SPIRITUALITY AND RELIGION IN YOUTH SUICIDE ATTEMPTERS’
TRAJECTORIES OF MENTAL HEALTH SERVICE UTILIZATION: THE
YEAR BEFORE A SUICIDE ATTEMPT

Marie Bullock
Department of Psychiatry
McGill University, Montreal
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CONTRIBUTION OF AUTHORS

CHAPTER 1 – Literature Review
Writing of text: Marie Bullock under the supervision of Dr. Johanne Renaud (supervisor) and Dr. Lucie Nadeau (co-supervisor).

CHAPTER 2 – Manuscript
Research design, execution, and analysis of data: Marie Bullock in consultation with Dr. Johanne Renaud, Dr. Lucie Nadeau, Dr. Pierre Pluye, Dr. Danielle Groleau, Dr. Charo Rodriguez, and Dr. Rob Whitley. Marie Bullock conducted all the interviews and transcriptions of the interviews in English (8 interviews) and Richard Violette conducted all the interviews and transcriptions the interviews in French (7 interviews). Marie translated any French quotations to English for this manuscript and had the accuracy checked by Dr. Renaud. Furthermore, Marie Bullock consulted Dr. Renaud and Dr. Nadeau to reduce bias in the interpretation of the interviews during analysis. Finally, Marie Bullock consulted Dr. Colleen Delaney regarding questions about the Spirituality Scale (the scale’s author).

Writing of text: Marie Bullock under the supervision of Dr. Johanne Renaud and Dr. Lucie Nadeau

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ABSTRACT

Youth suicide attempters are at high-risk for completing suicide. Many have untreated mental health problems and are not receiving services. Therefore, there is an urgent need to better understand potential influences associated with service use amongst this population. Spirituality and/or religion are potential cultural influences in all stages of youths’ mental health service trajectories. This thesis explored youths’ experiences of spirituality/religion as it relates to their help-seeking trajectories in the year prior to their suicide attempt. Fifteen youth (aged 14-18) who had made a suicide attempt(s) in the past 1 to 2 years were consecutively recruited through the Depressive Disorder Program of a psychiatric hospital and interviewed using open ended questions and one questionnaire. A mixed-methods design, including an adapted form of the psychological autopsy method, was used. Three themes emerged in the interviews. Religious community members acted as a bridge, step, or provider in relation to mental health services. Religious and spiritual discourses were encountered within services. Many youths reported different levels of spirituality and/or religious beliefs during the year prior to their suicide attempt. Spirituality and religion can have a role in youth suicide attempters’ service trajectories. How this confers protection or challenges for each youth’s trajectory needs to be clarified. Service providers need to be careful how they address these complex issues. Already, findings from the study in this thesis can inform policies in mental health services, suicide prevention and alert clinicians to suicidal youths’ perspectives about spirituality and religion which may affect service utilization.
RÉSUMÉ

Les jeunes ayant fait une tentative de suicide sont à haut risque de s’enlever la vie par suicide. De nombreux jeunes ayant des problèmes de santé mentale ne sont pas traités pour leurs problèmes de santé mentale et ne reçoivent pas de services. Ainsi, il y a un besoin urgent de mieux comprendre les influences potentielles liées à l’utilisation de services parmi cette population. La spiritualité et/ou la religion sont des influences culturelles potentielles à tous les stades de la trajectoire de services en santé mentale des jeunes qui ont fait une tentative de suicide. Cette thèse a exploré les expériences des jeunes au niveau de la spiritualité/religion en lien avec leur trajectoire de recherche d’aide dans l’année précédant leur tentative de suicide. Quinze jeunes (âgés de 14 à 18 ans) ayant fait une tentative de suicide dans la dernière ou les deux dernières années ont été recrutés consécutivement via le Programme des Troubles Dépressifs d’un hôpital psychiatrique et ont été interviewés en utilisant des questions « ouvertes » et un questionnaire. Une approche méthodologique mixte, incluant une version adaptée de l’autopsie psychologique, a été utilisée. Trois thèmes sont ressortis des entrevues. Les membres des communautés religieuses ont permis soit de faire le pont vers les services en santé mentale, d’être une étape dans l’offre de services ou de donner les soins proprement dits. Les jeunes ont été en contact avec des discours religieux et spirituels à différents moments dans les services de santé usuels. Plusieurs jeunes ont rapporté différents niveaux de spiritualité et/ou de croyances religieuses dans l’année précédant leur tentative de suicide. La spiritualité et la religion peuvent avoir un rôle dans la trajectoire de services de
ces jeunes. Comment ceci confère un effet protecteur ou encore constitue un défi reste à être approfondi. Les donneurs de soins doivent adresser ces enjeux complexes avec doigté. Déjà, les résultats générés par cette étude peuvent éclairer les politiques dans les services de santé mentale, la prévention de suicide et sensibiliser les cliniciens aux perspectives des jeunes suicidaires à propos de la spiritualité et la religion, perspectives qui pourraient influencer l’utilisation de services.
PREFACE

This thesis includes a study examining spirituality and religion amongst a clinical sample of youth (age 15-17) suicide attempters consecutively recruited from the Depressive Disorders Program of the Douglas Mental Health University Institute in Verdun, Quebec where they had been referred to receive treatment and services. Chapter 1 provides a review of the literature relevant to this complex area of research as well as the rationale and objectives for the study. Chapter 2 is presented as a formal manuscript accepted for publication: “Spirituality and Religion in Youth Suicide Attempters’ Mental Health Service Utilization Trajectories: A Qualitative Study” (Bullock, Nadeau, & Renaud, accepted). The manuscript includes all the details about methodology: participants, tools, data collection and analysis. Chapter 3 provides a thorough discussion and extensive analysis of the research findings in light of the background literature presented in Chapter 1 as well as recommendations for future research.
CHAPTER 1: INTRODUCTION
Burden of Suicide/Suicide Attempts

Suicide is a major public health concern and although recently the completed suicide rates in Quebec have decreased, Quebec’s rate is still one of the highest in Canada (Gagné, Légaré, Perron, & St-Laurent, 2011, Institut national de santé publique du Québec [INSPQ], 2009 (Figure 1 & 2), 2010 (Figure 3)). Suicide is especially significant amongst youth (aged 10-24) being the 2nd leading cause of death worldwide and rates (which exclude rates of suicide attempts) have been increasing in developed and developing countries (World Health Organization [WHO]: SUPRE, n.d.). In Canada, adolescent completed suicide rates are higher amongst non-immigrant than immigrant youths (Greenfield et al., 2006). In suicide research, the distinction is made between suicide ideation, suicide attempts, and suicide completion. This thesis will be focusing on spirituality and religion in youth who have made a suicide attempt.

Compared to other age groups in Canada, in 2005, youth between 15 and 24 years old had the highest rates of suicide attempts (Statistique Canada, 2005, INSPQ 2010 (see Figure 4)). In youth, mid-adolescence is when the incidence of suicide attempts reaches its peak (American Academy of Child and Adolescent Psychiatry [AACAP], 2001a). Moreover, making a suicide attempt increases the likelihood that a youth (aged 12-18) will complete suicide (AACAP, 2001b). Making a suicide attempt increases the risk of suicide by 30 times in boys, and 20 times in girls (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Shaffer et al., 1996; Shaffer & Craft, 1999). Suicide attempts are less common than suicidal
ideas, but they are the major clinical concern in a significant proportion of adolescents referred to mental health professionals (AACAP, 2001a).

**Characteristics of Suicide Attempters**

**Psychopathology**

Youth suicide attempters are a heterogeneous population with mixed psychosocial, biological, and psychiatric characteristics that put them at risk for attempting or completing suicide (AACAP, 2001a). These include a history of childhood sexual or physical abuse, substance and alcohol abuse, impulsive and aggressive traits, having a mental disorder such as clinical depression (or MDD: Major Depressive Disorder), being female, and having a diagnosis of borderline personality disorder (AACAP, 2001a; Brent et al., 1994; Davison et al., 2005; Garfinkel et al., 1982; Mann et al., 1999; Renaud et al., 2008). Although suicide attempts are more prevalent amongst adolescent females than males, anxiety disorders, mood disorders (early-onset major depressive disorder in particular), runaway behavior, and substance abuse each independently increase the risk of suicide attempts in both sexes (AACAP, 2001a). Youth suicide attempts often occur in the context of a relatively brief adjustment reaction (AACAP, 2001a). It is important to examine where these youth have sought care prior to their suicide attempt and whether the underlying psychosocial, biological, and psychiatric issues have been addressed.
Mental health services exist for early detection, intervention, and treatment of these underlying issues but barriers in accessing services increase the risk of youth making a suicide attempt and/or completing suicide. In terms of service usage history, youth suicide attempters aged 13 through 24 are more likely than suicide completers to have used services within the previous year (Beautrais, Joyce, & Mulder, 1998). Yet, in a Canadian study using data from the national Canadian Community Health Survey (CCHS) (cycle 1.2: this survey excluded people in the territories and institutions) which explored past year help-seeking, the researchers found that 24% of the people (aged 15 to 65+) reporting a suicide attempt in the past year did not perceive a need for mental health care in the past year (it is unclear in this study whether this perception was in reference to before or after their suicide attempt) (Pagura, Fotti, Katz, et al., 2009). In North America, less than 50% of suicidal youth aged 15 to 24 have used mental health services (Cheung, Dewa, Cairney, et al. 2009; Wu, Katic, Liu et al., 2010). In an outpatient clinic study of 115 consecutively referred 10-18 year old suicide attempters and of 110 nonattempters, where outpatient clinic appointment attendance patterns were compared, it was found that attempters kept significantly fewer appointments (were more likely to cancel their appointments) than did nonattempters (Trautman, Stewart, & Morishima, 1993). Furthermore, girls missed more of their appointments at the outpatient clinic than boys in this sample (Trautman et al., 1993). Yet, the gender issue is a complex one, as illustrated by the results of another study surveying youth who had attempted suicide in the past
12 months, where it was found that male adolescents had a tendency to receive outpatient services less often than females (Wu, Katic, Liu, et al. 2010). Finally, Only 5% of the Canadians surveyed who had attempted suicide in the past year went to the emergency room (ER) (Pagura, et al., 2009).

The trajectories of youth who have died by suicide can be distinguished from those youth who have attempted suicide as previously outlined. In a recent Canadian case-control study, more than two-thirds of a total sample of 55 child and adolescent suicide victims had no healthcare treatment contact (including psychiatric consultation) within the month prior to their suicide (Renaud, Berlim, Séguin et al. 2009). Only 7 youth (12.7%) were in contact with a psychiatrist in the month prior to their death by suicide. Although thirty-six of the fifty-five youth (65.5%) in this study saw a general practitioner (GP) in the year before their suicide, only twenty (36.4%) had been seen for psychiatric reasons (Renaud, et al., 2009). In this same study, the female youth who died by suicide seemed to have more psychiatric and mental health service in the month preceding their death therefore it seems that females may seek services more often to begin with than males (Renaud, et al., 2009).

Many suicidal youth are not receiving mental health services and their unmet mental health needs might increase the likelihood of completed suicide, thus there is an urgent need to better understand potential influences associated directly and/or indirectly with service use amongst suicidal youth (Cheung et al. 2009; Pagura, et al., 2009; Renaud, 2009).
A review article has shown that, across all age groups, contacts with primary care providers are more common than with mental health services amongst victims of suicide (Luoma, Martin, & Pearson, 2002).

The existing research literature on mental health services for youths has focused narrowly on services provided in inpatient and outpatient settings (Farmer, Burns, Phillips, et al., 2003). As a result, many types of services that youths may receive for mental health problems are overlooked. For youth suicide attempters and completers alike, there are many points of entry for them to access mental health services (the education sector, specialty mental health sector, juvenile justice) (Farmer, et. al., 2003). Youths may receive mental health care outside the mental health sector.

*Socio-cultural Background, Suicidality and Service Use*

Aspects of the heterogeneity of the population of suicide attempters were described earlier. Research also has discussed socio-cultural aspects in relation to suicidality. The rates of completed suicide differ between countries and ethnic groups (Hawton and Heeringen, 2009). For example, youth from an Aboriginal cultural background have high suicide rates (Goldston, Molock, Whitbeck, et al. 2008), yet the rates differ from one Aboriginal community to the other (Chandler and Lalonde, 1998). The American Academy of Child and Adolescent Psychiatry (AACAP, 2001a) has recommended that clinicians consider the cultural background of a suicidal youth and assess cultural attitudes in the child’s
community. However, differences in suicide rates in different cultural groups (or “ethnic differences”) may reflect contagion in isolated groups more so than cultural differences (AACAP, 2001a).

A Canadian study using data from the CCHS (cycle 1.1 which was conducted between 2000 and 2001, n= 125,493; respondent age 12 years and over with a response rate of 84.7%) to explore mental health service use in a nationally representative sample has found that cultural background (being from a visible minority or being an immigrant) can impact mental health service usage/help-seeking behavior as well (Sareen, Cox, Afifi, et al., 2005). In the second cycle of the CCHS (cycle 1.2, studied people aged 15 years and over) ethnicity as a predisposing factor for service use was associated only with Quebec (Vasiliadis, Lesage, Adair, & Boyer, 2005), although the relevance of this finding was not further explored. A U.S. national community survey of adolescent mental health service use amongst suicidal adolescents found that adolescents from “racial-ethnic” minority groups were less likely than “whites” to receive inpatient or outpatient mental health treatment, despite controlling for other demographic, individual, and family and community characteristics in the analyses (Wu, Katic, Liu et al., 2010). Because larger “racial-ethnic” disparities were found in use of inpatient and outpatient mental health services than in use of school-based services, the authors argued that perhaps factors that are usually viewed as affecting children’s use of services (i.e. “race-ethnicity”, country of origin, insurance, family income, and household structure) might not exert as strong a role in restricting or facilitating adolescents’ access to services in school-based
settings (Wu, et al., 2010). This is highly relevant in Canada given that visible minorities and immigrants form a significant proportion of the Canadian population, especially in urban centres like Toronto, Montreal, and Vancouver (Caron Malenfant, 2004; Clark, 2003; Sareen, et al., 2005). Overall, youth from different cultural backgrounds may differ in their rates and contexts of suicidal behaviors (e.g. precipitants, vulnerability and protective factors, and reactions to suicidal behaviors), and their patterns of help-seeking (Goldston et al., 2008).

**Spirituality and Religion**

Among cultural factors, spirituality and religion are increasingly seen as important domains to explore within mental health research. Yet this area does not appear to have been examined as it relates to the youths’ help-seeking trajectories in the year before their suicide attempt. As well, considering the different entry points into mental health care that youth may adopt, what has not been examined is religious or spiritual individuals and/or communities as a point of entry for youth who have attempted suicide.

**Definitions**

In terms of definitions, there is more consensus about religion than spirituality and often the words are used interchangeably in the research literature (Dein, 2005). *Religion* is here understood as an organized system of beliefs, rituals, and practices rooted in an established tradition oriented towards the numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or Reality; whereas *spirituality* refers to personal experiences of, or search
for ultimate reality/the transcendent that are not necessarily institutionally connected (Cotton et al. 2006; Dein, 2005; Delgado, 2005; Dew et al. 2008; Houskamp et al. 2004; Josephson & Dell, 2004; Koenig, 2009). In research, the traditional-historical understanding of spirituality was that only religious persons could be spiritual—there was no spirituality without religion (Koenig, 2008). Hence, there is much research where religion and spirituality are used interchangeably i.e. studies, which use R/S: Religion/Spirituality in their terminology. Recently, there has been an understanding of spirituality (the modern version) where it is no longer the exclusive domain of religion (Koenig, 2008) (see Figure 5). In the research literature, there tends to be a lack of consensus for definitions of spirituality (Dein, 2005; Zinnbauer, Pargament, Cole, et al., 1997). Furthermore, any definitions of spirituality are superimposed from the researchers—the definitions rarely come from the perspective of participants and if they do, it is to revise a scale that has already been developed by researchers for example (i.e. MacGillivray Sumsion & Wicks-Nicholls, 2006). Currently, most of the available research on adolescent spirituality is related to religiosity, where the tendency is to use spirituality as a blanket term collapsed with religiosity or religion (MacGillivray et al., 2006). Research in religion and spirituality is challenging in youth -- with few measures validated, thus it has been recommended that more qualitative, exploratory studies be done to demonstrate what religion and spirituality mean to youth (Cotton et al. 2006). Fortunately, qualitative work with youth has started to emerge, but research with youth who have made a suicide attempt(s) is under-researched (MacGillivray et al. 2006).
Canadian Context: Universal Health Care

In studying youths’ trajectories of mental health service utilization, it is important to have an understanding of the health care system in which they reside. There are many empirical studies demonstrating the predictors of mental health service utilization, however findings from these large-scale surveys are difficult to generalize across countries owing to considerable differences in health care systems (Lefebvre, Lesage, Cyr, et al., 1998). Under universal health care, coverage for medical care is free of charge everywhere in Canada, but the availability of specialized mental health care services and the corresponding attitudes towards mental health care vary from province to province (Lefebvre, et al., 1998). For example, there are many more psychologists in Quebec per capita than there are in Ontario or the United States (Lefebvre, 1998).

Quebec's Mental Health Care System

In Quebec, provincial hospital/community based psychiatric and mental health services are free, private mental health services are not. However, coverage for the services of psychologists and other psychotherapists, which are not always covered under the universal health care system, vary from province to province (Lefebvre et al., 1998). Psychologists and psychotherapists comprise one of the three primary components of the primary mental health care sector. Medical resources accessible through Canada’s universal health care comprise another component and non-profit organizations (i.e. self-help groups, crisis lines) constitute the other component (Lefebvre, et al., 1998). Figure 6 demonstrates how mental health services for youth in Quebec are organized. The province of
Quebec is divided into 11 public health regions, which each possess a regional health and social services council (Corin & Hanois, 1991). Similar to elsewhere in Canada, when a youth makes a suicide attempt, since it is often a symptom of an underlying psychiatric disorder, the youth will access mental health services through their general practitioner, pediatrician, or school counselor. The youth access the same system of mental health services and mental health providers as everyone else who has mental health problems -- the organization of services is not suicide specific. Continuity of care between various services is often sought in the intervention and treatment of suicidal youth.

**Historical background**

In order to understand Quebec’s health care system, and especially when exploring cultural factors such as spirituality and religion in youth, it is important to briefly outline the province’s historical background to provide the context in which the youth in our study reside. Quebec as a province was closely aligned with the Roman Catholic Church during the nineteenth and twentieth century, and thus the Church as an institution provided the official educational and health services to French Canadians in the province (Groleau, Whitley, Lespérance, & Kirmayer, 2010). For much of its history, Quebec was largely unaffected by the secularizing tendencies that were taking place elsewhere in Canada and the Western World i.e. it was unaffected by the French Revolution (Groleau, et al., 2010). Quebec is unique to the rest of Canada as the only province where the Roman Catholic religion was historically so influential (Groleau et al., 2010). During the 1960s and 1970s public Roman Catholic religious practices and church
attendance dropped significantly in Quebec. The Roman Catholic Church also lost
much of its influence in hospitals, schools, politics, government and social
services with secularization (Corin & Harnois, 1991; Groleau et al., 2010). Since
these transformations of secularization occurred so “unexpectedly, almost
quietly”, this historical period is often referred to as La Révolution Tranquille or
The Quiet Revolution (Krull & Trovato, 1994). This pivotal point in Quebec’s
history has been associated with an increase in rates of completed suicide as well
as a downturn in religiosity (religious attendance) -- specifically for French
Canadians (Krull & Trovato, 1994). It is against this historical backdrop, in
combination with increased immigration and multiculturalism (specifically in
large urban centres like Montreal) resulting from globalization, that “reasonable
accommodation” of religious beliefs in health care settings has emerged
(Bouchard & Taylor, 2008).

Religion in Canada

According to the General Social Survey (conducted by Statistics Canada), from
1985 to 2005, the percentage of the Canadian population (excluding institutions)
attending religious services (a religious practice) on a regular basis declined. This
survey found that in 2005, 21% of Canadians 15 and older reported that they
attended a religious service at least once a week compared to 30% in 1985 (a 9%
decrease) (Lindsay, 2008). Simultaneously, the percentage of Canadians
indicating that they never attended religious services (one form of religious
practice) in the previous year increased (Lindsay, 2008). It was found that
between 1985 and 2000, the majority of Canadians attended religious services less
frequently than weekly, but at least once in the previous year (Lindsay, 2008).
The percentage attending less frequently than weekly declined only slightly for
15-24 year olds, from 55% to 51% between 1985 and 2005 (Lindsay, 2008).
Across Canada, 34% of Canadian youth between the ages of 15 and 29 indicated
that religion was of high importance to them in 2002 on the EDS (Clark and
Schellenberg, 2006). In 2005, 51% of youth aged 15-24 attended religious
services “less frequently,” 33% had never attended religious services, and 15.6%
attended at least once a week (Note: the category “less frequently” covers quite
the range of religious service attendance. It includes: at least once a month, a few
times a year, and at least once a year) (Lindsay, 2008).

This survey also found that older Canadians are more likely than younger
Canadians to attend religious services on a regular basis (Lindsay, 2008). Across
all Canadian age groups, a decline in weekly (at least) church (it is unclear
whether Christianity was the only world religion measured in these statistics)
attendance has been observed in the past two decades, with the proportion of the
Canadian population indicating that they never attended religious services has
increased in all age ranges (Lindsay, 2008). The substantial increase in the share
of the Canadian population reporting no religious affiliation between 1985 and
2005 is reflected, at least in part, by the decline in regular attendance at religious
services (Lindsay, 2008). However, even amongst Canadians reporting a
religious affiliation, attendance at religious services has declined (Lindsay, 2008).
In 2005, the proportion of the Canadian adult population (aged 15 and over)
reporting that their religious affiliation was agnostic, atheist, humanist, or that
they had no religion doubled (it increased to 22% as compared to 11% in 1985) (Lindsay, 2008). In terms of trends pertaining to religious beliefs and practices in psychiatry, Canadian psychiatrists are less likely to be religious than their patients (Baetz, Griffin, Bowen, & Marcoux, 2004).

Some people argue against the assertion that the “demise of religion” in Canada has been a predictable decline, arguing that people’s spiritual needs continue to exist (Clark & Schellenberg, 2006). Although public religious behaviour, religious affiliation, and attendance have been declining among much of the Canadian population, this captures only one aspect of peoples’ religiosity (Clark & Schellenberg, 2006). For example, despite some Canadians having little or no connection with religious organizations, according to the 2002 Ethnic Diversity Survey (EDS), some Canadians do engage in private religious behaviour: at home or in other locations (Clark and Schellenberg, 2006). The EDS also found that, in 2002, 27% of Canadians between the ages of 15 and 29 who never attended religious services engaged in personal religious activities (Clark & Schellenberg, 2006). Furthermore, the EDS also found that, in 2002, 32% of 15 to 29 year olds engaged in religious practices (i.e. prayer, meditation, worship and reading of sacred texts) on their own on a weekly basis (Clark & Schellenberg, 2006). In addition, the public religious behaviours of immigrants and persons born in Canada are different, and there’s been a widening divergence observed since 1985 (but this divergence conceals heterogeneity in levels of religiosity in immigrants from different countries) (Clark & Schellenberg, 2006). In 2002, 44% of Canadians overall placed a high degree of importance of religion in their life (this
was associated with such variables as age, region of residence, immigration status and the frequency of public and private religious practices (Clark and Schellenberg, 2006).

**Religion in Quebec**

In Quebec, 43% of people living in the province engaged in religious practices on their own in 2002 (Clark & Schellenberg, 2006). Across all ages, 41% of people who live in Quebec indicated that religion was of high importance to them in 2002 on the Ethnic Diversity Survey (Clark and Schellenberg, 2006). According to data from the General Social Survey, in 1995 and 2004 Quebec had the largest proportion cross-provincially of Canadians who have a religious affiliation but do not attend religious services (this probably is attributable to the Quiet Revolution and identity in Quebec) (Clark and Schellenberg, 2006). Many factors influence the level of public religious practice (such as religious service attendance), including demographics (such as age), immigration patterns and the cultural history of the region (i.e. *La Revolution Tranquille* in Quebec) (Clark, 2003). Historically, the province of Quebec has been among the provinces with the lowest attendance rates (Clark, 2003). However, there are pockets of high religious attendance found in almost every province (Clark, 2003). Clearly, declining attendance rates do not reflect the fact that many Canadians (even youth) continue to practice their religion in private or do not attend services yet still attach a high degree of importance to religion in their life despite Canada’s secularization (Clark & Schellenberg, 2006). This demonstrates that deeply held religious beliefs and traditions might persist under the surface, resurfacing at key
points in the life trajectory of an individual or society (Groleau et al., 2010). Furthermore, religious and spiritual sensibilities may endure in apparently “secular populations” that were once characterized by intense religiosity, and whose identity was strongly linked to their religious affiliation (e.g. Quebec) (Groleau et al., 2010). The Canadian and Quebec context matters when conceptualizing and exploring cultural influences such as religion and spirituality in any population (Groleau et al., 2010).

*Importance for Suicidal Youth: Are Spirituality and Religion Risk or Protective Factors?*

Are youth who have made a suicide attempt, likely to have a spirituality or religion that is important to them? The evidence is mixed (as will be elaborated below), and most of the research has examined religiosity i.e. importance of religion, religious affiliation, adherence to religious beliefs, or religious involvement (measured by frequency of religious attendance, frequency of prayer, and degree of religious salience) and conflates spirituality with religion (Colucci & Martin, 2008; Gearing & Lizardi, 2009; Koenig, McCullough, & Larson, 2001; Rasic et al. 2009). Durkheim’s (1897/1951) investigations of the associations between suicide rates, religion, and social integration are among the early signs of academic interest in the social and cultural influences on suicidal behavior (Goldston et al. 2008). In addition, developmentally, adolescence may be a sensitive developmental period for spiritual and religious development characterized by spiritual exploration, conversion experiences, and making spiritual and religious commitments that may endure throughout the life span.
Adolescence may mark changes in youths’ faith in a broad sense as well as their identity, whether spiritual, religious, or non-religious (Fowler & Dell, 2004).

Religious affiliation, religious beliefs, and religious involvement are often inversely associated with a history of suicide attempts (Colucci & Martin, 2008; Gearing & Lizardi, 2009; Koenig et al. 2001). So it appears that religion may not be salient for youth who have made a suicide attempt. However, not all studies find inverse relationships (or any significant relationship) between religious involvement and suicide attempts (Koenig et al. 2001). In 1977, Marks and Haller found among adolescent psychiatric patients that girls with a history of suicide attempts attended church significantly less frequently as compared to nonsuicidal girls (in this study there was no difference observed amongst boys) (as cited in Koenig et al., 2001). Moreover, moral objections to suicide may mediate the association between religious affiliation (in general) and making a suicide attempt because it has been found that having few moral and religious objections to suicide is associated with an increased likelihood of having a lifetime history of suicide attempts (Dervic, Oquendo et al. 2004; Gearing & Lizardi, 2009). The American Academy of Child and Adolescent Psychiatry (AACAP) has suggested that religiosity might serve a protective function as an inhibitor against suicide if there is a strong taboo (see Figure 7). Currently, which aspects of religiosity and spirituality are protective against suicide needs to be further studied, because religious affiliation or simply attending church are not ‘necessary and sufficient’ conditions to prevent suicidal behavior (Colucci, 2008). One cross-cultural case-
control study found that organizational religiosity (frequency of religious attendance) yielded controversial results as to whether it was protective against suicide attempts, whereas subjective religiosity (when a person considers themselves religious) may confer protection against making a suicide attempt in some countries (e.g. Brazil, Estonia, the Islamic Republic of Iran, and Sri Lanka) (Sisask et al., 2010).

Religiosity has been shown to be associated with lower levels of aggression and hostility, drug use, and risky sexual activity, which are related to suicidal behavior (Cotton et al. 2006; Gearing & Lizardi, 2009; Renaud et al. 2008). There has often been a link made between religion and depression disorders (most clearly amongst adults – the research amongst youth has been mixed) (Dew et al., 2010). In a review conducted by Dew and colleagues (2008), the authors concluded that most studies reported conflicting results i.e. some comparisons demonstrated that religiousness related to lower levels of depression (as found amongst adults) but some studies showed no relationship. Furthermore, of the 21 studies Dew and colleagues reviewed (2008), four found religious variables (such as self reported importance of religion) and church attendance correlated with higher levels of depression. In a prospective study with depressed youth Dew and colleagues (2010) argued for a more complex understanding of the relationship between depression and religiousness, finding not all religious beliefs and experiences corresponding with better mental health. Furthermore, a Canadian survey suggests that social support is a key mediator because identifying oneself as spiritual and religious attendance were each associated with decreased odds of
making a suicide attempt (in both the general population and amongst people with mental illness) however identifying oneself as spiritual only was not significant after taking social supports into consideration (Rasic et al., 2009). However, spirituality may be an important coping strategy for these youth because in a recent U.S. study it was found that amongst the coping strategies used by people with a history of suicidal thoughts and/or attempts, spirituality ranked first and using the mental health system ranked fourth (Alexander et al. 2009). Research suggests that only certain aspects of religiosity (e.g., importance of religion) or some spiritual variables (e.g., sense of connectedness or coherence) might be associated with suicidal behaviour (Colucci & Martin, 2008). Research regarding religion/spirituality in youth, requires more exploratory studies to further this understanding (Cotton et al., 2006).

Models of Mental Health Service Utilization

In considering the potential role that spirituality and religion can have on mental health service utilization, it is important to conceptualize mental health service utilization and theoretical models help to serve this purpose. There are many models of mental health service utilization, but according to a summary by Pescosolido and Boyer (1999), the dominant traditional theories of help seeking behaviour are the sociobehavioral model (SBM) (Andersen 1968; Andersen & Newman 1973; Andersen 1995), the health belief model (HBM) (Rosenstock 1966; Eraker, Kirscht, & Becker, 1984) and the theory of reasoned action (TRA) (Ajzen & Fishbein, 1980). All of these models fall under the health services utilization perspective, but it is also worth mentioning that there is a socio-legal
perspective, which focuses on legal coercion into services (Pescosolido, Brooks Gardner, & Lubell, 1998). More dynamic, process oriented models developed later, such as the help-seeking decision-making model (HDM) (Goldsmith, Jackson, & Hough, 1988) and the network episode model (NEM) (Pescosolido 1991, 1992). All of these models were developed on the basis that social correlates -- gender, cultural background, age, and social class -- although strong and consistent predictors of outpatient mental health care utilization, are not sufficient to provide a complex picture of service use (Pescosolido & Boyer, 1999).

The preceding models are based on adults, so adaptations have been developed to address the particular situation of children and adolescents’ help-seeking: the Children’s Health Belief Model (Bush & Iannotti, 1990), a family network-based model (Costello, Pescosolido, Angold & Burns, 1998) the Gateway Provider Model (GPM) (Stiffman, Pescosolido, & Cabassa, 2004) and the Parent-mediated pathway to mental health services for adolescents (Logan & King (2001) for example. There also have been adaptations made of more qualitative, inductive attempts to understand help-seeking amongst youth based on youths’ narratives of their illness experiences i.e. the McGill Illness Narrative Interview (MINI) (Groleau, Young & Kirmayer, 2006) as adapted for children and youth by St-Arnaud (2009). The adapted models take into consideration that there are unique challenges in studying youths’ trajectories of mental health service utilization.

These challenges include structural challenges such as the fact that the mental health care system for youth is complex and fragmented with multiple entry
points (Owens et al., 2002). On the other hand, developmentally, adolescents (compared to children) have more independence over their decision to seek mental health services, may have access to more avenues for help (i.e. their parents do not necessarily have to be aware of their distress), and they may be more successful at resisting others’ attempts to convince them to seek help if they do not wish to receive services (Logan & King, 2001). On the other hand, because youth are minors (below the age of 18), guardian permission is needed to access many services (Stiffman et al., 2004). Furthermore, youth (more so than adults) may need the advice, encouragement, and guidance of others in their social network (informal gateway providers such as parents) in order to seek services (Stiffman et al., 2004). Many of the traditional models i.e. the SBM, HBM, and TRA, assumed that the underlying mechanism of service usage is both a rational and voluntary choice, which may not necessarily be the case for people of all ages (Kleinman, 1980; Pescosolido, 1992; Young, 1982). Finally, although it is not a unique challenge to youth, it is worth mentioning that the stigma that surrounds mental illness and mental health service utilization can result in denial of mental health problems and a reluctance to use services (Owens et al., 2002). Studying the complex trajectories of youth is no easy task.

Religion’s Impact on Pathways to Mental Health Services

Religion, as one aspect of culture, can affect the perception of mental illness and the stages of help-seeking behaviors, and the consequent pathways, which may or may not include the utilization of mental health services for prevention or treatment of suicidal behaviors (Boenhlein, 2006; Goldston et al., 2008). Religion
can influence youths’ actual need, perceived need and/or benefit, access, availability, and motivation to seek mental health services (Koenig, McCullough, & Larson, 2001; see Figure 8). The theoretical model in Figure 8 also acknowledges that not only religion on the personal level (i.e. beliefs and practices) but on the community level (i.e. social support) can affect various aspects in relation to mental health service use. However, it doesn’t acknowledge the possibility that there may be service providers within the religious community. Religion can affect the determinants of mental health service use directly or indirectly (by promoting beliefs that encourage or discourage service use or by affecting persons’ psychosocial resources for example) and can thereby increase or decrease the amount and cost of services used (Koenig, McCullough, & Larson, 2001). Religious communities can be a dynamic social support system, provide meaning, and may offer surveillance and detection of mental health problems in addition to integrative and regulative aspects (Koenig, et al., 2001; Pescosolido, & Georgianna, 1989; Pescosolido & Boyer, 1999). In specific ethnic groups, religion has been found to be a gateway to healing (Ellis et al., 2010), that spirituality can be an influence on health care seeking (Figueroa, Davis, Baker, & Bunch, 2006) and that religious leaders can act as a bridge, provider, or “barrier” to mental health care (Neighbors, Musick, & Williams, 1998). Deciding to receive services is rarely made alone, but affected by youths’ parents, peers, teachers, the police, and/or community groups including religious ones (Ellis et al., 2010; Koenig, McCullough, & Larson, 2001; Logan & King,
Finally, it has been reported that many individuals and families are seeking assistance from traditional healers or from their faith communities alongside mental health services (Goldston, et al., 2008). Regardless of whether problems are understood to be ‘spiritual’ in nature, religious leaders may be viewed as trusted sources of help within the community and more accessible than other helpers (Ellis et al. 2010). These lay individuals’ knowledge and awareness of services and assessment of the youth’s problems (including risk for suicide) are essential as to whether services will be recommended for these at-risk youth (Stifman, et al., 2004). It is important that the impact of adults in the help-seeking pathway for youth at-risk for suicide be understood (Ellis et al. 2010). Their actions can range from referral, consultation, and liaison – all of which qualify as quality care for these youth provided that these youth receive mental health services (Stifman, et al., 2004). Therefore, partnership with faith communities may provide many opportunities for suicide prevention activities within a culturally acceptable context as religious professionals and institutions may be untapped resources for clinical care for youths and their families (Goldston et al. 2008; Dell, 2004).

**Rationale**

Youth suicide attempters are at high-risk for suicide. Many have untreated mental disorders and are not receiving services. Therefore, it is crucial to understand potential influences associated with their service use. Spirituality and/or religion
are one cultural influence in youths’ mental health service trajectories. The
following study explored youths’ experiences of spirituality and religion as it
relates to their help-seeking the year before their suicide attempt.

**Research Question and Objectives**

In the year before a youth’s suicide attempt (the index period), what was the role
of spirituality and religion in their help-seeking trajectories of mental health
service utilization?

Using a semi-structured interview containing open-ended questions which were
adapted from Maugans’ (1996) “SPIRITual History” and a questionnaire (the
“Spirituality Scale”: Delaney, 2005) which measures non-religious spirituality, we
would like to explore and provide a description of spirituality and religion in
youths’ trajectories of mental health services in the index period. A better
understanding of the range of possible experiences of these youth can provide the
basis for recommendations for mental health service providers, policy makers,
service delivery, and suicide prevention efforts. This study is also an important
first step in generating hypotheses that can be tested in larger epidemiological
samples.
Figure 1: Rates of deaths by suicide according to age group for males in Quebec between 1981 and 2007.

Taux de mortalité par suicide selon les groupes d’âge, hommes, ensemble du Québec, 1981 à 2007\(^1\)\(^2\)

\(^1\) Moyennes mobiles calculées sur des périodes de trois ans.
\(^2\) Données provisionnelles pour les années 2006 et 2007.

MSSS, Perspectives démographiques basées sur le recensement de 2001.
Figure 2: Rates of deaths by suicide according to age group for females in Quebec between 1981 and 2007.

Taux de mortalité par suicide selon les groupes d’âge, femmes, ensemble du Québec, 1981 à 2007\textsuperscript{1,2}

\textsuperscript{1} Moyennes mobiles calculées sur des périodes de trois ans.

\textsuperscript{2} Données provisionnelles pour les années 2006 et 2007.

Figure 3: Provincial rates of deaths by suicide across Canada, 2006.

Rates by provinces (2006):
http://www.inspq.qc.ca/Santescope/element.asp?NoEle=64
Figure 4: Proportion of the population, aged 15 and older, who have made a suicide attempt in a 12 month period according to certain sociodemographic characteristics, Quebec, 2005.

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<td>Marié/union libre</td>
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<td>Veuf/séparé/divorcé/célibataire, jamais marié</td>
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1. La population de référence exclut les personnes ayant eu uniquement des idées suicidaires sérieuses au cours d’une période de 12 mois.

a. Le test d’association entre les tentatives de suicide et cette variable n’est pas significatif au seuil de 5 %.

* Coefficient de variation entre 15 % et 25 %; interpréter avec prudence.

** Coefficient de variation supérieur à 25%; estimation imprécise fournie à titre indicatif seulement.

– Taille de l’échantillon trop petite, risque de divulgation.

Source : Statistique Canada, Enquête sur la santé dans les collectivités canadiennes, cycle 3.1, fichier de partage 2005.

Compilation : Institut de la statistique du Québec.
Figure 5: The traditional-historical (left) versus the modern version (right) of spirituality

(Source: Koenig, 2008)
Figure 6: Organizational chart of child mental health services in Quebec

(Source: Breton, Plante, & St-Georges, 2005)
Figure 7: AACAP model of protective factors against making a suicide attempt/completing suicide

(Source: American Academy of Child & Adolescent Psychiatry (AACAP), 2001a)
Figure 8: A theoretical model demonstrating how religion may impact service utilization

(Source: Koenig, McCullough, & Larson, 2001)
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youths aged 13 through 24 years who have made serious suicide attempts. 


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SPIRITUALITY AND RELIGION IN YOUTH SUICIDE ATTEMPTERS’ MENTAL HEALTH SERVICE UTILIZATION TRAJECTORIES: A QUALITATIVE STUDY

Marie Bullock, BA1; Lucie Nadeau, MD, MSc, FRCP(C)2; Johanne Renaud, MD, MSc, FRCP(C)3

1 Masters Candidate, McGill University, Montreal, Quebec; McGill Group for Suicide Studies, Douglas Mental Health University Institute, Verdun, Quebec.

2 Assistant Professor, Department of Psychiatry, McGill University, Montreal, Quebec; Child psychiatrist, McGill University Health Center and Jewish General Hospital, Montreal, Quebec

3 Associate Professor, Department of Psychiatry, McGill University, Montreal, Quebec; Child psychiatrist, McGill Group for Suicide Studies, Douglas Mental Health University Institute, Montreal, Quebec.

Address for correspondence: Dr. Johanne Renaud, McGill Group for Suicide Studies, Douglas Mental Health University Institute, 6875 LaSalle Blvd, FBC-3 Pavilion, Rm. 3113-1, Montreal, QC, H4H 1R3. Ph.: +1 514 761.6131 ext.: 3318 Fax: +1 514 888.4466 Email: johanne.renaud@douglas.mcgill.ca

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Abstract

Objective: Youth suicide attempters are high-risk for suicide. Many have untreated mental disorders and are not receiving services. It is crucial to understand potential influences associated with service use. Spirituality/religion are one influence in youths’ mental health service trajectories. This study explored youths’ experiences of spirituality/religion as it relates to their help-seeking the year before their suicide attempt. Method: 15 youth (aged 14-18) who made a suicide attempt(s) 1 to 2 years prior were consecutively recruited through the Depressive Disorders Program of a psychiatric hospital and interviewed using a mixed-methods design, including an adapted psychological autopsy method. Results: Three themes emerged: religious community members acted as a bridge, step, or provider to mental health services; religious/spiritual discourses were encountered within services; and many youths reported changes in spirituality/religious beliefs the year before their suicide attempt. Conclusions: Spirituality/religion can have a role in these youths’ service trajectories. How this confers protection or challenges needs to be clarified. Our findings can inform policies supporting training religious leaders about suicide intervention to foster coordination with mental health services, and service-providers in judiciously approaching spiritual/religious themes in suicide prevention. Key Words: spirituality/religion, youth suicide attempt, mental health services, qualitative
Introduction

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

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

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

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

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

**Methods**

This study is a mixed-methods part of an ongoing psychological autopsy study examining the service trajectories of youth suicide attempters. This study adopted
the same recruitment site/strategies: youths were consecutively recruited from the Depressive Disorders Program of the Douglas Mental Health University Institute (DMHUI) where they had been referred for services. 15 out of 16 youths approached about the study agreed to participate (a 94% response rate). Audio-recorded interviews using open ended questions and one questionnaire with youths (aged 14-18) having made a suicide attempt (a potentially self-injurious act committed with at least some wish to die, as a result of act) (Oquendo et al., 2003), one to two years before the interview, were conducted November 2009 to September 2010. Interviews conducted by the first author (English interviews) and a research assistant (French interviews) took thirty minutes of the psychological autopsy study 3-hour interview at the DMHUI. Youths were predominantly female, alike usual sampling in such studies where females are overrepresented in suicide attempts and seeking services (Renaud, 2009). Written informed consent was obtained from both youth and parents. The Douglas Research Ethics Board approved this study.

The semi-structured interview on spirituality/religion consisted of 9 questions developed for the study. Questions regarding the youths’ definition(s) of spirituality/religion and their integration within a spiritual or religious community were adapted from Maugans’ (1996) SPIRITual History. Most questions were retrospective, focusing on the index period to explore the role spirituality/religion had in the youths’ trajectories of mental health service utilization (Appendix).

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

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

Description of the sample (Table 1) was provided through: (1) The Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (Kaufman, 1996) and the Structured Clinical Interview for DSM-IV Axis II (SCID II) (First et al., 1996; 2001) for retrospective psychopathology (these instruments demonstrate adequate to excellent reliability (0.77 to 0.94 kappa value) (Kaufman et al., 1997; Lobbestael et al., 2011)), (2) the psychological autopsy study for suicide attempt history, socio-demographics, and the mixed-methods component.
Half of the youth had a current depressive disorder in the index period, one-third met criteria for a Cluster B personality disorder; 60% had 1 lifetime suicide attempt, 40% had multiple attempts. Youths were predominantly Euro-Canadian and from Christian (Catholic, Protestant, or Orthodox) backgrounds. All were Canadian with heterogeneous ethnicities (i.e. mixed European, Aboriginal). One youth was a 2nd generation migrant (no new migrants).

Results

Three themes emerged from analysis: 1) religious community members’ role in youths’ trajectories 2) religious/spiritual discourses within services 3) changes in spirituality/religious beliefs during the index period. Quantitative results from the SS will be corroborated specifically with the third theme.

Religious Community Members’ Role in Youths’ Trajectories

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

Bridge

“…there’s a woman at the church who is a psychologist and I went to her ‘cause I knew she was like that and so I-I talked to her like once or twice and then she recommended like ‘go to [a psychiatric hospital]’ so actually it really did help me out a lot and so she gave me like an ‘in’ sort of thing.” (Female, age 16)

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1 The gender and age of the youth was included in response to one of the Examiner's comments. It does not appear in the version of the manuscript that was accepted for publication.
The quote highlights how religious community members can be a bridge for youths to receive services, especially if they know members with mental health expertise.

*Step*

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

“…My whole life, like if ever I had a problem or I was sad it was always a Christian person that I went to see. And I was like, I want to see a *real* person who will underst- who *knows* about this so yeah. Then I was like ‘kay get me a real therapist’.” (Female, age 15)

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

*Care Provider*

The previous theme suggests religious community members can act as mental health care providers. Care received from members of religious communities coincided with, and was perhaps an adjunct to, mental health services.
“…like if you had a problem like she [the Church youth leader] would come in and bring you out, bring you out for coffee or whatever. […] whenever anything happens y’know she knows right away. So she’ll come pick you up after school and bring you out for coffee.” (Female, age 16)

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

“Well they [parents] didn’t want to pay. I mean that’s understandable they don’t have the money for me to talk for an hour so, like the only reason that people who are Christian would do it for free is because they know us.” (Female, age 15)

Religious/Spiritual Discourses in Services

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

“I’ve been in the hospitals and I’ve had sitters [orderlies] like say like ‘Oh yeah you need a Bible and stuff’ and I’ll get really offended… Like if, if I thought I needed one y’know I would have one…In my group home the people were really really Christian. They wanted me to go to church in the morning with them and stuff… And they would talk a lot about the Bible and stuff and it was just like…” (Female, age 16)
Results suggest that religion/spirituality are sensitive topics during therapy, yet important:

“Umm, well I remember the psychologist I was seeing at the time umm sometimes went back to like a more Christian theme kind of thing and he talked about his own spirituality and then asked me about mine and how it related to Christianity but and that pretty much annoyed me[…] it made me feel kind’ve uncomfortable […]I think that actually discussing spirituality with kids is really important and I-I remember um like the psychologist he’d, he’d kind’ve barely talked about it he more talked about like God in general and he didn’t really talked about what I thought of, …I think it’s important for kids to talk about what they believe in because if they don’t believe in anything then that tends to mean that they’re kind’ve a little bitter or angry or it’s kind’ve maybe a sign that something’s going and if they do have beliefs then maybe try to work with that y’know?” (Female, age 16)

*Changes in Spirituality/Religious Beliefs during Index Period*

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

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

(Male, age 15)
“No I wasn’t really in tune with anything at that time. I used to when I was younger, and ever since I got depressed and all.” (Female, age 15)

“It’s not more so that the religion affected it, it was more the mental health affected the religion aspect of my life it’s that I just wanted to avoid everything and push it out of my life and so it’s pretty much just the opposite way.” (Male, age 15)

Exceptions were:

“Yes, I was going to church, I was singing in the choir, Sunday if I didn’t want to I didn’t go to Mass, but my spirituality was there.” (Female, age 18)

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

“Well spirituality, what I believe it is now, was always important to me. Like your soul like you. But like I’ve never well, I used to have to go to church, but I hated it. Umm so. Yeah no religion. But spirituality I guess you could say so.” (Female, age 15)

Another youth denied having a spirituality that was important in the index period, but they had core beliefs about human nature:
“...well it wasn’t like a spirituality it was more like a basis? That everyone was
created good? Like and people were inherently good and that the evil things that
happen were like were by people who just weren’t right y’know what I mean?
Like no sane people could do that but as far as God went I was kind’ve just
pushing that away at the time.” (Female, age 16)

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

“...I already had like a religious ‘trip’, Catholic, because I thought I was trying to
find answers to my questions, in the end it didn’t answer my questions.” (Female,
age 18)

Discussion

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

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

Quebec is unique to the rest of Canada as the only province where the Roman Catholic religion was historically so influential (Groleau et al., 2010). During the 1960s and 1970s formal Roman Catholic religious practices and church attendance dropped significantly in Quebec. This Church also lost much of its influence in hospitals, schools, politics, government and social services with secularization (Corin & Harnois, 1991; Groleau et al., 2010). Yet, religious/spiritual sensibilities may endure in apparently “secular populations” once characterized by intense religiosity, and whose identity was linked to religious affiliation (e.g. Quebec) (Groleau et al., 2010).

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

Youths reported different levels of spirituality/religion in the index period: e.g. some engaged in religious practice, a period of religious questioning, and endorsing spirituality but not religion for that time period; some attributed a decline in their spirituality/religiosity to the presence of symptomatology (Colucci & Martin, 2008). It needs to be put in perspective with the presence of depressive disorder, substance abuse, impulsive traits, number of suicide attempts, as well as social support and family discord (Dew et al., 2010). The themes highlight the complexity of this area and these youths’ diverse experiences.
This study has limitations: (1) it is based on accounts from youths’ perspectives only. Parents’, service providers’, and members of religious communities’ views would provide a more comprehensive picture. (2) This clinical sample cannot be generalized to a community sample.

**Conclusion**

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

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

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

The authors extend appreciation to the youth study participants and to Richard Violette for assistance with French interviews. The first author received financial support from the Canadian Institutes of Health Research, McGill Provost’s Graduate Fellowship, Robert C. Paterson Graduate Research Award, Alexander McFee Fellowship. The final author’s psychological autopsy study, received financial support from the National Alliance for Research on Schizophrenia and Affective Disorders (NARSAD) and the Canadian Institutes of Health Research. The authors do not have any conflicts of interest to report.
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Retrieved from:


### Tables and Figures

**Table 1**
Socio-demographic and clinical characteristics of youths

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>13</td>
<td>87</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Number of Suicide Attempts (SAs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index SA only</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td>One + index attempt</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Two + index attempt</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Three + index attempt</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Age at index SA (mean ± SD) (years)</td>
<td>15.2 ± 1.4</td>
<td></td>
</tr>
<tr>
<td>Time of interview after index SA (mean ± SD) (months)</td>
<td>11.4 ± 9.3</td>
<td></td>
</tr>
<tr>
<td>Psychopathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis I (index period)a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>8</td>
<td>53</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Cannabis Abuse</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Axis II personality disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cluster A</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cluster B</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Cluster C</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No pathological traits</td>
<td>10</td>
<td>67</td>
</tr>
<tr>
<td>Family religious background (according to youth)b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>8</td>
<td>53</td>
</tr>
<tr>
<td>Protestant</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Orthodox</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Hindu</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Aboriginal spirituality</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Mixed religions (2 religions)</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Mixed non-religious and religious c</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>20</td>
</tr>
</tbody>
</table>

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

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

*c Where one parent has religious beliefs/practices and the other doesn’t

* [INSERT TABLE 1 AFTER LAST PARAGRAPH IN METHODS SECTION]*
### Table 2
Spirituality Scale (SS) total scores distribution of 14 youths

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS—23 items (M±SD points)</td>
<td>71±15.2, range 47 to 99</td>
<td></td>
</tr>
<tr>
<td>SS cut-off range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 - 60, very low spirituality</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>61 - 91, low spirituality</td>
<td>9</td>
<td>64</td>
</tr>
<tr>
<td>92 - 117, moderate spirituality</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>118 - 138, high levels of spirituality</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*a Missing data for 1 youth

*b Used by Delaney (2005)

*INSERT TABLE 2 AFTER ‘Changes in Spirituality/Religious Beliefs during Index Period’ SUBHEADING IN RESULTS SECTION*
Appendix: Semi-structured interview guide*

1) What does “spirituality” mean for you? What does “religion” mean for you?

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

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

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

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

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

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

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

4 a) Did this group or community, provide help or advice in dealing with mental health issues*? (Y/N)

What was their opinion about receiving mental health services?

Did this affect your attitude about mental health services? (Y/N)

Did it impact your willingness to use services? (Y/N)

4 b) Did your spirituality or religion provide guidance in dealing with mental health issues? (Y/N)

What was your opinion about receiving mental health services?

Did your spirituality or religion affect your attitude about mental health services? (Y/N)

Did it impact your willingness to use services? (Y/N)

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

(If YES) Do you believe in the same spirituality or religion as your parent(s)? (Y/N)
(If NO), Did this bring about any difficulties? (i.e. Did it impact your willingness to share what’s bothering you with your parents? Did it impact your desire to use services?) (Y/N)

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

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

(If YES) What happened?

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

(If YES) What happened?

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

*Also available in French
CHAPTER 3: DISCUSSION
Summary of Key Findings

Our study results point to the potential role of spiritual or religious aspects in mental health service trajectories the year before a youth’s suicide attempt (the index period). Three main themes emerged which we will elaborate on below. The themes highlight the complexity of this area and these youths’ diverse experiences.

Religious community members may have key roles for some youth’s trajectories, as a bridge as well as an adjunct to services. Regardless of where youths stood in their spiritual/religious beliefs and practices, some encountered religious community members on their own initiative, others because of their parents. And for some, mental health services might not have been considered as an option by youths or their parents during the index period, especially if underlying mental health issues are not recognized by the youth or their parents.

The contributions of religious community members do not mean their actions are embedded in religious discourses, but demonstrate the importance of belonging for many families (Dell, 2004; Pescosolido, Brooks Gardner, & Lubell, 1998; Pescosolido & Boyer, 1999). Parents and members of religious communities acted as gatekeepers to mental health care. This makes sense in light of the Gateway Provider Model proposed by Stiffman, Pescosolido, and Cabassa (2004) in which social support systems and the potential role of members of religious communities as one avenue of social support are acknowledged in health care seeking. The results offer an opportunity to understand how different roles of religious
community members (bridge, step, or care provider patterns), similarly to the findings of Neighbors and colleagues (1998), may be found within a clinical youth suicide attempter sample. Suicide prevention efforts should include, when appropriate, an increase in collaboration with religious communities as they are potentially a resource where people will seek mental health support (Dell, 2004). This can include consulting with religious leaders, showing openness to complementary care between religious/spiritual and mental health care, as well as educating religious leaders/members of spiritual communities about suicide warning signs to foster referrals from such communities. Religious communities may offer surveillance and detection of mental health problems in addition to integrative and regulative aspects (Koenig, McCullough, & Larson, 2001; Pescosolido & Giorgianna, 1989).

Accounts from the youth of the topic of religion, in various stages of their trajectories within mental health services, contrast with the Quebec context of the secularization of health services (as comparable to the rest of Canada) (Clark & Schellenberg, 2006; Corin & Harnois, 1991; Groleau et al., 2010; Krull & Trovato, 1994), and the observed low religiousness of Canadian health professionals (Baetz, Griffín, Bowen, & Marcoux, 2004). Without taking youths’ own religious beliefs and practices into consideration, it is difficult to ascertain how overt expressions of religion will be received. Responses may range from reassurance and support to indifference and discomfort.

It is important to bear in mind that these service providers work with a difficult population -- youth at risk for suicide. Spirituality and religion, as one aspect of
culture, is a frame that gives meaning (about life and death). As adolescence may be a sensitive developmental period for spiritual and religious development (Good & Willoughby, 2008), clinicians might consider exploring these issues, but maintain a balanced stance in order to avoid the imposition of their values (American Psychiatric Association [APA], 1990; Baetz & Toews, 2009). To uncover reasons for living, including religious beliefs, is crucial in suicide prevention (APA, 1990). Spirituality/religion are not inherently positive or negative: one must clarify their meaning for youths and the role they take within their relationship to significant people (parents and others) to understand their potential protective aspects as well as any associated challenges (AACAP, 2001; Colucci & Martin, 2008; Dervic et al., 2004; Josephson, 2004; Koenig, 2009; Sisask et al., 2010).

In sum, suicidal behavior and help-seeking occur in a cultural context and are likely associated with different precipitating factors, different vulnerability and protective factors, differing reactions to and interpretations of the behavior, and different resources and options for help-seeking. Awareness of the interface of culture, adolescent suicidal behavior, and help-seeking is essential for culturally competent professionals and an important step en route to the development of effective culturally sensitive interventions to reduce suicidal behaviors (Goldston et al., 2008, p. 16).

The cultural and social contexts of mental health service utilization for youth at risk of suicide and their families need to be recognized. This study has highlighted how ‘continuity’ can no longer be thought of as merely a function of a person circulating within a world of services, but as a function of the person and his/her world; and the point may be to know how to participate in the restoration of this personal continuity at the level of the life course (Corin & Hanois, 1991). Our
results show that youth may circulate within the world of religious communities in addition to, or instead of, mental health services and this aspect may need to be considered in the youths’ trajectories of care and rehabilitation and may change with time. By focusing on spirituality and religion, this study has drawn attention to a specific aspect of youths’ social supports and social networks.

It is important to remember there are many points of entry for youth suicide attempters to access mental health services (the education sector, specialty mental health sector, juvenile justice) (Farmer, et. al., 2003). Furthermore, youths may receive mental health care outside the mental health sector. Considering the different entry points into mental health care that youth may adopt, it is interesting that it was found that religious or spiritual individuals and/or communities are a point of entry for youth who have attempted suicide.

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

Strengths

There are several strengths to this study. By using a semi-structured interview with open-ended questions, this study offers an in-depth and rich understanding of
the diverse experience of these youth. Furthermore, this study obtained the perspectives of youth who have attempted suicide thus giving them a voice. This study used a clinical sample, thus a high-risk population of youth was accessed.

The mixed-methods approach (the semi-structured interview in combination with the Spirituality Scale) provided a more comprehensive understanding of the experience of these youth. The quantitative scale confirmed what the youth were saying about different levels of spirituality (the qualitative data) in the index period (for the most part) as well as provided information about levels of non-religious spirituality, which to date, has been little examined. This study also may be one-of-a-kind in incorporating a mixed methods approach to an adaptation of the psychological autopsy to a population of youth who have attempted suicide. By examining cultural aspects such as spirituality and religion, this study highlighted the potential role of the social and cultural context as well as social networks in religious communities in youth suicide attempters’ help-seeking trajectories. This exploratory, mixed-methods study is hypothesis generating, and thus a good foundation for future research using quantitative approaches in larger epidemiological samples or case-control designs.

Limitations

There are several limitations in this study. This study is based on accounts from youths’ perspectives only. Therefore, in order to gain a more complete picture, it would be necessary to get the views of parents, service providers, and any involved members of religious communities. This clinical sample cannot be generalized to a community sample. This study offers an in-depth and rich
understanding of the experience of these youth; as expected this sample is
purposive and descriptive.

As with any retrospective study, recall bias cannot be ruled out. Although stable,
many of these youth suffered from a Axis I and/or Axis II disorder at the time of
interview so their mental disorder may have affected the tone of their self-reports.
Similarly, to some degree this study relied in part on an assumption that these
youth engaged in rational decision making in their help-seeking, which may have
been compromised by a current mood disorder or borderline personality disorder
as they are characterized by surges or deficits in affect.

Rapport and trust were necessary conditions for the interview process, however,
as with any interview study, the youth may have engaged in selective disclosure.
In addition, as is common with youth, they may have been ‘trivializing’ during the
interview process which may have affected their responses. ‘Trivializing,’
refers to the way in which children [and youth], at times, depending on the
company in which they find themselves [i.e. researchers and clinicians], seem
to prefer to dismiss that which is too awkward or difficult to speak about by
making light of, or trivializing, the subject. They displayed an outward façade
of complacency which served to mask or conceal their genuine values and
feelings, particularly in relation to those things that really mattered to them (de

However, despite this, all of the youth appeared comfortable with the subject
matter (spirituality, religion, the year before their suicide attempt) and readily
shared their views and experiences.
**Future Directions**

Service providers need to envisage how spirituality and religion are sensitive yet important themes for youth, and that the exploration of these themes needs to be timely and judicious to allow the expression of the youth’s position in relation to these topics. For example, it might be more appropriate to ask ‘how’ a person is religious rather than ‘whether’ a person is religious once the topic has been raised by the youth or, regardless of their spirituality or religiosity, whether religious community members are part of a youth’s social support network (Colucci, 2008; Pescosolido & Boyer, 1999). Our study highlights that youth might not always have a satisfying experience. Therefore, training within mental health services may be required for the various actors of the mental health care system i.e. orderlies in the Emergency Room, nurses, social workers, psychologists, psychiatrists in order to ensure that these topics are handled carefully with suicidal youth. Outreach approaches in the community such as gatekeeper training (including religious gatekeepers) and public awareness campaigns, represent an important avenue for identifying individuals with suicidal behaviours (Isaac, et al., 2009; Pagura, et al., 2009). Furthermore, psychiatrists and other service providers may need to exchange and collaborate with members of religious communities for collaboration in suicide prevention (Corin & Harnois, 1991; Lesage, 2005).

It has been observed that, probably one of the greatest risks encountered in Quebec and elsewhere is a growing gap between community intervention and psychiatry (Corin & Harnois, 1991). It is possible that religious communities are
well equipped to liaise with psychiatry (and “community follow up agents”) in that they have the time to explore questions related to life and death with suicidal youth. Perhaps this study calls into question the place that both religious and mental health care institutions occupy in the process of intervention and suicide prevention? (Corin & Harnois, 1991).

Research needs to be conducted to explore how aspects of spirituality and religion may become a protective or risk factor for youth suicide attempters and under what conditions for either trajectory in order to take advantage of the potential of spirituality/religiosity in suicide prevention strategies (Colucci, 2008).

In addition, an important area of inquiry is the degree to which informal or traditional sources of help within the community are effective in addressing suicide risk among youths, particularly given the fact that suicidal adolescents may be more comfortable speaking with lay helpers or native healers than talking about difficulties with strangers in unfamiliar settings. (Goldston et al. 2008, p. 26-27)

More research is needed to triangulate the youth’s representations with their parents’ and service providers’ views in order to provide a more nuanced portrayal of the interaction between all these individuals’ points of view around spirituality and religion to better indicate how, and if, intervention needs to address these issues. In addition, future research should explore how mental health services can integrate the themes of spirituality and religion to permit their expression while respecting the specific views of the youth. Our findings need to be replicated in a larger longitudinal sample to see if the same themes appear over time and to determine if there is an age effect. In accordance with the Network Episode Model (Pescosolido, 1991; 1992), it might be valuable to explore and
compare the patterns and pathways of spiritual and religious beliefs and practices and people consulted during the index period (and perhaps multiple index periods by youth who have made more than one suicide attempt) in order to map out the sequence of advisors, providers, and practices used by the youth and their families. This would include recruiting youth who have attempted suicide from other sites (i.e. schools, religious communities, youth centres, the juvenile justice sector). Furthermore, researchers will need to explore changes in youths’ spirituality and religion following a suicide attempt.

CONCLUSION

Despite the sensitivity of this topic and the youth’s mental health challenges, the youth willingly talked about their experience with spirituality and religion in the year before their suicide attempt, evoking spirituality and religion’s role in their service trajectories. Spirituality and religion can play a role in suicide attempters’ service trajectories: outside and within mental health services. Spiritual and religious topics and support networks should not be ignored in the assessment, treatment, and suicide prevention efforts of these youth.

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


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APPENDIX A: Consent Form

Research project entitled:
Patterns and Trajectories of Suicide Attempters in terms of the utilization of health care services

Researchers:

Dr. Johanne Renaud M.D. M.Sc. FRCPC
Dr. Monique Séguin Ph.D.
Dr. Alain D Lesage M.D. M.Phil.
Dr. Jean-Jacques Breton M.D. M.Sc.
Dr. Gustavo Turecki M.D. Ph.D.

Consent Form for Age of Consent Youth Participant

Research Ethics Board Douglas Hospital Research Centre
Approved: December 15th, 2009
1. **Request for Participation**

You have been invited to participate in a research project entitled: Patterns and Trajectories of Suicide Attempters in terms of the utilization of health care services.

2. **Name of Principal Researchers**

This study is under the direction of Dr. Johanne Renaud M.D. M.Sc. FRCPC, chief investigator and child psychiatrist at the Douglas Hospital Research Center, and Monique Séguy Ph.D., principal co-researcher and psychologist based at the Université du Québec en Outaouais, and their collaborators: Alain D. Lesage M.D. M.Phil., Jean-Jacques Breton M.D. MSc., and Gustavo Turecki M.D. Ph.D.

3. **Project Funding**

The research project is funded by the National Alliance for Research in Schizophrenia and Affective Disorders (NARSAD).

4. **Description and goals of research project**

The research project will encourage improved understanding of how individuals who attempt suicide differentiate themselves from those who have taken their own life in terms of unmet needs and trajectories of health service utilization in the twelve months preceding a suicide attempt; with a specific focus on protective factors, types of services used, frequency of use, and the collaboration of these services.

5. **Procedures**

Two interview meetings, with an approximate duration of 3 hours each, will be carried out with you following a suicide attempt. Preferably, the interviews will take place at the Douglas Hospital Research Centre, or alternatively, at your residence if you are unable to travel to the Hospital. Various interview instruments will be used to document the different health services consulted, the impact of protective factors, and to assess your mental health challenges.

6. **Advantages and Benefits**

There are no direct benefits or advantages related to your participation in this research project. However, we genuinely believe that this study will make important contributions to current knowledge concerning suicide among youth, adolescents and young adults.
Moreover, the study will be instrumental in improving health care services and intervention strategies for youth at risk of suicidal behaviours and their families.

7. Disadvantages and Risks

No physical risks are associated with your participation in this study. Some individuals may feel fatigue following the interviews. It is also possible that a number of painful memories and unpleasant emotions surface during the interview process. Consequently, your emotional state will be considered throughout the entire interview process in order to respect each individual’s rhythm of participation. The research assistants are health care professionals trained and qualified to assess the clinical state of the participants.

Furthermore, measures will be undertaken to assure complete participant confidentiality, as described in the confidentiality section of this consent form.

8. Withdrawal from Study

Please note that it is possible to withdraw from this study at any time. Should this be the case, all interview results will be destroyed. If you choose to withdraw participation, we request that you advise Dr. Johanne Renaud at the Douglas Hospital Research Centre.

9. Confidentiality

All information gathered and shared will be done so in a non-nominal fashion (ie. anonymously coded to ensure complete confidentiality of the participant). Only Dr. Johanne Renaud, chief investigator and psychiatrist in charge of the research project, and Marie-Martine Beaulieu, project coordinator, will have access to nominal or identifying information for the entire duration of the research project. This information will be kept under lock and key, completely separate from data gathered during the interview process. All results will be kept for a period not exceeding five years following the end of the study, at which point they will be destroyed. However, it is possible that members of the institutional ethics committee or of the funding agency (National Alliance for Research in Schizophrenia and Affective Disorders) consult the research data and/or nominal records of the participants in order to confirm the proper ethical and confidential management of the research project.

In addition, the results from this study may be published or shared within the framework of scientific congress, but no information allowing the identification of participants will be divulged.
10. Communication of the Results

The individual results of the interviews will not be shared, however, some of the general findings will be sent to you by the principal researcher Dr. Johanne Renaud by mail at the end of the study.

11. Responsibility

By signing this consent form, you are in no way renouncing any of your individual rights as proscribed by law. Furthermore, you are not liberating the researchers or the establishment of their civil and professional responsibilities.

12. Compensation

Compensation of 25$ is offered to cover the costs of your travel.

13. Freedom of participation

Your participation is completely free and voluntary. As such, any refusal or withdrawal from participation in the research project will have no negative consequences on the current and/or future relationship with the consulting doctor or any other health care provider.

14. Resource Persons

For any additional information concerning the research project, or if you would like to communicate any change of address, we invite you to correspond with the project coordinator, Marie-Martine Beaulieu at 514-323-7260 extension 3316, or alternatively at the toll free line 1-866-256-6888.

If you wish to discuss your participation in this research project with a person not directly involved with the project, or if you wish to file a complaint, we invite you to communicate with Francine Y. Bourassa (Ombudsman, Douglas Institute) at 514-761-6131 extension 3287.
15. **Consent**

The nature and procedures of the research project have been clearly explained to me. I have understood the content of the consent form and a copy has been handed to me. I have had sufficient time to ask questions, which were satisfactorily answered. Upon adequate reflection, I agree to participate in this research project.

Name of age of consent youth participant in block letters

Consent of youth participant ___________________________ Date ___________________

We remind you that there are two sets of consent forms which bear original signatures, one of which you may keep for your own records.

16. **Agreement of the Researcher**

This research project and its specific modalities for participation have been clearly described to the age of consent youth participant. A member of the research team has answered any questions and explained that participation is completely free and voluntary. I will respect the content and conditions as defined in this consent form.

Signature of Researcher ___________________________ Date ___________________

[Logo of Centre de Recherche in Douglas Hospital]
Audio Recording of Interviews

Consent Form

Within the framework of the aforementioned study: Patterns and Trajectories of Suicide Attempters in terms of the utilization of health care services, we are requesting your permission to make an audio recording of the interview process. These audio recordings will be made in order to assure accuracy of the information gathered.

These recordings will be treated in a confidential manner and will at no time identify you by name. You may withdraw participation in this study at any time. Should this be the case, all audio recordings will be retracted and destroyed. The audio recordings will be kept for a period not exceeding five years following the end of the study, at which point they will be destroyed.

 has explained to me the purpose of the audio recordings.

I have understood the content of this consent form and a copy has been handed to me. I have had sufficient time to ask questions, which were satisfactorily answered. Upon adequate reflection, I agree that audio recordings of the interviews be made.

__________________________
Name of age of consent youth participant in block letters

Consent of youth participant __________________________ Date __________

Agreement of the Researcher

This research project and its specific modalities for participation have been clearly described to the age of consent youth participant. A member of the research team has answered any questions and explained that participation is completely free and voluntary. I will respect the content and conditions as defined in this consent form.

__________________________
Signature of Researcher __________________________ Date __________
Research project entitled:
Patterns and Trajectories of Suicide Attempters in terms of the
utilization of health care services

Researchers:

Dr. Johanne Renaud M.D. M.Sc. FRCPC
Dr. Monique Séguin Ph.D.
Dr. Alain D Lesage M.D. M.Phil.
Dr. Jean-Jacques Breton M.D. M.Sc.
Dr. Gustavo Turecki M.D. Ph.D.

Consent Form for parent(s)/guardian(s) for the participation of their child

Research Ethics Board Douglas Hospital Research Centre
Approved: December 15th, 2009
1. **Request for Participation**

Your child is invited to participate in a research project entitled: Patterns and Trajectories of Suicide Attempters in terms of the utilization of health care services.

2. **Name of Principal Researchers**

This study is under the direction of Dr. Johanne Renaud M.D. M.Sc. FRCPC, chief investigator and child psychiatrist at the Douglas Hospital Research Center, and Monique Séguin Ph.D., principal co-researcher and psychologist based at the Université du Québec en Outaouais, and their collaborators: Alain D Lesage M.D. M.Phil., Jean-Jacques Breton M.D. MSc., and Gustavo Turecki M.D. Ph.D.

3. **Project Funding**

The research project is funded by the National Alliance for Research in Schizophrenia and Affective Disorders (NARSAD).

4. **Description and goals of research project**

The research project will encourage improved understanding of how individuals who attempt suicide differentiate themselves from those who have taken their own life in terms of unmet needs and trajectories of health service utilization in the twelve months preceding a suicide attempt; with a specific focus on protective factors, types of services used, frequency of use, and the collaboration of these services.

5. **Procedures**

Two interview meetings, with an approximate duration of 3 hours each, will be carried out with your child following a suicide attempt. Preferably, the interviews will take place at the Douglas Hospital Research Centre, or alternatively, at your residence if you are unable to travel to the Hospital. Various interview instruments will be used to document the different health services consulted, the impact of protective factors, and to assess your child's mental health challenges.

6. **Advantages and Benefits**

There are no direct benefits or advantages related to your child's participation in this research project. However, we genuinely believe that this study will make important contributions to current knowledge concerning suicide among youth, adolescents and
young adults. Moreover, the study will be instrumental in improving health care services and intervention strategies for youth at risk of suicidal behaviours and their families.

7. **Disadvantages and Risks**

No physical risks are associated with your child’s participation in this study. Some individuals may feel fatigue following the interviews. It is also possible that a number of painful memories and unpleasant emotions surface during the interview process. Consequently, the emotional state of the child and the parent(s)/guardian(s) will be considered throughout the entire interview process in order to respect each individual’s rhythm of participation. The research assistants are health care professionals trained and qualified to assess the clinical state of the participants.

Furthermore, measures will be undertaken to assure complete participant confidentiality, as described in the confidentiality section of this consent form.

8. **Withdrawal from Study**

Please note that it is possible to withdraw your child from this study at any time. Should this be the case, all interview results will be destroyed. If you choose to withdraw participation, we request that you advise Dr. Johanne Renaud at the Douglas Hospital Research Centre.

9. **Confidentiality**

All information gathered and shared will be done so in a non-nominal fashion (i.e. anonymously coded to ensure complete confidentiality of the participant). Only Dr. Johanne Renaud, chief investigator and psychiatrist in charge of the research project, and Marie-Martine Beaulieu, project coordinator, will have access to nominal or identifying information for the entire duration of the research project. This information will be kept under lock and key, completely separate from data gathered during the interview process. All results will be kept for a period not exceeding five years following the end of the study, at which point they will be destroyed. However, it is possible that members of the institutional ethics committee or of the funding agency (National Alliance for Research in Schizophrenia and Affective Disorders) consult the research data and/or nominal records of the participants in order to confirm the proper ethical and confidential management of the research project.

In addition, the results from this study may be published or shared within the framework of scientific congress, but no information allowing the identification of participants will be divulged.
10. Communication of the Results

The individual results of the interviews will not be shared, however, some of the general findings will be sent to you by the principal researcher Dr. Johanne Renaud by mail at the end of the study.

11. Responsibility

By signing this consent form, you are in no way renouncing any of your individual rights as proscribed by law. Furthermore, you are not liberating the researchers or the establishment of their civil and professional responsibilities.

12. Compensation

Compensation of 25$ is offered to cover the costs of your travel.

13. Freedom of participation

The participation of your child is completely free and voluntary. As such, any refusal or withdrawal from participation in the research project will have no negative consequences on the current and/or future relationship with the consulting doctor or any other health care provider.

14. Resource Persons

For any additional information concerning the research project, or if you would like to communicate any change of address, we invite you to correspond with the project coordinator, Marie-Martine Beaulieu at 514-323-7260 extension 3316, or alternatively at the toll free line 1-866-256-6888.

If you wish to discuss your child’s participation in this research project with a person not directly involved with the project, or if you wish to file a complaint, we invite you to communicate with Francine Y. Bourassa (Ombudsman, Douglas Institute) at 514-761-6131 extension 3287.
15. Consent

The nature and procedures of the research project have been clearly explained to me. I have understood the content of the consent form and a copy has been handed to me. I have had sufficient time to ask questions, which were satisfactorily answered. Upon adequate reflection, I agree that my child participates in this research project.

Name of adult/guardian of participant in block letters

Consent of adult/guardian ______________________________ Date

Name of child participating in project in block letters

Assent of child ______________________________ Date

We remind you that there are two sets of consent forms which bear original signatures, one of which you may keep for your own records.

16. Agreement of the Researcher

This research project and its specific modalities for child participation have been clearly described to the participant and the parent(s)/guardian(s). A member of the research team has answered any questions and explained that participation is completely free and voluntary. I will respect the content and conditions as defined in this consent form.

Signature of Researcher ______________________________ Date

[Image of the Centre de Recherche Hospital Douglas Research Centre]
Audio Recording of Interviews
Consent Form

Within the framework of the aforementioned study: Patterns and Trajectories of Suicide Attempters in terms of the utilization of health care services, we are requesting your permission to make an audio recording of the interview process. These audio recordings will be made in order to assure accuracy of the information gathered.

These recordings will be treated in a confidential manner and will at no time identify you or your child by name. You may withdraw participation in this study at any time. Should this be the case, all audio recordings will be retracted and destroyed. The audio recordings will be kept for a period not exceeding five years following the end of the study, at which point they will be destroyed.

has explained to me the purpose of the audio recordings. I have understood the content of this consent form and a copy has been handed to me. I have had sufficient time to ask questions, which were satisfactorily answered. Upon adequate reflection, I agree that audio recordings of the interviews be made.

_____________________________ Date
Name of adult/guardian of participant in block letters

_____________________________ Date
Consent of adult/guardian

_____________________________ Date
Name of child participating in project in block letters

_____________________________ Date
Assent of child

Agreement of the Researcher

This research project and its specific modalities for participation have been clearly described to the participant and the parent(s)/guardian(s). A member of the research team has answered any questions and explained that participation is completely free and voluntary. I will respect the content and conditions as defined in this consent form.

_____________________________ Date
Signature of Researcher
Projet de recherche intitulé :
Trajectoires et patrons d'utilisation de soins et de services de santé chez
des jeunes ayant fait une tentative de suicide.

Chercheurs :

Dre Johanne Renaud MD. M.Sc. FRCPC
Dre Monique Séguin Ph.D.
Dr Alain D Lesage M.D. M.Phil
Dr Jean-Jacques Breton M.D. MSc
Dr Gustavo Turecki M.D. Ph.D.

Formulaire de Consentement des Jeunes Majeurs

CÉR Hôpital Douglas
Approuvé : 15 Décembre, 2009
1. **Titre de l’étude**

Vous êtes invités à participer à un projet de recherche intitulé : Trajectoires et patrons d’utilisation de soins et de services de santé chez des jeunes ayant fait une tentative de suicide.

2. **Nom des chercheurs**

Cette étude est sous la responsabilité du Dr Johanne Renaud M.D. M.Sc. FRCPC, chercheur principal et pédopsychiatre travaillant au Centre de recherche de l’Hôpital Douglas et de Monique Séguin Ph.D., psychologue et co-chercheur principal travaillant à l’Université du Québec en Outaouais et de leurs collaborateurs: Alain D Lesage M.D. M.Phil., Jean-Jacques Breton M.D. MSc., et Gustavo Turecki M.D. Ph.D.

3. **Subvention au projet**

Le projet est financé par le National Alliance for Research in Schizophrenia and Affective Disorders (NARSAD).

4. **Description et but du projet**

Cette étude permettra de mieux établir en quoi les individus ayant fait une tentative de suicide se différencient de ceux qui se sont enlevés la vie en termes de besoins non comblés et de trajectoires d’utilisation de services de santé, dans les 12 mois précédant la tentative de suicide. Cette comparaison se fera en fonction du type de services utilisés, de la fréquence et de la collaboration aux services.

5. **Déroulement du projet**

Deux entrevues d’une durée approximative de 3 heures seront effectuées avec vous suite à une tentative de suicide. Les entrevues auront lieu de préférence à Centre de recherche de l’Hôpital Douglas ou à votre domicile si vous refusez de vous déplacer à l’hôpital. Les questionnaires porteront sur divers facteurs de protections, les différentes difficultés psychologiques que vous avez présentées et sur les services de santé consultés.

6. **Avantages et bénéfices**

Il n’y a aucun avantage ni bénéfice direct à votre participation à ce projet de recherche. Toutefois, nous croyons que cette étude québécoise contribuera à l’amélioration des connaissances concernant le suicide chez les jeunes et à l’amélioration des services et des interventions à promouvoir auprès des jeunes à risque de se suicider et de leur famille.
7. **Inconvénients et risques**

Certaines personnes ressentiront parfois une fatigue à la suite des entrevues. Il est possible que des souvenirs pénibles reviennent à votre mémoire pendant les entretiens. Des émotions désagréables peuvent apparaître. Par conséquent, votre état émotif sera pris en compte tout au long de l'entretien, afin de respecter votre rythme. Les assistantes de recherche sont des professionnelles de la santé formées et qualifiées pour juger de votre état clinique.

De plus, toutes les mesures requises afin d’assurer la confidentialité des participants seront prises tel que mentionné dans la section confidentialité.

8. **Retrait du projet**

Veuillez noter qu’en tout temps il vous est possible de vous retirer de l’étude, le cas échéant les résultats de l’entrevue seront détruits. Il vous sera possible de contacter Dr. Johanne Renaud au Centre de recherche de l'Hôpital Douglas à cette fin.

9. **Confidentialité**

Toutes les données recueillies et diffusées seront traitées de façon non nominale, c'est-à-dire codées, afin d’assurer la confidentialité. Seuls le Dr Johanne Renaud psychiatre responsable du projet et Mme Marie Martine Beaulieu coordonnatrice, auront accès aux informations nominales pendant le projet, qui seront gardées sous clé. Les résultats des investigations seront conservés dans le dossier de recherche pendant une durée de 5 ans après la fin de la recherche, puis détruits. Cependant, aux fins de vérifier la saine gestion de la recherche, il est possible qu’un délégué du comité d'éthique de la recherche ou de l'organisme subventionnaire (National Alliance for Research in Schizophrenia and Affective Disorders) consulte les données de recherche et le dossier médical du sujet à l'étude.

Par ailleurs, les résultats de cette étude pourront être publiés ou communiqués dans un congrès scientifique mais aucune information pouvant identifier les participants ne sera alors dévoilée.

10. **Communication des résultats**

Les résultats individuels aux tests ne seront pas communiqués. Les résultats généraux vous seront transmis par Dr Johanne Renaud par courrier à la fin de l'étude.

11. **Responsabilité**

En signant ce formulaire de consentement, vous ne renoncez à aucun de vos droits prévus par la loi et ne libérez ni les chercheurs ni l’établissement de leurs responsabilités civiles ou professionnelles.
12. **Indemnités**

Une indemnité de 25$ pour les frais de déplacement est donnée dans ce projet.

13. **Liberté de participation**

Votre participation est libre et volontaire. Cela signifie que le refus de participer à la recherche ne nuirait pas à vos relations avec votre médecin ou les autres intervenants.

14. **Personnes-ressources**

Pour toute information complémentaire concernant la progression du projet de recherche ou pour tout changement d’adresse, vous pouvez communiquer par téléphone avec le coordonnateur du projet de recherche, Madame Marie Martine Beaulieu au 514-761-6131 poste 3316, ou sur la ligne sans frais au 1-866-256-6888.

Si vous souhaitez discuter de votre participation à l’étude avec une personne qui n’est pas directement impliquée dans le projet de recherche ou formuler une plainte, nous vous invitons à communiquer avec Francine Y. Bourassa (Ombudsman, Institute Douglas) au 514-761-6131 poste 3287.
15. Consentement

On m’a expliqué la nature et le déroulement du projet de recherche. J’ai pris connaissance du formulaire de consentement et on m’en a remis un exemplaire. J’ai eu l’occasion de poser des questions auxquelles on a répondu. Après réflexion, j’accepte de participer à ce projet de recherche.

Nom du sujet majeur en lettres détachées

Consentement du sujet majeur ___________________________ Date ___________________________

Nous vous rappelons qu’il existe deux formulaires portant des signatures originales dont un vous est laissé pour vos dossiers.

16. Formule d’engagement du chercheur

Le projet de recherche a été décrit au participant ainsi que les modalités de sa participation. Un membre de l’équipe de recherche a répondu à ses questions et lui a expliqué que la participation est libre et volontaire. Je m’engage à respecter ce qui a été convenu dans le formulaire de consentement.

Signature du chercheur ___________________________ Date ___________________________

Centre de Recherche Hôpital Douglas Hospital Research Centre
Enregistrement de l'Entrevue
Formulaire de Consentement

Dans le cadre du projet de recherche : Trajectoires et patrons d'utilisation de soins et de services de santé chez des jeunes ayant fait une tentative de suicide, nous vous demandons la permission d'enregistrer le contenu de l'entrevue. Ces enregistrements audio seront effectués afin de soutenir la prise d'information.

L'enregistrement sera traité de façon à préservé la confidentialité du participant et ne vous identifiera pas par nom. Il est entendu que vous êtes libre de vous retirer de l'étude en tout temps. Si c'est le cas, votre enregistrement sera rétracé et détruit. Les bandes audio seront conservées pendant une durée de 5 ans après la fin de la recherche, à quel point elles seront détruites.

__________________________ m'a expliqué la raison de l'enregistrement audio. Je me suis familiarisé avec le formulaire de consentement et j'en ai reçu une copie. J'ai également eu la possibilité de poser des questions et le cas échéant, j'ai reçu des réponses satisfaisantes. Après réflexion, j'accepte que le contenu de l'entrevue soit enregistrée.

Nom du sujet majeur en lettres détachées

__________________________ Consentement du sujet majeur Date

Formule d'engagement du chercheur

Le projet de recherche a été décrit au participant ainsi que les modalités de sa participation. Un membre de l'équipe de recherche a répondu à ses questions et lui a expliqué que la participation est libre et volontaire. Je m'engage à respecter ce qui a été convenu dans le formulaire de consentement.

__________________________ Signature du chercheur Date
Projet de recherche intitulé :
Trajectoires et patrons d’utilisation de soins et de services de santé chez des jeunes ayant fait une tentative de suicide.

Chercheurs :

Drè Johanne Renaud M.D. M.Sc. FRCPC  
Drè Monique Séguin Ph.D.  
Dr Alain D Lesage M.D. M.Phil.  
Dr Jean-Jacques Breton M.D. M.Sc  
Dr Gustavo Turecki M.D. Ph.D.

Formulaire de Consentement des Parents pour la Participation de leur Enfant

CÉR Hôpital Douglas  
Approuvé : 15 Décembre, 2009
1. **Titre de l’étude**

Votre enfant est invité à participer à un projet de recherche intitulé : Trajectoires et patrons d'utilisation de soins et de services de santé chez des jeunes ayant fait une tentative de suicide.

2. **Nom des chercheurs**

Cette étude est sous la responsabilité du Dr Johanne Renaud M.D. M.Sc. FRCPC, chercheur principal et pédopsychiatre travaillant au Centre de recherche de l'Hôpital Douglas et de Monique Séguin Ph.D., psychologue et co-chercheur principal travaillant à l'Université du Québec en Outaouais et de leurs collaborateurs: Alain D Lesage M.D. M.Phil., Jean-Jacques Breton M.D. MSc., et Gustavo Turecki M.D. Ph.D.

3. **Subvention au projet**

Le projet est financé par le National Alliance for Research in Schizophrenia and Affective Disorders (NARSAD).

4. **Description et but du projet**

Cette étude permettra de mieux établir en quoi les individus ayant fait une tentative de suicide se différencient de ceux qui se sont enlevés la vie en termes de besoins non comblés et de trajectoires d'utilisation de services de santé, dans les 12 mois précédant la tentative de suicide. Cette comparaison se fera en fonction du type de services utilisés par votre enfant, de la fréquence et de la collaboration aux services.

5. **Déroulement du projet**

Deux entretiens d'une durée approximative de 3 heures seront effectuées avec votre enfant ayant fait une tentative de suicide. Les entretiens auront lieu de préférence au Centre de recherche de l'Hôpital Douglas ou à son domicile du participant si celui-ci refuse de se déplacer à l'hôpital. Les questionnaires porteront sur divers facteurs de protection, sur les différentes difficultés psychologiques de votre enfant et les services de santé consultés.

6. **Avantages et bénéfices**

Il n'y a aucun avantage ni bénéfice direct à sa participation à ce projet de recherche. Toutefois, nous croyons que cette étude québécoise contribuera à l'amélioration des connaissances concernant le suicide chez les jeunes et à l'amélioration des services et des interventions à promouvoir auprès des jeunes à risque de se suicider et de leur famille.
7. **Inconvénients et risques**

Aucun risque physique n’est associé à sa participation à l’étude. Certaines personnes ressentiront parfois une fatigue à la suite des entrevues. Il est possible que des souvenirs pénibles reviennent à la mémoire des participants pendant les entretiens. Des émotions désagréables peuvent apparaître. Par conséquent, l’état émotif de l’adolescent(e) et des parents sera pris en compte tout au long de l’entretien, afin de respecter leur rythme. Les assistantes de recherche sont des professionnelles de la santé formées et qualifiées pour juger de l’état clinique des adolescent(e)s.

De plus, toutes les mesures requises afin d’assurer la confidentialité des participants seront prises tel que mentionné dans la section confidentialité.

8. **Retrait du projet**

Veuillez noter qu’en tout temps il vous est possible de retirer votre enfant de l’étude, le cas échéant les résultats de l’entrevue seront détruits. Il vous sera possible de contacter Dr. Johanne Renaud au Centre de recherche de l’Hôpital Douglas à cette fin.

9. **Confidentialité**

Toutes les données recueillies et diffusées seront traitées de façon non nominale, c’est-à-dire codées, afin d’assurer la confidentialité. Seuls le Dr Johanne Renaud, psychiatre responsable du projet et Mme Marie Martine Beaulieu, coordonnatrice, auront accès aux informations nominales pendant le projet, qui seront gardées sous clé. Les résultats des investigations seront conservés dans le dossier de recherche pendant une durée de 5 ans après la fin de la recherche puis détruits. Cependant, aux fins de vérifier la saine gestion de la recherche, il est possible qu’un délégué du comité d’éthique de la recherche ou de l’organisme subventionnaire (National Alliance for Research in Schizophrenia and Affective Disorders) consulte les données de recherche et le dossier médical du sujet à l’étude.

Par ailleurs, les résultats de cette étude pourront être publiés ou communiqués dans un congrès scientifique mais aucune information pouvant identifier les participants ne sera alors dévoilée.

10. **Communication des résultats**

Les résultats individuels aux tests ne seront pas communiqués. Les résultats généraux vous seront transmis par Dr. Johanne Renaud par courrier à la fin de l’étude.

11. **Responsabilité**

En signant ce formulaire de consentement, vous ne renoncez à aucun de vos droits prévus par la loi et ne libérez ni les chercheurs ni l’établissement de leurs responsabilités civiles ou professionnelles.
12. **Indemnités**

Une indemnité de 25$ pour les frais de déplacement est donnée dans ce projet.

13. **Liberté de participation**

La participation de votre enfant est libre et volontaire. Cela signifie que le refus de participer à la recherche ne nuirait pas à ses relations avec son médecin ou les autres intervenants.

14. **Personnes-ressources**

Pour toute information complémentaire concernant le projet de recherche ou pour tout changement d’adresse, vous pouvez communiquer par téléphone avec le coordinateur du projet de recherche, Madame Marie Martine Beaulieu au 514-761-6131 poste 3316, ou sur la ligne sans frais au 1-866-256-6888.

Si vous souhaitez discuter de la participation de votre enfant à l’étude avec une personne qui n’est pas directement impliquée dans le projet de recherche ou formuler une plainte, nous vous invitons à communiquer avec Francine Y. Bourassa (Ombudsman, Institute Douglas) au 514-761-6131 poste 3287.
15. Consentement

On m’a expliqué la nature et le déroulement du projet de recherche. J’ai pris connaissance du formulaire de consentement et on m’en a remis un exemplaire. J’ai eu l’occasion de poser des questions auxquelles on a répondu. Après réflexion, j’accepte que mon enfant participe à ce projet de recherche.

Nom de l’adulte – parent du sujet en lettres détachées

Consentement de l’adulte – parent ___________________________ Date __________

Nom de l’enfant participant au projet en lettres détachées

Assentiment de l’enfant ___________________________ Date __________

Nous vous rappelons qu’il existe deux formulaires portant des signatures originales dont un vous est laissé pour vos dossiers.

16. Formule d’engagement du chercheur

Le projet de recherche a été décrit au parent et au participant ainsi que les modalités de la participation de l’enfant. Un membre de l’équipe de recherche a répondu à ses questions et lui a expliqué que la participation est libre et volontaire. Je m’engage à respecter ce qui a été convenu dans le formulaire de consentement.

Signature du chercheur ___________________________ Date __________

[Logo de l’Hôpital Douglas Hospital Research Centre]
Enregistrement de l'Entrevue
Formulaire de Consentement

Dans le cadre du projet de recherche : Trajectoires et patrons d'utilisation de soins et de services de santé chez des jeunes ayant fait une tentative de suicide, nous vous demandons la permission d'enregistrer le contenu de l'entrevue. Ces enregistrements audio seront effectués afin de soutenir la prise d'information.

L'enregistrement sera traité de façon à préserver la confidentialité du participant et ne vous identifiera pas par nom. Il est entendu que vous êtes libre de vous retirer de l'étude en tout temps. Si c'est le cas, votre enregistrement sera rétracté et détruit. Les bandes audio seront conservées pendant une durée de 5 ans après la fin de la recherche, à quel point elles seront détruites.

__m'a expliqué la raison de l'enregistrement audio. Je me suis familiarisé avec le formulaire de consentement et j'en ai reçu une copie. J'ai également eu la possibilité de poser des questions et le cas échéant, j'ai reçu des réponses satisfaisantes. Après réflexion, j'accepte que le contenu de l'entrevue soit enregistrée.__

Nom de l'adulte – parent du sujet en lettres détachées

Consentement de l'adulte – parent ___________________________ Date ___________________________

Nom de l'enfant participant au projet en lettres détachées

Assentiment de l'enfant ___________________________ Date ___________________________

Le projet de recherche a été décrit au participant ainsi que les modalités de sa participation. Un membre de l'équipe de recherche a répondu à ses questions et lui a expliqué que la participation est libre et volontaire. Je m'engage à respecter ce qui a été convenu dans le formulaire de consentement.

Signature du chercheur ___________________________ Date ___________________________
APPENDIX B: Semi-structured Interview Questions (Eng. and Fr.)

English version:

1) What does “spirituality” mean for you? What does “religion” mean for you?

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

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

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

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

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

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

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

4 a) Did this group or community, provide help or advice in dealing with mental health issues*? (Y/N)

What was their opinion about receiving mental health services?

Did this affect your attitude about mental health services? (Y/N)

Did it impact your willingness to use services? (Y/N)

4 b) Did your spirituality or religion provide guidance in dealing with mental health issues? (Y/N)

What was your opinion about receiving mental health services?

Did your spirituality or religion affect your attitude about mental health services? (Y/N)

Did it impact your willingness to use services? (Y/N)

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

(If YES) Do you believe in the same spirituality or religion as your parent(s)? (Y/N)
(If NO), Did this bring about any difficulties? (i.e. Did it impact your willingness to share what’s bothering you with your parents? Did it impact your desire to use services?) (Y/N)

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

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

(If YES) What happened?

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

(If YES) What happened?

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

1) Qu'est ce que la spiritualité signifie pour vous? Qu'est ce que la religion signifie pour vous?

2) a) Dans l’année précédant ton geste (TENTATIVE DE SUICIDE), y avait-t-il une spiritualité ou une religion importante pour toi? (O/N) *(Après cette question, utilisez seulement les croyances spirituelles ou religieuses selon les mots utilisés par le jeune).*

   Si OUI à la Question #2a, allez à la Q#3a

   Si NON à la Question #2a, allez à la Q#3b

2) b) Est-ce que cela a été ainsi depuis que ta naissance? (O/N) *(rechercher la possibilité de conversion).* *(Si la réponse est non), Quand cela a-t-il changé? (noter si cela s’est produit dans l’année précédant la tentative de suicide).*

2) c) Y a-t-il quelqu'un dans votre entourage pour qui la spiritualité ou à la religion est importante ? (O/N) Qui est cette personne?

3) a) Dans l’année précédant ton geste (TENTATIVE DE SUICIDE), appartenais-tu à un groupe/communauté spirituel(e) ou religieux (se)*? (O/N).

3) b) Est-ce que cela a été ainsi depuis ta naissance? (O/N). *(rechercher la possibilité de conversion).* *(Si la réponse est non), Quand cela a-t-il changé? (noter si cela s’est produit dans l’année précédant la tentative de suicide).*

4) a) Est-ce que ce groupe ou communauté t’a aidé ou guidé dans tes problèmes de santé mentale?

   Quelle était leur opinion sur le fait de recevoir des services de santé mentale? Est-ce que cela a influencé ton attitude à propos des services de santé mentale?

   Est-ce que cela a eu un impact sur ta volonté à utiliser des services?

4) b) Est-ce que tu crois que ta spiritualité ou religion t’a guidé dans tes problèmes de santé mentale?

   Quelle était ton opinion sur le fait de recevoir des services de santé mentale?

   Est-ce que ta spiritualité ou religion a influencé ton attitude à propos des services de santé mentale?

   Est-ce que cela a eu un impact sur ta volonté à utiliser des services?

5) Y a-t-il une spiritualité ou religion importante pour tes parents? (O/N)?

   *Si la réponse est oui: Crois-tu dans la même spiritualité ou religion que tes parents?
Si la réponse est non: Est-ce que cela t’a causé des problèmes? (C’est-à-dire : Est-ce que cela a eu un impact sur ta volonté à partager avec eux les raisons de tes difficultés? Est-ce que cela a eu un impact sur ton désir d’utiliser des services?)

6) Dans l’année précédant le geste (TENTATIVE DE SUICIDE) y a-t-il eu des éléments dans les services que tu as reçus qui étaient contraires à tes croyances spirituelles ou religieuses*?

7) Dans l’année précédant ton geste (TENTATIVE DE SUICIDE), étais-tu en contact avec quelqu’un en lien avec ta spiritualité ou religion pour recevoir de l’aide? (O/N)

(Si oui), qu’est-il arrivé?


(Si oui), qu’est-il arrivé?

9) Y a-t-il des aspects de ta spiritualité/religion que tu souhaiterais que les intervenants de santé/le système/services de santé mentale gardent en tête lorsqu’ils prennent soins de toi*? (Si oui), quels sont-ils?
**APPENDIX C: Spirituality Scale (Eng. and Fr.)**

**English version:**

Please indicate your level of agreement to the following statements by circling the appropriate number that corresponds with the answer key.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Mostly disagree</th>
<th>Mostly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find meaning in my life experiences.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have a sense of purpose.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am happy about the person I have become</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I see the sacredness in everyday life.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I meditate to gain access to my inner spirit.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I live in harmony with nature.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I believe there is a connection between all things that I cannot see but can sense.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My life is a process of becoming.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I believe in a Higher Power/Universal Intelligence.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I believe that all living creatures deserve respect.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The earth is sacred.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I value maintaining and nurturing my relationships with others.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I use silence to get in touch with myself.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I believe that nature should be respected.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have a relationship with a Higher Power/Universal Intelligence.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My spirituality gives me inner strength.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am able to receive love from others.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Please indicate your level of agreement to the following statements by circling the appropriate number that corresponds with the answer key.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Mostly disagree</th>
<th>Mostly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. My faith in a Higher Power/Universal Intelligence helps me cope during challenges in my life.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19. I strive to correct the excesses in my own lifestyle patterns/practices.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
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</tr>
<tr>
<td>20. I respect the diversity of people.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
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</tr>
<tr>
<td>21. Prayer is an integral part of my spiritual nature.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>22. At times, I feel at one with the universe.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>23. I often take time to assess my life choices as a way of living my spirituality.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
S'il te plaît, indique ton niveau d'accord avec les énoncés suivants en noircissant le cercle correspondant à ta réponse.

<table>
<thead>
<tr>
<th>Énoncé</th>
<th>Fortement en accord</th>
<th>En désaccord</th>
<th>Partiellement en accord</th>
<th>En accord</th>
<th>Partiellement en discorde</th>
<th>En discorde</th>
</tr>
</thead>
<tbody>
<tr>
<td>Je trouve du sens dans les expériences que je vis.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Je suis déterminé</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je suis content de la personne que je suis devenue</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je vois le caractère sacré de la vie de tous les jours</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je médite pour avoir accès à ma vie spirituelle.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je vis en harmonie avec la nature.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je crois qu'il y a un lien entre toutes les choses que je ne peux voir, mais je peux ressentir.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ma vie est un processus en devenir.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je crois en une puissance supérieure/intelligence universelle.</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je crois que toute créature vivante mérite le respect</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>La terre est sacrée</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J'apprécie maintenir et entretenir mes relations avec les autres</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J'utilise le silence pour entrer en contact avec moi-même</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je crois que la nature devrait être respectée</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J'ai une relation avec une puissance supérieure/intelligence universelle</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ma spiritualité me donne une force intérieure</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je suis capable de recevoir de l'amour des autres</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Échelle de Spiritualité -FRA (suite)

S'il te plaît, indique ton niveau d'accord avec les énoncés suivants en noirceur le cercle correspondant à ta réponse.

<table>
<thead>
<tr>
<th>Ma foi en une puissance supérieure/intelligence universelle m'aide à relever les défis dans ma vie</th>
<th>Fortement en désaccord</th>
<th>En désaccord</th>
<th>Partiellement en accord</th>
<th>En accord</th>
<th>Fortement en accord</th>
</tr>
</thead>
<tbody>
<tr>
<td>o o o o o o</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je m'efforce de corriger les excès de mon style/mon habitudes de vie</td>
<td>o o o o o o</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je respecte les différences entre les gens</td>
<td>o o o o o o</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>La prière fait partie intégrante de mon être spirituel</td>
<td>o o o o o o</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Par moment, je sens que je ne fais qu'un avec l'univers</td>
<td>o o o o o o</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Je prends souvent le temps d'évaluer mes choix de vie comme manière de vivre ma spiritualité</td>
<td>o o o o o o</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>