANOVA analysis, preliminary Chi-Square (in the case of acculturation strategy) and T-Tests (for the remaining variables) were performed to explicate possible gender differences.

Significant differences, between males and females, were seen for each of Depression, Nurturing Bonds, Death, Problem-Solving, Social Support and Self-esteem (results are presented in Table 5.7).

Table 5.7 Independent samples T-test for mental health variables

				Mean	
Variable	t	df	p	Males	Females
Depression	-4.105	670	.000	6.90	9.22
Nurturing Bonds	-5.279	670	.000	7.71	8.86
Death	-6.620	670	.000	7.45	8.96
Problem-Solving	2.637	670	.009	24.32	23.34
Social Support	-7.331	670	.000	20.92	24.10
Self esteem	-1.368	670	.000	31.85	29.30

Females scored significantly higher than males on each of Depression, Nurturing Bonds, Death and Social Support; while males scored significantly higher on Problem-Solving and Self-esteem. In the case of the TIPS subscales (namely, Nurturing Bonds and Death), a higher score indicates greater acceptance/understanding of the listed situations as precursors to suicidal behaviour suggesting that females, with regard to issues such as the experience of emotional abuse or death of a parent (in the case of Nurturing Bonds) and wanting to be with a loved one who has died or death of a close friend (in the case of Death), are more likely than males to view such experiences as "Very good reasons" for someone to take their own life.

A Pearson Chi-squared test was employed with regard to the variable acculturation strategy, given that it is nominal. Results from this analysis are presented in Table 5.8

Table 5.8Crosstabulation Gender * Acculturation strategy

		Acculturation Strategy				
Gender		Integration	Assimilation	Marginalization	Separation	Total
Male	Count	147	40	22	10	219
	Expected	162.3	33.9	16.6	6.2	219
Female	Count	351	64	29	9	453
	Expected	335.7	70.1	34.4	12.8	453

A significant relationship between gender and acculturation strategy was seen; $\chi^2 = 9.828$, df = 3, $p = .002$.

Table 5.9One-Way Analysis of Variance for mean differences by acculturation strategy

Variable	Sum of Squares	df	Mean Square	F	Sig.
Depression	4069.468	3	1356.489	28.754	.000
Hopelessness	776.945	3	258.982	19.753	.000
Anomie	89.851	3	29.950	7.983	.000
Role Status	90.407	3	30.136	6.297	.000
Physical Limitations	46.812	3	15.604	2.746	.042
Nurturing Bonds	32.521	3	10.840	1.494	.215
Death	51.097	3	17.032	2.087	.101
Problem-Solving	491.353	3	163.784	8.30	.000
Social Support	1169.175	3	389.725	13.741	.000
Avoidance	750.83	3	250.277	12.186	.000
Self-Esteem	1080.997	3	360.332	14.281	.000

It is evident that significant differences (see Table 5.9) according to acculturation strategy grouping existed in each of Depression, Hopelessness, Anomie, Role

Status, Physical Limitations, Problem-Solving, Social Support, Avoidance and Self-Esteem.

Table 5.10 Post Hoc LSD analysis for One-Way Analysis of Variance for mean differences by acculturation strategy.

	(I) Acculturation Strategy	(J) Acculturation Strategy	Mean Difference (I-J)	Sig.
Depression	Marginalization	Integration	9.3583	.000
		Assimilation	8.0362	.000
		Separation	8.4613	.000
Hopelessness	Integration	Assimilation	-1.3907	.000
		Marginalization	-3.7119	.000
		Separation	-2.0587	.015
	Assimilation	Marginalization	-2.3213	.000
Anomie	Marginalization	Integration	1.3411	.000
		Assimilation	.9617	.004
		Separation	1.4045	.007
Role Status	Integration	Assimilation	-.7911	.001
		Marginalization	-.8571	.008
		Separation	-1.0047	.050
Physical Limitations	Integration	Assimilation	-.5977	.020
Death	Integration	Assimilation	-.6543	.034
Problem-Solving	Integration	Marginalization	2.7762	.000
		Separation	2.8071	.007
	Assimilation	Marginalization	2.0136	.008
Social Support	Integration	Marginalization	3.6139	.000
		Separation	5.7253	.000
	Assimilation	Marginalization	2.4989	.006
		Separation	4.6103	.001
Avoidance	Integration	Assimilation	-1.4876	.002
		Marginalization	-3.6634	.000
	Assimilation	Marginalization	-2.1757	.005
Self-Esteem	Integration	Assimilation	1.3535	.013
		Marginalization	4.6601	.000
	Assimilation	Marginalization	3.3066	.000
	Marginalization	Separation	-3.7307	.006

Since ANOVA results in and of themselves, do not provide any information on the origins of such differences, post-hoc comparisons were performed using the Least Significant Difference (LSD) method on the origin of the significant differences with results displayed in Table 5.10

In the case of both depression and anomie, it can clearly be seen that the acculturation strategy of Marginalization is significantly related to higher levels of both than any of the other acculturation strategies. This is in keeping with general findings in the body of literature which suggests that in relative terms, Marginalization is indicative of poorer mental health (Berry, 1997).

With regard to hopelessness, a more complex pattern is seen such that Integration is indicative of the lowest levels of hopelessness, however; a significant difference also emerges between Assimilation and Marginalization with the former relating to a lower hopelessness score. Thus, in terms of cultural identification, identifying either with both cultures within which one is contextualised *or* fully identifying with the "new" culture significantly relates to lower levels of hopelessness.

The Nurturing Bonds subscale of TIPS shows no significant relationships in this analysis, however a shared pattern emerges across each of Role Status, Physical Limitations and Death insofar as Integration differs significantly from Assimilation across the three (with the result that being Integrated is significantly related to fewer situations being seen as "understandable" precursors to suicidal behaviour). This is perhaps suggestive of an important role for the maintenance of "old" cultural values etc. as it is on this point that Integration and Assimilation differ markedly, since only the former "allows" for identification with traditional cultural elements.

Problem-Solving and Social Support also show a shared theme- Integration in both cases differs significantly from each of Marginalization and Separation in a positive direction (i.e. Integration relates to increased use of these "outward" coping responses). The strategy of Assimilation exhibits a somewhat different

pattern in the case of Problem-Solving and Social Support, differing from Marginalization in the former but from both Marginalization and Separation in the latter. The common element however, is that (as in the case of the aforementioned results) Marginalization once again, implies poorer levels of functioning. In the case of Avoidant coping, significant differences emerge between Integration and both Marginalization and Separation in the expected directions, while a difference also emerges between Assimilation and Marginalization (but in the same direction as in the case of Integration).

Finally, looking at self-esteem; differences emerge across each of the three acculturation strategies resulting in a complex pattern of differences. The overall pattern of results clearly demonstrates not only the relevance of acculturation strategy but also the complexity of the nuances inherent in such relationships.

Given the various differences found at this stage of the analysis, ANOVA tests were repeated in order to look at both genders separately with the aim of further clarifying emergent patterns and themes. The ANOVA results are presented in Table 5.11 which follows, and post-hoc comparisons are to be seen in Table 5.12

Results obtained at this point indicate further support for the "gendered" approach to analysis. The Death subscale on TIPS (which did not show a significant relationship for the group as a whole) is clearly seen to be significant in the female group. Further, the significant result obtained with regard to the subscale of Physical Limitations, appears also to derive from female responses as there is no significant relationship in the male group.

Post-hoc analyses were again performed (results in Table 5.12).

Table 5.11 One-Way Analysis of Variance for mean differences by acculturation strategy, for males & females separately

Gender	Variable	Sum of Squares	df	Mean Square	F	Sig.
Male	Depression	1909.913	3	636.638	18.166	.000
	Hopelessness	270.916	3	90.305	6.698	.000
	Anomie	31.802	3	10.601	2.956	.033
	Role Status	62.809	3	20.936	4.383	.005
	Physical Limitations	9.876	3	3.292	.611	.608
	Nurturing Bonds	15.171	3	5.057	.810	.490
	Death	9.835	3	3.278	.457	.713
	Problem-Solving	286.899	3	95.633	5.239	.002
	Social Support	340.82	3	113.607	3.886	.010
	Avoidance	315.133	3	105.044	4.949	.002
	Self-Esteem	461.772	3	153.924	6.814	.000
Female	Depression Score	2609.313	3	869.771	17.182	.000
	Hopelessness Score	559.506	3	186.502	14.520	.000
	Anomie	92.316	3	30.772	8.192	.000
	Role Status	50.530	3	16.843	3.526	.015
	Physical Limitations	53.493	3	17.831	3.065	.028
	Nurturing Bonds	53.505	3	17.835	2.447	.063
	Death	113.865	3	37.955	4.870	.002
	Problem-Solving	519.111	3	173.037	8.828	.002
	Social Support	576.559	3	192.186	7.535	.000
	Avoidance	443.704	3	147.901	7.265	.000
	Self-Esteem	937.419	3	312.473	13.083	.000

Table 5.12 Post Hoc LSD analysis for One-Way Analysis of Variance for mean differences by acculturation strategy, Males

Dependent Variable	(I) Acculturation Strategy	(J) Acculturation Strategy	Mean Difference (I-J)	Sig.
Depression	Marginalization	Integration	9.8769	.000
		Assimilation	9.6273	.000
		Separation	9.727	.000
Hopelessness	Integration	Assimilation	-1.4080	.033
		Marginalization	-3.4375	.000
	Marginalization	Assimilation	2.0295	.038
Anomie	Marginalization	Assimilation	1.3818	.006
		Integration	1.1614	.008
Role Status	Integration	Assimilation	-1.2713	.001
Problem-Solving	Integration	Marginalization	2.6831	.007
	Assimilation	Marginalization	4.0273	.000
		Separation	3.8000	.013
Social Support	Integration	Marginalization	2.5739	.038
		Separation	5.0830	.004
	Assimilation	Separation	4.6750	.015
Avoidance	Integration	Assimilation	-1.8122	.028
		Marginalization	-3.5213	.001
Self-Esteem				
	Marginalization	Integration	-4.8058	.000
		Assimilation	-4.6136	.000

Examining depression scores in the male group, significant differences arise between the same acculturation strategies as in the case of the sample as a whole but differs from females (where the additional difference between Integration and Assimilation may be seen) with Marginalization showing higher mean scores on the depression measure thus indicating poorer levels of mental health (operationalised in this manner). Interestingly, the pattern of significant difference, and the direction of difference in the case of hopelessness is shared across genders suggesting some commonality on this particular aspect of mental health.

Table 5.13 Post Hoc LSD analysis for One-Way Analysis of Variance for mean differences by acculturation strategy, Females

Dependent Variable	(I) Acculturation Strategy	(J) Acculturation Strategy	Mean Difference (I-J)	Sig.
Depression	Integration	Assimilation	-2.3374	.016
	Marginalization	Integration	9.5335	.000
		Assimilation	7.1961	.000
		Separation	6.6475	.015
Hopelessness	Integration	Assimilation	-1.4776	.003
		Marginalization	-4.0816	.000
		Separation	-2.5835	.033
	Marginalization	Assimilation	2.6040	.001
Anomie	Integration	Assimilation	-.7849	.003
		Marginalization	-1.5279	.000
	Marginalization	Separation	2.0920	.005
Role Status	Integration	Marginalization	-1.1609	.006
Physical Limitations	Integration	Assimilation	-.7578	.021
		Separation	-1.6866	.039
Nurturing Bonds	Integration	Marginalization	-1.0290	.049
Death	Integration	Assimilation	-.9398	.014
		Marginalization	-1.6095	.003
Problem-Solving	Integration	Assimilation	2.1588	.000
		Marginalization	2.9778	.001
		Separation	3.4644	.021
Social Support	Integration	Marginalization	3.6587	.000
		Separation	4.9231	.004
	Assimilation	Marginalization	2.5533	.024
		Separation	3.8177	.034
Avoidance	Integration	Assimilation	-1.3025	.034
		Marginalization	-3.8004	.000
	Assimilation	Marginalization	-2.4978	.014
Self-Esteem	Integration	Assimilation	2.4347	.000
		Marginalization	5.1351	.000
	Assimilation	Marginalization	2.7004	.014
	Marginalization	Separation	-3.9157	.036

Differences between males and females are also seen in the case of anomie. For males, significant differences arise between the acculturation strategy of Marginalization and each of Assimilation and Integration (with higher mean scores seen in the Marginalized group) while for females a more complex pattern is seen with differences between the Integrated group and each of the

Assimilated and Marginalized groups; and, between the Marginalized group and the Separated group.

Despite this complexity, results indicate, as before, that the acculturation strategy of Marginalization relates to higher levels of anomie.

Regarding Role Status, it is the difference between Integration and another acculturation strategy which emerges in both genders, however; in the case of males, the significant difference seen is between Integration and Assimilation while for females, it is between Integration and Marginalization. This is perhaps suggestive of a differing impact of acculturation across genders, such that for those males who have no cultural "grounding" within traditional Irish culture (i.e. Assimilation) a greater number of role-related challenges (such as not being able to get a girlfriend or boyfriend) are thought to be "acceptable" antecedents of suicide.

Physical Limitations, which shows no significant finding in the case of males, is significant in the female group, with the results again showing that Integration is related to the endorsement of fewer scenarios in this theme being seen as "understandable" precursors to suicidal behaviour. The Nurturing Bonds subscale of TIPS also shows striking gender differences, not emerging as significant at all in the male group but with a difference in females seen between Integrated and Marginalized groups (as before, in the expected direction).

In the sample as a whole, no significant relationships emerged for the Death subscale of the TIPS measure. This was also the case for males. However; highly significant findings were obtained for females. Significance emerged from the differences between a strategy of Integration and each of Assimilation and Marginalization further suggesting a positive role for the inclusion of elements from *both* "Old" and "New" Irish culture.

In respect of coping, the only commonality between males and females was on the Social Support subscale. Differences between Integrated and each of

Marginalized and Separated groups emerged for both genders with an additional significant difference between Assimilation and Separation for males, and between Assimilation and Marginalization and Separation for females. Each of Problem-Solving and Avoidance showed different patterns across genders.

Finally, self-esteem showed the same pattern in females as in the group as a whole but for males significance emerged from the difference between Marginalized and both Integrated and Assimilated groups (with lower self-esteem scores seen in the Marginalized category).

On the whole, this stage of the analysis revealed important, although sometimes complex, differences both between acculturation strategies and across genders. Marginalization was consistently related to higher scores on the negative indicators (i.e. poorer mental health) and lower scores on positive or protective factors (e.g. self-esteem) while in contrast, Integration consistently indicated the reverse. Not only does this support previous research in the area of acculturation but further suggests the need to examine possible gender differences more closely in subsequent stages of the analysis.

Statistical Power

Before proceeding further in the presentation of results, it is important to address the issues of power and effect size with regard to the Multiple Regression analyses which will follow.

The issue of statistical power in research investigations is not a new one having first been mentioned in the work of Neyman & Pearson (1928; 1933). Cohen (1992) asserts that despite knowledge of the implications of sample size, effect size, statistical significance and the inclusion of variables, information on power may have been lost as a result of inaccessible presentation of the material. This is no longer the case, and given the numerous variables included in the current research, it was a matter of importance in the current analysis.

In short, and relating to Type II error, the role of power deals with the probability of *not* accepting the null hypothesis when false with a larger sample size (both in absolute terms but also relative to the number of variables included in the analysis) increasing the accuracy of interpretation of findings.

Cohen (1988; 1992) deals specifically with considerations of power surrounding Multiple Regression analyses. With a specification of power of .80 (β= .20) which is a convention for general use in the behavioural sciences, at a significance level of p <.01, medium and large effect sizes may be detected in MRC analyses, including seven variables (as in the current case) with a sample size of 102 or greater.

This sample size (relative to the number of included variables) is clearly exceeded in the current research with the sample approaching the size required to detect even small effect sizes (where 726 or more participants are called for). Thus, Multiple Regression analyses were undertaken with confidence regarding both the statistical and meaningful significance of findings.

Confirmatory Factor Analysis of TIPS

Having previously investigated the factor structure of the TIPS measure, an essential element of this phase of the research was to submit the measure to confirmatory factor analytic techniques and investigate the measure's concurrent and predictive validity.

Factor Structure

Table 5.14 Descriptive statistics and reliability of TIPS subscales

					Correlation among factors			
Factor	Mean	Range	SD	α	Role Status	Physical Limitations	Nurturing Bonds	Death
Role Status	5.79	3-14	2.21	.795	1.00			
Physical Limitations	7.83	3-15	2.40	.791	.462**	1.00		
Nurturing Bonds	8.47	3.15	2.69	.798	.488**	.588**	1.00	
Death	8.46	3-15	2.86	.876	.406**	.489**	.721**	1.00

** indicates significance at the 0.01 level (two-tailed).

In the evaluation of the factor structure of the TIPS, two models (see Figures 5. 6 and 5.7 which follow for diagrammatic representation) were selected to test using confirmatory factor analysis techniques. The first model was an orthogonal model based on the initial development of the measure (reflected in the use of the orthogonal Varimax rotation) which hypothesizes that while each of the four scales are inter-related, as above, they are also unique. The second was an oblique model, proposed on the basis that it is rare for psychological constructs or human characteristics to be completely unrelated, and thus variables comprising their underlying factors may be correlated (Child, 1990).

Both models were entered into AMOS (Arbuckle & Wothke, 1999) for analysis using the Maximum- Likelihood method of estimation. With regard to fit statistics, many textbooks suggest that overall model fit be assessed using the chi-squared statistic also referenced as the discrepancy method of fit analysis (Browne & Cudeck, 1993).

It is generally suggested that chi-squared be *non-significant* (Schumacker & Lomax, 1996). This discrepancy method of model assessment is however, problematic as it is sensitive both to sample size and model complexity. It is generally suggested that where sample size exceeds 150-200, the chi-squared

method of model fit is unreliable and alternative methods preferred (McDonald, 1999; Pinto, Whisman, & Conwell, 1998; Schumacker & Lomax, 1996; Stevens, 2002). Nonetheless, McDonald (1999) suggests that the chi-squared to degrees of freedom ratio (χ^2/df) of between two and five is satisfactory and indicates good overall model fit. Given the problematic nature of chi-squared, alternative methods, resistant to sample size, include the Goodness of Fit Index (GFI) (Bentler, 1983), Normed Fit Index (NFI) (Bentler & Bonett, 1980), Comparative Fit Index (CFI) (Bentler, 1990) and finally, the Tucker-Lewis index (TLI) (Bentler *et al.*, 1980). Table 5.15 outlines the acceptable ranges for each and the obtained levels for Models A and B.

Table 5.15 Fit Statistics for Models A & B

Fit Statistics							
	χ^2	df	χ^2/df	GFI	NFI	CFI	TLI
Acceptable level	-	-	2-5	≥ .9	≥ .9	≥ .9	≥ .9
Model A	1189.2*	54	22	.761	.694	.703	.637
Model B	190.72*	48	3.9	.956	.951	.963	.949

*denotes p<.001

As can be seen from Table 5.15, Model A meets none of the criteria for model-fit and so, was disregarded. In contrast, Model B provides a suitable fit for the data. Despite the fact that chi-squared is significant, the discrepancy ratio falls within acceptable limits and the remaining indices of fit (i.e. GFI, NFI, CFI and TLI) are clearly within acceptable limits. On this basis, Model B was accepted.

Figure 5.6 Diagrammatic representation of orthogonal model for TIPS factor structure

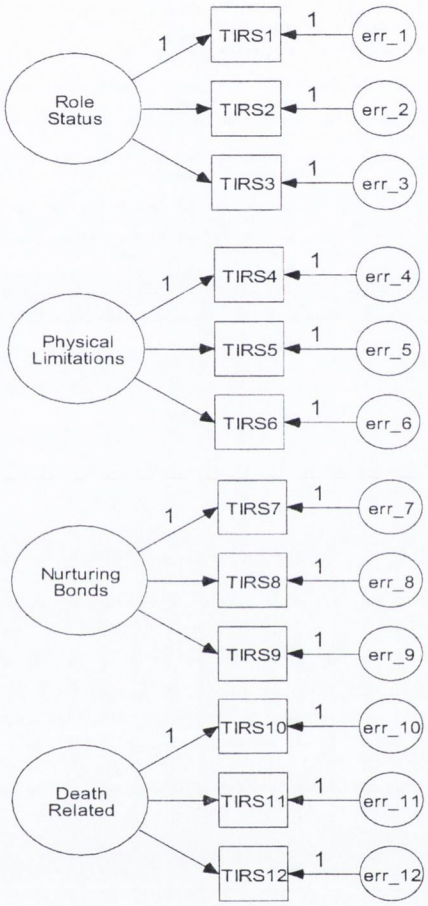
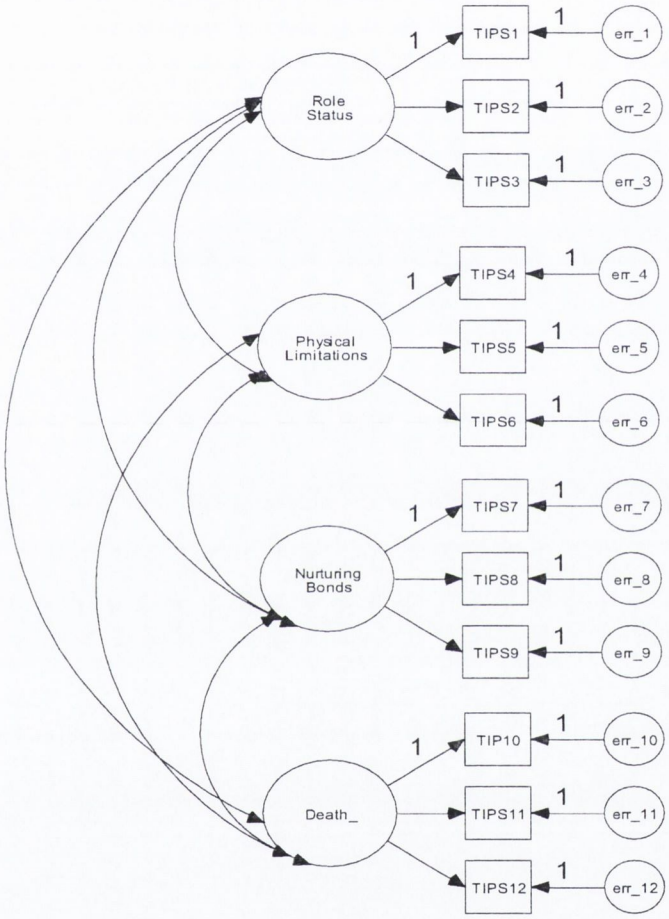


Figure 5.7 Diagrammatic representation of oblique model for TIPS factor structure



Concurrent Validity

Pearson correlations were performed with the TIPS, BDI and BHS to assess the concurrent validity of the measure (see Table 5.16). Each of the four TIPS subscales (Role Status, Physical Limitations, Nurturing Bonds and Death) were positively and significantly correlated with depression (as measured by the BDI), suicidality (as measured by BDI question 9, which directly assesses the desire to end one's life) and hopelessness (as measured by the BHS).

Table 5.16 Concurrent validity of TIPS subscales

	Role Status	Physical Limitations	Nurturing Bonds	Death
BDI	.226**	.213**	.233**	.289**
BDI, Q.9.	.195**	.157**	.218**	.235**
BHS	.27**	.246**	.259**	.288**

** denotes p <.01(two-tailed)

Given the notable gender imbalance in completed suicidal behaviour, some gender differences in the results were expected and I felt it important to re-assess these on this basis. Gender differences in mean scores were significant only for the Death (Male mean= 7.45, Female mean= 8.86, t= -6.620, df= 670, p <.0001, two-tailed) and Nurturing Bonds (Male mean= 7.7, Female mean= 8.96, t= -5.279, df= 670, p <.0001, two-tailed) subscales, with females scoring higher on these scales than males. The construct validity of the subscales was then assessed (see Table 5.17).

Table 5.17 Gender breakdown of construct validity of TIPS subscales

	Role Status	Physical Limitations	Nurturing Bonds	Death
Males				
BDI	.090	.043	.137*	.105
BDI, Q.9.	.175**	.124	.241**	.266**
BHS	.218**	.122	.228**	.240**
Females				
BDI	.283**	.275**	.238**	.326**
BDI, Q.9.	.204**	.171**	.207**	.223**
BHS	.294**	.300**	.261**	.298**

denotes p <.05 (two-tailed); ** denotes p <.01 (two-tailed)

It becomes clear that while the significant, positive correlations remain unchanged on each of the four subscales for females, the situation for males is quite different. In males, depression is related only to the Nurturing Bonds scale while suicidality and hopelessness show significant relationships with each of Role Status, Nurturing Bonds and Death. None of the measures of mental health are significantly related to the Physical Limitations subscale for males.

Predictive validity

Finally, a stepwise multiple regression analysis was performed to assess the predictive validity of the TIPS for each of BHS, BDI and BDI question 9. Given the results of the correlational analysis, results were compared across genders (see Tables 5.18 a & b for details of predictors). With regard to BHS scores; for males, the subscales of Death and Role Status accounted for 7.1% variance (Adjusted R-square= .071, $F_{1, 217} = 9.38$, $p<.0001$) while for females, the subscales of Physical Limitations, Role Status and Death accounted for 12.9% variance (Adjusted R-square = .129, $F_{3, 450} = 236.34$, $p <.0001$).

In the case of BDI score; for males, the subscale of Nurturing Bonds accounted for 1.4% variance (Adjusted R-square = .014, $F_{1, 217} = 4.13$, $p = .043$) while for females, the subscales of Death and Role Status accounted for 12.6% variance (Adjusted R-square = .126, $F_{3, 450} = 33.59$, $p <.0001$).

Finally, in the case of BDI question 9; for males the subscale of Death accounted for 6.7% variance (Adjusted R-square = .037, $F_{1, 217} = 16.56$, $p < .0001$) and for females, Death and Role Status accounted for 5.9% variance (Adjusted R-square= .059, $F_{3, 450} = 15.189$, $p < .0001$).

Table 5.18 (a) Stepwise regression analysis for TIPS subscales

Dependent Variable	*Step*	*Predictor Variable*	*Standardised Beta*	*F (df)*	*t*	*Adj R^2*
(1) BHS score						
Males	1	Death	.240	13.308** (1)	1.962*	.053
	2	Death	.190	9.383** (2)	2.752**	
		Role Status	.157		2.280*	.071
Females	1	Physical Limitations	.300	44.726** (1)	6.688**	.088
	2	Physical Limitations	.207	30.561** (2)	4.115**	
		Role Status	.195		3.874**	.115
	3	Physical Limitations	.147	23.335** (3)	2.705**	
		Role Status	.155		2.993**	
		Death	.151		2.818**	.129
(2) BDI score						
Males	1	Nurturing Bonds	.137	4.130* (1)	2.032*	.014
Females	1	Death	.326	53.905** (1)	7.342**	.105
	2	Death	.249	33.587** (2)	5.055**	
		Role Status	.170		3.458**	.126
(3) BDI, Q9						
Males	1	Death	.266	16.564** (1)	4.070**	.067

Dependent Variable	*Step*	*Predictor Variable*	*Standardised Beta*	*F (df)*	*t*	*Adj R^2*
Females	1	Death	.223	23.744** (1)	4.873**	.048
	2	Death	.165	15.189** (2)	3.226**	
		Role Status	.129		2.521*	.059

*denotes significance p<.05 and ** denotes significance p<.01

Table 5.18 (b) Excluded Variables

	Step	*Variable*	*Beta in*	*t*	*Sig*
BHS					
Males	1	Physical Limitations	.025	.349	.728
		Nurturing Bonds	.120	1.329	.185
	2	Physical Limitations	-.037	-.446	.605
		Nurturing Bonds	.067	.722	.471
Females	1	Role Status	.195	3.874	.000
		Nurturing Bonds	.121	2.132	.034
		Death	.194	3.739	.000
	2	Nurturing Bonds	.054	.905	.366
		Death	.151	2.818	.005
	3	Nurturing Bonds	-.054	-.760	.448
BDI					
Males	1	Role Status	.170	3.458	.001
		Physical Limitations	-.040	-.500	.617
		Death	.021	.227	.820
Females	1	Role Status	.170	3.458	.001
		Physical Limitations	.143	2.762	.006
		Nurturing Bonds	.007	.112	.911
	2	Physical Limitations	.096	1.776	.076
		Nurturing Bonds	-.072	-.1073	.284
BDI Q9					
Males	1	Role Status	.100	1.443	.150
		Physical Limitations	.014	.199	.842
		Nurturing Bonds	.110	1.228	.221

	Step	*Variable*	*Beta in*	*t*	*Sig*
Females	1	Role Status	.129	2.521	.012
		Physical Limitations	.074	1.370	.171
		Nurturing Bonds	.096	1.464	.144
	2	Physical Limitations	.034	.610	.542
		Nurturing Bonds	.048	.687	.493

Confirmatory Factor Analysis findings

It was found that an oblique factor solution was most appropriate for the data with high fit indices, and the original structure for each of the sub-scales was supported. Each of the four subscales was seen to have high levels of reliability ranging from .795 to .876, especially when the brevity of the scales is considered.

When the mean scores for each of the sub-scales are assessed, it is clear that suicidal behaviour in the context of "Role Status" issues ("Not being able to get a girlfriend/boyfriend", "Becoming unemployed" and "Having no money") was least "acceptable" or "understandable" to respondents, followed by Physical Limitations, Death and Nurturing Bonds respectively (in order of increasing acceptability). Across studies (for example, Ingram & Ellis, 1995 and Range & Martin, 1990) it has been found that suicidal behaviour in response to, or in the context of physical illness (categorized in TIPS under the subscale of "Physical Limitations") is rated as acceptable or understandable. Thus, the current findings are in keeping with previous work; however more complex results emerge when gender is evaluated.

Gender differences in sub-scale scores show that females rated "Death" and "Nurturing Bonds" as more understandable reasons for suicide than males. On *none* of the subscales did males score higher, thus indicating that suicide in whatever context is seen as more acceptable by females than males. This is at odds with the assertion that males (more than females) view suicide as a more "reasonable" course of action and hold more permissive attitudes generally towards suicidal behaviour (Deluty, 1988a, 1988b).

Further, a gender-specific pattern was seen in terms of the predictive validity of TIPS. With regard to *hopelessness*, it was "Death" and "Role Status" issues which were of relevance for males, while in the case of female respondents, "Physical Limitations" together with "Death" and "Role Status" scores were significant ("Physical Limitations" did not feature for male respondents in any of the other measures). In the case of *depression*, males' scores were related to the "Nurturing Bonds" subscale (a subscale which did not feature for females, contrary to popular intuition) while for females, it was "Death" and "Role Status" scores. Equally in the case of active *suicidal ideation*, "Death" was of relevance for male respondents but "Death" and "Role Status" together were relevant for females.

While the percentage variance explained overall is low, this is to be expected as the TIPS does not aim to assess active suicidal ideation, depression or hopelessness. Nonetheless, this differential pattern is of interest, perhaps especially when the gender imbalance in suicide statistics is considered. It is also important to note that while items included in the TIPS cover each of the four domains known to be related to youth suicidal behaviour, we would encourage researchers in different social and cultural contexts to re-analyse the factor structure and add items (if appropriate) in order to integrate etic and emic approaches and thus, more fully represent the context-based perspective underlying the TIPS (Leung et al., 2002; Yang, 2000)

The World Health Organization (1999a; 1999b) has reported a 60% increase in international suicide rates between 1950 and 1995, with the increase being almost entirely attributable to an increase in male suicide specifically (DeLeo, 2002a). Thus, a gender imbalance in suicide is seen at the international level making gender differences in attitudes towards suicide especially relevant. More specifically still, when the Irish situation is considered, the gender imbalance in suicidal behaviour is magnified such that a male to female ratio of 7:1 for youth suicide was reached in 1998 (Irish Association of Suicidology, 2000b). Figures for 2002 suggest that while this imbalance has reduced somewhat, in the 15-24 year

old age group, there are 5.5 male suicides for every one female suicide (Central Statistics Office, 2002)[20] making this gender specific pattern of particular interest.

The theme of loss has long been represented in research literature on suicide with the best illustration coming from Shneidman's (1985) term *"psychache"* that is, the desire to escape an unbearable, intolerable situation which is causing psychic pain in the most elementary way. The pattern which emerged was that of female concern with Physical Limitations and, perhaps counter intuitively, while the Nurturing Bonds subscale did not emerge as predictive of depression, hopelessness or suicidality for females, it was related to depression in the male subset. This subscale covers contexts such as experiencing emotional abuse in a relationship, losing a parent through death and experiencing sexual abuse in childhood- relational issues which held a greater resonance for males in the sample. This finding marks a departure from previous work, such as that of Reinherz et al., (1993; 1995) who found relational issues such as an insecure family milieu, the feeling of not being valued and interpersonal aggression and/or violence to be related to female suicide only. This can, perhaps, be interpreted to mean that relational issues hold a more central place in the male permissive attitudes and trajectory towards suicide than has previously been recognised.

In the Irish context, much has been written regarding the impact of social change on male gender roles. A century ago, "man" was determined by status or position- being a leader in the public arena and a patriarch at home. It is suspected that the continued traditional socialization of males towards inexpressiveness in relational issues is a key risk factor in the high rate of male suicide (Smyth et al., 2003).. Clearly, relational issues are of concern to males and are situational precursors from which suicide is an understandable outcome. However, this concern is not matched by expression or discussion of these same issues. Although this requires additional research, the present results indicate an interesting departure from previous findings and draws attention to the

[20] Personal communication

importance of education and prevention programs where such themes can be addressed- these points will later be returned to (see Chapter 6)

Regression Analyses

Continuing the gendered analysis of results and with the aim of examining the predictive strength of the indicators (mediating variables) of mental health included in the research on precursors to suicide, several hierarchical regression analyses were undertaken, structured by theoretical considerations of the relationships between the indicator variables (acculturation strategy), mediating variables (depression, hopelessness, coping, self-esteem and anomie) and the predicted variables (Role Status, Physical Limitations, Nurturing Bonds and Death). At each stage of the analysis, tolerance (a commonly used index of collinearity) was evaluated (in order to assess the suitability of the data for use in MRC analyses) with the finding that acceptable limits were achieved in all cases. Analysis was undertaken for both genders separately to further facilitate the examination of possible gender differences. Results will be presented in a format which is in keeping with the recommendations of Williams (1991).

On the whole, it may be said that although the effects are relatively small, they are highly significant and, in terms of ecological meaning are impressive; holding important implications for population-based research. Given the nature of the relationships in question (where cultural issues were investigated alongside attitudinal elements) the respective percentage variances which emerged were notable.

Table 5.19 Hierarchical Regressions for Males

Dependent Variable	Step	Predictor Variable	Standardized β	Partial Correlation	F (df)	Adj. R^2
Role Status	1	Assimilation	.195**	.195	8.61** (1)	.034
	2	Assimilation	.176**	.180		
		Hopelessness	.217**	.220	10.01**	.076
Physical Limitations	1	Self-esteem	-.180**	-.180	7.28 (1)**	.028
Nurturing Bonds	1	Hopelessness	.167**	.167	6.25 (1)**	.024
	2	Hopelessness	.066	.056		
		Self-Esteem	-.181*	-.152	5.75 (2)**	.042
Death	1	Hopelessness	.179**	.179	7.21 (1)**	.028
	2	Hopelessness	.071	.060		
		Self-esteem	-.193*	-.163	6.63 (2)**	.049
	3	Hopelessness	.085	.073		
		Self-esteem	-.200**	-.170		
		Social Support	.140*	.143	5.98 (3)**	.064

* denotes p <.05; ** denotes p <.01

It is clear from these results that a differential predictive "pathway" exists for each of the four TIPS subscales. Acculturation factors are significant only with regard to "Role Status" which, in combination with hopelessness accounts for 7.6% of the variance in this subscale.

Self-esteem was the only significant predictor of the "Physical Limitations" subscale, accounting for 2.8% variance in the male group. Moving to "Nurturing Bonds", 4.2% variance is accounted for by hopelessness and self-esteem and

finally; in the case of the "Death" subscale, hopelessness, self-esteem and the utilisation of social support coping mechanisms account for 6.4% variance.

Table 5.20 Hierarchical Regressions for Females

Dependent Variable	Step	Predictor Variable	Standardized β	Partial Correlation	F (df)	Adj. R^2
Role Status	1	Marginalization	.122 **	.122	6.75 (1)**	.013
	2	Marginalization	.055	.055		
		Hopelessness	.268 **	.262	20.10 (2)**	.078
	3	Marginalization	.034	.034		
		Hopelessness	.164**	.123		
		Depression	.156*	.115	15.56 (3)**	.088
	4	Marginalization	.033	.033		
		Hopelessness	.105	.075		
		Depression	.069	.046		
		Self-esteem	-.183**	-.128	13.695 (4)**	.101
Physical Limitations	1	Assimilation	.099*	.099	4.41 (1) *	.008
	2	Assimilation	.104*	.104		
		Separation	.095*	.096	4.29 (2)*	.014
	3	Assimilation	.074	.077		
		Separation	.072	.075		
		Hopelessness	.279**	.279	15.72 (3)**	.089
	4	Assimilation	.074	.077		
		Separation	.074	.078		
		Hopelessness	.177**	.132		
		Depression	.146**	.110	13.29 (4)**	.098
	5	Assimilation	.062	.065		
		Separation	.086*	.091		
		Hopelessness	.165**	.124		
		Depression	.066	.047		
		Anomie	.163**	.144	12.71	.115

Dependent Variable	Step	Predictor Variable	Standardized β	Partial Correlation	F (df) (5) **	Adj. R^2
Nurturing Bonds	1	Hopelessness	.257**	.257	31.71 (1)**	.064
	2	Hopelessness	.191**	.179		
		Anomie	.159**	.149	21.31 (2)**	.083
	3	Hopelessness	.158**	.146		
		Anomie	.146**	.138		
		Problem-Solving	-.130**	-.130	163.97 (3)**	.096
Death	1	Marginalization	.127**	.127	7.37 (1)**	.014
	2	Marginalization	.139**	.139		
		Assimilation	.115**	.115	6.75 (2)**	.025
	3	Marginalization	.045	.045		
		Assimilation	.083	.086		
		Depression	.303**	.291	18.76 (3)**	.106
	4	Marginalization	.038	.038		
		Assimilation	.075	.079		
		Depression	.216**	.160		
		Hopelessness	.128*	.097	15.28 (4)**	.112

* denotes p <.05; ** denotes p <.01

Table 5.21 Stepwise Regressions Excluded variables

	Step	*Predictor Variable*	*Beta In*	*t*	*Sig.*
Role Status					
Male	1	Marginalization	.063	.938	.349
		Separation	.119	1.790	.075
		Depression Score	.101	1.520	.130
		Hopelessness Score	.217	3.319	.001
		Problem-Solving	-.088	-1.302	.194
		Seeking Social Support	.057	.852	.395
		Avoidance	.054	.801	.424
		Anomy Total	.057	.855	.394

	Step	*Predictor Variable*	*Beta In*	*t*	*Sig.*
		Self-Esteem Total	-.208	-3.190	.002
	2	Marginalization	.007	.101	.920
		Separation	.103	1.571	.118
		Depression Score	-.035	-.437	.662
		Problem-Solving	-.020	-.293	.770
		Seeking Social Support	.086	1.311	.191
		Avoidance	-.021	-.307	.759
		Anomy Total	-.033	-.458	.648
		Self-Esteem Total	-.126	-1.601	.111
Female	1	Separation	.046	.976	.330
		Depression Score	.269	5.665	.000
		Hopelessness Score	.268	5.742	.000
		Problem-Solving	-.128	-2.738	.006
		Seeking Social Support	-.128	-2.713	.007
		Avoidance	.222	4.768	.000
		Anomy Total	.184	3.942	.000
		Self-Esteem Total	-.296	-6.426	.000
		Assimilation	.086	1.833	.067
	2	Separation	.022	.490	.624
		Depression Score	.156	2.453	.015
		Problem-Solving	-.063	-1.322	.187
		Seeking Social Support	-.051	-1.057	.291
		Avoidance	.125	2.398	.017
		Anomy Total	.096	1.935	.054
		Self-Esteem Total	-.212	-3.551	.000
		Assimilation	.052	1.126	.261
	3	Separation	.024	.531	.596
		Problem-Solving	-.053	-1.112	.267
		Seeking Social Support	-.041	-.842	.400
		Avoidance	.082	1.378	.169
		Anomy Total	.058	1.087	.278
		Self-Esteem Total	-.183	-2.728	.007
		Assimilation	.049	1.065	.287
	4	Separation	.029	.651	.516
		Problem-Solving	-.034	-.721	.471
		Seeking Social Support	-.019	-.388	.698
		Avoidance	.046	.755	.451
		Anomy Total	.029	.539	.590
		Assimilation	.036	.782	.435
Physical Limitations					
Male	1	Assimilation	.058	.869	.386
		Marginalization	.009	.135	.893
		Separation	.012	.181	.857
		Depression Score	-.140	-1.561	.120
		Hopelessness Score	-.001	-.007	.994
		Problem-Solving	.085	1.245	.215
		Seeking Social Support	-.035	-.514	.608

	Step	*Predictor Variable*	*Beta In*	*t*	*Sig.*
		Avoidance	-.024	-.303	.763
		Anomy Total	-.061	-.780	.436
Female	1	Marginalization	.026	.549	.583
		Separation	.095	2.036	.042
		Depression Score	.272	6.004	.000
		Hopelessness Score	.285	6.301	.000
		Problem-Solving	-.151	-3.216	.001
		Seeking Social Support	-.131	-2.811	.005
		Avoidance	.233	5.083	.000
		Anomy Total	.263	5.753	.000
		Self-Esteem Total	-.285	-6.273	.000
	2	Marginalization	.030	.640	.522
		Depression Score	.269	5.939	.000
		Hopelessness Score	.279	6.154	.000
		Problem-Solving	-.143	-3.032	.003
		Seeking Social Support	-.121	-2.581	.010
		Avoidance	.232	5.074	.000
		Anomy Total	.268	5.892	.000
		Self-Esteem Total	-.283	-6.246	.000
	3	Marginalization	-.048	-1.022	.308
		Depression Score	.146	2.348	.019
		Problem-Solving	-.071	-1.491	.137
		Seeking Social Support	-.033	-.692	.489
		Avoidance	.125	2.424	.016
		Anomy Total	.184	3.748	.000
		Self-Esteem Total	-.175	-2.937	.003
	4	Marginalization	-.070	-1.479	.140
		Problem-Solving	-.060	-1.259	.209
		Seeking Social Support	-.021	-.444	.657
		Avoidance	.086	1.457	.146
		Anomy Total	.163	3.067	.002
		Self-Esteem Total	-.140	-2.086	.038
	5	Marginalization	-.073	-1.555	.121
		Problem-Solving	-.052	-1.105	.270
		Seeking Social Support	-.013	-.278	.781
		Avoidance	.050	.837	.403
		Self-Esteem Total	-.104	-1.523	.129
Nurturing Bonds					
Male	1	Assimilation	.079	1.179	.240
		Marginalization	-.040	-.581	.562
		Separation	.023	.343	.732
		Depression Score	.062	.758	.449
		Problem-Solving	-.001	-.011	.991
		Seeking Social Support	.122	1.824	.070
		Avoidance	.089	1.250	.213
		Anomy Total	.076	1.054	.293
		Self-Esteem Total	-.181	-2.263	.025
	2	Assimilation	.097	1.445	.150

	Step	Predictor Variable	Beta In	t	Sig.
		Marginalization	-.071	-1.028	.305
		Separation	.021	.313	.755
		Depression Score	-.044	-.464	.643
		Problem-Solving	.014	.194	.846
		Seeking Social Support	.129	1.940	.054
		Avoidance	.025	.317	.752
		Anomy Total	.012	.159	.874
Female	1	Assimilation	.021	.453	.651
		Marginalization	.023	.489	.625
		Separation	.053	1.161	.246
		Depression Score	.104	1.641	.101
		Problem-Solving	-.143	-3.025	.003
		Seeking Social Support	-.055	-1.145	.253
		Avoidance	.141	2.695	.007
		Anomy Total	.159	3.203	.001
		Self-Esteem Total	-.133	-2.200	.028
	2	Assimilation	.005	.102	.919
		Marginalization	.013	.277	.782
		Separation	.044	.958	.339
		Depression Score	.086	1.354	.176
		Seeking Social Support	-.004	-.081	.936
		Avoidance	.139	2.682	.008
		Anomy Total	.146	2.959	.003
		Self-Esteem Total	-.104	-1.702	.089
	3	Assimilation	.001	.029	.977
		Marginalization	.003	.067	.947
		Separation	.048	1.063	.288
		Depression Score	.003	.042	.966
		Seeking Social Support	.016	.316	.752
		Anomy Total	.113	2.131	.034
		Self-Esteem Total	-.044	-.653	.514
	4	Assimilation	-.005	-.120	.904
		Marginalization	-.002	-.040	.968
		Separation	.058	1.281	.201
		Depression Score	-.038	-.506	.613
		Seeking Social Support	.016	.320	.749
		Self-Esteem Total	-.013	-.188	.851
Death					
Male	1	Assimilation	.060	.900	.369
		Marginalization	-.081	-1.184	.238
		Separation	-.008	-.120	.905
		Depression Score	.004	.053	.958
		Problem-Solving	.017	.238	.812
		Seeking Social Support	.133	1.984	.048
		Avoidance	.076	1.073	.285
		Anomy Total	.116	1.618	.107
		Self-Esteem Total	-.193	-2.424	.016
	2	Assimilation	.057	.856	.393

	Step	Predictor Variable	Beta In	t	Sig.
		Marginalization	-.069	-1.007	.315
		Separation	.015	.225	.822
		Depression Score	.011	.136	.892
		Problem-Solving	-.013	-.177	.860
		Avoidance	.086	1.222	.223
		Anomy Total	.129	1.805	.072
		Self-Esteem Total	-.200	-2.529	.012
	3	Assimilation	.076	1.145	.253
		Marginalization	-.104	-1.514	.131
		Separation	.014	.208	.835
		Depression Score	-.126	-1.357	.176
		Problem-Solving	.002	.032	.974
		Avoidance	.013	.167	.867
		Anomy Total	.068	.870	.385
Female	1	Assimilation	.115	2.458	.014
		Separation	.053	1.123	.262
		Depression Score	.312	6.675	.000
		Problem-Solving	-.173	-3.713	.000
		Seeking Social Support	-.090	-1.899	.058
		Avoidance	.268	5.825	.000
		Anomy Total	.229	4.939	.000
		Self-Esteem Total	-.260	-5.586	.000
		Hopelessness Score	.282	6.063	.000
	2	Separation	.060	1.286	.199
		Depression Score	.303	6.447	.000
		Problem-Solving	-.158	-3.370	.001
		Seeking Social Support	-.082	-1.751	.081
		Avoidance	.259	5.619	.000
		Anomy Total	.217	4.643	.000
		Self-Esteem Total	-.247	-5.243	.000
		Hopelessness Score	.271	5.786	.000
	3	Separation	.044	.975	.330
		Problem-Solving	-.096	-2.049	.041
		Seeking Social Support	-.005	-.097	.923
		Avoidance	.122	2.073	.039
		Anomy Total	.088	1.662	.097
		Self-Esteem Total	-.079	-1.250	.212
		Hopelessness Score	.128	2.055	.040
	4	Separation	.036	.809	.419
		Problem-Solving	-.084	-1.794	.074
		Seeking Social Support	.013	.267	.789
		Avoidance	.113	1.929	.054
		Anomy Total	.083	1.561	.119
		Self-Esteem Total	-.042	-.623	.534

In examining "pathways" to suicide for the female group, the most immediately obvious finding is that there is *no over-lap* between male and female pathways on

any of the subscales and equally, that none of the "pathways" for the four subscales is shared.

A total of 10.1% variance is accounted for on the "Role Status" subscale by Marginalization, hopelessness, depression and self-esteem. In the case of "Physical Limitations", the acculturation strategies of Assimilation and Separation, along with hopelessness, depression and anomie account for 11.5% variance.

It is a combination of hopelessness, anomie and the utilisation of a problem-solving coping strategy which account for 9.6% variance on the "Nurturing Bonds" subscale. Finally, in the case of the "Death" subscale, Marginalization, Assimilation, depression and hopelessness account collectively for 11.2% variance.

In short, it may be said that, *in toto*, these findings dramatically highlight the importance of interactions between both gender and acculturation strategy with regard to beliefs about those life circumstances/situational precursors which result in suicide coming to be seen as a "viable option" or form of problem solving in a youth population. A schematic summary of these results is presented Figure 5.8, with a detailed interpretation following in the next, concluding, Chapter.

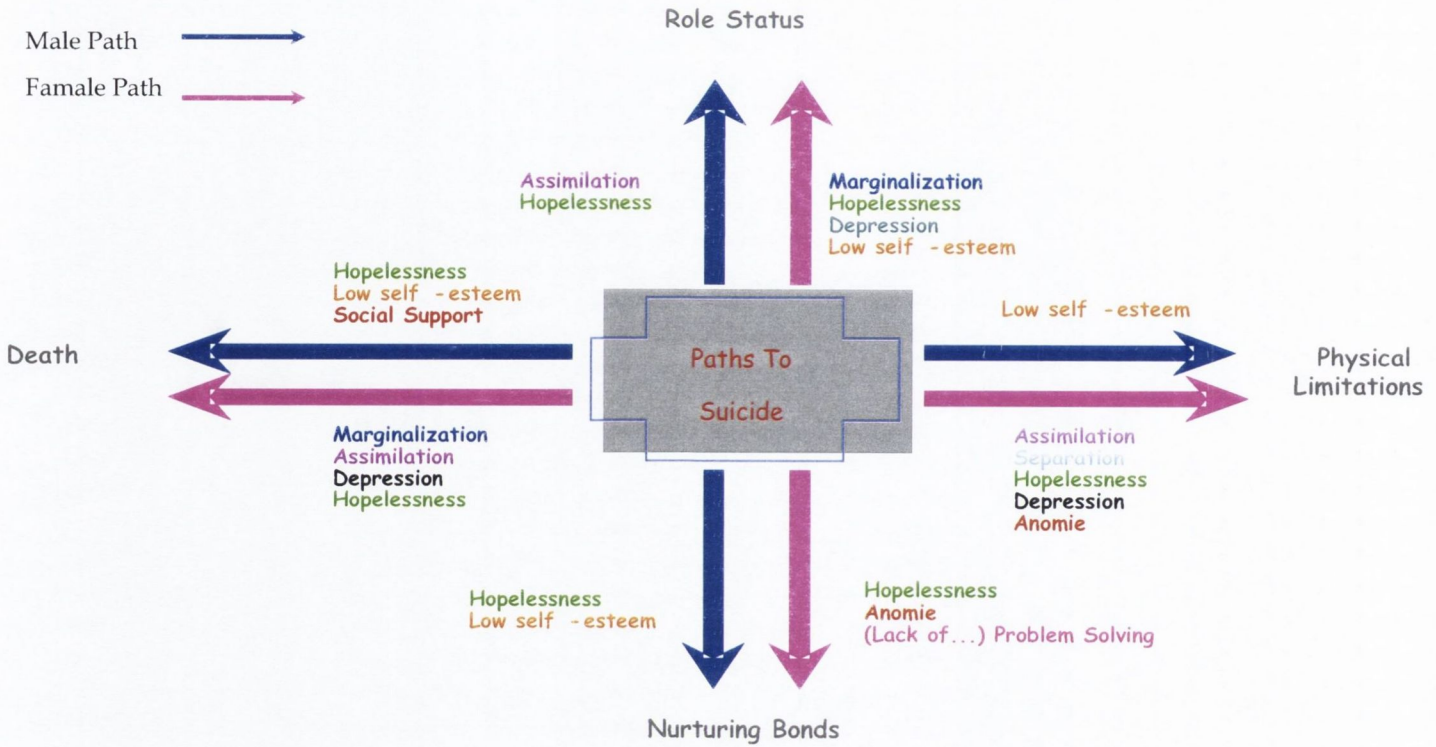


Figure 5.8: Schematic presentation of findings.

Chapter 6- Discussion & Conclusions

Chapter Aims

The objectives of this phase of research were;

- To consider and explicate the results of the research project
- To consider the theoretical implications of the results for a better conceptualization of youth suicide.
- To evaluate the implications of these findings with regard to suicide prevention

Research ethos

To date, two strands of research have predominated in considerations of suicide- clinical and social. Reflected in this dichotomy is the division between psychological/psychiatric and sociological/anthropological methods of inquiry (Smyth et al., 2003). While sociology provides insight into the operation of societal factors in suicide at a population level, this information has not been integrated into the psychological body of literature on the topic and as such, has not been considered from the methodological stance of contemporary psychology.

Simultaneously, the former (i.e. clinical elements) founded within biomedical, psychiatric and clinical models have dominated contemporary psychological investigations of the phenomenon. The vast majority of this research has concerned itself with the presentation of individual risk factors for suicide. The focus of the examination however; has been almost exclusively at the level of the individual[21]. Accordingly, suicide has come to be seen to fall within the sole remit of mental health professionals, limiting the availability of accessible information which may be used in community- or school-based settings. Consequently, clearly delineated groups have come to be defined as "expert" sources of information and relevant stakeholders and target groups (including, but not limited to, teachers, social workers, voluntary services, paramedics and adolescents themselves) have effectively been removed from participation in both

[21] There are some notable exceptions to this, for example O'Connor & Sheehy (2000)

the consideration and prevention of suicide. In light of the dramatic increase in suicide, and most especially in youth suicide, in Ireland since 1990, a clear call for this situation to change has been seen with the Psychological Society of Ireland clearly stating that "The problem [of suicide] can no longer be seen only as an individual and family tragedy, to be borne in secrecy and stigma. Suicide is everybody's business."

A further consequence of the common impetus of research is the general neglect of social and cultural factors which relate to both the individual and societal experience of suicide. This reductionist strategy of considering only aspects of the individual from within the confines of the "deficit-model" so common to psychology, has resulted in a dearth of information on the way in which social and cultural factors relate to suicidal behaviour and the recent increase in suicide rate seen in Ireland. In addition, while clinical[22] risk factors are frequently mentioned in causal terms with regard to suicide, this applies to only a limited number of cases of *youth* suicide which occur each year[23] with the vast majority of adolescents experiencing psychological distress at a sub-clinical level (thus not representing "mental illness" per se) indicative of more diffuse and global suffering- a subtlety the "deficit-model" often misses and with which it is ill-prepared to deal.

O'Connor (2001) summarises this division nicely by asking if we, as researchers in the area, believe suicide to be the result of a bad apple or rotten barrel? The former perspective personifies traditional psychological examinations while the latter is more akin to the sociological view. The answer? The current research clearly argues that much is to be learned from an examination of the individual "apple" but equally (and no less relevant) is the "barrel" in which the individual "apples" are located. Both matter, and there is no reason that these two diverse ideologies cannot be integrated effectively, within an empirically-sound, theoretically-informed model.

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[22] The term "clinical" as it is used here, refers to those set of experiences which may be diagnosed as a "disorder" or, in common usage, represent a "mental illness".

[23] The Dublin City Coroner, among others, is on public record as staging "in the majority of cases, I do not find any mental illness" (Sunday Independent, September 1st, 2002).

As stated throughout it was this principle tenet, of the integration of themes, upon which the current research was founded.

Thus, in this research, contextual factors were not examined only at one level in the multifaceted, complex course to suicidal behaviour; but rather, cultural "embededness" and situational factors were considered at *two* levels- in terms of the individual's acculturation strategy and at the situational level of contextual precursors to suicidal behaviour (through the inclusion of the TIPS).

In this way, the analysis sought to examine a culturally-rooted individual, whose psychological experience (investigated by means of standardised measures and reflective of current understandings on the role of such factors in suicidal behaviour) is considered in the context of situational precursors, or "trigger events" which are thought to be "understandable" or "acceptable" reasons to end one's life.

Trajectories towards suicide

The work of David Cole (1989) was mentioned in Chapter 3 with regard to the way in which theories specifically delineated in his research guided both the selection of measures and many of the theoretical underpinnings of the current research.

In short, Cole's assertion was that trajectories to suicide were gendered, with the antecedent psychological experience of males and females differing significantly, thus pointing to gendered "pathways" to suicidal behaviour. It was argued that for males, when depression was controlled for, the significance of the role of hopelessness diminished substantially thus calling into question the utility of assessing hopelessness in a male sample. In contrast, hopelessness was seen to maintain a significant relationship with suicidal behaviour in females.

While the current results strongly support the theory of gendered pathways, the nature of those pathways for males directly contradicts Cole in that hopelessness (in the absence of depression) consistently emerged as significant in "male pathways" but for females, the proposal that both remain significant was generally supported. Thus a slightly more complex pattern emerged from the present findings, nonetheless; the framework presented by Cole for the examination of gendered trajectories, remains useful.

Each of the pathways towards suicide which emerged from the present research will now be considered in greater detail.

Role Status

Those situations operationalised under the TIPS heading of "Role Status" include each of; being unable to get a girlfriend or boyfriend, becoming unemployed, and having no money.

In examining male and female paths to the point whereby "Role Status" situations were deemed "understandable" motivations for suicidal behaviour, some clear differences are seen.

For *males*, the experience of hopelessness within the context of an assimilated acculturation strategy significantly predicted an endorsement of "Role Status" situations as "acceptable" antecedents to suicidal behaviour. This pattern presents a picture of males who do *not* derive identity or cultural meaning within the "Old" or traditional Ireland, but who are wholly embedded within "Celtic Tiger" existence. Importantly however, this cultural setting appears *not* to be related to a sense of personal meaning as hopelessness at high levels is also seen.

Thus, for these males it is the experience of Role Status difficulties such as the absence of a romantic, interpersonal relationship; change in status through loss of employment and an inability to obtain material goals as a result of lack of money, which act as "triggers" to suicidal behaviour making such behaviour salient as an "option". This is very much in keeping with the stereotyped view of male

adolescents for whom identity is inextricably linked with each of the aforementioned domains (Clare, 2000).

In the case of *females*, it is the experience of hopelessness, depression and low self-esteem in combination, and within the context of a marginalised acculturation strategy which predict role status antecedents. These findings present a more complex picture than in the male case. Thus, it is suggested that in today's cultural setting, adolescent female identity has moved into previously "male" domains however, "triggers" to suicide become relevant *only* for those on the fringes of society who are marginalized and unable to find personal meaning within *either* traditional *or* modern Ireland.

These gendered patterns effectively represent much of what has been said about the nature of Irish culture change. That Ireland is now a consumer-driven society where perceived "status" is all-important, and lack of this status a significant risk factor related to psychological distress. Further, the theoretical underpinnings of the relative misery hypothesis (Barber, 2001) as it relates to youth suicide can clearly be seen.

Barber (2001) in proposing the relative misery hypothesis, argues that adolescent suicidal behaviour is influenced by the nature of social comparisons made by this group -specifically, upwards comparisons to an adolescent peer group. In short, when counterparts are perceived to be succeeding or attaining *relatively* more in terms of status (both real and symbolic), youth generally but young men specifically, become more likely to behave in a suicidal manner. In such settings, the distress of this vulnerable group is magnified and their susceptibility to suicide, increased.

This theory more generally would predict (as in the Irish situation) that as a nation experiences an overall increase in status or wealth the misery of the unhappiest group will be compounded by the isolation they come to experience and consequently, an increase in suicide is seen.

This theory builds on Durkheim's perspective buts adds the dimension of relativity. Thus, it is not the overall wealth of a nation *per se* which relates to suicide but the *relative* wealth (or poverty), and status (or lack thereof) which is of concern. Thus, the "triggers" to suicide lie in making salient to youth what is theoretically possible to attain but which will in practice never (or at least for a number of years) be theirs. This same pattern is discussed by De Botton (2004) in his proposals relating to the "modern condition" of status anxiety. The destructive impact on the individual of upward social comparisons is explicitly mentioned (albeit with the suggestion that this distress is most easily rectified by the more careful selection of one's peer group such that those with whom we interact socially have less than we do!).

De Botton asserts that, through the process of globalization, modernization and twentieth century sociocultural development, advertising (via all forms of media) has come to determine those things valued and sought by the individual in order to attain a definition of self. He argues that although the ideal is a state of self-acceptance *in the absence* of external feedback, where what others' think is unimportant to the value of the "I" (represented for example, by Maslow's hierarchy where "being" is in itself valued), this is rarely attained. The alternative, predominant in Western sociocultural settings, is that external reinforcement is required in order for the individual to be able to determine, and over time, regulate issues of self-worth. He likens this process to the theory outlined by William James in "The Principles of Psychology" (1890) whereby self-esteem was argued to be determined by the interaction of success and pretensions (where the latter refers to those areas in which an individual defines a talent or skill and in which they expect to succeed, making failure particularly cruel). Likening this process to the deflation of a helium balloon (which constantly needs to be "topped up" if it is to remain afloat), De Botton posits that constant external feedback in the form of status (and the recognition of such by others) is needed by modern individual's in order to feel valued, and is a "symptom" of the modern world; and at a most fundamental level is unhealthy and damaging to human existence.

That such processes are destructive to the already-developed adult psyche, and negatively impacts the individual's ability to find happiness and fulfilment within their social world speaks only to the increased vulnerability of youth to the same situation. At a time when one of the key developmental tasks is the establishment of a sense of self (Giddens, 1991), the stifling impact of such social comparisons and the possible relationship between this state and a vulnerability towards suicide is clear.

To perhaps illustrate further, home ownership is highly valued in the Irish context and recognised as a milestone marking individual achievement and maturation (Begley et al., 2000) however; the means to achieve this end have become increasingly unattainable for Ireland's young people (beyond teenage and early adult years into late adulthood). Thus, the resultant situation is one in which the "object of desire" which is deemed to be a personally meaningful status symbol and index of achievement by various social and cultural mores, is one which is beyond the reach of the majority.

Since this situation is shared across youth (not all of whom are at-risk of suicide) it is the "lens" though which this situation is perceived which is of importance, with this "lens" related to those significant cultural and psychological factors in the gendered pathways seen in these results for males and females.
Eckersley (1993) neatly sums up;

'I believe that behind suicide and other youth problems also lies a profound and growing failure of the culture of western industrial societies- a failure to provide a sense of meaning, belonging and purpose in our lives, and a framework of values' (p. S16)

It is suggested that this pattern is evident from the findings relating to the Role Status subscale of TIPS.

Death

In the case of the Death subscale, the emergent theme is one of loss as a result of death by means of loss of a spouse/lover, loss of a close friend and the desire to re-establish the lost relationship by wanting to be with a loved-one who has died.

For *males*; each of low self-esteem, hopelessness and the attempted use of social support as a coping mechanism were seen to significantly predict the endorsement of the Death subscale items as "good" or "very good" reasons to take one's own life. Thus, for those males who are hopeless, have low self-esteem and who look towards others for assistance, the prospect of an additional loss through death creates the situation whereby suicide comes to be seen as a viable option.

Of note is the absence of any significant relationship to acculturation strategy in this male "path". Thus, it would appear for males that irrespective of one's relationship to the culture in which one exists, loss as a result of death poses a risk setting for suicidal behaviour.

Importantly with regard to the significance of social support as a mechanism of coping, results presented by Curran (1987) mentioned previously in Chapter 1, which suggest that the use *either* of avoidant methods of coping (such as social isolation) *or* attempts at the use of social support mechanisms which fail (such as seeking support but not receiving effective or relevant support) are significantly related to suicidal behaviours, and as such, are of importance. In practical terms, attempts by adolescent males to seek support from those who are no longer available (as a result of death) makes this coping strategy less effective and would "fit" with Curran's suggested pattern of risk.

In contrast to the emergent picture of males with regard to Role Status issues, (who were firmly caught up in the "Celtic Tiger" psyche and were seeking, although unable to attain) the image of males here is of the isolated, withdrawn individual out of "place" within themselves (exhibited through low self-esteem) who cannot foresee continued existence in the face of additional loss.

For *females*, the meaning of this particular pathway is less clear. Females who are *either* marginalized *or* assimilated, who also experience high levels of depression and hopelessness are those for whom death-related issues make suicidal behaviour "understandable". The shared element between the strategies of marginalization and assimilation is the absence of old, traditional cultural values. Importantly and in relation to this, is the idea that an individual's sense of history (the "thread" of the past) derives in substantial part from interpersonal relationships which, in the case of the Death subscale are those which are lost (Stroebe, Gergen, Gergen, & Stroebe, 1992). Further, and as these same authors suggest, the psychological sense of self, so fundamental to a "healthy", "balanced" existence is resolutely linked to these relationships, such that loss poses a substantial challenge.

This importance of continuity of self is also addressed by Chandler & Lalonde (1998) who argue that continuity of a culturally-embedded self is an important protective factor against suicide. The role of a "continuous self" over time has long been accepted as an essential part of a healthy psychological existence (Haber, 1994; Habermas, 1991; Harré, 1979; Rorty, 1976) but has been returned to with regard to adolescent suicide risk. Chandler et al., (1998) assert that children are not born with a continuous sense of identity but rather, that this is developed and maintained over time. Throughout most of the lifespan changes in self (which are a "normal" part of development and reflect maturation, role changes etc.) occur in a smooth fashion where, despite those changes experienced, some remnant of the individual's former identity is clearly perceptible. This is not the case however, during adolescence where a "cocoon" type style of identity change is seen, where the former self is "outgrown" and the developmental changes which occur are so dramatic that, for a period at least, the individual may be left without any coherent sense of self. It is at these stages of "absence of self" that Chandler et al., (1998) argue the risk of suicide is greatest. It is important to note that Chandler's proposal regarding the specific characteristics of self development at adolescence is not inevitably linked to suicide (Chandler too is in agreement that adolescence need not be a period of "storm and stress") but that

in combination with a changing culture and social setting, where additional challenges are experienced, suicide becomes more salient for the adolescent.

Thus for females, in the context of a changing culture, and with the loss of personal history provided by interpersonal relationships, suicidal behaviours appear to seem to be understandable.

Physical Limitations

The contexts to which the Physical Limitations subscale referred were the experience of breast-cancer in a 30 year-old woman, being diagnosed with AIDS and finding out that you can't have children.

For *males, only* low self-esteem emerged as significantly predictive of a high score (thus endorsement of the Physical Limitations situations as understandable precursors to suicidal behaviour) on this subscale. As in the case of the Death subscale, no significant acculturation effects were seen.

That adolescent males would feel threatened and desire escape from what has been referred to as an "unbearable situation" resulting in *psychache* (Shneidman, 2001) to the point of considering suicide, as a result of these circumstances speaks to the possible domains in which male adolescent identity rests- health, strength, vitality, virility.

In the case of *females* a different and more complex pattern emerges with each of hopelessness, depression and anomie in the context of an acculturation strategy of *either* Assimilation *or* Separation being seen as significant predictors. The only commonality between the two acculturation strategies is the representation of dichotomised, "either-or" thinking (such that identification occurs *only and exclusively* within the traditional setting *or* the new). This sense of helplessness in the face of change is further reflected by the emergence of high anomie scores in this path. Thus, the emergent theme is the inability or lack of desire to deal with complexity both in terms of cultural identity and as would be posed by any of the Physical Limitations contexts.

There is a significant paucity of work considering adolescent suicide in situations of infertility and terminal illness. In the case of the former, the general consensus appears to be that such issues hold little relevance to youth samples (Catalan, 2000) while in the case of cancer or terminal illness more generally, research endeavour is related more closely to considerations of euthanasia than suicide, and is marked by a different theoretical base, utilising specific definitions and models and again, infrequently considered in youth populations (Leenaars et al., 2000).

Thus, in order to examine the possible meaning of these relationships (both for males and females), the work of Werth (1995) on the concept of "rational suicide" typified by suicide in response to a diagnosis of HIV/AIDS warrants consideration.

Werth (ibid) argues that most traditionalists, who adopt the biomedical approach to conceptualizations of suicide, assert that suicide in response to contextual factors such as relationship loss, loss of employment etc. is "irrational" and finds its basis in mental illness and dysfunction. Nonetheless, they increasingly accept that there are particular instances or life circumstances when suicide becomes "acceptable" or at the least "understandable". Most often, such a view is related to what this author describes as "painful, terminal illness" of which terminal cancer is the prototypic exemplar. The question of the positioning of HIV/AIDS along a continuum of illness experience relating to "rational" suicide thus arises. What becomes of particular relevance in the case of the HIV/AIDS - suicide link is the issue of quality of life (and importantly, the *perception* of quality of life).

In considering a diagnosis of HIV/AIDS as a "special risk factor" for suicide, numerous (by now familiar) elements are of relevance. Quality of life according to Werth is, perhaps, first and foremost "security, love, family, friends, achievements, pleasurable activity, the ability to control reinforcements, freedom from pain and suffering..."(p. 69). These same elements are those which may fundamentally be impaired by the diagnosis and subsequent experience of HIV/AIDS.

Specifically with regard to increased risk of suicidal behaviour among HIV/AIDS infected groups, there exist varying reports. For example, one study which focused on homosexual, HIV infected men in the New York reported this group was 36 times more likely than men in the general population and 66 times more likely than the general population as a whole to die as a result of suicide (Marzuc et al., 1988) while researchers in the area of youth suicide clearly present a diagnosis of AIDS as a "special risk" for youth suicide (Stillion & McDowell, 1996).

Thus, although scant thus far, what little research that has been done in the area clearly suggests that the perception of the impact of HIV/AIDS on quality of life and impairment in the attainment of goals is such that there are direct links to suicide in youth populations, as seen in the present research also. The additional significant findings in the contexts of infertility and cancer suggest that future research, inclusive of these issues, be extended to encompass youth populations as life challenges such as these are clearly salient to adolescents.

Nurturing Bonds

This subscale included the three items of suicide in response to death of a parent, the experience of sexual abuse in childhood and the experience of emotional abuse in a relationship, and is thus reflective of *loss* in the domain of intimate relationships; the fundamental loss of a relationship with a parent as a result of death, and loss of trust, love, acceptance and a positive view of self as a result of emotional or sexual abuse.

In the case of the *male* group, hopelessness and low self-esteem again emerged as significant predictors while for females; it was hopelessness, anomie and lack of problem-solving as a coping strategy which were significant. Of note is the absence of any acculturation relationship for either gender. And, as in each of the three aforementioned "paths", clear gender differences emerged.

Clear links between the experience of sexual abuse in childhood and subsequent suicide have been noted in previous chapters (Deykin et al., 1985; Rich et al.,

1986; Reinherz et al., 1995; and Molnar et al., 1998). In an extension of this research theme, Esposito & Clum (2002) examined the importance of additional moderating factors in the context of the experience of abuse, finding that lack of social support (either as a result of the unavailability of caregivers or by their absence as a result of abandonment or death) and problem-solving difficulties were equally important in predicting suicidal behaviour in adolescence. The similarity of these findings to those obtained for females in the current study (where the predictive path to an acceptance or understanding of suicide in response to Nurturing Bonds situations, included hopelessness, anomie and lack of problem-solving) is clear.

Importantly, research also suggests that the experience of abuse has a tremendously destructive impact on identity and self-esteem (Esposito & Clum, 2002) which elucidates the male pathway further.

Emotional abuse - formally a child protection registration category, but also recognised within the domain of clinical psychology with regard to each of parent-child, peer and romantic relationships (Doyle, 1997) is defined as; "... acts of omission and commission which are judged on the basis of a combination of community standards and professional expertise to be psychologically damaging... such acts damage immediately or ultimately behaviour, cognitive, affective, psychological and physiological functioning..." (p. 331) and represents a fundamental breakdown in interpersonal relationships.

Although not included directly in the present research, one of the principle and shared foci of the three Nurturing Bonds items relates to the issue of attachment, insofar as weakened attachment relationships are noted to be significantly related to the development of psychological difficulties in adolescence (Bowlby, 1980) leading to the development of known risk-indicators of suicidal behaviour (Lyddon, Bradford, & Nelson, 1993) . Thus, possible links between attachment patterns and adolescent suicide require attention.

Proposed in its earliest stages by John Bowlby (1969; 1973; 1980) and researched by means of the "Strange Situation" (where the behaviour of children and their caregivers was recorded in situations of separation and reunion) by Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) attachment relates, in its simplest form, to the nature of the relationship between the child and their primary caregiver (initially, referred specifically to the mother but has been expanded in recognition of changes in family structure to be more inclusive). Various attachment styles were noted - Secure (where the caregiver was seen to be responsive to the child's needs and respond in an effective and consistent manner accordingly), Anxious-Ambivalent (where, upon separation from the caregiver, the child was seen to behave in an angry manner and be difficult to settle and calm upon being reunited with their caregiver), Anxious-Avoidant (where caregivers were seen to be inconsistent in their dealings with children and the children, in turn, behave in a detached manner) and more recently, Disorganized (where, as a result of the mixed response from the primary caregiver, the child comes to perceive themselves as both frightening and frightened) (Rutter & Rutter, 1993).

In terms of developmental wellbeing, the Secure attachment style, which enables the child to develop and explore from the position of a "secure base" with their caregiver (in short, where it is always "safe" to come back for support and love following adventure and perhaps, more importantly, misadventure) is recognised as "healthiest", offering the greatest possibility for the attainment of a mature sense of self and identity, and the ability to be psychologically open in interpersonal relationships (Koski & Shaver, 1997).

Importantly, although attachment theory and the research which evolved as a result, was initially based on infants and children, developmental psychologists have recently recognised the psychological importance of attachment across the lifespan, as this early experience is now recognised as forming the working models which will guide both peer and romantic relationships across ages with a role of particular importance in the adolescent years (Rosenstein & Horowitz, 1996).

As with research on terminal illness and fertility and adolescent suicide however, attachment has infrequently been included in examinations of this phenomenon providing little assistance in the interpretation of the current results nonetheless; some possible explanations are to be considered.

As stated, the three elements comprising the Nurturing Bonds subscale relate fundamentally to loss in the interpersonal domain with the possibility of attachment issues arising as a result. That suicide would be considered "understandable" in the face of loss of, damage to and/or impairment in, intimate relationships, and further, that this would also be related to issues of self-esteem, anomie, or lack of sense of self within the context of a societal setting in flux, (Chandler et al., 1998), coping and indicators of mental distress (such as hopelessness) is in keeping with broad themes within research literature in the area.

Buelow, Schreiber, & Range, (2000) examined these links specifically finding that, during a lifestage of transition as dramatic as adolescence, substantial challenges[24] to and difficulties in interpersonal relationships pose a particular risk for the development of suicidal behaviour. At this crucial stage of development, when intimate relationships are undergoing a process of "transformation and disengagement" (Larson, Richards, Moneta, Holmbeck, & Duckett, 1996) where the adolescent is attempting to mange competing themes of autonomy/independence and a re-definition of the self in relation to others any further complexity (as presented by loss of intimate relationships) serves only to increase risk. Add to this the previously mentioned impact of a changing cultural setting - thus reflecting the image of an individual experiencing both developmental transition and loss of intimate relationships in what is an unstable and (often) unsupportive social and cultural context, and this possible "path" to suicide becomes all the more understandable.

[24] Important to note that it is "substantial" or "significant" challenges which are referred to, rather than the "daily hassles" of arguments etc. which may be seen as "normal" part of adolescent development. The Nurturing Bonds subscale however, reflects this level of severity.

What is clear throughout these results is that the evaluation of contextual factors, within a changing cultural setting adds much to the understanding of youth suicide risk. As stated, it is *not* the case that every adolescent will ever consider suicide, even where specific life stressors such as those outlined in TIPS are encountered. Neither is it the case that an individual's relationship to their culture can alone predict risk of suicidal behaviour. However, it is the combination of these elements which, for some at least, result in suicide being considered, and in a substantial group of males, being acted upon. Thus, these findings accurately reflect the complex and multifaceted nature of youth suicide and, by the elucidation of existing pathways offer some insight (more than the evaluation of psychological or cultural factors alone) into the life trajectory which leads to the point of suicidal behaviour.

Although not a specific aim of the research, but in recognition of the wide variety of statistical methods which may be applied to data of this type, it is possible to hypothesise a causal model of the inter-relationships observed in the current research. Based on existing theory, it would seem plausible to suggest that the direction of causality would be as follows; that an individual's acculturation status would influence their mental health directly (operationalized here as depression and hopelessness) and, in addition, indirectly influence the psychological variables of coping, anomie and self-esteem thus having *both* a direct and mediated impact on attitudes towards suicide (operationalised as the various TIPS subscales). This is an issue which warrants future research and the use of a Structural Equation Modelling package, such as LISREL or EQS.

Limitations

Use of self-report measures & Questionnaire ordering effects

Although self-report measures can be a source of fallible data (Schwarz, 1999) the continued widespread use of this method of data collection is founded on the assumption that in the assessment of psychological wellbeing and psychosocial status it is the individual who can provide the most meaningful and reliable (in

an ecological sense) data. Further, the utilisation of this method was adopted in the current research in order to facilitate the inclusion of large groups within the confines of the school-timetable, in a way in which interviews could not. Finally, and specifically relating to the issue of working with adolescents in a research setting, it has been noted that in the case of sensitive issues (for example, suicide) the use of self-report measures may facilitate a feeling of confidentiality thus leading to greater accuracy in responding (Society for Adolescent Medicine, 2003).

In the present study, questionnaires were completed in a fixed order. While this reduces a source of variance (across participants), it is also possible that the completion of one section of the questionnaire had an influence on subsequent sections. At the stage of questionnaire development, this issue was considered with the result that positive, negative and neutral measures were balanced across the questionnaire on the whole. Further, the age group involved and the setting in which questionnaires were administered (large groups, within a school) required the standardisation of order, such that instructions could be given in a comprehensive manner and questions posed at the group level (with regard to completion issues) answered as clearly and promptly as possible. Thus, although not ideal, the benefits of the fixed order of sections (as opposed to randomisation) were felt to outweigh any possible disadvantages.

Area of inclusion

The research was able to include only post-primary schools within the greater Dublin area, and thus, cannot be said to be representative on a nationwide scale. Therefore, it would be desirable that future research investigate these same cultural, social and psychological issues across Ireland as a whole.

Also, given that schools volunteered to participate once contacted, there may be certain selection effects, such that those who gave of time were also those aware of mental health issues however, there is no reason to suspect that the issues which emerged from the study would not be shared across groups. The principle

difference may be in the willingness of schools to facilitate the discussion of these issues and include psycho-educational components within the school as a result.

No follow-up permitted with "case" group

Due to the ethical restrictions placed on the research by the Department of Psychology, Ethics Committee, follow-up with those participants who were deemed "at-risk" and offered a referral as a result was not permitted. Thus, relevant information on this distinctive sub-group remained inaccessible. It is reasonable to assume that certain differences may exist and so, it would be advisable for future research in the same vein to proceed with the specific intention of follow-up with such groups.

Contextualizing the Research

In order to examine the relevance of the current research to the area of adolescent mental health and suicide prevention, each of general prevention issues, research-specific prevention recommendations and issues relating to the promotion of emotional health will be considered in turn.

Prevention issues & Recommendations

A great difficulty regarding suicide prevention is the inability of the systems already in place to identify those who are at risk of making a suicide attempt. Isometsa et al., (1995) report that at least 50% of those who go on to die by suicide have visited a physician in the month prior to death, however suicide is discussed in only a minority of these visits. The number of cases in which suicide was addressed ranged from 39% in the case of psychiatric out-patient visits and 11% in general-practice visits to 6% of those who visited other medical specialists. Clearly, there is a problem with communication which likely acts as one of the key barriers to the identification of risk and the prevention of suicide.

In addition to difficulties concerning the communication of suicide ideation, traditional biomedical and psychological models often adopt a causal and liner

model when considering suicide. Bancroft et al., (1979) identified clear incongruencies between healthcare professionals and suicidal individuals in the *type* of thinking surrounding suicide. The former were reported to think in terms of the *causes* of suicide while the latter speak of suicide in terms of the *reasons* or *motives* behind the behaviour. This difference is central as Hinkle & Schmidt (as cited by Michel et al., 2001) summarize; *reasons* offer an explanation in terms of the preceding intentions behind the action, while *causes* explain an action in terms of the properties of the environment that resulted in the action or made the action occur. This is a clear distinction and one which people are capable of making in everyday circumstances (Michel, Valach, & Waeber, 1994).

In order to approach the issue of suicide prevention, suicide must first be seen as preventable, and suicide prevention as both acceptable and desirable. This specific point is addressed in a comprehensive review of the area by Miller, Eckert, DuPaul, & White (1999). These authors argue that suicide intervention/ prevention *has* to be seen as an *extension* of healthcare provision for the youth population. This is in keeping with recommendations from others in the area such as Dryfoos (1994) and Gutkin (1995) where suicide prevention is not considered to be specialist-oriented or isolated aspect of healthcare. This perspective marks an important move away from seeing suicide as a problem for psychiatric or mental health settings alone and recognizes the important role schools and educators can play in issues of adolescent mental health generally, and suicide prevention more specifically. Furthermore, these authors suggest that few studies have been done of the *acceptability* of approaches to suicide prevention. This paucity of knowledge in the area appears to be a rather obvious omission as the likelihood of a program being implemented is fundamentally tied to the way in which it is "sold" to schools, its level of acceptability and the degree of comfort program presenters have with the material. This observation importantly positions schools as consumers of psychological, sociological and cultural information and interventions.

The aforementioned study (Miller et al., 1999) examined the three most common types of suicide prevention program. These were; (1) curriculum-based

presentations to students; (2) in-service training for teachers; and (3) student self-report, school-wide screening for identification of at-risk individuals. The principle aims of such programs are to (a) heighten awareness among students regarding suicide; (b) to train students to recognize possible signs of suicidal behaviour in order to assist others and better understand the experience; and (c) to provide students with information on available school and community-based sources of help (Shaffer, Garland, Gould, Fisher, & Trautman, 1988).

The noted outcomes of suicide prevention programs include each of; effective change in students' knowledge and attitudes towards suicide, a positive influence on previously unidentified suicidal adolescents and an increase in the likelihood of adolescents disclosing to parents/ adults information on peers who are at-risk. When the level of acceptability of each of the three programs was assessed, it was found that the school-wide screening of students for the identification of at-risk cases was *least* acceptable among both parents and educators. Suggested explanations for this finding included a feeling that adequate services do not exist to deal with such information, that the "labelling" of students in this manner may serve to increase individual's isolation and stigmatization and may worsen the problem it seeks to address. In spite of this, the screening method of suicide prevention remains common and is thoroughly in keeping with the biomedical approach with some even suggesting that such screening is a vital part of *any* prevention package (Miller & DuPaul, 1996; Reynolds & Mazza, 1994).

Moving to consider the other two approaches (provision of information to students and in-service training to teachers) these were seen to be equally acceptable and were generally viewed in favourable terms and as such, are more likely to be implemented in a school setting. In addition, the high level of acceptability of these two approaches, suggests that educators recognise the need for a two-strand approach whereby *both* teachers and students are involved in the prevention process.

Despite these positive findings, there remains concern in some quarters that the very mention of suicide (perhaps most especially in the form of suicide

prevention programs) motivates people to behave in a suicidal manner. It is of fundamental importance to note that this is something which has been extensively investigated with the Centres for Disease Control (in the United States) reaching the clear conclusion that "...there is absolutely no evidence for this..."(Centers for Disease Control, 1992). Kalafat & Elias (1995) assert, on this basis, that the widespread implementation of school-based prevention programs is a must in suicide prevention. Although the statistics indicate that more completed suicides take place in the 20-24 year old bracket, a more proactive approach is required whereby younger people are targeted for support *before* the point of highest risk occurs. Furthermore, and from a practical perspective, adolescents within the school system are relatively easily involved in such programs- more easily than at older ages (when gathering groups together presents more obstacles to both program research and implementation).

With specific regard to the type of information included in such prevention programs, Kalafat et al., (1995) assert that programs must *supplement* rather than replace existing healthcare education. This reflects the long-standing, public-health approach to mental health of Caplan (1964) which states that in "the absence of a knowledge of the causes of mental disorders, primary prevention must be directed toward improving non-specific helping resources in the community" (p.30). Such thinking blends well with the culture-based approach adopted by the present research.

Given that educational programs of the kind discussed here are not adolescents' first encounter (either at a personal or abstract level) with suicide (Kalafat & Elias, 1992), Kalafat et al., (1995) go on to make some specific recommendations which may be summarized as follows;

- Programs are to have practical, educational rather than clinical focus.

- While curriculum additions are certainly to be welcomed, a stand-alone approach is unlikely to be effective thus marking the need for a broad-spectrum, proactive, community-wide approach.

- Material must be problem, rather than content centred thus adding a clearly practical component which fits well within the school setting.

- School staff must be viewed by students (or come to be viewed by students) as approachable outside of their formal roles. The authors note that this is one of the more difficult aspects to implement as it, perhaps above and beyond others, calls for additional resources. Nonetheless, it is a vital component in the holistic support and education of adolescents.

- Administrative policies and procedures for responding to at-risk students, students who have attempted to end their own life or in the aftermath of a completed suicide must be put in place. This may involve the development and training of school-based crisis response teams.
- Educational programs for all adults involved in or in contact with the school system. These should address warning signs, initial response, referral and available resources/ sources of help.

- Classroom educational programs for students covering risk/warning signs, initial response, the process of referral and those resources that are available in their own school setting.

- Ensuring that there are established and known links between schools and wider community-based carers/healthcare professionals. This way, the intervention/prevention crosses over between school and community life.

- Development of clear and supportive procedures for the return of a student who has made a suicide attempt to the school system. This can also include the practical component of the school being informed of the student's return.

This perspective stresses the value of a multi-agency response to mental health generally (including suicide) where the "community" of school is involved in every stage of caring for the adolescent's development, ranging from

academic/scholastic achievement to general health and well-being and emotional support. This latter point is especially important when we recognize that historically, the family has been given primary responsibility for these aspects of child-care and development. While this approach at least had some chance of success within the confines of the traditional, nuclear family the many and varied family structures of today mean that in some cases, sole care for the adolescent's well-being cannot securely rest within the family and that perhaps, a broadening of the definition itself may be called for. As such, the inclusion of the school and broader community in which the adolescent exists and develops is clearly warranted and to be approached with optimism for prevention opportunity rather than the unfounded reluctance which currently exists.

Research-specific prevention recommendations

While the aforementioned issues relate to the prevention of suicide generally, the present findings suggest the inclusion of certain key elements in Irish suicide prevention.

In recognition of the impact of social and cultural change which emerged from the present research it would appear desirable to include a critical thinking component, relevant to citizenship within a modern culture and the various value-laden messages to which adolescents are continually exposed to the school curriculum, possibly under the existing Social, Political, Health & Education course available in post-primary schools.

At a more specific level, and in recognition of the context specific recommendations for suicide prevention programmes made by Miller et al., (1999) referred to both here and in Chapter 2, coping issues surrounding the experience of life circumstances outlined in TIPS warrant inclusion. While the general recommendation is that adaptive coping and effective problem-solving techniques be taught to adolescents, this is more readily achieved through the use of concrete exemplars (such as those used in the current project). Those adolescents included in the research responded well to the various items on TIPS with discussion following questionnaire administration producing some

interesting themes and plainly presenting the opportunity for the introduction of a suicide prevention package.

Mental health issues (hopelessness and depression) consistently emerged thus, a component on the recognition of distress both in others and one's peers (as in the gatekeeper model of prevention whereby adolescents themselves are "trained" to be an initial point of contact and source of information) would be recommended. The facilitation of communication and discussion surrounding these issues is highly desirable and relates to the role of teachers in the process of prevention. Through already-established relationships with the adolescents they come into daily contact with, the teacher is particularly well placed in a position of professionalism and trust to address many of these issues thus further supporting the National Task Force perspective that teachers are an important element of suicide prevention (see Chapter 1).

The regular emergence of gendered pathways suggests that males and females view the various antecedents to suicidal behaviour differently. Thus, the possibility for the development of gender-specific suicide prevention materials arises. Whether or not a gender-specific approach is practically feasible depends very much on the specific school setting (whether it be single-sex or co-educational). However, the Samaritans recommendation on this specific issue relates to the use of classes already-segregated by gender (in the UK this is seen to frequently occur in physical education classes) for the presentation of suicide prevention materials- again building on systems already in place.

The promotion of "Emotional Health"

In making recommendations on the implementation of school-based prevention programmes, it is informative to examine the recent history of such endeavours in an Irish context. Perhaps the best illustration of problems which can arise as a result of placing mental health issues in the school context comes from the "Exploring Masculinities" experience in Irish schools.

The "Exploring Masculinities" programme originated from the recognition, by the Department of Education & Science that Ireland had undergone rapid and extensive change, and that the impact of this change for young males in particular needed to be addressed. They stated;

"The last quarter of the twentieth century has seen profound changes in Irish society. Many of these changes have received extensive publicity, i.e. the onset of the information society, the impact of the scientific and technological world, and the internationalization of the economy... Paradoxically, this progress that is designed to create a better life for all is matched by a sense of fear in many ...The social, psychological and emotional consequences of such rapid change have not been given similar publicity and have not been addressed to the extent that is necessary for many. These changes are not without difficulties, but little attention has been paid to how individuals are coping or are being prepared to cope with them. Coping with change is about changing attitudes as well as structures and systems..." (p. vi-vii)

The rationale for the development of the Exploring Masculinities programme thus appears admirable and well-founded. However, despite this the programme was plagued from the outset by controversy and resistance and has come to the point whereby it is has been abandoned at official departmental level (although individual schools continue in a small number of cases to teach the course).

The most startling outcome with regard to the introduction of this programme was the threat by one parent, to sue the Department of Education & Science for making his son "gay" as a result of exposure to the material contained in the syllabus. While it is important to note that this case did not proceed through the court system and was settled in undisclosed circumstances, it was sufficient to establish an air of concern and stigma around the programme to such an extent that it was effectively eradicated.

Also problematic in the case of this programme were the training, union and pay-related issues which stifled its widespread use. Rather than be presented to

schools as a positive way in which to address the global health and development of students, the Exploring Masculinities programme became politicised and used as a pawn in broader issues relating to the working conditions of teachers. This, combined with the sensationalist response from the media, some parents and right-wing interest groups, meant that this programme was highly unlikely to succeed (Smyth et al., 2003) thus drawing attention to the need for consideration of the broader school framework into which newly developed health promotion/suicide prevention courses enter.

In contrast to this approach, and in recognition of the "image" problems inherent in health promotion efforts in the area of mental health, the Samaritans (following a process of re-branding, in an attempt to become more accessible to youth populations) have developed an emotional health promotion campaign which will be put in place in schools, workplaces and prisons in the UK and Ireland over the next three to five years. The ideology behind this campaign is that what is of fundamental importance in the promotion of mental health and wellbeing to youth populations is the various *skills* (such as coping, problem-solving, self-esteem, and stress management) which can be taught rather than the title or heading under which these skills fall. Thus, rather than present their campaign as "mental health promotion", it is "sold" to the various groups as "emotional health promotion". While this may appear to be a simple issue of semantics, the research undertaken at the consultation phase of the development of the programme, suggests that even a re-wording such as this, leads to greater acceptability, openness and tolerance of the presentation of material to adolescent groups.

This marks a departure in the area of mental health promotion, which clearly recognises the relevance of issues such as branding and image and interestingly, utilises the aforementioned developments in our society in an advantageous manner- if we are now a consumer-driven society, so concerned with status, image and appearance then mental health promotion and suicide prevention needs to be marketed with the same gusto applied to cars, coffee, mobile phones and alcohol.

This image-savvy, consumer aware, sales and marketing approach may well be the way forward and will require novel and innovative approaches to the issues in hand.

General conclusions

On the whole, the findings reported in this thesis, suggest an important role for both cultural and situational factors in the consideration of adolescent suicide. By the extension of acculturation theory to encompass the principle of temporal acculturation, significant results were seen to emerge. Importantly, clear gender differences were also seen which may serve to facilitate a better understanding of the significant gender difference in suicide rate.

Important to note, especially when the discussion of risk is mentioned, that the TIPS is not a measure of active suicidal ideation, however it provides important insight into the ways in which adolescents falling within the general "risk-category" for suicidal behaviour (that is, 15-19 years) consider suicide and the factors which bring one to a point of considering death by this means. Equally important, and with regard to the participants involved in this research, it is important to re-state that this was *not* a clinical sample but a broad cross-section of Dublin teenagers, thus the information provided is dissimilar to much of the previously undertaken research in Ireland and as a result, is of relevance in a wider range of settings. This suggests an important role for the evaluation of issues related to suicide in groups beyond those immediately at risk, or located within clinical settings.

Clearly, the experience of life circumstances and contextual factors such as those outlined in TIPS may be experienced by adolescents who do not, nor will ever, consider suicide. Thus, it is not the specific circumstance alone which may lead to suicidal behaviour but the circumstance experienced within a broader context, inclusive of psychological phenomena (such as depression, hopelessness, coping and self-esteem) and cultural factors (through the individual's acculturation

strategy and anomie) which marks out adolescents who may be at risk for suicidal behaviour. Equally, not all adolescents who experience low self-esteem, hopelessness or depression at some point will consider suicide. Thus, neither does an examination of psychological experience alone explicate the path to suicide.

By using a framework structured in this manner, explicitly including individual, situational/contextual and cultural factors, a richer picture emerges than is achievable by placing focus on these elements in isolation. Through an examination of the culturally-embedded individual, the various paths to suicide and the lens through which life events (which may act as "triggers" to suicidal behaviour) are viewed, is made more salient. Thus, the noted "gap" in the literature (outlined in Chapter 1) has begun to be addressed and offers future research possibilities for the meaningful and theoretically sound inclusion of such factors.

It is clear that the social and cultural change which Irish society has undergone since 1990 is of considerable significance to adolescent wellbeing and relates specifically to issues pertaining to suicide. Internationally, similar relationships have been observed, with Carr (2003) for example asserting that the rapid increase in male suicide among indigenous communities in the South Pacific region (including Australia and New Zealand), "reflect forms of alienation from the wider community" (p.373). Similar patterns have emerged from these findings. That change has occurred is undeniable. The idea of "going back", impossible. Thus, the challenge becomes one of emotional health promotion and suicide prevention *within* the altered cultural context: in spite of it.

While it is certainly more acceptable and in many ways, more "comfortable" to leave responsibility for suicidal behaviour at the feet of individual people, it is certainly not the most accurate or indeed constructive way to view suicide. Society and culture are undoubtedly implicated.

The current research does not propose a singular or definitive answer. However; what is proposed is the need for a mature, reflective look at Ireland's current culture and the implications the world we have created has for our youth. And, while it remains important to note that not all of the change seen has been negative, one of the most destructive consequences of this sociocultural redesign has been an increase in youth suicide.

In arguing for a position where culture is implicated in the creation of risk, it is also to be asserted that it is culture which holds the potential for suicide prevention. A home has to be found for suicide prevention in our schools. We must go beyond the common yet unfounded fear that the very mention of the word can increase its occurrence. We must move past what is perhaps, this last remaining taboo.

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APPENDICES

Appendix 1

Department of Psychology

University of Dublin, Trinity College

Dublin 2, Ireland

Tel: +353 1 608 1886
Fax: +353 1 671 2006

Head of Department: Professor Ian Robertson

Dear _____

I am a postgraduate researcher in psychology in Trinity College Dublin, looking into the impact of recent social and cultural change in Ireland on adolescent mental health. This work is being conducted in a number of post-primary schools in the greater Dublin area and it is hoped that you will agree for your school to join the study. This research is also supported by the Department of Education and the National Children's Office.

The project will involve fifth and sixth year students (16-18 year olds) completing a questionnaire concerned with their general health and well-being, coping and self esteem. With your agreement and at a convenient time, the questionnaire will be administered in class, supervised by the researcher. Teachers will not be asked to be present for this as all information is to be kept strictly confidential within the research team.

To support the wellbeing and safety of all children who take part, parents will be contacted directly in the event that their child is identified as experiencing serious difficulty and a referral to a professional counselor will be available, free of charge, if they feel it is necessary. The school will not be given details of any referrals made nor will they be involved in the counseling process.

Given the number of challenges faced by teenagers today, this is an important piece of research. It is hoped the information gathered will increase our understanding of these challenges and enable us to better support them during their teenage years.

Having read the **attached information sheet**, I very much hope that you will support this research and allow your school to take part. The success of the project depends on your participation and co-operation.

If you would like any further information or have any questions, please do not hesitate to contact either myself or Prof. MacLachlan. This may be done by telephone on (01) 6083911 or by e-mail at casmyth@tcd.ie.

I would ask that you complete and return the enclosed form (stamped addressed envelope included) to acknowledge receipt of this information and register your interest.

I look forward to hearing from you,

With best wishes,

_____

Caroline Smyth B.A. (Hons)
Department of Psychology,
Trinity College Dublin.

Appendix 2



INFORMATION FOR PARTICIPATING SCHOOLS

Adolescent Mental Health In Ireland

What is this project about? The title of this project is "Adolescent Mental Health In Ireland" It plans to investigate the way in which recent social and cultural changes have affected the mental health and coping abilities of Irish adolescents.

How did this project originate? The National Children's Office is funding this project as part of the implementation of the National Children's Strategy which is based on the belief that it is our collective responsibility to improve the lives of Irish young people.

Who will be doing the research? The project will be run by Caroline Smyth, a postgraduate researcher in psychology and will be supervised by Professor Malcom MacLachlan (Department of Psychology, Trinity College Dublin) and Professor Anthony Clare (Department of Psychiatry, Trinity College Dublin).

Who will be involved in the research? It is hoped that, based on your co-operation, the research may be carried out with 5th and 6th year Post-Primary Students.

What will involvement require? The first stage of the research will involve the in-class administering of a questionnaire (following parental consent). The participation of teachers and their suggestions is vital at every stage of the project.

Who will have access to the information provided? Information obtained from participating students **will not** be disclosed and will be treated with **strict confidentiality**. The only time at which information may be disclosed to parents, is if a participating student is identified as experiencing serious difficulty. In this case, for obvious ethical reasons, the research team will contact the parent/guardian directly and a referral to a professional counseling service will be offered. This service will be free of charge. The school will not be made aware of any referrals by the research team nor will they be involved in the counseling process.

What will our participation achieve? Participating schools will receive a brief summary of the research findings upon completion of the research. This document will address the way in which recent social and cultural changes have impacted on the mental health of 16-18 year olds living in Ireland and suggestions as to how mental health issues may be more successfully addressed in the future. When the research is written up, all identifying information will have been removed so that the information is **completely anonymous**.

Why is this research important and why should my school participate? Young people today are faced with many new challenges that previous generations did not encounter in quite the same way. It is the aim of the research to better understand the various ways in which we can offer support to adolescents at this time. By doing this research we hope to more fully address problems such as youth suicide, adolescent depression and the various forms of stress they experience.

Appendix 3



Adolescent Mental Health In Ireland

Receipt and registration of interest

Name of School _____

Name of Principal _____

Direct line/contact number _____

I would like my school to take part... Yes ☐ No ☐

Appendix 4

Department of Psychology

University of Dublin, Trinity College

Dublin 2, Ireland

Tel: +353 1 608 1886
Fax: +353 1 671 2006

Head of Department: Professor Ian Robertson

Dear Parent/ Guardian,

I am a postgraduate researcher in psychology in Trinity College Dublin, researching the impact of recent social and cultural change in Ireland on adolescent mental health. This work is being conducted in a number of schools in the greater Dublin area, one of which is the school your child attends. I would therefore be grateful if you would give permission for your child to take part.

The project will involve your child completing a questionnaire in class concerned with their general health and well-being, coping and self esteem. Only the research team will have access to information provided by your child. When the research findings are written up, all information will be **anonymous** and no personal details will be disclosed.

To support the wellbeing and safety of your child you will be informed if, at any stage during the study, he/she provides information that suggests they are experiencing any kind of serious difficulty. In this unlikely event I will personally contact you by letter and a referral to a professional counselor will be available if you feel it is necessary.

Given the number of challenges faced by teenagers today, this is an important piece of research. It is hoped that their responses will increase our understanding of these challenges and enable us to better support them during their teenage years.

Having read the attached information sheet, if you would like your child to participate, we ask that **both of you** (i.e. parent/ guardian **and** child) **sign and return** the consent form (also attached) **to your child's school for collection**. If either you or your child wishes to withdraw from the study at any time, this can be done without difficulty and will not result in any negative consequences. We very much hope that you will support this research and look forward to hearing from you soon.

If you would like any further information or have any questions on the research, please do not hesitate to contact either myself or Prof. MacLachlan. This may be done by telephone on (01) 6083911 or by e-mail at casmyth@tcd.ie (for Caroline Smyth) or Malcolm.MacLachlan@tcd.ie (for Malcolm MacLachlan)

Your co-operation and support is invaluable.

With best wishes,

Caroline Smyth B.A. (Hons)
Department of Psychology,
Trinity College Dublin.

Appendix 5



Consent form for participation in research

To be completed by **BOTH** Parent/ Guardian and participating Student

We ..... (Parent/ guardian) and..... (Student) have read the enclosed information sheets and give consent to take part in this research project as it has been explained. I understand that our participation is undertaken on a totally voluntary basis and that either of us can withdraw our consent at any time, and this will have no negative consequences. We are also clear that all the information obtained will be kept strictly confidential within the research team and, when it is written up at time of publication all identifying details will have been removed.

Parent's/ Guardian's Signature: _____

Parent/Guardian home address: _____

_____

_____

_____

_____

Parent/Guardian Home phone number: _____

Student's Signature: _____

Date: _____

Appendix 6



INFORMATION FOR PARENTS/ GUARDIANS

Adolescent Mental Health In Ireland

What is this project about? The title of this project is "Adolescent Mental Health in Ireland" It plans to investigate the way in which recent social and cultural changes have affected the mental health and coping abilities of Irish adolescents.

How did this project originate? The National Children's Office is funding this project through the National Children's Office Doctoral Fellowship as part of the implementation of the National Children's Strategy which is based on the belief that it is our collective responsibility to improve the lives of Irish young people.

Who will be doing the research? The project will be run by Caroline Smyth, a postgraduate researcher in psychology and will be supervised by Professor Malcom MacLachlan (Department of Psychology, Trinity College Dublin) and Professor Anthony Clare (Department of Psychiatry, Trinity College Dublin).

Who will be involved in the research? It is hoped that, based on your co-operation, the research may be carried out with your child, currently in 5th and/or 6th year of Post-Primary school.

What will involvement require? The first stage of the research will involve the in-class administering of a questionnaire. Your co-operation, by allowing your child to take part, is vital if the project is to succeed.

What support will there be? If at any stage during the study, your child provides information which suggests that he/she is experiencing any kind of serious difficulty you will personally be contacted and a referral to a professional counselor may be obtained if you feel it is necessary. Your child's school **will not** be aware of the referral and they will not be involved.

Why is this research important, and why should I allow my child to take part? Young people today are faced with many new challenges that previous generations did not encounter in quite the same way. It is the aim of the research to better understand the various ways in which we can offer support to adolescents at this time. By doing this research we hope to more fully address problems such as youth suicide, adolescent depression and the various forms of stress they experience.

Appendix 7



What is this research about? The title of the project is "Culture Change and Adolescent Mental Health in Modern Ireland". It plans to look at the way in which recent social and cultural changes have affected the mental health and coping abilities of Irish adolescents.

What will happen with the information I have given? All the information you have provided will be kept strictly confidential. The only time this will not be the case, is if any of your responses indicate that you are experiencing difficulty. If this is the case, you and your parents/ guardians will be contacted and a referral to a professional counselor may be made. Your school will not be aware of any referrals and they will not be involved at any stage. At the end of the research, the findings will be published but at this stage, all identifying information will have been removed so that people who read the report do not know anything about the students who took part.

Why is the research important? This research is important because a greater number of teenagers are experiencing problems than before. If we can better understand teenager's lives and those events that make them unhappy or stressed, it is easier to make sure they are helped.

What if I feel upset or worried by some of the questions asked? If you are concerned for yourself or a friend then there are several places you can contact for help. Some useful telephone numbers are written on the back of this sheet. It is important to talk to someone if you feel worried, upset or stressed. This person could be a parent/guardian, friend, teacher or another adult or someone on one of the phone lines. Your local GP or family medical centre is also a good place to contact if you would like to talk to someone about these issues.

Can I contact the people who did the research? The person who was in your class today was Caroline Smyth. You can contact her by telephone on

(01) 6083911, fax on (01) 6712006 or by post at the Department of Psychology, Aras an Phiarsaigh, Trinity College Dublin.

Telephone Help Lines

Rape Crisis Centre	1800-778888
The Samaritans	1850-609090
Alcoholics Anonymous	(01)-4538998
AWARE (Depression)	(01)- 6791711/ 6766166
Schizophrenia Ireland	1890-621631
Contraception Information Line	1850-425262
Pregnancy Counseling Hotline	1850-495051

Appendix 8



Adolescent Mental Health In Ireland

Instructions:

- Please read the instructions on each page very carefully.
- Answer the questions as honestly as possible.
- There are no right or wrong answers; it is your own opinion that is of interest to me.
- If you have problems understanding a question, raise your hand and I will discuss it with you.

Section 1

This section asks you some general information about yourself. All of this information will be kept strictly confidential. **Please give answers to all the questions.**

Name: _____ **Age:**_____

Gender (please tick): **Male** ☐ **Female** ☐

Area of Residence (e. g. Dublin 2): _____

Religion (please tick): **Roman Catholic** ☐ **Protestant** ☐

Other (please state):_____

What year are you in at school: _____

My school is ... (please tick): **Single-sex** ☐ **Mixed** ☐

My parents/guardians are... (please tick): **Married** ☐ **Separated** ☐

Divorced ☐ **Unmarried** ☐

Widow/Widower ☐

Other (please state): _____



Section 2

Listed below are several possible ways of coping. We would like you to **tick the box** that best indicates to what extent you, yourself, use each of these coping methods in dealing with everyday problems. Try to think of a problem you have encountered in the last six months or so.

In solving this problem, to what extent did you……,

1. Described your feelings to a friend?	A lot [ ]	A Little [ ]	Not at all [ ]
2. Rearranged things so that your problem could be solved?	A lot [ ]	A Little [ ]	Not at all [ ]
3. Thought of many ideas before deciding what to do?	A lot [ ]	A Little [ ]	Not at all [ ]
4. Tried to distract yourself from the problem	A lot [ ]	A Little [ ]	Not at all [ ]
5. Accepted sympathy and understanding from someone?	A lot [ ]	A Little [ ]	Not at all [ ]
6. Did all you could to keep others from seeing how bad things really were?	A lot [ ]	A Little [ ]	Not at all [ ]
7. Talked to people about the situation because talking about it made you feel better?	A lot [ ]	A Little [ ]	Not at all [ ]
8. Set some goals for yourself to deal with the situation?	A lot [ ]	A Little [ ]	Not at all [ ]
9. Weighed up your options very carefully?	A lot [ ]	A Little [ ]	Not at all [ ]
10. Daydreamed about better times?	A lot [ ]	A Little [ ]	Not at all [ ]
11. Tried different ways to solve the problem until you found one that worked?	A lot [ ]	A Little [ ]	Not at all [ ]
12. Talked about fears and worries to a relative or friend?	A lot [ ]	A Little [ ]	Not at all [ ]
13. Spent more time than usual alone?	A lot [ ]	A Little [ ]	Not at all [ ]
14. Told people about the situation because talking about it helped you come up with solutions?	A lot [ ]	A Little [ ]	Not at all [ ]
15. Thought about what needed to be done to straighten things up?	A lot [ ]	A Little [ ]	Not at all [ ]
16. Turned your full attention to solving the problem?	A lot [ ]	A Little [ ]	Not at all [ ]
17. Formed a plan in your mind?	A lot [ ]	A Little [ ]	Not at all [ ]
18. Watched television more than usual?	A lot [ ]	A Little [ ]	Not at all [ ]
19. Went to someone (friend or professional) in order to help you feel better?	A lot [ ]	A Little [ ]	Not at all [ ]

20. Stood firm and fought for what you wanted in the situation?	A lot [ ]	A Little [ ]	Not at all [ ]
21. Avoided being with people in general?	A lot [ ]	A Little [ ]	Not at all [ ]
22. Buried yourself in a hobby or sports activity to avoid the problem?	A lot [ ]	A Little [ ]	Not at all [ ]
23. Went to a friend to help you feel better about the problem?	A lot [ ]	A Little [ ]	Not at all [ ]
24. Went to a friend for advice on how to change the situation?	A lot [ ]	A Little [ ]	Not at all [ ]
25. Accepted sympathy and understanding from friends who had the same problem?	A lot [ ]	A Little [ ]	Not at all [ ]
26. Slept more than usual?	A lot [ ]	A Little [ ]	Not at all [ ]
27. Fantasized about how things could have been different?	A lot [ ]	A Little [ ]	Not at all [ ]
28. Identified with characters in novels or movies?	A lot [ ]	A Little [ ]	Not at all [ ]
29. Tried to solve the problem?	A lot [ ]	A Little [ ]	Not at all [ ]
30. Wished that people would just leave you alone?	A lot [ ]	A Little [ ]	Not at all [ ]
31. Accepted help from a friend or relative?	A lot [ ]	A Little [ ]	Not at all [ ]
32. Sought reassurance from those who know you best?	A lot [ ]	A Little [ ]	Not at all [ ]
33. Tried to carefully plan a course of action rather than acting on impulse?	A lot [ ]	A Little [ ]	Not at all [ ]



Please continue to the next page...

Section 3

Below, is a list of statements dealing with your general feelings about yourself. Please indicate, **by circling**, the degree to which you agree or disagree with the statement, by ticking the appropriate box. **Please be sure to read each statement carefully.**

I feel that I'm a person of worth, at least on an equal plane with others	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I feel that I have a number of good qualities	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
All in all, I am inclined to feel that I am a failure	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I am able to do things as well as most other people	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I feel I do not have much to be proud of	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I take a positive attitude toward myself	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
On the whole, I am satisfied with myself	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I wish I could have more respect for myself	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I certainly feel useless at times	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
At times, I think I am no good at all	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**



Please continue to the next page...

Section 4

Please read and complete fully each of Parts 1 and 2.

Part 1

Some people feel it is very important to value traditional Irish ideas. Some others feel that it is very important to value modern Irish ideas. Others still think it's important to combine the old and the new.

Below are 4 combinations of these ideas. Please read each of the four statements below **very carefully** and tick the **ONE** that you agree with most. None may express your opinion perfectly, but pick the one that is **CLOSEST** to how you feel.

I think that **both** the "Old", traditional Ireland and the more modern, "Celtic Tiger" Ireland have things to offer. I can see parts of **both** cultures that I can identify with. ☐

or

Nothing about "Old", traditional Ireland appeals to me. I can't identify with it at all. Instead, I like the more modern, "Celtic Tiger" Ireland. ☐

or

I don't think that the "Old", traditional Ireland has much to offer. Equally, I don't think that the modern, "Celtic Tiger" Ireland has much to offer. I don't really see myself fitting in with **either** of these. ☐

or

Nothing about modern, "Celtic Tiger" Ireland appeals to me. I can't identify with it. Instead, I like the more traditional, "Old" Ireland. ☐

Part 2

Below are **two** statements. Please **circle** the statement which **best** matches how you feel. Please give an answer to **both** items **a** and **b**.

(a) I think there has been a big change in Irish culture in the last 10 years.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

(b) I think that Ireland is a better place now than it was 10 years ago.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

Section 5

Given the number of suicides we see today, it is important to try and understand the possible reasons some people may feel that suicide is the only option open to them. Below are various reasons that have been given to explain suicide in **specific circumstances**. Whatever your personal views on suicide, please think of each item in turn and indicate what you think **by circling** whether it is a poor reason, good reason etc. **in that particular situation,** for someone to take their life.

1. Not being able to get a girlfriend/boyfriend	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
2. Becoming unemployed	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
3. Having no money	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
4. Breast cancer in a 30 year-old woman	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
5. Being diagnosed with AIDS	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
6. Finding out you can't have children	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
7. Suffering sexual abuse as a child	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
8. Death of a parent	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
9. Suffering emotional abuse in a relationship	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
10. Wanting to be with a loved one who has died	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
11. Death of a spouse/lover	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
12. Death of a close friend	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason



Please continue to the next page...

Section 6

This questionnaire consists of 21 statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today. Be sure to read all the statements in each group before making your choice.**

Question 1	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it
	3	I am so sad or unhappy that I can't stand it
Question 2	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future
	2	I feel I have nothing to look forward to
	3	I feel that the future is hopeless and that things cannot improve
Question 3	0	I do not feel like a failure
	1	I feel I have failed more than the average person
	2	As I look back on my life, all I can see is a lot of failures
	3	I feel I am a complete failure as a person
Question 4	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to
	2	I don't get real satisfaction out of anything anymore
	3	I am dissatisfied or bored with everything
Question 5	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time
Question 6	0	I don't feel I am being punished
	1	I feel I may be punished
	2	I expect to be punished
	3	I feel I am being punished
Question 7	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself
	3	I hate myself
Question 8	0	I don't feel I am any worse than anybody else
	1	I am critical of myself for my weaknesses or mistakes
	2	I blame myself all the time for my faults
	3	I blame myself for everything bad that happens
Question 9	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself
	3	I would kill myself if I had the chance.
Question 10	0	I don't cry any more than usual
	1	I cry more now than I used to
	2	I cry all the time now
	3	I used to be able to cry, but now I can't cry even though I want to
Question 11	0	I am no more irritated now than I ever am
	1	I get annoyed or irritated more easily than I used to
	2	I feel irritated all the time now
	3	I don't get irritated at all by the things that used to irritate me
Question 12	0	I have not lost interest in other people
	1	I am less interested in other people than I used to be
	2	I have lost most of my interest in other people
	3	I have lost all of my interest in other people

Question 13	0	I make decisions about as well as I ever could
	1	I put off making decisions more than I used to
	2	I have greater difficulty in making decisions than before
	3	I can't make decisions at all anymore
Question 14	0	I don't feel I look any worse than I used to
	1	I am worried that I am looking old or unattractive
	2	I feel that there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly
Question 15	0	I can work about as well as before
	1	It takes an extra effort to get started at doing something
	2	I have to push myself very hard to do anything
	3	I can't do any work at all
Question 16	0	I can sleep as well as usual
	1	I don't sleep as well as I used to
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
	3	I wake up several hours earlier than I used to and cannot get back to sleep
Question 17	0	I don't get more tired than usual
	1	I get tired more easily than I used to
	2	I get tired from doing almost anything
	3	I am too tired to do anything
Question 18	0	My appetite is no worse than usual
	1	My appetite is not as good as it used to be
	2	My appetite is much worse now
	3	I have no appetite at all anymore
Question 19	0	I haven't lost much weight, if any, lately
	1	I have lost more than 5 pounds
	2	I have lost more than 10 pounds
	3	I have lost more than 15 pounds
		I am purposely trying to lose weight by eating less. Yes _____ No _____
Question 20	0	I am no more worried about my health than usual
	1	I am worried about physical problems such as aches and pains; or upset stomach, or constipation
	2	I am very worried about physical problems and it's hard to think of much else
	3	I am so worried about my physical problems that I cannot think about anything else
Question 21	0	I have not noticed any recent change in my interest in sex
	1	I am less interested in sex than I used to be
	2	I am much less interested in sex than I used to be
	3	I have lost interest in sex completely



Please continue to the next page...

Section 7

This questionnaire is made up of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week, including today**, circle the word 'True'. If the statement does not describe your attitude, circle the word 'False'. **Please be sure to read each statement carefully.**

1	I look forward to the future with hope and enthusiasm	**True**	**False**
2	I might as well give up because there is nothing I can do about making things better for myself	**True**	**False**
3	When things are going badly, I am helped by the knowledge that they cannot stay that way forever	**True**	**False**
4	I can't imagine what my life would be like in ten years	**True**	**False**
5	I have enough time to accomplish the things I want to do	**True**	**False**
6	In the future, I expect to succeed in what concerns me most	**True**	**False**
7	My future seems dark to me	**True**	**False**
8	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person	**True**	**False**
9	I just can't get the breaks, and there's no reason I will in the future	**True**	**False**
10	My past experiences have prepared me well for the future	**True**	**False**
11	All I can see ahead of me is unpleasantness rather than pleasantness	**True**	**False**
12	I don't expect to get what I really want	**True**	**False**
13	When I look ahead to the future, I expect that I will be happier than I am now	**True**	**False**
14	Things just don't work out the way I want them to	**True**	**False**
15	I have great faith in the future	**True**	**False**
16	I never get what I want, so it's foolish to want anything	**True**	**False**
17	It's very unlikely that I will get any real satisfaction in the future	**True**	**False**
18	The future seems vague and uncertain to me	**True**	**False**
19	I can look forward to more good times than bad times	**True**	**False**
20	There's no use in really trying to get anything I want because I probably won't get it	**True**	**False**



Section 8

Below is a list of statements describing how you might feel about Irish society today. Please read each one **very carefully** and **indicate by circling** whether you agree or disagree with the statement. Please answer **all** the questions.

1	With everything so uncertain these days, it almost seems as though anything could happen	**Agree**	**Disagree**
2	What is lacking in the world today is the old kind of friendship that lasted for a lifetime	**Agree**	**Disagree**
3	With everything in such a state of disorder, it's hard for a person to know where he/she stands from one day to the next	**Agree**	**Disagree**
4	Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow	**Agree**	**Disagree**
5	I often feel that many things our parents stood for are just going to ruin before our eyes	**Agree**	**Disagree**
6	The trouble with the world today is that most people don't really believe in anything	**Agree**	**Disagree**
7	I often feel awkward and out of place	**Agree**	**Disagree**
8	People were better off in the old days when everyone knew just how he/she was expected to act	**Agree**	**Disagree**
9	It seems to be that other people find it easier to decide what is right than I do	**Agree**	**Disagree**



Thank you for your participation!

Appendix 9



Adolescent Mental Health In Ireland

INSTRUCTIONS

- Please read the instructions on each page very carefully.
- Answer the questions as honestly as possible.
- There are no right or wrong answers; it is your own opinion that is of interest to me.
- If you have problems understanding a question, raise your hand and I will discuss it with you.

SECTION 1

This section asks you some general information about yourself. All of this information will be kept strictly confidential. **Please give answers to all the questions.**

Name:_____

Age: _____

Gender: _____

Area of residence: _____

Religion (please put an 'X' beside the appropriate answer)

Roman Catholic

Protestant

Other



What year are you in at school? (please put an 'X' beside the appropriate answer)

Fifth
Sixth

My school is… (please put an 'X' beside the appropriate answer)

Single- sex
Mixed

My parents are… (please put an 'X' beside the appropriate answer)

Married
Separated
Divorced
Unmarried
Widow/Widower
Other (please state below)

_____

SECTION 2

Listed below and on following pages, are several possible ways of coping. We would like you to **put an 'X' in the box** that best indicates to what extent you, yourself, use each of these coping methods in dealing with everyday problems. Try to think of a problem you have encountered in the last six months or so.

In solving this problem, to what extent did you……,

1. Describe your feelings to a friend?	A lot	A Little	Not at all
2. Rearranged things so that your problem could be solved?	A lot	A Little	Not at all
3. Thought of many ideas before deciding what to do?	A lot	A Little	Not at all
4. Tried to distract yourself from the problem	A lot	A Little	Not at all
5. Accepted sympathy and understanding from someone?	A lot	A Little	Not at all

6. Did all you could to keep others from seeing how bad things really were?	A lot	A Little	Not at all
7. Talked to people about the situation because talking about it made you feel better?	A lot	A Little	Not at all
8. Set some goals for yourself to deal with the situation?	A lot	A Little	Not at all
9. Weighed up your options very carefully?	A lot	A Little	Not at all
10. Daydreamed about better times?	A lot	A Little	Not at all
11. Tried different ways to solve the problem until you found one that worked?	A lot	A Little	Not at all
12. Talked about fears and worries to a relative or friend?	A lot	A Little	Not at all
13. Spent more time than usual alone?	A lot	A Little	Not at all

14. Told people about the situation because talking about it helped you come up with solutions?	A lot	A Little	Not at all
15. Thought about what needed to be done to straighten things up?	A lot	A Little	Not at all
16. Turned your full attention to solving the problem?	A lot	A Little	Not at all
17. Formed a plan in your mind?	A lot	A Little	Not at all
18. Watched television more than usual?	A lot	A Little	Not at all
19. Went to someone (friend or professional) in order to help you feel better?	A lot	A Little	Not at all
20. Stood firm and fought for what you wanted in the situation?	A lot	A Little	Not at all
21. Avoided being with people in general?	A lot	A Little	Not at all

22. Buried yourself in a hobby or sports activity to avoid the problem?	A lot	A Little	Not at all
23. Went to a friend to help you feel better about the problem?	A lot	A Little	Not at all
24. Went to a friend for advice on how to change the situation?	A lot	A Little	Not at all
25. Accepted sympathy and understanding from friends who had the same problem?	A lot	A Little	Not at all
26. Slept more than usual?	A lot	A Little	Not at all
27. Fantasized about how things could have been different?	A lot	A Little	Not at all
28. Identified with characters in novels or movies?	A lot	A Little	Not at all

29. Tried to solve the problem?	A lot	A Little	Not at all
30. Wished that people would just leave you alone?	A lot	A Little	Not at all
31. Accepted help from a friend or relative?	A lot	A Little	Not at all
32. Sought reassurance from those who know you best?	A lot	A Little	Not at all
33. Tried to carefully plan a course of action rather than acting on impulse?	A lot	A Little	Not at all

Please continue to the next page

SECTION 3

Below and on the next page, is a list of statements dealing with your general feelings about yourself. Please **put an 'X' in the box** to indicate the degree to which you agree or disagree with the statement.
Please be sure to read each statement carefully.

I feel that I'm a person of worth, at least on an equal plane with others	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I feel that I have a number of good qualities	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
All in all, I am inclined to feel that I am a failure	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I am able to do things as well as most other people	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**

I feel I do not have much to be proud of	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I take a positive attitude toward myself	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
On the whole, I am satisfied with myself	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I wish I could have more respect for myself	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I certainly feel useless at times	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
At times, I think I am no good at all	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**



Please continue to the next page

SECTION 4

Please read and complete fully each of Parts 1 and 2.

Part 1

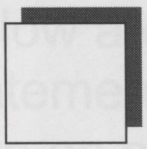
Some people feel it is very important to value traditional Irish ideas. Some others feel that it is very important to value modern Irish ideas. Others still think it's important to combine the old and the new.

On the next page are **4** combinations of these ideas.

Please read each of the four statements below **very carefully** and **PUT AN 'X' beside** the **ONE** that you agree with most. None may express your opinion perfectly, but pick the one that is **CLOSEST** to how you feel.



Please continue to the next page



I think that **both** the "Old", traditional Ireland and the more modern, "Celtic Tiger" Ireland have things to offer. I can see parts of **both** cultures that I can identify with.

OR



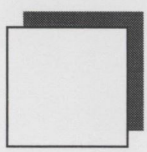
Nothing about "Old", traditional Ireland appeals to me. I can't identify with it at all. Instead, I like the more modern, "Celtic Tiger" Ireland.

OR



I don't think that the "Old", traditional Ireland has much to offer. Equally, I don't think that the modern, "Celtic Tiger" Ireland has much to offer. I don't really see myself fitting in with **either** of these.

OR



Nothing about modern, "Celtic Tiger" Ireland appeals to me. I can't identify with it. Instead, I like the more traditional, "Old" Ireland.

Part 2

Below are **two** statements. Please **circle** the statement which **best** matches how you feel. Please give an answer to **both** items **a** and **b**.

(a) I think there has been a big change in Irish culture in the last 10 years.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

(b) I think that Ireland is a better place now than it was 10 years ago.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

SECTION 5

Given the number of suicides we see today, it is important to try and understand the possible reasons some people may feel that suicide is the only option open to them. Below and on the next page, are various reasons that have been given to explain suicide in **specific circumstances**. Whatever your personal views on suicide, please think of each item in turn and indicate **by putting an 'X' in the corresponding box** that you think it is a poor reason, good reason etc. **in that particular situation,** for someone to take their life.

1. Not being able to get a girlfriend/ boyfriend	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
2. Becoming unemployed	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
3. Having no money	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
4. Breast cancer in a 30 year-old woman	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason

5. Being diagnosed with AIDS	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
6. Finding out you can't have children	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
7. Suffering sexual abuse as a child	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
8. Death of a parent	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
9. Suffering emotional abuse in a relationship	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
10. Wanting to be with a loved one who has died	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
11. Death of a spouse/lover	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason
12. Death of a close friend	Very poor reason	Poor reason	Not sure	Good reason	Very Good reason

SECTION 6

This questionnaire consists of 21 statements. After reading each group of statements carefully, **circle** the number (0, 1, 2 or 3) next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today**. **Be sure to read all the statements in each group before making your choice.**

Question 1	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it
	3	I am so sad or unhappy that I can't stand it
Question 2	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future
	2	I feel I have nothing to look forward to
	3	I feel that the future is hopeless and that things cannot improve
Question 3	0	I do not feel like a failure
	1	I feel I have failed more than the average person
	2	As I look back on my life, all I can see is a lot of failures
	3	I feel I am a complete failure as a person

Question 4	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to
	2	I don't get real satisfaction out of anything anymore
	3	I am dissatisfied or bored with everything
Question 5	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time
Question 6	0	I don't feel I am being punished
	1	I feel I may be punished
	2	I expect to be punished
	3	I feel I am being punished
Question 7	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself
	3	I hate myself
Question 8	0	I don't feel I am any worse than anybody else
	1	I am critical of myself for my weaknesses or mistakes
	2	I blame myself all the time for my faults
	3	I blame myself for everything bad that happens
Question 9	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself
	3	I would kill myself if I had the chance

Question 10	0	I don't cry any more than usual
	1	I cry more now than I used to
	2	I cry all the time now
	3	I used to be able to cry, but now I can't cry even though I want to
Question 11	0	I am no more irritated now than I ever am
	1	I get annoyed or irritated more easily than I used to
	2	I feel irritated all the time now
	3	I don't get irritated at all by the things that used to irritate me
Question 12	0	I have not lost interest in other people
	1	I am less interested in other people than I used to be
	2	I have lost most of my interest in other people
	3	I have lost all of my interest in other people
Question 13	0	I make decisions about as well as I ever could
	1	I put off making decisions more than I used to
	2	I have greater difficulty in making decisions than before
	3	I can't make decisions at all anymore
Question 14	0	I don't feel I look any worse than I used to
	1	I am worried that I am looking old or unattractive
	2	I feel that there are permanent changes in my appearance that make me look ugly
	3	I believe that I look ugly

Question 15	0 1 2 3	I can work about as well as before It takes an extra effort to get stated at doing something I have to push myself very hard to do anything I can't do any work at all
Question 16	0 1 2 3	I can sleep as well as usual I don't sleep as well as I used to I wake up 1-2 hours earlier than usual and find it hard to get back to sleep I wake up several hours earlier than I used to and cannot get back to sleep
Question 17	0 1 2 3	I don't get more tired than usual I get tired more easily than I used to I get tired from doing almost anything I am too tired to do anything
Question 18	0 1 2 3	My appetite is no worse than usual My appetite is not as good as it used to be My appetite is much worse now I have no appetite at all anymore
Question 19	0 1 2 3	I haven't lost much weight, if any, lately I have lost more than 5 pounds I have lost more than 10 pounds I have lost more than 15 pounds I am purposely trying to lose weight by eating less. Yes_____ No_____

Question 20	0	I am no more worried about my health than usual
	1	I am worried about physical problems such as aches and pains; or upset stomach or constipation
	2	I am very worried about physical problems and it's hard to think of much else
	3	I am so worried about my physical problems that I cannot thing about anything else
Question 21	0	I have not noticed any recent change in my interest in sex
	1	I am less interested in sex than I used to be
	2	I am much less interested in sex than I used to be
	3	I have lost interest in sex completely

Please continue to the next page



SECTION 7

This questionnaire is made up of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week, including today**, circle the word 'True'. If the statement does not describe your attitude, circle the word 'False'. **Please be sure to read each statement carefully.**

1	I look forward to the future with hope and enthusiasm	**True**	**False**
2	I might as well give up because there is nothing I can do about making things better for myself	**True**	**False**
3	When things are going badly, I am helped by the knowledge that they cannot stay that way forever	**True**	**False**
4	I can't imagine what my life would be like in ten years	**True**	**False**
5	I have enough time to accomplish the things I want to do	**True**	**False**
6	In the future, I expect to succeed in what concerns me most	**True**	**False**
7	My future seems dark to me	**True**	**False**
8	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person	**True**	**False**

9	I just can't get the breaks, and there's no reason I will in the future	**True**	**False**
10	My past experiences have prepared me well for the future	**True**	**False**
11	All I can see ahead of me is unpleasantness rather than pleasantness	**True**	**False**
12	I don't expect to get what I really want	**True**	**False**
13	When I look ahead to the future, I expect that I will be happier than I am now	**True**	**False**
14	Things just don't work out the way I want them to	**True**	**False**
15	I have great faith in the future	**True**	**False**
16	I never get what I want, so it's foolish to want anything	**True**	**False**
17	It's very unlikely that I will get any real satisfaction in the future	**True**	**False**
18	The future seems vague and uncertain to me	**True**	**False**
19	I can look forward to more good times than bad times	**True**	**False**
20	There's no use in really trying to get anything I want because I probably won't get it	**True**	**False**

SECTION 8

Below and on the next page, is a list of statements describing how you might feel about Irish society today. Please read each one **very carefully** and **indicate by putting an 'X' in the appropriate box** whether you agree or disagree with the statement. Please answer **all** the questions.

1	With everything so uncertain these days, it almost seems as though anything could happen	**Agree**	**Disagree**
2	What is lacking in the world today is the old kind of friendship that lasted for a lifetime	**Agree**	**Disagree**
3	With everything in such a state of disorder, it's hard for a person to know where he/she stands from one day to the next	**Agree**	**Disagree**
4	Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow	**Agree**	**Disagree**
5	I often feel that many things our parents stood for are just going to ruin before our eyes	**Agree**	**Disagree**

6	The trouble with the world today is that most people don't really believe in anything	**Agree**	**Disagree**
7	I often feel awkward and out of place	**Agree**	**Disagree**
8	People were better off in the old days when everyone knew just how he/she was expected to act	**Agree**	**Disagree**
9	It seems to be that other people find it easier to decide what is right than I do	**Agree**	**Disagree**



Thank you for your participation!

Appendix 10



What is this research about?

The title of the project is "Culture Change and Adolescent Mental Health in Modern Ireland". It plans to look at the way in which recent social and cultural changes have affected the mental health and coping abilities of Irish adolescents.

What will happen with the information I have given?

All the information you have provided will be kept strictly confidential. The only time this will not be the case, is if any of your responses indicate that you are experiencing difficulty. If this is the case, you and your parents/ guardians will be contacted and a referral to a professional counselor may be made. Your school will not be aware of any referrals and they will not be involved at any stage. At the end of the research, the findings will be published but at this stage, all identifying information will have been removed so that people who read the report do not know anything about the students who took part.

Why is the research important?

This research is important because a greater number of teenagers are experiencing problems than before. If we can better understand teenager's

lives and those events that make them unhappy or stressed, it is easier to make sure they are helped.

What if I feel upset or worried by some of the questions asked?

If you are concerned for yourself or a friend then there are several places you can contact for help. Some useful telephone numbers are written on the back of this sheet. It is important to talk to someone if you feel worried, upset or stressed. This person could be a parent/guardian, friend, teacher or another adult or someone on one of the phone lines. Your local GP or family medical centre is also a good place to contact if you would like to talk to someone about these issues.

Can I contact the people who did the research?

The person who was in your class today was Caroline Smyth. You can contact her by telephone on (01) 6083911, fax on (01) 6712006 or by post at the Department of Psychology, Aras an Phiarsaigh, Trinity College Dublin.

TELEPHONE HELPLINES

Rape Crisis Centre	**1800-778888**
The Samaritans	**1850-609090**
Alcoholics Anonymous	**(01)-4538998**
AWARE (Depression)	**(01)- 6791711/ 6766166**
Schizophrenia Ireland	**1890-621631**
Contraception Information Line	**1850-425262**
Pregnancy Counseling Hotline	**1850-495051**

Appendix 11

Department of Psychology

University of Dublin, Trinity College

Dublin 2, Ireland

Tel: +353 1 608 1886
Fax: +353 1 671 2006

Head of Department: Professor Ian Robertson

March 27th 2003

Dear

I was in contact with you before with regard to the research being carried out in your child's school on Adolescent Mental Health in Ireland. Following the receipt of your signed consent form and, having explained the research to your child, he completed a questionnaire in class.

As was previously explained, one of our key tasks throughout is to support the wellbeing and safety of your child. You are being contacted at this stage as some of the responses your child provided to certain questions indicate that he may benefit from a referral to a professional counseling service. This service is free of charge. In light of this information and out of concern for your child, we recommend that you make contact with the counseling service even if only to obtain further information on the service itself or the way in which your child may be helped. The counselor taking referrals is Mr. Martin Boyle, who be contacted by telephone on 087-2845637 or by post to St.Catherine's Counselling Service, Main Street, Tallaght, Dublin 24. Alternatively, you may feel more comfortable contacting your local GP or family medical center as referrals can also be made from there.

The school your child attends will not be informed of this recommendation as the matter is private and between your family and the counseling service. You may however, at a later stage, decide the school would benefit from this information in which case we would ask you to contact them directly.

If you would like any further information, have any questions on the research or would like to discuss this further, please do not hesitate to contact Prof. MacLachlan. A voice-message may be left on (01) 6081453. This service will be checked daily and your call returned as soon as possible. Alternatively, you may contact him by e-mail at Malcolm.MacLachlan@tcd.ie.

With best wishes,

Caroline Smyth,
Department of Psychology,
Trinity College Dublin.